AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED	
		152645	B. WING	<del></del>		06/02/	2023
NAME OF P	PROVIDER OR SUPPLIEI	R	9	9210 RC	EET ADDRESS, CITY, STATE, ZIP COD O ROCKVILLE RD STE D NANAPOLIS, IN 46234		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION	1	ΓAG	DEFICIENCY)		DATE
E 0000							
Bldg. 00	conducted by the Ir accordance with 42 participating End S Dates of survey: 05 06-02-2023 Facility #: 012543 CCN: 152645	ling 1 isolation room. Type: lysis: 48	E 0000	0			
V 0000 Bldg. 00	Dialysis, was found with the requirements for M and suppliers, inclu  OR completed on 6  This visit was for a survey of an ESRD	Preparedness survey, Avon do to have been in compliance into of Emergency Preparedness Medicare participating providers adding staffing, at 42 CFR 494.62.  6/6/2023 by Area 3.  CORE Federal recertification provider.  0/23, 06/31/23. 06/01/23,	V 000	0			
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	I_	TITLE		(X6) DATE

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

(X6) DATE

Jaclynn Jackson Facility Administrator 06/15/2023

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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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED				
		152645	B. WI	NG		06/02/	/2023
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 9210 ROCKVILLE RD STE D INDIANAPOLIS, IN 46234				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
V 0113	In Center Hemodial Home Peritoneal dia Total Census: 48 Isolation Room: 1  QR completed on 66 494.30(a)(1) IC-WEAR GLOVE	Type: ysis: 22 alysis: 26 /6/2023 by Area 3.					
Bldg. 00	patient or touching the dialysis station	gloves when caring for the g the patient's equipment at n. Staff must remove gloves between each patient or	VO	113	The Facility Administrator or		07/01/2023
	interview, the facility employees followed related to hand hygin hygiene observation PCT 1(3 times), RN 15, 20, 10, 29, 5, 1,	on, record review, and ty failed to ensure all I infection control practice ene for 19 of 19 incorrect hand as. (PCT 3, PCT 2 (3 times), N 3, and RN 4) (Patient # 6, 22, 18 and 21)			designee will in-service all clin teammates on Policy 1-05-01 "Infection Control For Dialysis Facilities". Verification of attendance will be evidenced an in-service sign in sheet. Teammates will be educated a surveyor observations as examples with emphasis on, but	oy using	
	Control for Dialysis indicated, but was n physicians, and non hygiene upon enteri treatment area, prior after removal of glo blood or infectious dialysis delivery sys with wall boxes, bet	ity policy 1-05-01, "Infection Facilities," last revised 04/23, not limited to, all teammates, -physicians will perform hand ng and exiting the patient r to gloving and immediately eves, after contamination with material, after patient and stem contact, after interacting tween patients, and before			not limited to the following:  1) All teammates, Physicians at Non-Physician (NPP) will perform hand hygiene: upon entering a exiting the patient treatment at prior to gloving and immediate after removal of gloves, after contamination with blood or ot infectious material, after patien and dialysis delivery system contact, after interacting with whomes (i.e., plugging/unplugging acid/bicarb lines form dialysis)	orm and rea, lly her nt	

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Event ID:

THWI11 Facility ID: 012543 If continuation sheet Page 2 of 22

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 152645		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  06/02/2023	
NAME OF P	PROVIDER OR SUPPLIEF		9210	T ADDRESS, CITY, STATE, ZIP COD ROCKVILLE RD STE D ANAPOLIS, IN 46234	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	
TAG		CLSC IDENTIFYING INFORMATION for handwashing unless	TAG	machine, changing acid type	DATE S,
	hands are visibly co	ontaminated with blood or		when exchanging a dialysis	
	•	able gloves will be worn when		machine), between patients	even if
		or touching the patient's		the contact is casual, before	
	equipment at the dis	alysis station. Gloves should		touching clean areas such as	3
	be changed when so	oiled, when going from a dirty		supplies, supply cart and	
	area/task to a clean	area/task, when moving from a		chairside keyboard/mouse.	
	contaminated body	site to a clean body site of the		2) Use of an alcohol-based h	and
	same patient, and a	fter touching one patient or		rub may be substituted for	
	their dialysis delive	ry system and before arriving		handwashing.	
	to care for or touch	another patient's dialysis		3) Disposable gloves will be	worn
	delivery system.			when caring for the patient of	r
			touching the patient's equipm	nent	
	2. On 05/30/23 at 11:30 AM, PCT 3 completed			at the dialysis station	
	hand hygiene, donn	ed gloves, and began opening		4) Gloves should be changed	d
		rside tray of occupied station		when: When soiledWhen g	joing
	4. Without removin	g her gloves, PCT 3 walked to		from a "dirty" area or task to	a
	the central drawers	and obtained supplies which		"clean" area or task; When m	oving
	she placed on the tr	ay at Station #4. PCT 3		from a contaminated body sit	e to
		s, completed hand hygiene,		a clean body site of the same	)
	donned new gloves	, and proceeded with patient		patient; and, After touching o	ne
		o remove her gloves and		patient or their dialysis delive	ry
		ene when moving from dirty to		system and before arriving to	care
	clean and after havi	ng direct patient contact.		for another patient or touch	
				another patient's dialysis deli	very
		:25 PM, PCT (Patient Care		system.	
		ted Patient #6 to don a glove,		5) Patients and caregivers w	
		to the AV (arterial venous) site		encouraged to: Perform hand	
	-	iscontinued. PCT 2 failed to		hygiene after treatment befor	e
	-	sanitizer before the patient		leaving treatment area.	
	_	nd after the patient discarded		The Facility Administrator or	
	the glove.			designee will conduct	
	4 0 05/01/00 0	40 DM DOT 1		observational audits on each	
		:48 PM, PCT 1 completed hand		daily x 2 weeks, then weekly	
		ean gloves, pulled the rolling		weeks to verify compliance w	/ith
	_	oser to Patient #34's chair, then		facility policy. Ongoing	
		eedles from the patient's AV		compliance will be verified m	-
		maintain infection control		during the internal infection of	ontrol
	when going from cl	ean to dirty and back.		audit.	
				The Facility Administrator wil	l

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

PRINTED: 06/19/2023 FORM APPROVED OMB NO. 0938-039

152645	A. BUILDING 00  B. WING	COMPLETED 06/02/2023				
NAME OF PROVIDER OR SUPPLIER  AVON DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP COD 9210 ROCKVILLE RD STE D INDIANAPOLIS, IN 46234					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG REGULATORY OR LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	ON (X5) BE COMPLETION DATE				
5. On 05/31/23 at 3:04 PM, PCT 1 completed hand hygiene, donned clean gloves, reinfused the circuit for Patient #22, picked the patient's bag up from the floor, folded the patient's blanket, adjusted the patient's oxygen mask, and had Patient #22 stand for the blood pressure check. After the patient was seated again, PCT 1 pulled her chair closer to the patient, assisted the patient to don a glove to hold pressure, and initiated discontinuation of dialysis. After bleeding stopped, PCT 1 discarded the patient's glove and escorted the patient to the scale. PCT 1 failed to follow infection control standards for hand hygiene when moving from clean to dirty to clean, failed to follow infection control protocol when discontinuing dialysis from an AV site, and failed to ensure the patient completed hand hygiene before and after gloving.  6. On 06/01/23 at 10:31 AM, PCT 1 donned gloves, silenced the circuit at Station #4, discarded her gloves, obtained supplies from the central drawers, took them to Station #11, donned clean gloves, and exited to the lobby to escort an incoming patient. PCT 1 failed to complete hand hygiene before and after changing gloves, when moving from clean to dirty, and prior to obtaining supplies when not wearing gloves.  7. On 06/01/23 at 11 AM, PCT 2 discarded her gloves after removing Patient #1's soiled CVC (Central Venous Catheter) dressing, applied a pump of hand sanitizer to her left palm, rubbed both palms together for 3 seconds, donned clean gloves, and performed the remainder of the dressing change. When finished, PCT 2 discarded her gloves, and performed the remainder of the dressing change. When finished, PCT 2 discarded her gloves, and began initiation of dialysis for Patient #1. PCT 2 failed to maintain infection	review audit results with the Medical Director during mo Quality Assurance Perform Improvement meetings, kneed Facility Health Meetings, we supporting documentation included in the meeting mire. The Facility Administrator is responsible for ongoing compliance with the Plan of Correction.	enthly ance own as ith nutes.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			ETED	
		152645	B. WING 06/02/2023			2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	ł.			OCKVILLE RD STE D		
AVON DI	ALYSIS				APOLIS, IN 46234		
	7121010			110000	711 0210, 111 10201		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	
	control standards for hand hygiene/gloving						
	-	ient contact, during a CVC					
	dressing change, an	d when changing gloves.					
		:55 AM, PCT 2 assisted Patient					
	_	and hold pressure to the AV					
	_	stopped, Patient #15					
		, weighed, and exited the					
	-	led to ensure Patient #17					
	performed hand hygiene prior to donning and doffing gloves.  9. On 06/02/22 at 10:28 AM, RN 4 assisted Patient						
	#20 to don a glove and hold pressure to the AV						
	_	stopped, RN 4 assisted the					
		the glove and escorted the					
	-	RN 4 failed to ensure Patient					
	_	d hygiene before and after					
	gloving.						
	11 On 06/02 23 at	11:45 AM, the Administrator					
		ene should be completed					
		gloving, before handling					
		and when typing at the shared					
		stations. Gloves should be					
	•	atients, when moving from					
		and patients should complete					
	-	e and after gloving to hold					
		e.12. During an observation					
	•	lash tour on 05-30-2023 at 9:50					
		n above the sink at the					
	-	tment area that stated, "Please					
	wash your hands and access."						
	13. During an obser	rvation on 05-30-2023 at 2:30					
	_	s observed holding pressure to					
		tula site post dialysis with a					
		CT 2 applied a new dressing to					
	-	site. Patient #10, removed					
		d their belongings, and left the					
	5 , 5						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

THWI11 Facility ID: 012543

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 152645		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  06/02/2023				
NAME OF F	PROVIDER OR SUPPLIEF	₹	9210 F	STREET ADDRESS, CITY, STATE, ZIP COD 9210 ROCKVILLE RD STE D INDIANAPOLIS, IN 46234				
(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 CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	IOULD BE COMPLETION			
	hand sanitizer or in	ent #10 was not offered any structed to perform hand ving the treatment area.						
	PM, RN 3 was obsed discontinuing Patie RN with gloved har machine alarm, the keyboard, without a performing hand hy to the nursing static and obtained alcoholotheir gloves and per RN then removed thand hygiene after the barrier on the transport of their right upper left gloved hand. The same of the same of the patient #29 was an according to the proper left gloved hand. The same of the patient #29 was an according to leaving the samitizer or instruct prior to leaving the	nt #26 dialysis treatment. The nds silenced the dialysate in entered data on the island removing their gloves and regions. The RN then proceeded on island opened the drawer of wiges without removing reforming hand hygiene. The their gloves and completed placing the alcohol pads on ay of the lounge chair.  Tryation on 06-01-2023 at 9:55 as observed holding pressure fistula site post dialysis with a the Registered Nurse (RN), RN 429, removed their glove, agings, and left the treatment as not offered any hand ed to perform hand hygiene treatment area.						
	treatment area. RN and instructed Patic 10 for initiation of a hand sanitizer or in	s observed entering the 1 took Patient #5's temperature ent #5 to proceeded to Station dialysis. RN 1 failed to offer struct Patient #5 to perform e going to their chair.						
	AM, Patient #1, wa treatment area. Pati	rvation on 06-01-2023 at 10:30 as observed entering the ent #1 proceeded to the scale r initiation of dialysis. The						

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Event ID:

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Facility ID: 012543

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 152645		1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		COMI	(X3) DATE SURVEY COMPLETED 06/02/2023		
NAME OF PRO	OVIDER OR SUPPLIER LYSIS		921	STREET ADDRESS, CITY, STATE, ZIP COD 9210 ROCKVILLE RD STE D INDIANAPOLIS, IN 46234				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFII TAG	(	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	hand sanitizer or ins	cian, PCT 3, failed to offer struct Patient #5 to perform e going to their chair.						
	AM, Patient #18, was treatment area. Patie for initiation of dialy hand sanitizer or ins	vation on 06-02-2023 at 9:55 as observed entering the ent #18 proceeded to Station 2 ysis. PCT #3 failed to offer struct Patient #18 to perform e going to their chair.						
	AM, Patient #21 wa to their left lower ar right gloved hand. F glove, gathered thei treatment area. Patie hand sanitizer or ins	vation on 06-02-2023 at 10:02 as observed holding pressure rm access post dialysis with a Patient #21, removed their r belongings, and left the ent #21 was not offered any structed to perform hand wing the treatment area.						
	was completed on 0 Personnel record co titled, "Star Learnin	Personnel Record for RN 3, 6-01-2023 at 2:00 PM. RN 3's ntained a facility certificate g" that indicated RN 3 tted the agency's Infection 02-28-2023.						
	Area Clinical Team the patient washing to initiation of dialy were to be offered haccess upon entering discontinuation of tream Lead further iremoved and hand he supply drawers, on the computer isla	ton 06-01-2023 at 3:05 PM, the Lead, when queried regarding their hands and access prior sis, confirmed the patients and hygiene and wash their g the treatment area and after reatment. The Area Clinical indicated; gloves were to be anygiene prior to getting into gloves were not to be worn and keyboards, and hand oves were to be donned after the machine.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 152645		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction (2)	(X3) DATE SURVEY COMPLETED 06/02/2023	
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD 9210 ROCKVILLE RD STE D INDIANAPOLIS, IN 46234			
(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 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 dialysis stations were cleaned and disinfected between patients, including but not limited to the surfaces of the dialysis machine, tubing, chair, counter, the blood pressure cuff, and shelf for 2 of 5 station cleaning observations. (PCT 6, RN 4)  Findings include:  1. A review of facility policy 1-05-01, "Infection Control for Dialysis Facilities," last revised 04/23, indicated, but was not limited to, disinfection should be completed by using a wiping motion with friction. All surfaces should be visibly wet. Surfaces should be allowed to air dry. At the end of each treatment, the dialysis station will be cleaned and disinfected, including but not limited to all surfaces in contact with the patient or their belongings and frequently contacted by healthcare personnel, such as the control panel, top/front/sides of dialysis machine, touchscreens, and countertops. The wall box, drain, and water supply lines and prime container are considered part of the delivery system. Non-disposable items are to be disinfected after each patient use. The chair side cart, monitor, and keyboard are considered clean areas.	V 0122	The Facility Administrator or designee will in-service all clinic teammates on Policy 1-05-01 "Infection Control For Dialysis Facilities". Verification of attendance will be evidenced by an in-service sign in sheet. Teammates will be educated us surveyor observations as examples with emphasis on, bu not limited to the following:  1) Disinfection should be completed by using a wiping motion with friction.  2) Sufficient disinfectant should applied so that surfaces are visiwet.  3) Surfaces should be allowed the air dry in order to provide sufficing disinfectant contact time.  4) At the end of each treatment the dialysis station will be clean and disinfected.  5) Surfaces to disinfect include are not necessarily limited to: a surfaces in contact with the patient or their belongings (e.g., dialysis chair, tray tables, blood	be ibly to ient , , , , , , , , , , , , , , , , , , ,	

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THWI11 Facility ID: 012543

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

PRINTED: 06/19/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING 00		(X3) DATE SURVEY  COMPLETED		
AND I LAIN	or condition	152645	B. W		<u></u>	06/02	
		102010	<i>D.</i> "			30/02/	2020
NAME OF F	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
AVON DI	ΔΙ VSIS				OCKVILLE RD STE D APOLIS, IN 46234		
AVOINDI	AL 1 010			INDIAN	I OLIO, IIN 40204		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
	2 0 - 05/21/22 -+ 2	21 DM DCT (D-4:4 C			pressure cuffs) and frequently		
		:21 PM, PCT (Patient Care observed cleaning Station #11			contacted by healthcare perso		
	· · · · · · · · · · · · · · · · · · ·	d vacated the station, PCT 6			(e.g., control panel; top, front	and	
		vipes and cleaned the surface			sides of dialysis machine;		
		p, then wiped the chair's center			touchscreens; countertops).	_4	
		or motion. PCT 6 failed to			6) The Wall box, Drain and W		
		and perform hand hygiene after			supply lines are considered pa	art Oi	
		lines and disposable			the dialysis delivery system.	- h-	
	_	-			7) Non-disposable items are to	o be	
	equipment, failed to clean the prime container inside and out, failed to visibly wet all areas of the				disinfected after each patient use8) The chair side cart,		
	machine, including the top, front, and side				terminals mounted on the cou	ntor	
	surfaces and dialysate hoses and connectors.				monitor and keyboard are	iilei,	
	PCT 6 failed to fully recline the chair and visibly				considered clean areas.		
		nt-facing and side-chair			The Facility Administrator or		
		down sides of the seat			designee will conduct		
		the trays, and failed to clean			observational audits on each		
	the TV.	the trays, and ranea to elean			daily x 2 weeks, then weekly		
	ine i v.				weeks to verify compliance wi		
	3. On 06/01/23 at 1	0:07 AM, RN (Registered			facility policy. Ongoing		
		ved cleaning Station #7, which			compliance will be verified mo	nthly	
	*	RN 4 obtained bleach wipes			during the internal infection co	-	
		viping the center surfaces of			audit.		
		seat. RN 4 partially opened the			The Facility Administrator will		
		ed the front surface of each			review audit results with the		
		nediately closed the sides, and			Medical Director during month	ıly	
	· ·	4 failed to fully open the chair			Quality Assurance Performan	-	
		osed areas, failed to fully wet			Improvement meetings, know		
		cing and side-chair surfaces,			Facility Health Meetings, with		
		the chair to air dry before			supporting documentation		
	closing the sides.				included in the meeting minute	es.	
					The Facility Administrator is		
	On 06/01/23 at 2:45 PM, the Administrator and				responsible for ongoing		
		as queried about dialysis			compliance with the Plan of		
	station cleaning. The Area Team Lead indicated				Correction.		
		cleaning was inclusive of the					
		chine/lines/hoses/sides/wall					
	box using 1:100 ble	each solution.					

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Event ID:

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

PRINTED: 06/19/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 152645		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/02/2023		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 9210 ROCKVILLE RD STE D INDIANAPOLIS, IN 46234			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
V 0146	494.30(c)(2) IC-CATHETERS:(	GENERAL				
Bldg. 00	(2) The "Guideline Intravascular Cathentitled "Recomme Intravascular Cathentitled "Recomme Intravascular Catheters, Includir and Pulmonary Ar Pediatric Patients, Weekly Report, vor pages 16 through Director of the Fedincorporation by respectively 5 U.S.C. 552(a) and publication is avaited CMS Information I Security Boulevard Baltimore, MD or and Records Adminary be obtained a Resource Center. availability of this 202-741-6030, or	es for the Prevention of neter-Related Infections" endations for Placement of neters in Adults and IV; and "Central Venousing PICCs, Hemodialysis, tery Catheters in Adult and "Morbidity and Mortality plume 51 number RR-10, 18, August 9, 2002. The deral Register approves this eference in accordance with and 1 CFR Part 51. This lable for inspection as the Resource Center, 7500 d, Central Building, at the National Archives inistration (NARA). Copies at the CMS Information For information on the material at NARA, call go to: es.gov/federal_register/code				
	interview the facility maintained aseptic to central vascular acceptatheter site care ob Technician (PCT) 3  Findings include:  1. A review of policy "Central Venous Cath HD [Hemodialysis] Procedure," indicate	on, record review, and y failed to ensure all staff technique while caring for esses for 4 of 4 central venous eservations (Patient Care (2 times) and PCT 2 (2 times)).  ey 1-04-02B, last revised 04/23, theter (CVC) with ClearGuard Antimicrobial End Caps ed, but was not limited to, ene and don clean gloves,	V 0146	The Facility Administrator or designee will in-service all clin teammates on Policy 1-04-028 "Central Venous Catheter (CV With CLEARGUARD HD Antimicrobial End Caps Procedure". Verification of attendance will be evidenced an in-service sign in sheet. Teammates will be educated a surveyor observations as examples with emphasis on, be not limited to the following:	B C) by using	

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		152645	B. W	ING		06/02/	2023
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			OCKVILLE RD STE D		
AVON DI	INI VQIQ				APOLIS, IN 46234		
AVON DI	ML 1 313			INDIAN	AFOLIS, IN 40234		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
		that clothing is away from the			procedure.		
	exit site, place a moisture proof barrier under				2) Put on PPE		
	catheter limbs, remove old dressing and discard.				3) Verify patient's clothing is		
	_	discard, perform hand			secured away from the exit		
		gloves. Hold catheter with			site/work area.		
		and clean the exit site with 2%			4) Place the second moisture		
		conate/70% Isopropyl Alcohol			proof barrier under catheter		
		m of 30 seconds using a			limbs.		
	•	ern with gentle friction			5) Remove old dressing and		
		e insertion site to the			discard.		
		h sides of the swab. Repeat if			6) Remove gloves and discard	d.	
	site is not free of exudates, using a new swab.				7) Perform hand hygiene per		
	Clean each CVC limb/cap with a new large alcohol				procedure and re-glove.		
		lose to the exit site and			8) Holding catheter with the		
	finishing with the c	ap.			nondominant hand and using		
					aseptic technique, clean exit s	ite	
		:40 AM, PCT 3 was observed			with 2% Chlorhexidine		
		e of the CVC for Patient #3.			Gluconate/70% Isopropyl Alco	hol	
		d discarded the old dressing,			swab for a minimum of 30		
		giene, and donned clean			seconds, apply to the CVC ex		
	_	the site using a 2%			site in a "back and forth" patte		
		conate/70%Isopropyl Alcohol			using gentle friction progressir	ng	
		bserved wiping the swab			from the insertion site to the		
	-	exposed area, moving back and			periphery using both sides of t	the	
		ide to the right, over the entry			swab. If site is not free of		
		atheter, and underneath the			exudates, repeat this step with	ו	
		inged sides of the swab			new 2% Chlorhexidine		
	-	g cleaning and returned			Gluconate/70% Isopropyl Alco	hol	
	_	eas already cleaned. PCT 3 was			swab.		
		ping the insertion point, then			9) Clean each CVC limb/cap v		
		e of the CVC area, wiping the			a new LARGE alcohol prep pa		
		ning to the insertion site and			starting close to the exit site a	nd	
	cleaning down the catheter again. PCT 3 failed to				finishing with the cap.		
	secure the catheter with her non-dominant hand,				The Facility Administrator or		
		side by moving from the			designee will conduct		
		periphery, and failed to switch			observational audits on each	shift	
	to a clean side of th	e swab when changing sides.			for CVC care daily x 2 weeks,		
	2 0 0 2/20/22	1 40 AM DOT 2			then weekly x 2 weeks to verif	-	
		1:40 AM, PCT 3 was observed			compliance with facility policy.		
	performing site care	e of the CVC for Patient #34.	1		Ongoing compliance will be		

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

PRINTED: 06/19/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 152645	l í	JILDING	onstruction 00	(X3) DATE COMPL <b>06/02</b> /	ETED
	PROVIDER OR SUPPLIEI			9210 R	ADDRESS, CITY, STATE, ZIP COD OCKVILLE RD STE D APOLIS, IN 46234		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	PCT 3 was observed over the exposed ar from each side of the site and down the catheter. PCT 3 chaintermittently during recleaned areas presobserved wiping the the right side of the then returning to the down the catheter at the catheter with he clean each side by to the periphery, and side of the swab what was observed wiping site car pCT 2 was observed over the exposed arcircular from the leentry site and down the catheter. PCT2 intermittently during intermittently to are failed to secure the non-dominant hand moving from the in and failed to switch when changing side of the swab when changing side of the swap observed wiping exposed area, moving from the left side to and down the catheter. PCT2 chaintermittently during the catheter.	d wiping the swab randomly rea, moving back and forth ne entry point, over the entry atheter, and underneath the anged sides of the swab g cleaning and intermittently viously cleaned. PCT 3 was re insertion point then wiping CVC area, wiping the left side, re insertion site and cleaning gain. PCT 3 failed to secure re non-dominant hand, failed to moving from the insertion site d failed to switch to a clean ren changing sides.  1:10 AM, PCT 2 was observed re of the CVC for Patient #3. d wiping the swab randomly rea, moving back and forth and fit side to the right, over the rea the catheter, and underneath changed sides of the swab g cleaning and returned reas already cleaned. PCT 2 catheter with her reas failed to clean each side by sertion site to the periphery, reas to a clean side of the swab			verified monthly during the interior infection control audit.  The Facility Administrator will review audit results with the Medical Director during month Quality Assurance Performant Improvement meetings, know Facility Health Meetings, with supporting documentation included in the meeting minute. The Facility Administrator is responsible for ongoing compliance with the Plan of Correction.	ernal ally ce n as	

FORM CMS-2567(02-99) Previous Versions Obsolete

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

PRINTED: 06/19/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 152645	A. BUILDING 00 COMPLETED  B. WING 06/02/2023				
132043			<u> </u>			06/02/	2023
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
AVON DI	ALYSIS				APOLIS, IN 46234		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		EFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION
TAG	failed to secure the one-dominant hand, moving from the instant failed to switch when changing side 6. On 06/02/23 at 11 indicated CVC site entry site and down Chlorhexidine Gluc swab. Then, using a beginning at the entand from top to bott side using the other Team Lead indicate site did not meet stacare.	failed to clean each side by sertion site to the periphery, to a clean side of the swab		AG	DA RELACTI		DATE
V 0190 Bldg. 00	494.40(a) SOFTENERS-AU <sup>T</sup> REGENERATE/TI 5.2.4 Softeners: au						
	restored; that is, n ions are placed on known as "regene						
	Automatically rege Automatically rege shall be fitted with water containing the sodium chloride us	enerated water softeners: enerated water softeners a mechanism to prevent ne high concentrations of sed during regeneration product water line during					

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Event ID:

THWI11 Facility ID: 012543

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA (X2)		LTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	00	COMPLETED	
152645		B. WIN	G		06/02	/2023	
NAME OF I	PROVIDER OR SUPPLIER	· {			ADDRESS, CITY, STATE, ZIP COD		
AVON D					OCKVILLE RD STE D APOLIS, IN 46234		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	regeneration cycle user.	ners used to control the e should be visible to the					
	6.2.4 Softeners						
		checked at the beginning of					
	1	uld be interlocked with the it the RO is stopped when					
	1	ration cycle is initiated.					
	a solitorior regente	ration by old to initiation.					
	The softener brine	e tank should be monitored					
	daily to ensure that	at a saturated salt solution					
		tank. Salt pellets should fill					
		nk. Salt designated as rock					
	salt should not be						
	_	e it is not refined and					
	1	sediments and other					
	1	y damage O-rings and orifices in the softener					
	control head.	offices in the softener					
		on, interview, and record	V 019	90	The Facility Administrator or		07/01/2023
		failed to accurately monitor and	, 01		designee will in-service all clir	nical	0770172023
	maintain the water	softener equipment and			teammates on Policy 2-03-01		
		ank to lack salt pellets to the			"Water Treatment System		
		aired levels. This failure had the			Minimum Component		
		ely affect the health and			Requirement" and 2-04-01A "	-	
		in-center hemodialysis			Log Explanation 3rd Doc "Wa		
	patients.				Treatment Minimum Compone	ent	
	Findings Include:				System". Verification of attendance will be evidenced an in-service sign in sheet.	by	
	1. A review of a Da	Vita Incorporated policy, with a			Teammates will be educated	using	
		tober 2021, titled, "Water			surveyor observations as	J	
	Treatment Systems	Minimum Component			examples with emphasis on, b	out	
		provided by the Facility			not limited to the following:		
	· · ·	, on 06-01-2023, at 8:30 AM.			1) When water softeners are		
		cated but was not limited to, "			required, the maximum hardn		
		eners are required, the maximum			of softened water produced w	ill	
		d water produced will meet the			meet the RO manufacturers'		
	Reverse Osmosis m	nanufacturer's specifications			specifications.		

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Event ID:

THWI11

Facility ID: 012543

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DATE PLAN OF CORRECTION  IDENTIFICATION NUMBER  A. BILLINNS B. WINO  STREET ADDRESS, CITY, STATE, APP COD 9210 ROCKVILLE RD STE D  INDIANAPOLIS, IN 46234  XAON DIALYSIS  AND SUMMARY STATEMENT OF DEFICIENCIE PREFEX GRACH DEFICIENCY MIST BE PRECIPED BY BELL AGE REQULATORY FOR SEE DENTIFYING INFORMATION Facilities are required to establish specific procedures that verify and demonstrate functionality of all critical alarm monitoring for both remote and proximal devices"  2. A review a DaVita Incorporated document dated August 2008, titled "Daily Water Treatment Log explanation" was proved by the FA, on 06-01-2023 at 8:30 AM. The document indicated but was not limited v., "Salt Level Briae Tank? Tank at least half full Yes/No/Not Applicably. Brine Tank. At the start of each operation day, check the salt level in the brine tank. If the salt level is above half fall, unter "N' (NO). Fill brine tank with salt to the appropriate level and record action taken on the daily log. If necessary, contact the Biomed Team for direction and assistance"  3. A review of the documents titled "Daily Water Log" dated 05-01-2023 through 05-31-2023, was provided by the FA on 06-01-2023, at 8:30 AM. The documents indicated in the section titled, "Stalt Level in Brine Tank" documented "No" on the dates of 05-05, 05-66, 05-07, 05-08, 05-10, 05-22, 05-23, 05-24, 05-25, 05-26, 05-27, 05-28, 05-29, 05-30, and 05-31-2023.  A Druing an observation during the facility flash tour on 05-30-2023 at 9.45 AM, observed the brine tank to be k full, water covered the salt pellets approximately six inches.  5. During an interview on 05-30-2023 at 12:30 PM, the Biomed Manager, when queried to restablish specific procedures that the Biomed Teach Tank at least half full Y / N /NA - Brine Tank Salt Level - Tank at least half full Y / N /NA - Brine Tank: Tank Salt Level - Tank at least half full Y / N /NA - Brine Tank: Tank Salt Level - Tank at least half full Y / N /NA - Brine Tank: Tank the least half full Y / N /NA - Brine Tank: Tank the lea			X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
STREET ADDRESS. CITY, STATE, ZIP COD 9210 ROCKVILLE RD STE D INDIANAPOLIS, IN 46234  (XA) ID SUMMARY STATEMENT OF DEFICIENCIE (SACH DEFICIENCY MAST ARE PRECEIPED BY PULL TAG. IN 16234 AND 16234 AN			IDENTIFICATION NUMBER	A. BU					
AVON DIALYSIS    AVON DIALYSIS   SUMMARY STATEMENT OF DEFICIENCE	152645		B. WING 06/02/2023				/2023		
AVON DIALYSIS    AVON DIALYSIS   SUMMARY STATEMENT OF DEFICIENCE			<u> </u>	1	STREET A	ADDRESS, CITY, STATE, ZIP COD			
ID   PREFIX   CACH DEFICENCY MUST BE PRECEDED BY FULL   TAG   CACH DEFICENCY MUST BY TAG   CACH DEFICENCY MUST BE PRECEDED BY FULL   TAG   CACH DEFICENCY MUST BY TAG   CACH DEFICENCY MUST BE PRECEDED BY FULL   TAG   CACH DEFICENCY MUST BY TAG   CACH DEFI	NAME OF P	ROVIDER OR SUPPLIER	8						
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION  TAG REGULATORY OR LSC IDENTIFYING INFORMATION  REGULATORY OR LAW PROPERATE  REGULATORY OR L	AVON DI	ALYSIS		_	INDIAN	IAPOLIS, IN 46234			
### REGULATORY OR LSC IDENTIFYING INFORMATION  ###################################		SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
		`				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE		
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both remote and proximal devices"  2. A review a DaVita Incorporated document dated August 2008, titled "Daily Water Treatment Log explanation" was proved by the FA, on 06-01-2023 at 8:30 AM. The document indicated but was not limited to, "Salt Level Brine Tank? Tank at least half full Y N [NA- Brine Tank: Fill Scavenger brine tank with salt to the appropriate level is above half full in the brine tank enter "Y" (YES) to indicate level is above half full, enter "N" (NO). Fill brine tank with salt to the appropriate level and record action taken on the daily log. If necessary, contact the Biomed Team for direction and assistance"  3. A review of the documents titled "Daily Water Log" dated 05-01-2023 through 05-31-2023, was provided by the FA on 06-01-2023, at 8:30 AM. The documents indicated in the section titled, "Salt Level in Brine Tank?" documented "No" on the dates of 05-05, 05-06, 05-07, 05-08, 05-10, 05-11, 05-12, 05-13, 05-14, 05-15, 05-16, 05-19, 05-29, 05-30, and 05-31-2023.  4. During an observation during the facility flash tour on 05-30-2002 at 9/45 AM, observed the brine tank to be ½ full, water covered the salt pellets approximately six inches.  5. During an interview on 05-30-2023 at 12:30 PM, the Biomed Manager, when queried regarding the		-	=			• • • • • • • • • • • • • • • • • • • •	that		
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Tank at least half full Yes/No/Not Applicably. Brine Tank. At the start of each operation day, check the salt level in the brine tank. If the salt level is above half full in the brine tank enter "V" (YES) to indicate level is appropriate. If "Y" is entered, no other action is required for that day. If the level is not half full, enter "N" (NO). Fill brine tank with salt to the appropriate level and record action taken on the daily log. If necessary, contact the Biomed Team for direction and assistance"  3. A review of the documents titled "Daily Water Log" and observe the salt pellet level in the brine tank daily x 2 weeks, then weekly x 2 weeks to verify compliance will be verified monthly x 3 months. Instances of non-compliance will be addressed immediately.  "Salt Level in Brine Tank?" documented "No" on the dates of 05-05, 05-06, 05-07, 05-08, 05-10, 05-11, 05-12, 05-13, 05-14, 05-15, 05-16, 05-19, 05-22, 05-23, 05-24, 05-25, 05-26, 05-27, 05-28, 05-29, 05-30, and 05-31-2023.  4. During an observation during the facility flash tour on 05-30-2023 at 9:45 AM, observed the brine tank to be ½ full, water covered the salt pellets approximately six inches.  5. During an interview on 05-30-2023 at 12:30 PM, the Biomed Manager, when queried regarding the							iger		
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the Biomed Manager, when queried regarding the		5 During an intervi	ew on 05-30-2023 at 12:30 DM						
		•				COTTECUOIT.			
brine tank level, confirmed the salt pellets should		· ·							
be above the water level but the water should still			-						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 152645		(X2) MULTIF A. BUILDIN B. WING	PLE CONSTRUCTION NG <u>00</u>	(X3) DATE SURVEY COMPLETED 06/02/2023	
NAME OF P	PROVIDER OR SUPPLIER ALYSIS		92	REET ADDRESS, CITY, STATE, ZIP COD 10 ROCKVILLE RD STE D DIANAPOLIS, IN 46234	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ank should be half full.	ID PREF TA	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	OBE COMPLETION
	6. During an observ AM, observed the b salt pellets ½ level of approximated 6 includes the salt pellets. A must the brine tank indicated the brine tank indicated the brine tank indicated the salt pellets. A must the Br. During an observed in the wall "Salt" above a salt.  8. During an intervities FA, indicated the and the order of salt mistake and the facility to the FA further the FA further the salt per salt.	ation on 05-31-2023 at 10:40 rine tank lid not closed, the of the tank level, and with nes of water (H2O) covering anufacture label adhered to ated, "Verify salt level is above			
V 0407 Bldg. 00	hemodialysis treat safety, (video survequirement). Based on observation staff failed to ensure were visable at all trand 36.) Findings Include:  1. During an observation AM, Patient #10 at with a gray blanket.	etw DURING  n view of staff during ment to ensure patient reillance will not meet this on, and interview the faiclity re that the patients' accesses times. (Patient: 10, 4, 22, 26, 9  ation on 05-31-2023 at 9:15 Station 10 was fully covered The patient's access was not taff. The patient's access	V 0407	The Facility Administrator designee will in-service all teammates on Policy 1-03 "Pre-Intra-Post Data Colled Monitoring and Nursing Assessment". Verification attendance will be evidence an in-service sign in sheet Teammates will be educat surveyor observations as examples with emphasis of	clinical -08 ction,  of ced by . ed using

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

THWI11

Facility ID: 012543

If continuation sheet Page 16 of 22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (AND PLAN OF CORRECTION IDENTIFICATION NUMBER 152645		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  06/02/2023	
NAME OF F	PROVIDER OR SUPPLIEF		9210 F	ADDRESS, CITY, STATE, ZIP COD ROCKVILLE RD STE D NAPOLIS, IN 46234	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	(X5) COMPLETION
TAG	remained covered u	antil 9:40 AM.	TAG	not limited to the following:  1) The vascular access site, but the following:	DATE
	tour, Patient #4 was while sleeping in a	0:31 AM, during the initial flash sobserved receiving dialysis reclined chair. The patient's with a blanket and the dialysis		line connections and the patie face should be visible through the dialysis treatment.  The Facility Administrator or designee will conduct observational audits on each	ent's nout
	observed receiving reclined chair. The	2:55 PM, Patient #22 was dialysis while sleeping in a patient's extremities, torso, and with a blanket. The patient's t visible.		daily x 2 weeks, then weekly weeks to verify compliance w facility policy. Ongoing compliance will be verified moduring the internal infection coaudit.	x 2 ith onthly
	PM, Patient #26 at	vation on 05-31-2023 at 3:20 Station 15 was fully covered The patient's access was not staff.		The Facility Administrator will review audit results with the Medical Director during montl Quality Assurance Performan Improvement meetings, know	hly
	PM, Patient #9 at S	ration on 05-31-2023 at 3:20 tation 6 was fully covered with patient's access was not fully		Facility Health Meetings, with supporting documentation included in the meeting minut. The Facility Administrator is responsible for ongoing	
	observed receiving reclined chair. The	:53 AM, Patient # 36 was dialysis while sleeping in a patient was covered with a o feet. The patient's dialysis		compliance with the Plan of Correction.	
	remained covered v site was not visible. Technician) was pro	t 10:15 AM, Patient #36 with a blanket and the dialysis PCT 6 (Patient Care esent in the patient's room and e dialysis site before leaving			
	the Area Clinical To	ov on 06-02-2023 at 12:00 PM, eam Lead, confirmed that the te to be visible to staff at all			

CTATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
			î î				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
152645			B. WING 06/02/2023				
NAME OF F	PROVIDER OR SUPPLIER	2	9210 R	ADDRESS, CITY, STATE, ZIP COD COCKVILLE RD STE D JAPOLIS, IN 46234			
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(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	times.						
V 0506 Bldg. 00	The patient's com	DN/MEDICATION HISTORY prehensive assessment is not limited to, the					
	Based on record reversal failed to ensure that was known and doct the facility in 1 of 2 reviewed, (Patient # patient records cont medications the patactive patient records Findings Include:  1. A review of an approximate that the patactive patient records are patient records.	view and interview, the facility that a TB (tuberculosis) status reumented prior to admission to the new admission records #1) and failed to ensure all reained an accurate list of itent takes at home, for 1 of 7 ds reviewed. (Patient #22)	V 0506	The Facility Administrator or designee will in-service all clir teammates on Policy 12-07-0 "Tuberculosis Infection Contro Policy". Verification of attenda will be evidenced by an in-ser sign in sheet. Teammates will educated using surveyor observations as examples with emphasis on, but not limited to the following:  1) PURPOSE: To minimize the exposure of tuberculosis in the dialysis setting.	3 ol ance vice I be h o		
	Control Policy" was Administrator (FA) The document indic "PURPOSE: To mi tuberculosis in the Admission New to Admission from a provide the following treatment Requirestep) completed with admission; or Requirestep) completed treatment; or Required documented Requirestep admission; or Required from the Requirement for Required from the Requirement for Required from the Requirement from the Requirement for Requirement from the Requirem	s provided by the Facility , on 05-31-2023, at 1:45 PM. cated but was not limited to, nimize the exposure of dialysis setting Permanent Dialysis OR Permanent Non-DaVita Facility is to ng documentation prior to first ement #1: Negative TST (one thin three (3) months prior to irement #2 Negative TST ed 3 months prior to first rement #4 Chest X-ray and uirement #1 met- Administer a ep of two step TST) one (1) to er the pre-admission TST was as possible following		2) Permanent Admission New Dialysis OR Permanent Admission from a Non-DaVita Facility is to provide the follow documentation prior to first treatment 3) Requirement # 1: Negative (one-step) completed within the (3) months prior to admission; Requirement # 2: Negative TS (two-step) completed within the (3) months prior to first treatment; Requirement # 4 CXR and documented 4) Requirement # 1 met – Administer a second TST (2nd step of two-step TST) one (1)	ving TST nree ST nree		

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Event ID:

THWI11

Facility ID: 012543

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 152645		A. BUILDING <u>00</u> COMPLI			(X3) DATE SURVEY COMPLETED 06/02/2023	
NAME OF	PROVIDER OR SUPPLIE	R	•		ADDRESS, CITY, STATE, ZIP COD	
		ı.			OCKVILLE RD STE D	
AVON D	HALYSIS			INDIAN	IAPOLIS, IN 46234	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	admission "				three (3) weeks after the	
		1. 1.06.074 811			pre-admission TST was obtain	
		lity procedure 1-06-07A, "Home			or as soon as possible follow	ing
		ciliation Procedure," indicated,			admissionThe Facility	
		to, home medication			Administrator or designee wil	
		uld be completed monthly. tion reconciliation, the licensed			audit 100% of medical record	is ior
	_	he home medications with the			patients admitted during the	vorify
		nd validate the list of			previous three (3) months to that a Tuberculosis status wa	-
		tient is taking by comparing it			known and documented in th	
	_	arce, such as the hospital			medical record prior to admis	
	1 -	y. Additional considerations			Ongoing compliance will be	551011.
		t limited to, reviewing the			verified with 10% of medical	
	· ·	medication, and reviewing			records audited, to include ne	2/W
		ation is correct for the condition			admissions, monthly during the	
	for which it was pr				internal medical record audit.	
	lor which it was pr	eserisea.			The Facility Administrator or	
	3. Review of the "I	Prescribers Digital Reference"			designee will in-service all ho	ome
		e is used for known or			dialysis teammates on Policy	
		verdose and is administered			1-06-07A "Home Medication	
		ılarly, intravenously, or under			Reconciliation Procedure".	
	1	is not manufactured in oral			Verification of attendance will	l be
	form.				evidenced by an in-service si	
					sheet. Teammates will be	
	4. A review of the	clinical record for Patient #1,			educated using surveyor	
		27-2023, was completed on			observations as examples wi	th
	06-05-31-2023 at 1	2:25 PM. The clinical record			emphasis on, but not limited	
	failed to evidence	medical documentation of a			the following:	
		skin test result completed prior			1) Home medication	
		hest x-ray report by a			reconciliations should be	
	radiologist that ind	icated a clear, negative, normal,			performed monthly per CMS	
	or unremarkable re	sult.			Quality Improvement Prograr	n
					(QIP).	
		ity document titled, "TB			2) The licensed nurse will	
	_	Patient #1's name, facility ID,			complete the home medication	on
		edical record number. The			reconciliation with the	
	document was blar	ık.			patient/caregiver.	
					3) During the medication	
		w on 05-31-2023 at 1:55 PM, the			reconciliation, the licensed nu	ırse
	FA, indicated Patie	ent #1 was to have had their TB			will: Review the Home Medic	ation I

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

PRINTED: 06/19/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u>			COMPLETED	
152645			B. WING 06/02/2023				
NAME OF F	PROVIDER OR SUPPLIER		•	9210 R	ADDRESS, CITY, STATE, ZIP COD OCKVILLE RD STE D APOLIS, IN 46234		
	1	CT L TEL VENT OF DEFICIENCIE			- , I	1	775)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		(X5)
TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	TE	COMPLETION DATE
IAG		nd it was being completed		IAG	List with the patient/caregiver	and	DATE
	_	er indicated they could not			validate the list of medications		
	find documentation	•			patient is or is not taking by		
		Kardex for Patient #22,			cross-referencing it against		
	reconciled by RN 5	on 05/15/23, indicated a home			another source hospital		
	medication of Nalo	xone (a medication used to			discharge summary.		
	treat narcotic/opioid	d overdose in an emergency			4) Additional questions to ask	and	
	via nasal, intramuso	cular, intravenous, or under the			things to consider during the h	ome	
		.) 12.5 mg (milligrams) by			medication reconciliation inclu	de:	
	mouth every morning	ng as needed.			What are the indications for th	е	
					medications? Was the right		
		nospital discharge summary			medication prescribed?The		
		st for Patient #22, dated			Facility Administrator or design		
		Naloxegol (a prescription			will audit the "Home Medicatio		
		rally to treat constipation			List" with 100% of home patier	nts	
		se) 12.5 mg by mouth daily as			or caregivers in person or by		
	_	tion. The medication list failed ne was prescribed for Patient			phone to verify accuracy of the "Home Medication List" in		
	#22.	ne was prescribed for Fatient			compliance with facility policy.		
	#22.				Ongoing compliance will be		
	7 On 05/31/23 at 2	:30 PM, the Administrator			verified monthly.		
		ation list on the Kardex for			The Facility Administrator will		
		ctly listed Naloxone instead of			review audit results with the		
		patient's medications were			Medical Director during month	lv	
	inaccurately reconc				Quality Assurance Performand	-	
					Improvement meetings, knowr		
					Facility Health Meetings, with		
					supporting documentation		
					included in the meeting minute	es.	
					The Facility Administrator is		
					responsible for ongoing		
					compliance with the Plan of		
					Correction.		
V 0543	494.90(a)(1)						
v 00-70	POC-MANAGE V	OLUME STATUS					
Bldg. 00		nust address, but not be					
J.49. 00	limited to, the follo						
		is. The interdisciplinary					

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Event ID:

THWI11 Facility ID: 012543

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 152645		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU  A. BUILDING 00 COMPLET  B. WING 06/02/20			LETED		
NAME OF I	PROVIDER OR SUPPLIER			9210 R	ADDRESS, CITY, STATE, ZIP COD OCKVILLE RD STE D APOLIS, IN 46234		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	F	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG	team must provide services to manage status; Based on record reversition failed to ensure that comprehensive asset to the initiation of the state of of the s	Vita Incorporated policy, with a ober 2021, titled, "New Patient uation" was provided by the tor (FA), on 05-31-2023, at 3:00 indicated but was not limited nurse (RN) as required by vill perform an initial ation of all peritoneal dialysis of the initiation of their first at the facility"  linical record for Patient #2, date of 05-09-2023, was -2023 at 1:35 PM. The record document titled, "New Patient al Nurse Assessment" dated and by RN 5, 17 days after reatment.  To on 05-31-2023 at 2:45 PM, the RN), RN 2, indicated they 2's admission paperwork, and tarent on 05-09-2023, and did	V 05	43	The Facility Administrator or designee will in-service all clir teammates on Policy 5-02-28 "New Patient Pre-Treatment Evaluation" 12-07-03 "Tubero Infection Control Policy". Verification of attendance will evidenced by an in-service sig sheet. Teammates will be educated using surveyor observations as examples wit emphasis on, but not limited to the following:  1) A registered nurse (RN) as required by federal regulation perform an initial pretreatment evaluation of all peritoneal dia (PD) patients prior to the initiation of their first treatment/training the facility. The Facility Administrator or designee will audit 100% of medical record patients admitted to the facility during the previous three more to verify compliance with facility policy requiring a pre-treatment evaluation was performed prior the first treatment. Ongoing compliance will be verified with percent (10%) of medical record including new admissions, author the facility Administrator will review audit results with the Medical Director during month Quality Assurance Performant	nical ulosis be gn in h o will t ulysis ution at s for y nths ity nt or to h ten ords, dited	07/01/2023

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  IDENTIFICATION NUMBER 152645  NAME OF PROVIDER OR SUPPLIER  AVON DIALYSIS	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP COD  9210 ROCKVILLE RD STE D  INDIANAPOLIS, IN 46234	(X3) DATE SURVEY COMPLETED 06/02/2023
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FUL TAG REGULATORY OR LSC IDENTIFYING INFORMATIO	ID PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)  Improvement meetings, know Facility Health Meetings, with supporting documentation included in the meeting minut The Facility Administrator is responsible for ongoing compliance with the Plan of	DATE In as

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