

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 152635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/18/2024	
NAME OF PROVIDER OR SUPPLIER US RENAL CARE LAFAYETTE DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP COD 915 MEZZANINE DR LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 0000 Bldg. 00	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62</p> <p>Survey Dates: 10/16/2024 to 10/18/2024</p> <p>Active Census: 72 In-center Hemodialysis Patients</p> <p>At this Emergency Preparedness Survey, US Renal Care Lafayette , was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62</p>			E 0000	The Governing Body (GB) convened on 11/1/24 to review the statement of deficiencies and the associated Plan of Correction (POC).		
V 0000 Bldg. 00	<p>This survey was for a federal ESRD recertification (CORE) survey.</p> <p>Survey Dates: 10/16/2024 to 10/18/2024</p> <p>Census:</p> <p>72 In-center Hemodialysis Patients No Home Hemodialysis Offered No Home Peritoneal Dialysis Offered</p> <p>QR: A 1 10/25/24</p>			V 0000			
V 0126 Bldg. 00	<p>494.30(a)(1)(i) IC-HBV-VACCINATE PTS/STAFF</p>			V 0126	All patient vaccination records		11/17/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Lisa Pharis

RN,BSN,CNN

11/08/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/18/2024	
NAME OF PROVIDER OR SUPPLIER US RENAL CARE LAFAYETTE DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 915 MEZZANINE DR LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Based on record review and interview the clinic failed to evidence they vaccinated their patients, identified to be susceptible to Hepatitis B (liver infection), for Hepatitis B in 16 of 28 Patients identified with a Hepatitis B surface antibody of less than 10 (susceptible to Hepatitis B) and who were not vaccinated, nor declined the vaccine nor were nonconverters (after 2 series of Hepatitis B vaccines antibodies remain less than 10) Patients (Patients # 5, 8, 16, 19, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, and 36).</p> <p>Findings include:</p> <p>1. A revised policy dated 11/2022, titled, "Patient Hepatitis B/Testing/Vaccination/Seroconversion," indicated all Patients would be tested to ensure Patients are managed based on test results for anti-hbs (develops in a person successfully vaccinated against Hepatitis B) and would be completed annually. The policy indicated a physician order would be obtained and offered a vaccine to all susceptible patients within 3 days of the lab results. The policy indicated that if the anti-HBs declined to less than 10 after annual results a booster would be administered.</p> <p>2. A Hepatitis Clinic Management form with Administrator documentation, received on 10/17/2024, indicated the following:</p> <p>A. Patient #5 had a Hepatitis B vaccine series in 2023, had a HBSQ (surface antibody) of <4 on 02/13/2024 and indicated a 2nd series would be offered.</p> <p>B. Patient #8 had a Hepatitis B vaccine series in 2017, 1 dose in 2020, had a HBSQ of <4 on 02/07/2024 and indicated a Hepatitis B vaccine would be offered.</p>				<p>were reviewed within seven days of the survey date. Patients who had missed hepatitis B vaccinations were educated on the vaccine's importance, offered the vaccination upon consent, and updated their records accordingly.</p> <p>The Facility Administrator (FA) will conduct an in-service for all clinical staff on Policy C-IC-0110 Patient Hepatitis B Testing/Vaccination/Seroconversion, related to protocols for patient hepatitis B testing, vaccination, and monitoring. This training will emphasize obtaining timely physician orders and offering hepatitis B vaccines to all susceptible patients within three days of receiving lab results. The first vaccine dose will be administered within 30 days of patient admission.</p> <p>The FA will implement a tracking system to monitor Hepatitis B vaccination schedules, ensuring the timely administration of follow-up doses. To verify adherence to this schedule, the FA or designee will audit 100% of hepatitis B-susceptible patients weekly for 4 weeks, then bi-weekly for an additional 4 weeks.</p> <p>The FA will review all education efforts and audit findings in monthly QAPI and Governing Body (GB) meetings to identify trends and monitor compliance. If progress is found to be</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 152635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/18/2024	
NAME OF PROVIDER OR SUPPLIER US RENAL CARE LAFAYETTE DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP COD 915 MEZZANINE DR LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>C. Patient #16 had a previous 1st Hepatitis B series vaccine, had a HBSQ <4 on 02/08/2024 and 07/25/2024, and indicated a 2nd series would be offered.</p> <p>D. Patient #19 had a Hepatitis B series, had a HBSQ <4 on 01/27/2024. and a series would be offered.</p> <p>E. Patient #25 had a previous 1st Hepatitis B series in 08/2022, had a HBSQ <4 on 02/07/2024, and a series would be offered.</p> <p>F. Patient #26 had HBSQ <4 on 06/26/2024, and a series would be offered.</p> <p>G. Patient #27 had a 1st Hepatitis B series in 2022, had a HBSQ <4 on 02/07/2024, and a series would be offered.</p> <p>H. Patient #28 had a HBSQ <4 on 02/07/2024, and a Hepatitis B series vaccine would be offered.</p> <p>I. Patient #29 had a HBSQ <4 on 02/08/2024, and a Hepatitis B series vaccine was ordered for November 2024.</p> <p>J. Patient #30 had a HBSQ <4 on 02/07/2024, and a Hepatitis B series vaccine would be offered.</p> <p>K. Patient #31 had a previous 1st Hepatitis B series, had a HBSQ <4 on 02/07/2024 and a Hepatitis B vaccine was ordered for November 2024.</p> <p>L. Patient #32 had a previous 1st Hepatitis B series, had a HBSQ <4 on 02/08/2024, and a 2nd Hepatitis B series vaccine would be offered.</p>				insufficient, the POC will be re-evaluated, and necessary adjustments will be made, including re-education, performance discussions, and continued monitoring until substantial compliance is achieved.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 152635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/18/2024	
NAME OF PROVIDER OR SUPPLIER US RENAL CARE LAFAYETTE DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP COD 915 MEZZANINE DR LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>M. Patient #33 had a HBSQ <4 on 03/21/2024, and a Hepatitis B series vaccine was ordered for November 2024.</p> <p>N. Patient #34 had a HBSQ of 6 on 01/03/2024, and a Hepatitis B series vaccine would be offered.</p> <p>O. Patient #35 had a HBSQ <4 on 02/09/2024, and a Hepatitis B series vaccine would be offered.</p> <p>P. Patient #36 had a HBSQ <4 on 02/08/2024, and a Hepatitis B series vaccine would be offered.</p> <p>3. During an interview on 10/16/2024 beginning at 7:30 PM, Registered Nurse (RN) 2 indicated the nurses look at Patients' labs and determine if a Hepatitis B vaccine was needed. RN2 indicated Hepatitis B antibodies (protection from Hepatitis B if >10) were checked every month and Hepatitis B antigen (test for liver infection) were completed 2 times per year.</p> <p>4. During an interview on 10/17/2024, beginning at 10:20 AM, RN 1 indicated he/she did not address the Hepatitis B labs.</p> <p>5. During an interview on 10/16/2024, beginning at 7:45 PM, the Administrator indicated she began reviewing the Hepatitis B labs in July 2024, after becoming the Interim Administrator. The Administrator indicated the facility does not give Hepatitis B boosters, they do give Hepatitis B vaccine series; she relayed antibodies were checked every year and if the antibodies are <10 should be addressed; she relayed antigens were drawn monthly. She relayed for a Patient who received 2 series of Hepatitis B vaccine and their antibodies were not >10 after the 2 vaccine series, were considered nonresponsive.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 152635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/18/2024	
NAME OF PROVIDER OR SUPPLIER US RENAL CARE LAFAYETTE DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP COD 915 MEZZANINE DR LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
V 0453 Bldg. 00	<p>6. During an interview on 10/18/2024, beginning at 8:40 AM, the Administrator indicated the HBSQ value on the lab results was the antibody test; if the antibodies were <10 the Patient was considered susceptible to Hepatitis B and should be offered a Hepatitis B vaccine. The Administrator indicated he/she had documented the Hepatitis B plan for each Patient on the Hepatitis B Clinic Management form, received on 10/17/2024.</p> <p>7. During an interview on 10/17/2024, beginning at 12:00 PM, the Medical Director indicated the Facility's Administrator should monitor the Hepatitis B labs and follow the Hepatitis B protocol.</p> <p>494.70(a)(2) PR-RECEIVE UNDERSTANDABLE INFORMATION</p> <p>Based on observation, record review, and interview the dialysis facility failed to ensure that a Spanish speaking patient received all information in a way that he or she could understand in 1 of 1 Spanish speaking patients observed (Patient #24).</p> <p>Findings include:</p> <p>1. A policy, revised date 01/2020, titled, "Limited English Proficiency," indicated limited English proficiency was defined as a person who could not speak, read write or understand the English language at a level that permitted them to interact effectively with health care providers. The policy indicated the dialysis facility would assess individual language needs upon initial contact, would utilize local interpreter resources/organizations and should contact the</p>			V 0453	<p>Upon identifying the issue, a tele-language interpreter was immediately provided to ensure the Spanish-speaking patient fully understood their care plan, rights, and responsibilities. Additionally, contact information for tele-language services has been posted at each telephone in the facility for immediate access to interpreter services.</p> <p>The Facility Administrator (FA) will conduct an in-service for all staff on Policy C-AD-0370 Limited English Proficiency, related to support for limited English proficiency (LEP) patients and the proper use of interpreter services and language resources. During admission, staff will document</p>		11/17/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 152635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/18/2024	
NAME OF PROVIDER OR SUPPLIER US RENAL CARE LAFAYETTE DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP COD 915 MEZZANINE DR LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>appropriate interpreter in the event that an interpreter was needed, outside of emergency situations, family members would not be used as interpreters unless specifically requested by the individual, children and other patients would not be used to interpret in order to ensure confidentiality of information and accurate communication, and the dialysis facility would reevaluate changes in the types of services or needs on an ongoing basis including mechanism for securing interpreter services and feedback from patients.</p> <p>2. A revised policy dated 07/2024, titled, "Intradialytic Monitoring of Patient," indicated patient teaching would include the Patient would recognize and report early signs or symptoms of complications.</p> <p>3. A Plan of Care dated 03/14/2024 indicated Patient #24 was Spanish speaking and may not fully comprehend what he/she would read, Patient does not speak English, the family members interpret for Patient, and it was difficult to evaluate Patient's understanding of medications related to the language barrier.</p> <p>A. A Psychosocial Progress note dated 08/22/2024 indicated the Social Worker [SW] spoke to Patient #24, Patient was wincing, the SW asked Patient if he/she was ok and Patient shook his/her head yes. The documentation indicated the SW asked Patient if he/she had any area of concern, and Patient shook his/her head no. The visit note failed to evidence a translation line was utilized or family members were contacted to translate and / or verify Patient understood the SW's questions.</p> <p>B. An Adverse Occurrence Note dated 06/15/2024,</p>				<p>each patient's preferred language in the medical record, with the EMR system flagging language needs at every interaction to ensure consistent communication support.</p> <p>The FA or designee will conduct monthly audits for four months, including 100% of all new admissions and 25% of all other patient records, to confirm language preference and interpreter use documentation.</p> <p>After four months of 100% of patient records audited, a transition to monthly and focus on 10% of all patient records.</p> <p>Monthly QAPI and Governing Body (GB) meetings will review audit findings and staff adherence to LEP policies. Any gaps in compliance will be addressed through performance discussions and additional support, with the POC reassessed and reinforced as needed to ensure sustained adherence.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/18/2024	
NAME OF PROVIDER OR SUPPLIER US RENAL CARE LAFAYETTE DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 915 MEZZANINE DR LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>indicated Patient #24 complained of headache, after Tylenol (pain reliever) was given the pain continued to escalate. The Note indicated Patient was not able communicate with staff or via interpreter and moaned and cried.</p> <p>C. A Patient Education Acknowledgement Form dated 09/11/2024, indicated Registered Nurse (RN) 2 instructed Patient #24 on flu and covid, resources for Patient and Patient Experience Survey via verbal instruction and handouts and Patient signed, acknowledging the education was received and was given an opportunity to ask questions. The documentation failed to indicate if a family member nor use of an interpreter.</p> <p>D. A request for Patient #24's Emergency Training documentation was made on 10/18/2024 at 8:45 AM; the clinic failed to evidenced Patient received emergency training.</p> <p>E. During an observation on 10/17/2024, beginning at 10:50 AM, Patient #24 was observed at Station #3 receiving dialysis, no family member /interpreter was present, nor was there a staff member available that spoke Patient #24's native language.</p> <p>During an interview on 10/17/2024, beginning at 10:50 AM, Patient Care Technician (PCT) 5, assigned to Patient #24, indicated Patient #24 was Spanish speaking only and the staff did not have a way to communicate with Patient. PCT 5 indicated Patient did get headaches, would make a face if he/she was having problems; PCT 5 indicated the staff would call Patient's family member if unable to understand Patient. PCT 5 indicated Patient could not read Spanish to utilize Google Translate Application. When asked, PCT 5 indicated they were unaware of a translation line</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 152635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/18/2024	
NAME OF PROVIDER OR SUPPLIER US RENAL CARE LAFAYETTE DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP COD 915 MEZZANINE DR LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>available to facilitate communication with Patient.</p> <p>F. During an interview on 10/17/2024, beginning at 10:50 AM, RN 1 indicated Patient #24 was Spanish speaking only and would utilize one PCT that could translate for Patient if the PCT was working.</p> <p>G. During an interview on 10/18/2024, beginning at 10:30 AM, RN 2 indicated he/she communicated the best they could with Patient #24, indicated they know if Patient has a problem by the expression on their face. RN 2 indicated Patient had ongoing headaches during dialysis, and they call Patient's family member to communicate, if needed.</p> <p>H. During an interview on 10/16/2024, beginning at 7:00 PM, PCT 2 indicated during care, he/she does not use a translator line for Patient #24, would use the Google Translate Application, or would utilize the one PCT that could translate if available. PCT 2 indicated they would call the family member to communicate with Patient, if needed. PCT 2 indicated in the event emergency procedures were implemented, staff would need to disconnect Patient due to Patient would not understand the emergency disconnect procedures.</p> <p>I. During an interview on 10/17/2024, beginning at 1:55 PM, the SW indicated no discussion had yet occurred with Patient #24 regarding transplant. The SW indicated there were 4 Spanish speaking Patients in their dialysis clinic and the staff were to utilize a translation line for interpreting.</p> <p>J. During an interview on 10/16/2024, beginning at 6:25 PM, RN 2 indicated he/she would call a family member to translate for Patient #24 and did not use a translation line.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 152635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/18/2024	
NAME OF PROVIDER OR SUPPLIER US RENAL CARE LAFAYETTE DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP COD 915 MEZZANINE DR LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
V 0543 Bldg. 00	<p>K. During an interview on 10/17/2024, beginning at 12:00 PM, the Medical Director indicated the dialysis facility staff should utilize a translator line for communication with a Patient with a language barrier and should not utilize the Google Translate Application. The Medical Director indicated that the nephrology physician's office connected to the dialysis facility had a translation device available however, the dialysis facility did not utilize the device. The Medical Director indicated concerns related to translation for Patients had been discussed with the governing body.</p> <p>L. During an interview on 10/18/2024, beginning at 8:40 AM, the Administrator indicated that the dialysis facility would begin staff in-service training for translation services available.</p> <p>494.90(a)(1) POC-MANAGE VOLUME STATUS</p> <p>Based on record review and interview, the dialysis clinic failed to evidenced blood pressures, outside of standing orders or reportable parameters,were reported to the registered nurse [RN] per policy, in 2 of 3 Patients clinical records reviewed with an admission date after 04/08/2024 (Patient #2 and 6).</p> <p>Findings include:</p> <p>1. A revised policy dated 07/2024, titled, "Intradialytic Monitoring of Patient," indicated the charge nurse would be notified of vital signs outside of standing orders and/or reportable parameters. The policy indicated direct care staff would monitor the Patient's volume status indicated by changes in blood pressure parameters.</p>			V 0543	<p>The Facility Administrator (FA) will conduct in-service training for all clinical staff on Policies C-ID-0010 Intradialytic Monitoring of Patient and C-Forms-0081 Reportable Parameters, emphasizing the importance of timely monitoring and reporting of blood pressure readings outside reportable parameters to the RN. This training will reinforce proper documentation and the need for effective communication regarding abnormal readings.</p> <p>The FA will conduct audits daily on each shift of 25% of patients x 2 weeks, then weekly x 4 on 10% of patient records to verify that</p>		11/17/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 152635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/18/2024	
NAME OF PROVIDER OR SUPPLIER US RENAL CARE LAFAYETTE DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP COD 915 MEZZANINE DR LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>2. A form dated 01/2020, titled, "Reportable Parameters to CN [clinical nurse]," indicated the Patient Care Technician (PCT) should report to charge nurse post dialysis systolic blood pressure >180 or diastolic blood pressure >100.</p> <p>3. The clinical record for Patient #2, included a review of the most recent 10 Treatment Flow Sheets:</p> <p>A. The flow sheet dated 10/01/2024, indicated Patient's blood pressure, post treatment, was 195/85.</p> <p>B. The flow sheet dated 10/05/2024, indicated Patients post treatment blood pressure was 178/111 and 189/87.</p> <p>C. The flow sheet dated 10/10/2024, indicated Patients post treatment blood pressure was 182/96.</p> <p>The record failed to evidence documentation the PCT notified the RN of the post treatment blood pressures outside of the reportable parameters on October 01, 05, and 10, 2024.</p> <p>4. The clinical record for Patient #6, included a review the dialysis treatment flow sheets dated 9/21/24 to 10/15/24.</p> <p>The flow sheet, dated 9/21/24, included a post treatment orthostatic blood pressure (blood pressure change with change of position) of 172/72 sitting and 131/71 standing.</p> <p>The flow sheet dated 9/28/24 noted the post treatment orthostatic blood pressure of 188/83 sitting and 144/67 standing.</p> <p>The flow sheet dated 10/03/24 noted the post</p>				<p>blood pressure readings outside reportable parameters were communicated to the RN and appropriately documented. When adherence is achieved per the GB, audits will transition to monthly per the Quality Management Workbook (QMWB) audit schedule.</p> <p>Audit results and adherence to reporting protocols will be reviewed monthly in Quality Assurance and Performance Improvement (QAPI) and Governing Body (GB) meetings. Any deficiencies identified will prompt re-education or adjustments to the process, with continued monitoring to ensure sustained compliance.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 152635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/18/2024	
NAME OF PROVIDER OR SUPPLIER US RENAL CARE LAFAYETTE DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP COD 915 MEZZANINE DR LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>treatment orthostatic blood pressure was 184/62 sitting and 135/66 standing.</p> <p>The flow sheet dated 10/05/2024, noted the post treatment blood pressure was 146/124.</p> <p>The flowsheet dated 10/08/2024, the post treatment orthostatic blood pressure was 133/56 sitting and 99/66 standing.</p> <p>The flowsheet dated 10/10/2024, the post treatment orthostatic blood pressure was 165/98 sitting and 133/69 standing.</p> <p>The flowsheet dated 10/15/2024, the post treatment orthostatic blood pressure was 159/83 sitting and 139/77 standing.</p> <p>The Treatment Flow Sheets failed to evidence documentation the nurse was notified of the orthostatic blood pressure changes or the blood pressures outside of the reportable parameters.</p> <p>5. During an interview on 10/16/2024, beginning at 7:00 PM, PCT 2 indicated vitals signs outside of the parameters should be reported to the nurse and documentation of the notification should be completed.</p> <p>6. During an interview on 10/17/2024, beginning at 12:00 PM, the Medical Director indicated a systolic blood pressure greater than 180 may require an as needed blood pressure medication (clonidine) if the Patient had an order. If the Patient did not have an order for an as needed blood pressure medication, a systolic blood pressure greater than 180 would require notifying the physician.</p> <p>7. During an interview on 10/18/2024, beginning at</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/18/2024	
NAME OF PROVIDER OR SUPPLIER US RENAL CARE LAFAYETTE DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 915 MEZZANINE DR LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
V 0550 Bldg. 00	<p>10:00 AM, the Administrator indicated the PCT should notify the nurse and document a Patient's blood pressure post dialysis treatment outside of reportable parameters and orthostatic blood pressure changes greater than 20 points.</p> <p>494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS</p> <p>Based on observation, record review, and interview, the clinic failed to ensure their staff cleansed the arteriovenous fistula (AVF) (entry into the blood vessel for hemodialysis [process to clean the blood of a patient whose kidneys do not work properly]) prior to cannulation (needle insertion) in 3 of 3 AVF cannulations observed (Patient Care Technicians 1, 2, and 3).</p> <p>Findings include:</p> <p>1. A revised policy dated 10/2023, titled, "Assessment and Cannulation for AV Fistula/Graft and Patient Self Cannulation," indicated the access preparation for an AVF would include to disinfect each access site separately with alcohol prep pad and repeat access preparation if cannulation area had been touched/contaminated.</p> <p>2. During an observation on 10/16/2024 at station #4 beginning at 11:30 AM, Patient Care Technician (PCT) 2 cleaned Patient #13's right AVF site with alcohol prep pads, then palpated the site again and cannulated using the 1st line without disinfecting the access prior to cannulation. Then PCT 2 palpated the AVF and cannulated the 2nd line.</p> <p>3. During an observation on 10/17/2024, beginning</p>			V 0550	<p>The Facility Administrator (FA) will conduct an in-service training for all clinical staff on Policy C-TI-0030: Assessment and Cannulation for AV Fistula/Graft and Patient Self-Cannulation. The training will focus on proper assessment and cannulation techniques for AV Fistulas (AVF) and grafts and the critical "no re-palpation after disinfection" rule. If "re-palpation is unavoidable, re-disinfection of site will be completed per policy. Practical demonstrations will be included to reinforce the correct techniques for AVF cannulation.</p> <p>The FA will conduct vascular access audits daily x 5 and weekly x 4 each shift on 10% of cannulation procedures to ensure compliance with disinfection protocols. These audits will focus on adherence to the "no re-palpation after disinfection" requirement. Audits will transition to monthly per the QMWB schedule when adherence is achieved per the GB.</p> <p>Audit results and overall compliance with AVF disinfection</p>		11/17/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 152635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/18/2024	
NAME OF PROVIDER OR SUPPLIER US RENAL CARE LAFAYETTE DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP COD 915 MEZZANINE DR LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
V 0551 Bldg. 00	<p>at 9:35 AM, PCT 1 cleaned Patient #19's left upper arm AVF site with alcohol prep pads, then palpated the site and cannulated the 1st line without disinfecting the access. PCT 2 then palpated the AVF and cannulated the 2nd line. PCT 1 failed to disinfect the area after the site was palpated and prior to cannulation.</p> <p>4. During an observation on 10/17/2024, beginning at 9:40 AM, PCT 3 cleaned Patient #20's left arm AVF site with alcohol prep pads at station #10, palpated the site and cannulated using the 1st line, and PCT 3 palpated the AVF and cannulated the 2nd line. PCT 3 failed to disinfect the area after the site was palpated and prior to cannulation.</p> <p>5. During an interview on 10/16/2024, beginning at 7:00 PM, PCT 2 indicated an AVF site should not be palpated after being disinfected and if the site was to be re-palpated, disinfection with an alcohol pad was to be completed.</p> <p>6. During an interview on 10/17/2024, beginning at 11:00 AM, PCT 3 indicated he/she tried not to palpate an AVF site after disinfecting and before cannulation; she indicated the AVF site should not be palpated after disinfection.</p> <p>494.90(a)(5) POC-VA MONITOR/PREVENT FAILURE/STENOSIS</p> <p>Based on observation, record review, and interview, the dialysis facility failed to ensure the arteriovenous fistula (AVF) (entry into a blood vessel to receive hemodialysis [process to clean the blood of a patient whose kidneys do not work properly]) was auscultated (listening usually with a stethoscope) for a bruit (swishing sound caused</p>			V 0551	<p>protocols will be reviewed in monthly Quality Assurance and Performance Improvement (QAPI) and Governing Body (GB) meetings. Any instances of non-adherence will trigger re-education, including retraining and potential performance discussions if necessary.</p> <p>The Facility Administrator (FA) will conduct an in-service training for all clinical staff on Policy C-TI-0030: Assessment and Cannulation for AV Fistula/Graft and Patient Self-Cannulation. The training will focus on properly assessing AV fistulas (AVF) and</p>		11/17/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 152635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/18/2024	
NAME OF PROVIDER OR SUPPLIER US RENAL CARE LAFAYETTE DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP COD 915 MEZZANINE DR LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
V 0637 Bldg. 00	<p>by blood flow through an artery) in 2 of 3 AVF cannulations observed (PCT 1 and 3).</p> <p>Findings include:</p> <p>1. A revised policy dated 10/2023, titled, "Assessment and Cannulation for AV Fistula/Graft and Patient Self Cannulation," indicated an AVF access assessment would include palpating access for thrill (vibration felt by touch) and using a stethoscope to listen for a bruit.</p> <p>2. During an observation on 10/17/2024, beginning at 9:30 AM, Patient Care Technician (PCT) 1 palpated Patient #19's left upper arm AVF and cannulated (accessed with needle) the AVF without auscultating for a bruit, prior to cannulating the AVF.</p> <p>3. During an observation on 10/17/2024, beginning at 9:40 AM, PCT 3 palpated Patient #20's left AVF and cannulated the AVF, without auscultating for a bruit, prior to cannulating the AVF.</p> <p>4. During an interview on 10/17/2024, beginning at 11:00 AM, PCT 3 indicated he/she does not auscultate the AVF for a bruit unless there are concerns with the thrill assessment.</p> <p>5. During an interview on 10/17/2024, beginning at 5:00 PM, the Administrator indicated an AVF should be auscultated for a bruit prior to cannulation and each station had a dedicated stethoscope available for use.</p> <p>494.110(a)(2)(ix) QAPI-INDICATOR-INF CONT-TREND/PLAN/ACT</p>			V 0637	<p>grafts, prior to effective cannulation techniques. Specific emphasis will be placed on prevention of access site failure and stenosis.</p> <p>The FA will conduct vascular access audits daily x 5 and weekly x 4 on each shift on 10% of cannulation procedures to ensure adherence to an assessment of AVF/AVG. These audits will focus on adherence to the auscultation and palpitation requirements. Audits will transition to monthly per the QMWB schedule when adherence is achieved per the GB.</p> <p>The results of these audits and overall compliance with AVF disinfection protocols will be reviewed in monthly quality assurance and performance improvement (QAPI) and governing body (GB) meetings. Any non-adherence will prompt re-education, retraining, and potential performance discussions, if necessary, to ensure ongoing improvement and compliance.</p> <p>The Facility Administrator (FA) will</p>		11/17/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/18/2024	
NAME OF PROVIDER OR SUPPLIER US RENAL CARE LAFAYETTE DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 915 MEZZANINE DR LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Based on record review and interview, the clinic failed to evidence their quality assessment and performance improvement (QAPI) program in place included actions plans developed to promote Hepatitis B (liver infection) immunizations for hepatitis B susceptible patients for 1 of 1 clinic.</p> <p>Findings include:</p> <p>A Facility Quality Management meeting for the month of August 2024 indicated 57% of Patients had Hepatitis B antibodies <10 (susceptible to Hepatitis B). The Plan of Action for August 2024 indicated tracking tools were not utilized or not kept up to date, indicated low immunization rates were related to issues such as patient education, and labs which were not drawn, per policy.</p> <p>During an interview on 10/16/2024, beginning at 7:45 PM, the Administrator indicated he/she started tracking the Hepatitis B labs in July 2024, after becoming the Interim Administrator.</p> <p>During an interview on 10/17/2024, beginning at 10:20 AM, Registered Nurse (RN) 1 indicated he/she did not address the Hepatitis B labs.</p> <p>During an interview on 10/16/2024 beginning at 7:30 PM, RN 2 indicated the nurses look at Patients' labs and determine if a Hepatitis B vaccine was needed. She indicated the Hepatitis B antibodies (protection from Hepatitis B if >10) were checked every month, the Hepatitis B antigen (test for liver infection) were completed 2 times per year.</p> <p>During an interview on 10/17/2024, beginning at 12:00 PM, the Medical Director indicated Facility's Administrator should monitor the Hepatitis B labs</p>				<p>in-service all clinical staff on Policy C-QM-0010: Introduction to Quality Assessment and Performance Improvement (QAPI), focusing on action plans to promote Hepatitis B immunizations for susceptible patients. Training will cover identification, documentation, and follow-up to ensure timely immunizations.</p> <p>The FA will implement a tracking system to monitor compliance with Hepatitis B immunizations. For four weeks, 100% of susceptible patients will be audited weekly, then bi-weekly for the next four weeks, followed by monthly audits per the QAPI schedule.</p> <p>Monthly QAPI and Governing Body (GB) meetings will review audit results and progress. If compliance is not on track, the POC will be re-evaluated, with necessary revisions and staff re-education.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/18/2024	
NAME OF PROVIDER OR SUPPLIER US RENAL CARE LAFAYETTE DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 915 MEZZANINE DR LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
V 0638 Bldg. 00	<p>and follow the Hepatitis B protocol. The Medical Director indicated infection issues were discussed during Quality Assessment and Performance Improvement meetings and if problems were noted audits and interventions were to be implemented.</p> <p>494.110(b) QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE</p> <p>Based on record review and interview, the facility failed to ensure a quality assessment and performance improvement (QAPI) program was in place that systematically monitored the hepatitis B [liver infection] immunization status of all patients, with performance improvements activities and tracking in place to ensure improvements were sustained in 1 of 1 dialysis clinic.</p> <p>Findings include:</p> <p>A Quality Management Meeting note dated June 2024 indicated 61% of Patients had a Hepatitis B antibody <10 (susceptible to Hepatitis B), in July 2024 61% of Patients had a Hepatitis B antibody <10, and in August 2024 57% of Patients had a Hepatitis B antibody <10.</p> <p>During an interview on 10/16/2024, beginning at 7:45 PM, the Administrator indicated he/she started tracking the Hepatitis B labs in July 2024, after becoming the Interim Administrator.</p> <p>During an interview on 10/17/2024, beginning at 12:00 PM, the Medical Director indicated Facility's Administrator should monitor the Hepatitis B labs and follow the Hepatitis B protocol. The Medical Director indicated infection issues were discussed during Quality Assessment and Performance Improvement meetings and if problems were noted</p>			V 0638	<p>The Facility Administrator (FA) will in-service clinical staff and IDT on Policy C-QM-0010: Introduction to QAPI, focusing on monitoring Hepatitis B vaccination compliance for susceptible patients. Training will cover documentation, tracking vaccination status, and ensuring timely vaccination per guidelines. The FA or designee will audit 100% of susceptible patients weekly for four weeks, then bi-weekly for four weeks. Monthly audits will follow as part of the regular QAPI schedule. Audit results will be reviewed in monthly QAPI and Governing Body (GB) meetings. If compliance does not improve, the POC will be reassessed, with necessary revisions and re-education or corrective actions for staff.</p>		11/17/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 152635		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/18/2024	
NAME OF PROVIDER OR SUPPLIER US RENAL CARE LAFAYETTE DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP COD 915 MEZZANINE DR LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	audits and interventions were to be implemented. See V0126.						