| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 152607 | A. BUILDING 00<br>B. WING | 03/20/2025 |

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| US RENAL CARE NORTH MUNCIE DIALYSIS | 800 S TILLOTSON STE 1<br>MUNCIE, IN 47303 |

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| E 0000<br><br>Bldg. 00 | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62.<br><br>Survey Dates: March 17, 18, 19 and 20, 2025<br><br>Active Census: 128<br><br>At this Emergency Preparedness survey, US Renal Care North Muncie was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62. | E 0000 | | |
| V 0000<br><br>Bldg. 00 | This visit was for a CORE Federal recertification survey of an ESRD provider.<br><br>Survey dates: March 17, 18, 19 and 20, 2025<br><br>Census by Service Type:<br><br>In-Center Hemodialysis: 104<br>Home Hemodialysis: 2<br>Home Peritoneal dialysis: 22<br><br>Total Active Census: 128<br><br>Isolation Room/Waiver: 1 Isolation Room<br><br>Abbreviations Used:<br>CM-Clinical Manager | V 0000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Ian Thornton | Facility Administrator | 04/03/2025 |

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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| | CVC-Central Venous Catheter<br>ICHD-In-Center Hemodialysis<br>RN-Registered Nurse<br>PCT-Patient Care Technician | | | |
| V 0111<br><br>Bldg. 00 | 494.30<br>IC-SANITARY ENVIRONMENT<br><br>Based on observation, record review, and interview, the facility failed to provide and monitor a sanitary environment within the dialysis facility unit during 1 of 2 station disinfections. (Station 12)<br><br>Findings include:<br><br>1. A policy titled "Disinfection and Cleaning of Dialysis Machine Equipment" indicated but was not limited to "empty prime container into a designated dirty sink".<br><br>2. During an observation on 03/17/2025 at 10:45 AM, PCT 1 was observed emptying the prime container into a clean sink. The facility failed to provide and monitor a sanitary environment within the unit.<br><br>3. During an interview on 03/17/2025 at 10:56 AM, PCT 1 indicated that she should have emptied prime container in the dirty sink and admitted she made a mistake. | V 0111 | The FA will in-service all direct care staff on policy **C-IC-0080 (Disinfection and Cleaning of Dialysis Machine Equipment. Education will emphasize maintaining a sanitary environment by emptying the prime container into a designated dirty sink. Staff unable to attend the in-service will be educated on their first day back at work.**<br>**The** Facility Administrator or Clinical Coordinator will conduct audits on 100% of treatment stations to observe and validate proper prime bucket disposal practices:<br>a. Daily for five days<br>b. Then every week for 2 weeks.<br>c. Then every month for 2 months.<br>d. Any deviations will be immediately corrected, and coaching provided at the time of observation<br>e. Once adherence has been achieved, infection control audits will resume, per the Quality Management Workbook schedule.<br>**The Facility Administrator (FA) will be responsible for ensuring adherence to this** | 04/20/2025 |

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| | | | **Plan of Correction. The FA will review all education and audit results in the monthly QAPI and Governing Body (GB) meetings to track and trend adherence. If adherence does not improve, the Plan of Correction (POC) will be re-evaluated, revisions made as needed, and additional education provided. Monitoring will continue until adherence is achieved.** | |
| V 0113<br><br>Bldg. 00 | 494.30(a)(1)<br>IC-WEAR GLOVES/HAND HYGIENE<br><br>Based on observation, record review and interview, staff failed to appropriately disinfect the AVF site prior to cannulating (inserting dialysis needles) for 1 of 2 AVF initiations observations (Patient #8) and failed to remove gloves and complete hand hygiene after removing a CVC dressing for 1 of 2 CVC exit site observations. (Patient #11)<br><br>Findings Include:<br><br>1. A policy titled, "Assessment and Cannulation for AV Fistula/Graft and Patient Self Cannulation" indicated site disinfection for at least 30 seconds using an alcohol prep pad prior to inserting the dialysis needles.<br><br>2. A policy titled, "Dialysis Catheter Dressing Change Procedure" indicated after removal of the old CVC dressing, gloves should be removed, hand hygiene performed, and new gloves donned. | V 0113 | The FA will in-service all direct care staff on policies **C-IC-0060 (Hand Hygiene), C-TI-0030 (Assessment and Cannulation of AV Fistula/Graft and Patient Self-Cannulation), and C-TI-0070 (Dialysis Catheter Dressing Change Procedure) related to vascular access initiation/termination procedures. The requirement to disinfect each access AVF/AVG site with an alcohol pad utilizing a rubbing motion for at least 30 seconds cannulation can be done immediately.**<br>**The requirement to remove gloves and perform hand hygiene after CVC dressing removal and before donning clean gloves to proceed with** | 04/20/2025 |

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| | 3. A policy titled, "Hand Hygiene" indicated hand hygiene is to be performed when moving from a contaminated body site to a clean body site of the same patient.<br><br>4. During an observation on 03/17/2025 at 10:41 AM, PCT 4 disinfected Patient #8's cannulation site using an alcohol pad for 15 seconds prior to inserting the dialysis needles.<br><br>During an interview on 03/19/2025 at 12:30 PM, PCT 4 indicated disinfection using an alcohol pad prior to inserting the needles is 15 seconds.<br><br>During an interview on 03/19/2025 at 12:354 PM, RN 2 indicated disinfection using an alcohol pad prior to inserting the needles is 30 seconds.<br>5. During an observation on 03/18/2025 at 10:22 AM, PCT 7 performed care for Patient #11's CVC exit site. PCT 7 removed the old CVC dressing but failed to remove her soiled gloves and perform hand hygiene before disinfecting the CVC site. PCT 7 failed to remove gloves, perform hand hygiene, and apply clean gloves after removing dirty dressing.<br><br>During an interview on 03/18/2025 at 10:34 AM, PCT 7 indicated that staff must remove gloves and complete hand hygiene after removing a dirty dressing and before applying clean gloves. | | **care.**<br>**Staff unable to attend the in-service will be educated on their first day back at work.**<br><br>**The** FA or clinical coordinator will perform vascular access audits on 100% of AVF Cannulations and CVC dressing changes until adherence is achieved. If any deviations are noted re-educate staff as needed:<br>a. Daily for five days<br>b. Then every week for 2 weeks.<br>c. Then every month for 2 months.<br>d. Once adherence has been established, vascular access audits will be completed per Quality Management workbook schedule<br>**The Facility Administrator (FA) will be responsible for ensuring adherence to this Plan of Correction. The FA will review all education and audit results in monthly QAPI**/b> **to track and trend adherence. If adherence does not improve, the Plan of Correction (POC) will be re-evaluated, revisions made as needed, and additional education provided. Monitoring will continue until adherence is achieved.** | |
| V 0114<br><br>Bldg. 00 | 494.30(a)(1)(i)<br>IC-SINKS AVAILABLE | | | |

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| | Based on observation, record review, and interview, the facility failed to ensure hand soap/sanitizer was available and not expired for 1 of 1 facility reviewed.<br><br>Findings Include:<br><br>1. A policy titled, "Facility Space/Design and Safety Requirements" indicated all supplies are checked at least monthly for expiration. Expired items will be discarded appropriately prior to or on the day of expiration.<br><br>2. During an observation on 03/19/2025 at 10:25 AM, three clean sinks located in training room #1 and #2 housed wall-mounted hand soap that had expired on 09/2024. A clean sink located in the home lab area also housed a wall-mounted soap dispenser that had expired on 09/2024. Three wall-mounted hand sanitizers located in the home department hallway had expired on 06/2024. The back hallway of the dialysis center housed a wall-mounted hand sanitizer dispense near the staff restrooms that had expired on 06/2024.<br><br>3. During an interview on 03/19/2025 at 10:42 AM, RN 5 indicated all soap and hand sanitizers dispensers are to be checked for expiration and discarded & replaced appropriately. She indicated that this was the responsibility of Biomed.<br><br>4. During an interview on 03/19/2025 at 2:31 PM, the Area Home Manager indicated that it is not BioMed's responsibility to check for expired hand soap and hand sanitizer, it is the responsibility of all staff. | V 0114 | The FA will in-service all direct care staff on policy **C-AD-0380 (Facility Space/Design and Safety Requirements). Education will emphasize that Staff unable to attend the in-service will be educated on their first day back at work. All wall mounted hand soap and hand sanitizer has been checked and any expired items have been discarded. This will continue to be monitored monthly by the Facility Administrator.**<br><br>**The Facility Administrator (FA) will be responsible for ensuring adherence to this Plan of Correction. The FA will review all education and audit results in monthly QAPI/b> to track and trend adherence. If adherence does not improve, the Plan of Correction (POC) will be re-evaluated, revisions made as needed, and additional education provided. Monitoring will continue until adherence is achieved.** | 04/20/2025 |
| V 0122 | 494.30(a)(4)(ii)<br>IC-DISINFECT SURFACES/EQUIP/WRITTEN | | | |

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| Bldg. 00 | PROTOCOL<br>Based on observation and record review, the dialysis facility failed to ensure employees cleaned and disinfected the entire station prior to setting up the machine for 1 of 2 machine set-up observations performed (PCT 8).<br><br>Findings include:<br><br>1. The facility policy "Infection Control", last updated 7/2023, indicated cleaning and disinfection of the dialysis station (e.g., chairs, beds, tables, integrated keyboards, dialysis machines, ancillary equipment) after patient has vacated the station.<br><br>2. During an observation on 3/17/25 at 10:20 AM, PCT 8 was observed setting up the dialysis machine in Station #16. After the machine set-up was complete, PCT 8 changed their gloves, obtained bleach wipes and then cleaned the chair, remote, blood pressure cuff, and cords in Station #16. PCT 8 failed to cleanse the entire station prior to setting up the dialysis machine.<br><br>3. During an interview on 3/20/24 at 9:40 AM, PCT 8 relayed the machine in Station #16 was acting up and they wanted to get it set up to ensure it was working properly. PCT 8 verified the entire station should have been cleaned prior to setting up the machine.<br><br>4. During an interview on 3/20/25 at 10:25 AM, the CM relayed the entire station should be cleaned before setting up the machine for the next patient. | V 0122 | The FA will in-service all direct care staff on policy **C-IC-0010 (**Infection Control and Precautions for All Patients**). Education will emphasize** . Staff unable to attend the in-service will be educated on their first day back at work.<br><br>**The FA or clinical coordinator will audit staff compliance and re-educate staff as needed:**<br>a. Daily for five days<br>b. Then every week for 2 weeks.<br>c. Then every month for 2 months.<br>d. Once adherence has been established, routine inflection control audits will resume per QM Workbook schedule.<br>**The Facility Administrator (FA) will be responsible for ensuring adherence to this Plan of Correction. The FA will review all education and audit results in the monthly QAPI and Governing Body (GB) meetings to track and trend adherence. If adherence does not improve, the Plan of Correction (POC) will be re-evaluated, revisions made as needed, and additional education provided. Monitoring will continue until adherence is achieved.** | 04/20/2025 |
| V 0556<br><br>Bldg. 00 | 494.90(b)(1)<br>POC-COMPLETED/SIGNED BY IDT & PT<br><br>Based on record review and interview, the dialysis | V 0556 | The FA will in-service all | 04/20/2025 |

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| | facility failed to ensure the plan of care (POC) was reviewed and signed by the patient for 1 of 1 unstable ICHD patient record reviewed (Patient #4) and 1 of 2 ICHD patient records reviewed who have been on treatment more than two years (Patient #5).<br><br>Findings include:<br><br>1. The facility policy "Comprehensive Interdisciplinary Patient Assessment/Plan of Care (CIPA/POC)", last revised 4/2024, indicated the CIPA/POC will be signed by the IDT members including the patient or the patient's legal representative. If the patient chooses to not sign the plan of care, this will be documented on the plan of care, along the reason the signature was not provided.<br><br>2. Patient #5's clinical record evidenced an admission on 4/14/22 and included a POC, last revised 5/20/24. The clinical record failed to evidence the POC was reviewed and signed by Patient #5.<br><br>During an interview on 3/18/25 at 12:08 PM, Corporate Person 1 verified the POC for Patient #5 was not signed and relayed the clinical record failed to evidence documentation of the 5/20/24 POC was reviewed with Patient #5.<br>3. A document titled "CIPA" indicated that Patient #4 did not attend the Plan of Care meeting scheduled for 02/13/2025. The facility could not provide a signed document confirming that Patient #4 acknowledged the POC. The facility failed to review the care plan with the patient and provide a signed document indicating the patient's acknowledgement of the POC.<br><br>A document titled "CIPA" indicated that Patient | | Interdisciplinary Team (IDT) members on policy **C-AD-0480 (**Comprehensive Interdisciplinary Patient Assessment/Plan of Care (CIPA/POC)**). Education will emphasize that**. Staff unable to attend the in-service will be educated on their first day back at work.<br>**The** FA or Clinical Coordinator will complete medical record audits on 100% of Plan of Care (POC) monthly x 3.<br><br>**The Facility Administrator (FA) will be responsible for ensuring adherence to this Plan of Correction. The FA will review all education and audit results in monthly QAPI**/b> **to track and trend adherence. If adherence does not improve, the Plan of Correction (POC) will be re-evaluated, revisions made, additional education provided as needed, and monitoring will continue until adherence is achieved.** | |

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| | #4 did not attend the Plan of Care meeting scheduled for 01/23/2025. The facility could not provide a signed document confirming that Patient #4 acknowledged the POC. The facility failed to review the care plan with the patient and provide a signed document indicating the patient's acknowledgement of the POC.<br><br>A document titled "CIPA" indicated that Patient #4 did not attend the Plan of Care meeting scheduled for 11/14/24. The facility could not provide signed documentation confirming that Patient #4 acknowledged the POC. The facility failed to review the care plan with the patient and provide a signed document indicating the patient's acknowledgement of the POC.<br><br>A document titled "CIPA" indicated that Patient #4 did not attend the Plan of Care meeting scheduled for 10/17/24. The facility could not provide signed documentation confirming that Patient #4 acknowledged the POC. The facility failed to review the care plan with the patient and provide a signed document indicating the patient's acknowledgement of the POC.<br><br>During an interview on 03/18/2025 at 12:20 PM, Corporate Person 1 indicated there was not documentation to support the Plan of Care was reviewed with Patient #4. | | | |
| V 0715<br><br>Bldg. 00 | 494.150(c)(2)(i)<br>MD RESP-ENSURE ALL ADHERE TO P&P<br><br>Based on record review and interview, the medical director failed to ensure staff monitored ICHD patients every 30 minutes for 3 of 8 ICHD records reviewed (Patient #2, 5 and 8); failed to ensure the RN was notified of low blood pressures (BP) for 2 of 8 ICHD patient records reviewed (Patient #2 | V 0715 | The FA will in-service all direct care staff on policies **C-ID-0010 (**Intradialytic Monitoring of Patient**), C-FORMS-0081 (Reportable Parameters to CN), C-MA-0010 (Guidelines for** | 04/20/2025 |

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| | and 5) and failed to ensure prescribed medications were administered during treatment for 2 of 8 ICHD patient records reviewed (Patient #3 and 8).<br><br>Findings include:<br><br>1. The facility policy "Intradialytic Monitoring of Patient", last updated 7/2024, indicated vitals signs must be obtained and documented at least every 30 minutes and reported to charge nurse if outside of standing orders and/or reportable parameters; Delivery of dialysis prescription: review prescribed treatment orders against actual machine settings and Blood Flow Rate and Dialysate flow rate: any variance from prescribed order requires documentation of reason.<br><br>2. The facility policy "Reportable Parameters to CN", last updated 1/2020, indicated the Charge Nurse should be notified when Systolic >200 or <90 and Diastolic >100 intra-dialysis blood pressure parameters are out of parameters.<br><br>3. The facility policy "Guidelines for Administration of Medication" indicated medications should be administered in accordance with a physician's order.<br><br>4. Patient #2's ICHD treatment sheets, dated 3/05/25 to 3/17/25, were reviewed and evidenced the following:<br><br>a. On 3/12/25, the ICHD treatment began at 9:40 AM. A routine BP check was conducted at 10:32 AM with a follow-up BP check at 12:07 PM, 1 hour and 35 minutes later.<br><br>During an interview on 3/17/25 at 10:50 AM, PCT 4 relayed BP checks should have been performed every 30 minutes. | | **Administration of Medication). Education will emphasize . All Staff unable to attend the in-service will be educated on their first day back at work. The Facility Administrator (FA) will review this deficiency as well as all other listed deficiencies in this survey with the Medical Director in a Governing Body.**<br><br>**The** FA or Clinical Coordinator will complete patient flowsheet audits on 25% of treatments:<br>a. Daily for five days<br>b. Then every week for 2 weeks.<br>c. Then every month for 2 months.<br>d. Once adherence has been achieved, flowsheet audits will completed per QM Workbook schedule.<br>**The Facility Administrator (FA) will be responsible for ensuring adherence to this Plan of Correction. The FA will review all education and audit results in monthly QAPI/b> to track and trend adherence. If adherence does not improve, the Plan of Correction (POC) will be re-evaluated, revisions made, additional education provided as needed, and monitoring will continue until adherence is achieved.** | |

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| | 5. A document titled "Patient Summary" indicated Patient #3 had a physician order for Venofer (iron replacement medication) 100 milligrams (mg) every treatment.<br><br>A treatment sheet dated 03/06/2025 for Patient #3 indicated Venofer was not administered as ordered.<br><br>A treatment sheet dated 03/11/2025 for Patient #3 indicated Venofer was not administered as ordered.<br><br>During an interview on 03/20/2025 at 11:23 AM, RN 1 indicated that an error led to the missed Venofer medications on 03/06/2025 and 03/11/2025 for Patient #3. The medication was accidentally discontinued and rescheduled for a future date.<br><br>6. A treatment sheet dated 03/10/2025 for Patient #8 indicated a BP & pulse check completed at 12:32 PM with a subsequent BP & pulse check completed at 1:32 PM.<br><br>A treatment sheet dated 03/17/2025 for Patient #8 indicated a BP & pulse check completed at 1:31 PM with a subsequent BP & pulse check completed at 2:31 PM.<br><br>During an interview on 03/20/2025 at 9:40 AM, PCT 8 indicated that blood pressure checks should be completed at least every 30 minutes and more frequently if BP is out of parameters.<br><br>During an interview on 03/20/2025 at 11:43 AM, RN 2 indicated blood pressures are normally checked every 30 minutes unless the reading is unstable, then every 15 minutes. | | | |

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| US RENAL CARE NORTH MUNCIE DIALYSIS | 800 S TILLOTSON STE 1<br>MUNCIE, IN 47303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | A document titled "Patient Summary" indicated Patient #8 was ordered Epogen (a drug that helps the body produce red blood cells) 9100 units every treatment.<br><br>A treatment sheet dated 03/14/2025 for Patient #8 indicated that staff did not document the administration of the prescribed 9100 unit dose of Epogen during treatment<br><br>During an interview on 03/20/2025 at 11:23 AM, RN 1 indicated that an error led to the missed Epogen medication to be administered on 03/14/2025 for Patient #8. The medication was accidentally discontinued instead of the dosage changed.<br><br>7. During an interview on 3/20/25 at 10:25 AM, the CM relayed the patients should have been monitored every 30 minutes; reassessed anytime the BP is out of parameters and the RN should have been notified.<br>8. Patient #5's ICHD treatment sheets, dated 3/03/25 to 3/17/25, were reviewed and evidenced the following:<br><br>a. On 3/14/25, the ICHD treatment began at 10:18 AM. A routine BP check conducted at 10:32 AM indicated a BP of 90/72. The clinical record failed to evidence the PCT notified the RN regarding the low BP and failed to evidence the PCT reassess Patient #5's blood pressure until 11:47 AM, 1 hour and 15 minutes later.<br><br>The BP check at 2:27 PM indicated a BP of 85/50. The clinical record failed to evidence the PCT notified the RN regarding the low BP and failed to evidence the PCT reassess Patient #5's blood pressure until 2:52 PM, 25 minutes later. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 152607 | A. BUILDING 00<br>B. WING | 03/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| US RENAL CARE NORTH MUNCIE DIALYSIS | 800 S TILLOTSON STE 1<br>MUNCIE, IN 47303 |

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|---|---|---|---|---|
| | b. On 3/17/25, the ICHD treatment began at 10:42 AM. A routine BP check was conducted at 11:01 AM with a follow-up BP check at 12:42 PM, 1 hour and 41 minutes later.<br><br>A routine BP check conducted at 1:32 PM indicated a BP of 92/56. The clinical record failed to evidence the PCT notified the RN regarding the low BP.<br><br>A routine BP check conducted at 2:55 PM indicated a BP of 93/59. A BP recheck at 2:59 PM indicated a BP of 94/52. The clinical record failed to evidence the PCT notified the RN regarding the low BP.<br><br>During an interview on 3/20/25 at 9:40 AM, PCT 8 relayed BP checks should have been performed every 30 minutes and anytime the systolic is below 100, should recheck BP and notify the RN. | | | |