STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152524	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
US RENAL CARE NORTHWEST INDIANAPOLIS DIALYSIS	6488 CORPORATE WAY INDIANAPOLIS, IN 46278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
E 000	Initial Comments 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. Dates of survey: 2-14, 02-15 and 02-16-2023 Facility #: 006144 CCN: 152524 Stations: 16, with no isolation room ICDH Patients: 32 No Home Program. Total Census: 32 At this Emergency Preparedness survey, US Renal Care Northwest, was found to have been in compliance with the requirements of Emergency Preparedness Requirements for Medicare participating providers and suppliers, including staffing and implementation of staffing during a Pandemic, at 42 CFR 494.62. QR by Area 3 on 2-20-2023	E 000	POC accepted on 3-2-2023 Deborah Franco, RN	
V 000	INITIAL COMMENTS This visit was for a CORE Federal Recertification of an ESRD provider by the Indiana Department of Health. Dates of survey: 2-14, 02-15, and 02-16-2023	V 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/22/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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V 000	Continued From page 1 Facility #: 006144 CCN: 152524 Stations: 16, with no isolation rooms ICDH Patients: 32 No Home program. Total Census: 32	V 000		
V 113	QR by Area 3 on 2-20-2023 IC-WEAR GLOVES/HAND HYGIENE CFR(s): 494.30(a)(1) 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. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the proper use of Personal Protective Equipment (PPE) while on the treatment floor during 3 of 3 observation days. (Patients: #3, 5, 7, 17, 22, and 30) (Employees: Facility Administrator, Admin #1, PCT #1, 2 (five times), 3(three times), 4 (two times), 5 (two times) and 6) Findings include: 1. On 02-15-2023 at 4:05 PM, a 01-2020 and revised date of 08-2020, US Renal Care policy titled, "Hand Hygiene," was provided by the	V 113		3/16/23

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V 113	Continued From page 2	V 113		

Facility Administrator, Admin #1. The policy required hand hygiene, inclusive of, but not limited to, " ... 9. After gloves are removed ... 12. After contact with inanimate objects, including medical equipment or environmental surfaces at the patient station ..."

2. During an observation on 02-14-2023 at 9:40 AM, the Patient Care Technician (PCT), PCT #2, was observed touching the dialysis delivery system at station 9, then entered data into the computer using the mobile computer keyboard. PCT #2 failed to discard their gloves, perform hand hygiene, and don new gloves prior to using the computer keyboard.

3. During an observation on 02-14-2023 at 10:35 AM, Patient #5 was observed wearing a glove on their right hand and leaving the treatment area after completing their treatment of holding a pressure dressing to their left access site with a gloved hand. Patient #5, spoke to the Facility Administrator, Admin #1, and PCT #2 at the nurse's station prior to leaving the treatment floor. The patient was not instructed to remove their glove, perform hygiene, or offered hand sanitizer prior to leaving the treatment floor.

4. During an observation on 02-15-2023 at 8:35 AM, Patient #3 was observed removing their glove from their right hand after completing their treatment of holding a pressure dressing to their left access site. Patient #3 was assisted by PCT #3 with their walking leaving the treatment floor without performing hand hygiene or being offered hand sanitizer.

5. During an observation on 02-15-2023 at 9:20 AM, PCT #5 was observed touching the dialysis

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V 113	Continued From page 3	V 113		

delivery system at station 3, then entered data into the computer using the mobile computer keyboard. PCT #5 failed to discard their gloves, perform hand hygiene, and don new gloves prior to using the computer keyboard.

6. During an observation on 02-15-2023 at 11:03 AM, PCT #2 was observed to evaluate by auscultation Patient #17's access with a stethoscope. PCT #2 proceeded to cannulate the needles to initiate treatment without discarding their gloves, performing hand hygiene, and donning clean gloves.

7. During an observation on 02-15-2023 at 11:35 AM PCT, PCT #4 was observed to evaluate by auscultation Patient #30's access with a stethoscope. PCT #4 proceeded to cannulate the needles to initiate treatment without discarding their gloves, performing hand hygiene, and donning clean gloves.

8. During an observation on 02-15-2023 at 12:08 PM, PCT #5 was observed touching the dialysis delivery system at station 14, then entered data into the computer using the mobile computer keyboard. PCT #5 failed to discard their gloves, perform hand hygiene, and don new gloves prior to using the computer keyboard.

9. During an observation on 02-15-2023 at 11:10 AM, Patient Care Technician (PCT), #3, verified the dialysis script for Patient #13 at station #9. PCT #3 moved from the computer to the dialysis machine to adjust the settings without removing their gloves and completing hand hygiene.

10. During an observation on 02-15-2023 at 11:41 AM, PCT #4, was documenting on the computer at station #8 and moved to the dialysis machine

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V 113	Continued From page 4	V 113		

to make adjustments without removing their gloves and completing hand hygiene.

11. During an observation on 02-15-2023 at 11:44 AM, PCT #3 assisted the Patient #22 from their wheelchair to the dialysis chair at station #5. PCT #3 adjusted the television with the remote control, and moved to the station computer to document. PCT #3 did not remove their gloves or perform hand hygiene.

12. During an observation on 02-16-2023 at 6:25 AM, PCT #2 was completing a pre dialysis setting check at station #8. PCT #2 moved from the computer to the dialysis machine without removing their gloves or performing hand hygiene.

13. During an observation on 02-16-2023 at 6:27 AM, PCT #6 was completing a central venous catheter (a central line into a large vein) (CVC) dressing change of Patient #7. PCT #6 removed their gloves after removing the old dressing and donned a new pair of gloves without performing hand hygiene. PCT #6 moved to document on the station computer, adjusted the dialysis settings on the dialysis machine without removing their gloves and performing hand hygiene.

14. During an observation on 02-16-2023 at 6:55 AM, PCT #1 was documenting on the computer at station #7. PCT #1 moved from the computer to the dialysis machine to adjust the settings, moved back to the station computer. PCT #1 did not remove their gloves or perform hand hygiene.

15. During an interview on 02-15-2023 at 4:05 PM, the Facility Administrator, Admin #1, confirmed staff were to remove their gloves and

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V 113	Continued From page 5 perform hand hygiene, and don new gloves when going to the dialysis machine to the computer keyboard and patient to computer keyboard.	V 113		
V 147	IC-STAFF EDUCATION-CATHETERS/CATHETER CARE CFR(s): 494.30(a)(2) Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters. II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].	V 147		3/16/23

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V 147	Continued From page 6 This STANDARD is not met as evidenced by: Based on record review, observation, and interview, the agency failed to ensure the maintenance and care of a central venous catheter (CVC) was followed according to policy as observed with 2 of 4 CVC dressing changes. (Patient #5 and 7) Findings include: 1. On 02-16-2023 at 7:30 AM, Administrator #1 provided a revised April, 2021 US Renal Care policy titled, "Accessing and De-Accessing the Dialysis Catheter". The policy indicated but was not limited to, " ... Disinfect the hub with an alcohol prep pad ... Scrub the end of the hub and sides (threads) thoroughly with friction... Leave hubs "open" ... do not allow the catheter hubs to touch non-sterile surfaces ..." 2. During an observation on 02-16-2023 at 6:10 AM, Patient Care Technician (PCT), PCT #1 was observed changing the CVC (a central line inserted into a major vein) of Patient #5. PCT #1 was observed cleaning the blue and red hubs and did not vigorously scrub them. 3. During an observation on 02-16-2023 at 6:25 AM, PCT #6 was observed cleaning the hubs of the CVC of Patient #7. PCT# 6 allowed the hub of the CVC to lay on the chux (a non-sterile barrier between the patient and the CVC hub) contaminating the hub. PCT#6 did not attempt to scrub the hub prior to inserting the dialysis tubing into the hub. 4. On 02-16-2023 at 8:12 AM, Corporate Employee #2 was queried on the process of	V 147		

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V 147	Continued From page 7 caring for the CVC when preparing to initiate treatment. Corporate Employee #2 indicated the hub should be scrubbed for 30 seconds and then indicated it should be vigorously scrubbed. Corporate Employee #2 indicated the hub should never touch the chux and should be scrubbed again if it came in contact with the chux.	V 147		
V 402	PE-BUILDING-CONSTRUCT/MAINTAIN FOR SAFETY CFR(s): 494.60(a) The building in which dialysis services are furnished must be constructed and maintained to ensure the safety of the patients, the staff and the public. This STANDARD is not met as evidenced by: Based on record review, observation, and interview, the facility failed to ensure the safety of patients and staff, as observed over 3 of 3 survey days. Findings Include: 1. On 01-16-2023 at 7:42 AM, a 01-2020 and revised date of 09-2020, US Renal Care policy titled, "Facility Space/Design and Safety Requirements," was provided by the Facility Administrator, Admin #1. The policy indicated but was not limited to, " ... 15. Storage areas will be kept clean and orderly at all times. Supplies will not be stored directly on the floor but on pallets or shelves ...." 2. On 02-14-2023 at 11:20 AM, during a flash tour, eleven (11) boxes containing gowns were found on the floor of the supply closet.	V 402		3/16/23

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V 402	Continued From page 8 3. On 02-14-2023 at 11:20 AM, during a flash tour, there was a large box containing hot and cold cups found on the floor of the conference room. 4. On 02-15-2023 at 8:00 AM, observed in the conference room a large box containing hot and cold cups on the floor along the back wall. 5. On 02-15-2023 at 8:05 AM, observed in the storage closet, where there were eleven (11) boxes containing gowns found on the floor of the supply closet. 6. On 02-15-2023 at 12:55 PM, observed an empty box on the floor in the treatment area by the nurse's station. 7. During an interview on 02-16-2023 at 8:10 AM, the Facility Administrator, Admin #1, confirmed that boxes are not to be stored on the floors.	V 402		