STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152681	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE NORTH DIALYSIS	415 E DUPONT RD FORT WAYNE, IN 46825

(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: November 21, 22, and 25, 2024. Active Census: 49. At this Emergency Preparedness survey, Fort Wayne North Dialysis was not found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62.	E 0000		
E 0025 Bldg. 00	403.748(b)(7), 418.113(b)(5), 441.184(b) Arrangement with Other Facilities Based on record review and interview, the facility failed to obtain agreements with all hospital providers included in the EP plan to receive facility patients in the event the facility would be unable to provide services during an emergency for 1 of 1 facility. Findings include: 1. Review of the facility Emergency Management Plan indicated each facility shall have a prearranged hospital patient transfer agreement with local hospital(s) that can provide inpatient care, and routine and emergency dialysis. 2. Review of the facility EP plan included contact information for Entity 2 as a hospital provider to receive facility patients during an emergency. Documentation failed to evidence documentation	E 0025	The Facility administrator or Group Facility Administrator will in-service all teammates on Policy 4-07-01 Facility Emergency Management Plan" to be completed 12/10/2024. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples, to include, but not limited to the following: 1) Agreement(s) in place to provide dialysis services in the event of disruption of facility operations, hospital services…2) Each facility shall have a prearranged hospital patient transfer agreement with a local	12/24/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chantal Crabtree	Group Facility Administrator	12/13/2024

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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	of an agreement between the facility and Entity 2. During an interview on 11/25/2024 at 1:00 PM, when asked to see the hospital agreement with Entity 2, Group FA indicated could not find the agreement.		hospital(s) that can provide inpatient care, routine and emergency dialysis and other hospital services. 3) Agreements shall be reviewed on an ANNUAL basis, in conjunction with EMP, to determine agreement(s) remain current, applicable and effective. The facility's Emergency Preparedness binder was updated with a current transfer agreement with a local hospital on 12/10/24. A copy of the hospital transfer agreement will be maintained with the facility's Emergency Management Plan. The Facility Administrator or Group Facility Administrator will audit the facility's Emergency Management Plan annually to verify compliance with facility policy. Instances of non-compliance will be addressed. The Facility Administrator or designee will review results of the audits with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for ongoing	

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			compliance with this plan of correction. 12/24/24	
E 0031 Bldg. 00	403.748(c)(2), 416.54(c)(2), 418.113(c)(Emergency Officials Contact Information Based on record review and interview, the facility failed to ensure the EP communication plan included contact information for federal and state EP officials for 1 of 1 agency. Findings include: 1. Review of the facility's EP communication plan failed to evidence contact information for the federal and state EP officials. During an interview on 11/25/2024 at 1:00 PM, when asked to see the contact information for the federal and state EP officials in the EP communication plan, the FA from another location indicated it is not in the EP communication plan.	E 0031	The Facility administrator or Group Facility Administrator will in-service all teammates on Policy 4-07-01 Facility Emergency Management Plan" to be completed 12/10/2024. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples, to include, but not limited to the following: 1) …Communication… will be established by leadership, based on scope of event, which may include facility, Divisional, Group leadership, and DEM, with local, tribal, regional, State, and/or Federal emergency preparedness officials, to maintain an integrated response and continuity of patient care during a disaster or emergency situation. The Facility Administrator or Group Facility Administrator updated the facility's Emergency Management Plan on 12/10/24 to include contact information for federal and state Emergency Preparedness officials. The Facility Administrator or Group Facility Administrator will audit the facility's Emergency Management	12/24/2024

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			Plan annually to verify compliance with facility policy. Instances of non-compliance will be addressed. The Facility Administrator or designee will review results of the audits with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with this plan of correction. 12/24/24	
E 0039 Bldg. 00	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to test the EP plan with participation in a full-scale community-based EP exercise, facility-based functional exercise, actual emergency of activation of the EP plan, mock disaster drill, or tabletop exercise for 1 of 1 agency. Findings include: 1. Review of the facility's EP testing indicated participation in functional exercises, on 05/25/2022	E 0039	The Facility administrator or Group Facility Administrator will in-service all teammates on Policy 4-07-01 Facility Emergency Management Plan" to be completed 12/10/2024. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples, to include, but not limited to the	12/24/2024

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	and 06/28/2024, presented by the state Healthcare Coalition. The testing failed to identify facility employees who participated. The EP failed to evidence facility participation in a full-scale community-based exercise, actual emergency activation, mock disaster drill, or tabletop exercise for the past three years. 2. Review of the facility Safety Binder failed to evidence facility participation in mock disaster drills. 3. During an interview on 11/25/2025 at 1:00 PM, when asked who attended the functional exercise on 06/28/2024, the Group FA indicated FA's from other locations attended the functional exercise. The FA indicated no one from this location attended.;		following: 1) The facility will conduct and/or participate in one (1) exercise to test the facility EMP at least ANNUALLY, conducted on OPPOSITE years (one year full-scale exercise, next year facility-based / exercise of choice). 2) The Facility Administrator or Group Facility Administrator will schedule a full-scale community based or individual facility-based emergency drill to be conducted annually. The FACILITY EMERGENCY PLAN ACTIVATION template will be utilized and documentation will include: Event that occurred; Plan and policies activated; Evaluation of plan; Plan revisions required; and Governing Body review. Documentation for all emergency drills will be maintained with the facility's Emergency Management Plan. The facility participated in a community-based drill on 6/24/24 and conducted a facility-based drill for "Winter Storm" on 12/10/24. All required documentation for each drill will be maintained with the facility's Emergency Management Plan. The Facility Administrator or Group Facility Administrator will audit the facility's Emergency Management Plan annualy to verify compliance with facility policy. Instances of non-compliance will be addressed. The Facility Administrator or designee will review results of the audits with the Medical Director	

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			during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with this plan of correction. 12/24/24	
V 0000 Bldg. 00	This visit was for a CORE Federal recertification survey of an ESRD provider in conjunction with 1 complaint. Survey dates: November 21, 22, and 25, 2024. Complaint: IN00447243 with unrelated deficiencies cited. Census by Service Type: In-Center Hemodialysis: 49 Total Active Census: 49 Isolation Room/Waiver: 1 Abbreviations: CVC Central Venous Catheter	V 0000		

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	EP Emergency Preparedness FA Facility Administrator ICHD In-Center Hemodialysis PCT Patient Care Technician QR 12/5/24 A2			
V 0113 Bldg. 00	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Based on observation, record review, and interview, the facility failed to ensure employees performed proper hand hygiene in 4 of 12 observations over 2 of 3 observation periods (PCT 2). Findings include: 1. Review of an agency policy titled "Infection Control for Dialysis Facilities" indicated all teammates will perform hand hygiene prior to gloving and immediately after removal of gloves and before touching clean areas such as supplies and chairside keyboard. 2. During an observation on 11/21/2024 at 11:49 AM, observed PCT 2 while wearing gloves touched skin below the eyes, and while wearing the same gloves disconnected the AV (arteriovenous) fistula (an artery and vein are surgically connected for dialysis) bloodline of Patient #6 at Station #9. 3. During an observation on 11/21/2024 at 12:55 PM, observed PCT 2 rubbing nose without wearing gloves and touched the chairside keyboard at Station #10. Observed PCT 2 don gloves without performing hand hygiene and cleaned and connected central venous catheter (tube inserted into a vein to provide access to the	V 0113	The Facility administrator or Group Facility Administrator will in-service all teammates on Policy 1-05-01 “infection Control For Dialysis Facilities” starting on 12/10/2024. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples, to include, but not limited to the following: 1) All teammates, Physicians and Non-Physician (NPP) will perform hand hygiene: … prior to gloving and immediately after removal of gloves… before touching clean areas such as supplies, supply cart and chairside keyboard/mouse. The Facility Administrator, Group Facility Administrator, MCS, or Charge Nurse will conduct observational infection control audits daily for two (2) weeks, then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during internal infection control audits. Instances of	12/24/2024

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	superior vena cava used for dialysis) bloodline of Patient #7, then removed gloves. PCT 2 failed to perform hand hygeine after removing gloves. 4. During an observation on 11/22/2024 at 9:56AM, observed PCT 2 don gloves without performing hand hygiene and picked up clean patient supplies from the treatment center counter and placed supplies on chairside table at Station #5 for the next patient. 5. During an observation on 11/22/2024 at 9:58 AM, observed PCT 2 while wearing gloves touch hair and while wearing the same gloves placed new dialysis tubing at Station #9 for use with the next patient. 6. During an interview on 11/22/2024 at 10:10 AM, when asked what should be done after touching face or hair while wearing gloves and providing care, PCT 2 indicated should remove gloves, use hand sanitizer and put on new gloves. When asked what is done before putting on new gloves, PCT 2 indicated should have used hand sanitizer before putting on gloves and after removing gloves.		non-compliance will be addressed. The Facility Administrator, Group Facility Administrator, MCS, or Charge Nurse will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with this plan of correction. 12/24/24	
V 0122 Bldg. 00	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL Based on observation and interview, the facility failed to ensure staff stored disinfectants in the treatment area to prevent loss of disinfectant properties to clean and disinfect the dialysis stations and equipment in 1 of 3 treatment floor observation periods completed creating the potential to affect all the facility's 49 current incenter patients. Findings include:	V 0122	The Facility administrator, Group Facility Administrator, or Manager of Clinical Services (MCS) will in-service all teammates on Policy 1-05-08 “Bleach Policy”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples, to	12/24/2024

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	1. During on observation 11/21/2024 at 10:51 AM, across from Station 3, observed two bleach containers, which are used for wetting paper towels for station cleaning, with opened lids. No employees observed cleaning at that time. During an interview on 11/21/2024 at 10:51 AM, when asked when the lids to the bleach containers can be open, PCT 1 indicated when using the bleach to clean. 3. During an observation on 11/21/2024 at 11:50 AM, across from Station 9, observed one bleach container with an opened lid. Further observations at 12:08 PM and 12:18 PM evidenced the same container lid remained open. No employees observed cleaning at those times. 4. During an interview on 11/22/2024 at 4:00 PM, when asked where the lids to the bleach containers should be, the FA indicated they should be left on top of the container.		include, but not limited to the following: 1) Bleach solution needs to be covered with a secure lid…2) NOTE: Without a secure lid, the bleach solution is open to air causing the solution to degrade over time and become less effective. The Facility Administrator, Group Facility Administrator, MCS, or Charge Nurse will conduct observational infection control audits daily for two (2) weeks, then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during internal infection control audits. Instances of non-compliance will be addressed. The Facility Administrator, Group Facility Administrator, MCS, or Charge Nurse will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is	

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			responsible for ongoing compliance with this plan of correction. 12/24/24	
V 0715 Bldg. 00	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P Based on record review, observation, and interview, the medical director failed to ensure the policies and procedures related to patient care and safety were followed creating the potential to affect all 49 in-center dialysis patients. Findings include: 1. Review of an agency document titled "Parenteral (intravenous) Medication Preparation and Administration" indicated multiple dose vials are labeled with the date opened. 2. During an observation on 11/21/2024 at 10:10 AM, observed PCT 1 withdraw Heparin (blood thinner) into a syringe from an opened multiple dose vial at the medication prep area. Observation of the vial failed to evidence the date opened. During an interview on 11/21/2024 at 10:15 AM, when asked what is done to a multiple dose vial when opened, the FA indicated the vial should have been dated when opened.	V 0715	A Governing Body meeting with the Medical Director, Facility Administrator, Nursing Manager and Regional Operations Director was conducted on 12/10/24 for review of the results for the survey ending on 12/10/2024. The Governing Body reviewed Policy COMP-DD-017 “Medical Director Qualifications And responsibilities” with the Medical Director, to include the following: **Medical Director Responsibilities - …**Oversight of 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, including attending physicians and non-physician providers. Qualifications and Responsibilities. The Medical Director acknowledged that he/she is responsible to ensure the facility teammates are trained, follow policy and procedure. Plans of correction have been developed and initiated to correct identified deficiencies and to sustain compliance. The Facility Administrator, Group	12/24/2024

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			Facility Administrator, or MCS will in-service all clinical teammates on Policy 1-06-01 “Medication Policy” beginning 12/10/24. Verification of attendance will be verified with an in-service signature sheet. Teammates will be educated using surveyor observations as examples, to include, but not limited to the following: 1) Each vial is labeled with the initials of the person opening the vial and the expiration date. The The Facility Administrator, Group Facility Administrator, or MCS will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal medication audit. Instances of non-compliance will be addressed. The Facility Administrator, Group Facility Administrator, MCS, or Charge Nurse will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator is responsible for ongoing compliance with this plan of correction. 12/24/24	

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V 0727 Bldg. 00	494.170(a) MR-PROTECT PT RECORDS FM LOSS/CONFIDENTIAL Based on observation, record review, and interview, the facility failed to safeguard patient records against loss or unauthorized use for active and discharged patient records creating the potential to affect the facility's patients on service within the past two years. Findings include: 1. Review of an agency policy titled "Medical Records Custodian and Maintenance" indicated hardcopy medical records for the previous 12 months are maintained in a secure medical records storage site in the facility, and medical records two years, but not less than 12 months should remain on site if space allows, and after that time, medical records may be stored off site with an approved medical records storage facility. 2. During the entrance conference on 11/21/2024, the Group FA indicated 90% of facility medical records are electronic and the remainder 10% are paper patient records and paper medical records older than 2 years are taken to Entity 1 for storage. 3. On 11/21/2024 and 11/22/2024 this writer was taken to an unlocked room in the administrative area of the facility and observed multiple banker boxes containing paper medical records. 4. On 11/25/2024 at 8:30 AM arrived at the facility and taken to the same unlocked room and observed the banker boxes with paper medical records were no longer present. 5. During an interview on 11/25/2024 at 9:32 AM, when asked what happened to the paper medical	V 0727	Inservice on Policy 3-02-01 completed 12/10/2024 The Facility Administrator, Group Facility Administrator, MCS, or Charge Nurse will in-service all teammates on Policy 3-02-01 “Medical Record Custodian And Maintenance” 12/10/24. Verification of attendance will be verified with an in-service signature sheet. Teammates will be educated using surveyor observations as examples, to include, but not limited to the following: 1) Verifies that the medical records are complete, documented accurately, and maintained in accordance with accepted professional standards and practices. 2) Records for the previous 12 months are maintained in a secure medical records storage site in the facility. 3) Two (2) years, but not less than 12 months of medical records should remain on site if space allows. 4) After that time, medical records may be stored off site with an approved medical records storage facility. All of the boxes of hardcopy medical records were relocated for storage in a secure area with locks to prevent unauthorized access. The Facility Administrator, Group Facility Administrator, MCS, or Charge Nurse will conduct observational	12/24/2024

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FORT WAYNE NORTH DIALYSIS	415 E DUPONT RD FORT WAYNE, IN 46825

(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
	records that had been in the unlocked room, the FA from another location indicated the medical records that had been in the unlocked room were waiting to go to Entity 1 for storage. When asked to describe the measures the facility had taken to maintain the confidentiality of these records, the FA from another location indicated no one can walk in off the street because the facility interior doors are password protected. 6. A tour of the facility medical record storage site began on 11/25/2024 at 9:32 AM. Tour began in the patient lobby. Observed sliding glass windows with no visible locks which separated the lobby from the receptionist area. The FA from another location was unable to locate the brackets that lock the glass windows. No employees observed in the unsecured receptionist area. Walked from the lobby through a password protected door into the administration area and observed a locked door leading from the administration area to the receptionist area. Observed no door from the receptionist area to the medical record room and observed medical records in separate patient binders on shelves and in unlocked file cabinets. Observed the banker boxes with paper medical records stored in the medical record area. The facility failed to evidence paper medical records were stored in a secured space with the observation of no locks on the sliding glass windows that separated the front lobby to the medical record room.		audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during an internal audit. Instances of non-compliance will be addressed. The Facility Administrator, Group Facility Administrator, MCS, or Charge Nurse will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with this plan of correction. 12/24/24	