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	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
US RENAL CARE NORTH MUNCIE DIALYSIS	800 S TILLOTSON STE 1 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
V 0000 Bldg. 00	This visit was for a Federal Complaint survey of an ESRD provider. Survey Dates: August 5 and 6, 2025 Complaint: IN00463619 was investigated, with related deficiencies cited. Census by Service Type: In-Center Hemodialysis: 108 Home Hemodialysis: 5 Peritoneal Dialysis: 24 Isolation Room: 1 Abbreviations: ICHD In-Center Hemodialysis PCT Patient Care Technician RN Registered Nurse CVC Central Venous Catheter QR 8/13/25 A2	V 0000		
V 0111 Bldg. 00	494.30 IC-SANITARY ENVIRONMENT Based on observation, policy review, and interview, the dialysis facility failed to ensure bleach solution for disinfection was stored with the lid closed for two of four 1:100 bleach solution containers on the treatment floor.	V 0111	The Facility Administrator will in-service all direct care staff on policy C-IC-0080 (Disinfection and Cleaning of Dialysis Machine Equipment). Education will emphasize ensuring that the lids	09/05/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Pharis	RN,BSN,CNN	08/22/2025

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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	Findings include: 1. Review of the Disinfection and Cleaning of Dialysis Equipment policy, revised 07/2023, indicated " ... A 1:100 dilution bleach solution will be made daily ... Both container and lid must be opaque to prevent weakening of the bleach solution ... Container will remain covered at all times ..." 2. During an ICHD treatment floor observation on 08/05/2025 at 10:59 AM, observed one bleach container with the lid partially off on the "clean" sink near the patient entrance to the treatment floor and another bleach container holding used clamps with the lid partially off on the "dirty" sink near Station 25. At 11:13 AM and 12:38 AM, observed the lids of both bleach containers were still partially uncovered. 3. During an ICHD treatment floor observation on 08/06/2025 at 10:06 AM, observed one bleach container with the lid partially off on the "clean" sink near the patient entrance to the treatment floor and another bleach container holding used clamps with the lid partially off on the "dirty" sink near Station 25. At 10:22 AM, observed the lids of both bleach containers were still partially uncovered. 4. During an interview on 08/05/2025 at 11:24 AM, PCT 4 indicated they didn't know if there was a time limit for how long bleach container lids can remain open, but indicated they were usually always on.		for the 1:100 bleach solution containers remains fully closed. Staff unable to attend the in-service will be educated on their first day back at work.The Facility Administrator or Clinical Coordinator will conduct audits on 100% of 1:100 bleach solution containers to ensure that they are properly closed:a. Daily for five daysb. Then every week for 2 weeks.c. Then every month for 2 months.d. Any deviations will be immediately corrected, and coaching provided at the time of observatione. Once adherence has been achieved, infection control audits will resume, per the Quality Management Workbook schedule.The Facility Administrator (FA) will be responsible for ensuring adherence to this Plan of Correction. The FA will review all education and audit results in the monthly QAPI and Governing Body (GB) meetings to track and trend adherence. If adherence does not improve, the Plan of Correction (POC) will be re-evaluated, revisions made as needed, and additional education provided. Monitoring will continue until adherence is achieved. ="" a<="" p="">	
V 0113 Bldg. 00	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE			

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	Based on observation, policy review, and interview, the dialysis facility failed to ensure staff performed hand hygiene per policy for 1 of 8 PCTs observed on the ICHD treatment floor (PCT 4). Findings include: 1. Review of the Hand Hygiene policy, revised 08/2020, indicated " ... Hand Hygiene will be performed ... Before clean/aseptic procedure ... eg. vascular access cannulation/decannulation ... After gloves are removed ..." 2. During an ICHD treatment floor observation on 08/05/2025 beginning at 10:41 AM, PCT 4 discontinued dialysis for Patient #5, who had an arteriovenous fistula. Prior to removing the first needle, PCT 4 changed gloves without performing hand hygiene after glove removal. Prior to changing the gauze on the first needle site, PCT 4 again changed gloves without performing hand hygiene after glove removal. 3. During an interview on 08/05/2025 at 10:57 AM, PCT 4 indicated hand hygiene should be performed each time you touch the machine, touch the patient, touch dirty material, and after removing gloves.	V 0113	The Facility Administrator will in-service all direct care staff on policy C-IC-0060 (Hand Hygiene). Education will emphasize glove changes and hand hygiene when transitioning between clean and dirty tasks and performing hand hygiene after glove removal. Staff members unable to attend the in-service will be educated on their first day back at work. The Facility Administrator or Clinical Coordinator will conduct Staff Infection Control Audits on 25% of patient treatments. If any deviations are noted re-educate staff as needed:a. Daily for five daysb. Then every week for 2 weeks.c. Then every month for 2 months.d. Once adherence has been established infection control audits will be completed per Quality Management workbook scheduleThe Facility Administrator (FA) will be responsible for ensuring adherence to this Plan of Correction. The FA will review all education and audit results in the monthly QAPI and Governing Body (GB) meetings to track and trend adherence. If adherence does not improve, the Plan of Correction (POC) will be re-evaluated, revisions made as needed, and additional education provided. Monitoring will continue until adherence is achieved. ="" span="">="" span=""> ="" p="">	09/05/2025

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V 0147 Bldg. 00	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Based on observation, policy review, and interview, the dialysis facility failed to ensure staff followed infection control procedure related to CVC exit site care for 1 of 2 CVC exit site care observations (RN 1). Findings include: 1. Review of the Dialysis Catheter Dressing Change Procedure policy, revised 02/2023, indicated " ... Using aseptic technique, cleanse the skin surrounding the exit site with the appropriate skin antiseptic ... Acceptable cleansing agents include ... ChloraPrep (chlorhexidine 2% with 70% alcohol) ... Use gentle back and forth strokes,	V 0147	The Facility Administrator will in-service all direct care staff on policy C-TI-0070 (Dialysis Catheter Dressing Change Procedure). Education will emphasize infection control procedures related to CVC exit site care and the requirement to use gentle back and forth strokes, progressing from catheter exit site outwards for 30 seconds when using chloraprep. Staff unable to attend the in-service will be educated on their first day back at work.The Facility Administrator or Clinical Coordinator will perform	09/05/2025

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	progressing from the catheter exit site outwards for 30 seconds ..." 2. During an ICHD treatment floor observation on 08/05/2025 beginning at 9:18 AM, observed RN 1 provided CVC exit site care for Patient #4. RN 1 cleansed the area around the exit site with ChloraPrep for 25 seconds. RN 1 failed to cleanse the area around the exit site for 30 seconds. 3. During an interview on 08/05/2025 at 12:36 PM, RN 1 indicated the area around a CVC exit site should be cleansed for a minute using ChloraPrep and then allowed to dry. 4. During an interview on 08/05/2025 at 12:35 PM, PCT 1 indicated the area around a CVC exit site should be cleansed with two ChloraPrep swabs, cleansing for 10 to 15 seconds per swab.		audits on 25% of CVC dressing changes. If any deviations are noted re-educate staff as needed:a. Daily for five days b. Then every week for 2 weeks.c. Then every month for 2 months.d. Once adherence has been established, audits will be completed per Quality Management workbook scheduleThe Facility Administrator (FA) will be responsible for ensuring adherence to this Plan of Correction. The FA will review all education and audit results in the monthly QAPI and Governing Body (GB) meetings to track and trend adherence. If adherence does not improve, the Plan of Correction (POC) will be re-evaluated, revisions made as needed, and additional education provided. Monitoring will continue until adherence is achieved. ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p="">	