STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152512	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARION COUNTY DIALYSIS	3834 S EMERSON AVE BLDG B INDIANAPOLIS, IN 46203

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E 0000 Bldg. 00		E 0000		
	An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62, for a Medicare participating End Stage Renal Disease Supplier. Date of survey: 04-12 and 04-13-2023 Facility #: 005157 CCN: 152512 ICHD: 65 Total Census: 65 At this Emergency Preparedness survey, Marion County Dialysis was found to have been in compliance with the requirements of Emergency Preparedness for Medicare and Medicaid participating providers and suppliers, at 42 CFR 494.62. QR by Area 3 on 4-22 and 4-24-2023			
V 0000 Bldg. 00		V 0000		
	This visit was for a Federal Core Recertification survey survey of an ESRD supplier. Survey dates: 04-12 and 04-13-2023 Facility #: 005157			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jenni Bossom	Facility Administrator	05/02/2023

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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	CCN#: 152512 Census By Service Type: ICHD Census: 65 No Home Hemodialysis Program. No Home Peritoneal Dialysis Program. Total Census: 65 Station: 24, with no isolation room/waiver. QR by Area 3 on 4-22 and 4-23-2023			
V 0113 Bldg. 00	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. Based on observation, record review, and interview, the facility failed to ensure staff used Personal Protective Equipment (PPE) appropriately and the staff and patients had completed appropriate hand hygiene and gloving according to their hand hygiene and gloving policies and procedures in 4 of 4 observations completed. (Employees: Patient Care Technician (PCT)1, 2, 3, 4, and 5, and Registered Nurse (RN) 1, 2, and 3) (Patients: #14, 22, 24, and 26) Findings Include: 1. A review of a DaVita Incorporated policy dated September 2007 and revised on April 2023 was provided by the Facility Administrator (FA), Admin 1, on 04-06-2023 at 11:09 AM. The "Infection Control For Dialysis Facilities," policy	V 0113	The Facility Administrator or designee will inservice all clinical teammates on Policy 1-05-01 “Iinfection Control For Dialysis Facilities”, Policy 1-05-01A “Use of Alcohol-Based Hand Rubs”, and Policy 1-05-01B “Handwashing” beginning 4/10/23. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited	05/13/2023

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	indicated but was not limited to, " ... Hand Hygiene: 1. All teammates ... will perform hand hygiene ... a. prior to gloving and immediately after removal of gloves ... d. after patient and dialysis delivery system contact, e. after interacting with wall boxes ... g. before touching clean areas such as supplies, supply cart, and chairside keyboard/mouse ... 3. Use of an alcohol-based hand rub may be substituted for handwashing ... 2. Patients ... will be encouraged to: a. Wash their hands and access extremity upon entering the treatment area prior to the initiation of dialysis. B. Perform hand hygiene after treatment before leaving the treatment area ..." 2. A review of a DaVita Incorporated policy dated September 2007 and revised on April 2023 was provided by Admin 1, on 04-06-2023 at 11:09 AM. The "Use of Alcohol-Based Hand Rubs" policy indicated but was not limited to, " ... Alcohol-based hand rub containing 60%-95% ethyl alcohol, isopropyl, or a combination of both ... 2. Apply product in palm of one (1) hand. 3. Rub hands together, covering all surfaces of hands and fingers until hand rub has evaporated and hands are dry ..." 3. A review of a DaVita Incorporated policy dated September 2007 and revised on October 2020 was provided by Admin 1, on 04-06-2023 at 11:09 AM. The "Handwashing" policy indicated but was not limited to, " ... 2. Wet hands and apply antibacterial liquid soap. 3. Cover hands (palms, back of hands, between fingers) and wrists with lather and wash vigorously for a minimum of 20 seconds ..." 4. On 04-12-2023 at 11:20 AM, 3 signs were posted on the wall above the sink at the entrance of the		to: 1) HAND HYGEINE - All teammates, Physicians and Non-Physician (NPP) will perform hand hygiene…prior to gloving and immediately after removal of gloves…after patient and dialysis delivery system contact, after interacting with wall boxes…before touching clean areas such as supplies, supply cart and chairside keyboard/mouse. 2) Use of an alcohol-based hand rub may be substituted for handwashing. 3) Patients and caregivers will be encouraged to: Wash their hands and access extremity upon entering the treatment area prior to the initiation of dialysis. Perform hand hygiene after treatment before leaving treatment area. 4) Alcohol-based hand rub containing 60% - 95% ethyl alcohol, isopropyl alcohol, or a combination of both. 5) Apply product in palm of one (1) hand. 6) Rub hands together covering all surfaces of hands and fingers until hand rub has evaporated and hands are dry. 6) Wet hands and	

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	treatment area and were reviewed, "Stay Safe Wash Your Hands with Soap &Water. Patients, Please wash your hands and access after you weigh before going to your chair. Don't forget to Wash your Hands." 5. During an observation on 04-12-2023 at 11:50 AM, RN 3, discontinued the treatment for Patient #14 at station #20. Patient #14 held pressure on their left upper arm vascular access site with a gloved right hand. RN 3 failed to offer or instruct Patient #14 to perform hand hygiene after removing their glove. 6. During an observation on 04-12-2023 at 12:35 PM, PCT 2, was observed to obtain a stethoscope with gloved hands from the computer keyboard stand. The PCT failed to clean the stethoscope prior to use. PCT 2 then palpated and auscultated Patient #12's left lower access site. PCT 2 applied antiseptic over the cannulation sites without discarding their gloves, performing hand hygiene, and donning new gloves, and inserted the cannulation needles to initiate treatment. PCT #2 failed to complete appropriate hand hygiene and gloving per the company policy. 7. During an observation on 04-12-2023 at 12:50 PM, RN 2, was observed applying antiseptic over the left upper cannulation sites of Patient #13's. RN 2 discarded their gloves. RN 2 obtained a dressing from the drawer at the nurse's station. RN 2 failed to perform hand hygiene after they discarded their gloves. RN donned gloves without performing hand hygiene and applied an antiseptic to Patient #13's cannulation site for initiation of treatment. RN 2 failed to complete appropriate hand hygiene and gloving per the company policy.		apply antibacterial liquid soap. 7) Cover hands (palms, back of hands, between fingers) and wrists with lather and wash vigorously for a minimum of 20 seconds. The Facility Administrator or designee will conduct infection control audits daily for two (2) weeks then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal infection control audit. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for the compliance with this plan of correction.	

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	8. During an observation on 04-13-2023 at 9:34 AM, PCT 4 discontinued the treatment for Patient #26 at station #2. Patient #26 held pressure on their left upper arm vascular access site with a gloved right hand. PCT 4 failed to offer or instruct Patient #26 to perform hand hygiene after removing their glove. 9. During an observation on 04-13-2023 at 10:02 AM, PCT 4, discontinued the treatment for Patient #24 at station #1. Patient #24 held pressure on their left upper arm vascular access site with a gloved right hand. PCT 4 failed to offer or instruct Patient #24 to perform hand hygiene after removing their glove. 10. During an observation on 04-13-2023 at 10:40 AM, PCT 4, discontinued the treatment for Patient #22 at station #3. Patient #22 held pressure on their left upper arm vascular access site with a gloved right hand. PCT 4 failed to offer or instruct Patient #22 to perform hand hygiene after removing their glove. During an interview on 04-12-2023 at 3:33 PM, the FA, Admin 1, confirmed hand hygiene is to be performed by the staff before donning gloves, after gloves are removed, after touching the machine with gloves, prior to touching the keyboard on the islands, after touching the patient, and the patients are encouraged to wash prior to treatment and after gloves are removed after holding the access.11. During an observation on 04-12-2023 at 11:43 AM, RN 2 was observed at Station #1, doffed their gloves after holding Patient #9's fistula access site (arterio-venous access for dialysis), went to the storage cabinet for another cannula needle, and then donned clean pair of gloves to restart cannulation. RN 2 failed to use appropriate hand hygiene prior to			

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	leaving the station and before donning a clean pair of gloves. 12. During an observation on 04-12-2023 at 12:18 PM, RN 2 was observed at Station #3 with Patient #8, took the patient's bag with their bare hand, placed it behind the patient's chair, and donned a clean pair of gloves without performing hand hygiene. 13. During an observation on 04-12-2023 at 12:37 PM RN 2 was observed at Station #3 with Patient #8. RN 2 removed Patient #8 dressing from their CVC (Central Venous Catheter) site and discarded it. RN 2 doffed dirty gloves and donned a clean pair of gloves, without performing hand hygiene. 14. During an observation on 04-13-2023 at 6:38 AM, PCT 5 was observed at Station #13 doffing and donning gloves during the cannulation for Patient #20. PCT 5 failed to use appropriate hand hygiene between glove changes. 15. During an observation on 04-13-2023 at 6:15 AM, PCT 5 was observed with gloves on, going to different supply stations to collect supplies for patient #20, PCT 5 returned to Station 13, with supplies, and began setting up the dialysis machine without hand hygiene and changing gloves.16. On 04/12/23 at 12:10 PM, RN 1 was observed to apply hand sanitizer, rub hands together briefly, then wave his hands to augment drying. RN #1 donned a right glove and entered data using the pump screen at station #2. RN 1 discarded the glove, then typed on the computer system keyboard without completing hand hygiene. RN 1 left the treatment area, removed the barrier gown, and entered the office area and picked up some paperwork. RN 1 donned a barrier gown, returned to the computer keyboard at			

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	station #2, and entered data without completing hand hygiene. RN 1 obtained a single glove, folded it into his palm, and used it to cover his finger to silence an alarm. RN 1 discarded the glove, completed hand hygiene by applying sanitizer, briefly rubbing, and then waving his hands. 17. On 04/12/23 at 12:43, RN 1 was observed performing auscultation on Patient #18. RN #1 failed to complete hand hygiene and don gloves prior to the patient assessment. 18. On 4/12/23 at 1 PM, PCT 2 was observed entering data at station #9. The PCT left the station and went to station #7, obtained a single glove and initially used the finger of it as a barrier to silence an alarm, then folded the glove fully in her palm and used her bare finger to finish silencing the alarms. PCT 1 donned the glove she was holding, the removed it a discarded it in the trash. PCT 2 failed to complete hand hygiene before and after gloving and failed to wear gloves when touching clean patient areas. 19. On 04/13/23 at 10 AM, PCT 1 was observed providing direct care to Patient #29 at station #6. PCT 1 removed a single glove from the box, moved to station #7, folded the glove into her palm, and used the finger of it to silence an alarm at station #7. PCT 1 then returned to the direct care for Patient #29 at station #6. PCT 1 failed to complete hand hygiene before and after changing gloves and before and after patient contact.			
V 0117 Bldg. 00	494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS Clean areas should be clearly designated for the preparation, handling and storage of			

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	medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled. When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station. Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients. Based on observation and interview, the facility failed to ensure clean and contaminated areas were maintained in the ESRD treatment area for 2 of 2 days of treatment floor observations. Findings included: 1. During Day 1 of 2 observations during the flash tour on 04-12-2023 at 9 AM, the following was observed: Station #18 had a blood pressure cuff on top of the dialysis machine, Station #15 had an unopened needle and a clamp on top of the dialysis machine, Stations #2, 3, 4, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 20, 21, 22, 23, and 24 had caps on top of the dialysis machines, a small animal trap and rust build-up under the dirty sink next to the entrance, trash was under the clean sink at the	V 0117	The Facility Administrator or designee will inservice all clinical teammates on Policy 1-05-01 “Infection Control for Dialysis Facilities” and Policy 1-06-01A “Preparation and Administration of Parenteral Medications (Non-EPO, Non-Parsabiv) With All Dialyzer Types” beginning 4/10/2023. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations	05/13/2023

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	entrance of the treatment area, and trash was under the sink across from station #14. 2. During Day 2 of 2 observations during the flash tour on 04-13-2023 at 5:45 AM, the following was observed: Stations #1, 2, 4, 5, 6, 7, 8, and 9 had caps on top of the dialysis machines, Station #16 had patient information and blood collection vials on top of the dialysis machine, a small animal trap was under the dirty sink next to the entrance and rust build-up, trash was under the clean sink at the entrance, and trash was under the sink across from station #14. 3. During an interview on 04-13-2023 at 8:58 AM, the Facility Administrator (FA), Admin 1, when quired regarding items being stored under the sinks and on top of the dialysis machines, stated, "Nothing should be under the sinks or on top of the dialysis machines."		as examples with emphasis on, but not limited to: 1) Dialysis delivery systems…are considered 'dirty' equipment. 2) Patient charts are not to be placed on top of dialysis delivery systems. 3) Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. The Facility Administrator or designee will conduct infection control audits daily for two (2) weeks then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal infection control audit. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation	

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			included in the meeting minutes. The Facility Administrator is responsible for the compliance with this plan of correction.	
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 record review, observation, and interview, the agency failed to ensure the preparation of one to one hundred (1:100) bleach solution was changed every 24 hours for 2 of 2 observation survey days. Findings include: 1. A DaVita Incorporated policy dated September 2007, and revised on April 2021, was provided by the Regional Clinical Director on 04-13-2023 at 9:50 AM. The policy, "PREPARATION OF ONE TO ONE HUNDRED (1:100) BLEACH SOLUTION," indicated but was not limited to " ... 12. The solution must be changed when the maximum allowable time is exceeded 24 hours ..." 2. During an observation on 04-12-2023 at 9:27 AM, observed on the treatment floor 2 containers labeled "bleach solution 1:100", dated "04-11-2023 at 0600" at the clean sink and at the dirty sink	V 0122	The Facility Administrator or designee will inservice all clinical teammates on Policy 1-05-08B “Preparation Of One to One Hundred (1:100) Bleach Solution” beginning 4/10/2023. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to: 1) The solution is good for 24 hours only. 2) The solution must be changed when the maximum allowable time is exceeded (24 hours)…The Facility Administrator or designee will	05/13/2023

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	across from the entrance. The bleach solution was more than 24 hours old. 3. During an observation on 04-13-2023 at 9:39 AM, observed on the treatment floor 1 container labeled "bleach solution 1:100", dated "04-12-2023 at 0800" at the clean sink across from POD 5. The bleach solution was more than 24 hours old. 4. During an interview on 04-13-2023 at 9 AM, the Facility Administrator indicated the bleach solution should be changed every 24 hours and was used to disinfect items on the treatment floor.		conduct infection control audits daily for two (2) weeks then weekly for two (2) weeks then monthly during internal infection control audits to verify compliance. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review the results of the audits with teammates during homeroom meetings and with Medical Director during monthly Quality Assurance and Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0143 Bldg. 00	494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and Based on observation, record review, and interview, the facility failed to ensure the staff initialed and dated opened medications in 3 of 4	V 0143	The Facility Administrator or designee will inservice all clinical teammates on Policy	05/13/2023

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	observations. Findings Include: 1. A review of a DaVita Incorporated policy dated September 2007, and revised on October 2022, was provided by the Facility Administrator (FA), Admin 1, on 04-13-2023 at 6:15 AM. The "Medication Policy," policy indicated but was not limited to, " ... All medications in the facility are checked monthly. Insulin and other medication with preservatives are dated and initialed opened ... " 2. During a flash tour observation on 04-12-2023 at 9:05 AM, observed on the counter of the nurse's station medication preparation area a half-full open container of Acetaminophen 325 milligrams (mg) tablets, an open ½ full vial of Hecterol 4 micrograms (mcg)/2 milliliters (ml), an open vial of Epogen 20,000 units/2 ml, an open container of Calcitriol 0.25 mcg capsules, an open ½ full container or Cinacalcet 60 mg tablets, an open ½ full container of Cinacalcet 30 mg tablets, an open ½ full container of Calcitriol 0.50 mcg capsules containing two capsules. The cabinet below the medication prep island in the third drawer contained an open vial of Ondansetron 4 mg/2 mL, an open box of antidiarrheal 2 mg capsules, an open container of Nitroglycerin sublingual 0.4 mg tablets, an open vial of Vancomycin 1 gram (gm), an open vial of Vancomycin 500 mg, and open ½ full container of chewable Antacid 750 mg tablets. The open containers and medication vials failed to have the date open and staff initial label. 3. During a flash tour observation on 04-12-2023 at 9:25 AM, observed on top of a black cart next to the crash cart containing an open Heparin 30,000 units/30 ml vial. The open vial failed to have the		1-06-01 Medication Policy". Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to: 1) All medications in the facility are checked monthly. 2) Insulin and other medications with preservatives are dated and initialed once opened. All open, unlabeled medications, to include: Acetaminophen 325mg tablets, Hecterol 4 microgram vials, Epogen 20,00 unit vials, Calcitriol 025 mcg capsules, Cinacalcet 60 mg tablets, Cinacalcet 30mg tablets, Calcitriol 0.50 mcg capsules, Ondansetron 4 mg/2ml vials, anti diarrheal 2mg capsules, Nitroglycerin sublingual 0.4 mg tablets, Vancomycin 1 gm vial, Vancomycin 500mg vial, chewable antacid 750 mg tablets, Heparin 30,00 units/30 ml vial, were removed from the treatment area and disposed of in accordance with state and local	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152512	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	date open and staff initial label. 4. During an observation on 04-12-2023 at 11:20 AM, observed on the counter of the nurse's station medication preparation area a half-full open container of Acetaminophen 325 milligrams (mg) tablets, an open ½ full vial of Hecterol 4 micrograms (mcg)/2 milliliters (mL), an open vial of Epogen 20,000 units/2 mL, an open container of Calcitriol 0.25 mcg capsules, an open ½ full container or Cinacalcet 60 mg tablets, an open ½ full container of Cinacalcet 30 mg tablets, an open ½ full container of Calcitriol 0.50 mcg capsules containing two capsules. The cabinet below the medication prep island in the third drawer contained an open vial of Ondansetron 4 mg/2 mL, an open box of antidiarrheal 2 mg capsules, an open container of Nitroglycerin sublingual 0.4 mg tablets, an open vial of Vancomycin 1 gram (gm), an open vial of Vancomycin 500 mg, and open ½ full container of chewable Antacid 750 mg tablets. The open containers and medication vials failed to have the date open and staff initial label. 5. During an observation on 04-12-2023 at 11:20 AM, observed on top of a black cart next to the crash cart that contained an open Heparin 30,000 units/30 mL vial. The open vial failed to have the date open and staff initial label. 6. During an observation on 04-13-2023 at 5:50 AM, observed on the counter of the nurse's station medication preparation area a half-full open container of Acetaminophen 325 milligrams (mg) tablets, an open ½ full vial of Hecterol 4 micrograms (mcg)/2 milliliters (mL,) an open vial of Epogen 20,000 units/2 mL, an open container of Calcitriol 0.25 mcg capsules, an open ½ full container or Cinacalcet 60 mg tablets, an open ½ full container of Cinacalcet 30 mg tablets, an open		regulations. The discarded medications were replaced with new unopened medications that will be labeled per policy when opened. The Facility Administrator or designee will conduct observational audits daily for two (2) weeks then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal medication audit. Instances of noncompliance will be addressed immediately. The Facility Administrator or designee will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for the compliance with this plan of correction.	

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	½ full container of Calcitriol 0.50 mcg capsules containing two capsules. The cabinet below the medication prep island in the third drawer contained an open vial of Ondansetron 4 mg/2 mL, an open box of antidiarrheal 2 mg capsules, an open container of Nitroglycerin sublingual 0.4 mg tablets, an open vial of Vancomycin 1 gram (gm), an open vial of Vancomycin 500 mg, and open ½ full container of chewable Antacid 750 mg tablets. The open containers and medication vials failed to have the date open and staff initial label. During an interview on 04-13-2023 at 6:05 AM, the Registered Nurse, RN 1, indicated they opened the vial of Hecterol and did not label or date open the medication per the facility policy. 7. During an observation on 04-13-2023 at 5:50 AM, observed on top of a black cart next to the crash cart that contained an open Heparin 30,000 units/30 mL vial. The open vial failed to have the date open and staff initial label. 8. During an interview on 04-13-2023 at 6:04 AM, the FA, Admin 1, confirmed that all medications are to be labeled with the date opened and staff initials.			