STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152607	A. BUILDING 00 B. WING	09/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
US RENAL CARE NORTH MUNCIE DIALYSIS	2705 W NORTH ST MUNCIE, IN 47303

(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		E 0000		
	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 494.62. Survey Dates: September 8th, 9th, 10th, 13th, and 14th of 2021. Facility Number: 005138 Census: 118 In-center Hemodialysis 20 Home Peritoneal Dialysis 3 Home Hemodialysis At this Emergency Preparedness survey, US Renal Care North Muncie, was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62. QR Completed 9/28/2021 A4			
V 0000 Bldg. 00		V 0000		
	This visit was for a federal core ESRD (Core) recertification survey in conjunction with a COVID-19 infection control focused survey. Survey Dates: September 8th, 9th, 10th, 13th, and 14th of 2021. Facility Number: 005138 Census: 118 In-center Hemodialysis			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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.

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	20 Home Peritoneal Dialysis 3 Home Hemodialysis			
V 0101 Bldg. 00	494.20 COMPLIANCE WITH FED/STATE/LOCAL LAWS The facility and its staff must operate and furnish services in compliance with applicable Federal, State, and local laws and regulations pertaining to licensure and any other relevant health and safety requirements. Based on observation, record review, and interview, the facility failed to maintain proper storage of compressed oxygen cylinders in 1 of 2 cylinders identified. Finding includes: 1. The National Fire Protection Agency 99 2012 edition, Section 11.6.2.3 (11) states, "Free standing cylinders should be properly chained or supported in a proper cylinder stand or cart" for safety purposes. 2. A policy titled, "Oxygen Storage and Special Precautions," revised 1/2020 was provided by the administrator on 9/10/2021 at 2:00 p.m. The policy indicated, but was not limited to, "Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart." 3. During an observation on 9/10/2021 at 12:40 p.m. an oxygen cylinder was observed resting directly on the floor with no support next to the emergency crash cart. 4. During an interview on 9/10/2021 at 1:30 p.m., the administrator indicated that he was unaware of the unsecured oxygen tank on the treatment floor.	V 0101	FA or designee will in-service all clinical staff on policy C-OS-0170: Oxygen Storage & Special Precautions as it relates to oxygen cylinders being properly chained or supported in a cylinder stand or cart. FA or designee will conduct physical environment audit for 100% of oxygen cylinders daily x2 weeks, weekly x4. Resume monthly auditing per the technical audit schedule. FA is responsible to review all education and audit results in the monthly QAPI and governing body (GB) meetings for tracking and trending. If compliance is not progressing in a favorable direction, the Plan of Correction (POC) will be re-evaluated, revisions made, re-education (if indicated), corrective action for staff (if indicated) and monitoring will continue until compliance is met.	10/29/2021

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	Confirmed that the tanks were exchanged out last week and one tank must have been left behind.			
V 0113 Bldg. 00	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. Based on observation, policy review, and interview, the facility failed to ensure staff performed hand hygiene after gloves were removed in 1 of 2 observations on the treatment floor. (Employee D) The findings include: 1. A policy titled, "Hand Hygiene," revised on 8/2020, was provided by the administrator on 9/14/2021 at 10:48 a.m. The policy indicated, but was not limited to, "Hand Hygiene will be performed:" ... "9. After gloves are removed." 2. During an observation on the treatment floor on 9/10/2021 at 12:11 p.m., surveyor was observing Employee D draw up a medication. Employee D stopped drawing up the medication, removed the gloves, and walked over the nurse's station to look up a patient's lab work on the computer. Hand hygiene was not completed after gloves were removed. 3. An interview with the administrator was conducted on 9/10/2021 at 3:05 p.m. during the daily conference. Administrator was notified of lack of hand hygiene observed by Employee D after gloves were removed. Agreed that staff should be performing hand hygiene after	V 0113	Facility Administrator (FA) or designee will in-service all direct care staff on policies C-IC-0060: Hand Hygiene and C-IC-0010: Infection Control and Precautions for all Patients as it relates to moving between clean and dirty tasks, moving between patient stations, and hand hygiene completed after glove removal. Education will include but not limited to: removing gloves & performing hand hygiene going in between dirty and clean procedures/ stations. FA or designee will conduct infection control audit for 25% of staff daily x2 weeks, then weekly x4, monthly x3. Resume quarterly auditing per the Quality Management Workbook audit schedule. FA is responsible to review all education and audit results in the monthly QAPI and governing body (GB) meetings for tracking and trending. If compliance is not progressing in a favorable direction, the Plan of Correction	10/29/2021

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	removing gloves. No further information was provided.		(POC) will be re-evaluated, revisions made, re-education (if indicated), corrective action for staff (if indicated) and monitoring will continue until compliance is met.	
V 0122 Bldg. 00	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. Based on observation, record review, and interview, the facility failed to ensure all staff demonstrated proper infection control procedures for cleaning and disinfection of contaminated surfaces and equipment to safeguard against potential bloodborne pathogens with the potential to affect all patients and staff during hemodialysis treatments. Findings include: 1. A policy titled, "Disinfection and Cleaning of Dialysis Machine Equipment," revised 7/2021, was provided by the administrator on 9/10/2021 at 2:00 p.m. The policy indicated, but was not limited to, "Proper disinfection of the dialysis station, machine, equipment and surrounding surfaces with the appropriate method prevents the transmission of disease/infection to dialysis population" ... "10. Clean counter tops behind the	V 0122	FA or designee will in-service all direct care staff on policy C-IC-0080: Disinfection and Cleaning of Dialysis Machine/ Equipment as it relates to staff properly disinfects patient station including walls and floor in area. FA or designee will conduct infection control audit for 25% of staff during cleaning and disinfection of the patient station daily x2 weeks, then weekly x4, monthly x3. Resume quarterly auditing per the Quality Management Workbook audit schedule. FA is responsible to review all education and audit results in the monthly QAPI and governing body (GB) meetings for tracking and trending. If compliance is not	10/29/2021

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	patient station." 2. During an observation on 9/10/2021 at 12:06 p.m. on the treatment floor, surveyor noted bright red substance splattered on the wall behind the treatment chair of station 7. Three distinct areas noted. A patient was running treatment. The nurse was notified of the bright red substance splatter and immediately addressed the concern, cleaning from the wall using appropriate infection control measures. 3. An interview was conducted with Employee E at 9/10/2021 at 12:06 p.m. Surveyor advised Employee E of bright red substance splatter noted on wall, Employee E indicated she was unaware but would clean the area immediately.		progressing in a favorable direction, the Plan of Correction (POC) will be re-evaluated, revisions made, re-education (if indicated), corrective action for staff (if indicated) and monitoring will continue until compliance is met.	
V 0403 Bldg. 00	494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations. Based on observation, record review, and interview, the facility failed to ensure the emergency pull cord in the Home Department was maintained to ensure the safety of all the home dialysis patients. Findings Include: 1. A document titled, "QAPI Meeting Minutes," dated 8/1/2021 was provided by the administrator on 9/14/2021 at 10:48 a.m. The document	V 0403	Biomed to replace faulty speaker to allow sound to be heard when system is activated. FA or designee will in-service all clinical and biomed staff on policy C-AD-0380: Facility Space/Design and Safety Requirements as it relates to the ability of call light system to function properly. FA or Biomed will conduct 100% of call light stations physical environment audit daily x2 weeks, weekly x4.	10/29/2021

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	indicated, but was not limited to, "Physical Plant (inspections completed)" ... "K. Call bell system Yes." 2. During an observation on 9/9/2021 at 10:20 a.m. a tour of the Home Department was completed with the administrator. While in the patient training room the administrator pulled the emergency cord located on the wall next to the patient chair. No staff members reported to the room where the emergency cord was pulled. 3. An interview with the administrator was conducted on 9/9/2021 at 10:20 a.m. The administrator indicated that there was not a crash cart located in the Home Department. If emergency assistance was needed, the emergency pull cord located on the wall by the patient chair would be pulled. The in-center hemodialysis staff would hear an audible alarm on the treatment floor and respond. The alarm was not audible in the Home Department. 4. An interview with the administrator was conducted on 9/9/2021 at 3:45 p.m. The administrator confirmed that the emergency pull cord in the Home Department training room was not working. Indicated that he was unsure when it stopped working. Suspects is may have been disconnected during the previous remodel prior to the COVID-19 pandemic, greater than 1 year ago. Indicated that this concern was discussed with the biomed who is currently working on resolving the problem.		Resume monthly auditing per the biomed auditing schedule. If a malfunction of the call light system is found in any room or area, the area or room will be closed/out of service until the malfunction is repaired. FA is responsible to review all education and audit results in the monthly QAPI and governing body (GB) meetings for tracking and trending. If compliance is not progressing in a favorable direction, the Plan of Correction (POC) will be re-evaluated, revisions made, re-education (if indicated), corrective action for staff (if indicated) and monitoring will continue until compliance is met.	
V 0543 Bldg. 00	494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary			

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	team must provide the necessary care and services to manage the patient's volume status; Based on observation, record review, and interview, the facility failed to follow policy and ensure the PCT (Patient Care Technician), CCHT (Certified Clinical Health Technician), and LVN (Licensed Vocational Nurse) notified the Charge Nurse of patient weights, BP (blood pressure) rates, and pulse rates, not within parameters pre-dialysis, intra-dialysis, and post dialysis in 4 of 10 patients reviewed (Patient 3, 5, 6, and 9). Findings Include: 1. An untitled document provided by the administrator on 9/9/2021 at 1:09 p.m. indicated, but was not limited to, "PCT/CCHT, LVN: Report to Charge Nurse PRE-DIALYSIS: BP Systolic > 180 or < 90, Diastolic > 110" ... "Nurse must complete assessment before treatment is initiated if any parameters not met" ... "PCT/CCHT, LVN: Report to Charge Nurse Intra-Dialysis: BP Systolic > 180 or < 90, Diastolic > 110. Pulse <60 or >100 beats per minutes" ... "PCT/CCHT, LVN: Report to Charge Nurse POST DIALYSIS: BP Systolic > 180 or < 90, Diastolic > 110" ... "Post Dialysis Weight > 2 kg (kilograms) above or below EDW (Estimated Dry Weight)." 2. The clinical record for Patient 3 was reviewed on 9/9/2021 for treatments dated 8/26/2021, 8/31/2021, 9/2/2021, 9/4/2021, and 9/7/2021 indicated the following: On 8/26/2021 at 6:20 a.m. Patient 3's treatment sheet indicated a Pre-Dialysis Sitting BP of 198/82 by Employee R (PCT). At 6:25 a.m. treatment was initiated by Employee R (PCT). At 7:45 a.m.	V 0543	FA or designee will in-service all direct care staff on policies C-NU-0050: Vital Signs; C-PT-0010: Pretreatment Assessment of Patient; C-ID-0010: Intradialytic Monitoring of Patient; and C-TP-0060: Post Dialysis Assessment of Patient; Reportable Parameters tool as it relates to ensuring all vital signs outside of clinic approved ranges are reported to the charge nurse; documentation by the RN and physician notification if indicated. FA or designee will conduct Machine Setting audit for 25% of patients daily x2 weeks, weekly x4 and resume monthly auditing per the Quality Management Workbook audit schedule. FA or designee will conduct Flow Sheet audit for 10% of patents daily x2 weeks, weekly x4 and resume monthly auditing per the Quality Management Workbook audit schedule. FA is responsible to review all education and audit results in the monthly QAPI and governing body (GB) meetings for tracking and trending. If compliance is not progressing in a favorable direction, the Plan of Correction (POC) will be re-evaluated, revisions made, re-education (if indicated), corrective action for staff (if indicated) and monitoring	10/29/2021

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	Employee C (RN-registered nurse) completed Patient 3's assessment. The PCT failed to notify the RN of patient's BP not within parameters. On 8/31/2021 at 6:29 a.m. Patient 3's treatment sheet indicated a Pre-Dialysis Sitting BP of 242/95 and a Standing BP of 198/160 by Employee Q (PCT). Treatment was initiated by Employee Q (PCT) at 6:31 a.m. by Employee Q (PCT). At 6:35 a.m. Employee F (RN) completed Patient 3's assessment. The PCT failed to notify the RN of patient's BP not within parameters On 9/2/2021 at 6:26 a.m. Patient 3's treatment sheet indicated a Pre-Dialysis Sitting BP of 197/87 and a Standing BP of 184/86 by Employee R (CCHT). Treatment was initiated by Employee R (CCHT) at 6:33 a.m. At 6:50 a.m. Employee G (RN) completed Patient 3's assessment. The CCHT failed to notify the RN of patient's BP not within parameters On 9/4/2021 at 6:20 a.m. Patient 3's treatment sheet indicated a Pre-Dialysis Sitting BP of 219/94 and a Standing BP of 209/101 by Employee Q (PCT). Treatment was initiated by Employee Q (PCT) at 6:28 a.m. At 6:57 a.m. Employee D (RN) completed Patient 3's assessment. The PCT failed to notify the RN of patient's BP not within parameters On 9/7/2021 at 6:23 a.m. Patient 3's treatment sheet indicated a Pre-Dialysis Sitting BP of 242/101 and a Standing BP of 221/100 by Employee L (CCHT). Treatment was initiated by Employee L (CCHT) at 6:24 a.m. At 6:32 a.m. Employee E (RN) completed Patient 3's assessment. The CCHT failed to notify the RN of patient's BP not within parameters 3. The clinical record for Patient 5 was reviewed on 9/10/2021 for treatments dated 8/25/2021 and 8/30/2021 and indicated the following:		will continue until compliance is met.	

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	On 8/25/2021 at 3:01 p.m. Patient 5's treatment sheet indicated an Intra-Dialytic BP of 81/52 by Employee L (CCHT). The Charge Nurse was not notified of BP not within parameters. On 8/30/2021 at 12:02 p.m. Patient 5's treatment sheet indicated an Intra-Dialytic BP of 76/54 by Employee N (CCHT). The Charge Nurse was not notified of BP not within parameters. 4. The clinical record for Patient 6 was reviewed on 9/10/2021 for treatments dated 8/25/2021, 8/27/2021, and 9/8/2021, indicated the following: On 8/25/2021 at 6:49 a.m. Patient 6's treatment sheet indicated a Standing Pre-Dialysis BP of 200/103 assessed by Employee N (CCHT). At 6:50 a.m. treatment was initiated by Employee N (CCHT). At 7:59 a.m. Employee BB (RN) completed Patient 6's assessment. At 10:39 a.m. the treatment sheet indicated a Post Sitting BP of 184/104 and a Post Standing BP of 184/100 by Employee N (CCHT). A registered nurse was not notified of BP not within parameters. On 8/27/2021 at 6:42 a.m. Patient 6's treatment sheet indicated a Sitting Pre-Dialysis BP of 232/127 and a Standing Pre-Dialysis BP of 221/122 noted by Employee N (CCHT). At 6:46 a.m. treatment was initiated by Employee N (CCHT). At 7:49 a.m. Employee G (RN) completed Patient 6's assessment. At 10:38 a.m. the treatment sheet indicated a Post Sitting BP of 186/148 and a Post Standing BP of 189/103 by Employee N (CCHT). A registered nurse was not notified of BP not within parameters. On 9/8/2021 at 6:50 a.m. Patient 6's treatment sheet indicated a Sitting Pre-Dialysis BP of 244/133 and			

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	a Standing Pre-Dialysis BP of 244/134 noted by Employee J (LPN-Licensed Practical Nurse). At 6:53 a.m. Patient 6's treatment was initiated by Employee J (LPN). At 7:11 a.m. Employee V (RN) verified Patient's 6's prescription, no assessment noted by an RN, only by Employee J (LPN). At 10:36 a.m. the treatment sheet indicated a Post Sitting BP of 209/110 and a Post Standing BP of 209/110 by Employee J (LPN). The treatment sheet indicated a Post Dialysis Weight of 94.8 kg. Ordered EDW is 90 kg. A registered nurse was not notified of BP's and weights not within parameters. 5. The clinical record for Patient 9 was reviewed on 9/14/2021 for treatment dated 7/21/2021 indicated the following: On 7/21/2021 at 7:19 a.m. Patient 9's treatment sheet indicated a Pre-dialysis pulse of 123 beats per minute and a Pre-Dialysis weight of 114.4 kg, a 21.4 kg increase from patients ordered EDW of 93 kg, by Employee CC (PCT). Treatment was initiated at 7:31 a.m. by Employee CC (PCT). At 7:39 a.m. Employee E (RN) completed an assessment. RN was not notified of pre-dialysis pulse and weight not within parameters. 6. An interview with the administrator was conducted on 9/9/2021 at 11:52 p.m. The administrator confirmed that the LPN is to report all abnormal findings regarding patient vital signs, patient complaints, and symptoms to the registered nurse. 7. An interview with the administrator was conducted on 9/9/2021 at 3:45 p.m. during the daily conference. Administrator was notified of findings during the continued record reviews of increased blood pressures and weights, not within			

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	parameters, and not being reported the charge nurse. No further information was provided.			
V 0544 Bldg. 00	494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. Based on record review, and interview, the facility failed to follow and ensure patients prescribed BFR's (Blood flow rates) were maintained throughout dialysis treatment as ordered by the physician in 2 of 10 patients reviewed. (Patient 7 and 9) Findings Include: 1. A policy titled, "Intradalytic Monitoring of Patient," revised on 9/2020 was provided by the administrator on 9/9/2021 at 11:45 a.m. The policy indicated, but was not limited to, "Monitoring: Direct patient care staff will monitor the following parameters during each dialysis treatment" ... "Delivery System:" ... "3. Blood flow rate." 2. An 8/23/2021 treatment sheet for Patient 7 was reviewed on 9/13/2021 and indicated the following. A prescribed BFR of 350. Patient 7 ran a BFR of 400 for the entire treatment without documentation providing reasoning for change in prescription. 3. An 8/26/2021 treatment sheet for Patient 9 was reviewed on 9/14/2021 and indicated the following. A prescribed BFR of 400. Patient 9 ran a BFR of 195 for the entire treatment without	V 0544	FA or designee will in-service all direct care staff on policy C-TI-0010: Initiation of Dialysis Treatment as it relates to ensuring Blood Flow Rate (BFR) set to the prescribed rate throughout treatment; if unable to achieve ordered BFR, the reason is documented in EMR and RN is notified; documentation by the RN and physician notification in indicated. FA or designee will conduct Machine Setting audit for 25% of patients daily x2 weeks, weekly x4 and resume monthly auditing per the Quality Management Workbook audit schedule. FA or designee will conduct Flow Sheet audit for 10% of patents daily x2 weeks, weekly x4 and resume monthly auditing per the Quality Management Workbook audit schedule. FA is responsible to review all education and audit results in the monthly QAPI and governing body (GB) meetings for tracking and trending. If compliance is not progressing in a favorable	10/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152607	A. BUILDING 00 B. WING	09/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
US RENAL CARE NORTH MUNCIE DIALYSIS	2705 W NORTH ST MUNCIE, IN 47303

(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
	documentation providing reasoning for change in prescription. 5. An interview with the administrator was conducted on 9/14/2021 at 4:11 p.m. The administrator was notified of the incorrect BFR's found on record review and could not offer any explanation or documentation as to why patients ran incorrect BFR.		direction, the Plan of Correction (POC) will be re-evaluated, revisions made, re-education (if indicated), corrective action for staff (if indicated) and monitoring will continue until compliance is met.	
V 0715 Bldg. 00	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers; Based on observation, record review, and interview, the medical director failed to ensure staff followed policy and procedure when completing chlorine checks in 1 of 1 facilities observed. Findings include: 1. A policy titled, "Total Chlorine Testing," revised on 8/2021 was provided by Employee DD on 9/13/2021 at 11:40 a.m. The policy indicated, but was not limited to, "The charge nurse must verify documentation that total chlorine test is completed prior to the start of each patient shift and that the test results are within normal limits." 2. A document titled, "ELF Log Print Report (FOR SURVEYORS ONLY)," was provided by Employee DD on 9/13/2021 at 9:45 a.m. The document	V 0715	FA or designee will in-service all clinical staff on policies TM02-03: Daily Water Treatment Monitoring and TM 02-06: Total Chlorine Testing as it relates to water testing being completed properly and verified appropriately. FA or designee will conduct Total Chlorine Testing Log audit daily x2 weeks, weekly x4 and resume monthly auditing per the Technical Audit Schedule. FA and Biomed is responsible to review all education and audit results in the monthly QAPI and governing body (GB) meetings for tracking and trending. If compliance is not progressing in a favorable direction, the Plan of Correction (POC) will be	10/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152607	A. BUILDING 00 B. WING	09/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
US RENAL CARE NORTH MUNCIE DIALYSIS	2705 W NORTH ST MUNCIE, IN 47303

(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
	indicated that Total Chlorine Testing was completed on 7/24/2021 at 3:29 a.m. A subsequent Total Chlorine Test was completed at 7:37 a.m. 3. An interview was conducted with Employee DD 9/13/2021 at 11:15 a.m. Employee DD confirmed that the start of the first patient shift was at 6:15 a.m. On 7/24/2021 no chlorine check was completed with the nurse prior to the start of the first dialysis treatment at 6:15 a.m. Confirmed that with the limited number of staff trained to open and close the water room, the employee that opened that morning, only opened the water room and then left for the day. The next chlorine check was completed at 7:37 a.m., after treatments had already begun. 4. An interview was conducted with the administrator on 9/13/2021 at 4:15 p.m. The administrator confirmed that the chlorine check should have been completed and then validated by the Registered Nurse prior to the start of treatments that day, 7/24/2021. Confirmed that the first treatment of the day started at 6:15 a.m.		re-evaluated, revisions made, re-education (if indicated), corrective action for staff (if indicated) and monitoring will continue until compliance is met.	