

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

PRINTED: 03/11/2021
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152547	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2021
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER DIALYSIS CLINIC INC	STREET ADDRESS, CITY, STATE, ZIP COD 1719 W 10TH ST INDIANAPOLIS, IN 46222
---------------------------------------------------------	----------------------------------------------------------------------------------

(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
E 0000 Bldg. 00	<p>An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62, for End Stage Renal Suppliers.</p> <p>Survey dates: 2-22, 2-23, 2-24, and 2-25-2021</p> <p>Facility #: 010129</p> <p>In Center Hemodialysis stations: 26</p> <p>Isolation room: 1</p> <p>Total: 27</p> <p>Home Program: Home Peritoneal Dialysis only</p> <p>At this Emergency Preparedness survey, Dialysis Clinic Inc., was found to have been in compliance with Emergency Preparedness Requirements for Medicare participating providers and suppliers, at 42 CFR 494.62.</p>	E 0000		
V 0000 Bldg. 00	<p>This visit was for a Federal Recertification survey of an Medicare and Medicaid participating End Stage Renal Disease Supplier.</p> <p>Survey dates: 2-22, 2-23, 2-24, and 2-25-2021</p>	V 0000		

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

TITLE

(X6) DATE

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 disclosed days 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152547	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2021
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER DIALYSIS CLINIC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 W 10TH ST INDIANAPOLIS, IN 46222
---------------------------------------------------------	-----------------------------------------------------------------------------------

(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 0147 Bldg. 00	<p>Facility #: 010129</p> <p>In Center Hemodialysis stations: 26</p> <p>Isolation room: 1</p> <p>Total: 27</p> <p>Home Program: Home Peritoneal Dialysis only</p> <p>Quality Review completed on 3/2/2021 A4</p> <p>494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children</p> <p>I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters.</p> <p>II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152547	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2021
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER DIALYSIS CLINIC INC	STREET ADDRESS, CITY, STATE, ZIP COD 1719 W 10TH ST INDIANAPOLIS, IN 46222
---------------------------------------------------------	----------------------------------------------------------------------------------

(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
	<p>Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.</p> <p>VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].</p> <p>Based on record review and observation, the patient care technicians (employees E and P) failed to implement agency policy and manufacturer's instructions in relation to contact time for the antiseptic product in the care of CVC (central venous catheter) hubs prior to initiation of in-center hemodialysis for 2 (Patients # 11 and 12) of 2 initiation of CVC catheter initiation of hemodialysis treatments observed, of a total of 2 days of 3 days of observations.</p> <p>Findings include:</p> <p>1. Review of a policy, "Initiation of Dialysis Per Central Venous Catheter, procedure No. 8.8," evidenced the policy stated, " ... Place fluid resistant barrier under patients catheter caps ... Scrub CVC [central venous catheter] cap connections with Alcavis soaked gauze packet for 1 minute, then wrap connections and allow to soak for an additional minute ... "</p> <p>2. Review of the manufacturer's directions for use, on the Internet at http://site.aaawholesalecompany.com/Files/Alcavis.pdf, 2-23-2021, evidenced the directions for use included:</p> <p>PREPARATION OF CENTRAL VENOUS CATHETER FOR INITIATION AND</p>	V 0147	<p>All clinical staff were educated immediately by Nurse Manager between 02/23-02/26/2021 on CVC procedure and manufacturer's instructions related to contact time for antiseptic product Alcavis for CVC hubs prior to initiation of hemodialysis treatments. Nurse Manager started in-services on 03/05/21 for all staff on Policy/Procedure #8.8 "Initiation of Dialysis Per Central Venous Catheter" -- to be completed by 03/11/21. The clinical staff in-services will be followed by a skills checklist to be conducted between 03/15/2021-03/26/2021 and led by the Nurse Manager. Daily infection control audits started 03/09/2021 and will continue daily for 4 weeks, then weekly for 1 month, and monthly for 3 months. Findings will be presented in QAPI to Governing Body who will determine any further audit frequency and/or any educational needs based on the findings. Nurse Manager is responsible for ensuring audits are completed.</p>	03/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152547	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2021
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER DIALYSIS CLINIC INC	STREET ADDRESS, CITY, STATE, ZIP COD 1719 W 10TH ST INDIANAPOLIS, IN 46222
---------------------------------------------------------	----------------------------------------------------------------------------------

(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
	<p>DISCONTINUATION OF HEMODIALYSIS TREATMENTS PROCEDURE</p> <ul style="list-style-type: none"> o SUPPLIES o Alcavis 50 o (2) packages of sterile 4x4 gauze pads o Chux sheet o Sterile underpad o Non sterile gloves o Staff face shield o Patient mask <p>Staff member should wash hands and comply with clinic PPE. Patient should don a face mask.</p> <ul style="list-style-type: none"> o A sterile underpad should be placed under the catheter. o On a chux sheet, carefully open both packages of 4x4 gauze pads keeping pads on sterile wrappers. o Saturate both sets of 4x4 gauze pads with ample amounts of Alcavis 50 (8 - 12 ml). o Put on clean, non sterile gloves. o Carefully place the catheter venous port in an Alcavis 50 saturated 4x4 gauze pad and scrub the catheter end and port for 1 minute. o Carefully place the catheter arterial port in an Alcavis 50 saturated 4x4 gauze pad and scrub the catheter end and port for 1 minute. Make sure to rub in an agitating motion when cleaning ports. o Carefully wrap the arterial port in an Alcavis 50 saturated gauze pad. o Carefully wrap the venous port in an Alcavis 50 saturated gauze pad. Leave each port wrapped for at least 1 minute. o Carefully unwrap the catheter ports for initiation of dialysis treatment per clinic protocol. o Repeat this process for the discontinuation of the dialysis treatment per clinic protocol. <p>3. During treatment floor observations on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152547	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2021
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER DIALYSIS CLINIC INC	STREET ADDRESS, CITY, STATE, ZIP COD 1719 W 10TH ST INDIANAPOLIS, IN 46222
---------------------------------------------------------	----------------------------------------------------------------------------------

(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
	<p>2-23-2021, at 5:42 AM, by CCHT (certified clinical hemodialysis technician) employee E, for patient #11, during preparation of the 2 CVC hubs, the CCHT was observed to scrub each hub for 10 seconds and did not leave the Alcavis saturated gauze pad on the hubs for 1 minute. The CCHT failed to implement agency policy and the manufacturer's directions for use.</p> <p>4. During treatment floor observations on 2-24-2021, at 10:15 AM, by CCHT, employee P, for patient #12, during preparation of the 2 CVC hubs, the CCHT was observed to scrub each hub for 15 seconds and did not leave the Alcavis saturated gauze pad on the hubs for 1 minute. The CCHT failed to implement agency policy and the manufacturer's directions for use.</p> <p>5. On 2-23-2021, at 7:45 AM, when the above observations were shared with the director of nursing, and when queried related to agency expectation for the correct time for antisepsis of CVC access hubs prior to initiation of in-center hemodialysis, the nursing supervisor indicated CCHTs and nurses should follow policy and Alcavis manufacturer's directions for use to scrub each hub 1 minute, then wrap each hub with antiseptic Alcavis, for another minute, prior to initiating hemodialysis. When queried what the most common source of CVC infection was, the nursing director indicated the area where the catheter enters the skin, and access of the CVC hubs. The nursing director indicated CVC care is performed with Alcavis due to low allergic response and comparability of the product with silicon and other CVC materials.</p>			