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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152617	A. BUILDING 00 B. WING	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
US RENAL CARE KOKOMO DIALYSIS	3760 S REED ST KOKOMO, IN 46902

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E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62. Survey Dates: 05/05/2025 - 05/07/2025 Active Census: 38 At this Emergency Preparedness survey, US Renal Care Kokomo was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62. QR on 05/12/2025 by A4	E 0000		
V 0000 Bldg. 00	This visit was for a CORE Federal recertification survey of an ESRD provider. Survey Dates: 05/05/2025 - 05/07/2025 Census by Service Type: In-Center Hemodialysis: 28 Home Peritoneal dialysis: 10 Total Active Census: 38 Isolation room/Waiver: 1 isolation room Abbreviations: RN Registered Nurse	V 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Pharis	RN,BSN,CNN	05/16/2025

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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	PCT Patient Care Technician FA Facility Administrator CVC Central Venous Catheter IV Intravenous			
V 0113 Bldg. 00	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Based on observation, record review, and interview, the facility failed to ensure staff were following standard hand hygiene protocol to prevent the spread of communicable disease for 2 of 2 CVC observations (Patient #3, 6) and 1 of 2 Arterial Venous Graft (AVG) (permanent dialysis access) observations. (Patient #7) Findings Include: 1. A policy titled, "Hand Hygiene" (08/2020) indicated that hand hygiene will be performed before and after touching a patient, prior to contact with vascular access sites, before clean/aseptic procedures (vascular access cannulation), after body fluid exposure risk, after gloves are removed, after contact with inanimate objects, including medical equipment or environmental surfaces at the patient station, when moving from a contaminated body site to a clean body site of the same patient, and after handling biohazardous waste. 2. A policy titled, "Infection Control and Precautions for All Patients" (07/2023) indicated staff will perform hand hygiene using soap and water or antimicrobial hand sanitizer before/after all patient contact and before applying and after removing PPE (personal protective equipment), including gloves. Hand hygiene will also be performed after contact with integrated keyboard	V 0113	The Facility Administrator (FA) will in-service all direct care staff on policies C-IC-0060: Hand Hygiene, C-IC-0010: Infection Control and Precautions for All Patients, and C-TI-0030: Assessment and Cannulation for AV Fistula/Graft and Patient Self-Cannulation, related to infection control. Education will emphasize the importance of hand hygiene while transitioning between clean and dirty tasks, moving between patient stations, glove removal, handling clean supplies and equipment, and vascular access preparation. Training will include, but is not limited to: ·Removing gloves and performing hand hygiene when transitioning between dirty and clean procedures or stations ·Performing hand hygiene before retrieving clean supplies or using the machine or keyboard ·Repeating antiseptic preparation if the cannulation site is touched or contaminated prior to needle insertion The FA or designee will conduct infection control audits on 25% of	06/06/2025

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	or chairside computer, regardless of whether contact occurred through gloved or ungloved hands. 3. During an observation on 05/05/2025 at 10:00 AM, PCT 4 initiated Patient #6's CVC dialysis treatment. With gloved hands, PCT 4 went from patient care to the integrated keyboard failing to remove gloves and complete hand hygiene. 4. During an observation on 05/05/2025 at 10:34 AM PCT 5 initiated Patient #3's CVC dialysis treatment. With gloved hands, PCT 5 went from patient care to the integrated keyboard several times failing to remove gloves and complete hand hygiene between tasks 5. During an observation on 05/07/2025 at 10:30 AM, RN 1 initiated treatment for Patient #7 using his/her AVG. After entering information on the dialysis machine via the integrated keyboard with gloved hands, RN 1 removed his gloves and left the station to retrieve a clean pad to place under Patient #7's arm. Hand hygiene was not performed with glove removal. Upon returning to the station, new gloves were applied without hand hygiene being performed. The clean pad was placed under Patient #7's arm. RN 1 then noted the pre-made pack sitting on the patient's side table was missing clamps and left the patient station with gloves on to retrieve two clean clamps. Using the same gloves, RN 1 then disinfected the cannulation (needle insertion) sites using an alcohol pad. Next, he palpated the access to assess needle placement and cannulated the patient. RN 1 failed to re-disinfect the access prior to needle placement. 6. During an interview on 05/05/2025 at 10:41 AM, PCT 5 indicated that hand hygiene should be		patients daily for 1 week, then weekly for 3 weeks, and monthly for 2 months. Audits will include direct observation of glove removal, hand hygiene practices, transitions between tasks and equipment, and adherence to vascular access initiation and termination protocols. Auditing will then resume quarterly per the Quality Management Workbook schedule. All education and audit results will be reviewed during the monthly QAPI and Governing Body (GB) meetings to monitor trends and ensure compliance. If adherence does not improve, the Plan of Correction (POC) will be re-evaluated and revised as needed, and additional education will be provided. Monitoring will continue until sustained adherence is achieved.	

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	completed between patient care and integrated keyboard use, between patients, and anytime gloves are removed. 7. During an interview on 05/07/2025 at 11:20 AM, PCT 1 indicated that the computer is considered a clean area and hand hygiene should be completed between patient care and keyboard use. 8. During an interview on 05/07/2025 at 11:45 AM, RN 1 indicated that staff are expected to complete hand hygiene between patient care and touching the machine and/or keyboard. RN 1 also indicated that staff should not retrieve clean supplies with dirty gloves on, gloves should be removed and hand hygiene completed first.			
V 0142 Bldg. 00	494.30(b)(1) IC-O-SIGHT-MONITOR ACTIVITY/IMPLEMENT P&P Based on record review and interviews, the facility failed to ensure Tuberculosis (TB) (airborne respiratory infection) testing was completed for 2 of 3 personnel files reviewed. (PCT 5, FA) Findings Include: 1. A policy titled, "TB Surveillance Testing - Employee" (02/2023) indicated new hire, baseline, TB testing should include a two-step Tuberculin Skin Test (TST) on or within 10 days of the hire date unless the employee provides evidence of a previous negative TB test. 2. The personnel file reviewed for PCT 5, date of hire 01/30/2024, indicated that the facility failed to administer a TB skin test upon hire. A TB skin test was administered on 02/02/2025 but failed to administer a second step TB test.	V 0142	The Clinical Specialist will review and re-educate the FA on policy **C-EH-0030: TB Surveillance Testing—Employee to ensure proper understanding and consistent implementation of two-step Tuberculin Skin Testing (TST) requirements. Education will include the requirement that all new hires** complete a two-step TST within 10 days of hire unless valid documentation of prior negative testing is provided. The FA will complete a personnel file audit of all current staff files to ensure compliance with TB testing requirements. If an employee is missing the second step of TB testing, the second step will be	06/06/2025

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	3. The personnel file reviewed for the FA, date of hire on 03/31/2025, indicated that the facility administered a one-step TB skin test on 03/07/2025 upon hire but, failed to administer the second step TB test. 4. An interview on 05/07/2025 at 12:22 PM, the FA indicated that a second step TB test is only required if the staff member has never had a TB test completed. No further documentation was provided.		administered immediately unless acceptable prior documentation is provided. Going forward, the FA or designee will ensure all new hires complete required TB testing by maintaining a checklist as part of the onboarding process. This checklist will be reviewed prior to the end of orientation to ensure both steps are completed or adequately documented. Adherence will be monitored monthly for the next 3 months, with audit results reported in **QAPI** and **Governing Body (GB)** meetings. If issues are identified, additional staff training will be provided. Monitoring will continue until full and sustained adherence is achieved.	
V 0147 Bldg. 00	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Based on observation, record review and interview, the facility failed to follow appropriate infection control procedures for 1 of 2 CVC (dialysis catheter access) treatment initiations. (Patient #6) Findings Include: 1. A policy titled, "Dialysis Catheter Dressing Change Procedure" (02/2023) indicated when disinfecting the catheter exit site, using aseptic technique, cleanse the skin surrounding the exit site with ChloraPrep (skin disinfectant) using gentle back and forth strokes, progressing from	V 0147	The Facility Administrator (FA) will re-educate all direct care staff on Policy C-TI-0070: Dialysis Catheter Dressing Change, focusing on the proper use of cleansing agents, the cleaning technique, required contact time, and dry time during catheter care. Emphasis will be placed on using ChloraPrep as the preferred solution for long-term catheter sites. Training will include the following key elements:	06/06/2025

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	catheter exit site outwards for 30 seconds. 2. During an observation on 05/05/2025 at 10:00 AM, PCT 4 initiated Patient #6's CVC treatment. PCT 4 disinfected the CVC exit site for ten seconds using Chloraprep. 3. During an interview on 05/05/2025 at 10:17 AM, PCT 4 indicated that the disinfection time for CVC exit site was one minute. 4. During an interview on 05/07/2025 at 11:20 AM, PCT 1 indicated that the CVC exit site should be disinfected with Chloraprep for 30 seconds and allow it to dry. 5. During an interview on 05/07/2025 at 11:45 AM, RN 1 indicated that he disinfects the CVC exit site for 1 minute and did not know what the facility policy stated.		·Use gentle back-and-forth strokes starting from the catheter exit site and moving outward for a full 30 seconds ·Allow the site to air dry completely for 30 seconds before proceeding The FA will conduct direct observation audits on 25% of CVC dressing changes daily for 1 week, then weekly for 3 weeks, and monthly for 2 months. Auditing will then resume quarterly per the Quality Management Workbook schedule. Audits will assess proper antiseptic application, technique, and adherence to drying time. Monthly QAPI and Governing Body (GB) meetings will review audit results and staff adherence. If performance does not meet expectations, the Plan of Correction will be re-evaluated, further training will be provided, and continued monitoring will be implemented until sustained adherence is achieved.	
V 0715 Bldg. 00	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P Based on observation, record review and interview the medical director failed to ensure staff followed policy and procedure related to medication securement and monitoring for expired supplies in 1 of 1 facility reviewed, complete initial nursing assessments per policy for 1 of 1 new patient admissions (Patient #1), complete AVF	V 0715	The Medical Director will reinforce the expectation that all staff strictly adhere to established policies and procedures related to patient admissions, infection control, patient care, and safety. This will be achieved through a	06/06/2025

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	assessments for 2 of 2 Arterial Venous Fistula (AVF)(dialysis access) observations (Patient #7, #8), and ensure standard infection control practices were followed for 1 of 2 CVC initiations. (Patient #6) Findings Include: Medication Securement 1. A policy titled, "Guidelines for Administration of Medication" (02/2025) indicated medications will be locked in a cabinet or medication refrigerator. 2. During an observation on 05/05/2025 at 11:27 AM, a medication refrigerator housing IV Albumin (medication used to treat low protein levels and assist with fluid removal) was found unlocked/unsecured. 3. During an observation on 05/05/2025 at 10:49 AM, a medication cabinet that houses Ondansetron (used to treat nausea), Diphenhydramine (used to treat itching), and Venofer (used to treat anemia) was found unsecured/unlocked. 4. During an interview on 05/07/2025 at 11:20 AM, PCT 1 indicated that all medications should always be secured/locked. 5. During an interview on 05/07/2025 at 11:45 AM, RN 1 indicated that medications are to be always locked. Expired Supplies 1. A policy titled, "Guidelines for Administration of Medication" (02/2025) indicated all supplies		collaborative approach involving the Medical Director and Facility Administrator (FA) to re-educate staff and implement consistent monitoring strategies. **1. Medication Securement:** The FA will re-educate all licensed staff on policy C-MA-0010: Guidelines for Administration of Medication, emphasizing that all medications must remain in locked cabinets or medication refrigerators. Daily checks of medication storage areas will be initiated for 2 weeks, then weekly for 1 month, to ensure adherence. Any findings of unsecured medications will be addressed immediately, and staff re-education. **2. Expired Supplies:** Staff will be re-educated on policies C-AD-0380: Facility Space/Design & Safety Requirements and C-MA-0010: Guidelines for Administration of Medication, specifically the requirement to check expiration dates on all medical supplies and testing materials at least monthly. A standardized expiration check log will be implemented for all supply areas, including emergency carts, treatment floors, and the water room. The FA will assign clear responsibilities for monthly expiration checks and ensure documentation is maintained and reviewed. **3. Nursing Initial Assessments:**	

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	and testing strips are to be checked at minimum monthly for expiration and ensure expired supplies are discarded appropriately. 2. A policy titled, "Facility Space/Design & Safety Requirements" (04/2023) indicated staff ensure all supplies and testing strips are checked at least monthly for expiration and discarded appropriately prior to or on the day of expiration. 3. During an observation of the emergency preparedness box on 05/05/2025 at 09:54 AM, 2 Intravenous administration sets were found to have expired on 12/04/2023. 4. During an observation of the treatment floor on 05/05/2025 at 10:23 AM, 14 RPC caps (used to cap patients when they pause treatment) were found to have expired on 03/31/2025. 5. During an observation of the treatment floor on 05/05/2025 at 10:46 AM, 7 white top laboratory tubes and 1 purple top laboratory tube were found to have expired on 05/02/2025. 6. During an observation of the water room on 05/05/2025 at 11:24 AM, one opened bottle of RPC Chlorine Testing Strips (used to test for Chlorine in purified water for dialysis) containing 8 strips inside were found to have expired on 03/31/2025. The vial of RPC strips were located on a cart where testing chlorine testing is completed. 7. During an interview on 05/05/2025 at 11:33 AM, the FA indicated that she is responsible for checking for expired supplies along with the Biomed and Administrative Assistant and that all expired supplies should be discarded. 8. During an interview on 05/05/2025 at 12:58 PM,		All RNs will be re-educated on policy C-AD-0440: Medical Records, which requires the completion of a Nursing History and Assessment prior to the initiation of a patient's first dialysis treatment. The FA will conduct weekly audits of new admissions for 3 months to verify the timely completion of initial assessments. Any non-adherence will be addressed with targeted coaching and re-education. **4. AVF Assessment and Disinfection:** Direct care staff will be re-educated on policy C-TI-0030: Assessment and Cannulation for AV Fistula/Graft and Patient Self-Cannulation, focusing on: ·Proper auscultation using a stethoscope prior to cannulation ·Identifying cannulation sites through palpation ·Disinfecting each site with alcohol for a minimum of 30 seconds Staff will complete return demonstrations and be observed during cannulation for compliance. Spot audits will be conducted on 25% of AVF patients weekly for 4 weeks and monthly for 2 months. **5. Infection Control and Catheter Access:** The FA will provide re-education on policy C-TI-0070: Accessing and De-Accessing the Dialysis Catheter, with focus on aseptic technique and the importance of	

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	the Biomed indicated that the PCTs should be checking the strips for expiration dates prior to using them. 9. During an interview on 05/07/2025 at 11:20 AM, PCT 1 indicated that whoever is doing the water checks should be checking the expiration date on the strips. PCT 1 also indicated that whoever is stocking supplies on the treatment floor is responsible for checking expiration dates. 10. During an interview on 05/05/2025 at 11:45 AM, RN 1 indicated that the Biomed is responsible for checking the storage room for expiration dates, RN 1 is responsible for checking the treatment floor for expiration dates, and the Administrative Assistant checks the emergency supplies. Nursing Initial Assessment 1. A policy titled, "Medical Records" (02/2023) indicated an initial nursing history and assessment is to be completed prior to the first dialysis treatment. 2. The medical record for Patient #1 indicated an admission date of 03/14/2025, their first dialysis treatment. 3. A treatment sheet dated 03/14/2025 for Patient #1 indicated the start of treatment at 4:02 PM. 4. A document titled, "Nursing History and Assessment" for Patient #1 indicated a nursing assessment is to be completed prior to initiation of the first dialysis treatment. The assessment was dated 03/14/2025 at 4:33 PM. 5. During an interview on 05/07/2025 at 11:45 AM,		discarding and replacing contaminated supplies. Staff will be reminded that if a clean field is contaminated (e.g., by a fallen face shield), the entire field must be replaced. Direct observation audits will be conducted on CVC initiations weekly for 4 weeks, then monthly for 2 months. **6. Medical Director Oversight:** The Medical Director will review all related policies and participate in monthly QAPI meetings to monitor staff compliance with patient admission processes, infection control, patient safety, and access care. The Medical Director will provide documented review and support policy enforcement by actively addressing patterns of non-adherence and participating in staff education discussions. **Monitoring and Follow-Up:** All audit results and education efforts will be documented and reviewed in monthly QAPI and Governing Body (GB) meetings. If continued non-adherence is identified, the Plan of Correction will be reassessed, and additional training, including targeted education, will be provided. Monitoring will continue until sustained adherence is demonstrated across all areas.	

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RN 1 indicated that the initial patient assessment is completed right after treatment is started.

AVF Disinfection/Auscultation

1. A policy titled, "Assessment and Cannulation for AVF Fistula/Graft and Patient Self Cannulation" (10/2023) indicated the access to be cannulated should be assessed for bruit (access sound) using a stethoscope. Staff should locate the needle cannulation sites via palpating the access prior to skin disinfection; remove gloves, perform hand hygiene, don clean gloves, and disinfect each access site utilizing an alcohol pad at least 30 seconds

2. During an observation on 05/05/2025 at 11:48 AM, PCT 4 disinfected Patient # 8's fistula access site with an alcohol prep for 10 seconds.

3. During an observation on 05/07/2025 at 10:30 AM, RN 1 failed to listen to Patient #7's fistula prior to cannulating the access site.

4. During an interview on 05/07/2025 at 11:20 AM, PCT 1 indicated that the fistula access site should be disinfected for 30 seconds, and staff should be assessing the site by palpating, auscultation, and visualizing the site.

5. During an interview on 05/07/2025 at 11:45 AM, RN 1 indicated that the fistula access site should be disinfected with alcohol for 15-30 seconds.

Infection Control

1. A policy titled, Accessing and De-Accessing the Dialysis Catheter" (06/2024) indicated the procedure for accessing and de-accessing the dialysis catheter should be completed using

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	aseptic techniques to avoid potential catheter contamination or injury. 2. During an observation on 05/05/2025 at 10:06 AM, PCT 4 was accessing Patient #6's CVC when her face shield fell onto the clean field. PCT 4 picked up the face shield and continued with care, failing to dispose of contaminated supplies and obtaining new supplies. 3. During an interview on 05/5/2025 at 10:17 AM, PCT 4 indicated that she should have disposed of the supplies after dropping her face shield onto the clean field and retrieved new supplies. 4. During an interview on 05/07/2025 at 11:20 AM, PCT 1 indicated that the supplies should have been disposed of, and new supplies retrieved. 5. During an interview on 05/07/2025 at 11:45 AM, RN 1 indicated that staff would be expected to dispose of contaminated supplies and replace with new.			