STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152518	A. BUILDING 00 B. WING	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE WARSAW	3334 LAKE CITY HWY WARSAW, IN 46580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 0000 Bldg. 00	This survey was for a Federal complaint of an ESRD supplier Survey Date: June 26, 2025 Complaint #IN00461770 Regarding involuntary discharge was investigated with one unrelated finding. Census by Service Type: In-Center Hemodialysis: 58 Home Hemodialysis: 3 Home Peritoneal Dialysis: 13 Total Active Census: 74 Isolation Room/Waiver: No isolation room. Approved Waiver in place. Fresenius Medical Care Warsaw was found to be in compliance with Condition for Coverage 42 CFR 494.70 Patient Rights. Abbreviations: FA Facility Administrator MSW Medical Social Worker IDT Interdisciplinary Team	V 0000		
V 0520 Bldg. 00	494.80(d)(2) PA-FREQUENCY REASSESSMENT-UNSTABLE Q MO Based on record review and interview, the IDT failed to reassess a patient at risk of involuntary discharge due to behavior for 1 of 2 at risk patients (Patient #1).	V 0520	On 7/11/2025, the Facility Administrator (FA) held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the following Policy.	07/26/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Allison Cruea	Director of Operations	07/15/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Findings include: The facility policy "Comprehensive Interdisciplinary Assessment," version 6, evidenced the definition of an unstable patient which included " ...Any patient considered at risk for involuntary discharge or transfer must be considered unstable ...." According to the policy, unstable patients required the IDT to complete a monthly comprehensive assessment and update to the plan of care " ... until the issues have been resolved." The IDT is responsible for adjusting and implementing new interventions if the issues continue. The facility "Immediate and Non- Immediate Involuntary Patient Discharge" policy, version 5 stated, " ... there must be evidence in the patient's medical record of the IDT's efforts to help the patient resolve any conflict or psychological issues contributing to the behavior." The facility list of unstable patients dated 6/26/2025, 4/22/2025, and 1/21/2025 failed to identify Patient #1 as unstable. Review of the agency complaint log evidenced 9 complaints for 2025. Patient #1 made one complaint regarding staff harassing him/her about keeping their face uncovered. There was one complaint regarding Patient #1's disrespectful behavior toward the staff. Patient #1's clinical record evidenced an admission date of 10/17/2024. The record included a "letter of concern" dated 12/27/2024 to Patient #1. The letter outlined concerning behaviors such as " ... rude behavior when interacting with staff, yelling and use of negative language with staff and behaving in a manner that		· Comprehensive Interdisciplinary Assessment · Immediate and Non- Immediate Involuntary Patient Discharge Emphasis will be placed on: · Unstable patients must be reassessed by the IDT monthly. Monthly re-assessment and any POC updates related to the reason the patient is considered “unstable” must be documented until the issues have been resolved or the IDT (including the patient if possible) determines that the condition is chronic. · The following is unstable criteria: o Significant change in psychosocial needs a. Change in mentation or psychosocial needs severe enough to interfere with the patient’s ability to follow aspects of the treatment plan and may include situations related to immediate family members. (Any patient considered at risk for involuntary discharge or transfer must be considered “unstable” under this category.) · Except when a patient’s behavior is a severe and immediate threat to the health and safety of others, a patient who is at risk for involuntary discharge must be considered unstable and reassessed by the interdisciplinary team (IDT). o The IDT must document in the patient’s medical record the reassessments, ongoing problems(s), and effort(s) made to	

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	causes disruption to the treatment of other patients." The letter stated, "Please accept this letter as our first attempt at identifying any barriers to resolving the concerning behavior that has become more frequently demonstrated." Patient #1's medical record evidenced a 90-day Comprehensive Interdisciplinary Assessment, dated 2/4/2025. The assessment failed to identify behavioral issues. The next Comprehensive Interdisciplinary Assessment is due 2/4/2026. During a telephone interview on 6/27/2025 at 10 AM, the Medical Director briefly explained the incident on 6/14/2025 with Patient #1. The Medical Director indicated there had been a longstanding issue with Patient #1's behavior, especially around the facility's policies. Patient #1 often had their hood covering their face as they wanted to nap and the lights prevented it. Patient #1 became angry and verbally abusive with staff when they asked Patient #1 to remove the hood so they could visualize Patient #1's face. The Medical Director indicated Patient #1 would say things such as "you need to walk away or I'm going to hit you." An interview with the FA, Director of Operations, and the Social Work Manager, occurred on 6/27/2025 at 10:30 AM. They indicated the incident occurred as the Medical Director explained it, however, they indicated RN 1 called the police for assistance. The officers attempted to help redirect Patient #1 while staff ended their dialysis treatment. Police escorted Patient #1 off the premises. IDT held a phone call on 6/16/2025 and made the decision to do an immediate involuntary discharge. The Medical Director wrote an order for immediate discharge and the FA notified Patient #1 by phone and a certified		resolve the problem(s). Effective 7/11/2025, the FA will conduct 3 days per week audits, for 2 weeks utilizing the facility specific audit tool, with focus on ensuring all unstable patients are reassessed by the IDT monthly. A focus will be on ensuring that any patient that is at risk for an involuntary discharge is made unstable. A focus will also be on ensuring that any patient at risk for an involuntary discharge will document in the patients record any and all efforts made to resolve the problem prior to a discharge. 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 QAPI Committee meeting monthly. The FA 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 QAPI Committee monthly. The DO 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	

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	letter of immediate involuntary discharge. The MSW notified the End Stage Renal Disease Network of the details of the immediate involuntary discharge. The Social Work Manager indicated the first MSW contact with Patient #1 regarding their behavior was 12/27/2025, when they developed the letter of concern with the FA. The Social Work Manager indicated the MSW was involved in the attempts to de-escalate Patient #1.		Body meeting through to the sustained resolution of all identified issues. The QAPI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAPI monthly. The Governing Body is responsible to provide 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 QAPI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic. Completion DATE: 7/26/2025	