STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152654	A. BUILDING 00 B. WING	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FISHERS	13648 OLIVIA WAY FISHERS, IN 46037

(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
E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62 Survey Dates: Survey dates: February 19, 20, 21, 22, 23, 26, 27, 28, and 29, 2024 Census by Service Type: In-Center Hemodialysis: 58 Home Hemodialysis: 22 Home Peritoneal dialysis: 6 Total Active Census: 86 At this Emergency Preparedness survey, Fresenius Medical Care Fishers was not found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62.	E 0000		
E 0003 Bldg. 00	494.62 Establishment of the EP Program Dialysis §494.62 Condition for Coverage: The dialysis facility must comply with all applicable Federal, State, and local emergency preparedness requirements. These emergencies include, but are not limited to, fire, equipment or power failures, care related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. The dialysis facility must establish and maintain an emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Nelson	Administrator	04/04/2024

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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	the following elements: . Based on record review and interview, the dialysis facility failed to ensure the emergency plan was updated, at least, every 2 years (E004); failed to collaborate with local emergency officials annually to confirm they were aware the facility's needs in an emergency (E009); failed to ensure the emergency cart was checked monthly for expired supplies/medications (E028); failed to ensure the facility's communication plan included primary and alternate contact information for all facility staff (E032); failed to ensure emergency training upon hire (E038); and failed to ensure patients were provided appropriate orientation and training related to emergency preparedness policies and procedures E040). The cumulative effect of these systemic problems has resulted in the facility's inability to ensure the provision of quality health care in a safe environment for the Condition for Coverage 42 CFR 494.62 for Emergency Preparedness with the potential to affect all of the facility's 86 active patients.	E 0003	E003 The Governing Body of this facility acknowledges its responsibility to ensure that the facility establish and maintain an emergency preparedness program that meets the requirements, inclusive of, but not limited to develop emergency plan, update and review at minimal every two years; collaborate with local emergency officials annually to confirm they are aware of the facility needs; emergency cart checked monthly for expired supplies/ medications; ensure communication plan includes primary and alternate contact information for all facility staff; ensure emergency training is completed upon hire for all staff; all patients provided orientation and training related to emergency preparedness policies and procedures. As such, the Governing Body held a conference call on 2/29/2024, and 3/8/2024 to review the information provided by the surveyors during this survey and actively participate in the development of the Plan of Correction. The Governing Body has committed to meet weekly to review the status of the Plan of Correction until all issues are resolved and the facility is back in compliance.	04/05/2024

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			The Governing Body met again on 3/29/2024, to review the Statement of Deficiencies and develop the following Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The Governing Body began meeting weekly beginning 2/29/2024 to review the results of the progress on the Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The Governing Body will determine when the frequency of these meetings may be reduced to the regular quarterly schedule. Effective immediately: The Director of Operations will analyze and trend all data and monitor/audit results as related to this Plan of Correction prior to presenting the monthly data to the QAI Committee. A specific plan of action encompassing the citations as cited in the Statement of Deficiency has been added to the facility's monthly QAI (Quality Assessment and Performance Improvement) agenda. The QAI Committee is responsible for reviewing and evaluating the Plan of Correction to ensure it is effective and providing resolution of the issues.	

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			The Director of Operations (DO) will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The Governing Body, at its meeting of 2/29/24, designated the Director of Operations (DO) to serve as Plan of Correction Monitor and provide additional oversight. They will participate in QAPI and Governing Body meetings. This additional oversight is to ensure the ongoing correction of deficiencies cited in the Statement of Deficiency through to resolution as well as ensure the Governance of the Facility is presented current and complete data to enhance their governance oversight role. Minutes of the Governing Body and QAI meetings, as well as monitoring forms and educational documentation will provide evidence of these actions, the Governing Body's direction, and oversight and the QAI Committees ongoing monitoring of facility activities. These are available for review at the facility. The responses provided for E 004; E009; E028; E032; E038; and E040 describe, in detail, the processes and monitoring steps taken to ensure that all	

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			deficiencies cited within this Condition are corrected to ensure ongoing compliance. The Medical Director will provide oversight of education and training for all staff regarding issues identified by the surveyor. The Medical Director reviewed all training provided to staff on 2/29/24, 3/12/24 and will review the subsequent training that will be provided on 4/02/24. The Director of Operations held a mandatory staff meeting on 2/29/24 to review the surveyor's reported issues and the absolute requirement to follow all policies with follow-up audits and re-education as needed. For staff who are not present at the facility for the initial education, they will receive education upon return to the clinic. On 3/12/24, 3/26/2024, & 4/02/24, after receipt of the Statement of Deficiencies, the Education Coordinator held a staff meeting to reeducate and reinforce the expectations and responsibilities of the facility staff on policies listed below: Policies reviewed include: Guidelines for Emergency Preparedness Emergency Medications,	

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			Equipment and Supplies Emergency Box Contents Emergency Code Cart, Medications and Machine Hand Crank Checklist	
E 0004 Bldg. 00	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency			

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	preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the dialysis facility failed to ensure the emergency plan was updated at least every 2 years for 1 of 1 facility. Findings include: 1. The Emergency Preparedness Guidelines policy, revised 7/23/2023, indicated the Facility Specific Disaster Safety Plan will be reviewed annually. 2. The Emergency Preparedness binder failed to evidence the Emergency plan had been reviewed and updated at least every 2 years. 3. During an interview on 2/29/2024 beginning at 2:03 PM, the Administrator stated she was unable to show when the emergency plan was last reviewed and updated.	E 0004	**E004** On 04/02/24, the Director of Operations and Education Coordinator held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the policy. Guidelines for Emergency Preparedness Emphasis was placed on: The Governing Body will review and approve the Facility Specific Disaster Safety plan initially and annually. The Emergency Preparedness binder will be updated annually. On 4/02/2024, the Director of	04/05/2024

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			Operations updated the Emergency Preparedness binder. Effective 4/03/24, the Director of Operations will conduct monthly audit with focus on ensuring the Emergency Preparedness binder is updated, as required, utilizing specific plan of correction Audit Tool for 3 months and then an additional 2 months. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.	

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			The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024.	
E 0009 Bldg. 00	403.748(a)(4), 416.54(a)(4), 418.113(a)(4), 441.184(a)(4), 482.15(a)(4), 483.475(a)(4), 483.73(a)(4), 484.102(a)(4), 485.625(a)(4), 485.68(a)(4), 485.727(a)(5), 485.920(a)(4), 486.360(a)(4), 491.12(a)(4), 494.62(a)(4) Local, State, Tribal Collaboration Process §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency			

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	preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. Based on record review and interview, the dialysis facility failed to collaborate with local emergency officials annually to confirm they were aware of the facility's needs in an emergency for 1 of 1 facility. Findings include: 1. The Emergency Preparedness Guidelines policy, revised 7/23/2023, indicated the facility will contact their local disaster management agency annually to ensure the agency is aware of the facility's presence in the community in the event of an emergency. 2. The Emergency Preparedness binder included an email from the Administrator to the local	E 0009	**E009** On 04/02/24, the Director of Operations and Education Coordinator held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the policy. Guidelines for Emergency Preparedness Emphasis was placed on: The DO must contact the local Emergency Operations Center	04/05/2024

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	disaster management agency. The binder failed to evidence any previous communications between the facility and the agency. 3. During an interview on 2/29/2024 beginning at 2:03 PM, the Administrator indicated she looked for but did not find documentation of communication with a local disaster management agency prior to the Administrator's email sent during the survey on 2/28/2024.		(EOC) or similar agency to: · Understand the agency's capabilities and capacities Share our capabilities and capacities · Discuss participating in a community-based drill they are running Annually per procedure, the facility will contact their local disaster management agency to ensure that the agency is aware of the dialysis facility's presence in the community in the event of an emergency. On 04/02/2024, the Director of Operations contacted the local EOC and updated the Emergency Preparedness binder with documentation. Effective 04/03/24, the Director of Operations will conduct monthly audit with focus on ensuring the Emergency Preparedness binder is updated, as required, utilizing specific plan of correction Audit Tool for 3 months and then an additional 3 months. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar.	

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			The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring	

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			documentation are available for review at the clinic. Completion 04/05/2024.	
E 0028 Bldg. 00	494.62(b)(9) Dialysis Emergency Equipment §494.62(b)(9) Condition for Coverage: [(b) Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (9) A process by which the staff can confirm that emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, are on the premises at all times and immediately available. Based on record review and interview the facility failed to ensure the emergency cart was checked monthly for expired supplies/medications and that staff were trained on where it was located and immediately available at all times in 1 of 1 facility reviewed. Findings include: 1. A policy titled, "Emergency Medications, Equipment and Supplies" indicated but was not limited to; "The emergency cart must be: ...	E 0028	**E028** On 04/02/24, the Director of Operations and Education Coordinator held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the policy. Emergency Medications, Equipment and Supplies	04/05/2024

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	Checked monthly or after use for contents, expiration dates, cleanliness, and proper functioning of all equipment ... An itemized log must be kept indicating the contents and expiration dates of the contents ... All staff must know the location of the evacuation box and who is responsible to grab it during an emergency evacuation ... Emergency medical equipment must be tested as required according to manufacturer's instructions." 2. A 2023 monthly log titled, "Emergency Box Contents" evidenced a completed checklist of the emergency box contents for the following months: January, February, March, July, & November of 2023. No documentation was evidenced for 2024. 3. A 2023 monthly log titled, "Emergency Code Cart, Medications and Machine Hand Crank Checklist" evidenced a completed checklist for the Emergency code cart, emergency medications, and machine hand crank for the following months: January, February, March, and July of 2023. No documentation was evidenced for 2024. 4. A document titled, "FKC Log Readings Grid Report" indicated that a digital checklist was completed for the emergency crash cart and emergency box in October and November of 2023. The digital checklist failed to evidence any additional checks completed after November of 2023. 5. During an interview on 02/28/2024 at 9:25 AM, RN 6 indicated that the crash cart is to be monitored and updated monthly and the Emergency Preparedness cart is to be monitored and updated quarterly. 6. During an interview on 02/28/2024 at 9:30 AM,		Emphasis was placed on: The emergency cart must be: Locked when not in use: Checked monthly or after use for contents, expiration dates, cleanliness, and proper functioning of all equipment. Equipped with a dedicated oxygen tank. Staff must check the pressure gauge on the oxygen cylinder weekly. Replace the tank when the pressure gauge reaches 500 psi. The emergency cart should be located where it is readily accessible during medical emergency situations and shall NOT be blocked by wheelchairs, equipment, or other facility supplies. An itemized log must be kept indicating the contents and expiration dates of contents. Items approaching expiration must be reordered and replaced prior to the actual expiration date. On 04/02/2024, the Director of Operations, checked the emergency cart for expired supplies/ and medications per policy. Director of Operations orientated staff to location of the cart and frequency for monitoring. Effective 04/03/24, the Director of Operations will conduct monthly audit with focus on ensuring the	

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FRESENIUS MEDICAL CARE FISHERS	13648 OLIVIA WAY FISHERS, IN 46037

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	PCT 7 was unable to communicate and/or locate where the Emergency Cart was and indicated that there was signage placed in the facility to assist her in an emergency advising her of where the emergency cart was located. PCT 7 continued to walk around the treatment floor looking for signage and was unable to find it. PCT 7 then asked PCT 3 where the Emergency cart was and PCT 3 also did not know. Once the surveyor pointed out where the Emergency Cart was, PCT 7 and PCT 3 both indicated not being aware of what was contained in the cart or the purpose of the cart. PCT 7 indicated not being oriented to the unit before starting at the facility. 7. During an interview on 02/28/2024 at 9:39 AM, RN 6 clarified that the crash cart and Emergency Preparedness cart are both checked monthly. The Emergency Preparedness cart patient information is updated quarterly. RN 6 indicated the paper charting identifying crash cart and emergency cart checks were completed that was found in the emergency cart was not up-to-date. RN 6 Indicated this would be completed in TMS, an online (digital) application used by the facility if it was done. 8. During an interview on 02/28/2024 at 10:40 AM, Biomed 1 indicated that the crash cart/emergency cart should be updated quarterly.		Emergency cart is checked for expired supplies/ and medications, as required, utilizing Emergency Code Cart, Medications and Machine Hand Crank Checklist Audit Tool for 3 months and then an additional 3 months. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause	

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			analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024.	
E 0032 Bldg. 00	403.748(c)(3), 416.54(c)(3), 418.113(c)(3), 441.184(c)(3), 482.15(c)(3), 483.475(c)(3), 483.73(c)(3), 484.102(c)(3), 485.625(c)(3), 485.68(c)(3), 485.727(c)(3), 485.920(c)(3), 486.360(c)(3), 491.12(c)(3), 494.62(c)(3) Primary/Alternate Means for Communication §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:			

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	(3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. Based on record review and interview, the dialysis facility failed to ensure the facility's communication plan included primary and alternate contact information for all facility staff for 1 of 1 agency. Findings include: 1. The Emergency Preparedness Guidelines policy, revised 7/23/2023, indicated the facility will create and maintain a staff contact list and that the Administrator is responsible for retaining a copy. 2. The facility's communication plan failed to include primary and/ or secondary contact information for 20 of the 22 staff on the facility's staff contact list. 3. During an interview on 2/29/2024 beginning at 2:03 PM, the Administrator indicated the staff contact list was missing phone numbers and alternate contact information and that the staff contact list needed to be updated.	E 0032	**E032** On 04/02/24, the Director of Operations and Education Coordinator held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the policy. Guidelines for Emergency Preparedness Emphasis was placed on: The facility must develop a communication plan for primary and alternate means for communicating with all facility staff (in-center and home). This plan includes the following: Create and maintain staff, patient, and facility emergency information contact lists: Quarterly, the Director of Operations/Area Manager or designee will review and update: The Emergency and Disaster	04/05/2024

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			Staff Contact Information Sheet A current copy of the emergency lists must: Be kept locked in the emergency supply boxes, or cart. Be sent to the facility's Director of Operations (DO) The DO will retain copies for each facility they manage. The patient contact lists contain PHI and must be maintained in a secure location such as on a laptop or in a locked location. Per the Emergency Regulations E0032, dialysis facilities must identify a primary and an alternate form of communication: The primary form of communication at a dialysis facility is a landline telephone. Alternative forms of communication include: Mobile phones, walkie-talkies, texting apps, HAM radios On 04/02/2024, the Director of Operations updated the facility communication plan with alternate contact information for all facility staff. Effective 04/03/24, the Director of Operations will conduct monthly audit with focus on ensuring communication plan has all current staff alternate contact information listed, as required, utilizing specific plan of correction	

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			Audit Tool for 3 months and then an additional 3 months. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible	

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			for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024.	
E 0038 Bldg. 00	494.62(d)(1) ESRD EP Training Program §494.62(d)(1): Condition for Coverage: (d)(1) Training program. The dialysis facility must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. Staff training must: (iii) Demonstrate staff knowledge of emergency procedures, including informing patients of- (A) What to do; (B) Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated; (C) Whom to contact if an emergency occurs while the patient is not in the dialysis facility. This contact information must include an alternate emergency phone number for the facility for instances when the dialysis facility is unable to receive phone calls due to an			

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	emergency situation (unless the facility has the ability to forward calls to a working phone number under such emergency conditions); and (D) How to disconnect themselves from the dialysis machine if an emergency occurs. (iv) Demonstrate that, at a minimum, its patient care staff maintains current CPR certification; and (v) Properly train its nursing staff in the use of emergency equipment and emergency drugs. (vi) Maintain documentation of the training. (vii) If the emergency preparedness policies and procedures are significantly updated, the dialysis facility must conduct training on the updated policies and procedures. Based on record review and interview the facility failed to ensure emergency training upon hire for 2 of 2 contracted Registered Nurse's personnel records reviewed. (RN 1 & RN 3) Findings Include: 1. A policy titled, "Guidelines for Emergency Preparedness", indicated but was not limited to, "Staff will be trained on emergency disaster preparedness such as fire drills, emergency disconnection, and emergency evacuation". 2. The personnel file for RN 1 failed to evidence emergency preparedness training upon hire. 3. The personnel file for RN 3 failed to evidence emergency preparedness training upon hire. 4. During an interview on 02/28/2024 at 1:30 PM, the Administrator indicated the information provided to the surveyors was all the staffing agency sent for RN 1 and what was completed by the facility. The Administrator indicated that	E 0038	**E038** On 04/02/24, the Director of Operations and Education Coordinator held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the policy. Guidelines for Emergency Preparedness Emphasis was placed on: Upon New hire and annually, all facility staff, including but not limited to agency staff, will be trained on emergency disaster preparedness such as fire drills, emergency disconnection and emergency evacuation. Documentation of training and orientation to facility will be	04/05/2024

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	emergency training was not found in the personnel record. 5. During an interview on 02/28/2024 at 9:30 AM, PCT 7 was unable to communicate and/or locate where the Emergency Cart was and indicated that there was signage placed in the facility to assist her in an emergency advising of where the emergency cart was located. PCT 7 continued to walk around the treatment floor looking for signage and was unable to find it. PCT 7 then asked PCT 3 where the Emergency cart was and PCT 3 also did not know. Once the surveyor pointed out where the Emergency Cart was, PCT 7 and PCT 3 both indicated not being aware of what was contained in the cart or the purpose of the cart. PCT 7 indicated not being oriented to the unit before starting at the facility. 6. During an interview on 02/29/2024 at 2:29 PM the Administrator indicated there were no policies for contracted staff.		available in personnel file upon request. Effective 04/03/24, the Director of Operations will conduct monthly audit with focus on ensuring all current staff completes emergency training and facility orientation, as required, utilizing employee personnel tracker Audit Tool for 3 months and then an additional 3 months. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.	

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			The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024.	
E 0040 Bldg. 00	494.62(d)(3) ESRD Patient Orientation Training The dialysis facility must provide appropriate orientation and training to patients, including the areas specified in paragraph (d)(1) of this section. Based on record review and interview, the dialysis facility failed to ensure all patients were provided appropriate orientation and training in emergency preparedness for 11 of 11 active in-center hemodialysis patient records reviewed (Patient #1, #2, #3, #4, #5, #9, #11, #12, #13, #14, #15, #20). Findings include:	E 0040	**E040** On 04/02/24, the Director of Operations and Education Coordinator held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the policy. Guidelines for Emergency	04/05/2024

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	1. The Emergency Preparedness Guidelines policy, revised 7/23/2023, indicated, but not limited to, that facility staff will educate patients on emergency disconnection procedures and emergency preparedness. 2. A clinical record review for Patient #1 failed to evidence training on emergency preparedness procedures. 3. A clinical record review for Patient #2 failed to evidence training on emergency preparedness procedures. 4. A clinical record review for Patient #3 failed to evidence training on emergency preparedness procedures. 5. A clinical record review for Patient #4 failed to evidence training on emergency preparedness procedures. 6. A clinical record review for Patient #15 failed to evidence training on emergency preparedness procedures. 7. The clinical record review for Patient #5 failed to evidence training on emergency preparedness procedures. 8. The clinical record review for Patient #9 failed to evidence training on emergency preparedness procedures. 9. The clinical record review for Patient #11 failed to evidence training on emergency preparedness procedures. 10. The clinical record review for Patient #12 failed to evidence training on emergency preparedness procedures. 11. The clinical record review for Patient #13 failed to evidence training on emergency preparedness		Preparedness Emphasis was placed on: On admission and annually, all facility patients will be trained in emergency disaster preparedness such as fire drills, emergency disconnection and emergency evacuation. Documentation of training will be available on site and available upon request. Effective 04/03/24, the Director of Operations will conduct monthly audit with focus on ensuring all current patients are trained with facility emergency preparedness training, as required, utilizing Fire Drill Checklist and Emergency/Disaster Preparedness checklist Audit Tool for 3 months and then an additional 3 months. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit	

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	procedures. 12. The clinical record review for Patient #14 failed to evidence training on emergency preparedness procedures. 13. The clinical record review for Patient #20 failed to evidence training on emergency preparedness procedures. 14. During an interview on 2/29/2024 beginning at 3:35 PM, the Administrator indicated the clinical records for Patient #1, 2, 3, 4, 5, 9, 11, 12, 13, 14, 15 and 20 failed to include any emergency training documentation.		results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024.	
V 0000 Bldg. 00				

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	V 0000 This visit was for a Federal complaint survey of an ESRD provider. Survey dates: February 19, 20, 21, 22, 23, 26, 27, 28, and 29, 2024 Complaint: IN00427447 with related deficiencies cited. A full Federal CORE survey was announced to the Administrator on 02/20/2024 at 4:21 PM. Census by Service Type: In-Center Hemodialysis: 58 Home Hemodialysis: 22 Home Peritoneal dialysis: 6 Total Active Census: 86 Isolation Room: 1 An Immediate Jeopardy at 42 CFR 494.90 Patient plan of care was identified and announced on 02/28/2024. The Immediate Jeopardy was identified as beginning on 7/09/2023. The immediacy was not abated prior to survey exit on 2/29/2024. The facilities 4th removal plan and action removed the immediacy component of the immediate jeopardy on 03/18/2024. QR Completed by A4 on 03/19/2024			
V 0110 Bldg. 00	494.30 CFC-INFECTION CONTROL Based on observation, record review, and interview, the dialysis facility failed to maintain a sanitary environment in the dialysis treatment area (See V0111); failed to ensure all staff followed	V 0110	**V 110** The Governing Body of this facility acknowledges its responsibility to ensure that the facility maintains a	04/05/2024

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	policies and procedures related to hand hygiene (See V0113); failed to ensure staff wore the required personal protective equipment (PPE) when spurting or spattering of blood might occur (See V0115); and failed to ensure their policies were followed related to medication storage (See V0119). The cumulative effect of these systemic problems has resulted in the facility's inability to ensure the provision of quality health care in a safe environment for the Condition for Coverage 42 CFR 494.30 for Infection Control with the potential to affect all 58 of the facility's active in-center hemodialysis patients.		sanitary environment in the dialysis treatment area, staff perform proper hand hygiene, that staff wears the required personal protective equipment (PPE) that when spurting or spattering of blood might occur, as well as, ensuring policies related to medication storage are followed per policy. As such, the Governing Body held a conference call on 2/29/2024, and 3/8/2024 to review the information provided by the surveyors during this survey and actively participate in the development of the Plan of Correction. The Governing Body has committed to meet weekly to review the status of the Plan of Correction until all issues are resolved and the facility is back in compliance. The Governing Body met again on 3/29/2024, to review the Statement of Deficiencies and develop the following Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The Governing Body began meeting weekly beginning 2/29/2024 to review the results of the progress on the Plan of Correction ensuring that	

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			deficiencies are addressed, both immediately and with long term resolution. The Governing Body will determine when the frequency of these meetings may be reduced to the regular quarterly schedule. Effective immediately: The Director of Operations will analyze and trend all data and monitor/audit results as related to this Plan of Correction prior to presenting the monthly data to the QAI Committee. A specific plan of action encompassing the citations as cited in the Statement of Deficiency has been added to the facility's monthly QAI (Quality Assessment and Performance Improvement) agenda. The QAI Committee is responsible for reviewing and evaluating the Plan of Correction to ensure it is effective and providing resolution of the issues. The Director of Operations (DO) will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The Governing Body, at its meeting of 2/29/24, designated the Director of Operations (DO) to serve as Plan of Correction Monitor and provide additional	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FISHERS	13648 OLIVIA WAY FISHERS, IN 46037

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			oversight. They will participate in QAPI and Governing Body meetings. This additional oversight is to ensure the ongoing correction of deficiencies cited in the Statement of Deficiency through to resolution as well as ensure the Governance of the Facility is presented current and complete data to enhance their governance oversight role. Minutes of the Governing Body and QAI meetings, as well as monitoring forms and educational documentation will provide evidence of these actions, the Governing Body's direction, and oversight and the QAI Committees ongoing monitoring of facility activities. These are available for review at the facility. The responses provided for V 111; V113; V115; and V119 describe, in detail, the processes and monitoring steps taken to ensure that all deficiencies cited within this Condition are corrected to ensure ongoing compliance.	
V 0111 Bldg. 00	494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas. Based on observation, record review, and interview, the dialysis facility failed to maintain a sanitary environment in the dialysis treatment area	V 0111	**V111** On 04/02/2024, the Director of Operations and Education	04/05/2024

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	for 1 of 1 agency. Findings include: 1. A review of agency policy "Cleaning and Disinfecting the Dialysis Station" indicated staff should pick up all trash or visible medical debris from around the patient chair. 2. A review of agency policy "Cleaning the Dialysis Treatment Area and Isolation Area" indicated general cleaning of the dialysis treatment area included picking up loose trash and emptying the trash cans at the workstations. 3. A review of agency policy "PCT Job Description" indicated employee will support staff and patient adherence to infection control practices and follows infection control policies and procedures. 4. A review of agency "Staff Registered Nurse" indicated the employee ensures a clean, safe, and sanitary environment in the dialysis facility treatment area. 5. During the flash tour observation on 2/19/2024 beginning at 12:16 PM, the trash can next to the "dirty" sink was overflowing; the "dirty" sink was overflowing with used tubing and clamps; the trash can next to the "clean" sink on the north side was overflowing; trash/debris was on the floor in Station #1; trash/debris/dirty glove was on the floor in Station #7; Stations #10, 11 and 12 flooring was soiled with a dry white powdery substance; a new roll of paper towels was sitting on the east "clean" sink with a large amount of paper towel hanging across the sink, and multiple individual station trash cans were full.		Coordinator held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy and procedure: Cleaning and Disinfecting the Dialysis Station Cleaning the Dialysis Treatment Area and Isolation Area General Cleanliness and Infection Control Guidelines Clinic Audit Checklist Emphasis was placed on: Importance of ensuring that a sanitary environment is maintained in all areas of the treatment floor. Effective 04/03/24, Director of Operations or Clinical Manager will conduct audits 3 days per week, with focus on ensuring staff maintain a sanitary environment per policy, as required, utilizing the Infection Control Monitoring Tool for 2 weeks and then weekly for an additional 2 weeks or until 90% compliance is achieved. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly.	

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	6. During an observation on 2/19/2024 beginning at 3:48 PM, the floor remained soiled in Stations #10, 11 and 12; the trash can under the "dirty" sink was overflowing; the trash can near Station #3 was overflowing and a dirty glove was on the floor; the trash can was overflowing next to the "clean sink" near Station #2; and the wall box near Station #11 was covered with a white powdery substance that was dripping onto the floor. 7. During an observation on 2/20/2024 beginning at 4:05 PM, multiple individual station trash cans were full, and water was on the floor behind Station #10, running towards the patient chair. 8. During an observation on 2/21/2024 beginning at 5:05 PM, multiple individual station trash cans were full; a dirty glove was noted on the floor next to the trash can on the east wall and a dirty glove was noted on the floor next to the trash can near the west "clean" sink.9. On 2/19/2024 at 5:36 PM, the Administrator indicated trash cans in patient stations should be emptied between patients, and other trash cans on the treatment floor should be emptied when full. The Administrator also indicated the "dirty" sink should not be full of tubing and clamps. The Administrator also indicated the white, powdery substance on the floor in and around Station #10, #11, and #12, was bicarb that had been leaking and indicated it had been there for less than an hour. 10. During an interview on 2/20/2024 beginning at 11:05 AM, Patient #2 relayed the bicarb on the floor is there all the time. Patient #2 further indicated when he/she came to the facility for treatment, the small trashcans were usually overflowing, the needle containers on the machines were often full, and there was usually debris on the floor.		The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic.	

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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 dialysis facility failed to ensure all staff followed policies and procedures related to hand hygiene for 1 of 3 Registered Nurse (RN) and 2 of 6 Patient Care Technicians (PCT) observed in the treatment area (RN 3, PCT 1 and PCT 3); for 1 of 1 PCT's observed performing discontinuation of AV fistula/graft dialysis (PCT 3); and for 1 of 2 PCT's observed performing central venous catheter exit site care (PCT 3). Findings include: 1. A review of agency policy "Personal Protective Equipment" indicated staff must remove gloves and wash hands after patient care, exposure to blood and body fluids and touching any surfaces within the patient station. 2. A review of agency policy "Hand Hygiene" indicated hand hygiene should be performed before and after direct contact with patients; after contact with the dialysis wall box, concentrate, drain or water lines and after contact with other object within the patient station or treatment space. 3. During an observation on 2/19/2024 beginning at 2:45 PM, PCT 3 discontinued dialysis treatment on Patient #10. PCT 3 failed to perform hand hygiene after removing gloves.	V 0113	**V113** On 04/02/2024, the Director of Operations and Education Coordinator held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy and procedure: Hand Hygiene Personal Protective Equipment Changing the Catheter Dressing Procedure Emphasis was placed on: Hands will be decontaminated using alcohol-based hand rub (without waving hands to dry, due to potential air borne contaminants) or by washing hands with antimicrobial soap and water: *Before and after direct contact with patients* Entering and leaving the treatment area Before performing any invasive procedure such as vascular access cannulation or administration of parenteral	04/05/2024

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	4. During an observation on 2/19/2024 at 4:06 PM, PCT 1 donned a glove to their right hand. PCT 1 failed to perform hand hygiene prior to donning the glove. 5. During an observation on 2/19/2024 at 4:41 PM, PCT 1 donned a glove to their right hand. PCT 1 failed to perform hand hygiene prior to donning the glove. PCT 1 entered the isolation room to reset the monitor. PCT 1 then exited the isolation room while removing the glove. PCT 1 failed to perform hand hygiene after removing the glove. PCT 1 donned a new glove to their right hand, walked to Station #4 to reset the monitor without performing hand hygiene. 6. During an observation on 2/19/2024 at 5:33 PM, PCT 1 was donned a glove to their right hand. PCT 1 failed to perform hand hygiene prior to donning the glove. PCT 1 walked to Station #7 to reset the monitor. PCT 1 removed the glove. PCT 1 failed to perform hand hygiene after removing the glove. PCT 1 donned a new glove to their right hand, walked to Station #3 to reset the monitor. 7. During an observation on 2/21/2024 at 6:51 AM, RN 3 donned new gloves. RN 3 failed to perform hand hygiene prior to donning gloves. 8. On 2/21/2024 at 5:32 PM, PCT 3 provided central venous catheter (CVC) exit site care for Patient #21. PCT 3 failed to perform hand hygiene after removing the CVC dressing and prior to placing the new dressing. 9. During an interview on 2/19/2024 beginning at 5:38 PM, the Administrator indicated hand hygiene should be performed before and after wearing gloves.		medications *Immediately after removing gloves.* After contact with body fluids or excretion, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled. *After contact with inanimate objects near the patient* When moving from a contaminated body site to a clean body site of the same patient After contact with the dialysis wall box, concentrate, drain, or water lines. After contact with other objects within the patient station or treatment space Washing Hands with Soap and Water - *Duration of the entire procedure: 40-60 seconds* Decontaminating Hands with Alcohol Based Hand rubs - Duration of the entire procedure: 20-30 seconds. Apply alcohol-based hand rub to the palm of one hand using the amount recommended by the product manufacturer. An adequate amount of product must be used for maximum effectiveness. Rub hands together covering all surfaces of the hands and fingers, *until hands are dry*. Allowing alcohol to dry completely allows adequate contact time to kill germs, allows alcohol to evaporate and prevents risk of igniting flames	

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			due to alcohol's flammable properties. Importance of donning gloves on both hands when touching any part of the dialysis machine or equipment at the dialysis machine, to include but not limited to answering alarms or entering data into the dialysis machine computer screen. Never wear only one glove or wrap a finger with a glove to perform any dialysis task. Disinfect cannulation site as follows using any of the disinfectants below: 70% isopropyl alcohol pad: Using gentle friction, clean the access site beginning in the center and continuing outward 2 inches in a concentric circle for 30 seconds and allow to dry before cannulating. 2% Chlorhexidine and 70% alcohol: Work outward 2 inches in a concentric circle using gentle back and forth friction to clean for a minimum 30 seconds and allow to dry before cannulating Perform skin antisepsis on one site at a time, allow to dry and then cannulate. Do not touch cannulation sites after skin disinfection. Note: This method minimizes the risk of contaminating the second site while cannulating the first site Observe cannulation site for any reaction to antimicrobial solution.	

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			Follow the steps below to clean the catheter exit site: Perform hand hygiene and don clean gloves. Remove swabstick from package by stick end without touching foam applicator. Handle only the stick portion. 2% Chlorhexidine and 70% alcohol: Using gentle back and forth friction, clean the exit site beginning in the center and continuing outward the area of the size of the dressing to be applied (2 inches) in a concentric circle for 30 seconds and allow to dry a minimum of 30 seconds. If exudate or crusting is noted, an additional swabstick may be necessary to clean the exit site. Applying CHG on the skin in a gentle back and forth motion allows the solution to penetrate the cell layers of the epidermis where 80% of microorganisms reside. Reminder: Chlorhexidine swab contains alcohol. The alcohol must vaporize to dry. Allow the area to air dry for approximately 30 seconds. Do not blot or wipe away. If a dressing is applied prior to drying, the alcohol vapors will be trapped resulting in blistering of the skin. Note: If unable to use chlorhexidine due to skin sensitivity, utilize other approved disinfectants such as povidone iodine prep pads or 70% alcohol	

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			pads or per physician order. If using povidone pad: Using gentle friction, disinfect the exit site beginning in the center and continuing outward 2 inches in a concentric circle for 30 seconds and allow to dry for at least 2 minutes. If using 70% alcohol pad: Using gentle friction, disinfect the access site beginning in the center and continuing outward 2 inches in a concentric circle for 30 seconds and allow to dry. If using ExSept Plus: Using gentle friction, use one saturated 4x4 to disinfect the access site beginning in the center and continuing outward 2 inches in a concentric circle for 30 seconds. Discard and repeat with second 4x4. Allow to dry at least 2 minutes. Triple antibiotic ointment (bacitracin/neomycin/polymyxin) is the preferred therapeutic exit site antibiotic unless otherwise prescribed by provider. Per prescriber order, apply antimicrobial ointment around exit site minimizing ointment contact with the catheter material. Follow the steps below to apply a dressing to the exit site: Using aseptic technique, apply the catheter dressing over dry exit site, being careful not to touch the patient side of the dressing with gloved hands or to any surface. Remove the backing of adhesive	

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			dressing or apply tape to edges of gauze dressing. Effective 04/03/2024, Director of Operations or Clinical Manager will conduct infection control audits 3 times per week, with alternating shifts with focus on ensuring staff perform hand hygiene per policy, and with Central Venous Catheter dressing change, as required, utilizing Infection Control Monitoring Tool for 2 weeks and then 2 times per week for an additional 4 weeks. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting	

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			through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024.	
V 0115 Bldg. 00	494.30(a)(1)(i) IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory.			

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	Based on observation, record review, and interview, the dialysis center failed to ensure staff wore the required personal protective equipment (PPE) when spurting or spattering of blood might occur for 2 of 6 Patient Care Technicians (PCT's) observed on the treatment floor (PCT 3 and PCT 5). Findings include: 1. A review of agency policy "Personal Protective Equipment" indicated PPE including a full-face shield or a mask and protective goggles must be worn when performing procedures during which spurting or spattering of blood might occur. 2. A review of agency policy "Initiation and Termination of Treatment Using a Central Venous Catheter (CVC)" indicated staff must wear a mask that covers the nose and mouth for all procedures that require accessing the catheter. 3. A review of agency policy "Employee Dress Code" indicated when in a patient care or lab area, footwear must be worn that has a solid foot-box (no holes or vents). 4. During the flash tour observation on 2/19/2024 beginning at 12:16 PM, a cup of coffee was observed sitting on the counter in the treatment area. 5. During an observation on 2/19/2024 beginning at 3:59 PM, PCT 3 accessed a fistula for Patient #9 with a face shield on and wearing a mask below their nose. PCT 3 failed to wear their face mask properly, covering the nose, when performing a procedure during which spurting or spattering of blood might occur.	V 0115	**V115** On 04/02/2024, the Director of Operations and Education Coordinator held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy and procedure: General Cleanliness and Infection Control Guidelines Personal Protective Equipment Guidance on Dialyzing and Infection Control Practices of COVID-19 in Fresenius Kidney Care (FKC) Dialysis Clinics Initiation of Treatment Using a Central Venous Catheter and Optiflux Single Use Ebeam Dialyzer Termination of Treatment Using a Central Venous Catheter Employee Dress Code Emphasis was placed on: Eating, drinking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure. Personal protective equipment including a full-face shield or mask and protective eyewear with full side shield, fluid-resistant gowns, and gloves,	04/05/2024

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	6. PCT 2 was observed outside under the carport wearing a mask, face shield on the top of their head and a gown. PCT 2 walked back into the building and reentered the treatment area without changing PPE. 7. During an observation on 2/21/2024 at 6:58 AM, PCT 5 was observed providing care on the treatment floor wearing rubber shoes with holes throughout them. PCT 5 failed to wear the required footwear while in the patient care area. 8. On 2/28/2024 at 3:25 PM, during an interview in the Administrator's office, observed PCT 5 performing care on the treatment floor through the window. PCT 5 was accessing Patient #14's right arm fistula in Station #12. PCT 5 was wearing a face shield and mask below the nose. PCT 5 failed to wear their face mask covering the nose when performing a procedure during which spurting or spattering of blood might occur. 9. During an interview on 2/19/2024 beginning at 5:38 PM, the Administrator indicated feet must be completely covered, shoes must be washable with no holes. They also indicated masks should be worn above the nose, all PPE should be removed before leaving the treatment area and there should not be any food or drink on the treatment floor.		must be worn to protect employees from blood or other potentially infectious materials (OPIM). PPE is used to protect employees who are occupationally exposed to blood or OPIM when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). All personal protective equipment shall be removed prior to leaving the treatment area. All FKC Staff, physicians and physician extenders are required to surgical face masks or wear N95 respirator during all patient facing activities. Face mask should be worn above the nose and covering the mouth. When in a patient care or lab area, footwear must be worn that meets the following safety requirements: water and slip resistant, can be easily cleaned and has a solid foot-box (no holes or vents). Inappropriate footwear includes, but is not limited to canvas sneakers, mesh top athletic shoes, or any type of shoe or sandal that is not enclosed. Effective 04/03/2024, Director of Operations or Clinical Manager will conduct infection control audits 3	

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			times per week, with alternating shifts with focus on ensuring PPE worn per policy with mask above nose and covering mouth; staff wearing shoes with no holes or vents; all PPE should be removed before leaving treatment area and there is no food or drink on the treatment floor, utilizing Infection Control Monitoring Tool for 2 weeks and then 2 times per week for an additional 4 weeks. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.	

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			The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024.	
V 0119 Bldg. 00	494.30(a)(1)(i) IC-SUPPLY CART DISTANT/NO SUPPLIES IN POCKETS If a common supply cart is used to store clean supplies in the patient treatment area, this cart should remain in a designated area at a sufficient distance from patient stations to avoid contamination with blood. Such carts should not be moved between stations to distribute supplies. Do not carry medication vials, syringes, alcohol swabs or supplies in pockets.			

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	Based on observation, record review, and interview, the dialysis facility failed to ensure their policies were followed related to medication storage for 1 of 1 patient treatment area. Findings include: 1. A review of agency policy "Medication Preparation and Administration" indicated all medications will be kept in a locked cabinet when not in use and vials should never be stored in clothing or pockets. 2. During the flash tour observation on 2/19/2024 beginning at 12:16 PM, 1 bottle of Heparin and 2 vials of Venofer were sitting unattended on the counter in the treatment area. RN 4 walked from the nurse desk to the counter and placed the medication in their pocket. 3. During an interview on 2/19/2024 beginning at 5:38 PM, the Administrator indicated medications should never be stored in the clinician's pocket.	V 0119	**V119** On 04/02/2024, the Director of Operations and Education Coordinator held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy and procedure: Medication Preparation and Administration Emphasis was placed on: All medication should be secured/ locked in cabinet if not immediately administered. Staff should never store medication vials in clothing or pockets. Effective 04/03/2024, Director of Operations or Clinical Manager will conduct infection control audits 3 times per week, with alternating shifts with focus on ensuring medication secured if not immediately being administered, no medication stored in staff clothing or pockets, utilizing Infection Control Monitoring Tool for 2 weeks and then 2 times per week for an additional 4 weeks. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic	04/05/2024

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			Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.	

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			The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024.	
V 0175 Bldg. 00	494.40 CFC-WATER & DIALYSATE QUALITY Based on observation, record review, and interview, the End Stage Renal Disease (ESRD) facility failed to ensure facility staff had completed and/or passed the Ishihara Color Blindness Test, according to facility policy, upon employment that include testing for total chlorine of the in-center hemodialysis (ICHD) product water and hard water testing to be completed when opening the water room (See V0196), failed to ensure that the water room door remained locked and inaccessible to anyone other than facility staff (See V0184), and failed to maintain water training records for facility staff (See V0260). The cumulative effect of these systemic problems has resulted in the facility's inability to ensure the provision of quality health care in a safe environment for the Condition for Coverage 42 CFR 494.40 for Water & Dialysate Quality with the potential to affect all 58 of the facility's active in-center hemodialysis patients.	V 0175	**V 175** The Governing Body of this facility acknowledges its responsibility to ensure that the facility staff has completed and/or passed the Ishihara Color Blindness Test, upon employment that include testing for total chlorine of the in-center hemodialysis product water and hard water testing to be completed when opening the water room; ensuring facility water room door remains locked and inaccessible to only facility staff; and as well as, maintaining water training records for facility staff available upon request per policy. As such, the Governing Body held a conference call on 2/29/2024, and 3/8/2024 to review the information provided by the surveyors during this survey and actively participate in the development of the Plan of Correction. The Governing Body has committed to meet weekly to review the status of the Plan of Correction until all issues are	04/05/2024

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			resolved and the facility is back in compliance. The Governing Body met again on 3/29/2024, to review the Statement of Deficiencies and develop the following Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The Governing Body began meeting weekly beginning 2/29/2024 to review the results of the progress on the Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The Governing Body will determine when the frequency of these meetings may be reduced to the regular quarterly schedule. Effective immediately: The Director of Operations will analyze and trend all data and monitor/audit results as related to this Plan of Correction prior to presenting the monthly data to the QAI Committee. A specific plan of action encompassing the citations as cited in the Statement of Deficiency has been added to the facility's monthly QAI (Quality Assessment and Performance Improvement) agenda. The QAI Committee is	

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			responsible for reviewing and evaluating the Plan of Correction to ensure it is effective and providing resolution of the issues. The Director of Operations (DO) will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The Governing Body, at its meeting of 2/29/24, designated the Director of Operations (DO) to serve as Plan of Correction Monitor and provide additional oversight. They will participate in QAPI and Governing Body meetings. This additional oversight is to ensure the ongoing correction of deficiencies cited in the Statement of Deficiency through to resolution as well as ensure the Governance of the Facility is presented current and complete data to enhance their governance oversight role. Minutes of the Governing Body and QAI meetings, as well as monitoring forms and educational documentation will provide evidence of these actions, the Governing Body's direction, and oversight and the QAI Committees ongoing monitoring of facility activities. These are available for review at the facility. The responses provided for V 196;	

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			V184; and V260 describe, in detail, the processes and monitoring steps taken to ensure that all deficiencies cited within this Condition are corrected to ensure ongoing compliance.	
V 0184 Bldg. 00	494.40(a) ENVIRONMENT-SECURE & RESTRICTED 8 Environment: secure & restricted The water purification and storage system should be located in a secure area that is readily accessible to authorized users. The location should be chosen with a view to minimizing the length and complexity of the distribution system. Access to the purification system should be restricted to those individuals responsible for monitoring and maintenance of the system. Based on observation, record review, and interview, the dialysis facility failed to ensure the water purification and storage system room access was restricted from unauthorized entry for 1 of 1 facility. Findings include: 1. The Physical Security and Facility Access Policy, revised 9/05/2023, indicated all doors that allow access to the water treatment equipment must be kept locked. 2. On 2/19/2024 at 12:28 PM, the water treatment room was unlocked. 3. On 2/19/2024 at 4:17 PM, BioMed 1 indicated the water room door should be locked at all times. 4. On 2/19/2024 at 5:36 PM, the Administrator relayed the water treatment room door should be	V 0184	**V184** On 04/02/2024, the Director of Operations and Education Coordinator held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy and procedure: Physical Security and Facility Access Emphasis was placed on: Restricted access must be maintained to prevent unwanted tampering with the water treatment equipment. The facility must be maintained to prevent unwanted entry by outside persons not	04/05/2024

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	kept locked at all times.		involved in the daily operation of the clinic. This is accomplished by: Locking all doors that allow access to the water treatment equipment. No exterior building door will be left unlocked unless under the continual supervision of a facility staff member. Non-FKC employees and third-party personnel who repair/maintain water treatment equipment or deliver supplies in the water treatment area must be always monitored by a FKC employee while in the area. Technical staff will supervise any work being performed in the water treatment area of a technical nature; this may not be delegated to non-technical staff. Effective 04/03/2024, Director of Operations or Clinical Manager will conduct audits utilizing Building Interior Physical Environment inspection for 2 weeks, 3 times per week, with alternating shifts with focus on ensuring water room secured/ door always locked, utilizing Physical Environment inspection Tool for 2 weeks and then 2 times per week for an additional 4 weeks. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done	

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			through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.	

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			The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024.	
V 0196 Bldg. 00	494.40(a) CARBON ADSORP-MONITOR, TEST FREQUENCY 6.2.5 Carbon adsorption: monitoring, testing freq Testing for free chlorine, chloramine, or total chlorine should be performed at the beginning of each treatment day prior to patients initiating treatment and again prior to the beginning of each patient shift. If there are no set patient shifts, testing should be performed approximately every 4 hours. Results of monitoring of free chlorine, chloramine, or total chlorine should be recorded in a log sheet. Testing for free chlorine, chloramine, or total chlorine can be accomplished using the N.N-diethyl-p-phenylene-diamine (DPD) based test kits or dip-and-read test strips. On-line monitors can be used to measure chloramine concentrations. Whichever test system is used, it must have sufficient sensitivity and specificity to resolve the maximum levels described in [AAMI] 4.1.1 (Table 1) [which is a maximum level of 0.1 mg/L]. Samples should be drawn when the system has been operating for at least 15 minutes. The analysis should be performed on-site, since chloramine levels will decrease if the			

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	sample is not assayed promptly. Based on record review and interview the facility failed to obtain and/or ensure a passing color blindness test for facility staff upon hire for 3 of 6 personnel records reviewed. (RN 1, RN 4, & PCT 2) Findings Include: 1. A policy titled, Color Blindness Testing" indicated but was not limited to, "Certain positions within the company require employees to distinguish or interpret color when performing various functions of the job including, but not limited to water and/or other quality tests or maintenance on dialysis machines or other equipment ... required to take the Ishihara Test for Color Blindness. The Ishihara Test for Color Blindness should be administered after an offer of employment is made and prior to starting the new position ... applies to new hires, rehires or transferring employees in positions that require the ability to interpret or distinguish color ... The manager or designee is responsible for administering and recording the results of the Ishihara Test for Color Blindness ... manager is responsible for confirming the results are documented and placed in the employee's medical file ... Employees who have a deficiency for distinguishing certain colors may use a corrective device such as glasses or contact lenses". 2. The personnel record for PCT 2 evidenced a failed color blindness testing upon hire dated 07/20/2017. A subsequent color blindness test was completed on 02/24/2024 once identified by facility administration with PCT 2 using color blindness glasses purchased by the facility. This second color blindness test evidence a passing score.	V 0196	**V196** On 04/02/2024, the Director of Operations and Education Coordinator held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy and procedure: Color Blindness Testing Emphasis was placed on: New hire, rehire, or transfer staff working in a direct patient care or biomedical position are required to take the Ishihara Test for Color Blindness to ensure the ability to perform the essential functions of their job. The direct supervisor is responsible for confirming the results and contacting the Employee Service Center if the staff fails the test. Failing the Ishihara Test for Color Blindness does not preclude employment. If an employee fails the color blindness test, the Clinical Manager MUST submit a case to the Employee Service Center to discuss alternative options. On 04/03/2024, the Director of	04/05/2024

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	3. The personnel record for RN 1 failed to evidence color blindness testing prior to starting the position. 4. The personnel record for RN 4 failed to evidence color blindness testing prior to starting the position. 5. A document titled, "FKC Log Readings Report for Total Chlorine (TCL)" indicated the following Chlorine tests completed by PCT 2 upon opening the water room on the following dates: 01/04/2024, 01/13/2024, 01/19/2024, 01/24/2024, 01/25/2024, 02/05/2024, 02/10/2024, 02/14/2024, 02/16/2024, & 02/24/2024. 6. A document titled, "Post Worker Carbon Tank - TCL-1" indicated the following Chlorine tests completed by PCT 2 for the required every 4-hour Chlorine check for the following dates/times: 02/02/2024 at 7:30 AM, 02/05/2024 at 5:10 AM, 02/05/2024 at 8:35 AM, 02/05/2024 at 12:00 PM, 02/06/2024 at 11:55 AM, 02/10/2024 at 8:00 AM, 02/10/2024 at 5:00 AM, 02/14/2024 at 5:10 AM, 02/16/2024 at 5:05 AM, 02/27/2024 at 8:40 AM, 01/04/2024 at 8:40 AM, 1/13/2024 at 10:40 AM, 01/13/2024 at 2:00 PM, 01/19/2024 at 9:00 AM, 01/24/2024 at 5:00 AM, 01/24/2024 at 8:46 AM. 7. A document titled, "Water Pre-TX Opening - 78904" indicated the following dates the water room was opened by PCT 2: 01/03/2024, 01/08/2024, 01/12/2024, 01/15/2024, 01/16/2024, 01/18/2024, 01/22/2024, 01/24/2024, 01/25/2024, 01/30/2024, 01/31/2024, 02/02/2024, 02/05/2024, 02/10/2024, 02/14/2024, 02/16/2024, 02/19/2024, 02/20/2024, 02/23/2024, 02/26/2024, 02/27/2024, & 02/29/2024.		Operations reviewed 100% of all clinical staff currently working at the facility to ensure a color-blind test was performed and employee successfully passed. Employee records available upon request at the facility for review. Effective 04/03/24, the Director of Operations will conduct monthly audit with focus on ensuring new hire, rehire or transfer staff have administered a color-blind test, as required, utilizing Personnel Tracker Audit Tool for 3 months and then an additional 3 months. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at	

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	8. A document titled, Post Worker Carbon Tank-TCL-1" indicated the following Chlorine tests completed by RN 4 for the required every 4-hour Chlorine check for the following dates: 01/02/2024, 01/06/2024, 01/08/2024, 01/09/2024, 01/10/2024, 01/12/2024, 01/15/2024, 01/16/2024, 01/17/2024, 01/20/2024, 01/22/2024, 01/23/2024, 01/25/2024, 01/30/2024, 02/01/2024, 02/03/2024, 02/06/2024, 02/08/2024, 02/09/2024, 02/13/2024, 02/15/2024, 02/17/2024, 02/19/2024, 02/20/2024, 02/22/2024, 02/23/2024, 02/26/2024, & 02/27/2024. 9. A document titled, Post Worker Carbon Tank-TCL-1" indicated the following Chlorine tests completed by RN 1 for the required every 4-hour Chlorine check for the following dates: 01/05/2024, 01/10/2024, 01/12/2024, 01/17/2024, 01/19/2024, 01/22/2024, 01/26/2024, 01/29/2024, 01/31/2024, 02/02/2024, 02/07/2024, 02/09/2024, & 02/14/2024. 10. During an interview on 02/28/2024 at 1:30 PM, the Administrator indicated the information provided to the surveyors was all the staffing agency sent for RN 1 personnel files and what was completed by the facility. 11. During an interview on 02/28/2024 at 1:30 PM, the Administrator indicated that the information provided for RN 4's personnel record was provided. RN 4's personnel record failed to include a color blindness test completed upon hire. 12. During an interview on 02/29/2024 at 12:58 PM, Biomed 1 indicated that a color blindness test dated 07/20/2017 by PCT 2 evidenced a failed test. This concern was identified on 02/23/2024 and the facility's response was to purchase a pair of color-blind glasses online. These glasses were		each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024.	

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	obtained on 02/24/2024 with a subsequent color blindness test completed on 02/24/2023 with a passing score. PCT 2 is required to wear color-blind glasses when completing Chlorine and hard water testing. The second color-blind test was administered to PCT 2 with confirmation from Biomed 1. Biomed 1 indicated that when opening the water room, PCT does not use an RPC strip (color-indicating chlorine strip to test for the presence of chlorine) in the morning, and only reads the results from the machine. The concern with opening the water room was PCT 2 using a color-indicating strip to test water hardness. Another concern was PCT 2 reading the required 4-hour chlorine test strips prior to obtaining the color-blind glasses.			
V 0260 Bldg. 00	494.40(a) PERSONNEL-TRAINING PROGRAM/PERIODIC AUDITS 9 Personnel: training program/periodic audits A training program that includes quality testing, the risks and hazards of improperly prepared concentrate, and bacterial issues is mandatory. Operators should be trained in the use of the equipment by the manufacturer or should be trained using materials provided by the manufacturer. The training should be specific to the functions performed (i.e., mixing, disinfection, maintenance, and repairs). Periodic audits of the operators' compliance with procedures should be performed. The user should establish an ongoing training program designed to maintain the operator's			

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	knowledge and skills. Based on record review and interview the facility failed to ensure staff completed water room training for 3 of 3 contracted Registered Nurses (RN). (RN 1, RN 2 & RN 3) Findings Include: 1. A policy titled, "Progressive Renal Education Program (PREP) Orientation for Inexperienced New Employees" indicated but was not limited to, "The topics covered in PREP orientation are required by CMS Conditions for Coverage, state specific regulations, and specific job descriptions, and include: ... Role-specific employee training ... New Employee: ... Full participation in and successful completion of: ... LMS requirements including assigned e-learning ... clinical skills assessment". 2. The personnel record for RN 1 failed to include water room training. 3. A document titled, "Healthcare Staffing Hire Skills Checklist by Healthcare Staffing Hire" indicated that RN 1 completed a self-assessment of dialysis-related skills, but this document failed to include a self-assessment on components of water room training. 4. During an interview on 02/28/2024 at 1:30 PM, the Administrator indicated the information provided to the surveyors for RN 1 was inclusive of all the staffing agency sent. No additional information was able to be provided from the facility personnel file. The Administrator indicated that personnel files for RN 1 were not kept by the facility and would need to be obtained from the source, clarifying the source was the staffing agency. 5. The personnel file for RN 2 indicated a	V 0260	**V260** On 04/02/2024, the Director of Operations and Education Coordinator held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy and procedure: Progressive Renal Education Program (PREP) Orientation for Inexperienced New Employees Emphasis was placed on: New employees performing direct patient care, ancillary, and biomedical services must complete the FKC standardized new employee orientation program. PREP provides the new employee: An initial and ongoing assessment of their knowledge and skills is essential for a highly functional and well-trained workforce. Both classroom setting and clinical time to apply their knowledge. An educational foundation necessary for cultivation of their individual potential. The topics covered in PREP orientation are required by CMS Conditions for Coverage, state specific regulations, and specific	04/05/2024

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	hire date of 1/08/2024. The file failed to include the required water room training and skills checkoffs. 6. The personnel file for RN 3 indicated a hire date of 1/05/2024. The file failed to include the required water room training and skills checkoffs. 7. During an interview on 2/29/2024 beginning at 11:08 AM, the Administrator indicated the personnel files for RN 2 and RN 3 were missing the required water room training and skills checkoffs.		job descriptions, and include: Fresenius Kidney Care organizational structure End stage renal disease, acute kidney injury, and chronic kidney disease concepts. Review of the appropriate Human Resources policies and procedures Role-specific employee training The content will be delivered using various methods which may include: Classroom sessions Study guides. Training materials Interactive distance learning Self-directed e-learning activities Activities in the classroom and in the clinical practice setting Success will be measured through: Demonstration of applied learning Successfully passing exams with a score of at least 80%* Successful completion of the skills competency assessment Observed engagement when applicable. Documented graduation from PREP orientation On 04/03/2024, the Director of Operations reviewed 100% of all	

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			clinical staff currently working at the facility to ensure a required water room training and skills checkoffs color-blind was performed and employee successfully passed. Employee records available upon request at the facility for review. Effective 04/03/24, the Director of Operations will conduct monthly audit with focus on ensuring all clinical staff performing water room assignment has successful passed water room training and skills checkoffs completed, as required, utilizing Personnel Tracker Audit Tool for 3 months and then an additional 3 months. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is	

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			responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024.	
V 0455 Bldg. 00	494.70(a)(4) PR-PRIVACY & CONFIDENTIALITY-RECORDS The patient has the right to- (4) Privacy and confidentiality in personal medical records; Based on observation, record review and	V 0455	**V455**	04/05/2024

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	interview, the facility failed to ensure the confidentiality of patient medical records in 1 of 1 facility reviewed. Findings Include: 1. A policy titled, "Storing, Filing, Thinning and Retrieving of Medical Records" indicated but was not limited to, "Hard charts must be placed in chart racks or carts or medical record rooms that are locked during non-working hours". 2. A policy titled, "Patient Rights and Responsibilities" indicated but was not limited to, "4. Privacy and confidentiality in personal medical records". 3. During an observation on 02/26/2024 at 1:30 PM, the door to the medical records room was found to be propped open by a cart with patient charts easily accessible. Upon further observation, it was noted that the lock portion of the door jamb was covered with a sticker that would prevent the door from being locked. Patient medical records were found to be visible on the desk in front of the front lobby window. Staff were not observed in the area at that time. Surveyors confirmed that the door was unable to lock and appeared to be broken. 4. During an interview on 02/26/2024 at 1:30 PM, an Anonymous staff member indicated the door to the Medical Record room door has been broken and unable to be locked for a while, indicating this concern has been on-going, not just today. 5. During an interview on 02/26/2024 at 1:30 PM, the Dietician indicated being aware the door was broken and unable to be locked.		On 04/02/2024, the Director of Operations and Education Coordinator held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy and procedure: Storing, Filing, Thinning and Retrieving of Medical Records Patient Rights and Responsibilities Procedure Emphasis was placed on: Hard charts must be placed in chart racks or carts or medical records rooms that are locked during non-work hours. Thinned records of active patients shall be maintained in a lockable file cabinet or medical records room that has a locked door. The medical record rooms must be constructed so not to prevent damage due to adverse environmental conditions (ex. moisture) or due to pests (ex. rodents, insects). It is acceptable to use storage boxes to store records in the medical record room; however, metal files or cabinets are preferable. On 3/05/2024, the Area Technical	

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	6. During an interview on 02/26/2024 at 1:43 PM, BioMed 1 indicated not being aware of the broken door lock in the Medical Records room.		Operation Manager installed a new lock on the medical record room door. Effective 04/03/24, Director of Operations or Clinical Manager will conduct 3 days per week audits with focus on ensuring medical record room is locked per policy, as required, utilizing Building Interior Physical Environment inspection Tool for 2 weeks and then weekly for an additional 2 weeks or until 100% compliance is achieved. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting	

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			through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024.	
V 0463 Bldg. 00	494.70(a)(12) PR-RECEIVE SERVICES OUTLINED IN POC The patient has the right to- (12) Receive the necessary services outlined in the patient plan of care described in §494.90; Based on record review and interview, the dialysis facility failed to ensure the patient or their representative was informed about and able to participate in all aspects of the patient's care and	V 0463	**V463** On 04/02/2024, the Director of Operations and Education Coordinator held a staff meeting	04/05/2024

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	failed to ensure the patient received the services outlined in the patient's plan of care (POC) for 9 of 11 active in-center hemodialysis (ICHD) patient records reviewed and interviewed (Patient #2, #3, #5, #9, #11, #12, #13, #14, #20). Findings include: 1. The Patient Rights and Responsibilities policy, revised 4/04/2012, indicated the patient or their representative has the right to be informed about and participate, if desired, in all aspects of the patient's care and the patient has the right to receive the necessary services outlined in the plan of care (POC). 2. Patient #2's ICHD treatment sheets, dated 1/22/2024 to 2/21/2024, were reviewed and evidenced a physician ordered total run time of 4 hours 35 minutes for dialysis treatments. On 2/12/2024, the total run time was 4 hours and 3 minutes. The Registered Nurse (RN) documented the reason for the shortened run time as clotting in the venous chamber and failed to notify the physician regarding the shortened run time. Patient #2's clinical record failed to evidence the patient received their mid-treatment heparin dose mid-run during the treatment. During an interview on 2/23/2024 beginning at 11:55 AM, the Administrator indicated that the clinical record for Patient #2 failed to include documentation that the RN notified the physician regarding the shortened treatment time. 3. Patient #3's ICHD treatment sheets, dated 1/29/2024 to 2/23/2024, were reviewed and evidenced a physician ordered total run time of 4 hours and 0 minutes for dialysis treatments.		and reinforced the expectations and responsibilities of the facility staff on policy and procedure: Patient Rights and Responsibilities Procedure Early Termination or Arriving Late for Treatment Medication Preparation and Administration Emphasis was placed on: All facilities should post the Patient and Staff Partnership Poster where it is easily visible and accessible to patients. Copies of the FMCNA Rights and Responsibilities brochures should be placed in the designated pockets on the poster. Multiple quantities of these brochures should always be available. Each patient or his/her representative will be provided a copy of the FMCNA Patient Rights brochure and the FMCNA Patient Responsibilities brochures within the first six (6) dialysis treatments in the facility. The FMCNA Patient Rights and Responsibilities brochures should be provided to patients in their primary language if it is not English or Spanish. A Social Worker or Nurse should review specific information related to facility policies that are contained in the FMCNA Patient Rights and Responsibilities brochures with a patient or his or	

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	On 1/29/2024, the total run time was 2 hours and 54 minutes. The clinical record evidenced that the documented reason for the shortened run time was late arrival with the inability to extend treatment and failed to evidence the physician was notified of the shortened run time. Patient #2's clinical record failed to evidence that the patient received their mid-treatment heparin dose during the treatment. During an interview on 2/23/2024 beginning at 4:43 PM, the Administrator indicated the clinical record for Patient #3 failed to include documentation the physician was notified regarding the shortened treatment time. On 1/31/2024, the total run time was 2 hours and 22 minutesThe clinical record evidenced the documented reason for the shortened run time was facility issue and failed to evidence the physician was notified of the shortened run time. During an interview on 2/23/2024 beginning at 4:43 PM, the Administrator indicated the clinical record for Patient #3 failed to include documentation the physician was notified regarding the shortened treatment time. On 2/02/2024, the total run time was 3 hours and 10 minutes. The clinical record evidenced the documented reason for the shortened run time was late arrival with the inability to extend treatment and failed to evidence the physician was notified of the shortened run time. During an interview on 2/23/2024 beginning at 4:43 PM, the Administrator indicated the clinical record for Patient #3 failed to include documentation the physician was notified		her representative. This should occur when the information is given or shortly thereafter, and discussed or reviewed over a period of time, to ensure understanding. The patient or his/her representative is presented with an Acknowledgement of Receipt of FMCNA Patient Rights and Responsibilities to sign when information is provided the first time. Document in the medical record each time patient rights information is provided or discussed with patients and/or their representative. Staff should document in the medical record how patient rights information was explained to a patient who has vision, speech, or hearing barriers and those who do not speak or read English. Patients must be informed about facility policies related to patient care. Examples of this requirement would be providing information about how requests to interrupt treatment to use the restroom are handled or what changes in schedule or seating a patient might expect if he or she is diagnosed with an infectious disease requiring isolation (i.e., Hepatitis B). Information about reasons why a patient might be involuntarily discharged from the facility should also be explained. The signed Acknowledgement of	

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	regarding the shortened treatment time. On 2/05/2024, the total run time was 3 hours and 0 minutes. The clinical record evidenced the documented reason for the shortened run time was late arrival with the inability to extend treatment and failed to evidence the physician was notified of the shortened run time. During an interview on 2/23/2024 beginning at 4:43 PM, the Administrator indicated the clinical record for Patient #3 failed to include documentation the physician was notified regarding the shortened treatment time. On 2/07/2024, the total run time was 3 hours and 10 minutes. The clinical record evidenced the documented reason for the shortened run time was late arrival with the inability to extend treatment and failed to evidence the physician was notified of the shortened run time. During an interview on 2/23/2024 beginning at 4:43 PM, the Administrator indicated the clinical record for Patient #3 failed to include documentation the physician was notified regarding the shortened treatment time. On 2/09/2024, the total run time was 3 hours and 1 minute. The clinical record evidenced the documented reason for the shortened run time was late arrival with the inability to extend treatment and failed to evidence the physician was notified of the shortened run time. During an interview on 2/26/2024 beginning at 1:56 PM, the Administrator indicated the clinical record for Patient #3 failed to include documentation the physician was notified regarding the shortened treatment time.		Receipt of FMCNA Patient Rights and Responsibilities will be filed in the patient's medical record. The Acknowledgement of Receipt of FMCNA Patient Rights and Responsibilities is only required the first time this information is provided to the patient. Documentation in the patient's medical record shall be made each time information about patient rights and responsibilities is provided or discussed with patients and/or their representative. If a patient insists on terminating treatment early and this has not been previously approved by the patient's physician, the patient must take full responsibility for the consequences of the missed or shortened treatment. If a patient requests to leave treatment early: Patients requesting early termination of treatment in an outpatient facility early will be referred to the supervising registered nurse. The registered nurse (RN) will evaluate the patient and discuss with the patient their reasons for requesting to terminate their treatment earlier than prescribed. If the patient's reasons for terminating the treatment early are due to complications of the	

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	On 2/12/2024, the total run time was 2 hours and 53 minutes. The clinical record evidenced the documented reason for the shortened run time was late arrival with the inability to extend treatment and failed to evidence the physician was notified of the shortened run time. During an interview on 2/26/2024 beginning at 1:56 PM, the Administrator indicated the clinical record for Patient #3 failed to include documentation the physician was notified regarding the shortened treatment time. On 2/14/2024, the total run time was 3 hours and 23 minutes. The clinical record evidenced the documented reason for the shortened run time was late arrival with the inability to extend treatment and failed to evidence the physician was notified of the shortened run time. During an interview on 2/26/2024 beginning at 1:56 PM, the Administrator indicated the clinical record for Patient #3 failed to include documentation the physician was notified regarding the shortened treatment time. On 2/16/2024, the total run time was 2 hours and 38 minutes. The clinical record evidenced the documented reason for the shortened run time was late arrival with the inability to extend treatment and failed to evidence the physician was notified of the shortened run time. During an interview on 2/26/2024 beginning at 1:56 PM, the Administrator indicated the clinical record for Patient #3 failed to include documentation the physician was notified regarding the shortened treatment time.		treatment such as cramping, discomfort, or anxiety, the RN will discuss these issues with the patient and physician and implement any prescribed measure to alleviate the patient's symptoms. The RN who evaluates the patient must document the rationale for early termination and reinforce the consequences of not receiving the entire prescribed treatment. The RN is responsible for notifying the physician, and document on the "AMA", or Against Medical Advice form. · If the patient frequently requests to end their treatment before the prescribed time, the RN should discuss the patient's reasons for frequently terminating early. Against Medical Advice forms are Signed by the patient and witnessed by the supervising nurse upon completion of the above steps. Signed with each early termination event and filed in the patient's medical record. Tracked, trended and reported to the QAI committee monthly. There may be times when a patient's transportation is delayed and arrives late for their scheduled time. If a patient arrives after	

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	On 2/19/2024, the total run time was 2 hours and 58 minutes. The clinical record evidenced the documented reason for the shortened run time was late arrival with the inability to extend treatment and failed to evidence the physician was notified of the shortened run time. During an interview on 2/26/2024 beginning at 1:56 PM, the Administrator indicated the clinical record for Patient #3 failed to include documentation the physician was notified regarding the shortened treatment time. On 2/21/2024, the total run time was 2 hours and 25 minutes. The clinical record evidenced the documented reason for the shortened run time was late arrival with the inability to extend treatment and failed to evidence the physician was notified of the shortened run time. During an interview on 2/26/2024 beginning at 1:56 PM, the Administrator indicated the clinical record for Patient #3 failed to include documentation the physician was notified regarding the shortened treatment time. 4. On 2/23/2024 at 3:02 PM, Person A, who has power of attorney for Patient #3, relayed Patient #3's scheduled chair time was 5:45 PM and that they usually arrived at the facility between 5:35 and 5:40 PM but were occasionally as late as 5:50 PM. Person A indicated some days they would be in the lobby for 10 to 15 minutes before staff would answer the doorbell. Person A indicated no one from the facility had brought up being late for treatments in 2024 so he/ she was under the impression they had been on time. Person A also relayed he/ she was unaware Patient #3 had not been receiving the full treatment time in 2024.		their scheduled time for dialysis treatment, start the patient's treatment as soon as possible. Staff should do their best to accommodate the patient's prescribed treatment time. If this is not possible due to all stations being filled or impacting facility hours of operation, the physician must be notified to review the time delay and determine the appropriate intervention. § For example, if the treatment was shortened so much as to not provide adequate fluid removal that may take priority over the inconvenience of the next patient and a delay of the next treatment may be necessary or if ordered by the physician an additional treatment may be needed. § Similarly depending on the time delay, if the patient has a history of hyperkalemia, that may also require the delay of the next patient's treatment or if ordered by the physician an additional treatment. The facility staff should make every attempt to assist the patient with rescheduling any lost treatment time. If late arrivals are not due to an atypical problem with the patient's transportation, but rather a habitual behavior consider the following: Discuss the late arrivals with the patient and determine	

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	5. During an interview on 2/23/2024 at 4:43 PM, the Administrator indicated there was no staff in the lobby area so there was no way for facility staff to know what time the patient arrived at the facility. 6. During an interview on 2/20/2024 beginning at 11:05 AM, Patient #2 relayed they don't always get put on treatment on time, and when that happens, they don't get their full treatment because the water room shuts down at 10:00 PM. 7. During an interview on 2/26/2024 at 4:37 PM, Patient #2 indicated he/ she had recently found out his/ her chair time had been changed to 25 minutes later and that no one could tell him/ her when the chair time had been changed. Patient #2 relayed he/ she had not been previously informed of the change and had not signed anything agreeing to the change. 8. During an interview on 2/26/2024 beginning at 3:12 PM, PCT 6 relayed staff had to take some patients off treatment early on 2/19/2024 because everyone had been put on late and the water tanks regenerated at 11:00 PM, so the latest they could run a patient was 10:00 PM. PCT 6 also relayed a patient had consistently been taken off treatment around 9:15 PM because staff had not realized the patient's scheduled chair end time had changed to 9:45 PM until they received a call about it the week prior to the interview. 9. During an interview on 2/26/2024 at 4:18 PM, Patient #12 relayed he/ she had been put on treatment late and taken off treatment early before and has been told by staff they were short-staffed. At 4:27 PM, Patient #12 indicated his/ her treatment on-time was 4:25 PM, so they were already late taking him/her back.10. Patient		what measures can be done to help the patient arrive on time for scheduled treatments. The facility Social Worker should discuss available assistance from community agencies to improve timely attendance. Note: Determine if activities in the patient's personal life are interfering with timely arrival, such as class schedule, work responsibilities, childcare, etc. and evaluate what measures the facility Social Worker and Clinical Manager may take to assist the patient with a schedule that may work better for the patient. Counsel and educate the patient on the effects of shortened treatment. Pursue Interdisciplinary team meetings with patient/family and/or develop a behavioral contract if arriving late becomes habitual. There may be times when a patient's treatment is delayed due to unforeseen circumstances occurring at the dialysis facility such as, equipment breakdown or water issues. Start the patient's treatment as soon as possible. Staff should do their best to accommodate the patient's prescribed treatment time. If this is not possible due to all stations being filled or	

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	#5's ICHD treatment sheets, dated 2/02/24 to 2/21/2024, were reviewed and evidenced a physician ordered total run time of 3 hours 45 minutes during the dialysis treatments. On 2/14/2024, the total run time was 3 hours and 6 minutes. The PCT documented the shortened run time reason as an unexpected facility issue and failed notify the physician regarding the shortened run time. During an interview on 2/22/2024 beginning at 3:48 PM, the Administrator indicated the clinical record for Patient #5 failed to include documentation the physician was notified regarding shortened treatment time. 11. Patient #9's ICHD treatment sheets, dated 1/31/2024 to 2/21/2024, were reviewed and evidenced a physician ordered total run time of 3 hours 15 minutes during the dialysis treatments. On 1/31/2024, the ICHD treatment began at 4:38 PM, 28 minutes after the scheduled start time. The total run time was 2 hours and 44 minutes. RN 1 documented the shortened run time reason as unexpected facility issue and failed notify the physician regarding the shortened run time. On 2/12/2024, the ICHD treatment began at 4:37 PM, 27 minutes after the scheduled start time. The total run time was 2 hours and 45 minutes. RN 2 documented the shortened run time reason as an unexpected facility issue and failed to notify the physician regarding the shortened run time. During an interview on 2/23/2024 beginning at 12:29 PM, the Administrator indicated the clinical record for Patient #9 failed to include documentation the physician was notified		impacting facility hours of operation, the physician must be notified to review the time delay and determine the appropriate intervention. § For example, if the treatment was shortened so much as to not provide adequate fluid removal that may take priority over the inconvenience of the next patient and a delay of the next treatment may be necessary or if ordered by the physician an additional treatment may be needed. § Similarly depending on the time delay, if the patient has a history of hyperkalemia, that may also require the delay of the next patient's treatment or if ordered by the physician an additional treatment. The facility staff should make every attempt to assist the patient with rescheduling any lost treatment time (a nearby facility may also be an option). Document in Chairside the specific unexpected end reason that the treatment was shortened. All discussions with the patient, including information or instructions given, and any notification or discussion with the physician, must be documented in the patient's medical record. Complete documentation Early Termination of Treatment Against Medical Advice form. Medications must be	

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	regarding shortened treatment times. 12. Patient #11's ICHD treatment sheets, dated 1/29/2024 to 2/21/2024, were reviewed and evidenced a physician ordered total run time of 3 hours 45 minutes during the dialysis treatments. On 2/07/2024, the ICHD treatment began at 4:46 PM, 1 hour and 6 minutes after the scheduled start time. The total run time was 2 hours and 31 minutes. RN 1 documented the shortened run time reason as unexpected facility issue and failed notify the physician regarding the shortened run time. During an interview on 2/27/2024 beginning at 4:38 PM, the Administrator indicated the clinical record for Patient #11 failed to include documentation the physician was notified regarding shortened treatment times. 13. Patient #12's ICHD treatment sheets, dated 1/31/2024 to 2/21/2024, were reviewed and evidenced a physician ordered total run time of 4 hours during the dialysis treatments. On 2/07/2024, the ICHD treatment began at 5:10 PM, 45 minutes after the scheduled time. The total run time was 3 hours and 35 minutes. RN 1 documented the shortened run time reason as an unexpected facility issue and failed to notify the physician regarding the shortened run time. On 2/12/2024, the ICHD treatment began at 4:58 PM, 23 minutes after the scheduled time. The total run time was 3 hours and 42 minutes. RN 2 documented the shortened run time reason as an unexpected system problems / technical difficulties (Non-Pt related) and failed notify the physician regarding the shortened run time.		administered with an order by a physician (or physician extender where allowed) on the medical staff of the facility. Medical algorithms are orders. By 4/5/2024, the Area Technical Operation Manager will install a video monitor for the patient lobby. The video monitor will allow staff visibility into the lobby to know when patients or visitors are present. By 3/02/2024, the facility Social Worker met and reviewed with all patients the FMCNA Patient Rights and Responsibilities. The acknowledgement is in the patient record and available at facility upon request. Effective 04/03/24, the Director of Operations or Clinical Manager will conduct 10 treatment sheets daily, 3 times per week, alternating shifts, with focus on ensuring all staff adhere to physician order or notify physician whenever unable to follow order as written,(i.e. shortened treatment time, heparin medication), utilizing Treatment Sheet Audit Tool for 2 weeks and then will complete weekly treatment audits on 10% of completed treatments for an additional 4 weeks. The Governing Body will determine	

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	During an interview on 2/23/2024 beginning at 11:43 AM, the Administrator indicated the clinical record for Patient #12 failed to include documentation the physician was notified regarding shortened treatment times. 14. Patient #13's ICHD treatment sheets, dated 1/29/2024 to 2/21/2024, were reviewed and evidenced a physician ordered total run time of 4 hours and 45 minutes during the dialysis treatments and an order for foot checks to be performed PRN, at a minimum annually in December. On 1/29/2024, the ICHD treatment began at 3:11 PM. The total run time was 4 hours and 16 minutes. RN 1 documented the shortened run time reason as unexpected, other* and failed to notify the physician regarding the shortened run time. On 1/31/2024, the ICHD treatment began at 3:00 PM. The total run time was 4 hours and 26 minutes. RN 1 documented the shortened run time reason as an unexpected facility issue and failed to notify the physician regarding the shortened run time. On 2/05/2024, the ICHD treatment began at 3:59 PM, 54 minutes after the scheduled time. The total run time was 4 hours and 2 minutes. RN 1 documented the shortened run time reason as an unexpected facility issue and failed to notify the physician regarding the shortened run time. On 2/07/2024, the ICHD treatment began at 3:19 PM, 14 minutes after the scheduled time. The total run time was 4 hours and 8 minutes. RN 1 documented the shortened run time reason as an unexpected facility issue and failed to notify the		on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by	

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	physician regarding the shortened run time. On 2/12/2024, the ICHD treatment began at 2:56 PM. The total run time was 4 hours and 25 minutes. RN 1 documented the shortened run time reason as an unexpected patient request and failed to notify the physician regarding the shortened run time. The clinical record failed to evidence an Against Medical Advice (AMA) form was signed by Patient #13. On 2/14/2024, the ICHD treatment began at 3:11 PM. The total run time was 3 hours and 48 minutes. RN 1 documented the shortened run time reason as an unexpected patient request and failed to notify the physician regarding the shortened run time. The clinical record failed to evidence an Against Medical Advice form was signed by Patient #13. During an interview on 2/28/2024 beginning at 3:20 PM, the Administrator indicated the clinical record for Patient #13 failed to include documentation the physician was notified regarding shortened treatment times; failed to include signed AMA forms and failed to include documentation that the foot check was performed in December. 15. Patient #14's ICHD treatment sheets, dated 1/29/2024 to 2/21/2024, were reviewed and evidenced a physician ordered total run time of 4 hours during the dialysis treatments. On 1/31/2024, the ICHD treatment began at 4:07 PM, 52 minutes after the scheduled time. The total run time was 3 hours and 27 minutes. RN 1 documented the shortened run time reason as an unexpected facility issue and failed to notify the physician regarding the shortened run time.		the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024.	

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	On 2/07/2024, the ICHD treatment began at 3:56 PM. The total run time was 3 hours and 34 minutes. RN 1 documented the shortened run time reason as an unexpected facility issue and failed to notify the physician regarding the shortened run time. During an interview on 2/28/2024 beginning at 2:55 PM, the Administrator indicated the clinical record for Patient #14 failed to include documentation the physician was notified regarding shortened treatment times. 16. Patient #20's ICHD treatment sheets, dated 1/29/2024 to 2/21/2024, were reviewed and evidenced a physician ordered total run time of 3 hours and 30 minutes during the dialysis treatments. On 1/29/2024, the ICHD treatment began at 5:49 AM. The total run time was 1 hour and 57 minutes. RN 2 documented the shortened run time reason as an unexpected patient request, Against Medical Advice and documented the AMA form was completed. RN 2 failed to notify the physician regarding the shortened run time and the clinical record failed to evidence a completed AMA form. On 2/02/2024, the ICHD treatment began at 5:51 AM. The total run time was 1 hour and 5 minutes. RN 7 documented the shortened run time reason as an unexpected patient request, Against Medical Advice and documented the AMA form was completed. RN 7 failed to notify the physician regarding the shortened run time and the clinical record failed to evidence a completed AMA form. On 2/09/2024, the ICHD treatment began at 7:12 AM, 1 hour and 37 minutes after scheduled time.			

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	The total run time was 2 hours and 53 minutes. RN 4 documented the shortened run time reason as an unexpected patient request. RN 4 failed to notify the physician regarding the shortened run time and the clinical record failed to evidence an Against Medical Advice (AMA) form was signed by Patient #20. On 2/14/2024, the ICHD treatment began at 5:37 AM. The total run time was 2 hours and 47 minutes. RN 2 documented the shortened run time reason as an unexpected patient request. RN 2 failed to notify the physician regarding the shortened run time and the clinical record failed to evidence an Against Medical Advice (AMA) form was signed by Patient #20. On 2/16/2024, the ICHD treatment began at 5:38 AM. The total run time was 2 hours and 31 minutes. RN 2 documented the shortened run time reason as an unexpected patient request. RN 2 failed to notify the physician regarding the shortened run time and the clinical record failed to evidence an Against Medical Advice (AMA) form was signed by Patient #20. On 2/19/2024, the ICHD treatment began at 7:06 AM, 1 hour and 31 minutes after scheduled time. The total run time was 2 hours and 18 minutes. RN 4 documented the shortened run time reason as an unexpected patient request. RN 4 failed to notify the physician regarding the shortened run time and the clinical record failed to evidence an Against Medical Advice (AMA) form was signed by Patient #20. On 2/21/2024, the ICHD treatment began at 5:54 AM. The total run time was 2 hours and 7 minutes. RN 3 documented the shortened run time reason as an unexpected patient request, Against			

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	Medical Advice and documented the AMA form was completed. RN 3 failed to notify the physician regarding the shortened run time and the clinical record failed to evidence a completed AMA form. During an interview on 2/27/2024 beginning at 4:50 PM, the Administrator indicated the clinical record for Patient #20 failed to include documentation the physician was notified regarding shortened treatment times and failed to include signed AMA forms. 17. During an interview on 2/23/2024 beginning at 1:09 PM, the Administrator indicated the ESRD facility does not have any records regarding any unexpected facility issues on 1/31/2024, 2/07/2024, 2/12/2024 or 2/14/2024.			
V 0540 Bldg. 00	494.90 CFC-PATIENT PLAN OF CARE Based on observation, record review, and interview, the dialysis facility failed to ensure the patient's blood pressure, estimated dry weights, and pulse were assessed and responded to as required (See V0543); failed to verify all treatments were being run as ordered by the physician (See V0544); and failed to verify all medication prescriptions were followed as ordered (See V0546). The cumulative effect of these systemic problems has resulted in the facility's inability to ensure the provision of quality health care in a safe environment for the Condition for Coverage 42 CFR 494.90 Patient plan of care with the potential to affect all 58 of the facility's active in-center hemodialysis patients.	V 0540	**V540** The Governing Body takes seriously the management of the day-to-day operations of the facility and their responsibilities for ensuring safe dialysis treatments for all patients receiving hemodialysis at the facility, inclusive of, but not limited to having direct employees hired, staffing is adequate, and staff is knowledgeable of the patients and facility to ensure the plan of care is consistently implemented to prevent serious injury, serious harm, serious impairment, or death. The Governing Body met initially on 2/29/24, and again on 3/8/24	04/05/2024

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	An Immediate Jeopardy was announced on 02/28/2024 at 3:52 PM at Condition for Coverage 42 CFR §494.90 Patient plan of care. The immediate jeopardy was identified as beginning on 07/09/2023. The Immediate Jeopardy was unabated at exit on 02/29/2024. The facility's 4th Removal of the Immediacy Plan was accepted on 03/11/2024. The agency's 4th immediate jeopardy removal plan and actions were confirmed to have removed the immediacy component for the immediate jeopardy on 03/18/2024.		after receipt of the Statement of Deficiencies to review and develop the following Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The Governing Body met again on 3/29/2024, to review the Statement of Deficiencies and develop the following Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The Governing Body began meeting weekly beginning 2/29/24 to review the results of the progress on the Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The Governing Body will determine when the frequency of these meetings may be reduced to the regular quarterly schedule. Effective immediately: The Director of Operations will analyze and trend all data and monitor/audit results as related to this Plan of Correction prior to presenting the monthly data to the QAI Committee. A specific plan of action encompassing the citations as cited in the Statement of Deficiency has been added to the facility's monthly QAI (Quality Assessment and	

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			Performance Improvement) agenda. The QAI Committee is responsible for reviewing and evaluating the Plan of Correction to ensure it is effective and providing resolution of the issues. The Director of Operations (DO) will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The Governing Body, at its meeting of 2/29/24, designated the Director of Operations (DO) to serve as Plan of Correction Monitor and provide additional oversight. They will participate in QAPI and Governing Body meetings. This additional oversight is to ensure the ongoing correction of deficiencies cited in the Statement of Deficiency through to resolution as well as ensure the Governance of the Facility is presented current and complete data to enhance their governance oversight role. Minutes of the Governing Body and QAI meetings, as well as monitoring forms and educational documentation will provide evidence of these actions, the Governing Body's direction, and oversight and the QAI Committees ongoing monitoring of facility	

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			activities. These are available for review at the facility. The responses provided for V 543, V544, and V546 describe, in detail, the processes and monitoring steps taken to ensure that all deficiencies cited within this Condition are corrected to ensure ongoing compliance.	
V 0543 Bldg. 00	494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; Based on observation, record review, and interview, the dialysis facility failed to ensure the patient's blood pressure (BP) was checked every 30 minutes during in-center hemodialysis (ICHD) for 12 of 12 ICHD clinical records reviewed (Patient #1, #2, #3, #4, #5, #9, #11, #12, #13, #14, #15, #20); failed to ensure the Registered Nurse (RN) completed an assessment within one hour of the start of hemodialysis treatment for 9 of 11 active ICHD clinical records reviewed (Patient #2, #3, #5, #9, #11, #12, #13, #14, #20); failed to ensure the RN was notified of BP's and/or pulse rates outside of parameters during ICHD treatment for 12 of 12 clinical records reviewed (Patient #1, #2, #3, #4, #5, #9, #11, #12, #13, #14, #15, #20); failed to ensure the RN performed interventions and/or reported BP's and/or pulse rates outside of parameters to the physician for 6 of 11 active ICHD clinical records reviewed (Patient #2, #3, #5, #9, #11, #20); failed to ensure pre-treatment and/or	V 0543	**V543** On 04/02/2024, the Director of Operations and Education Coordinator held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy and procedure: Nursing Supervision and Delegation Patient Assessment and Monitoring Determination of Blood Pressure Hypertension Intradialytic Hypotension Emphasis was placed on: Direct patient care staff may collect data such as weight, blood pressures (sitting/ standing), pulse, respirations,	04/05/2024

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	post-treatment standing BP checks were performed for 6 of 11 active ICHD clinical records reviewed (Patient #2, #3, #5, #11, #12, #13); and failed to ensure the physician was notified of post-treatment weights that did not meet the estimated dry weight (EDW) parameters for 7 of 7 active ICHD patients who did not meet their EDW after treatment (Patient #2, #3, #5, #9, #11, #12, #20). Findings include: 1. The Determination of Blood Pressure policy, revised 02/07/22, indicated the following conditions can lead to serious outcomes and even death: untreated or unattended systolic blood pressure (BP) greater than 200 or less than 80 and BPs not rechecked to verify correctness of the result when a significant drop or increase occurs. The policy also indicated for in-center hemodialysis (ICHD) patients BP should be taken pre-dialysis and post-dialysis with the patient sitting and standing and every 30 minutes or more during treatment as indicated. 2. The Patient Assessment and Monitoring policy, revised 05/01/23, indicated BP and pulse rate should be monitored every 30 minutes or more often as needed but not to exceed 45 minutes during ICHD treatments. The policy indicated systolic blood pressures greater than 180 or less than 100, diastolic blood pressures greater than 100, and pulse rates greater than 100 or less than 60 are to be reported to the registered nurse (RN). 3. The Nursing Supervision and Delegation policy, revised 11/06/23, indicated RN's may not delegate assessment of the patient within one hour of ICHD treatment start time and must review patient treatment prescription and equipment		temperature, general observations, access, and complaints reported by the patient. If the PCT/LPN note any changes or abnormal findings in the patient's condition or vascular access are observed or reported by the patient, or the patient was hospitalized, the registered nurse must assess the patient. Report to the nurse: Systolic blood pressures greater than 180 mm/Hg Diastolic blood pressure greater than 100 mm/Hg Blood Pressure less than or equal to 100 mm/hg systolic Any complaints by the patient before, during, or after treatment (i.e., nausea, vomiting, cramping) Record pulse. Verify pulses manually if automated readings display below 60 or greater than 100 beats per minute. Document irregular rhythms. Fluid balance is an integral component of the HD treatment to prevent patient hyper- or hypovolemia both of which have been demonstrated to influence mortality and cardiovascular complications in ESRD patients on HD. Registered nurse should complete a fluid assessment on all ESRD patients receiving HD treatments. Assessment should evaluate patients for hypo- and hypervolemia. At a minimum, fluid assessment will include review of the following	

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	parameters to verify correct settings and whether the dialysis prescription is being followed. 4. The Hypertension policy, dated 09/07/21, indicated the nurse should be notified if the systolic BP is greater than 180 and/or if the diastolic BP is greater than 100. The RN should then assess the patient and decrease estimated dry weight (EDW) following the fluid management algorithm if the hypertension is related to hypervolemia (fluid overload.) If the hypertension is not related to hypervolemia, the RN should notify the physician for additional orders or treatments, and these steps should be documented in the patient's treatment record. 5. The Intradialytic Hypotension policy, revised 07/03/23, indicated staff will monitor for the occurrence of intradialytic hypotension and immediately perform interventions to mitigate progression of symptoms and prevent serious consequences and recurrence. 6. Patient #1's ICHD treatment sheets, dated 2/03/24 to 2/17/24, were reviewed and evidenced the following: On 2/03/24, the ICHD treatment began at 12:27 PM. The treatment sheet indicated the following: at 12:29 PM, the BP was 99/81; at 1:08 PM, the BP was 88/72; at 1:33 PM, the BP was140/115; at 3:34 PM, the BP was 99/75; and at 3:48 PM, the BP was 136/106. The clinical record failed to evidence the PCT notified the RN of the BPs outside of parameters. On 2/06/24, the ICHD treatment began at 12:25 PM. The treatment sheet indicated the following: at 1:33 PM, the BP was 153/107; at 2:00 PM, the BP was 174/106; at 3:42 PM, the BP was 102/56; and		clinical indicators: EDW Pre/Post Weight Post Weight comparison to EDW Pre/Post Blood Pressure Lowest Intradialytic Blood Pressure Signs/symptoms of fluid overload Physical examination including lung assessment, cardiovascular (i.e., heart sounds) and peripheral vascular assessment (edema) If any of the following patient clinical conditions occur refer to the volume algorithm if applicable or consult with provider for appropriate fluid interventions: Pre-treatment signs or symptoms of hypervolemia Pre-treatment sitting systolic BP is greater than 160 mmHg and prior treatment post dialysis sitting systolic BP is greater than 140 mmHg. Pre-treatment signs or symptoms of hypovolemia Unable to achieve EDW due to UF intolerance. New to dialysis within 13 treatments Post-hospitalization Pre-treatment weight is less than or equal to EDW. Prior treatment was shortened by more than 15 minutes. Prior Missed Treatment Treatment adjustments based	

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	at 4:08 PM, the BP was 102/56. The clinical record failed to evidence the PCT notified the RN of the BPs outside of parameters. Patient #1's BP was checked at 2:33 PM and not checked again until 3:42 PM, 1 hour and 9 minutes later. On 2/10/24, the ICHD treatment began at 11:54 AM. The treatment sheet indicated the following: at 11:56 AM, the pulse was 120; at 12:35 PM, the pulse was 127; at 1:32 PM, the BP was 97/92; at 2:30 PM, the BP was 141/110, and the pulse was 43; and at 3:38 PM, the BP was 145/115, and the pulse was 50. The clinical record failed to evidence the PCT notified the RN of the BPs and pulses outside of parameters.\ On 2/13/24, the ICHD treatment began at 12:15 PM. The treatment sheet indicated the following: at 12:30 PM, the BP was 94/64, and the pulse was 113; at 2:04 PM, the BP was 142/124; at 2:32 PM, the BP was 132/102, and the pulse was 106; and at 3:22 PM, the BP was 99/80. The clinical record failed to evidence the PCT notified the RN of the BPs and pulses outside of parameters. During an interview on 2/22/24 beginning at 4:25 PM, the Administrator indicated the above findings for Patient #1 were accurate. 7. Patient #2's ICHD treatment sheets, dated 1/22/24 to 2/21/24, were reviewed and evidenced the following: On 1/22/24, the ICHD treatment began at 4:57 PM. At 4:58 PM, the BP was 158/103. The clinical record failed to evidence the PCT notified the RN of the BP outside of parameters. The nurse assessment indicated Patient #2 was able to walk without assistance. The clinical record failed to evidence the pre-dialysis standing BP check was		on fluid assessment, symptoms, and blood pressure are critical to improve a patient's volume status. EDW order should be updated post treatment to reflect treatment adjustments and patient fluid status. The RN is accountable for delivering care within the framework of the nursing process. The RN uses clinical findings to formulate nursing diagnoses and prioritize problems according to patient need. The registered nurse must evaluate each patient *within one hour of treatment initiation* or according to state requirements to: Confirm identity. Review the patient's condition. Review accuracy and completeness of treatment and patient data. Review patient treatment prescription and equipment parameters to verify correct settings, and if dialysis prescription is being followed. Confirm that the correct vascular access is being used, and that the access is visible. Observe patient's response to treatment. Verify machine safety checks have been completed. Confirm heparin was	

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	performed. On 1/24/24, the ICHD treatment began at 5:07 PM. The nurse assessment indicated Patient #2 was able to walk without assistance. The clinical record failed to evidence the pre-dialysis standing BP check was performed. On 1/26/24, the ICHD treatment began at 5:23 PM. The nurse assessment was performed at 6:56 PM, 1 hour and 33 minutes after treatment began. Patient #2's BP was checked at 5:26 PM and not checked again until 6:35 PM, 1 hour and 9 minutes later. Patient #2's BP was next checked at 7:33 PM, 58 minutes later. On 1/29/24, the ICHD treatment began at 4:53 PM. At 4:57 PM, the BP was 172/107; at 5:05 PM, the BP was 179/103; and at 5:42 PM, the BP was 181/70. The clinical record failed to evidence the RN was notified of the BPs out of parameters. At 6:05 PM, the BP was assessed by the RN as 151/129. The clinical record failed to evidence the RN performed any interventions or notify the physician regarding the high diastolic BP. On 1/31/24, the ICHD treatment began at 5:35 PM. The RN assessment was completed at 7:16 PM, 1 hour and 41 minutes after the start of treatment. A BP check was performed at 5:34 PM with the next BP check at 7:07 PM, 1 hour and 33 minutes later. The next BP check was performed at 8:09 PM, 1 hour and 2 minutes later. The next BP check was performed at 9:34 PM, 1 hour and 25 minutes later. At 5:25 PM, Patient #2's standing BP was 147/111. The clinical record failed to evidence the RN was notified of the BP outside of the parameters. On 2/2/24, the ICHD treatment began at 5:10 PM. Patient #2's BP was180/109 at 6:36 PM and 154/101		administered per physician orders. Talk to the patient to elicit information such as changes in condition, response to treatment, new injuries, information/education needs or complaints, satisfaction with care. The RN will notify the patient's physician/physician extender of any abnormal findings, if necessary, based on clinical judgment for additional instruction. The Registered Nurse will assess/reassess any findings addressed pre or during treatment as needed. Prior to discharge, the RN must confirm the patient is stable for discharge and review the treatment record for: Slow/fast/irregular heart rate Low or high blood pressures Whether patient is achieving dry weight and identifying reason for patient not achieving dry weight Heart rate <60 or >100 addressed by the registered nurse with documentation present. Blood pressures < 100 systolic or greater than 180 systolic addressed by the registered nurse with or documentation present. Reported fall, and if heparin was held and MD notified. Correct dialysate prescription was delivered. Obtain blood pressure readings pre- and post-dialysis sitting and standing and every 30	

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	at 8:02 PM. The clinical record failed to evidence the RN was notified of the BP outside of the parameters. On 2/5/24, the ICHD treatment began at 4:51 PM. A BP check was performed at 6:58 PM and was next checked at 7:45 PM, 47 minutes later. On 2/7/24, the ICHD treatment began at 5:12 PM. The RN assessment indicated Patient #2 could walk without assistance. The clinical record failed to evidence a pre-treatment standing BP was performed. At 5:12 PM, Patient #2's BP was 99/24. The clinical record failed to evidence an immediate recheck of the BP or RN notification. At 7:05 PM, Patient #2's BP was 165/102. The clinical record failed to evidence the RN was notified of the BP outside of parameters. On 2/9/24, the ICHD treatment began at 4:41 PM. At 4:33 PM, Patient #2's standing pre-treatment BP was 172/103. The clinical record failed to evidence the RN was notified of the BP outside of parameters. On 2/12/24, the ICHD treatment began at 5:32 PM. Patient #2's pre-treatment sitting BP was 191/98 and pre-treatment standing BP was 195/112. The clinical record failed to evidence the RN was notified of the BP outside of parameters. On 2/14/24, the ICHD treatment began at 4:59 PM. Patient #2's pre-treatment sitting BP was 146/102 and the BP at 5:03 PM was 169/104. The clinical record failed to evidence the RN performed any interventions or notified the physician of the BPs outside of parameters. On 2/16/24, the ICHD treatment began at 4:47 PM. Patient #2's pre-treatment sitting BP was 184/91.		minutes or more during hemodialysis treatments as indicated. Recheck blood pressures after a drop-in blood pressure that requires a hemodialysis patient to receive normal saline. Obtain blood pressure and pulse rate every 30 minutes, not to exceed 45 minutes. Standing blood pressure pre and post treatment is required for ambulatory patients. Effective 04/03/24, the Director of Operations or Clinical Manager will conduct 10 treatment sheets daily, 3 times per week, alternating shifts, with focus on ensuring patient's vital sign obtained per policy frequency, Registered Nurse and/or physician notified for vital signs out of parameters, and Registered Nurse to re-assess patients with abnormal assessment identified, utilizing Treatment Sheet Audit Tool for 2 weeks and then will complete weekly treatment audits on 10% of completed treatments for an additional 4 weeks. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per	

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	The clinical record failed to evidence the RN performed any interventions or notified the physician of the BPs outside of parameters. A BP check was performed at 4:47 PM with the next BP check at 5:38 PM, 51 minutes later. On 2/19/24, the ICHD treatment began at 5:36 PM. Patient #2's pre-treatment standing BP was 167/110. The clinical record failed to evidence the RN performed any interventions or notified the physician of the high BP. The post-treatment sitting BP was 126/48, and the standing BP was 110/50. The clinical record failed to evidence the low diastolic BPs were reported to the RN. On 2/21/24, the ICHD treatment began at 5:01 PM. An RN assessment was performed at 6:33 PM, 1 hour and 32 minutes after treatment start time. A BP check was performed at 5:06 PM with the next BP check at 6:13 PM, 1 hour and 7 minutes later. A BP check was performed at 8:31 PM with the next BP check at 9:43 PM, 1 hour and 12 minutes later. During an interview on 2/23/24 beginning at 11:55 AM, the Administrator indicated the above findings for Patient #2 were accurate. 8. Patient #3's ICHD treatment sheets, dated 1/29/24 to 2/23/24, were reviewed and evidenced the following: On 1/29/24, the ICHD treatment began at 6:23 PM. Patient #3's pulse was 52 at 6:06 PM, 53 at 6:23 PM, 55 at 7:04 PM, 57 at 8:08 PM, and 56 at 9:17 PM. The clinical record failed to evidence the RN was notified of these low pulse rates. The RN recorded Patient #3's pulse as 53 at 6:31 PM and 56 at 7:34 PM. The clinical record failed to evidence the RN notified the physician of the low pulse rates. Patient #3's prescribed EDW was		QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by	

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	86.50 kilograms (kg), and the post-treatment weight was 88.20 kg. The clinical record failed to evidence the physician was notified of the post-treatment weight greater than 1 kg over the EDW. The RN assessment indicated Patient #3 could walk. The clinical record failed to evidence pre-treatment and post-treatment standing BPs. On 1/31/24, the ICHD treatment began at 6:57 PM. Patient #3's pulse was 52 at 6:39 PM, 53 at 6:59 PM, 55 at 7:30 PM, and 58 at 8:04 PM at 9:20 PM. The clinical record failed to evidence the RN was notified of these pulse rates. The RN was notified of Patient #3's BP of 76/42, pulse rate of 110, and the patient's 5 minutes of unresponsiveness at 9:20 PM. The clinical record failed to evidence the RN notified the physician of the low BP, high pulse rate, and/or the patient's 5 minutes of unresponsiveness. The RN recorded Patient #3's pulse rate of 54 at 9:26 PM. The clinical record failed to evidence the RN notified the physician of the low pulse rate. The RN assessment indicated Patient #3 could walk. The clinical record failed to evidence pre-treatment and post-treatment standing BPs. On 2/2/24, the ICHD treatment began at 6:07 PM. The RN assessment was recorded at 8:55 PM with a note stating "late entry" but with no assessment time, which was 2 hours and 48 minutes after treatment start time. Patient #3's pulse was 56 at 5:54 PM, 52 at 6:10 PM, 54 at 6:34 PM, 59 at 7:08 PM, 58 at 7:31 PM, and 59 at 9:17 PM. The clinical record failed to evidence the RN was notified of these low pulse rates. The RN recorded Patient #3's pulse as 53 at 6:31 PM and 56 at 8:00 PM. The RN recorded a BP of 152/124 at 8:32 PM. The clinical record failed to evidence the RN performed interventions or notified the physician of the high diastolic BP or the low pulse rates. The RN		the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024.	

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	assessment indicated Patient #3 could walk. The clinical record failed to evidence pre-treatment and post-treatment standing BPs. On 2/5/24, the ICHD treatment began at 6:17 PM. Patient #3's pulse rate was 52 at 6:07 PM, 51 at 6:19 PM, 52 at 6:38 PM, 53 at 7:05 PM, 56 at 7:43 PM, 59 at 9:05 PM, and 56 at 9:19 PM. The clinical record failed to evidence the RN was notified of the low pulse rates. The RN assessment indicated Patient #3 could walk. The clinical record failed to evidence pre-treatment and post-treatment standing BPs. On 2/7/24, the ICHD treatment began at 6:08 PM. The RN assessment was completed at 8:14 PM, 2 hours and 6 minutes after the treatment start time. Patient #3's pulse rate was 52 at 5:56 PM, 53 at 6:12 PM and 6:40 PM, 55 at 7:07 PM, 56 at 8:02 PM, 57 at 8:33 PM and 9:03 PM, and 56 at 9:18 PM. The clinical record failed to evidence the RN was notified of the low pulse rates. The RN recorded a pulse rate of 57 at 7:33 PM. The clinical record failed to evidence the RN notified the physician of the low pulse rate. Patient #3's prescribed EDW was 86.50 kg, and the post-treatment weight was 90.70 kg. The clinical record failed to evidence the physician was notified of the post-treatment weight greater than 1 kg over the EDW. The RN assessment indicated Patient #3 could walk. The clinical record failed to evidence pre-treatment and post-treatment standing BPs. On 2/9/24, the ICHD treatment began at 6:08 PM. Patient #3's pulse rate was 53 at 6:01 PM, 52 at 6:10 PM, 58 at 6:37 PM, and 59 at 7:04 PM. The clinical record failed to evidence the RN was notified of the low pulse rates. The RN recorded Patient #3's pulse rate of 58 and a BP of 123/58 at 8:04 PM. The clinical record failed to evidence the			

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	RN performed interventions or notified the physician of the low pulse rates or the low diastolic BP. The RN assessment indicated Patient #3 could walk. The clinical record failed to evidence pre-treatment and post-treatment standing BPs. On 2/12/24, the ICHD treatment began at 6:23 PM. The RN assessment was performed at 7:30 PM, 1 hour and 7 minutes after treatment start time. A BP check was performed at 8:04 PM with the next BP check at 9:14 PM, 1 hour and 10 minutes later. Patient #3's pulse rate was 54 at 6:04 PM and 6:24 PM, 53 at 7:03 PM, 58 at 7:38 PM, and 57 at 8:04 PM. The clinical record failed to evidence the RN was notified of the low pulse rates. Patient #3's prescribed EDW was 86.50 kg, and the post-treatment weight was 88.60 kg. The clinical record failed to evidence the physician was notified of the post-treatment weight 2 kg over the EDW. The clinical record failed to evidence pre-treatment and post-treatment standing BPs. On 2/14/24, the ICHD treatment began at 5:58 PM. Patient #3's pulse rate was 55 at 5:51 PM and 54 at 6:00 PM and 6:34 PM. The clinical record failed to evidence the RN was notified of the low pulse rates. The RN recorded pulse rates of 54 at 7:12 PM, 56 at 7:40 PM, 59 at 8:04 PM, and 57 at 9:22 PM. The clinical record failed to evidence the physician was notified of the low pulse rates. The RN assessment indicated Patient #3 could walk. The clinical record failed to evidence pre-treatment and post-treatment standing BPs. On 2/16/24, the ICHD treatment began at 6:33 PM. The RN assessment was documented at 10:06 PM with a note indicating it was a late entry without an assessment time. The clinical record failed to evidence the RN assessment was completed			

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	withing 1 hour of treatment start time. Patient #3's pulse rate was 52 at 6:20 PM, 53 at 6:34 PM, 55 at 7:04 PM and 7:35 PM, and 54 at 21:13 PM. The clinical record failed to evidence the RN was notified of the low pulse rates. The RN recorded a pulse rate of 56 at 8:34 PM. The clinical record failed to evidence the physician was notified of the low pulse rate. The clinical record failed to evidence standing pre-treatment and post-treatment BPs. On 2/19/24, the ICHD treatment began at 6:32 PM. The RN assessment was documented at 10:06 PM, 3 hours and 34 minutes after treatment start time. Patient #3's pulse rate was 52 at 6:19 PM and 6:32 PM, 55 at 7:11 PM, 58 at 7:40 PM, and 59 at 8:41 PM and 9:02 PM. The clinical record failed to evidence the RN was notified of the low pulse rates. The clinical record failed to evidence standing pre-treatment and post-treatment BPs. On 2/21/24, the ICHD treatment began at 6:50 PM. The RN assessment was documented at 10:07 PM, 3 hours and 17 minutes after treatment start time. Patient #3's pulse rate was 54 at 6:27 PM, 55 at 6:51 PM, 56 at 7:36 PM, 59 at 8:02 PM and 8:33 PM, and 56 at 9:04 PM. Patient #3's BP was 117/58 at 9:04 PM. The clinical record failed to evidence the RN was notified of the low pulses or low diastolic BP. The clinical record failed to evidence standing pre-treatment and post-treatment BPs. On 2/23/24, the ICHD treatment began at 5:31 PM. The RN assessment was documented at 9:54 PM with a note that it was a late entry but did not include the time of the assessment. The clinical record failed to evidence the RN assessment was completed within 1 hour of treatment start time. Patient #3's pulse rate was 56 at 5:16 PM and 5:32 PM. The clinical record failed to evidence the RN			

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	in charge was notified of the low pulse rates. The RN recorded a pulse rate of 59 at 7:34 PM. The clinical record failed to evidence the physician was notified of the low pulse rate. The prescribed EDW was 86.50 kg, and the post-treatment weight was 87.60 kg. The clinical record failed to evidence the physician was notified of the post-treatment weight being 1.10 kg over the EDW. The clinical record failed to evidence standing pre-treatment and post-treatment BPs. During interviews on 2/23/24 beginning at 4:43 PM and 2/26/24 at 1:56 PM, the Administrator indicated the above findings for Patient #3 were accurate. During an interview on 2/23/24 at 5:10 PM, Person A, the caregiver and POA for Patient #3, relayed Patient #3 could stand for a BP if someone was holding the patient to steady him/her and that Patient #3 uses a wheelchair out in public but walks at home. On 2/26/24 at 5:30 PM, observed Patient #3 exit their vehicle and stand to transfer to the facility's wheelchair with contact assist by Person A. 9. During an interview on 2/22/24 beginning at 4:25 PM, the Administrator relayed BPs and pulse rates should be checked every 30 minutes, but no more than every 45 minutes and that pulses lower than 60 or greater than 100 should be reported to the RN. 10. During an interview on 2/26/24 beginning at 1:56 PM, the Administrator relayed that if the patient is able to stand and walks at home, standing BP should be taken.11. The following Treatment Sheets reviewed (09/25/2023-10/11/2023) for Patient #15 failed to			

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	evidence blood pressure (BP) monitoring every 30-45 minutes during treatment and failed to evidence abnormal blood pressures had been reported to the Registered Nurse. A 09/25/2023 treatment sheet for Patient #15 indicated a BP at 6:04 AM with the next BP at 7:15 AM, (71 minutes). A 10/02/2023 treatment sheet for Patient #15 indicated a BP at 9:07 AM with the next BP at 9:55 AM, (48 minutes). At the start of treatment, a blood pressure of 70/60 was obtained by PCT 4. PCT 4 failed to notify the Registered Nurse. A 10/11/2023 treatment sheet for Patient #15 indicated a BP at 6:06 AM with the next BP at 7:03 AM, (57 minutes). A BP was obtained at 8:34 AM with the next BP at 9:33 AM, (59 minutes). 12. The following Treatment Sheets reviewed (02/09/2024-02/19/2024) for Patient # 4 failed to evidence blood pressure monitoring every 30-45 minutes during treatment and failed to evidence abnormal blood pressures had been reported to the Registered Nurse. 02/09/2024 treatment sheet for Patient #4 indicated a BP of 94/73 at 6:49 AM, start of treatment, obtained by PCT 7. PCT 7 failed to notify the Registered Nurse. 02/16/2024 treatment sheet for Patient #4 indicated a BP at 6:41 AM with the next BP at 7:34 AM, (53 minutes). 13. During an observation on 02/28/2024 at 10:44 AM, PCT 7 was overheard advising RN 4 that Patient #28's blood pressure "came up". No			

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	further details were provided to RN 4, nor did RN 4 inquire specifics about the retaken blood pressure. RN 4 just acknowledged by saying okay and walked over to the nurse's station. The surveyor noted the dialysis machine for Patient #28 indicated a previous blood pressure of 82/44 with a pulse rate of 58. The subsequent blood pressure was taken and read, 210/133 with a pulse rate of 40. Patient #28 was standing after having blood returned post-treatment. After 3-4 minutes of observing, RN 4 and PCT 7 did not communicate any further regarding the retaken blood pressure. The surveyor asked RN 4 what Patient #28's second blood pressure was and RN 4 indicated not knowing the subsequent blood pressure but the previous pressure was low so PCT 7 retook it and it came up. RN 4 then walked over to Patient #28 after the surveyor indicated that the second blood pressure appeared concerning, noting the increased blood pressure and low pulse rate, RN 4 advised PCT 7 to retake the blood pressure. RN 4 then completed an assessment and provided education to the patient. A subsequent blood pressure was found to be 155/52 with a pulse of 72. Patient #28 was escorted to the lobby door. RN 4 indicated that Patient #28's treatment ended early due to machine problems. Indicated a blood leak and that Patient #28's blood was not returned. Treatment was restarted on another machine and ended early per Patient #28's request. RN 4 indicated that the physician was not notified of the blood leak prior to restarting treatment, or before Patient #28 completed treatment and was escorted to the lobby post-treatment. RN 4 indicated the physician would be notified. During an interview on 02/28/2024 at 11:00 AM, the Administrator indicated when inquired about the procedure for staff in the event of a blood leak			

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	with no adverse reaction the patient's blood would not be returned and treatment would be restarted with another dialysis machine. The Administrator further indicated that the RN completed an assessment with no findings of an adverse reaction, so treatment was restarted. The surveyor indicated an erratic blood pressure witnessed with Patient #28 after restarting the treatment and asked if that was considered a typical treatment/adverse reaction. The Administrator replied, "What's a typical treatment?" When asked if the physician is to be notified before restarting treatment where a blood leak occurred, the Administrator indicated she would get the policy. During an interview on 02/28/2024 at 11:02 AM, the Administrator indicated that Patient #28 signed off treatment early against medical advice (AMA) and signed the document. A policy on blood leaks was provided and the administrator agreed that the policy was vague as to when to notify the physician and could not verbalize when the physician should be notified and what the staff should specifically do if this reoccurs. 14. Patient #5's ICHD treatment sheets, dated 2/02/24 to 2/21/24, were reviewed and evidenced the following: On 2/02/24, the ICHD treatment began at 12:23 PM. A BP check was conducted at 12:28 PM with a follow-up BP check at 1:36 PM, 1 hour and 8 minutes later. The BP check at 1:36 PM indicated BP of 93/64. The clinical record evidenced the PCT notified the RN of low BP. The RN failed to reassess the low BP. The BP at 2:03 PM indicated BP of 85/53. RN 1 failed to reassess the low BP. The BP check at 3:03 PM indicated BP of 96/58. PCT 4 failed to notify the RN regarding low BP. The BP check at 4:02 PM indicated BP of 97/65.			

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	PCT 4 failed to notify the RN regarding low BP. The BP check at 4:02 PM indicated BP of 97/65. Patient #5's post dialysis weight was 87.0 kg (3.2 kg above ordered EDW). The clinical record failed to evidence the RN notified the physician and/or performed interventions to address low BP or EDW. The clinical record evidenced that the patient was ambulatory and failed to evidence the pre dialysis standing BP check was performed. On 2/05/24, the ICHD treatment began at 12:23 PM. The routine check at 1:39 PM indicated BP of 97/57 and HR of 102. PCT 4 failed to notify the RN regarding low BP and elevated HR. The BP check at 2:33 PM indicated BP of 86/51. RN 1 failed to reassess the low BP. The follow-up BP check was conducted at 4:02 PM, 1 hour and 29 minutes later. The BP check at 4:19 PM indicated BP of 98/56. Patient #5's post dialysis weight was 86.5 kg (2.7 kg above ordered EDW). The clinical record failed to evidence RN 1 notified the physician and/or performed interventions to address low BP, elevated HR or EDW. The clinical record evidenced that the patient was ambulatory and failed to evidence the pre and post dialysis standing BP checks were performed. On 2/07/24, the ICHD treatment began at 12:02 PM; the RN assessment was performed at 1:14 PM, 1 hour and 12 minutes after treatment began. The heart rate check at 12:32 PM indicated HR of 103. PCT 1 failed to notify the RN regarding the elevated HR. The HR check at 1:06 PM indicated HR of 102. PCT 2 failed to notify the RN regarding high HR. The BP check at 1:37 PM indicated BP of 92/53 and the BP check at 2:05 PM indicated BP of 86/47. PCT 2 failed to notify the RN regarding low BP readings. The HR check at 2:35 PM indicated HR of 104. PCT 8 failed to notify the RN regarding the high HR. The HR check at 4:01 PM indicated a			

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	HR of 121. PCT 4 failed to the RN regarding the high HR. The clinical record evidenced that the patient was ambulatory and failed to evidence the pre and post dialysis standing BP checks were performed. On 2/10/24, the ICHD treatment began at 11:08 AM; the HR check at 11:08 AM indicated HR of 115. PCT 5 failed to notify the RN regarding high HR reading. The BP check at 11:32 AM indicated BP of 85/52. PCT 5 failed to notify the RN regarding the low BP reading. The BP check at 12:01 PM indicated BP of 86/38. PCT 9 failed to notify the RN regarding the low BP reading. The clinical record evidenced that the patient was ambulatory and failed to evidence the post dialysis standing BP check was performed. On 2/12/24, the ICHD treatment began at 12:21 PM; the routine check at 12:31 PM indicated BP of 92/53 and HR 113. PCT 2 failed to notify the RN regarding the low BP and high HR readings. The follow-up BP check was conducted at 1:34 PM, 1 hour and 3 minutes later. The HR check at 1:34 PM indicated HR of 126. RN 2 failed to recheck the elevated HR. The BP check at 2:03 PM indicated BP of 97/48. The HR check at 3:36 PM indicated HR of 120. RN 2 failed to recheck the elevated HR. Patient #5's post dialysis weight was 85.0 kg (1.2 kg above ordered EDW). The clinical record failed to evidence the RN notified the physician and/or performed interventions to address the low BP, elevated HR and not meeting EDW. The clinical record evidenced that the patient was ambulatory and failed to evidence the pre and post dialysis standing BP checks were performed. On 2/14/24, the ICHD treatment began at 12:36 PM and the BP check indicated BP of 98/56. PCT 5 failed to notify the RN regarding the low BP. The			

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	HR check at 3:00 PM indicated HR of 110. PCT 5 failed to notify the RN regarding the high HR. The HR check at 3:35 PM indicated HR of 116. PCT 5 failed to notify the RN regarding the high HR. The BP check at 3:45 PM indicated BP of 97/53. PCT 8 failed to notify the RN regarding the low BP. The clinical record evidenced that the patient was ambulatory and failed to evidence the pre and post dialysis standing BP checks were performed. On 2/16/24, the ICHD treatment began at 12:07 PM; the BP check at 12:32 PM indicated BP of 90/59. PCT 5 failed to notify the RN regarding low BP. The HR check at 1:03 PM indicated HR of 108. PCT 9 failed to notify the RN regarding high HR. The BP check at 1:34 PM indicated BP of 85/50. The clinical record evidenced the PCT notified the RN of low BP and BP was set for every 5 minutes. The clinical record failed to evidence BP was taken every 5 minutes. The BP check at 2:09 PM indicated BP of 86/53. RN 1 documented the UF was off. The BP check at 2:36 PM indicated BP of 95/53. PCT 9 failed to notify the RN regarding low BP. The routine check at 3:05 PM indicated BP of 87/58 and HR of 105. RN 1 failed to recheck the low BP and elevated HR. The routine check at 3:32 PM indicated BP of 87/51 and HR of 116. The clinical record evidenced the PCT notified the RN of low BP and high HR. The RN failed to reassess the low BP and elevated HR. The clinical record failed to evidence the RN notified the physician and/or performed interventions to address the low BP and elevated HR. The clinical record evidenced that the patient was ambulatory and failed to evidence the pre dialysis standing BP checks were performed. On 2/20/24, the ICHD treatment began at 11:35 AM; the BP check at 1:12 PM indicated BP of 99/62. PCT 2 failed to notify the RN regarding the			

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	low BP. The BP check at 1:36 PM indicated BP of 94/53. The clinical record evidenced the PCT notified the RN of low BP. The RN failed to reassess the low BP. The BP check at 2:03 PM indicated BP of 95/27. The clinical record evidenced the PCT notified the RN of low BP. The RN failed to reassess the low BP. Patient #5's post dialysis weight was 86.4 kg (2.6 kg above ordered EDW). The clinical record failed to evidence the RN notified the physician and/or performed interventions to address the low BP or EDW. The clinical record evidenced that the patient was ambulatory and failed to evidence the pre and post dialysis standing BP checks were performed. On 2/21/24, the ICHD treatment began at 12:06 PM; the HR check at 12:35 PM indicated HR of 107. PCT 5 failed to notify the RN regarding the high HR. The HR check at 3:01 PM indicated HR of 101. PCT 5 failed to notify the RN regarding the high HR. The clinical record evidenced that the patient was ambulatory and failed to evidence the pre and post dialysis standing BP checks were performed. During an interview on 2/22/24 beginning at 3:48 PM, the Administrator indicated the above findings for Patient #5 were accurate, verified BP checks were missing for Patient #5 on 2/02/24, 2/05/24 and 2/12/24 and indicated the clinical record failed to include documentation of notifications or interventions related to Patient #5's vital signs out of parameter and indicated standing BP checks should be done pre and post dialysis treatment if the patient walks in and out of the clinic. They indicated the physician should have been notified regarding Patient #5's EDW not being met and when the treatment was ended early or the if the patient signs the AMA form			

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	requesting the treatment to end early. 15. Patient #9's ICHD treatment sheets, dated 1/31/24 to 2/21/24, were reviewed and evidenced the following: On 1/31/24, the ICHD treatment began at 4:38 PM; the RN assessment was performed at 7:18 PM, 2 hours and 40 minutes after treatment began. The HR check at 5:06 PM indicated HR of 59. RN 1 failed to reassess the low HR. The HR check at 5:30 PM indicated HR of 59. RN 1 failed to reassess the low HR. A routine BP check was conducted at 6:06 PM and a follow-up BP check was not conducted until after treatment had been discontinued at 7:23 PM, 1 hour and 17 minutes later. The clinical record failed to evidence RN 1 notified the physician and/or performed interventions to address the low HR. On 2/02/24, the ICHD treatment began at 3:56 PM; the RN assessment was performed at 5:36 PM, 1 hour and 40 minutes after treatment began. The HR check at 4:33 PM indicated HR of 58. RN 1 failed to reassess the low HR. The HR check at 5:14 PM indicated HR of 59. PCT 4 failed to notify the RN regarding the low HR. A routine BP check was conducted at 5:32 PM with a follow-up BP check at 6:35 PM, 1 hour and 3 minutes later. The clinical record failed to evidence RN 1 notified the physician and/or performed interventions to address the low HR.On 2/05/24, the ICHD treatment began at 4:09 PM. A BP check was conducted at 4:44 PM with a follow-up BP check conducted at 5:32 PM, 48 minutes later. The HR check at 6:00 PM			

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	indicated HR of 56. PCT 6 failed to notify the RN regarding the low HR. On 2/09/24, the ICHD treatment began at 4:07 PM with a BP check being conducted. A follow-up BP check was conducted at 5:00 PM, 53 minutes later. On 2/12/24, the ICHD treatment began at 4:37 PM. The HR check at 4:37 PM indicated HR of 55. RN 2 failed to reassess the low HR. The HR check at 5:12 PM indicated HR of 59. RN 5 failed to reassess the low HR. The follow-up HR check was conducted at 6:05 PM, 52 minutes later. The clinical record failed to evidence the RN notified the physician and/or performed interventions to address the low HR.On 2/14/24, the ICHD treatment began at 4:23 PM with BP and HR checks being conducted. The HR check at 4:23 PM indicated HR of 59. PCT 10 failed to notify the RN regarding low HR. The follow-up BP and HR checks were conducted at 5:09 PM, 46 minutes later. The BP check at 7:05 PM indicated BP of 186/93. RN 1 failed to reassess the high BP. The BP check at 7:26 PM indicated BP of 188/154. The clinical record failed to evidence RN 1 notified the physician and/or performed interventions to address the high BP.On 2/16/24, the ICHD treatment began at 4:08 PM. The HR check at 4:34 PM indicated HR of 58. PCT 3 failed to reassess the low HR and failed to notify the			

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	RN regarding the low HR. The HR check at 5:36 PM, conducted 1 hour and 2 minutes later, indicated a HR of 58. PCT 3 failed to notify the RN regarding the low HR. Patient #9's post dialysis weight was 58.6 kg (1.6 kg above ordered EDW). The clinical record failed to evidence the RN notified the physician and/or performed interventions to address the EDW.On 2/19/24, the ICHD treatment began at 4:12 PM. The HR check at 4:40 PM indicated HR of 55. PCT 1 failed to notify the RN regarding low HR. The clinical record failed to evidence any patient checks were performed from 4:40 PM to 6:07 PM, 1 hour and 27 minutes. The BP check at 7:05 PM indicated BP of 186/88. PCT 6 failed to notify the RN regarding high BP. The BP check at 7:29 PM indicated BP of 197/94. PCT 3 failed to notify the RN regarding high BP. On 2/21/24, the ICHD treatment began at 4:04 PM. A BP check was conducted at 4:10 PM with follow-up BP checks conducted at 5:03 PM, 53 minutes later and then 6:36 PM, 1 hour and 33 minutes later. The BP check at 7:16 PM indicated BP of 192/75. PCT 6 failed to notify the RN regarding the high BP. During an interview on 2/23/24 beginning at 12:29 PM, the Administrator indicated the above findings for Patient #9 were accurate, verified BP checks were missing for Patient #9 on 1/31/24, 2/02/24,			

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	2/05/24 2/09/24, 2/12/24, 2/16/24, 2/19/24 and 2/21/24. They indicated the clinical record failed to include documentation of notifications or interventions related to Patient #9's vital signs out of parameter the physician should have been notified regarding Patient #9's EDW not being met and when the treatment was ended early.16. Patient #11's ICHD treatment sheets, dated 1/29/24 to 2/21/24, were reviewed and evidenced the following:On 1/29/24, the ICHD treatment began at 3:24 PM. The HR check at 3:33 PM indicated HR of 57. PCT 3 failed to notify the RN regarding the low HR. On 1/31/24, the ICHD treatment began at 3:54 PM; the RN assessment was performed at 5:33 PM, 1 hour and 39 minutes after treatment began. A routine BP check was conducted at 5:07 PM with a follow-up BP check conducted at 6:02 PM, 55 minutes later. Patient #11's HR was below 60 the entire treatment. The clinical record failed to evidence the RN notified the physician and/or performed interventions to address the low HR.On 2/05/24, the ICHD treatment began at 3:54 PM. A routine BP check was conducted at 4:41 PM with a follow-up BP check conducted at 5:34 PM, 53 minutes later. The pre dialysis standing BP check was not performed. Patient #11's post dialysis weight was 78.0 kg (2.0 kg below ordered EDW). The clinical record			

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	failed to evidence the RN notified the physician and/or performed interventions to address the EDW.On 2/07/24, the ICHD treatment began at 4:46 PM. A pre-treatment sitting BP was obtained at 4:26 PM. RN 1 failed to obtain a BP at 4:46 PM when the dialysis treatment was started. A BP check was conducted at 5:38 PM, 1 hour and 12 minutes later. On 2/09/24, the ICHD treatment began at 3:25 PM with a BP check being performed. The follow-up BP check was conducted at 4:45 PM, 1 hour and 20 minutes after starting treatment. The pre dialysis standing BP check was not performed. Patient #11's post dialysis weight was 81.3 kg (1.3 kg above ordered EDW). The clinical record failed to evidence the RN notified the physician and/or performed interventions to address the EDW.On 2/12/24, the ICHD treatment began at 3:41 PM; the RN assessment was performed at 6:33 PM, 2 hours and 52 minutes after treatment began. A BP check was conducted at 5:02 PM with a follow-up BP check conducted at 6:09 PM. On 2/14/24, the ICHD treatment began at 5:59 AM. A routine BP check was conducted at 6:30 AM with a follow-up BP check conducted at 7:19 AM, 49 minutes later. A routine BP check was conducted at 8:31 AM with a follow-up BP check conducted at 9:30 AM, 59 minutes later.On 2/16/24, the ICHD			

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	treatment began at 3:40 PM. A routine BP check was conducted at 4:36 PM with a follow-up BP check conducted at 5:39 PM, 1 hour and 3 minutes later.On 2/19/24, the ICHD treatment began at 3:38 PM. A routine BP check was conducted at 3:42 PM with a follow-up BP check conducted at 4:40 PM, 58 minutes later, with a follow-up BP check conducted at 6:08 PM, 1 hour and 28 minutes later. On 2/21/24, the ICHD treatment began at 3:37 PM. A routine BP check was conducted at 4:01 PM with a follow-up BP check conducted at 5:01 PM, 1 hour later, with a follow-up BP check conducted at 6:09 PM, 1 hour and 8 minutes later. During an interview on 2/27/24 beginning at 4:38 PM, the Administrator indicated the above findings for Patient #11 were accurate, verified BP checks were missing for Patient #11 on 1/31/24, 2/05/24, 2/07/24, 2/09/24, 2/12/24, 2/14/24, 2/16/24, 2/19/24 and 2/21/24. They indicated the clinical record failed to include documentation of notifications or interventions regarding Patient #11's EDW not being met and when the treatment ended early. 17. Patient #12's ICHD treatment sheets, dated 1/31/24 to 2/21/24, were reviewed and evidenced the following:On 1/31/24, the ICHD treatment began at 4:58 PM; the RN assessment was performed at 7:19 PM, 2 hours and 53			

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	minutes after treatment began. A routine BP check was conducted at 4:58 PM with a follow-up BP check conducted at 7:02 PM, 2 hours and 4 minutes later. A routine BP check was conducted at 8:05 PM with a follow-up BP check conducted at 8:59 PM, 54 minutes later. The clinical record evidenced that the patient was ambulatory and failed to evidence the pre standing BP check was performed. On 2/02/24, The clinical record evidenced that the patient was ambulatory and failed to evidence the pre dialysis standing BP checks was performed. On 2/05/24, the ICHD treatment began at 4:29 PM. A routine BP check was conducted at 4:41 PM with a follow-up BP check conducted at 5:34 PM, 53 minutes later. The clinical record evidenced that the patient was ambulatory and failed to evidence the pre dialysis standing BP check was performed. On 2/07/24, the ICHD treatment began at 5:10 PM; the RN assessment was performed at 7:11 PM, 2 hours and 1 minute after treatment began. The clinical record evidenced that the patient was ambulatory and failed to evidence the pre dialysis standing BP check was performed.On 2/09/24, the ICHD treatment began at 4:33 PM with a BP check of 97/51. PCT 4 failed to notify the RN regarding low BP. RN 1 failed to perform an RN assessment during this treatment. The			

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	clinical record evidenced that the patient was ambulatory and failed to evidence the pre dialysis standing BP check was performed.On 2/12/24, the ICHD treatment began at 4:58 PM; the RN assessment was documented at 10:03 PM, 5 hours and 5 minutes after treatment began. A routine BP check was conducted at 5:01 PM with a follow-up BP check conducted at 6:08 PM, 1 hour and 7 minutes later. The clinical record evidenced that the patient was ambulatory and failed to evidence the pre dialysis standing BP check was performed. Patient #12's post dialysis weight was 101.2 kg (1.8 kg above ordered EDW). The clinical record failed to evidence the RN notified the physician and/or performed interventions to address the EDW.On 2/14/24, the ICHD treatment began at 4:55 PM; the RN assessment was performed at 6:22 PM, 1 hour and 27 minutes after treatment began. The clinical record evidenced that the patient was ambulatory and failed to evidence the pre dialysis standing BP check was performed.On 2/16/24, the ICHD treatment began at 4:30 PM with a routine BP check conducted at 4:31 PM. A follow-up BP check was conducted at 5:35, 1 hour and 4 minutes later. On 2/21/24, the ICHD treatment began at 4:36 PM. A routine BP check was conducted at 5:02 PM with a follow-up BP			

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	check conducted at 6:16 PM. During an interview on 2/23/24 beginning at 11:43 AM, the Administrator indicated the above findings for Patient #12 were accurate, verified the RN assessment was not completed on 2/09/24; BP checks were missing for Patient #12 on 1/31/24, 2/05/24, 2/12/24, 2/16/24 and 2/21/24. They indicated the clinical record failed to include documentation of notifications or interventions regarding Patient #12's EDW not being met and when the treatment ended early. 18. Patient #13's ICHD treatment sheets, dated 1/29/24 to 2/21/24, were reviewed and evidenced the following:On 1/29/24, the ICHD treatment began at 3:11 PM. The BP check at 3:35 PM indicated BP of 52/25. PCT 3 failed to notify the RN regarding the low BP. The clinical record evidenced that the patient was ambulatory and failed to evidence the pre dialysis standing BP check was performed.On 1/31/24, the ICHD treatment began at 3:00 PM. The pre-treatment BP check was conducted at 2:50 PM with a follow-up BP check conducted at 4:42 PM, 1 hour and 52 minutes later. The next BP check was conducted at 6:08 PM, 1 hour 26 minutes later with a BP of 92/58. PCT 8 failed to notify the RN regarding the low BP. The next BP check was conducted at 7:08 PM, 1 hour later. The BP check at 7:26 PM			

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	indicated BP of 99/72. PCT 6 failed to notify the RN regarding low BP. The clinical record evidenced that the patient was ambulatory and failed to evidence the pre dialysis standing BP check was performed.On 2/05/24, The clinical record evidenced that the patient was ambulatory and failed to evidence the pre dialysis standing BP check was performed. On 2/07/24, the ICHD treatment began at 3:19 PM. A routine BP check was conducted at 4:30 PM with a follow-up BP check conducted at 5:35 PM, 1 hour and 5 minutes later. On 2/09/24, the ICHD treatment began at 2:42 PM. A routine BP check was conducted at 2:44 PM with a follow-up BP check conducted at 3:31 PM, 47 minutes later. A BP check at 5:04 PM indicated BP of 96/83. PCT 8 failed to notify the RN regarding the low BP. The clinical record evidenced that the patient was ambulatory and failed to evidence the pre dialysis standing BP check was performed. On 2/12/24, the ICHD treatment began at 2:56 PM; the RN assessment was performed at 7:48 PM, 4 hours and 52 minutes after treatment began and 27 minutes after treatment ended. A BP check was conducted at 5:06 PM with a follow-up BP check conducted at 6:10 PM, 1 hour and 4 minutes later. A BP check at 6:45 PM indicated BP of 96/58 with an immediate			

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	reassessment BP check of 81/27. PCT 6 failed to notify the RN regarding the low BP. The clinical record evidenced that the patient was ambulatory and failed to evidence the pre dialysis standing BP check was performed. On 2/16/24, the ICHD treatment began at 2:48 PM. A BP check was conducted at 4:35 PM with a follow-up BP check conducted at 5:40 PM, 1 hour and 5 minutes later. On 2/19/24, the ICHD treatment began at 3:21 PM. A BP check was conducted at 3:36 PM with a follow-up BP check conducted at 4:39 PM, 1 hour and 3 minutes later. The next routine BP check was conducted at 6:06 PM, 1 hour and 27 minutes later. The clinical record evidenced that the patient was ambulatory and failed to evidence the pre and post dialysis standing BP checks were performed. On 2/21/24, the ICHD treatment began at 2:49 PM. A BP check was conducted at 3:00 PM with a follow-up BP check conducted at 4:01 PM, 1 hour and 1 minute later. The next routine BP check was conducted at 5:01 PM, 1 hour later. The next routine BP check was conducted at 6:10 PM, 1 hour and 9 minutes later. The clinical record evidenced that the patient was ambulatory and failed to evidence the pre and post dialysis standing BP checks were performed. During an interview on 2/28/24 beginning at 3:20 PM,			

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	the Administrator indicated the above findings for Patient #13 were accurate, verified the RN assessment was not completed within the first hour of treatment on 2/12/24; BP checks were missing for Patient #13 on 1/31/24, 2/07/24, 2/09/24, 2/12/24, 2/16/24, 2/19/24 and 2/21/24. 19. Patient #14's ICHD treatment sheets, dated 1/29/24 to 2/21/24, were reviewed and evidenced the following:On 1/31/24, the ICHD treatment began at 4:07 PM; the RN assessment was performed at 7:13 PM, 3 hours and 6 minutes after treatment began. A BP check was conducted at 5:07 PM with a follow-up BP check conducted at 6:01 PM, 54 minutes later. The next routine BP check was conducted at 7:09 PM, 1 hour and 8 minutes later.On 2/02/24, the ICHD treatment began at 3:07 PM. A BP check was conducted at 3:08 PM with a follow-up BP check conducted at 4:02 PM, 54 minutes later.On 2/07/24, the ICHD treatment began at 3:56 PM. A BP check at 3:59 PM with a BP of 61/28. PCT 4 failed to notify the RN of the low BP. A BP check was conducted at 4:30 PM with a follow-up BP check conducted at 5:40 PM, 1 hour and 10 minutes later.On 2/12/24, the ICHD treatment began at 4:01 PM; the RN assessment was performed at 7:29 PM, 3 hours and 28 minutes after treatment began. On 2/14/24, the ICHD treatment began at			

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	3:43 PM with a routine BP check being conducted. The follow-up BP check was conducted at 5:08 PM, 1 hour 25 minutes later. The next routine BP check was conducted at 6:04 PM, 56 minutes later, with a follow-up BP check conducted at 7:08 PM, 1 hour and 4 minutes later. On 2/16/24, the ICHD treatment began at 3:27 PM. A BP check was conducted at 4:35 PM with a follow-up BP check conducted at 5:41 PM, 1 hour and 6 minutes later. On 2/19/24, the ICHD treatment began at 3:29 PM. A BP check was conducted at 4:41 PM with a follow-up BP check conducted at 6:08 PM, 1 hour and 27 minutes later. On 2/21/24, the ICHD treatment began at 3:15 PM. A BP check was conducted at 4:09 PM with a follow-up BP check conducted at 5:03 PM, 54 minutes later. The next BP check was conducted at 6:18 PM, 1 hour and 15 minutes later.During an interview on 2/28/24 beginning at 2:55 PM, the Administrator indicated the above findings for Patient #14 were accurate, verified the RN assessment was not completed within the first hour of treatment on 1/31/24 and 2/12/24; BP checks were missing for Patient #14 on 1/31/24, 2/02/24, 2/07/24, 2/14/24, 2/16/24, 2/19/24 and 2/21/24. 20. Patient #20's ICHD treatment sheets, dated 1/29/24 to 2/21/24, were reviewed and evidenced the following:On 1/29/24, the			

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	ICHD treatment began at 5:49 AM; the RN assessment was performed at 8:03 AM, 2 hours and 14 minutes after treatment began. Patient #20's post dialysis weight was 86.0 kg (9.0 kg above ordered EDW). The clinical record failed to evidence the RN notified the physician and/or performed interventions to address the EDW.On 1/31/24, the ICHD treatment began at 5:35 AM with a BP check of 187/107. PCT 2 failed to notify the RN regarding the high BP. The next BP check was conducted at 6:32 AM, 1 hour and 7 minutes later, with a BP of 188/122. PCT 2 failed to notify the RN regarding the high BP. A BP check at 7:06 AM indicated BP of 224/142. PCT 1 failed to notify the RN regarding the high BP. Patient #20's post dialysis weight was 90.1 kg (13.1 kg above ordered EDW). The clinical record failed to evidence the RN notified the physician and/or performed interventions to address the EDW.On 2/02/24, the ICHD treatment began at 5:51 AM with a routine BP check conducted. The next BP check was conducted at 6:54 AM, 1 hour and 3 minutes later. Patient #20's post dialysis weight was 90.9 kg (13.9 kg above ordered EDW). The clinical record failed to evidence the RN notified the physician and/or performed interventions to address the EDW.On 2/05/24, the ICHD treatment began at 5:55 AM with a BP			

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	check of 165/109. PCT 5 failed to notify the RN regarding the high BP. A BP check at 6:39 AM indicated BP of 182/105. PCT 2 failed to notify the RN regarding the high BP. A BP check at 7:11 AM indicated BP of 171/101. PCT 2 failed to notify the RN regarding the high BP. A BP check at 8:03 AM indicated BP of 171/102. PCT 5 failed to notify the RN regarding the high BP. A BP check at 9:07 AM indicated BP of 195/110. PCT 5 failed to notify the RN regarding the high BP. Patient #20's post dialysis weight was 87.1 kg (10.1 kg above ordered EDW). The clinical record failed to evidence the RN notified the physician and/or performed interventions to address the EDW.On 2/07/24, the ICHD treatment began at 5:32 AM. A pre-dialysis BP check indicated BP of 183/103. PCT 3 failed to notify the RN regarding the high BP. A BP check at 5:35 AM indicated BP of 166/106. PCT 3 failed to notify the RN regarding the high BP. A BP check at 7:31 AM indicated BP of 164/101. PCT 3 failed to notify the RN regarding the high BP. A BP check at 8:01 AM indicated BP of 161/103. PCT 3 failed to notify the RN regarding the high BP. Patient #20's post dialysis weight was 84.9 kg (7.9 kg above ordered EDW). The clinical record failed to evidence the RN notified the physician and/or performed interventions to address the EDW.On			

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	2/09/24, the ICHD treatment began at 7:12 AM. A BP check at 7:21 AM indicated BP of 182/113. At 7:33 AM, BP check indicated BP of 179/105. RN 4 failed to reassess BP. A BP check at 8:03 AM indicated BP of 172/103. RN 8 failed to reassess BP. A BP check at 8:30 AM indicated BP of 161/104. PCT 7 failed to notify the RN regarding high BP. A BP check at 9:00 AM indicated BP of 173/108. PCT 7 failed to notify the RN regarding high BP. A BP check at 9:34 AM indicated BP of 160/102. PCT 7 failed to notify the RN regarding high BP. Patient #20's post dialysis weight was 83.5 kg (6.5 kg above ordered EDW). The clinical record failed to evidence the RN notified the physician and/or performed interventions to address the EDW.On 2/12/24, the ICHD treatment began at 5:36 AM with a BP check conducted. BP check indicated BP of 172/109. PCT 3 failed to notify the RN regarding the high BP. A BP check at 6:01 AM indicated BP of 160/102. PCT 3 failed to notify the RN regarding the high BP. A BP check at 7:02 AM indicated BP of 164/101. PCT 3 failed to notify the RN regarding the high BP. A BP check at 7:36 AM indicated BP of 164/104. PCT 3 failed to notify the RN regarding the high BP. A BP check at 8:01 AM indicated BP of 170/109. PCT 3 failed to notify the RN			

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	regarding the high BP. A BP check at 8:31 AM indicated BP of 177/114. PCT 3 failed to notify the RN regarding the high BP. A BP check at 9:09 AM indicated BP of 155/114. PCT 3 failed to notify the RN regarding the high BP. Patient #20's post dialysis weight was 82.2 kg (5.2 kg above ordered EDW). The clinical record failed to evidence the RN notified the physician and/or performed interventions to address the EDW.On 2/14/24, the ICHD treatment began at 5:37 AM; the RN assessment was performed at 6:39 AM, 1 hour and 2 minutes after treatment began. A BP check at 5:37 AM indicated BP of 195/116. PCT 2 failed to notify the RN regarding the high BP. A BP check at 6:15 AM indicated BP of 167/114. PCT 2 failed to notify the RN regarding the high BP. A BP check at 6:30 AM indicated BP of 166/107. PCT 2 failed to notify the RN regarding the high BP. A BP check at 7:02 AM indicated BP of 165/103. PCT 2 failed to notify the RN regarding the high BP. A BP check at 7:36 AM indicated BP of 153/104. PCT 2 failed to notify the RN regarding the high BP. A BP check at 8:00 AM indicated BP of 153/101. PCT 5 failed to notify the RN regarding the high BP. A BP check at 8:23 AM indicated BP of 159/105. PCT 5 failed to notify the RN regarding the high BP. Patient #20's post dialysis weight was 81.4			

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	kg (4.4 kg above ordered EDW). The clinical record failed to evidence the RN notified the physician and/or performed interventions to address the EDW.On 2/16/24, the ICHD treatment began at 5:38 AM with a BP check of 209/109. RN 2 failed to reassess the BP. A BP check at 6:13 AM indicated BP of 195/120. PCT 2 failed to notify the RN regarding high BP. A BP check at 6:39 AM indicated BP of 180/120. PCT 2 failed to notify the RN regarding high BP. A BP check at 7:03 AM indicated BP of 177/116. PCT 2 failed to notify the RN regarding high BP. A BP check at 7:31 AM indicated BP of 155/109. PCT 2 failed to notify the RN regarding high BP. A BP check at 8:10 AM indicated BP of 150/101. PCT 2 failed to notify the RN regarding high BP. Patient #20's post dialysis weight was 81.4 kg (4.4 kg above ordered EDW). The clinical record failed to evidence the RN notified the physician and/or performed interventions to address the EDW.On 2/19/24, the ICHD treatment began at 7:06 AM. A BP check at 7:07 AM indicated BP of 181/111. PCT 1 failed to notify the RN regarding high BP. A BP check at 7:32 AM indicated BP of 163/106. RN 4 failed to reassess the BP. A BP check at 8:05 AM indicated BP of 169/106. RN 4 failed to reassess the BP. A BP check at 8:33 AM indicated BP of 163/111. PCT 1			

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	failed to notify the RN regarding high BP. Patient #20's post dialysis weight was 82.8 kg (5.8 kg above ordered EDW). The clinical record failed to evidence the RN notified the physician and/or performed interventions to address the EDW.On 2/21/24, the ICHD treatment began at 5:54 AM. A BP check at 5:57 AM indicated BP of 168/111. PCT 7 failed to notify the RN regarding high BP. A BP check at 6:03 AM indicated BP of 170/112. RN 3 failed to reassess BP. Patient #20's post dialysis weight was 83.3 kg (6.3 kg above ordered EDW). The clinical record failed to evidence the RN notified the physician and/or performed interventions to address the EDW.During an interview on 2/27/24 beginning at 4:50 PM, the Administrator indicated the above findings for Patient #20 were accurate, verified the RN assessment was not completed within the first hour of treatment on 1/29/24 and 2/14/24; BP checks were missing for Patient #20 on 1/31/24, 2/02/24, 2/05/24, 2/07/24, 2/09/24, 2/12/24, 2/14/24, 2/16/24, 2/19/24 and 2/21/24. They indicated the clinical record for Patient #20 failed to include documentation of physician notification when the treatment ended early.During an interview on 2/28/24 beginning at 2:50 PM, the Administrator indicated the clinical record and plan of care			

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	for Patient #20 failed to include documentation of notifications or interventions regarding Patient #20's EDW not being met and when the treatment ended early.			
V 0544 Bldg. 00	494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. Based on record review, and interview, the dialysis facility failed to ensure the dialysate flow rate (DFR) and/ or blood flow rate (BFR) were set according to physician orders, failed to ensure machine settings, including BFR and DFR, were checked no less often than every 45 minutes, and/ or failed to ensure the patient received their entire treatment time for 12 of 12 in-center hemodialysis (ICHD) patient records reviewed (Patient #1, #2, #3, #4, #5, #9, #11, #12, #13, #14, #15, #20); based on observation, record review, and interview, the dialysis facility failed to ensure dialysis treatment was being performed as prescribed for 3 of 6 randomly chosen ICHD patients whose treatment settings were observed (Patient #25, #26, and #27). Findings include: 1. The Patient Assessment and Monitoring policy, revised 05/01/23, indicated staff must check machine settings every 30 minutes or as needed during treatment, not to exceed 45 minutes, to ensure the prescribed blood flow rate (BFR) is being achieved and the dialysate flow rate (DFR)	V 0544	**V544** On 04/02/2024, the Director of Operations and Education Coordinator held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy and procedure: Nursing Supervision and Delegation Patient Assessment and Monitoring Pre-Treatment Safety Checks Procedure Early Termination or Arriving Late for Treatment Emphasis was placed on: Document machine parameters and safety checks every 30 minutes, not to exceed 45 minutes. Check machine settings and measurements: Check prescribed blood flow is being achieved or reason is	04/05/2024

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	is set as prescribed. If there is a deviation from the prescribed rates, the reason must be documented in the clinical record. 2. The Pre-Treatment Safety Checks policy, revised 02/06/23, indicated the clinician initiating treatment must verify the prescribed set up matches the prescription for dialysate composition, DFR, time, sodium modeling, ultrafiltration rate (UFR), and heparin dose. The policy indicated the DFR and proper dialysate composition must be verified by 2 direct patient care staff prior to treatment. 3. The Nursing Supervision and Delegation policy, revised 11/06/23, indicated RN's may not delegate assessment of the patient within one hour of ICHD treatment start time and must review patient treatment prescription and equipment parameters to verify correct settings and whether the dialysis prescription is being followed. 4. Patient #1's clinical record included ICHD Treatment Sheets dated 02/03/24 through 02/17/24 which evidenced the following: On 02/03/24, the ordered BFR was 350. Patient #1's treatment began at 12:27 PM. The first recorded BFR was 400 at 12:29 PM and continued at that rate for the entire treatment without documentation of the reason for the change to the physician-ordered prescription. On 02/06/24, the ordered DFR was manual 700. Patient #1's treatment began at 12:25 PM. The first recorded DFR was 600 at 12:33 PM and continued at that rate for the entire treatment without documentation of the reason for the change to the physician-ordered prescription.		documented in medical record if unable to meet prescribed blood flow. Check dialysate flow rate setting is correct, and the prescribed flow is being delivered Ensure access remains uncovered throughout the treatment. Observe and ensure: Tape is secure. Needles are intact. No bleeding or infiltration is noted. If a patient insists on terminating treatment early and this has not been previously approved by the patient's physician, the patient must take full responsibility for the consequences of the missed or shortened treatment. If a patient requests to leave treatment early: Patients requesting early termination of treatment in an outpatient facility early will be referred to the supervising registered nurse. The registered nurse (RN) will evaluate the patient and discuss with the patient their reasons for requesting to terminate their treatment earlier than prescribed. If the patient’s reasons for terminating the treatment early are due to complications of the treatment such as cramping, discomfort, or anxiety, the RN will discuss these issues with the	

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	On 02/10/24, the ordered BFR was 350. Patient #1's treatment began at 12:27 PM. The first recorded BFR was 400 at 12:34 PM and continued at that rate for the entire treatment without documentation of the reason for the change to the physician-ordered prescription. On 02/13/24, the ordered DFR was 700. Patient #1's treatment began at 12:15 PM. The first recorded DFR was 500 at 1:02 PM and continued at that rate for the remainder of the treatment without documentation of the reason for the change to the physician-ordered prescription. During an interview on 2/22/24 beginning at 4:25 PM, the Administrator indicated the above findings were accurate. 5. Patient #2's clinical record included ICHD Treatment Sheets dated 01/22/24 through 02/21/24 which evidenced the following: On 01/29/24, the ordered DFR was 800. Patient #2's treatment began at 4:53 PM. The first recorded DFR was 800 at 4:57 PM and continued at that rate until 7:06 PM when the DFR was changed to 700 and ran at 700 for the remainder of the treatment without documentation of the reason for the change to the physician-ordered prescription. On 01/31/24, the ordered BFR was 450. Patient #2's treatment began at 5:34 PM with a BFR of 400. The next recorded BFR was 450 at 7:07 PM and continued at that rate until 8:09 PM when the BFR changed to 350 and ran at 350 until 9:34 PM when the BFR changed to 320 and ran at 320 for the remainder of the treatment without documentation of the reason for the change to the physician-ordered prescription.		patient and physician and implement any prescribed measure to alleviate the patient's symptoms. The RN who evaluates the patient must document the rationale for early termination and reinforce the consequences of not receiving the entire prescribed treatment. The RN is responsible for notifying the physician, and document on the "AMA", or Against Medical Advice form. · If the patient frequently requests to end their treatment before the prescribed time, the RN should discuss the patient's reasons for frequently terminating early. Against Medical Advice forms are Signed by the patient and witnessed by the supervising nurse upon completion of the above steps. Signed with each early termination event and filed in the patient's medical record. Tracked, trended, and reported to the QAI committee monthly. There may be times when a patient's transportation is delayed and arrives late for their scheduled time. If a patient arrives after their scheduled time for dialysis treatment, start the patient's treatment as soon as possible.	

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	On 02/07/24, the ordered BFR was 450. Patient #2's treatment began at 5:12 PM with a BFR of 350. The next recorded BFR was 425 at 5:40 PM and continued at that rate until 7:35 PM when the BFR changed to 400 and ran at 400 for the remainder of the treatment without documentation of the reason for the change to the physician-ordered prescription. On 02/09/24, the ordered BFR was 450, and the ordered DFR was 800. Patient #2's treatment began at 4:41 PM. The first recorded BFR was 300 at 4:47 PM. The next recorded BFR was 450 at 5:05 PM and ran at 450 until 7:41 PM when the BFR changed to 425. The BFR ran at 425 for the remainder of the treatment. The first recorded DFR was 800 at 4:47 PM and ran at 800 until 7:03 PM when the DFR was changed to 700. The DFR then ran at 700 for the remainder of the treatment without documentation of the reason for the change to the physician-ordered prescription. On 02/12/24, the ordered BFR was 450, and the ordered DFR was 800. Patient #2's treatment began at 5:32 PM. The first recorded BFR was 300 at 6:07 PM. The next recorded BFR was 450 at 6:43 PM and ran at 450 until 7:04 PM when the BFR changed to 400. The BFR ran at 400 until 7:36 PM when it changed to 350 and ran at 350 until 9:14 PM when it changed to 325. The BFR ran at 325 for the remainder of the treatment. The first recorded DFR was 700 at 6:07 PM and ran at 700 for the remainder of the treatment without documentation of the reason for the change to the physician-ordered prescription. Patient #2's treatment ran for 4 hours and 3 minutes of the prescribed 4 hours and 35 minutes treatment time. An RN note indicated this was due		Staff should do their best to accommodate the patient's prescribed treatment time. If this is not possible due to all stations being filled or impacting facility hours of operation, the physician must be notified to review the time delay and determine the appropriate intervention. § For example, if the treatment was shortened so much as to not provide adequate fluid removal that may take priority over the inconvenience of the next patient and a delay of the next treatment may be necessary or if ordered by the physician an additional treatment may be needed. § Similarly depending on the time delay, if the patient has a history of hyperkalemia, that may also require the delay of the next patient's treatment or if ordered by the physician an additional treatment. The facility staff should make every attempt to assist the patient with rescheduling any lost treatment time. If late arrivals are not due to an atypical problem with the patient's transportation, but rather a habitual behavior consider the following: Discuss the late arrivals with the patient and determine what measures can be done to help the patient arrive on time for scheduled treatments.	

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	to clotting in the venous chamber and elevated venous pressure. The clinical record failed to evidence the physician was notified of the shortened treatment time. On 02/14/24, the ordered BFR was 450, and the ordered DFR was 800. Patient #2's treatment began at 4:59 PM. The first recorded BFR was 350 at 5:03 PM. The next recorded BFR was 450 at 5:08 PM and ran at 450 until 6:07 PM when the BFR changed to 425. The BFR ran at 425 until 7:07 PM when it changed to 400 and ran at 400 for the remainder of the treatment. The first recorded DFR was 800 at 5:03 PM and ran at 800 until 7:39 PM when the DFR was changed to 700. The DFR ran at 700 for the remainder of the treatment without documentation of the reason for the change to the physician-ordered prescription. During an interview on 2/23/24 beginning at 11:55 AM, the Administrator indicated the above findings were accurate. 6. Patient #3's clinical record included ICHD Treatment Sheets dated 01/29/24 through 02/23/24 which evidenced the following: On 01/29/24, the ordered BFR was 400. Patient #3's treatment began at 6:23 PM with a BFR of 300 and ran at 300 until the BFR changed to 400 at 7:04 PM. The BFR ran at 400 for the remainder of the treatment without documentation of the reason for the change to the physician-ordered prescription. The ordered treatment time was 4 hours. Patient #3 was on treatment for 2 hours and 54 minutes. The treatment sheet indicated the reason was late arrival with inability to extend treatment. The clinical record failed to evidence the patient requested to end the treatment early, a reason the		The facility Social Worker should discuss available assistance from community agencies to improve timely attendance. Note: Determine if activities in the patient's personal life are interfering with timely arrival, such as class schedule, work responsibilities, childcare, etc. and evaluate what measures the facility Social Worker and Clinical Manager may take to assist the patient with a schedule that may work better for the patient. Counsel and educate the patient on the effects of shortened treatment. Pursue Interdisciplinary team meetings with patient/family and/or develop a behavioral contract if arriving late becomes habitual. There may be times when a patient's treatment is delayed due to unforeseen circumstances occurring at the dialysis facility such as, equipment breakdown or water issues. Start the patient's treatment as soon as possible. Staff should do their best to accommodate the patient's prescribed treatment time. If this is not possible due to all stations being filled or impacting facility hours of operation, the physician must be notified to review the time delay	

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	treatment ended earlier than scheduled, and/ or physician notification the patient was taken off treatment early. During an interview on 2/23/24 beginning at 4:43 PM, the Administrator indicated the above findings were accurate and indicated Patient #3's treatment was scheduled to end at 9:45 PM had the patient been put on treatment at their assigned chair time, but the treatment ended at 9:18 PM. On 1/31/24, machine settings were checked at 6:59 PM and next checked at 7:55 PM, 56 minutes later. The ordered treatment time was 4 hours. Patient #3 was on treatment for 2 hours and 22 minutes. The treatment sheet indicated the reason was a facility issue. The clinical record failed to evidence the patient requested to end the treatment early, a reason the treatment ended earlier than scheduled, and/ or physician notification that the patient was taken off treatment early. During an interview on 2/23/24 beginning at 4:43 PM, the Administrator indicated the above findings were accurate and indicated Patient #3's treatment was scheduled to end at 9:45 PM had the patient been put on treatment at their assigned chair time, but the treatment ended at 9:19 PM. On 2/02/24, the ordered treatment time was 4 hours. Patient #3 was on treatment for 3 hours and 10 minutes. The treatment sheet indicated the reason was late arrival with inability to extend treatment. The clinical record failed to evidence the patient requested to end the treatment early, a reason the treatment ended earlier than scheduled, and/ or physician notification that the patient was taken off treatment early. During an interview on 2/23/24 beginning at 4:43		and determine the appropriate intervention. § For example, if the treatment was shortened so much as to not provide adequate fluid removal that may take priority over the inconvenience of the next patient and a delay of the next treatment may be necessary or if ordered by the physician an additional treatment may be needed. § Similarly depending on the time delay, if the patient has a history of hyperkalemia, that may also require the delay of the next patient's treatment or if ordered by the physician an additional treatment. The facility staff should make every attempt to assist the patient with rescheduling any lost treatment time (a nearby facility may also be an option). Document in Chairside the specific unexpected end reason that the treatment was shortened. All discussions with the patient, including information or instructions given, and any notification or discussion with the physician, must be documented in the patient's medical record. Complete documentation Early Termination of Treatment Against Medical Advice form. Effective 04/03/24, the Director of Operations or Clinical Manager will conduct 10 treatment sheets	

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	PM, the Administrator indicated the above findings were accurate and indicated Patient #3's treatment was scheduled to end at 9:45 PM had the patient been put on treatment at their assigned chair time, but the treatment ended at 9:17 PM. On 2/05/24, the ordered treatment time was 4 hours. Patient #3 was on treatment for 3 hours and 0 minutes. The treatment sheet indicated the reason was late arrival with inability to extend treatment. The clinical record failed to evidence the patient requested to end the treatment early, a reason the treatment ended earlier than scheduled, and physician notification the patient was taken off treatment early. During an interview on 2/23/24 beginning at 4:43 PM, the Administrator indicated the above findings were accurate and indicated Patient #3's treatment was scheduled to end at 9:45 PM had the patient been put on treatment at their assigned chair time, but the treatment ended at 9:17 PM. On 2/07/24, the ordered treatment time was 4 hours. Patient #3 was on treatment for 3 hours and 10 minutes. The treatment sheet indicated the reason was late arrival with inability to extend treatment. The clinical record failed to evidence the patient requested to end the treatment early, a reason the treatment ended earlier than scheduled, and/ or physician notification the patient was taken off treatment early. During an interview on 2/23/24 beginning at 4:43 PM, the Administrator indicated the above findings were accurate and indicated Patient #3's treatment was scheduled to end at 9:45 PM had the patient been put on treatment at their assigned chair time, but the treatment ended at 9:18 PM.		daily, 3 times per week, alternating shifts, with focus on ensuring all patient treatments are delivered as physician ordered, utilizing Treatment Sheet Audit Tool for 2 weeks and then will complete weekly treatment audits on 10% of completed treatments for an additional 4 weeks. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained	

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	On 2/09/24, the ordered treatment time was 4 hours. Patient #3 was on treatment for 3 hours and 1 minute. The treatment sheet indicated the reason was late arrival with inability to extend treatment. The clinical record failed to evidence the patient requested to end the treatment early, a reason the treatment ended earlier than scheduled, and/ or physician notification the patient was taken off treatment early. During an interview on 2/26/24 beginning at 1:56 PM, the Administrator indicated the above findings were accurate and indicated Patient #3's treatment was scheduled to end at 9:45 PM had the patient been put on treatment at their assigned chair time, but the treatment ended at 9:09 PM. On 2/12/24, the clinical record indicated the machine settings were checked at 8:04 PM and next checked at 9:13 PM, 1 hour and 9 minutes later. The ordered treatment time was 4 hours. Patient #3 was on treatment for 2 hours and 53 minutes. The treatment sheet indicated the reason was late arrival with inability to extend treatment. The clinical record failed to evidence the patient requested to end the treatment early, a reason the treatment ended earlier than scheduled, and/ or physician notification the patient was taken off treatment early. During an interview on 2/26/24 beginning at 1:56 PM, the Administrator indicated the above findings were accurate and indicated Patient #3's treatment was scheduled to end at 9:45 PM had the patient been put on treatment at their assigned chair time, but the treatment ended at 9:16 PM. On 2/14/24, the ordered treatment time was 4		resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024.	

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	152654	A. BUILDING 00 B. WING	02/29/2024

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	hours. Patient #3 was on treatment for 3 hours and 23 minutes. The treatment sheet indicated the reason was late arrival with inability to extend treatment. The clinical record failed to evidence the patient requested to end the treatment early, a reason the treatment ended earlier than scheduled, and/ or physician notification the patient was taken off treatment early. During an interview on 2/26/24 beginning at 1:56 PM, the Administrator indicated the above findings were accurate and indicated Patient #3's treatment was scheduled to end at 9:45 PM had the patient been put on treatment at their assigned chair time, but the treatment ended at 9:21 PM. On 02/16/24, the ordered DFR was manual 700. Patient #3's treatment began at 6:33 PM. The first recorded DFR was 800 at 6:34 PM and continued at that rate for the entire treatment without documentation of the reason for the change to the physician-ordered prescription. The ordered treatment time was 4 hours. Patient #3 was on treatment for 2 hours and 38 minutes. The treatment sheet indicated the reason was late arrival with inability to extend treatment. The clinical record failed to evidence the patient requested to end the treatment early, a reason the treatment ended earlier than scheduled, and/ or physician notification the patient was taken off treatment early. During an interview on 2/26/24 beginning at 1:56 PM, the Administrator indicated the above findings were accurate and indicated Patient #3's treatment was scheduled to end at 9:45 PM had the patient been put on treatment at their assigned chair time, but the treatment ended at 9:11 PM.			

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	On 02/19/24, the ordered DFR was manual 700. Patient #3's treatment began at 6:32 PM with a DFR of 800. The next recorded DFR was 500 at 7:11 PM and continued at that rate for the entire treatment without documentation of the reason for the change to the physician-ordered prescription. The ordered treatment time was 4 hours. Patient #3 was on treatment for 2 hours and 58 minutes. The treatment sheet indicated the reason was late arrival with inability to extend treatment. The clinical record failed to evidence the patient requested to end the treatment early, a reason the treatment ended earlier than scheduled, and physician notification the patient was taken off treatment early. During an interview on 2/26/24 beginning at 1:56 PM, the Administrator indicated the above findings were accurate and indicated Patient #3's treatment was scheduled to end at 9:45 PM had the patient been put on treatment at their assigned chair time, but the treatment ended at 9:30 PM. On 2/21/24, the ordered treatment time was 4 hours. Patient #3 was on treatment for 2 hours and 25 minutes. The treatment sheet indicated the reason was late arrival with inability to extend treatment. The clinical record failed to evidence the patient requested to end the treatment early, a reason the treatment ended earlier than scheduled, and/ or physician notification the patient was taken off treatment early. During an interview on 2/26/24 beginning at 1:56 PM, the Administrator indicated the above findings were accurate and indicated Patient #3's treatment was scheduled to end at 9:45 PM had the patient been put on treatment at their assigned chair time, but the treatment ended at 9:15 PM.			

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	7. During an interview on 2/22/24 at 3:48 PM, the Administrator indicated the physician should be notified if a patient has a shortened treatment time and the patient should be asked to sign an Against Medical Advice (AMA) form if the patient requests to end treatment early. 8. During an interview on 2/22/24 at 4:45 PM, the Administrator indicated the patient's treatment should always be run at the prescribed rate unless there is a problem and further indicated if there was a problem staff should contact the physician to try to troubleshoot why and document the physician notification and interventions on the treatment run sheet. 9. On 2/19/24 at 12:10 PM, entered facility and rang doorbells to both ICHD floor and home therapy. No staff was at the front desk. Rang bell again after a minute with no answer. Three minutes after the doorbells were first rung, the home therapy door was opened for Surveyors. 10. During an interview on 2/23/24 at 4:43 PM, the Administrator indicated there was no staff in the lobby area so there was no way for facility staff to know what time the patient arrived at the facility. 11. On 2/23/24 at 3:02 PM, Person A, who has power of attorney for Patient #3, relayed Patient #3's scheduled chair time was 5:45 PM and that they usually arrived at the facility between 5:35 and 5:40 PM but were occasionally as late as 5:50 PM. Person A indicated some days they would be in the lobby for 10 to 15 minutes before staff would answer the doorbell. Person A indicated no one from the facility had brought up being late for treatments in 2024 so he/ she was under the impression they were on time.			

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	12. During an interview on 2/26/24 beginning at 3:12 PM, PCT 6 relayed they had to take some patients off treatment early on 2/19/24 because everyone had been put on late and the water tanks regenerated at 11:00 PM, so the latest they could run a patient was 10:00 PM. PCT 6 also relayed a patient had consistently been taken off treatment around 9:15 PM because staff had not realized the patient's scheduled chair end time had changed to 9:45 PM until they received a call about it the week prior to the interview.13. During an observation on 02/27/2024 at 2:00 PM, PCT 9 assisted the surveyor in verifying 6 active patients running treatments, the ordered prescriptions versus actual running treatment. 3 of 6 treatments reviewed evidenced the following incorrect prescriptions: Patient #25 sodium physician order was 138, currently running at 144. Bicarbonate physician order was 35, running on 40. Patient #26 Sodium physician order was 140, running on 138. The bicarbonate physician order was 35: running on 38. Patient #27 DFR physician order: 1.5x, currently running 700. 14. The following Treatment Sheets reviewed (02/09/2024-02/19/2024) for Patient #4 failed to evidence that the physician ordered Dialysate Flow Rate (DFR) of 700 and Blood Flow Rates (BFR) of 400 during the following treatments. A 02/12/2024 treatment sheet for Patient #4 evidenced a DFR of 800 for the entire 4-hour hour treatment without documented reason of a change in physician order.			

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	A 02/14/2024 treatment sheet for Patient #4 evidenced a decrease in the BFR to 300 and DFR 600 at 9:04 AM by PCT 5 without documenting notification of the decrease to the Registered Nurse and the reason for a change in physician-ordered prescription. A 02/16/2024 treatment sheet for Patient #4 evidenced a BFR of 350 and a DFR of 800 and 600 during the 4-hour treatment without documenting notification to the Registered Nurse of change or reason for change in the physician-ordered BFR. 02/19/2024 treatment sheet for Patient #4 evidenced a BFR of 350 during the 4-hour treatment without documenting notification to the Registered Nurse or reason of change in physician order. 15. The following Treatment Sheets reviewed (09/25/2023-10/11/2023) for Patient #15 failed to evidence that the physician ordered DFR of 500 was achieved during the following treatments. A 09/25/2023 treatment sheet for Patient #15 evidenced a DFR of 800 for the entire 4-hour treatment without documented reason for a change in physician order. A 10/11/2023 treatment sheet for Patient #15 evidenced a DFR of 800 for the entire 4-hour treatment without documented reason for a change in physician order. 16. During an interview on 02/27/2024 at 9:15 AM, PCT 3 and PCT 7 indicated patients are to run all treatments per physician order, however, sometimes this cannot be met due to circumstances related to the patient's access,			

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	referring to blood flow rates. Staff are to notify the nurse of changes to the prescription and document why the prescription is not being met. Second checks are completed and currently being done after treatment starts to ensure patients are running on the correct prescription. Patient accesses would not affect sodium and bicarbonate prescription errors. 17. During an interview on 02/26/2024 at 11:56 AM, the Administrator indicated that in the case of uncaptured arterial/venous pressures and Dialysate and blood flow rates on the treatment sheet for Patient #4, if the blood pressure is not captured within five minutes of the machine alarming, this information is not captured and recorded on the treatment sheets. The Administrator indicated that staff should be manually entering those values when this happens. 18. During an interview on 02/26/2024 at 1:15 PM, the Administrator was notified of Patient #4's dialysis prescription not being met and late blood pressure checks found on review. The administrator indicated staff should be following physician orders, notifying the RN of changes, and documenting. 19. Patient #5's ICHD treatment sheets, dated 2/02/24 to 2/21/24, were reviewed and evidenced a physician ordered BFR of 400 and DFR of 1.5 Autoflow (600ml/hour), with a total run time of 3 hours 45 minutes during the dialysis treatments. On 2/02/24, the ICHD treatment began at 12:23 PM with a DFR setting of 700 ml/hour for the entire treatment. On 2/05/24, the ICHD treatment began at 12:23 PM with a BFR setting of 350 and DFR setting of 400			

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	ml/hour for the entire treatment. On 2/10/24, the ICHD treatment began at 11:08 AM with a BFR setting of 400, then at 11:32 AM, began a BFR at 350 for the remainder of the treatment. The DFR setting was started at 800 ml/hour, then at 12:01 PM, began DFR at 600 ml/hour for the remainder of the treatment. On 2/12/24, the ICHD treatment began at 12:21 PM with a BFR setting of 350 for the entire treatment. On 2/14/24, the ICHD treatment began at 12:36 PM with a BFR setting of 300 and DFR setting of 500 ml/hour. The BFR and DFR settings were not recorded until 2:34 PM, 1 hour and 58 minutes after treatment began. PCT 5 failed to record BFR and DFR settings during the 1:04 PM, 1:30 PM and 2:00 PM checks. At 2:34 PM, the BFR was 300 and the DFR was 500 ml/hour. PCT 5 failed to record the BFR and DFR setting at the 3:00 PM check. At 3:35 PM, the BFR was 300 and the DFR was 500 ml/hour. The total run time was 3 hours and 6 minutes. The PCT documented the shortened run time reason as unexpected facility issue and failed notify the physician regarding the shortened run time. On 2/16/24, the ICHD treatment began at 12:07 PM with a BFR setting of 400 and DFR setting of 500 ml/hour. At 2:09 PM, the BFR was 350 for the remainder of the treatment and at 12:32 PM, began a DFR of 700 ml/hour for the remainder of the treatment. On 2/21/24, the ICHD treatment began at 12:06 PM with a DFR setting of 800 ml/hour for the entire treatment. During an interview on 2/22/24 beginning at 3:48			

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	PM, the Administrator indicated the above machine settings and run time for Patient #5 were accurate and indicated the clinical record failed to include documentation the physician was notified regarding shortened treatment times. 20. Patient #9's ICHD treatment sheets, dated 1/31/24 to 2/21/24, were reviewed and evidenced a physician ordered BFR of 450 and DFR of 1.5 Autoflow (675 ml/hour), with a total run time of 3 hours 15 minutes during the dialysis treatments. On 1/31/24, the ICHD treatment began at 4:38 PM, 28 minutes after the scheduled start time, with a BFR setting of 350 and a DFR setting of 800 ml/hour. At 5:06 PM, the BFR was changed to 400 for the remainder of the treatment. The total run time was 2 hours and 44 minutes. RN 1 documented the shortened run time reason as unexpected facility issue and failed notify the physician regarding the shortened run time. During an interview on 2/23/24 beginning at 1:09 PM, the Administrator indicated the ESRD facility does not have any records regarding an unexpected facility issue on 1/31/24. On 2/05/24, the ICHD treatment began at 4:09 PM with a BFR setting of 450 and a DFR setting of 300 ml/hour. At 4:44 PM, the DFR setting was 700 ml/hour for the remainder of the treatment. On 2/09/24, the ICHD treatment began at 4:07 PM with a BFR setting of 800 ml/hour for the entire treatment. On 2/12/24, the ICHD treatment began at 4:37 PM, 27 minutes after the scheduled start time, with a BFR setting of 300. At 5:13 PM, the BFR was changed to 400 for the remainder of the treatment.			

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	The total run time was 2 hours and 45 minutes. RN 2 documented the shortened run time reason as unexpected facility issue and failed notify the physician regarding the shortened run time. On 2/19/24, the ICHD treatment began at 4:12 PM with a BFR setting of 250 and a DFR setting of 300 ml/hour. At 4:40 PM, the BFR setting was 450 and the DFR setting was 700 ml/hour for the remainder of the treatment. On 2/21/24, the ICHD treatment began at 4:04 PM with a BFR setting of 175 and a DFR setting of 500 ml/hour. At 5:03 PM, the BFR setting was 400 and the DFR setting was 600 ml/hour for the remainder of the treatment. During an interview on 2/23/24 beginning at 12:29 PM, the Administrator indicated the above machine settings and run times for Patient #9 were accurate and indicated the clinical record failed to include documentation the physician was notified regarding shortened treatment times. 21. Patient #11's ICHD treatment sheets, dated 1/29/24 to 2/21/24, were reviewed and evidenced a physician ordered BFR of 400 and DFR of 800 ml/hour, with a total run time of 3 hours 45 minutes during the dialysis treatments. On 1/29/24, the ICHD treatment began at 3:24 PM with a BFR setting of 250. At 4:06 PM, the BFR was changed to 400 for the remainder of the treatment. On 2/05/24, the ICHD treatment began at 3:54 PM with a BFR setting of 300. At 4:04 PM, the BFR was changed to 400 for the remainder of the treatment.			

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	On 2/07/24, the ICHD treatment began at 4:46 PM, 1 hour and 6 minutes after scheduled start time, with a BFR setting of 350 and a DFR setting of 700 ml/hour. At 5:38 PM, the BFR was 400 and the DFR was 600 ml/hour for the remainder of the treatment. The total run time was 2 hours and 31 minutes. RN 1 documented the shortened run time reason as unexpected facility issue and failed notify the physician regarding the shortened run time. On 2/09/24, the ICHD treatment began at 3:25 PM with a DFR setting of 700 ml/hour. At 4:45 PM, the DFR was 800 ml/hour for the remainder of the treatment. On 2/12/24, the ICHD treatment began at 3:41 PM with a BFR setting of 300. At 5:02 PM, the BFR was 400 for the remainder of the treatment. On 2/14/24, the ICHD treatment began at 5:59 AM with a BFR setting of 400 and a DFR setting of 400 ml/hour. At 8:31 AM, the BFR was 700 ml/hour for the remainder of the treatment. On 2/16/24, the ICHD treatment began at 3:40 PM with a DFR setting of 800 ml/hour. At 4:09 PM, the DFR was at 700 ml/hour. At 6:13 PM, the DFR was at 500 ml/hour for the remainder of the treatment. On 2/19/24, the ICHD treatment began at 3:38 PM with a BFR setting of 300 and a DFR setting of 500 ml/hour. At 4:40 PM, the BFR setting was 400 and the DFR setting was 600 ml/hour for the remainder of the treatment. On 2/21/24, the ICHD treatment began at 3:37 PM with a DFR setting of 500 ml/hour for the duration of the treatment.			

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	During an interview on 2/27/24 beginning at 4:38 PM, the Administrator indicated the above machine settings and run times for Patient #11 were accurate and indicated the clinical record failed to include documentation the physician was notified regarding shortened treatment times. 22. Patient #12's ICHD treatment sheets, dated 1/31/24 to 2/21/24, were reviewed and evidenced a physician ordered BFR of 400 and DFR of 2.0 Autoflow (800 ml/hour), with a total run time of 4 hours during the dialysis treatments. On 1/31/24, the ICHD treatment began at 4:58 PM. The BFR setting was 250 and the DFR setting was 800 ml/hour. At 7:02 PM, the BFR setting was 400 and the DFR setting was 700 ml/hour for the remainder of the treatment. On 2/07/24, the ICHD treatment began at 5:10 PM, 45 minutes after the scheduled time. The DFR setting was 800 ml/hour. At 6:02 PM, the DFR setting was 700 ml/hour for the remainder of the treatment. The total run time was 3 hours and 35 minutes. RN 1 documented the shortened run time reason as unexpected facility issue and failed notify the physician regarding the shortened run time. On 2/09/24, the ICHD treatment began at 4:33 PM. The BFR setting was 400 and the DFR setting was 800 ml/hour. At 5:04 PM, the DFR setting was 500 ml/hour for the remainder of the treatment. On 2/12/24, the ICHD treatment began at 4:58 PM, 23 minutes after the scheduled time. The BFR setting was 300 and the DFR setting was 600 ml/hour for the duration of the treatment. The total run time was 3 hours and 42 minutes. RN 2 documented the shortened run time reason as			

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	unexpected system problems / technical difficulties (Non-Pt related) and failed notify the physician regarding the shortened run time. On 2/19/24, the ICHD treatment began at 4:36 PM. The BFR setting was 400 and the DFR setting was 800 ml/hour. At 5:33 PM, the BFR was 375 and at 7:11 PM the BFR was 400 for the remainder of the treatment. At 7:40 PM, the DFR was 700 ml/hour and at 8:01 PM, the DFR was 500 ml/hour for the remainder of the treatment. On 2/21/24, the ICHD treatment began at 4:36 PM. The BFR setting was 300 for the duration of the treatment. During an interview on 2/23/24 beginning at 11:43 AM, the Administrator indicated the above machine settings and run times for Patient #12 were accurate and indicated the clinical record failed to include documentation the physician was notified regarding shortened treatment times. 23. Patient #13's ICHD treatment sheets, dated 1/29/24 to 2/21/24, were reviewed and evidenced a physician ordered BFR of 400 and DFR of 2.0 Autoflow (800 ml/hour), with a total run time of 4 hours and 45 minutes during the dialysis treatments. On 1/29/24, the ICHD treatment began at 3:11 PM. The BFR setting was 400 and the DFR setting was 300 ml/hour. At 3:35 PM, the DFR setting was 800 ml/hour. At 4:07 PM, the DFR setting was 700 ml/hour for the remainder of the treatment. At 4:47 PM, the BFR setting was 350 for the remainder of the treatment. The total run time was 4 hours and 16 minutes. RN 1 documented the shortened run time reason as unexpected, other* and failed to notify the physician regarding the shortened run			

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FRESENIUS MEDICAL CARE FISHERS	13648 OLIVIA WAY FISHERS, IN 46037

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	time. On 1/31/24, the ICHD treatment began at 3:00 PM. The BFR setting was 350 and the DFR setting was 600 ml/hour. At 4:42 PM, the BFR setting was 375 and the DFR setting was 700 ml/hour. At 6:08 PM, the DFR setting was 800 ml/hour. At 6:39 PM, the BFR setting was 300 for the remainder of the treatment and the DFR setting was 700 ml/hour. At 7:08 PM, the DFR setting was 600 ml/hour. The total run time was 4 hours and 26 minutes. RN 1 documented the shortened run time reason as an unexpected facility issue and failed to notify the physician regarding the shortened run time. On 2/02/24, the ICHD treatment began at 2:36 PM. The BFR setting was 400 and the DFR setting was 800 ml/hour. At 6:35 PM, the BFR setting was 375 for the remainder of the treatment. On 2/05/24, the ICHD treatment began at 3:59 PM, 54 minutes after the scheduled time. The BFR setting was 400 and the DFR setting was 300 ml/hour. At 4:05 PM, the DFR setting was 500 ml/hour for the remainder of the treatment. The total run time was 4 hours and 2 minutes. RN 1 documented the shortened run time reason as an unexpected facility issue and failed to notify the physician regarding the shortened run time. On 2/07/24, t he ICHD treatment began at 3:19 PM, 14 minutes after the scheduled time. The BFR setting was 350 and the DFR setting was 700 ml/hour. At 3:49 PM, the BFR setting was 400 and the DFR setting was 800 ml/hour for the remainder of the treatment. The total run time was 4 hours and 8			

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	minutes. RN 1 documented the shortened run time reason as an unexpected facility issue and failed to notify the physician regarding the shortened run time.On 2/09/24, the ICHD treatment began at 2:42 PM. The BFR setting was 400 and the DFR setting was 700 ml/hour. At 3:31 PM, the BFR setting was 350. At 4:01 PM, the BFR setting was 400 and the DFR setting was 800 ml/hour for the remainder of the treatment.On 2/12/24, the ICHD treatment began at 2:56 PM. The BFR setting was 400 and the DFR setting was 800 ml/hour. At 3:44 PM, the BFR setting was 300 and the DFR setting was 700 ml/hour. At 7:03 PM, the BFR setting was 375 for the remainder of the treatment. The total run time was 4 hours and 25 minutes. RN 1 documented the shortened run time reason as an unexpected patient request and failed to notify the physician regarding the shortened run time. The clinical record failed to evidence an Against Medical Advice (AMA) form was signed by Patient #13. On 2/14/24, the ICHD treatment began at 3:11 PM. The BFR setting was 400 and the DFR setting was 800 ml/hour. At 6:31 PM, the BFR setting was 375 and the DFR setting was 800 for the remainder of the treatment. The total run time was 3 hours and 48 minutes. RN 1 documented the shortened run time reason as an unexpected			

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	patient request and failed to notify the physician regarding the shortened run time. The clinical record failed to evidence an Against Medical Advice form was signed by Patient #13. On 2/16/24, the ICHD treatment began at 2:48 PM. The BFR setting was 400 and the DFR setting was 800 ml/hour. At 4:07 PM, the BFR setting was 350 and the DFR setting was 700 ml/hour. At 4:35 PM, the BFR setting was 400 and the DFR setting was 800 ml/hour. At 6:13 PM, the BFR setting was 300 and the DFR setting was 600 ml/hour for the remainder of the treatment.On 2/19/24, the ICHD treatment began at 3:21 PM. The BFR setting was 300 and the DFR setting was 300 ml/hour. At 3:36 PM, the BFR setting was 400 and the DFR setting was 600 ml/hour. At 7:37 PM, the BFR setting was 350 and the DFR setting was 600 ml/hour for the remainder of the treatment.On 2/21/24, the ICHD treatment began at 2:49 PM. The BFR setting was 400 and the DFR setting was 800 ml/hour. At 4:01 PM, the BFR setting was 335 and the DFR setting was 700 ml/hour for the remainder of the treatment.During an interview on 2/28/24 beginning at 3:20 PM, the Administrator indicated the above machine settings and run times for Patient #13 were accurate and indicated the clinical record failed to include documentation the			

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	physician was notified regarding shortened treatment times. 24. Patient #14's ICHD treatment sheets, dated 1/29/24 to 2/21/24, were reviewed and evidenced a physician ordered BFR of 400 and DFR of 700 ml/hour, with a total run time of 4 hours during the dialysis treatments.On 1/29/24, the ICHD treatment began at 3:09 PM. The BFR setting was 400 and the DFR setting was 700 ml/hour. At 6:27 PM, the BFR setting was 350 for the remainder of the treatment.On 1/31/24, the ICHD treatment began at 4:07 PM, 52 minutes after the schedule time. The BFR setting was 400 and the DFR setting was 700 ml/hour for the duration of the treatment. The total run time was 3 hours and 27 minutes. RN 1 documented the shortened run time reason as an unexpected facility issue and failed to notify the physician regarding the shortened run time.On 2/02/24, the ICHD treatment began at 3:07 PM. The BFR setting was 250 and the DFR setting was 800 ml/hour. At 4:02 PM, the BFR setting was 400 and the DFR setting was 700 ml/hour. At 6:08 PM, the BFR setting was 350 and the DFR setting was 600 ml/hour. At 6:34 PM, the BFR setting was 300 and the DFR setting was 600 ml/hour. At 7:02 PM, the BFR setting was 400 for the remainder of the treatment. On 2/07/24, the ICHD treatment began at 3:56 PM. The BFR setting was			

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	400 and the DFR setting was 800 ml/hour for the duration of the treatment. The total run time was 3 hours and 34 minutes. RN 1 documented the shortened run time reason as an unexpected facility issue and failed to notify the physician regarding the shortened run time.On 2/09/24, the ICHD treatment began at 3:30 PM. The BFR setting was 350 and the DFR setting was 800 ml/hour for the duration of the treatment.On 2/12/24, the ICHD treatment began at 4:01 PM. The BFR setting was 400 and the DFR setting was 800 ml/hour. RN 5 failed to record the BFR/DFR settings at the 4:30 PM routine check. At 5:16 PM, the BFR setting was 300. At 6:06 PM, the BFR setting was 350. At 6:42 PM, the BFR setting was 300 and the DFR setting was 700 ml/hour for the remainder of the treatment.On 2/16/24, the ICHD treatment began at 3:27 PM. The BFR setting was 350 and the DFR setting was 600 ml/hour. At 4:35 PM, the BFR setting was 300 and the DFR setting was 500 ml/hour. For the remainder of the treatment.During an interview on 2/28/24 beginning at 2:55 PM, the Administrator indicated the above machine settings and run times for Patient #14 were accurate and indicated the clinical record failed to include documentation the physician was notified regarding shortened treatment times. 25. Patient #20's ICHD treatment sheets, dated			

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	1/29/24 to 2/21/24, were reviewed and evidenced a physician ordered BFR of 400 and DFR of 500 ml/hour, with a total run time of 3 hours and 30 minutes during the dialysis treatments.On 1/29/24, the ICHD treatment began at 5:49 AM. The BFR setting was 300 and the DFR setting was 800 ml/hour. At 6:35 AM, the BFR setting was 400 and the DFR setting was 800 ml/hour for the remainder of the treatment. The total run time was 1 hour and 57 minutes. RN 2 documented the shortened run time reason as an unexpected patient request, Against Medical Advice and documented the AMA form was completed. RN 2 failed to notify the physician regarding the shortened run time and the clinical record failed to evidence a completed AMA form.On 1/31/24, the ICHD treatment began at 5:35 AM. PCT 2 failed to record the BFR and DFR settings until 6:32 AM, 57 minutes after the treatment began. On 2/02/24, the ICHD treatment began at 5:51 AM. The BFR setting was 400 and the DFR setting was 500 ml/hour. At 6:54 AM, the BFR setting was 350 for the remainder of the treatment. The total run time was 1 hour and 5 minutes. RN 7 documented the shortened run time reason as an unexpected patient request, Against Medical Advice and documented the AMA form was completed. RN 7 failed to notify the physician regarding			

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	the shortened run time and the clinical record failed to evidence a completed AMA form.On 2/07/24, the ICHD treatment began at 5:32 AM. The BFR setting was 400 and the DFR setting was 800 ml/hour. At 6:02 AM, the DFR setting was 500 for the remainder of the treatment. At 7:04 AM, the BFR setting was 350 for the remainder of the treatment. On 2/09/24, the ICHD treatment began at 7:12 AM, 1 hour and 37 minutes after scheduled time. The BFR setting was 350 and the DFR setting was 500 ml/hour for the duration of the treatment. The total run time was 2 hours and 53 minutes. RN 4 documented the shortened run time reason as an unexpected patient request. RN 4 failed to notify the physician regarding the shortened run time.On 2/12/24, the ICHD treatment began at 5:36 AM. The BFR setting was 300 and the DFR setting was 800 ml/hour. At 6:32 AM, the BFR setting was 400 and the DFR setting was 800 ml/hour for the remainder of the treatment.On 2/14/24, the ICHD treatment began at 5:37 AM. The clinical record failed to evidence BFR and DFR settings recorded at the start of the treatment. At 6:15 AM, the BFR setting was 405 and the DFR setting was 800 ml/hour. At 7:36 AM, the BFR setting was 300. At 8:23 AM, the BFR setting was 400 for the remainder of the treatment. The total run			

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	time was 2 hours and 47 minutes. RN 2 documented the shortened run time reason as an unexpected patient request. RN 2 failed to notify the physician regarding the shortened run time.On 2/16/24, the ICHD treatment began at 5:38 AM. The BFR setting was 400 and the DFR setting was 800 ml/hour. At 6:13 AM, the BFR setting was 400 and the DFR setting was 700 ml/hour for the remainder of the treatment. The total run time was 2 hours and 31 minutes. RN 2 documented the shortened run time reason as an unexpected patient request. RN 2 failed to notify the physician regarding the shortened run time.On 2/19/24, the ICHD treatment began at 7:06 AM, 1 hour and 31 minutes after scheduled time. The BFR setting was 300 and the DFR setting was 500 ml/hour. At 7:32 AM, the BFR setting was 400 and the DFR setting was 500 ml/hour for the remainder of the treatment. The total run time was 2 hours and 18 minutes. RN 4 documented the shortened run time reason as an unexpected patient request. RN 4 failed to notify the physician regarding the shortened run time.On 2/21/24, the ICHD treatment began at 5:54 AM. The BFR setting was 400 and the DFR setting was 800 ml/hour for the duration of the treatment. The total run time was 2 hours and 7 minutes. RN 3 documented the shortened run time reason			

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	as an unexpected patient request, Against Medical Advice and documented the AMA form was completed. RN 3 failed to notify the physician regarding the shortened run time and the clinical record failed to evidence a completed AMA form.During an interview on 2/27/24 beginning at 4:50 PM, the Administrator indicated the above machine settings and run times for Patient #20 were accurate and indicated the clinical record failed to include documentation the physician was notified regarding shortened treatment times. 26. During an interview on 2/23/24 beginning at 1:09 PM, the Administrator indicated the ESRD facility does not have any records regarding any unexpected facility issues on 1/31/24, 2/07/24, 2/12/24 or 2/14/24.			
V 0546 Bldg. 00	494.90(a)(3) POC-MANAGE MINERAL METABOLISM Provide the necessary care to manage mineral metabolism and prevent or treat renal bone disease. Based on record review and interview, the registered nurse (RN) failed to administer Vitamin D medication as prescribed for 2 of 7 active clinical records reviewed with Vitamin D ordered (Patient #14 and #20). Findings include: 1. A policy titled, "Staff Registered Nurse', indicated but was not limited to, "Enforces all company approved policies and procedures, as well as regulations set forth by state and federal	V 0546	**V546** On 04/02/2024, the Director of Operations and Education Coordinator held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy and procedure: Physician Order Documentation Staff Registered Nurse Emphasis was placed on: Nurse practice acts require nurses	04/05/2024

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	agencies and departments ... Administers medications as prescribed or in accordance with approved algorithm(s) and documents appropriate medical justification if indicated." 2. A policy titled, "Physician Order Documentation" indicated but was not limited to, "Nurse practice acts require nurses to carry out ... medication administration ... based on physician order." 3. Patient #14's hemodialysis treatment sheets, dated 1/29/2024 to 2/21/2024, were reviewed and evidenced a physician order for Vitamin D 0.25 mcg oral to be administered before every dialysis treatment. On 1/29/2024, the ICHD treatment began at 3:09 PM; Vitamin D was administered at 3:24 PM, 15 minutes after treatment began. On 1/31/2024, the ICHD treatment began at 4:07 PM; Vitamin D was administered at 7:35 PM, 3 hours and 28 minutes after treatment began. On 2/02/2024, the ICHD treatment began at 3:07 PM; Vitamin D was administered at 3:24 PM, 23 minutes after treatment began. On 2/05/2024, the ICHD treatment began at 3:14 PM; Vitamin D was administered at 5:25 PM, 2 hours and 9 minutes after treatment began. On 2/07/2024, the ICHD treatment began at 3:56 PM; Vitamin D was administered at 5:23 PM, 1 hour and 27 minutes after treatment began. On 2/09/2024, the ICHD treatment began at 3:30 PM; Vitamin D was administered at 3:50 PM, 20 minutes after treatment began.		to carry out treatment care, Medication administration, lab tests, procedures, and other treatments, based on physician orders. These orders can be entered electronically, given by telephone, or by facsimile if allowed by state law. Providing service without physician orders is in violation of nurse practice acts. Other disciplines such as dietitians are required to follow their scope of practice according to state law. Effective 04/03/24, the Director of Operations or Clinical Manager will conduct 10 treatment sheets daily, 3 times per week, alternating shifts, with focus on ensuring all patient medication prescriptions are followed (i.e. vitamin D medication), as prescribed by physician, utilizing Treatment Sheet Audit Tool for 2 weeks and then will complete weekly treatment audits on 10% of completed treatments for an additional 4 weeks. The Governing Body will determine on-going frequency of the audits based on compliance. Once Compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review	

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	On 2/12/2024, the ICHD treatment began at 4:01 PM; Vitamin D was administered at 7:28 PM, 3 hours and 27 minutes after treatment began. On 2/14/2024, the ICHD treatment began at 3:43 PM; Vitamin D was administered at 3:55 PM, 12 minutes after treatment began. On 2/16/2024, the ICHD treatment began at 3:27 PM; Vitamin D was administered at 3:42 PM, 15 minutes after treatment began. On 2/19/2024, the ICHD treatment began at 3:29 PM. Vitamin D was administered at 7:15 PM, 3 hours and 46 minutes after treatment began. On 2/21/2024, the ICHD treatment began at 3:15 PM; Vitamin D was administered at 3:36 PM, 21 minutes after treatment began. During an interview on 2/28/2024 beginning at 2:55 PM, the Administrator indicated the above Vitamin D administration times were accurate for Patient #14 and indicated the Vitamin D should have been administered prior to treatment per the order. 4. Patient #20's hemodialysis treatment sheets, dated 1/29/2024 to 2/21/2024, were reviewed and evidenced a physician order for Vitamin D 0.25 mcg oral to be administered before every dialysis treatment. On 1/29/2024 the ICHD treatment began at 5:49 AM; Vitamin D was administered at 6:00 AM, 11 minutes after treatment began. On 1/31/2024, the ICHD treatment began at 5:35 AM; Vitamin D was administered at 6:55 AM, 1		the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the	

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	hour and 20 minutes after treatment began. On 2/02/2024, the ICHD treatment began at 5:51 AM; Vitamin D was administered at 5:55 AM, 4 minutes after treatment began. On 2/05/2024, the ICHD treatment began at 5:55 AM; Vitamin D was administered at 6:22 AM 27 minutes after treatment began. On 2/07/2024, the ICHD treatment began at 5:32 AM; Vitamin D was administered at 6:04 AM, 32 minutes after treatment began. On 2/09/2024, the ICHD treatment began at 7:12 AM; Vitamin D was administered at 7:23 AM, 11 minutes after treatment began. On 2/12/2024, the ICHD treatment began at 5:36 AM; Vitamin D was administered at 5:41 AM, 5 minutes after treatment began. On 2/14/2024, the ICHD treatment began at 5:37 AM; Vitamin D was administered at 6:37 AM, 1 hour after treatment began. On 2/16/2024, the ICHD treatment began at 5:38 AM; Vitamin D was administered at 6:23 AM, 45 minutes after treatment began. On 2/19/2024, the ICHD treatment began at 7:06 AM; Vitamin D was administered at 7:14 AM, 8 minutes after treatment began. On 2/21/2024, the ICHD treatment began at 5:54 AM; Vitamin D was administered at 6:05 AM, 9 minutes after treatment began. During an interview on 2/28/2024 beginning at 2:50 PM, the Administrator indicated the above		issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024.	

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	Vitamin D administration times were accurate for Patient #20 and indicated the Vitamin D should have been administered prior to treatment per the order.			
V 0550 Bldg. 00	494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement. Based on observation, record review, and interview, the facility failed to ensure infection control practices were maintained in 2 of 2 observations of a fistula/graft cannulation (Patient #7 & Patient #9) and failed to ensure patient access sites remained visible during 2 of 2 treatment center observation periods (Patient #6, #30, #31 and #32). Findings include: 1. A policy titled, "Access Assessment and Cannulation" indicated but was not limited to, "Disinfect cannulation site as follows: ... 70% isopropyl alcohol pad: using gentle friction, clean the access site beginning in the center and continuing outward 2 inches in a concentric circle for 30 seconds and allow to dry before cannulating ... Povidone Iodine pad ... 30 seconds ... 2% Chlorhexidine and 70% alcohol ... 30 seconds."	V 0550	**V550** On 04/02/2024, the Director of Operations and Education Coordinator held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy and procedure: Access Assessment and Cannulation Patient Assessment and Monitoring Emphasis was placed on: Disinfect cannulation site as follows using any of the disinfectants below: 70% isopropyl alcohol pad: Using gentle friction, clean the access site beginning in the center and continuing outward 2 inches in a concentric circle for 30 seconds and allow to dry before	04/05/2024

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	2. A policy titled, "Patient Assessment and Monitoring" indicated but was not limited to, "Access: Observe connections are secure and visible ... Ensure access remains uncovered throughout the treatment." 3. On 2/19/2024 at 12:20 PM, Patient #6 and Patient #30 were observed with access sites covered. 4. On 2/19/2024 at 3:57 PM, Patient #31 and Patient #32 were observed with access sites covered. 5. On 2/19/2024 at 12:31 PM, PCT 1 was observed accessing Patient #7's fistula or graft. PCT 1 disinfected Patient #7's first cannulation site for 20 seconds and then disinfected the second cannulation site for 15 seconds. PCT 1 failed to disinfect each cannulation site for at least 30 seconds. 6. On 2/19/2024 at 3:59 PM, Patient #9 was observed cleansing their left arm fistula access sites simultaneously for 38 seconds. Once dry, PCT 3 performed cannulation to Patient #9's fistula. PCT 3 failed to cleanse Patient #9's second access site prior to cannulation. During an interview on 2/23/2024 beginning at 1:30 PM, the Administrator indicated the clinical record failed to include documentation that Patient #9 had been trained to perform self-cleaning of the access sites. 7. During an interview on 2/22/2024 beginning at 4:25 PM, the Administrator indicated access sites should never be covered during treatment. 8. During an interview on 2/19/2024 beginning at 5:38 PM, the Administrator indicated each fistula/graft access site should be disinfected for		cannulating. 2% Chlorhexidine and 70% alcohol: Work outward 2 inches in a concentric circle using gentle back and forth friction to clean for a minimum 30 seconds and allow to dry before cannulating. Perform skin antisepsis on one site at a time, allow to dry and then cannulate. Do not touch cannulation sites after skin disinfection. Note: This method minimizes the risk of contaminating the second site while cannulating the first site Observe cannulation site for any reaction to antimicrobial solution. Observe connections are secure and visible. If an external catheter is in use, observe and document that the HemaClip device is in place. · Ensure access remains uncovered throughout the treatment Observe and ensure: Tape is secure Needles are intact No bleeding or infiltration is noted Effective 04/03/2024, Director of Operations or Clinical Manager will conduct infection control audits 3 times per week, with alternating shifts with focus on ensuring infection control practices are maintained for cannulation of a fistula/graft, and all patient access	

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	at least 30 seconds before cannulation. 9. During an interview on 2/20/2024 at 5:08 PM, the Administrator indicated that if the patient is disinfecting their own access site, they have to follow the facility's policy for disinfecting access sites.		sites remained uncovered during treatment, utilizing Infection Control Monitoring Tool for 2 weeks and then 2 times per week for an additional 4 weeks. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause	

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			analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024.	
V 0556 Bldg. 00	494.90(b)(1) POC-COMPLETED/SIGNED BY IDT & PT The patient's plan of care must- (i) Be completed by the interdisciplinary team, including the patient if the patient desires; and (ii) Be signed by the team members, including the patient or the patient's designee; or, if the patient chooses not to sign the plan of care, this choice must be documented on the plan of care, along with the reason the signature was not provided. Based on record review and interview, the dialysis facility failed to ensure the Plan of Care (POC) was signed by the patient in 11 of 11 active in-center hemodialysis patient records reviewed (Patient #1,	V 0556	**V556** On 04/02/2024, the Director of Operations and Education Coordinator held a staff meeting	04/05/2024

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	#2, #3, #4, #5, #9, #11, #12, #13, #14, #20). Findings include: 1. A policy titled, "Comprehensive Interdisciplinary Assessment and Plan of Care" indicated but was not limited to, "The patient must sign the plan of care meant to acknowledge the information in the plan. If the patient chooses not to sign their plan of care, the reason for refusal must be documented in the patient's medical record." 2. A policy titled, "Comprehensive Interdisciplinary Assessment and Plan of Care" indicated but was not limited to, "The patient must sign the plan of care meant to acknowledge the information in the plan. If the patient chooses not to sign their plan of care, the reason for refusal must be documented in the patient's medical record." 3. The Plan of Care for Patient #4 dated 01/30/2024 failed to evidence a patient signature. 4. During an interview on 02/26/2024 at 1:15 PM, the Administrator was unable to provide a signed plan of care for Patient #4 and further indicated that the Patient plan of care has not been reviewed with or signed by any patients for more than a year.5. Patient #1's clinical record included a POC, last revised 12/27/2023. The POC failed to evidence Patient #1's POC approval signature. 6. Patient #2's clinical record included a POC, last revised 06/27/2023. The POC failed to evidence Patient #2's POC approval signature. 7. Patient #3's clinical record included a POC, last revised 04/25/2023. The POC failed to evidence		and reinforced the expectations and responsibilities of the facility staff on policy and procedure: Comprehensive Interdisciplinary Assessment and Plan of Care Emphasis was placed on: The interdisciplinary team must ensure the patient signs the completed plan of care after the meeting, or as soon as possible if not held in person. The following are recommendations for involving the patient in the development and review of the Plan of Care: Provide appropriate patient education to enable the patient to participate in the development of the Plan of Care. Encourage both patient and family to participate in the Plan of Care discussions in whatever format the facility and attending physician develop. Notify the patient in writing of the time and date of the Plan of Care review. Review expectation for participation in the Plan of Care with each patient. Review this expectation again when Rights and Responsibilities are reviewed. On 04/03/2024 the facility reviewed 100% of all In Center and Home patients Plan of Care. Any patients care plan not completed	

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	Patient #3's POC approval signature.8. The review of Patient #5's clinical record included a POC, last revised 3/21/2023. The POC failed to evidence Patient #5's POC approval signature. 9. The review of Patient #9's clinical record included a POC, last revised 7/25/2023. The POC failed to evidence Patient #9's POC approval signature. 10. The review of Patient #11's clinical record included a POC, last revised 8/09/2023. The POC failed to evidence Patient #11's POC approval signature. 11. The review of Patient #12's clinical record included a POC, last revised 1/23/2024. The POC failed to evidence Patient #12's POC approval signature. 12. The review of Patient #13's clinical record included a POC, last revised 3/15/2023. The POC failed to evidence Patient #13's POC approval signature. 13. The review of Patient #14's clinical record included a POC, last revised 7/18/2023. The POC failed to evidence Patient #14's POC approval signature. 14. The review of Patient #20's clinical record included a POC, last revised 7/25/2023. The POC failed to evidence Patient #20's POC approval signature. 15. During an interview on 2/27/2024, beginning at 1:09 PM, the Medical Director indicated all patient POC's are reviewed with the patient and should be signed by the patient.		per policy; facility scheduled to re-do patient care plan within 30 days. Effective 04/03/2024 the Director of Operations will audit monthly to ensure all patients who had a plan of care meeting within that month, signed their plan of care for 4 months or until 100% compliance is achieved utilizing Plan of Correction Monitoring Tool. Once compliance is sustained, the Governing Body will decrease frequency to resume regularly scheduled audits based on the QAI calendar. Monitoring will be done through the medical record audit with any non-compliance noted in the meeting minutes in eQUIP. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the	

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	16. During an interview on 2/28/2024 beginning at 3:35 PM, the Administrator indicated the clinical records for Patient's #5, 9, 11, 12, 13, 14 and 20 failed to include POC's that had been signed by the patient.		sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024.	
V 0681 Bldg. 00	494.140 PQ-STAFF LIC AS REQ/QUAL/DEMO COMPETENCY All dialysis facility staff must meet the applicable scope of practice board and licensure requirements in effect in the State in which they are employed. The dialysis facility's staff (employee or contractor) must			

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	meet the personnel qualifications and demonstrated competencies necessary to serve collectively the comprehensive needs of the patients. The dialysis facility's staff must have the ability to demonstrate and sustain the skills needed to perform the specific duties of their positions. Based on record review and interview the facility failed to ensure contracted staff personnel files included a skills checklist for 2 of 2 agency staffing Registered Nurses. (RN 1 & RN 3) Findings Include: 1. The personnel record for RN 1 failed to evidence a skills check-off for duties/responsibilities assigned to a staff nurse. Included in the personnel file was a self-rated assessment completed by RN 1's assessing his/her abilities. 2. The personnel record for RN 3 failed to evidence a skills check-off for duties/responsibilities assigned to a staff nurse. Included in the personnel file was a self-rated assessment completed by RN 3's assessing his/her abilities. 3. A document titled, "Healthcare Staffing Hire Skills Checklist by Healthcare Staffing Hire" indicated that RN 1 completed a self-assessment of dialysis-related skills. 4. During an interview on 02/28/2024, the Administrator agreed that the skills check-off for RN 1 included in the agency-provided personnel file only included a self-assessment of skills. Further indicated that this information would be sent to education, reviewed, and if found not to be sufficient, further training and education would	V 0681	**V681** On 04/02/2024, the Director of Operations and Education Coordinator held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy and procedure: Progressive Renal Education Program (PREP) Orientation for Inexperienced New Employees Healthcare staffing hire skills checklist by healthcare staffing hire Emphasis was placed on: New employees performing direct patient care, ancillary, and biomedical services must complete the FKC standardized new employee orientation program. PREP provides the new employee: An initial and ongoing assessment of their knowledge and skills is essential for a highly functional and well-trained workforce. Both classroom setting and clinical time to apply their knowledge. An educational foundation	04/05/2024

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	be provided to that staff member. 5. During an interview on 02/28/2024 at 1:30 PM, the Administrator indicated the information provided to the surveyors for RN 1 was inclusive of all the staffing agency sent. No additional information was able to be provided from the facility personnel file. The Administrator indicated that personnel files for RN 1 were not kept by the facility and would need to be obtained from the source, clarifying the source was the staffing agency. 6. During an interview on 02/29/2024 at 2:29 PM, the Administrator indicated that the facility did not have any policies regarding contracted staff. 7. During an interview on 2/29/2024 beginning at 11:08 AM, the Administrator indicated the personnel file for RN 3 was missing the skills competency check-off's, water room check-off's, orientation to the ESRD facility and the employment contract.		necessary for cultivation of their individual potential. The topics covered in PREP orientation are required by CMS Conditions for Coverage, state specific regulations, and specific job descriptions, and include: Fresenius Kidney Care organizational structure End stage renal disease, acute kidney injury, and chronic kidney disease concepts. Review of the appropriate Human Resources policies and procedures Role-specific employee training The content will be delivered using various methods which may include: Classroom sessions Study guides. Training materials Interactive distance learning Self-directed e-learning activities Activities in the classroom and in the clinical practice setting Success will be measured through: Demonstration of applied learning Successfully passing exams with a score of at least 80%* Successful completion of the skills competency assessment Observed engagement	

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			when applicable. Documented graduation from PREP orientation On 04/03/2024, the Director of Operations reviewed 100% of all clinical staff currently working at the facility to ensure a required clinical skills checkoff was performed and employee successfully passed. Employee records available upon request at the facility for review. Effective 04/03/24, the Director of Operations will conduct monthly audit with focus on ensuring all clinical staff performing patient care has a clinical skills checkoff completed, as required, utilizing Personnel Tracker Audit Tool for 3 months and then an additional 3 months. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to	

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			the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024	
V 0684 Bldg. 00	494.140(b)(1) PQ-NURSE MANAGER-12 MO RN+6 MO DIALYSIS (1) Nurse manager. The facility must have a nurse manager responsible for nursing			

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	services in the facility who must- (i) Be a full time employee of the facility; (ii) Be a registered nurse; and (iii) Have at least 12 months of experience in clinical nursing, and an additional 6 months of experience in providing nursing care to patients on maintenance dialysis. Based on record review and interview, the dialysis facility failed to ensure the facility had a nurse manager responsible for nursing services in the facility and was a full-time employee of the facility for 1 of 1 facility. Findings include: 1. The Clinical Manager job description included but not limited to the following responsibilities: accountable for quality of patient care by ensuring all facility policies and procedures are commuted to and followed by staff; implement appropriate training; maintain integrity of medical records; maintain facility environmental integrity, including safety; coordinate all aspects of patient care from admission through discharge; directs initiation, maintenance, and communication of efficient and timely patient schedules; is aware of and develops a mechanism or process for knowing the specific situation of each patient, including hospitalizations, no-shows, catheter use, and any significant change in patient care status; develop action plans for unexcused and missed treatments in collaboration with the Medical Director; responsible for appropriate training of all patient care staff according to facility policy; responsible for overseeing the performance of all licensed and direct patient care staff and provide guidance and feedback related to performance; create, maintain, and communicate efficient and timely employee schedules according to the needs of the facility;	V 0684	**V684** On 04/02/2024, the Director of Operations and Education Coordinator held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy and procedure: Clinical Manager Job Description Emphasis was placed on: Facility will ensure a full-time nurse manager on site to provide oversight and responsible for nursing services. On 03/04/2024, the facility appointed a full-time employee as Clinical Manager. The Clinical Manager is on site Monday through Friday to provide oversight and be responsible for nursing services. Effective 04/03/24, the Director of Operations will conduct monthly audit with focus on ensuring Clinical Manager is in place for oversight of all nursing services for facility, as required, utilizing Personnel Tracker Audit Tool for 3 months and then an additional 3 months. The Governing Body will	04/05/2024

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	ensure regular and effective communication with all physicians; responsible for the integrity and safety of the facility water system; and accountable for the completion of the annual standing order review. 2. The Key Personnel list provided by the Administrator on 2/20/2024 had no name listed next to Clinical Manager. 3. On 2/20/2024 at 4:58 PM, the Administrator was asked who the Clinical Manager was. The Administrator relayed the Alternate Administrator was the Facility Administrator. 4. During an interview on 2/24/2024 beginning at 4:25 PM, the Administrator was again asked who the facility's Clinical Manager was. The Administrator indicated a new Charge Nurse had been hired for the facility and was scheduled to start working at the facility on 3/04/2024. 5. On 2/27/2024 at 2:28 PM, the Administrator relayed the last person to be employed as Clinical Manager at the facility was Corporate Person 1, whose last day as Clinical Manager at the facility was 7/08/2023.		determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written	

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FRESENIUS MEDICAL CARE FISHERS	13648 OLIVIA WAY FISHERS, IN 46037

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			to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024	
V 0710 Bldg. 00	Based on observation, record review, and interview, the dialysis facility failed to maintain documentation of the required skills competencies (V713), failed to ensure staff followed all policies and procedures related to medication storage and administration, staff training and skills check off, and tuberculosis (TB) testing of new hires (V715). The cumulative effect of these systemic problems has resulted in the facility's inability to ensure the provision of quality health care in a safe environment for the Condition for Coverage 42 CFR 494.150 for Responsibilities of the medical director.	V 0710	**V710** The Governing Body of this facility acknowledges its responsibility to ensure that the facility maintain documentation of the required skills competencies, ensure staff follow all policies and procedures related to medication storage and administration, staff training and skills check off, and tuberculosis (TB) testing of new hires. As such, the Governing Body held a conference call on 2/29/2024, and 3/8/2024 to review the information provided by the surveyors during this survey and actively participate in the development of the Plan of Correction. The Governing Body has committed to meet weekly to review the status of the Plan of Correction until all issues are resolved and the facility is back in compliance.	04/05/2024

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			The Governing Body met again on 3/29/2024, to review the Statement of Deficiencies and develop the following Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The Governing Body began meeting weekly beginning 2/29/2024 to review the results of the progress on the Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The Governing Body will determine when the frequency of these meetings may be reduced to the regular quarterly schedule. Effective immediately: The Director of Operations will analyze and trend all data and monitor/audit results as related to this Plan of Correction prior to presenting the monthly data to the QAI Committee. A specific plan of action encompassing the citations as cited in the Statement of Deficiency has been added to the facility's monthly QAI (Quality Assessment and Performance Improvement) agenda. The QAI Committee is responsible for reviewing and evaluating the Plan of Correction to ensure it is effective and	

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			providing resolution of the issues. The Director of Operations (DO) will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The Governing Body, at its meeting of 2/29/24, designated the Director of Operations (DO) to serve as Plan of Correction Monitor and provide additional oversight. They will participate in QAPI and Governing Body meetings. This additional oversight is to ensure the ongoing correction of deficiencies cited in the Statement of Deficiency through to resolution as well as ensure the Governance of the Facility is presented current and complete data to enhance their governance oversight role. Minutes of the Governing Body and QAI meetings, as well as monitoring forms and educational documentation will provide evidence of these actions, the Governing Body's direction, and oversight and the QAI Committees ongoing monitoring of facility activities. These are available for review at the facility. The responses provided for V713; and V715 describe, in detail, the processes and monitoring steps taken to ensure that all	

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			deficiencies cited within this Condition are corrected to ensure ongoing compliance. The Medical Director will provide oversight of education and training for all staff regarding issues identified by the surveyor. The Medical Director reviewed all training provided to staff on 2/29/24, 3/12/24 and will review the subsequent training that will be provided on 4/02/24. The Director of Operations held a mandatory staff meeting on 2/29/24 and 3/26/24, to review the surveyor's reported issues and the absolute requirement to follow all policies with follow-up audits and re-education as needed. For staff who are not present at the facility for the initial education, they will receive education upon return to the clinic. On 3/12/24 & 4/02/24, after receipt of the Statement of Deficiencies, the Education Coordinator held a staff meeting to reeducate and reinforce the expectations and responsibilities of the facility staff.	
V 0713 Bldg. 00	494.150(b) MD RESP-STAFF ED, TRAINING & PERFORM Medical director responsibilities include, but are not limited to, the following:			

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	(b) Staff education, training, and performance. Based on record review and interview, the dialysis facility failed to maintain documentation of the required skills competencies for 4 of 4 new hire records reviewed (Patient Care Technician (PCT) 5, Registered Nurse (RN) 1, RN 2 and RN 3). Findings include: 1. The personnel file for PCT 5 indicated a hire date of 8/28/2023. The file included a skills competency workbook/checklist. The workbook/checklist failed to be completed and signed by the Clinical Manager or the Medical Director. During an interview on 2/29/2024 beginning at 10:00 AM, the Administrator relayed PCT 5 had completed orientation, and the checklist should have been signed. 2. The personnel file for RN 2 indicated a hire date of 1/08/2024. The file failed to include the required new hire skills competency checkoffs. During an interview on 2/29/2024 beginning at 10:20 AM, the Administrator indicated the personnel file for RN 2 was missing the skills competency checkoffs and orientation to the ESRD facility. 3. The personnel file for RN 3 indicated a hire date of 1/05/2024. The file failed to include the required new hire skills competency checkoffs. During an interview on 2/29/2024 beginning at 11:08 AM, the Administrator indicated the personnel file for RN 3 was missing the skills competency checkoffs, water room check-off's, orientation to the ESRD facility, and the	V 0713	**V713** On 04/02/2024, the Director of Operations and Education Coordinator held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy and procedure: Progressive Renal Education Program (PREP) Orientation for Inexperienced New Employees Emphasis was placed on: New employees performing direct patient care, ancillary, and biomedical services must complete the FKC standardized new employee orientation program. PREP provides the new employee: An initial and ongoing assessment of their knowledge and skills is essential for a highly functional and well-trained workforce. Both classroom setting and clinical time to apply their knowledge. An educational foundation necessary for cultivation of their individual potential. The topics covered in PREP orientation are required by CMS Conditions for Coverage, state specific regulations, and specific job descriptions, and include: Fresenius Kidney Care	04/05/2024

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	employment contract. 4. During an interview on 2/27/2024 beginning at 1:09 PM, the Medical Director indicated all new hires are trained by the education department and the Medical Director reviews all new hires.5. A policy titled, "Progressive Renal Education Program (PREP) Orientation for Inexperienced New Employees" indicated but was not limited to, "The topics covered in PREP orientation are required by CMS Conditions for Coverage, state specific regulations, and specific job descriptions, and include: ... Role-specific employee training ... New Employee: ... Full participation in and successful completion of: ... LMS requirements including assigned e-learning ... clinical skills assessment". 6. The personnel file for RN 1 failed to include the required new hire skills competency checkoffs. 7. During an interview on 02/28/2024 at 1:30 PM, the Administrator indicated the information provided to the surveyors for RN 1 was inclusive of all the staffing agency sent. No additional information was able to be provided from the facility personnel file. The Administrator indicated that personnel files for RN 1 were not kept by the facility and would need to be obtained from the source, clarifying the source was the staffing agency. 8. During an interview on 02/29/2024 at 2:29 PM, the Administrator indicated that the facility did not have any policies regarding contracted staff.		organizational structure End stage renal disease, acute kidney injury, and chronic kidney disease concepts. Review of the appropriate Human Resources policies and procedures Role-specific employee training The content will be delivered using various methods which may include: Classroom sessions Study guides. Training materials Interactive distance learning Self-directed e-learning activities Activities in the classroom and in the clinical practice setting Success will be measured through: Demonstration of applied learning Successfully passing exams with a score of at least 80%* Successful completion of the skills competency assessment Observed engagement when applicable. Documented graduation from PREP orientation On 04/03/2024, the Director of Operations reviewed 100% of all clinical staff currently working at the facility to ensure all clinical	

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			staff had the required skills competencies documented, signed by Clinical Manager and Medical Director, and facility orientation checklist. Employee records available upon request at the facility for review. Effective 04/03/24, the Director of Operations will conduct monthly audit with focus on ensuring all clinical staff performing patient care has all clinical skills competencies documented, signed by Clinical Manager and Medical Director, and facility orientation checklist as required, utilizing Personnel Tracker Audit Tool for 3 months and then an additional 3 months. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is	

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			responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024	
V 0715 Bldg. 00	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility,			

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	including attending physicians and nonphysician providers; Based on observation, record review, and interview, the Medical Director failed to ensure staff followed all policies and procedures related to medication storage and administration, staff training and skills check off, and tuberculosis (TB) testing of new hires for 1 of 1 facility. Findings include: 1. The Medical Director Compliance policy, revised 1/01/07, indicated the Medical Director is responsible for the execution of patient care policies. 2. The Medication Preparation and Administration policy, revised 2/06/23, indicated medications may be pre-drawn up to 4 hours prior to administration and must be labeled and be kept under the preparer's control or in a locked designated medication storage area until delivery to the appropriate patient for administration. The policy also indicated the principles of right drug, right dose, right route, right time, right patient, and right documentation must be followed. The policy further indicated medications will be kept in a locked cabinet except when in use. 3. The Employee Tuberculosis Testing policy, revised 2/05/24, indicated the two-step tuberculin (TST) skin test method is required upon hire unless the new employee has a documented baseline TST within the previous 12 months, in which case the new employee could have a single TST administered upon hire. The policy further indicated the TB risk assessment questionnaire is required to be completed by all new employees and that a facility risk assessment would	V 0715	**V715** On 04/02/2024, the Director of Operations and Education Coordinator held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy and procedure: Medical Director Compliance Guidelines Medication Preparation and Administration Employee Tuberculosis Testing Medical Evaluation Requirements for New Hires/Rehires Progressive Renal Education Program (PREP) Orientation for Inexperienced New Employees Emphasis was placed on: Medications may be pre-drawn up to 4 hours prior to administration. These pre-drawn medications shall be labeled and must be kept under the preparer's control or in a locked designated medication storage area or refrigerated, if necessary, until delivery to the appropriate patient for administration. Preparing and Administering Medications During Hemodialysis Treatment It's preferred that medications be prepared for one patient shift at a	04/05/2024

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	determine the frequency of screening required for employees. 4. The Medical Evaluation Requirements for New Hires/ Rehires policy, revised 6/09/21, indicated an Employee Baseline TB Assessment Form and TB Risk Assessment Questionnaire must be completed by all applicable new hires and that a TB test using the TST method is required upon hire. 5. The Progressive Renal Education Program (PREP) Orientation for Inexperienced New Employees policy, revised 5/03/21, indicated employees are required to successfully complete all skills requirements within the given timeframe. On 2/21/24 at 5:06 PM, 1 vial of Heparin was observed unattended on the counter in the medication preparation area of the in-center hemodialysis (ICHD) treatment floor. 6. On 2/21/24 at 5:20 PM, two medication drawers were observed to be unlocked and contained including but not limited to the following: a 3 milliliter (ml) vial of Venofer (intravenous iron sucrose used to treat iron deficiency anemia), 2 vials of 2.5 ml Venofer, a vial of Adrenaline 1 mg (a drug used for the treatment of serious shock), 3 boxes of Glutose 15 (a product used to treat low blood sugar levels), 9 - 1.3 ml vials of Korsuva (a medication used to treat moderate to severe itching associated with chronic kidney disease), a bottle of 0.2 microgram (mcg) Clonidine tablets (a drug used to lower blood pressure and heart rate), a bottle of Clonidine 0.1 mg tablets, 2 bottles of 5 milligram (mg) Midodrine tablets (a medication used to treat a sudden fall in blood pressure upon standing), Gentamicin sulfate 1% cream (an antibiotic cream used to topically treat bacterial infections of the skin), a bottle of Calcitriol 0.25		time after the patients have arrived for treatment or a home clinic visit to prevent discarding of medications due to a patient not arriving as expected. Prior to administration of the medication: The patient receiving the medication shall be identified by visual and verbal confirmation. Verify there is a physician order. Ensure patient does not have an allergy to the medication. The nurse shall be aware of: Nature of the drug Desired effects Standard dosage Side effect Method of preparation Route of administration Emergency preparedness A physician order is required for all heparin doses and dose adjustments. Heparin must be given at least 3-5 minutes prior to dialysis. This allows time for full anticoagulation at the start of treatment. Heparin prolongs clotting time and prevents blood coagulation in the extracorporeal circuit. A bolus loading dose is administered 3-5 minutes pretreatment with a second bolus dose administered mid treatment. New employees performing direct patient care, ancillary, and	

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	mg tablets (a medication used to treat low calcium levels caused by kidney disease), a bottle of Calcitriol 0.5 mg tablets, a bottle of Cinacalcet 60 mg tablets (a medication used to treat overactive parathyroid gland in dialysis patients), a bottle of Cinacalcet 90 mg tablets, 3 containers of Cryodos (a topical anesthetic spray used to temporarily control pain associated with injections and venipuncture), a bottle of Acetaminophen 325 mg tablets (a medication used to treat minor aches and pains and fever), 24 vials of Ondansetron 4 mg per 2 ml (a medication used to prevent nausea and vomiting), 5 vials of Diphenhydramine 50 mg per ml (a medication used to relieve allergy symptoms), 25 vials of Doxercalciferol 4 mcg per 2 ml (a medication used to lower high levels of parathyroid hormone in dialysis patients, a box of Diphenhydramine 25 mg capsules, and 6 vials of Ferrlecit 62.5 mg per 5 ml (an intravenously administered iron medication for treatment of iron deficiency anemia in dialysis patients). 7. Patient #2's hemodialysis treatment sheets, dated 1/22/24 to 2/21/24, were reviewed and evidenced a physician order for Heparin Sodium (medication to prevent blood clotting during dialysis) 4000 units intravenous push (IVP) mid-run every treatment with a total run time of 4 hours and 35 minutes. On 2/12/24, the in-center hemodialysis (ICHD) treatment began at 5:32 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was administered at 5:12 PM, 20 minutes prior to treatment start. During an interview on 2/23/24 at 11:55 AM, the Administrator indicated Patient #2's mid-run Heparin was given 20 minutes prior to treatment start time and indicated the patient's pre-treatment Heparin dose of 9,000 units had expired and failed		biomedical services must complete the FKC standardized new employee orientation program. PREP provides the new employee: An initial and ongoing assessment of their knowledge and skills is essential for a highly functional and well-trained workforce. Both classroom setting and clinical time to apply their knowledge. An educational foundation necessary for cultivation of their individual potential. The topics covered in PREP orientation are required by CMS Conditions for Coverage, state specific regulations, and specific job descriptions, and include: Fresenius Kidney Care organizational structure End stage renal disease, acute kidney injury, and chronic kidney disease concepts. Review of the appropriate Human Resources policies and procedures Role-specific employee training The content will be delivered using various methods which may include: Classroom sessions Study guides. Training materials Interactive distance learning	

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	to be renewed. 8. Patient #3's hemodialysis treatment sheets, dated 1/29/24 to 2/23/24, were reviewed and evidenced a physician order for Heparin Sodium (medication to prevent blood clotting during dialysis) 2000 units IVP mid-run every treatment with a total run time of 4 hours. On 1/31/24, the ICHD treatment began at 6:57 PM and ended at 9:19 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was documented as administered at 9:20 PM, 1 minutes after treatment ended. During an interview on 2/23/24 at 4:43 PM, the Administrator indicated Patient #3's mid-run Heparin was documented as given 1 minutes after treatment end time and indicated the mid-run Heparin should not be given after treatment has ended. On 2/07/24, the ICHD treatment began at 6:08 PM and ended at 9:18 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was documented as administered at 9:20 PM, 2 minutes after treatment ended. During an interview on 2/23/24 at 4:43 PM, the Administrator indicated Patient #3's mid-run Heparin was documented as given 2 minutes after treatment end time and that no reason was given in the clinical record. On 2/12/24, the ICHD treatment began at 6:23 PM and ended at 9:16 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was documented as administered at 10:09 PM, 53 minutes after treatment ended. During an interview on 2/26/24 at 1:56 PM, the Administrator indicated Patient #3's mid-run Heparin was documented as given 53 minutes		Self-directed e-learning activities Activities in the classroom and in the clinical practice setting Success will be measured through: Demonstration of applied learning Successfully passing exams with a score of at least 80%* Successful completion of the skills competency assessment Observed engagement when applicable. Documented graduation from PREP orientation TB testing using the two-step tuberculin skin test (TST) method is required upon hire. If a new employee has a documented baseline TST result within the previous 12 months, a single TST can be administered as this additional TST represents the second stage of the two-step testing. If an employee provides Interferon-Gamma Release Assay (IGRA) results, these results can be accepted upon hire in lieu of the two-step TST. The results must be within the previous 12 months and reviewed and interpreted by the ordering physician. Examples of IGRAs include: QuantiFERON® - TB Gold	

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	after treatment end time and that no reason was given in the clinical record. On 2/16/24, the ICHD treatment began at 6:33 PM and ended at 9:11 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was documented as administered at 9:05 PM, 6 minutes prior to treatment end. During an interview on 2/26/24 at 1:56 PM, the Administrator indicated Patient #3's mid-run Heparin was documented as given 6 minutes prior to treatment end time and that no reason was given in the clinical record. On 2/19/24, the ICHD treatment began at 6:32 PM and ended at 9:30 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was documented as administered at 10:04 PM, 34 minutes after treatment ended. During an interview on 2/26/24 at 1:56 PM, the Administrator indicated Patient #3's mid-run Heparin was documented as given 34 minutes after treatment end time and that no reason was given in the clinical record. On 2/21/24, the ICHD treatment began at 6:50 PM and ended at 9:15 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was documented as administered at 9:19 PM, 4 minutes after treatment ended. During an interview on 2/26/24 at 1:56 PM, the Administrator indicated Patient #3's mid-run Heparin was documented as given 4 minutes after treatment end time and that no reason was given in the clinical record. On 2/23/24, the ICHD treatment began at 5:31 PM and ended at 9:32 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was documented as administered at 9:17 PM, 15		IN-tube Test (QFT-GIT) SPOT-TB Test (T-Spot) NOTE: IGRA testing is not performed at FKC. A recent chest x-ray within the previous 6-months can be used as evidence to exclude diagnosis of TB in employees with the following: Previously positive TST or IGRA Newly positive TST or IGRA Evidence of severe scarring at an old TST site (denotes a prior positive reaction) History of previous treatment for latent tuberculosis infection (LTBI) or TB disease The Healthcare Personnel TB Baseline Risk Assessment and TB Risk Assessment Review Questionnaire (TB-RAQ) are required to be completed on all new employees. On 04/03/2024, the Director of Operations reviewed 100% of all clinical staff currently working at the facility to ensure all clinical staff follow policy and procedure related to medication storage and administration, ensure clinical staff had the required skills competencies documented, signed by Clinical Manager and Medical Director, as well as a facility orientation checklist, and tuberculosis testing for new hires. Employee records available upon request at the facility for review.	

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	minutes before treatment ended. During an interview on 2/26/24 at 1:56 PM, the Administrator indicated Patient #3's mid-run Heparin was documented as given 15 minutes before treatment end time and that no reason was given in the clinical record. 9. During the flash tour observation on 2/19/24 beginning at 12:16 PM, 1 bottle of Heparin and 2 vials of Venofer were observed to be sitting unattended on the counter in the treatment area. 10. During an observation on 2/21/24 beginning at 5:56 AM, 1 vial of Venofer was observed to be sitting unattended on the counter in the treatment area. At 6:03 AM, RN 3 placed the vial of Venofer in the locked medication cabinet. 11. Patient #11's hemodialysis treatment sheets, dated 1/29/24 to 2/21/24, were reviewed and evidenced a physician order for Heparin Sodium (medication to prevent blood clotting during dialysis) 4000 units IVP bolus every treatment. On 2/21/24, the ICHD treatment began at 3:37 PM. The clinical record evidenced the medication was administered at 9:09 PM, 1 hour and 44 minutes after the treatment ended. RN 2 failed to document an accurate time the Heparin Sodium was given. During an interview on 2/27/24 beginning at 4:38 PM, the Administrator indicated the Heparin Sodium administration time was a charting error and indicated they were sure it was given at the end of the treatment and not 1 hour and 44 minutes after the treatment ended. 12. Patient #12's hemodialysis treatment sheets, dated 1/31/24 to 2/21/24, were reviewed and evidenced a physician order for Heparin Sodium (medication to prevent blood clotting during dialysis) 1000 units IVP mid run every treatment		Effective 04/03/24, the Director of Operations will conduct monthly audit with focus on ensuring all clinical staff performing patient care has all clinical skills competencies documented, signed by Clinical Manager and Medical Director, and facility orientation checklist, and tuberculosis testing for new hires as required, utilizing Personnel Tracker Audit Tool for 3 months and then an additional 3 months. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. Effective 04/03/2024, Director of Operations or Clinical Manager will conduct infection control audits 3 times per week, with alternating shifts with focus on ensuring all policies and procedures related to medication storage and administration are followed, utilizing Infection Control Monitoring Tool for 2 weeks and then 2 times per week for an additional 4 weeks. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review	

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	with a total run time of 4 hours. On 1/31/24, the ICHD treatment began at 4:58 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was administered at 7:30 PM, 2 hours and 32 minutes after treatment began. On 2/02/24, the ICHD treatment began at 4:26 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was administered at 4:20 PM, 6 minutes prior to treatment starting. On 2/05/24, the ICHD treatment began at 4:29 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was administered at 7:00 PM, 2 hours and 31 minutes after treatment began. On 2/07/24, the ICHD treatment began at 5:10 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was administered at 7:47 PM, 2 hours and 37 minutes after treatment began. On 2/09/24, the ICHD treatment began at 4:33 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was administered at 7:30 PM, 2 hours and 57 minutes after treatment began. On 2/12/24, the ICHD treatment began at 4:58 PM. The Clinical record failed to evidence the mid-run dose of Heparin Sodium was administered during treatment. Patient #12's dialysis treatment ended early due to patient "clotted off." RN 2 failed to notify the physician regarding Patient #12 clotting off, resulting in the shortened treatment time. On 2/14/24, the ICHD treatment began at 4:55 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was administered at 6:30 PM, 1 hours and 35 minutes after treatment began.		the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for	

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	On 2/16/24, the ICHD treatment began at 4:30 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was administered at 7:30 PM, 3 hours after treatment began. On 2/19/24, the ICHD treatment began at 4:36 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was administered at 9:08 PM, 4 hours and 32 minutes after treatment began and 38 minutes after treatment ended. On 2/21/24, the ICHD treatment began at 4:36 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was administered at 7:59 PM, 3 hours and 23 minutes after treatment began. 13. Patient #13's hemodialysis treatment sheets, dated 1/29/24 to 2/21/24, were reviewed and evidenced a physician order for Heparin Sodium (medication to prevent blood clotting during dialysis) 4000 units IVP mid run every treatment; 2100 units Catheter Lock Arterial Red Port and 2200 units Catheter Lock Venous Blue Port post dialysis with a total run time of 4 hours and 45 minutes. On 1/29/24, the ICHD treatment began at 3:11 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was administered at 5:56 PM, 2 hours and 45 minutes after treatment began and the post dialysis Red and Blue Catheter Lock Heparin was administered at 7:03 PM, 24 minutes before the treatment ended. On 1/31/24, the ICHD treatment began at 3:00 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was administered at 7:25 PM, 4 hours and 25 minutes after treatment began and 1 minute before treatment ended.		review at the clinic. Completion 04/05/2024	

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	On 2/02/24, the ICHD treatment began at 2:36 PM. The Clinical record evidenced the post dialysis Red and Blue Catheter Lock Heparin was administered at 6:42 PM, 41 minutes before the treatment ended. On 2/07/24, the ICHD treatment began at 3:19 PM, The Clinical record evidenced the post dialysis Red and Blue Catheter Lock Heparin was administered at 7:12 PM, 14 minutes before the treatment ended. On 2/09/24, the ICHD treatment began at 2:42 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was administered at 6:08 PM, 3 hours and 26 minutes after treatment began. On 2/16/24, the ICHD treatment began at 2:48 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was administered at 5:49 PM, 2 hours and 1 minute after treatment began. On 2/19/24, the ICHD treatment began at 3:21 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was administered at 7:05 PM, 3 hours and 44 minutes after treatment began and the post dialysis Red and Blue Catheter Lock Heparin was administered at 8:01 PM, 10 minutes before the treatment ended. On 2/21/24, the ICHD treatment began at 2:49 PM. The Clinical record evidenced the mid-run dose of Heparin Sodium was administered at 5:58 PM, 3 hours and 9 minutes after treatment began. During an interview on 2/22/24 beginning at 3:48 PM, the Administrator indicated the mid-dose of Heparin should be given when half of the treatment has completed, give or take 10 to 15 minutes and the post dialysis catheter lock should			

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	be given after dialysis has ended. 14. The personnel file for PCT 5 indicated a hire date of 8/28/23 and the employee's duties included direct patient contact. The file included a skills competency workbook/checklist. The workbook/checklist failed to be completed and signed by the Clinical Manager or the Medical Director. The personnel health file for PCT 5 failed to evidence a 2-step TB test had been performed upon hire. 15. The personnel file for RN 2 indicated a hire date of 1/08/24 and the employee's duties included direct patient contact. The file for RN 2 failed to evidence a 2-step TB test had been performed upon hire. 16. The personnel file for RN 3 indicated a hire date of 1/05/24 and the employee's duties included direct patient contact. The file for RN 3 failed to evidence a 2-step TB test had been performed upon hire. 17. During an interview on 2/27/24 beginning at 1:09 PM, the Medical Director indicated all new hires are trained by the education department and the Medial Director reviews all new hires. 18. During an interview on 2/29/24 beginning at 10:20 AM, the Administrator relayed PCT 5 had completed orientation and the checklist should have been signed.			
V 0750 Bldg. 00	Based on observation, record review, and interview, the dialysis facility failed to ensure an adequate number of qualified and trained staff	V 0750	**V750** The Governing Body of this facility acknowledges its responsibility to	04/05/2024

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	were present whenever patients were undergoing dialysis to meet the needs of the patients (V757); and failed to maintain documentation of the required orientation to the facility (V760). The cumulative effect of these systemic problems has resulted in the facility's inability to ensure the provision of quality health care in a safe environment for the Condition for Coverage 42 CFR 494.180 for Governance with the potential to impact all 58 of the in-center hemodialysis active patients.		ensure that the facility has adequate number of qualified and trained staff whenever patients are undergoing hemodialysis treatments and maintain documentation of the required orientation to the facility. As such, the Governing Body held a conference call on 2/29/2024, and 3/8/2024 to review the information provided by the surveyors during this survey and actively participate in the development of the Plan of Correction. The Governing Body has committed to meet weekly to review the status of the Plan of Correction until all issues are resolved and the facility is back in compliance. The Governing Body met again on 3/29/2024, to review the Statement of Deficiencies and develop the following Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The Governing Body began meeting weekly beginning 2/29/2024 to review the results of the progress on the Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The Governing Body will determine when the frequency	

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			of these meetings may be reduced to the regular quarterly schedule. Effective immediately: The Director of Operations will analyze and trend all data and monitor/audit results as related to this Plan of Correction prior to presenting the monthly data to the QAI Committee. A specific plan of action encompassing the citations as cited in the Statement of Deficiency has been added to the facility's monthly QAI (Quality Assessment and Performance Improvement) agenda. The QAI Committee is responsible for reviewing and evaluating the Plan of Correction to ensure it is effective and providing resolution of the issues. The Director of Operations (DO) will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The Governing Body, at its meeting of 2/29/24, designated the Director of Operations (DO) to serve as Plan of Correction Monitor and provide additional oversight. They will participate in QAPI and Governing Body meetings. This additional oversight is to ensure the ongoing correction of deficiencies cited in the	

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			Statement of Deficiency through to resolution as well as ensure the Governance of the Facility is presented current and complete data to enhance their governance oversight role. Minutes of the Governing Body and QAI meetings, as well as monitoring forms and educational documentation will provide evidence of these actions, the Governing Body's direction, and oversight and the QAI Committees ongoing monitoring of facility activities. These are available for review at the facility. The responses provided for V757; and V760 describe, in detail, the processes and monitoring steps taken to ensure that all deficiencies cited within this Condition are corrected to ensure ongoing compliance. The Medical Director will provide oversight of education and training for all staff regarding issues identified by the surveyor. The Medical Director reviewed all training provided to staff on 2/29/24, 3/12/24 and will review the subsequent training that will be provided on 4/02/24. The Director of Operations held a mandatory staff meeting on 2/29/24 and 3/26/24, to review the surveyor's reported issues and the absolute requirement to follow all	

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			policies with follow-up audits and re-education as needed. For staff who are not present at the facility for the initial education, they will receive education upon return to the clinic. On 3/12/24 & 4/02/24, after receipt of the Statement of Deficiencies, the Education Coordinator held a staff meeting to reeducate and reinforce the expectations and responsibilities of the facility staff.	
V 0757 Bldg. 00	494.180(b)(1) GOV-STAFF # & RATIO MEET PT NEEDS The governing body or designated person responsible must ensure that- (1) An adequate number of qualified personnel are present whenever patients are undergoing dialysis so that the patient/staff ratio is appropriate to the level of dialysis care given and meets the needs of patients; Based on observation, record review, and interview, the dialysis facility failed to ensure an adequate number of qualified and trained staff were present whenever patients were undergoing dialysis to meet the needs of the patients for 1 of 1 facility. Findings include: 1. The Medical Director Compliance Guidelines policy, revised 1/01/2007, indicated but not limited to the Medical Director is required to ensure adequate supervision of dialysis operations through proper scheduling of direct patient care personnel, supervisory personnel, and emergency coverage.	V 0757	**V757** On 04/02/2024, the Director of Operations and Education Coordinator held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy and procedure: Medical Director Compliance Guidelines Governing Body Policy Emphasis was placed on: The Medical Director is required to ensure adequate	04/05/2024

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	2. The Governing Body Policy, dated 7/3/2023, indicated the governing body duties (generally in conjunction with the Medical Director) include but not limited to facility professional staff appointments, training and educating staff, and ensuring adequate staff coverage. 3. On 2/21/2024 6:03 AM, 1 Registered Nurse (RN) and 2 Patient Care Technician (PCT)s were observed working on the treatment floor. RN 3 relayed he or she was a contracted travel nurse and had never worked at this facility before. The RN indicated the clinic is short-staffed. PCT 7 relayed they are part of the float pool and had worked at this facility 1 other time in the past 3 years. PCT 4 relayed he or she was the only employee on the treatment floor with machine log in access. Observed RN 3 and PCT 7 asking PCT 4 to verify patients. RN 3 and PCT 7 relayed they did not know where anything was located in the facility. 4. On 2/21/2024 from 5:40 AM to 5:56 AM, 4 patients were observed sitting in the lobby waiting. Patient #24 mentioned they had been waiting since 5:15 AM. Patient #23 relayed they are taken back late all the time, and it has made them late for work. 5. During observation on 2/21/2024 from 5:06 PM to 5:44 PM, 1 RN and 1 PCT were observed to be working on the ICHD treatment floor. 6. On 2/20/2024 at 11:05 AM, Patient #2 indicated staffing was an issue every day they came to treatment. Patient #2 relayed there would be 1 RN and 1 PCT, sometimes another floater PCT, when he/she came in for treatment but that after 6:00 PM, there would only be 1 RN and 1 PCT.		supervision of dialysis operations by medical and patient care staff through proper scheduling of medical personnel, direct patient care personnel, supervisory personnel, and emergency coverage. Governing Body duties (generally in conjunction with the Medical Director) include but are not limited to: Fiscal management Medical staff appointments, coverage, and compliance with facility policies Facility professional staff appointments Regulatory Compliance to include: Routine quarterly review of regulatory approval letters to determine if the numbers of stations and modalities of dialysis being delivered is exactly consistent with what is stated in the most recent CMS/Medicare approval letter, state certificate of need (if applicable) and state license (if applicable). Review of each statement of deficiency resulting from an internal or external facility survey, as well as review of the development and implementation of any related plans of correction Training and educating staff Ensuring adequate staff coverage Operation of Quality	

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	7. On 2/23/2024 at 10:38 AM, Patient #5 indicated there are not enough staff and sometimes 2 people working with all patient stations full. Staff cannot get to everyone. There are alarms going off and no one available to help them. Patient #5 relayed he or she sometimes goes the whole treatment without anyone speaking to or acknowledging him. Staff are rude and don't answer questions and often ignore you. The patient indicated the facility is very cluttered and has noticed spills not cleaned up and trash on the floor and oftentimes does not want to go to treatment because it is dirty. Patient #5 stated, "They haven't killed me yet, so that's good, but I'm nervous." Patient #5 indicated they are put on late all the time, and he or she refuses to let staff cut the treatment short. 8. On 2/21/2024 at 10:50 AM, Patient #12 indicated the facility does not have enough staff. The patient relayed he/she witnessed other patients with treatment issues where it took a long time for staff to address and also witnessed a patient pass out with only 2 staff working. The staff attended to that patient and left the rest of the patients unattended with machines alarming. Patient #12 relayed the facility always runs late, and treatments are ended early. 9. During an interview on 2/26/2024 at 3:37 PM, Patient #9 indicated for a while it was just 1 PCT and 1 RN on 3rd shift. 10. During an interview on 2/26/2024 at 4:12 PM, Patient #8 indicated he/she has been told by staff they were short-staffed. Patient #8 indicated they had frequently been put on late, sometimes an hour and a half late. 11. During an interview on 02/26/2024 at 4:00 PM,		Assessment and Improvement Program Directing and overseeing the facility's internal grievance process and issues Ensuring involuntary patient discharges are carried out in compliance with regulations and facility policy and procedure Ensuring that facility emergency coverage and facility backup plans are in place and effective Ensuring that requisite data is submitted timely and accurately to ESRD Network and/or CMS, as required Maintaining the facility's relationship with the ESRD Network Maintaining compliance and adherence to federal healthcare program requirements/state regulations including staffing. Effective 04/03/24, the Director of Operations will conduct monthly audit with focus on ensuring adequate number of qualified and trained staff are present whenever patients are undergoing dialysis to meet the patient needs, utilizing Personnel Tracker Audit Tool for 3 months and then an additional 3 months. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar.	

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FRESENIUS MEDICAL CARE FISHERS	13648 OLIVIA WAY FISHERS, IN 46037

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	Patient #11 indicated typically starting treatment at least a half an hour late each treatment and that the facility appears short staffed a majority of the time. Patient #11 further indicated that staff have also told him/her they were short staffed. Typically, there is only 1 PCT and 1 RN on the last shift of the day per Patient #11. 12. During an interview on 2/26/24 at 5:20 PM, Patient #7 indicated there were usually 2 staff on the treatment floor when he/she left the treatment area. 13. During an interview on 2/26/24 at 5:32 PM, Person A, the power of attorney (POA) for Patient #3, indicated he/she found out Patient #3 had not been getting his/her full treatment. Person A further indicated he/she is sometimes scared when coming to pick up Patient #3 because he/she doesn't know what might have happened to Patient #3 during treatment. Patient #3 also indicated there was nobody to talk to at the facility, and the front desk should not be empty. 14. On 2/27/24 at 1:25 PM, the Medical Director indicated the measure of whether you have enough staff is if the patients are getting adequate care. 15. On 2/19/24 at 5:00 PM, RN 2 relayed the facility is dangerous, often running with 1 RN and 1 PCT, and consistently starting treatments late and having to end treatments early. The schedule appears to be fully staffed, but people don't show up. 16. On 2/26/24 at 3:12 PM, PCT 6 relayed the facility is not adequately staffed and has often worked with just 1 RN and no other PCT since December. The PCT indicated he or she felt they		The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body	

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	were putting their certification at risk due to the staffing issues. 17. On 2/21/2024 at 3:13 PM, an Anonymous Staff Member indicated there was not adequate staffing on the ICHD treatment floor and that typically there was 1 nurse and 1 PCT on 3rd shift, and if there was a second PCT, they would leave at 6:00 PM. The Anonymous Staff Member indicated the Medical Director had asked pointed questions regarding staffing in January, but nothing had improved since then. 18. On 2/20/2024 at 1:44 PM, the Administrator was heard telling a patient that 2 PCTs and an RN is considered adequate staffing, but 1 RN and 1 tech would not be. 19. During an interview on 2/20/2024 at 2:35 PM, Social Worker 1 indicated he/she had received complaints from patients regarding staffing. 20. During an interview on 2/20/2024 at 2:57 PM, Dietitian 1 indicated he/she had heard complaints from patients regarding staffing. 21. The dialysis facility failed to ensure emergency training upon hire for 2 of 2 contracted Registered Nurse's (RN) personnel records reviewed (RN 1 & RN 3). 22. The dialysis facility failed to obtain and/or ensure a passing color blindness test for facility staff upon hire for 3 of 6 personnel records reviewed. 23. The facility failed to ensure staff completed water room training for 3 of 3 contracted Registered Nurses.		minutes, education and monitoring documentation are available for review at the clinic. Completion 04/05/2024	

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	24. The dialysis facility failed to ensure adequate staff to meet the patients' needs as evidenced by the following: failed to ensure the patient's blood pressure (BP) was checked every 30 minutes during in-center hemodialysis (ICHD) for 12 of 12 ICHD clinical records reviewed; failed to ensure the Registered Nurse (RN) completed an assessment within one hour of the start of hemodialysis treatment for 9 of 11 active ICHD clinical records reviewed; failed to ensure the RN was notified of BP's and/or pulse rates outside of parameters during ICHD treatment for 12 of 12 clinical records reviewed; failed to ensure the RN performed interventions and/or reported BP's and/or pulse rates outside of parameters to the physician for 6 of 11 active ICHD clinical records reviewed; failed to ensure pre-treatment and/or post-treatment standing BP checks were performed for 6 of 11 active ICHD clinical records reviewed; and failed to ensure the physician was notified of post-treatment weights that did not meet the estimated dry weight (EDW) parameters for 7 of 7 active ICHD patients who did not meet their EDW after treatment. 25. The dialysis facility failed to ensure adequate staff to meet the patients' needs as evidenced by the following: failed to ensure the dialysate flow rate (DFR) and/ or blood flow rate (BFR) were set according to physician orders, failed to ensure machine settings, including BFR and DFR, were checked no less often than every 45 minutes, and/ or failed to ensure the patient received their entire treatment time for 14 of 14 in-center hemodialysis (ICHD) patient records reviewed and the dialysis facility failed to ensure dialysis treatment was being performed as prescribed for 3 of 6 randomly chosen ICHD patients whose treatment settings were observed. (See V544.)			

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	26. The dialysis facility failed to ensure contracted staff personnel files included a skills checklist for 2 of 2 agency staffing Registered Nurses. 27. The dialysis facility failed to ensure the facility had a nurse manager who was responsible for nursing services in the facility who was a full-time employee of the facility. 28. The dialysis facility failed to maintain documentation of the required skills competencies for 4 of 4 new hire records reviewed. 29. The dialysis facility failed to maintain documentation of the required orientation to the facility for 4 of 4 new hire records reviewed.			
V 0760 Bldg. 00	494.180(b)(3) GOV-GB RESP FOR STAFF ORIENTATION The governing body or designated person responsible must ensure that- (3) All staff, including the medical director, have appropriate orientation to the facility and their work responsibilities; Based on record review and interview, the dialysis facility failed to maintain documentation of the required orientation to the facility for 4 of 4 new hire records reviewed (Patient Care Technician (PCT) 5, Registered Nurse (RN) 1, RN 2 and RN 3). Findings include: 1. The personnel file for PCT 5 indicated a hire date of 8/28/2023. The file failed to include the required orientation to the facility. During an interview on 2/29/2024 beginning at 10:20 AM, the Administrator indicated the personnel file for PCT 5 was missing the	V 0760	**V760** On 04/02/2024, the Director of Operations and Education Coordinator held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy and procedure: Governing Body Policy Facility Orientation Checklist Emphasis was placed on: All staff, including the medical director, have an appropriate orientation to the	04/05/2024

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	orientation to the ESRD facility. 2. The personnel file for RN 2 indicated a hire date of 1/08/24. The file failed to include the required orientation to the facility. During an interview on 2/29/2024 beginning at 10:20 AM, the Administrator indicated the personnel file for RN 2 was missing the orientation to the ESRD facility. 3. The personnel file for RN 3 indicated a hire date of 1/05/2024. The file failed to include the required orientation to the facility. During an interview on 2/29/2024 beginning at 11:08 AM, the Administrator indicated the personnel file for RN 3 was missing orientation to the ESRD facility. 4. During an interview on 2/27/2024 beginning at 1:09 PM, the Medical Director indicated all new hires are trained by the education department and the Medical Director reviews all new hires.5. A document titled, "Facility Orientation Checklist for Travel Staff" indicated a checklist to be completed and initialed by new staff members and their preceptors orienting him/her to the unit. 6. The personnel file for RN 1 failed to include the required orientation to the facility. 7. During an interview on 02/29/2024 at 12:13 PM the Administrator provided a blank copy of a document titled, "Facility Orientation Checklist for Travel Staff" and indicated that travel/agency staff have not been oriented to the unit but will be starting today.		facility and their work responsibilities. On 04/03/2024, the Director of Operations reviewed 100% of all staff currently working at the facility to ensure all staff had a documented, facility orientation checklist. Employee records available upon request at the facility for review. Effective 04/03/24, the Director of Operations will conduct a monthly audit with a focus on ensuring all staff have a documented, facility orientation checklist as required, utilizing Personnel Tracker Audit Tool for 3 months and then an additional 3 months. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly.	

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