

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2025
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NAME OF PROVIDER OR SUPPLIER HAMMOND DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 7 SIBLEY STREET HAMMOND, IN 46320
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E 0000 Bldg. 00	<p>An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 494.62</p> <p>Survey Dates: 07/28/2025, 07/29/2025, 07/30/2025, and 07/31/2025</p> <p>Total Census: 51</p> <p>At this Emergency Preparedness Survey, Hammond Dialysis Center was found to be out of compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62.</p> <p>The abbreviations used in this survey report: FA for Facility Administrator.</p> <p>QR: 8/11/2025 A1</p>	E 0000	E 000 The governing body and management staff of this facility take this deficiency statement very seriously and will work to bring the cited deficiencies into compliance and will ensure that they remain in compliance. The governing body met on August 22, to review and approve the Plan of Correction (POC) and the tools that will keep the approved plan in compliance. All attachments and in-services are also available at the facility for review. The governing body will meet monthly for the next six months to review the Plan of Correction and ensure that the citations in compliance. The findings from these reviews will also be discussed at monthly QAPI meetings.	
E 0003 Bldg. 00	<p>494.62 Establishment of the EP Program Dialysis</p> <p>Based on record review, interview, and observation, the facility failed to maintain compliance with the condition of Emergency Preparedness at 42 CFR 494.62. The requirement was not met as evidenced by: the supplier failed to identify and document and have a system of that secures and maintains availability of patient records (See V0023); facility failed to keep updated and current contact information of staff names and contact information for use in an</p>	E 0003	E 003 Establishment of the EP Program Dialysis CFR 494.62 The Regional Corporate Clinical and Regulatory manager met with facility staff to review the Emergency Preparedness issues as cited in the referenced E tags. It was stressed during the in-service that to ensure the greatest degree of safety and survival of all staff and patients	08/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cynthia lowrance	RN/CM	08/25/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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E 0023 Bldg. 00	<p>emergency (See V0030); facility failed to identify in their communication plan, a primary and alternate means of communication for use during an emergency (See V0032); and facility failed to evidence that exercises were conducted to test the emergency plan, annually at a minimum (See V0039).</p> <p>The cumulative effect of these systemic problems resulted in the Dialysis Centers' inability to ensure the provision of quality health care in a safe environment and resulted in the agency being found out of compliance with condition 42 CfC 494.62 Emergency preparedness.</p> <p>403.748(b)(5), 416.54(b)(4), 418.113(b)(Policies/Procedures for Medical Documentation</p> <p>Based on record review, observation, and interview, the dialysis facility failed to evidence they followed their policy and had a system of medical documentation that secures and maintains availability of patient records in 1 of 1 dialysis facility.</p> <p>Findings include:</p> <p>A revised policy, dated 06/01/2023, titled "RM700 Disaster and Emergency Preparedness", indicated</p>	E 0023	<p>during an emergency, the evacuation box must contain current and updated patient information, the employee contact list must be current and updated, facility staff must be aware of the alternate means of communication in the event of a communication failure, and the emergency response plan should be tested annually. The CM will ensure compliance by ensuring all emergency plans are reviewed, emergency equipment and evacuation contacts are current and updated, and emergency testing is completed annually. All findings will be reviewed in the monthly QAPI meeting. Additionally, the governing body will meet monthly for 6 months to ensure sustained improvement is noted. Cross Reference E 023, E 030, E 032, E 039</p> <p>E 023</p> <p>An in-service was initiated to all Direct Patient Care (DPC) staff and the Clinic Manager (CM) by the Regional Clinical and Regulatory Manager regarding the Emergency Evacuation Box policy and patient information included in the box (See attached in-service record). Per policy EM06 Emergency Evacuation Box "Purpose: To ensure that supplies</p>	08/31/2025

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	<p>that items needed for immediate access during an evacuation include monthly updated reports for all patients.</p> <p>During an observation, on 07/28/2025 beginning at 11:55 AM, a review of the dialysis facility emergency preparedness kit failed to evidence a current list of patients, with their demographics and dialysis prescription. The "kit" included a patient report, most recently dated 08/01/2024.</p> <p>During an interview, on 07/31/2025 beginning at 2:38 PM, the FA indicated that patient information for the emergency preparedness kit is probably updated annually, and should be done more often.</p>		<p>needed for patient care in an emergency evacuation are readily available to provide care to the patients; and each patient's dialysis prescription, medication list and any other necessary medical information is available to continue care in case of an emergency evacuation." The policy was reviewed in entirety including the review of the Emergency Box Supplies Checklist with focus on ensuring the Patient (Demographics), HD Flowsheets, and treatment orders are updated and located in the box. All patient information will be updated and present in the Emergency Evacuation box /31/2025. The charge nurse or designee is responsible for checking the emergency box monthly to ensure all supplies listed are available in the box, including ensuring the patient information, treatment sheets, and orders are up to date and in Emergency Box. Additionally, the CN at the end of each treatment day will update the patient list with any new admissions or discharges, to ensure the information is current. The clinic manager will review the emergency box weekly for a minimum of 12 weeks, until 100% compliance is achieved, to ensure all patient information is included in the box and is updated and current (See attached CM</p>	

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			<p>monitoring tool). The clinic manager will ensure compliance through direct observation and use of the CM monitoring tools. The CM monitoring tool will be brought to the monthly QAPI meeting, of which the medical director is a member, for review and where additional action will be taken as deemed appropriate such as continuing the weekly monitoring, further education, and/or disciplinary action.</p> <p>TRAINING/INSERVICE DOCUMENTATION FORM</p> <p>Training</p> <p>Date(s) Training Location Hammond Dialysis Center Facilitator(s) Name Qualifications of Facilitator(s) Emergency Preparedness – E 023 (Condition E 003) Per policy EM06 Emergency Evacuation Box “Purpose: To ensure that supplies needed for patient care in an emergency evacuation are readily available to provide care to the patients; and each patient’s dialysis prescription, medication list and any other necessary medical information is available to continue care in case of an emergency evacuation.” Review policy EM06 in entirety. The Emergency Box Supplies Checklist must include the Patient</p>	

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			<p>(Demographics), HD Flowsheets, and treatment orders and all are updated and located in the box. All patient information must be updated and present in the Emergency Evacuation box by 9/1/25. The charge nurse or designee is responsible for checking the emergency box monthly to ensure all supplies listed are available in the box, including ensuring the patient information, treatment sheets, and orders are up to date and in Emergency Box. Additionally, the CN at the end of each treatment day will update the patient list with any new admissions or discharges, to ensure the information is current. The clinic manager will review the emergency box weekly for a minimum of 12 weeks, until 100% compliance is achieved, to ensure all patient information is included in the box and is current. The clinic manager will ensure compliance through direct observation and use of the CM monitoring tools. The CM monitoring tool will be brought to the monthly QAPI meeting for review. Review CM monitoring tool.</p> <p>Hammond Dialysis Center Clinic Manager Tracking Tool To be brought to the monthly QAPI meeting</p>	

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E 0030 Bldg. 00	<p>403.748(c)(1), 416.54(c)(1), 418.113(c)(Names and Contact Information</p> <p>Based on record review, observation, and interview, the dialysis facility failed to keep updated and current contact information of staff names and contact information for use in an emergency in 1 of 1 dialysis facility.</p> <p>Findings include:</p> <p>A revised policy, dated 06/01/2023, titled "RM700 Disaster and Emergency Preparedness," indicated that the communication plan will include a roster of all center associates with home phone numbers and addresses.</p> <p>During an observation, on 07/28/2025 beginning at 11:55 AM, the emergency preparedness failed to evidence a roster to include their staff, nor their current home phone numbers or their current addresses. The Information Emergency Contacts List was dated 08/24/2024 and failed to evidence their current staff and patients.</p> <p>During an interview, on 07/31/2025 beginning at 2:38 PM, the FA indicated that staff information</p>	E 0030	<p>Noted:Discrepancies Noted: CM Initials / Date CM Monitoring Tool and all indicated documents were reviewed at the monthly QAPI Meeting Held on _____.</p> <p>Clinic Manager Signature: _____</p> <p>Date: _____</p> <p>E 030 An in-service was initiated to all staff, including the Clinic Manager, by the Regional Clinical and Regulatory Manager (CRM) regarding the requirement for keeping the Emergency Contact Listing up to date with all current employee contact information (See attached in-service record). Per policy EPM-03 Facility Emergency Response Team "All ERT staff are responsible for knowing: The location of the Facility Emergency Contract Numbers and Reports (print and kept updated information in emergency box): Facility Listing – HUB, Employee emergency contact – UKG, Patient emergency contact – EMR, Attending physicians contact information – facility specific." During the in-service it was stressed that staff contact</p>	08/31/2025

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	for the emergency preparedness kit is probably updated annually, and should be done more often.		information must be current, be updated anytime there are incoming or outgoing staff, and the list must include all staff members. The information must be readily accessible for facility leadership and staff in the event of an emergency, and a copy should be included in the emergency evacuation box. The emergency contact list on the HUB and in UKG will be updated by 8/31/2025 and a copy of all employee contact information will be printed and placed in the emergency evacuation box. The clinic manager is responsible for maintaining the emergency contact list and ensuring the list is current and includes all current staff. All new staff will be added to this list upon hire and staff no longer employed will be removed as indicated. The CM will observe this list weekly, for 12 weeks, to ensure all current staff contact information is up to date on this list (See attached CM monitoring tool). The CM will ensure compliance through direct observation of the emergency contact list (on the HUB and UKG) and use of the CM monitoring tool. The CM monitoring tool and emergency contact list will be reviewed monthly at the monthly Quality Assessment Performance Improvement (QAPI) meeting, of which the medical director is a member, and where further action	

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			<p>will be taken by the committee, such as continued monitoring, further education, or disciplinary action.</p> <p>TRAINING/INSERVICE DOCUMENTATION FORM</p> <p>Training</p> <p>Date(s) Training Location Hammond Dialysis Center Facilitator(s) Name Qualifications of Facilitator(s) Emergency Preparedness – E 030 (Condition E 003) Per policy EPM-03 Facility Emergency Response Team “All ERT staff are responsible for knowing: The location of the Facility Emergency Contract Numbers and Reports (print and kept updated information in emergency box): Facility Listing – HUB, Employee emergency contact – UKG, Patient emergency contact – EMR, Attending physicians contact information – facility specific.” Staff contact information must be current, be updated anytime there are incoming or outgoing staff, and the list must include all staff members. The information must be readily accessible for facility leadership and staff in the event of an emergency, and a copy should be included in the emergency evacuation box. The emergency</p>	

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			<p>contact list on the HUB and in UKG ust be updated by 9/1/25 and a copy of all employee contact information will be printed and placed in the emergency evacuation box. The clinic manager is responsible for maintaining the emergency contact list and ensuring the list is current and includes all current staff. All new staff will be added to this list upon hire and staff no longer employed will be removed as indicated. The CM will observe this list weekly, for 12 weeks, to ensure all current staff contact information is up to date on this list. The CM will ensure compliance through direct observation of the emergency contact list (on the HUB and UKG) and use of the CM monitoring tool. The CM monitoring tool and emergency contact list will be reviewed monthly at the monthly Quality Assessment Performance Improvement (QAPI) meeting. Review CM monitoring tool.</p> <p>Hammond Dialysis Center Clinic Manager Tracking Tool To be brought to the monthly QAPI meeting Weekly (x 12 weeks) ItemWeek of:Week of:Week of:Week of:Week of:Week of: E 023 and E 030 -</p>	

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E 0032 Bldg. 00	<p>403.748(c)(3), 416.54(c)(3), 418.113(c)(Primary/Alternate Means for Communication</p> <p>Based on record review and interview, the dialysis facility failed to identify in their communication plan, a primary and alternate means of communication for use during an emergency in 1 of 1 dialysis facility.</p> <p>Findings include:</p> <p>A revised policy, dated 06/01/2023, titled "RM700 Disaster and Emergency Preparedness", indicated that the communication plan should define how associates and patient will be notified of emergency conditions at the center.</p> <p>The Emergency Preparedness Plan for Hammond Dialysis Center, failed to list primary nor their alternate means of communication for use during an emergency.</p> <p>During an interview, on 07/31/2025 beginning at 2:38 PM, the FA indicated that the facility does not have any other alternate means of communication in the event that phones are unavailable.</p>	E 0032	<p>Meeting Held on _____.</p> <p>Clinic Manager Signature: _____</p> <p>Date: _____</p> <p>E 032</p> <p>An in-service was initiated to the Clinic Manager (CM) and all staff by the Regional Clinical and Regulatory Manager (CRM) regarding the policy for Communication Failures (See attached in-service record). Per EPM-19 Types of Disasters 8. Communication Failure "In the event a communication failure occurs, the following plan will be implemented: The Nurse in charge will designate a staff member to notify the local telephone company cell phone usage. The Clinic Manager and the Facility Technical Manager will be notified, and they will provide their company cell phone for usage by the clinic during the time of the communication failure. If the communication failure continues after the hours of operation, the facility lines will be forwarded to a designated number that is agreed to by management.....If the cell phone does not work the Nurse in charge will designate a staff member to go to the nearest area</p>	08/31/2025
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			<p>with cell service or drive to the local emergency management agency." It was stressed during the in- that the company cell phone (if allocated), or individual staff cell phones, should be available for staff during a communication failure of the phone system in the facility. Additionally, the facility should have a plan to forward calls to a designated number, if needed. Calls can be forwarded to local/regional management, regional office, or the corporate office for answering. The facility also has a NOAA weather radio located in the crash cart that can be used for obtaining information in the event of an emergency. The CM will ensure compliance by ensuring that the emergency plan is updated and reviewed at a minimum of every two years and includes updates to alternate means of communication. The emergency preparedness plan will also be reviewed and a minimum of annually by the facility governing body of which the clinic manager is a member.</p> <p>TRAINING/INSERVICE DOCUMENTATION FORM</p> <p style="text-align: right;">Training</p> <p>Date(s) Training Location Hammond Dialysis Center Facilitator(s)</p>	

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			Name Qualifications of Facilitator(s) Emergency Preparedness – E 032 (Condition E 003) Per EPM-19 Types of Disasters 8. Communication Failure “In the event a communication failure occurs, the following plan will be implemented: The Nurse in charge will designate a staff member to notify the local telephone companyvia cell phone usage. The Clinic Manager and the Facility Technical Manager will be notified, and they will provide their company cell phone for usage by the clinic during the time of the communication failure. If the communication failure continues after the hours of operation, the facility lines will be forwarded to a designated number that is agreed to by management.....If the cell phone does not work the Nurse in charge will designate a staff member to go to the nearest area with cell service or drive to the local emergency management agency.” The company cell phone (if allocated), or individual staff cell phones (CM or BT), should be available for staff during a communication failure of the phone system in the facility. Additionally, the facility should have a plan to forward calls to a designated number, if needed. Calls can be forwarded to local/regional management, regional office, or the corporate	

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E 0039 Bldg. 00	<p>403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements</p> <p>Based on record review and interview, the dialysis facility failed to evidence that exercises were conducted to test the emergency plan, annually at a minimum, in 1 of 1 dialysis facility.</p> <p>Findings include:</p> <p>A revised policy, dated 06/01/2023, titled "RM700 Disaster and Emergency Preparedness", indicated that each associates will participate in quarterly disaster exercises and each shift will have a minimum of one disaster exercise annually.</p> <p>During a record review of Hammond Dialysis Center's Emergency Preparedness Plan, the documentation failed to evidence the clinic tested their emergency plan at least annually nor</p>	E 0039	<p>office for answering. The facility also has a NOAA weather radio located in the crash cart that can be used for obtaining information in the event of an emergency. The CM will ensure compliance by ensuring that the emergency plan is updated and reviewed at a minimum of every two years and includes updates to alternate means of communication. The emergency preparedness plan will also be reviewed and updated a minimum of annually by the facility governing body of which the clinic manager is a member.</p> <p>E 039 An in-service was initiated the Clinic Manger (CM) and all staff on by the Regional Clinical and Regulatory Manager (CRM) regarding the requirement to conduct emergency preparedness exercises to evaluate the effectiveness of the facilities emergency preparedness plan (See attached in-service record). Per EM01 Facility Emergency Management Plan states "The facility will perform quarterly drills/testing and will complete a full-scale exercise to every two years, and the alternate year will conduct an additional exercise</p>	08/31/2025

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	<p>participated in a full scale community event.</p> <p>During an interview, on 07/31/2025 beginning at 1:15 PM, the FA indicated there were no exercise or test of their emergency plan that occurred within the last 2 years time, and further relayed the facility does not participate in community-wide full scale exercises.</p>		<p>such as a second full scale exercise that is community-based or individually, facility -based functional exercise; or a mock disaster drill; or a tabletop exercise or workshop.” It was stressed during the in-service that the goal of these exercises is to test the facility readiness in response to a disaster or an emergency as identified in the facility’s Hazard and Vulnerability Assessment tool and to ensure that all staff, patients, and visitors know the facilities emergency plans. The exercise should be appropriately documented on the Emergency Testing Exercise Worksheet and should include the date, location, type of emergency and details or scenario of the drill. The facilities will conduct an exercise 31, and a detailed description of the exercise will be documented on the Emergency Testing Exercise Worksheet. The dates of all exercises (e.g., tabletop and community-based or full-scale exercises) will be documented in the Quality Assessment and Performance Improvement (QAPI) meeting minutes and the next due dates will be tracked. As a member of the QAPI committee, the CM will ensure compliance by scheduling and coordinating the exercises annually and will ensure the appropriate documentation is kept in the Disaster Manual and</p>	

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			<p>reviewed at the QAPI meeting monthly. Additionally, as a member of the Governing Body the CM will ensure the Emergency Preparedness plan is reviewed and updated at minimum every two years and documentation of this review is kept in the Disaster Manual.</p> <p>TRAINING/INSERVICE DOCUMENTATION FORM</p> <p style="text-align: right;">Training</p> <p>Date(s) Training Location Hammond Dialysis Center Facilitator(s) Name Qualifications of Facilitator(s) Emergency Preparedness – E 039 (Condition E 003) Per EM01 Facility Emergency Management Plan states “The facility will perform quarterly drills/testing and will complete a full-scale exercise to every two years, and the alternate year will conduct an additional exercise such as a second full scale exercise that is community-based or individually, facility -based functional exercise; or a mock disaster drill; or a tabletop exercise or workshop.” The goal of these exercises is to test the facility readiness in response to a disaster or an emergency as identified in the facility’s Hazard and Vulnerability Assessment tool and to ensure that all staff,</p>	

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V 0000 Bldg. 00			patients, and visitors know the facilities emergency plans. The exercise should be appropriately documented on the Emergency Testing Exercise Worksheet and should include the date, location, type of emergency and details or scenario of the drill. The facility will conduct an exercise by 9/1/25 and a detailed description of the exercise will be documented on the Emergency Testing Exercise Worksheet. The dates of all exercises (e.g., tabletop and community-based or full-scale exercises) will be documented in the Quality Assessment and Performance Improvement (QAPI) meeting minutes and the next due dates will be tracked. As a member of the QAPI committee, the CM will ensure compliance by scheduling and coordinating the exercises annually and will ensure the appropriate documentation is kept in the Disaster Manual and reviewed at the QAPI meeting monthly. Additionally, as a member of the Governing Body the CM will ensure the Emergency Preparedness plan is reviewed and updated at minimum every two years and documentation of this review is kept in the Disaster Manual.	

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	<p>This visit was for a CORE Federal recertification survey of an ESRD provider.</p> <p>Survey dates: 07/28/2025, 07/29/2025, 07/30/2025, and 07/31/2025</p> <p>Census by Service Type:</p> <p>In Center Hemodialysis: 51</p> <p>Total Census: 51</p> <p>Isolation Room: Yes - 1</p> <p>During this Recertification Survey, Hammond Dialysis Center was found to be out of compliance with Conditions for Coverage at 42 CfC 494.30 Infection Control and 42 CfC 494.70 Patient Rights.</p> <p>The abbreviations used in this survey report: RN-Registered Nurse, PCT-Patient Care Technician, MSW-Medical Social Worker, FA-Facility Administrator.</p> <p>QR: A1, 8/11/25</p>	V 0000	<p>V 000</p> <p>The governing body and management staff of this facility take this deficiency statement very seriously and will work to bring the cited deficiencies into compliance and will ensure that they remain in compliance. The governing body met on August 22, to review and approve the Plan of Correction (POC) and the tools that will keep the approved plan in compliance. All attachments and in-services are also available at the facility for review. The governing body will meet monthly for the next six months to review the Plan of Correction and ensure that the citations in compliance. The findings from these reviews will also be discussed at monthly QAPI meetings.</p> <p>Hammond Dialysis Center Clinic Manager Tracking Tool To be brought to the monthly QAPI meeting Weekly (x 12 weeks) ItemWeek of:Week of:Week of:Week of:Week of:Week of: E 023 and E 030 -</p> <ol style="list-style-type: none"> 1. Review the emergency box weekly to ensure all patient information is included in the box and it is updated and current. (See Emergency Evacuation Box List) 2. Review the staff contact information on the HUB and UKG to ensure it is updated and current. Place in emergency 	

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	<p>Based on observation, record review, and interview, the dialysis facility failed to ensure: disinfecting solutions were covered to prevent transmission of infectious agents (See V111); hand hygiene was performed to maintain aseptic technique (See V113); aseptic techniques were maintained during parenteral medication administration (See V143); and CVC standard infection control precautions were implemented (See V147).</p> <p>The cumulative effect of these systemic problems has resulted in the dialysis facility's inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 494.30 Infection Control.</p>	V 0110	<p>V 110 CFC Infection Control CFR 494.30</p> <p>An in-service was provided to all Direct Patient Care (DPC) regarding the Infection Control Issues as cited in the referenced V tags. It was stressed during the in-service that all infection control practices, such as keeping bleach solution covered, hand hygiene practices, central venous catheter care, aseptic techniques with administering medications must be adhered to by all staff. The IC audit, normally completed monthly, has been increased to weekly for a minimum of 12 weeks by an assigned DPC staff member, until 100% compliance is achieved. Additionally, the Clinic Manager will be responsible for observing the treatment floor daily for 1 week until 100% compliance is achieved, and then one day a week for a minimum of 12 weeks, until 100% compliance is achieved, to ensure staff are adhering to all infection control practices. A CM monitoring tool was developed to monitor this and all be addressed at the monthly Quality Assurance Performance Improvement (QAPI) meeting. Additionally, the governing body will meet monthly for 6 months to ensure sustained improvement is noted. Cross Reference V111, V 113, V 143, V 147</p> <p>Infection Control Assessment-Clinic Name & #: Hammond</p>	08/31/2025

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			<p>Dialysis Center POC page to be attached to your IC audit tool and this tool increased to weekly for 12 weeks as part of the POC. Place a "Y" in the box indicating the observation is in compliance or "N" for observation not met. Any observation with a "N" must have a description in comments of what was not met. At the discretion of the Clinic Manager, this assessment tool can be delegated to a DPC Team Member. If discrepancies are found Clinic Manager should be notified and the frequency of doing this assessment should be increased. Non-compliance to be addressed with staff members and tool to be brought to the monthly QAPI meetings. Date: _____</p> <p>_____ Auditor's Signature</p> <p>YESNOCOMMENTS VTAGPlan of Correction V 111Bleach solution is covered V 113• Hand hygiene is to be performed after each glove removal, prior to donning a new pair of gloves. • After removing the patients' CVC dressing, gloves must be removed and hand hygiene performed, prior to donning a new pair of gloves to continue cleaning the CVC site. • Upon discontinuation of the treatment, after the patient's blood has been returned, gloves must be</p>	

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			<p>removed, hand hygiene performed prior to donning a pair of gloves to continue care of the patient.</p> <ul style="list-style-type: none"> • After palpating the patient's access to determine cannulation site, gloves must be removed, hand hygiene performed prior to donning a new pair of gloves and prior to continuing to cannulate the patient's access <p>V 143When administering medications via the patient's blood line port, the blood line is disinfected with an alcohol wipe prior to administering the medication.</p> <p>V 147• When disinfecting the patient CVC staff must ensure to disinfect the limbs, caps, and hubs prior to attaching the sterile syringes to each CVC port.</p> <ul style="list-style-type: none"> • After removing the patients' CVC dressing, the dressing and gloves must be immediately discarded in the biohazardous waste container and these dirty items never placed on a clean field containing patient clean supplies. <p>TRAINING/INSERVICE DOCUMENTATION FORM</p>	

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			<p>SCXW193315414 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" Training Date(s) div class="TableCellContent SCXW193315414 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" Training Location Hammond Dialysis Center div class="TableCellContent SCXW193315414 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" Facilitator(s) Name div class="TableCellContent SCXW193315414 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" Qualifications of Facilitator(s) div class="TableCellContent SCXW193315414 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" Infection Control – V 143</p>	

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			<p>(Condition V 110)</p> <p>div class="TableCellContent SCXW193315414 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;"</p> <p>p paraid="1057938955" paraeid="{ef6d677c-f852-4d35-a5eb-f78d6cd896c7}{115}" >Per G40 Infection Control "31. All blood line ports, saline bag ports and medication vial ports will be disinfected with an appropriate disinfectant prior to entry with needles."</p> <p>To reduce the risk of cross contamination when administering medication via the patient's blood line port, the blood line must be disinfected with an alcohol wipe prior to administering the medication. The above has been added to the monthly Infection Control (IC) Audit which will be increased to weekly for a minimum of 12 weeks by an assigned Direct Patient Care (DPC) staff member, until 100% compliance is achieved and will include observation of all DPC staff. All breaks in Infection Control will be immediately addressed by the Clinic Manager. Additionally, The CM will observe medication administration daily for one week</p>	

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V 0111 Bldg. 00	494.30 IC-SANITARY ENVIRONMENT Based on record review, observation, and interview, the dialysis facility failed to ensure bleach/water solution was covered with a lid to minimize transmission of infectious agents in 1 of 3 observations on the dialysis treatment floor [observation period #1] . Findings include:	V 0111	until 100% compliance is achieved, and then, weekly for a minimum of 12 weeks, until 100% compliance is achieved, to ensure all staff are administering medication using aseptic technique by wiping the infection port with alcohol prior to administering medication. The Clinic Manager will ensure compliance through direct observation and review of the Infection Control Audits at least monthly prior to the QAPI meeting. All findings from the IC audit tool and CM monitoring tool will be addressed at the monthly QAPI meeting. Review DPC IC audit tool. Review CM monitoring tool. V 111 An in-service was initiated with all Direct Patient Care (DPC) staff by the Clinic Manager (CM) regarding maintaining a clean and sanitary environment to reduce the risk of cross contamination (See attached in-service record). Per policy G45	08/31/2025

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	<p>A revised policy, dated 06/20/2024, titled "G45 Cleaning and Disinfection of Equipment, Supplies, and Treatment Area," indicated that bleach solutions must be covered with a lid to prevent contamination.</p> <p>During observation period #1, on 07/28/2025 from 10:10 AM - 12:10 PM, a container of clear solution, labeled as 1:100 was left uncovered, with the lid on the counter beside the container, throughout the duration of the observation period from 10:10 AM - 12:12 PM.</p> <p>During an interview, on 07/30/2025 beginning at 1:51 PM, PCT 4 indicated the clear solution was 1:100 bleach, and should remain covered.</p>		<p>Cleaning & Disinfection of Equipment, Supplies & Treatment Area "1. Unless equipment manufacturers specify use of another agent, equipment, treatment area and work surfaces will be disinfected using a 1:100 bleach water solution using 5.25% - 6% bleach.... 1:10 bleach/water solution should be used for blood spills >10cc. 2. Bleach solutions for this purpose must be made fresh each and all containers are labeled per Risk Management policies for labeling of chemical containers and must be covered with a lid to prevent contamination." It was stressed during the in-service that all bleach solutions containers must remain covered to ensure the solution does not become contaminated. This item has been added to the Infection Control (IC) Audit. The IC audit, normally completed monthly, will now be completed weekly for a minimum of 12 weeks by an assigned DPC staff member, until 100% compliance is achieved (See attached IC audit tool). The Clinic Manager will also observe the treatment floor daily for 1 week until 100% compliance is achieved, and then one day a week for a minimum of 12 weeks, until 100% compliance is achieved, to ensure the are See attached CM monitoring tool). The Clinic Manager will</p>	

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			<p>ensure compliance through direct observation and through review of the Infection Control Audits. All findings will be addressed at the monthly Quality Assurance Performance Improvement (QAPI) meeting, of which the medical director is a member, where additional action will be taken as deemed appropriate by the committee, such as more education, continuing the weekly audits or if trends are identified, disciplinary action.</p> <p>Training Date(s) Training Location Hammond Dialysis Center Facilitator(s) Name Qualifications of Facilitator(s) Infection Control – V 111 (Condition V 110) Per policy G45 Cleaning & Disinfection of Equipment, Supplies & Treatment Area “1. Unless equipment manufacturers specify use of another agent, equipment, treatment area and work surfaces will be disinfected using a 1:100 bleach water solution using 5.25% - 6% bleach.... 1:10 bleach/water solution should be used for blood spills >10cc. 2. Bleach solutions for this purpose must be made fresh each day and all containers are labeled per Risk Management policies for labeling of chemical containers and must be covered with a lid to prevent contamination.” All bleach solutions containers must remain</p>	

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			<p>covered to ensure the solution does not become contaminated. This item has been added to the Infection Control (IC) Audit. The IC audit, normally completed monthly, will now be completed weekly for a minimum of 12 weeks by an assigned DPC staff member, until 100% compliance is achieved. The Clinic Manager will also observe the treatment floor daily for 1 week until 100% compliance is achieved, and then one day a week for a minimum of 12 weeks, until 100% compliance is achieved, to ensure the bleach containers are covered. The Clinic Manager will ensure compliance through direct observation and through review of the Infection Control Audits. All findings will be addressed at the monthly Quality Assurance Performance Improvement (QAPI) meeting. Review DPC IC audit tool.</p> <p>Infection Control Assessment- Clinic Name & #: Hammond Dialysis Center POC page to be attached to your IC audit tool and this tool increased to weekly for 12 weeks as part of the POC. Place a "Y" in the box indicating the observation is in compliance or "N" for observation not met. Any observation with a "N" must have a description in comments of what</p>	

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			<p>was not met. At the discretion of the Clinic Manager, this assessment tool can be delegated to a DPC Team Member. If discrepancies are found Clinic Manager should be notified and the frequency of doing this assessment should be increased. Non-compliance to be addressed with staff members and tool to be brought to the monthly QAPI meetings.</p> <p>Date: _____</p> <p>____ Auditor's Signature</p> <p>YESNOCOMMENTS</p> <p>VTAGPlan of Correction</p> <p>V 111Bleach solution is covered</p> <p>V 113• Hand hygiene is to be performed after each glove removal, prior to donning a new pair of gloves.</p> <ul style="list-style-type: none"> • After removing the patients' CVC dressing, gloves must be removed and hand hygiene performed, prior to donning a new pair of gloves to continue cleaning the CVC site. • Upon discontinuation of the treatment, after the patient's blood has been returned, gloves must be removed, hand hygiene performed prior to donning a pair of gloves to continue care of the patient. • After palpating the patient's access to determine cannulation site, gloves must be removed, hand hygiene performed prior to donning a new pair of gloves and prior to continuing to cannulate the patient's access 	

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			<p>V 143When administering medications via the patient's blood line port, the blood line is disinfected with an alcohol wipe prior to administering the medication.</p> <p>V 147• When disinfecting the patient CVC staff must ensure to disinfect the limbs, caps, and hubs prior to attaching the sterile syringes to each CVC port.</p> <ul style="list-style-type: none"> • After removing the patients' CVC dressing, the dressing and gloves must be immediately discarded in the biohazardous waste container and these dirty items never placed on a clean field containing patient clean supplies. <p>Review CM monitoring tool.</p> <p>div="" div="" div="" div="" div="" div="" p="" paraid="55525735" paraeid="{48feb774-76e0-45b1-8c48-727dd37e9ad2}{107}"> Hammond Dialysis Center Clinic Manager Tracking Tool To be brought to the monthly QAPI meeting Daily x 1 weeks ItemDate: Date: Date: Date: Date: Date:</p> <p>V 111 - Review DPC IC audit tool. Bleach solutions remain covered throughout treatment day.Discrepancies Noted:</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2025
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NAME OF PROVIDER OR SUPPLIER HAMMOND DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7 SIBLEY STREET HAMMOND, IN 46320
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			<p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>CM Initials / Date Weekly x 12 weeks Item Week of: Week of: Week of: Week of: V 111 - Review DPC IC audit tool. Bleach solutions remain covered throughout treatment day. Discrepancies Noted:</p> <p>Discrepancies Noted:</p>	

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NAME OF PROVIDER OR SUPPLIER HAMMOND DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7 SIBLEY STREET HAMMOND, IN 46320
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			Discrepancies Noted:	
			Discrepancies Noted:	
			Discrepancies Noted:	
			Discrepancies Noted:	
			ItemWeek of:Week of:Week of:Week of:Week of:Week of:Week of:Week of: V 111 - Review DPC IC audit tool. Bleach solutions remain covered throughout treatment day. Discrepancies Noted:	
			Discrepancies Noted:	
			Discrepancies Noted:	
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V 0113 Bldg. 00	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Based on record review, observation, and interview, the dialysis facility failed to ensure their	V 0113	Discrepancies Noted: Discrepancies Noted: CM Initials / Date CM Monitoring Tool and all indicated documents were reviewed at the monthly QAPI Meeting Held on _____. Clinic Manager Signature: _____ Date: _____ p="" paraid="376766537" paraeid="{48feb774-76e0-45b1-8c48-727dd37e9ad2}">TRAINING/INSERVICE DOCUMENTATION FORM	08/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152671	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2025
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	<p>staff removed contaminated gloves and performed hand hygiene at the appropriate times to maintain aseptic technique in 2 of 3 (PCT 1) observations of central venous catheter [CVC] (catheter into large vein) exit site care, 1 of 2 (PCT 6) observations of discontinuation of dialysis with a CVC, and 1 of 3 (PCT 5) observations of accessing of arteriovenous fistula [AVF] (dialysis access) for initiation of dialysis.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. A revised policy, dated 11/29/2025, titled "G40 Infection Control", indicted that hand hygiene should be performed after touching contaminated items. 2. A revised procedure, dated 09/01/2023, titled "IC05C CVC: Dressing Change", indicated that once the old dressing is removed, hand hygiene should be performed and new gloves should be donned. 3. A revised procedure, dated 06/11/2025, titled "IC05A CVC: Initiation and Discontinuation of Treatment", indicated that once the patient blood has been returned, contaminated gloves should be removed, hand hygiene should be performed, and new gloves should be donned. 4. During an observation, on 7/28/2025 beginning at 10:35 AM, at station 8, PCT 1 was performing CVC exit site care to Patient 11. After removing the old CVC dressing, PCT 1 failed to remove contaminated gloves, perform hand hygiene, and don clean gloves prior to disinfecting the CVC exit site. 5. During an observation, on 7/28/2025 beginning at 11:00 AM, at station 5, PCT 1 was performing 		<p>including PCT #1, 5, 6 by the Clinic Manager (CM) regarding the importance of preventing cross contamination through proper hand hygiene (See attached in-service record). Per policy G40 Infection Control "30. Aseptic technique will be used to prepare the access site prior to needle insertion and to clean the CVC exit site." Per IC05C CVC: Dressing change procedure "3. Remove the old dressing from the catheter site and with contaminated gloves. Hand hygiene don new gloves." Lastly per policy IC05A Initiation & Discontinuation of Treatment "22. Once the patient's blood is close all camps. Remove gloves, hand hygiene, don clean gloves..." To reduce the risk of cross contamination the following was stressed: Hand hygiene is to be performed after each glove removal, prior to donning a new pair of gloves. After removing the patients' CVC dressing, gloves must be removed and hand hygiene performed, prior to donning a new pair of gloves to continue cleaning the CVC site. Upon discontinuation of the treatment, after the patient's blood has been returned, gloves must be removed, hand hygiene performed prior to donning a pair of gloves to continue care of the patient. After palpating the patient's access to determine cannulation site, gloves must be removed, hand hygiene</p>	

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NAME OF PROVIDER OR SUPPLIER HAMMOND DIALYSIS CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 7 SIBLEY STREET HAMMOND, IN 46320		
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	<p>CVC exit site care to Patient 12. After removing the old CVC dressing, PCT 1 failed to remove contaminated gloves, perform hand hygiene, and don clean gloves prior to disinfecting the CVC exit site.</p> <p>6. During an observation, on 07/30/2025 beginning at 1:55 PM, at station 16, PCT 6 was performing discontinuation of dialysis with a CVC on Patient 2. After returning the patient blood, PCT 6 failed to remove contaminated gloves, perform hand hygiene, and don new gloves prior to disinfecting the CVC connections and disconnecting the blood lines.</p> <p>7. During an observation, on 07/28/2025 beginning at 11:24 AM, at station 4, PCT 5 was performing access of AVF for initiation of dialysis on Patient 13. PCT 5 located and palpated the AVF cannulation sites and failed to perform hand hygiene and don clean gloves prior to disinfecting cannulation sites.</p> <p>8. During an interview, on 07/30/2025 beginning at 1:15 PM, PCT 6 indicated that hand hygiene and glove change should be performed after contamination.</p> <p>9. During an interview, on 07/30/2025 at 3 PM, PCT 1 described how she cleans a CVC exit including when she would change her gloves. She described she would continue to wear the same gloves to clean the CVC exit site as she wore to removed the soiled dressing.</p>		<p>performed prior to donning a new pair of gloves and prior to continuing to cannulate the patient's access.</p> <p>These items have been added to the monthly Infection Control (IC) Audit which will be done weekly for a minimum of 12 weeks by an assigned Direct Patient Care (DPC) staff member, until 100% compliance is achieved and will include observation of all staff including PCT #1, 5, and 6 (See attached IC audit tool). All breaks in Infection Control will be immediately addressed by the Clinic Manager. Additionally, The CM will observe the treatment floor daily for 1 week until 100% compliance is achieved and then, weekly for a minimum of 12 weeks until 100% compliance is achieved, to ensure all staff are performing hand hygiene per policy (See attached CM monitoring tool). The Clinic Manager will ensure compliance through direct observation and review of the Infection Control Audits at least monthly prior to the QAPI meeting. All findings will be addressed at the monthly QAPI meeting, of which the medical director is a member, where additional action will be taken as deemed appropriate, such as additional training, continuing the weekly audits.</p> <p>Training Date(s) Training</p>		

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			<p>Location Hammond Dialysis Center Facilitator(s) Name Qualifications of Facilitator(s) Infection Control – V 113 (Condition V 110) Per policy G40 Infection Control “30. Aseptic technique will be used to prepare the access site prior to needle insertion and to clean the CVC exit site.” Per IC05C CVC: Dressing change procedure “3. Remove the old dressing from the catheter site and discard with contaminated gloves. Hand hygiene don new gloves.” Lastly per policy IC05A Initiation & Discontinuation of Treatment “22. Once the patient’s blood is returned close all camps. Remove gloves, hand hygiene, don clean gloves...” To reduce the risk of cross contamination: Hand hygiene is to be performed after each glove removal, prior to donning a new pair of gloves. After removing the patients’ CVC dressing, gloves must be removed and hand hygiene performed, prior to donning a new pair of gloves to continue cleaning the CVC site. Upon discontinuation of the treatment, after the patient’s blood has been returned, gloves must be removed, hand hygiene performed prior to donning a pair of gloves to continue care of the patient. After palpating the patient’s access to determine cannulation site, gloves must be removed, hand hygiene performed prior to donning a new</p>	

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			<p>pair of gloves and prior to continuing to cannulate the patient's access. These items have been added to the monthly Infection Control (IC) Audit which will be done weekly for a minimum of 12 weeks by an assigned Direct Patient Care (DPC) staff member, until 100% compliance is achieved and will include observation of all staff. All breaks in Infection Control will be immediately addressed by the Clinic Manager. Additionally, The CM will observe the treatment floor daily for 1 week until 100% compliance is achieved and then, weekly for a minimum of 12 weeks until 100% compliance is achieved, to ensure all staff are performing hand hygiene per policy. The Clinic Manager will ensure compliance through direct observation and review of the Infection Control Audits at least monthly prior to the QAPI meeting. All findings will be addressed at the monthly QAPI meeting. Review DPC IC audit tool.</p> <p>Infection Control Assessment- Clinic Name & #: Hammond Dialysis Center POC page to be attached to your IC audit tool and this tool increased to weekly for 12 weeks as part of the POC. Place a "Y" in the box indicating the observation is in compliance or "N" for observation not met. Any</p>	

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			<p>observation with a "N" must have a description in comments of what was not met. At the discretion of the Clinic Manager, this assessment tool can be delegated to a DPC Team Member. If discrepancies are found Clinic Manager should be notified and the frequency of doing this assessment should be increased. Non-compliance to be addressed with staff members and tool to be brought to the monthly QAPI meetings.</p> <p>Date: _____</p> <p>____ Auditor's Signature</p> <p>YESNOCOMMENTS</p> <p>VTAGPlan of Correction</p> <p>V 111Bleach solution is covered</p> <p>V 113• Hand hygiene is to be performed after each glove removal, prior to donning a new pair of gloves.</p> <ul style="list-style-type: none"> • After removing the patients' CVC dressing, gloves must be removed and hand hygiene performed, prior to donning a new pair of gloves to continue cleaning the CVC site. • Upon discontinuation of the treatment, after the patient's blood has been returned, gloves must be removed, hand hygiene performed prior to donning a pair of gloves to continue care of the patient. • After palpating the patient's access to determine cannulation site, gloves must be removed, hand hygiene performed prior to donning a new pair of gloves and 	

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			<p>prior to continuing to cannulate the patient's access</p> <p>V 143When administering medications via the patient's blood line port, the blood line is disinfected with an alcohol wipe prior to administering the medication.</p> <p>V 147• When disinfecting the patient CVC staff must ensure to disinfect the limbs, caps, and hubs prior to attaching the sterile syringes to each CVC port.</p> <ul style="list-style-type: none"> • After removing the patients' CVC dressing, the dressing and gloves must be immediately discarded in the biohazardous waste container and these dirty items never placed on a clean field containing patient clean supplies. <p>Review CM monitoring tool.</p> <p>div="" div="" div=""</p> <p>div="" div="" div=""</p> <p>p="" paraid="138071547"</p> <p>paraeid="{113db65a-0d52-47c4-83c0-5dfd3e16bd72}{171}"></p> <p>Hammond Dialysis Center Clinic Manager Tracking Tool To be brought to the monthly QAPI meeting Daily x 1 weeks ItemDate: Date: Date: Date: Date: Date:</p> <p>V 113 - Review DPC IC audit tool:</p> <ul style="list-style-type: none"> • Hand hygiene is to be performed 	

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			<p>after each glove removal, prior to donning a new pair of gloves.</p> <ul style="list-style-type: none"> • After removing the patients' CVC dressing, gloves must be removed and hand hygiene performed, prior to donning a new pair of gloves to continue cleaning the CVC site. • Upon discontinuation of the treatment, after the patient's blood has been returned, gloves must be removed, hand hygiene performed prior to donning a pair of gloves to continue care of the patient. • After palpating the patient's access to determine cannulation site, gloves must be removed, hand hygiene performed prior to donning a new pair of gloves and prior to continuing to cannulate the patient's access. <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2025
FORM APPROVED
OMB NO. 0938-039

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			<p>Discrepancies Noted:</p> <p>CM Initials / Date Weekly x 12 weeks Item Week of: Week of: Week of: of: Week of: Week of: Week of: V 113 - As per above Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p>	

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			ItemWeek of:Week of:Week of: of:Week of:Week of:Week of: V 113 - As per aboveDiscrepancies Noted: Discrepancies Noted: Discrepancies Noted: Discrepancies Noted: Discrepancies Noted: Discrepancies Noted: Discrepancies Noted: CM Initials / Date CM Monitoring Tool and all indicated documents were reviewed at the monthly QAPI Meeting Held on _____. Clinic Manager Signature: _____	

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V 0143 Bldg. 00	<p>494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS</p> <p>Based on record review, observation, and interview, the dialysis facility failed to ensure LPN 1 demonstrated aseptic techniques when administering parenteral medications in 1 of 2 observations of parenteral medication preparation and administration.</p> <p>Findings include:</p> <p>A revised policy, dated 11/29/2022, titled "G40 Infection Control", indicated that blood line ports will be disinfected with an appropriate disinfectant prior to entry with needles.</p> <p>During an observation on 07/30/2025, beginning at 10:58 AM, at station 1, LPN 1 performed parenteral medication administration to Patient 4. LPN 1 failed to disinfect the blood line port prior to entry of needle for medication administration.</p> <p>During an interview on 07/30/2025, beginning at 2:20 PM, RN 2 indicated that the blood line port should be disinfected prior to administering parenteral medication.</p>	V 0143	<p>Date: _____</p> <p>p="" paraid="376766537" paraeid="{113db65a-0d52-47c4-83c0-5dfd3e16bd72}{86}">TRAINING/INSERVICE DOCUMENTATION FORM</p> <p>V 143</p> <p>An in-service was initiated to all Direct Patient Care (DPC) staff, including LPN #1, by the Clinic Manager (CM) on reinforcing that all medications must be administered using strict aseptic technique (See attached in-service record). Per G40 Infection Control "31. All blood line ports, saline bag ports and medication vial ports will be disinfected with an appropriate disinfectant prior to entry with needles." It was stressed during the in-service to reduce the risk of cross contamination when administering medication via the patient's blood line port, the blood line must be disinfected with an alcohol wipe prior to administering the medication. The above has been added to the monthly Infection Control (IC) Audit which will be increased to weekly for a minimum of 12 weeks by an assigned Direct Patient Care (DPC) staff member, until 100%</p>	08/31/2025

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			<p>compliance is achieved and will include observation of all DPC staff including LPN #1 (See attached IC Audit). All breaks in Infection Control will be immediately addressed by the Clinic Manager. Additionally, The CM will observe medication administration daily for one week until 100% compliance is achieved, and then, weekly for a minimum of 12 weeks, until 100% compliance is achieved, to ensure all staff are administering medication using aseptic technique by wiping the infection port with alcohol prior to administering medication (See attached CM monitoring tool). The Clinic Manager will ensure compliance through direct observation and review of the Infection Control Audits at least monthly prior to the QAPI meeting. All findings from the IC audit tool and CM monitoring tool will be addressed at the monthly QAPI meeting, of which the medical director is a member, where additional action will be taken as deemed appropriate, such as additional training, continuing the weekly audits or if trends are identified, disciplinary action.</p> <p>Training Date(s) Training Location Hammond Dialysis Center Facilitator(s) Name Qualifications of Facilitator(s) Infection Control – V 143 (Condition V 110) Per G40</p>	

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(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
			Infection Control "31. All blood line ports, saline bag ports and medication vial ports will be disinfected with an appropriate disinfectant prior to entry with needles." To reduce the risk of cross contamination when administering medication via the patient's blood line port, the blood line must be disinfected with an alcohol wipe prior to administering the medication. The above has been added to the monthly Infection Control (IC) Audit which will be increased to weekly for a minimum of 12 weeks by an assigned Direct Patient Care (DPC) staff member, until 100% compliance is achieved and will include observation of all DPC staff. All breaks in Infection Control will be immediately addressed by the Clinic Manager. Additionally, The CM will observe medication administration daily for one week until 100% compliance is achieved, and then, weekly for a minimum of 12 weeks, until 100% compliance is achieved, to ensure all staff are administering medication using aseptic technique by wiping the infection port with alcohol prior to administering medication. The Clinic Manager will ensure compliance through direct observation and review of the Infection Control Audits at least monthly prior to the QAPI	

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			<p>meeting. All findings from the IC audit tool and CM monitoring tool will be addressed at the monthly QAPI meeting. Review DPC IC audit tool. Review CM monitoring tool.</p> <p>div="" div="" div="" div="" p="" paraid="1057938955" paraeid="{ae48a819-92c5-4a39-9718-4a08c9e43ad7}{115}"> Hammond Dialysis Center Clinic Manager Tracking Tool To be brought to the monthly QAPI meeting Daily x 1 weeks ItemDate: Date: Date: Date: Date:</p> <p>V 143 - Review DPC IC audit tool. All medication ports are cleaned with an alcohol pad prior to administration of any medication. Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p>	

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			<p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>CM Initials / Date Weekly x 12 weeks Item Week of: Week of: Week of: Week of: Week of: Week of: Week of: Week of: V 143 - Review DPC IC audit tool.</p> <p>Infection Control Assessment- Clinic Name & #: Hammond Dialysis Center POC page to be attached to your IC audit tool and this tool increased to weekly for 12 weeks as part of the POC. Place a "Y" in the box indicating the observation is in compliance or "N" for observation not met. Any observation with a "N" must have a description in comments of what was not met. At the discretion of the Clinic Manager, this assessment tool can be delegated to a DPC Team Member. If discrepancies are found Clinic Manager should be notified and</p>	

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			<p>the frequency of doing this assessment should be increased. Non-compliance to be addressed with staff members and tool to be brought to the monthly QAPI meetings.</p> <p>Date: _____</p> <p>____ Auditor's Signature</p> <p>YESNOCOMMENTS</p> <p>V TAG Plan of Correction</p> <p>V 111 Bleach solution is covered</p> <p>V 113• Hand hygiene is to be performed after each glove removal, prior to donning a new pair of gloves.</p> <ul style="list-style-type: none"> • After removing the patients' CVC dressing, gloves must be removed and hand hygiene performed, prior to donning a new pair of gloves to continue cleaning the CVC site. • Upon discontinuation of the treatment, after the patient's blood has been returned, gloves must be removed, hand hygiene performed prior to donning a pair of gloves to continue care of the patient. • After palpating the patient's access to determine cannulation site, gloves must be removed, hand hygiene performed prior to donning a new pair of gloves and prior to continuing to cannulate the patient's access <p>V 143 When administering medications via the patient's blood line port, the blood line is disinfected with an alcohol wipe prior to administering the medication.</p>	

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			<p>V 147• When disinfecting the patient CVC staff must ensure to disinfect the limbs, caps, and hubs prior to attaching the sterile syringes to each CVC port.</p> <ul style="list-style-type: none"> • After removing the patients' CVC dressing, the dressing and gloves must be immediately discarded in the biohazardous waste container and these dirty items never placed on a clean field containing patient clean supplies. <p>All medication ports are cleaned with an alcohol pad prior to administration of any medication. Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p>	

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V 0147 Bldg. 00	<p>494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE</p> <p>Based on record review, observation, and interview, the dialysis facility failed to ensure central venous catheter [CVC] (catheter into large vein) standard infection control precautions were implemented to prevent catheter related infections in 2 of 2 (PCT 1) observations of initiation of dialysis with a CVC and 3 of 3 (PCT 1 and PCT 4) observations of CVC exit site care.</p> <p>Findings include:</p> <p>1. A revised policy, dated 11/29/2022, titled "G40 Infection Control", indicated that aseptic technique will be used to clean the CVC exit site and all CVC connections will be handled using aseptic technique.</p>	V 0147	<p>reviewed at the monthly QAPI Meeting Held on _____.</p> <p>Clinic Manager Signature: _____</p> <p>Date: _____</p> <p>p="" paraid="376766537" paraeid="{ae48a819-92c5-4a39-9718-4a08c9e43ad7}{30}"> TRAINING/INSERVICE DOCUMENTATION FORM</p> <p>147 V An in-service was initiated with all Direct Patient Care staff (DPC), including PCT #1 and 4, by the Clinic Manager (CM) regarding the importance of maintaining aseptic techniques when caring for a patient with a central venous catheter (CVC) (See attached in-service record). Per policy G40 Infection Control "30. Aseptic technique will be used to prepare the access site prior to needle insertion and to clean the CVC exit site." Per IC05C CVC: Dressing change procedure "3. Remove the old dressing from the</p>	08/31/2025

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	<p>2. A revised procedure, dated 06/11/2025, titled "IC05A CVC: Initiation and Discontinuation of Treatment" indicated that CVC limbs, caps, and hubs should be disinfected prior to attaching a sterile syringe for initiation of dialysis.</p> <p>3. A revised procedure, dated 09/01/2023, titled "IC05C CVC: Dressing Change", indicated that after removal of the old dressing for CVC exit site care, the old dressing and contaminated gloves should be discarded.</p> <p>4. During an observation, on 07/25/2025 beginning at 10:36 AM, PCT 1 was performing initiation of dialysis to Patient 11. PCT 1 failed to disinfect the CVC limbs, caps, and hubs prior to attaching the sterile syringes to each CVC port.</p> <p>5. During an observation, on 07/28/2025 beginning at 11:05 AM, PCT 1 was performing initiation of dialysis to Patient 12. PCT 1 failed to disinfect the CVC limbs, caps, and hubs prior to attaching the sterile syringes to each CVC port.</p> <p>6. During an observation, on 07/25/2025 beginning at 10:35 AM, PCT 1 was performing CVC exit site care to Patient 11. PCT 1 failed to discard the old dressing and contaminated gloves, instead placing them onto a clean field that contained unused supplies needed for initiation of dialysis for Patient 11. PCT 1 then proceeded to use the clean supplies for initiation of dialysis on Patient 11.</p> <p>7. During an observation, on 07/25/2025 beginning at 11:00 AM, PCT 1 was performing CVC exit site care to Patient 12. PCT 1 failed to discard the old dressing and contaminated gloves, instead placing them onto a clean field that contained</p>		<p>catheter site and with contaminated gloves. Hand hygiene done new gloves." Lastly per policy IC05A CVC: Initiation & Discontinuation of Treatment "3. Prior to cap removal, disinfect the arterial cap and limb, using the same antiseptic pad, apply antiseptic with friction to the catheter, moving from the hub at least several centimeters towards the body. Hold the Limb until the antiseptic is dry. Discard antiseptic pad. 4. Repeat Step #3 for the venous limb, using a new disinfectant pad. 5. Ensuring the limb clamp is closed, remove the arterial cap, and disinfect the hub with a new antiseptic pad. Scrub the sides (threads) and end of the hub thoroughly with friction, making sure to remove any residue." To reduce the risk of cross contamination and risk of infection in patients with a CVC the following was stressed: When disinfecting the patient CVC staff must ensure to disinfect the limbs, caps, and hubs prior to attaching the sterile syringes to each CVC port. After removing the patients' CVC dressing, the dressing and gloves must be immediately discarded in the biohazardous waste container and these dirty items never placed on a clean field containing patient clean supplies. This has been added to the monthly Infection Control (IC) Audit which will be done weekly,</p>	

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	<p>unused supplies needed for initiation of dialysis for Patient 12. PCT 1 then proceeded to use the clean supplies for initiation of dialysis on Patient 12.</p> <p>8. During an observation, on 07/25/2025 beginning at 11:18 AM, PCT 4 was performing CVC exit site care to Patient 4. PCT 4 failed to discard the old dressing, instead placing it onto a clean field that contained unused supplies needed for initiation of dialysis for Patient 4. PCT 4 then proceeded to use the clean supplies for initiation of dialysis on Patient 4.</p> <p>9. During an interview, on 07/30/2025 beginning at 1:15 PM, PCT 6 indicated that during CVC care, the old dressing and contaminated gloves should be discarded in the trash, and that the CVC catheter limbs/caps/and hubs should be cleaned prior to connecting syringes.</p> <p>10. During an interview, on 07/30/2025 beginning at 2:59 PM, PCT 1 indicated that she does not discard old dressing and contaminated gloves, instead places them on the clean field containing clean supplies. PCT 1 additionally indicated that she connects the syringes to the CVC ports without disinfecting first. PCT 1 indicated she disinfects ports after withdrawing heparin from the CVC port and prior to connecting the blood lines to the CVC port afterwards.</p>		<p>for a minimum of 12 weeks by an assigned Direct Patient Care (DPC) staff member, until 100% compliance is achieved and will include observation of all DPC staff including PCT# 1 and 4 (See attached IC audit tool). All breaks in Infection Control will be immediately addressed by the Clinic Manager. Additionally, The CM will observe the treatment floor daily for 1 week until 100% compliance is achieved and then weekly for a minimum of 12 weeks, until 100% compliance is achieved, to ensure all staff are following aseptic techniques when caring for a patient with a CVC (See attached CM monitoring tool). The Clinic Manager will ensure compliance through direct observation and review of the Infection Control Audits at least monthly prior to the QAPI meeting. All findings will be addressed at the monthly QAPI meeting, of which the medical director is a member, where additional action will be taken as deemed appropriate, such as additional training, continuing the weekly audits.</p> <p>Hammond Dialysis Center Clinic Manager Tracking Tool To be brought to the monthly QAPI meeting Daily x 1 weeks ItemDate: Date: Date:</p>	

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			<p>Date: Date: Date:</p> <p>V 147 - Review DPC IC audit tool:</p> <ul style="list-style-type: none"> • When disinfecting the patient CVC staff must ensure to disinfect the limbs, caps, and hubs prior to attaching the sterile syringes to each CVC port. • After removing the patients' CVC dressing, the dressing and gloves must be immediately discarded in the biohazardous waste container and these dirty items never placed on a clean field containing patient clean supplies. Discrepancies Noted: <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p>	

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			<p>CM Initials / Date Weekly x 12 weeks Item Week of: Week of: Week of: Week of: Week of: Week of: Week of: Week of:</p> <p>V 147 - Review DPC IC audit tool:</p> <ul style="list-style-type: none"> When disinfecting the patient CVC staff must ensure to disinfect the limbs, caps, and hubs prior to attaching the sterile syringes to each CVC port. After removing the patients' CVC dressing, the dressing and gloves must be immediately discarded in the biohazardous waste container and these dirty items never placed on a clean field containing patient clean supplies. Discrepancies Noted: <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p>	

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			<p>Discrepancies Noted:</p> <p>ItemWeek of:Week of:Week of:Week of:Week of:Week of:Week of:Week of:</p> <p>V 147 - Review DPC IC audit tool:</p> <ul style="list-style-type: none"> • When disinfecting the patient CVC staff must ensure to disinfect the limbs, caps, and hubs prior to attaching the sterile syringes to each CVC port. • After removing the patients' CVC dressing, the dressing and gloves must be immediately discarded in the biohazardous waste container and these dirty items never placed on a clean field containing patient clean supplies. Discrepancies Noted: <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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			<p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>CM Initials / Date CM Monitoring Tool and all indicated documents were reviewed at the monthly QAPI Meeting Held on _____.</p> <p>Clinic Manager Signature: _____</p> <p>Date: _____</p> <p>TRAINING/INSERVICE DOCUMENTATION FORM</p> <p>div class="TableCellContent SCXW108401258 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;"</p>	

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			Training Date(s) div class="TableCellContent SCXW108401258 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" Training Location Hammond Dialysis Center div class="TableCellContent SCXW108401258 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" Facilitator(s) Name div class="TableCellContent SCXW108401258 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" Qualifications of Facilitator(s) div class="TableCellContent SCXW108401258 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" Infection Control – V 147 (Condition V 110) div class="TableCellContent SCXW108401258 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding:	

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			<p>0px 2px; user-select: text; overflow: visible;" ·p paraid="1033633521" paraeid="{e756e618-2251-4ffa-94c5-a31d66776e54}{179}" >Per policy G40 Infection Control "30. Aseptic technique will be used to prepare the access site prior to needle insertion and to clean the CVC exit site."</p> <p>Per IC05C CVC: Dressing change procedure "3. Remove the old dressing from the catheter site and with contaminated gloves. Hand hygiene done new gloves." Lastly per policy IC05A CVC: Initiation & Discontinuation of Treatment "3. Prior to cap removal, disinfect the arterial cap and limb, using the same antiseptic pad, apply antiseptic with friction to the catheter, moving from the hub at least several centimeters towards the body. Hold the Limb until the antiseptic is dry. Discard antiseptic pad. 4. Repeat Step #3 for the venous limb, using a new disinfectant pad. 5. Ensuring the limb clamp is closed, remove the arterial cap, and disinfect the hub with a new antiseptic pad. Scrub the sides (threads) and end of the hub thoroughly with friction, making sure to remove any residue." To reduce the risk of cross contamination and risk of infection in patients with a</p>	

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			CVC: When disinfecting the patient CVC staff must ensure to disinfect the limbs, caps, and hubs prior to attaching the sterile syringes to each CVC port. After removing the patients' CVC dressing, the dressing and gloves must be immediately discarded in the biohazardous waste container and these dirty items never placed on a clean field containing patient clean supplies. This has been added to the monthly Infection Control (IC) Audit which will be done weekly, for a minimum of 12 weeks by an assigned Direct Patient Care (DPC) staff member, until 100% compliance is achieved and will include observation of all DPC staff. All breaks in Infection Control will be immediately addressed by the Clinic Manager. Additionally, The CM will observe the treatment floor daily for 1 week until 100% compliance is achieved and then weekly for a minimum of 12 weeks, until 100% compliance is achieved, to ensure all staff are following aseptic techniques when caring for a patient with a CVC. The Clinic Manager will ensure compliance through direct observation and review of the Infection Control Audits at least monthly prior to the QAPI meeting. All findings will be addressed at the monthly QAPI meeting. Review DPC IC audit tool. Review CM monitoring	

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V 0402 Bldg. 00	<p>494.60(a) PE-BUILDING-CONSTRUCT/MAINTAIN FOR SAFETY</p> <p>Based on observation, record review, and interview, the dialysis facility failed to ensure the safety of the patients was maintained by properly storing medications in 1 of 3 observations on the treatment floor (observation period 1).</p> <p>The findings include:</p> <p>A policy revised 06/11/2025 titled "Medications: Administration, Storage, [and] Disposal" indicated medications must never be left unsecured or unattended.</p> <p>During an observation on the treatment floor on 07/28/2025, at 11:25 AM, an open box of 10 ampules of epinephrine (an emergency medication) were observed unsecured and unattended on top of the crash cart on the treatment floor until the conclusion of the observation on the treatment floor at 12:15 PM.</p> <p>On 07/28/2025, at 11:45 AM, the FA was directed to the open box of epinephrine on top of the crash cart, and the FA indicated the medication should not be left on top of the crash cart but locked inside.</p>	V 0402	<p>tool.</p> <p>V 402 An in-service was initiated to all Direct Patient Care (DPC) Staff by the Clinic Manager (CM) regarding the keeping all medications secure (See attached in-service record). Per policy G48 Medications policy "4. Medications must never be left unsecured or unattended." During the in-service it was stressed that all medication, including medications on the crash cart (such as epinephrine ampules) must always be secured. Each staff member has the responsibility to ensure the medications are secure and if it is noted that a medication is not secured staff must immediately secure the medication. The clinic manager (CM) will ensure compliance by observing the treatment floor, weekly for 12 weeks, to ensure all medications are secured (See attached CM monitoring tool). The CM will ensure compliance through direct observation and use of the CM monitoring tool. Additionally, the CM monitoring tool will be reviewed at the monthly QAPI meeting, of which the medical director is a member, where further action will be taken as</p>	08/31/2025

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			<p>deemed appropriate, which could include additional monitoring, more education, and/ or disciplinary action.</p> <p>Hammond Dialysis Center Clinic Manager Tracking Tool To be brought to the monthly QAPI meeting Weekly x 12 weeks ItemWeek of:Week of:Week of: of:Week of:Week of:Week of: V 402 - All medications, including medications on the crash cart, must be secured at all times.Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2025
FORM APPROVED
OMB NO. 0938-039

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			<p>ItemWeek of:Week of:Week of:Week of:Week of:Week of:Week of:Week of:</p> <p>V 402 - All medications, including medications on the crash cart, must be secured at all times.Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>CM Initials / Date CM Monitoring Tool and all indicated documents were reviewed at the monthly QAPI Meeting Held on</p>	

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			<p>_____ Clinic Manager Signature:</p> <p>_____ Date:</p> <p>TRAINING/INSERVICE DOCUMENTATION FORM</p> <p>div class="TableCellContent SCXW49572271 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" Training Date(s)</p> <p>div class="TableCellContent SCXW49572271 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" Training Location Hammond Dialysis Center div class="TableCellContent SCXW49572271 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text;</p>	

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			<p>overflow: visible;" Facilitator(s) Name div class="TableCellContent SCXW49572271 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" Qualifications of Facilitator(s) div class="TableCellContent SCXW49572271 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" Physical Environment – V 402 div class="TableCellContent SCXW49572271 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" ·p paraid="1350387040" paraeid="{d7fe1a8a-014b-4fc2-b31 9-47aa5b3d377f}{89}" >Per policy G48 Medications policy "4. Medications must never be left unsecured or unattended."</p> <p>All medication, including medications on the crash cart (such as epinephrine ampules) must always be secured. Each staff member has the responsibility to ensure the medications are secure and if it is</p>	

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V 0407 Bldg. 00	<p>494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS</p> <p>Based on record review, observation, and interview, the dialysis facility failed to ensure patient safety by ensuring the hemodialysis [HD] (a process to filter the blood in a patient whose kidneys do not work normally) access sites were visible during HD treatment in 2 of 3 observation periods of in-center HD treatment (observation periods #1 and #2).</p> <p>Findings include:</p> <p>1. A revised policy, dated 11/29/2022, titled "IC08 Monitoring & Documentation of Patient Care During Treatment" indicated that a patient's vascular access should remain uncovered and visible throughout the course of the patient's treatment.</p> <p>2. During an observation on 07/28/25, at station 6,</p>	V 0407	<p>noted that a medication is not secured staff must immediately secure the medication. The clinic manager (CM) will ensure compliance by observing the treatment floor, weekly for 12 weeks, to ensure all medications are secured. The CM will ensure compliance through direct observation and use of the CM monitoring tool. Additionally, the CM monitoring tool will be reviewed at the monthly QAPI meeting. Review CM Monitoring tool.</p> <p>V 407 An in-service was initiated to all Direct Patient Care (DPC) staff by the Clinic Manager (CM) regarding the importance of monitoring patients to ensure their vascular access is visible during the treatment (See Attached - In-service Record). Per policy IC08 Monitoring & Documentation of Patient Care During Treatment it states, "The patient's vascular access should remain uncovered and readily visible throughout the course of the patient's treatment. If the patient refuses to allow the access to remain uncovered and visible, the caregiver must enter a detailed note at the first observation that fully explains the</p>	08/31/2025

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	<p>Patient 10 had his/her dialysis access site covered with a blanket at 10:35 AM, and the access site remained covered throughout the observation period that ended at 12:10 PM.</p> <p>3. During an observation on 07/28/2025, at station 5, Patient 12 had his/her dialysis access site covered with a disposable PPE gown at 11:10 AM, and the access site remained covered throughout the observation period that ended at 12:10 PM.</p> <p>4. During an observation on 07/28/2025, at station 8, Patient 11 had his/her dialysis access site covered with a blanket at 11:10 AM, and the access site remained covered throughout the observation period that ended at 12:10 PM.</p> <p>5. During an observation on 07/30/2025, at station 8, Patient 10 had his/her dialysis access site covered with a blanket at 10:30 AM, and the access site remained covered throughout the observation period that ended at 11:45 AM.</p> <p>6. During an interview on 07/30/2025, beginning at 11:29AM, PCT 4 indicated that HD access sites must be visible at all times during HD treatment.</p> <p>7. During an interview on 07/30/2025, beginning at 10:40 AM, Patient 10 indicated that he/she is aware that access should be visible, but states he often gets cold and uses a blanket.</p>		<p>patient refusal, and may simply document "No visibility of the vascular access"....Any patient that refuses to allow the access to remain uncovered must be reported, as soon as possible, to the Center Manager, Attending Physician, and Medical Director for intervention." It was stressed during the in-service to prevent the potential for exsanguination staff must take immediate action when patient's access sites, including CVC sites, or bloodline connections are covered with a blanket, patient clothing, or other covering, such as a disposable gown. Staff are to gently wake any patient whose access is covered and remind them that their access must stay uncovered. Staff are also to educate the patient regarding this and document this on the treatment sheet. A letter was given to all patients, including patients #10, #12, and # that their access and bloodline connection must be uncovered (see attached – patient letter). The charge nurse (CN) is to round on all patients during every patient shift to make sure that no access or bloodline connection is covered. Any patient who requires further prompting, on keeping their access uncovered, will have this education documented on the treatment sheet and the CM will be notified (See attached CN rounding tool). The Clinic Manager</p>	

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			<p>(CM) will ensure compliance by observing the treatment floor daily for 1 week until 100% compliance is achieved and the, one day a week for 12 weeks until 100% compliance is achieved, to ensure compliance with access and bloodline connections remaining uncovered. The CM will meet with the nurses in charge to determine patients who are not compliant, and further education will be provided to these patients (See attached CM monitoring tool). The CM will ensure compliance through review of the CN rounding tool and use of the CM monitoring tool. The findings from the CN rounding tool and CM monitoring tool will be reviewed at the monthly QAPI meetings, of which the medical director is a member, where further action will be taken by the committee such as the continued weekly monitoring and/or disciplinary action.</p> <p>Training Date(s) Training Location Hammond Dialysis Center Facilitator(s) Name Qualifications of Facilitator(s) Physical Environment – V 407 Per policy IC08 Monitoring & Documentation of Patient Care During Treatment it states, “The patient’s vascular access should remain uncovered and readily visible throughout the course of the patient’s treatment. If the patient refuses to allow the</p>	

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			access to remain uncovered and visible, the caregiver must enter a detailed note at the first observation that fully explains the patient refusal, and may simply document "No visibility of the vascular access"....Any patient that refuses to allow the access to remain uncovered must be reported, as soon as possible, to the Center Manager, Attending Physician, and Medical Director for intervention." To prevent the potential for exsanguination staff must take immediate action when patient's access sites, including CVC sites, or bloodline connections are covered with a blanket, patient clothing, or other covering, such as a disposable gown. Staff are to gently wake any patient whose access is covered and remind them that their access must stay uncovered. Staff are also to educate the patient regarding this and document this on the treatment sheet. A letter given to all patients instructing that their access and bloodline connection must be uncovered. The charge nurse (CN) is to round on all patients during every patient shift to make sure that no access or bloodline connection is covered. Any patient who requires further prompting, on keeping their access uncovered, will have this education documented on the treatment sheet and the CM will	

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			<p>be notified. The Clinic Manager (CM) will ensure compliance by observing the treatment floor daily for 1 week until 100% compliance is achieved and the, one day a week for 12 weeks until 100% compliance is achieved, to ensure compliance with access and bloodline connections remaining uncovered. The CM will meet with the nurse in charge to determine patients who are not compliant, and further education will be provided to these patients. The CM will ensure compliance through review of the CN rounding tool and use of the CM monitoring tool. The findings from the CN rounding tool and CM monitoring tool will be reviewed at the monthly QAPI meetings. Review CN rounding tool. Review CM monitoring tool.</p> <p>div="" div="" div="" div="" p="" paraid="1185839124" paraeid="{31d1a64f-3556-47e7-a5f0-d4f6745783a4}{155}"> Hammond Dialysis Center Clinic Manager Tracking Tool To be brought to the monthly QAPI meeting Daily x 1 weeks ItemDate: Date: Date: Date: Date: Date:</p>	

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			<p>V 407 - Review CN rounding tool. Observe treatment floor to ensure patient access and bloodline connections remain uncovered throughout treatment. Meet with CN to determine patient who are no compliant and further education to be provided to those patient and this documented on the treatment record. Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>CM Initials / Date Weekly x 12 weeks Item Week of: Week of: Week</p>	

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			<p>of:Week of:Week of:Week of: V 407 - Review CN rounding tool. Observe treatment floor to ensure patient access and bloodline connections remain uncovered throughout treatment. Meet with CN to determine patient who are no compliant and further education to be provided to those patient and this documented on the treatment record.Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>ItemWeek of:Week of:Week of:Week of:Week of:Week of:Week of:</p>	

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			<p>V 407 - Review CN rounding tool. Observe treatment floor to ensure patient access and bloodline connections remain uncovered throughout treatment. Meet with CN to determine patient who are no compliant and further education to be provided to those patient and this documented on the treatment record.</p> <p>Charge Nurse Rounding Tool V 407 Shift 1 All rounds completed on all patients with the following discrepancies Noted (if any): Pt Initials>Description of Discrepancy>Action Take:Comments Shift 2 Shift 3 To be completed daily by the charge nurse and reviewed by the clinic manager. Charge Nurse Signature: _____ Charge Nurse Rounding Tool and all indicated documents were reviewed at the monthly QAPI Meeting Held on _____ CM Signature: _____ Date: _____ Discrepancies Noted: Discrepancies Noted:</p>	

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			<p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>CM Initials / Date CM Monitoring Tool and all indicated documents were reviewed at the monthly QAPI Meeting Held on _____.</p> <p>Clinic Manager Signature: _____</p> <p>Date: _____</p> <p>p="" paraid="1031169801" paraeid="{62d93c51-f773-4a5e-ba0b-df6ff0a168a0}{90}">Patient Education: Access Must Remain Uncovered Date: Dear Patient, I am sending this letter to inform</p>	

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			<p>you of an issue that was brought to my attention in a recent survey at the facility. The quality of care that we deliver to you is of utmost importance and I am asking you to do help us in maintaining the best and safest care for you, our patients. For your safety, after your dialysis treatment has been initiated, it is of utmost importance that your dialysis access, including blood tubing connections, and face remain uncovered at all times. This is a safety issue for you and ensures that the staff of the facility can always see your access to make sure that everything is fine and no bleeding is observed. I am asking you please to develop this practice now, if you are not already doing so. The staff will also remind you of this practice if they see that your access and/or face is covered. I appreciate your acceptance of these and we will continue to strive to make this facility the best and safest in the area. Type text here. Thank you, Medical Director</p> <p>TRAINING/INSERVICE DOCUMENTATION FORM</p>	

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V 0450 Bldg. 00	<p>494.70 CFC-PATIENTS- RIGHTS</p> <p>Based on record review and interview, the dialysis failed to ensure: the patient was treated with respect (See V452) and the care was provided as directed in the plan of care (See V463).</p> <p>The cumulative effect of these systemic problems has resulted in the dialysis facility's inability to ensure provision of quality health care in a safe environment for the condition of participation at 42 Cfc 494.70 Patient Rights.</p>	V 0450	<p>V 450 CFC Patients' Rights CFR 494.70 An in-service was provided to all staff regarding the Patient Rights issues as cited in the referenced V tags. It was stressed during the in-service that all patients have a right to be treated with respect and dignity, and to voice grievances without fear of discrimination or reprisal, and to receive the necessary services as outlined in the patient plan of care and as ordered by the physician. The grievance policy was reviewed during the in-service and policies for monitoring during treatment to ensure all physician orders were followed, was also reviewed. A Clinical and Regulatory Manager (CRM) monitoring tool was developed, and the CRM will review the QAPI minutes monthly for 3 months to ensure all grievances are trended, tracked and monitored to ensure a resolution is provided to all patients. Additionally, the charge nurse and clinic manager will be responsible for monitoring the treatment flow sheets to ensure all treatment orders are followed and the results of this action will be documented on the CN rounding tool, and CM monitoring tool and findings reviewed in the monthly QAPI</p>	08/31/2025

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			<p>meetings. Additionally, the governing body will meet monthly for 6 months to ensure sustained improvement is noted. Cross Reference V 452, V 463 TRAINING/INSERVICE DOCUMENTATION FORM</p> <p>div class="TableCellContent SCXW3240074 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" Training Date(s)</p> <p>div class="TableCellContent SCXW3240074 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" Training Location Hammond Dialysis Center div class="TableCellContent SCXW3240074 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" Facilitator(s) Name</p>	

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			<div style="font-family: monospace; font-size: 0.8em;"> <div class="TableCellContent SCXW3240074 BCX0" style="border: 1px solid black; padding: 2px;"> style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" Qualifications of Facilitator(s) <div class="TableCellContent SCXW3240074 BCX0" style="border: 1px solid black; padding: 2px;"> style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" RM 300 Incident / Event Reporting </div> <div class="TableCellContent SCXW3240074 BCX0" style="border: 1px solid black; padding: 2px;"> style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" ·p paraid="1787977035" paraeid="{44c85228-0303-4664-afb0-ad1a78f35901}{93}" >Reviewed policy RM 300 Incident Reporting in entirety with all staff. </div> Focus on incidents that are reportable. Notifications: Patient physician, Medical Director, CM, Clinical and Regulatory Manager. How to complete and document an incident in the incident reporting portal. Follow up and monitoring in QAPI. </div> </div>	

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V 0452 Bldg. 00	<p>494.70(a)(1) PR-RESPECT & DIGNITY</p> <p>Based on record review and interview, the agency failed to ensure patients had the right to recognition of individual needs and the ability to question procedures without fear of reprisal in 1 of 1 clinical record listed as unstable related to missed visits in a total sample of 6 clinical records reviewed. (Patient #6)</p> <p>The findings include:</p> <p>A policy dated 06/11/2025 titled "Grievance Process: Patients" indicated patients using the grievance process would not be threatened or intimidated.</p> <p>A review of a Patient Complaint or Grievance Form dated 05/15/2025 indicated Patient #6 informed the MSW he/she felt unsafe on the treatment floor. The MSW indicated she offered to refer the Patient to another facility; the document failed to evidence the resolution.</p> <p>A Progress Note completed by the MSW, dated 05/15/2025, indicated Patient 6 did not feel safe at the facility and wanted to transfer to another facility. The note indicated Patient was unsure if he would be able to transfer due to past behaviors at other dialysis facilities and did not want to pursue a transfer to another facility.</p> <p>On 07/28/2025, at 10:41 AM, Patient #7 indicated the FA had not followed up on his/her complaints. Patient #7 indicated management was a problem, and the attitude of the staff changed when</p>	V 0452	<p>V 452</p> <p>An in-service was initiated to all Direct Patient Care (DPC) staff and the Interdisciplinary Team of which includes the Clinic Manager and Medical Director by the Regional Clinical and Regulatory Manager (CRM) to review the reporting requirements for patient complaints (See attached in-service record). Per policy G 10 Patient Rights & Responsibilities states "3. Be treated with consideration and respect and in full recognition of the patient's individual and personal needs....15. Voice grievances and recommend changes in policies without fear of discrimination or reprisal." Also, during the in-service policy G 11A Grievance Process was reviewed in entirety with emphasis on "6. The Center Manager will investigate the grievance and make every attempt possible to resolve the issue and communicate the resolution in writing to the patient and/or family within 15 workings days." During the in-service it was stressed that all patients have the right to voice complaints without fear of retaliation. All complaints should be addressed, investigated, and a</p>	08/31/2025

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	<p>management come out onto the treatment floor.</p> <p>Review of the Quality Assurance and Performance Improvement (QAPI) program indicated Patient #6 had the following number of missed HD treatment visits: January 2025: 1, February 2025: 0, March 2025: 5, April 2025: 4, May 2025: 5, June 2025: 3, and July 2025: 2.</p> <p>During an interview on 07/29/2025, at 12:37 PM, the MSW indicated Patient 6 did not feel safe at the facility, Patient did not like their physician. The MSW indicated the facility did not provide a referral to or contact information for another physician.</p> <p>On 07/29/2025, at 1:54 PM, Patient #6 indicated he/she missed treatments due to not feeling safe at the facility and indicated the reason for feeling unsafe was because he/she felt "targeted" by the FA for making complaints about his/her concerns regarding treatment(s) initiated late, not seeing their physician, and staff changing her/his dry weight and the amount of fluid being pulled off. The Patient indicated the FA does not speak to him/her since the Patient has spoken up about his/her concerns.</p> <p>On 07/30/2025, beginning at 12:11 PM, Person 1 (former employee) indicated Patient #6 felt unsafe because Patient #6 voiced a complaint about treatment(s) being started late and the FA then "had it out for [Patient #6]."</p> <p>On 07/30/2025, beginning at 2:20 PM, RN 2 indicated on 07/28/2025 Corporate Person 1 "highly encouraged" her to not tell the surveyors of patients wanting to speak to the surveyors. RN 2 indicated patients that made frequent complaints were labeled as "troublemakers" by the FA, and</p>		<p>resolution provided to the patient within 15 working days of receiving the complaint. If the patient and/or family are still not satisfied with the decisions reached, then this decision may be appealed to the Medical Director. The IDT will meet with patient #6 by August 31, to review the patient's current plan of care and address recent complaints with a resolution provided to the patient. Documentation of the investigation into the complaint and resolution will be documented the Grievance Summary Report and tracked on the Grievance log that will be reviewed in the monthly QAPI meeting. The IDT will follow the patient monthly until all treatment goals are met, including goals developed to address missed treatments. All complaints should be reviewed in the monthly QAPI meeting and monitored for trends and develop action plans, with root cause analysis, when trends are identified. The CM will document the details of all grievances on the Grievance Summary Report form and ensure a resolution is provided to all grievances within 15 working days. This form and the Grievance Tracking log must be brought to the monthly Quality Assessment Performance Improvement (QAPI) meeting, where the complaints are analyzed by the committee and an action plan put into place as deemed necessary and resolution</p>	

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	<p>the FA did not investigate and follow-up with the patient's complaints. RN 2 indicated the FA encouraged staff to write incident reports for the behaviors of certain patients to include Patient #6 and Patient #7 and ignored other patients who made complaints to include Patient #1. RN 2 indicated patient rights were not maintained by treating patients with respect if they were not management's "favorite."</p> <p>On 07/31/2025, at 3:26 PM, the Nurse Practitioner 1 indicated the FA shows favoritism to patients and indicated the tension between the FA and nursing staff was palpable on the treatment floor by the patients.</p> <p>On 07/31/2025, at 1:37 PM, the FA indicated she had no idea why Patient #6 felt unsafe at the facility, because the next time she saw the Patient on the floor after making the grievance, Patient #6 referred to the FA as "Sexy Red", so she did not ask the Patient why he/she felt unsafe.</p>		<p>is determined by the committee. The resolution is to be discussed with the patient who filed the complaint (or family member designated by the patient) and documentation to this effect must appear in the QAPI minutes. The CM, as a member of the QAPI committee, will ensure compliance through review of this form, and the Complaint and Grievance Tracking Log prior to the monthly QAPI meeting, of which the medical director is a member, where further action will be taken as deemed appropriate by the committee such as disciplinary action. To ensure further compliance the Regional Clinical and Regulatory Manager will review the QAPI minutes, monthly for 3 months, to ensure all grievances are trended, tracked, and monitored and ensuring a resolution was provided to the patient per policy (See attached CRM monitoring tool). Hammond Dialysis Center Clinic Regulatory Manager Tracking Tool To be brought to the monthly QAPI meeting Monthly x 3 months ItemAug-25Sep-25Oct-25 Review QAPI minutes to ensure: 1. V 452 - All grievance reports are reviewed, resolution is given to patient within 15 working days. QAPI tracks and trends all grievances.</p>	

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			<p>2. V 628 - QAPI is trending and analyzing all personnel qualifications and root cause is determined with an action plan developed if any issues are determined that qualifications led to poor facility outcomes.</p> <p>3. V 634 - Facility staff are completing the incident reports and all incidents are reviewed, tracked, trended, and action plans developed if indicated. Discrepancies Noted: Discrepancies Noted: Discrepancies Noted: CRM Initials / Date CRM Monitoring Tool and all indicated documents were reviewed at the monthly QAPI Meeting Held on _____.</p> <p>Clinic Manager Signature: _____</p> <p>Date: _____</p> <p>TRAINING/INSERVICE DOCUMENTATION FORM</p> <p style="text-align: right;">Training</p> <p>Date(s) Training Location Hammond Dialysis Center Facilitator(s) Name Qualifications of Facilitator(s) Patient Rights – V 452 (Condition V 450) Per policy G 10 Patient Rights & Responsibilities states “3. Be treated with consideration and respect and in full recognition of the patient’s individual and</p>	

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			personal needs.... 15. Voice grievances and recommend changes in policies without fear of discrimination or reprisal." Per policy G 11A Grievance Process "6. The Center Manager will investigate the grievance and make every attempt possible to resolve the issue and communicate the resolution in writing to the patient and/or family within 15 workings days." All patients have the right to voice complaints without fear of retaliation. All complaints should be addressed, investigated, and a resolution provided to the patient within 15 working days of receiving the complaint. If the patient and/or family are still not satisfied with the decisions reached, then this decision may be appealed to the Medical Director. The IDT must meet with patient #6 to review the patient's current plan of care and address recent complaints with a resolution provided to the patient. Documentation of the investigation into the complaint and resolution will be documented the Grievance Summary Report and tracked on the Grievance log that will be reviewed in the monthly QAPI meeting. The IDT will follow the patient monthly until all treatment goals are met, including goals developed to address missed treatments. All complaints should be reviewed in	

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			the monthly QAPI meeting and monitored for trends and develop action plans, with root cause analysis, when trends are identified. The CM will document the details of all grievances on the Grievance Summary Report form and ensure a resolution is provided to all grievances within 15 working days. This form and the Grievance Tracking log must be brought to the monthly Quality Assessment Performance Improvement (QAPI) meeting, where the complaints are analyzed by the committee and an action plan put into place as deemed necessary and resolution is determined by the committee. The resolution is to be discussed with the patient who filed the complaint (or family member designated by the patient) and documentation to this effect must appear in the QAPI minutes. The CM, as a member of the QAPI committee, will ensure compliance through review of this form, and the Complaint and Grievance Tracking Log prior to the monthly QAPI meeting. To ensure further compliance the Regional Clinical and Regulatory Manager will review the QAPI minutes, monthly for 3 months, to ensure all grievances are trended, tracked, and monitored and ensure a resolution was provided to the patient per policy. Review	

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			<p>CRM monitoring tool.</p> <p>TRAINING/INSERVICE DOCUMENTATION FORM</p> <p>Tr</p> <p>aining Date(s)</p> <p>Training Location Hammond Dialysis Center Facilitator(s) Name Qualifications of Facilitator(s) Patient Rights – V 452 (Condition V 450) Per policy G 10 Patient Rights & Responsibilities states “3. Be treated with consideration and respect and in full recognition of the patient’s individual and personal needs.... 15. Voice grievances and recommend changes in policies without fear of discrimination or reprisal.” Per policy G 11A Grievance Process “6. The Center Manager will investigate the grievance and make every attempt possible to resolve the issue and communicate the resolution in writing to the patient and/or family within 15 workings days.” All patients have the right to voice complaints without fear of retaliation. All complaints should be addressed, investigated, and a resolution provided to the patient within 15 working days of receiving the complaint. If the patient and/or family are still not satisfied with the decisions reached, then</p>	

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			<p>this decision may be appealed to the Medical Director. The IDT must meet with patient #6 to review the patient's current plan of care and address recent complaints with a resolution provided to the patient. Documentation of the investigation into the complaint and resolution will be documented on the Grievance Summary Report and tracked on the Grievance log that will be reviewed in the monthly QAPI meeting. The IDT will follow the patient monthly until all treatment goals are met, including goals developed to address missed treatments. All complaints should be reviewed in the monthly QAPI meeting and monitored for trends and develop action plans, with root cause analysis, when trends are identified. The CM will document the details of all grievances on the Grievance Summary Report form and ensure a resolution is provided to all grievances within 15 working days. This form and the Grievance Tracking log must be brought to the monthly Quality Assessment Performance Improvement (QAPI) meeting, where the complaints are analyzed by the committee and an action plan put into place as deemed necessary and resolution is determined by the committee. The resolution is to</p>	

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V 0463 Bldg. 00	<p>494.70(a)(12) PR-RECEIVE SERVICES OUTLINED IN POC</p> <p>Based on record review and interview, the facility failed to ensure the services were provided as directed in the plan of care in 3 of 6 clinical records reviewed. (Patient #1, 4, 6)</p> <p>The findings include:</p> <p>1. A clinical record review for Patient #1 evidenced a Treatment Flowsheet dated 06/18/2025 (Wednesday) which indicated the Patient's treatment days were Monday, Wednesday, and Friday and indicated the facility was to administer Mircera (medication to treat low</p>	V 0463	<p>be discussed with the patient who filed the complaint (or family member designated by the patient) and documentation to this effect must appear in the QAPI minutes. The CM, as a member of the QAPI committee, will ensure compliance through review of this form, and the Complaint and Grievance Tracking Log prior to the monthly QAPI meeting. To ensure further compliance the Regional Clinical and Regulatory Manager will review the QAPI minutes, monthly for 3 months, to ensure all grievances are trended, tracked, and monitored and ensure a resolution was provided to the patient per policy. Review CRM monitoring tool.</p> <p>V 463 An in-service was initiated to all Direct Patient Care (DPC) staff and the Clinic Manager (CM) by the Regional Clinical and Regulatory Manager (CRM) reinforcing that every part of the dialysis prescription must be supported by a physician order or justified in writing on the treatment sheet as to why the order could not be achieved. This includes the prescribed dose, Blood Flow Rates (BFR) and/or Dialysate</p>	08/31/2025

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	<p>red blood cells) during the second treatment weekly. The record failed to evidence the facility administered Mircera on the second treatment day of the week on 06/18/2025.</p> <p>On 07/28/2025 at 11:00 AM, Patient #1 indicated the facility did not administer Mircera several weeks ago due to "a shipment didn't come in."</p> <p>On 07/30/2025 at 2:20 PM, RN 2 indicated Mircera was supposed to be given on the second treatment day of the week, but if the medication was not available, the medication would be given on the third treatment day. RN 2 indicated the staff was instructed by the FA to document the medication as "not due" instead of medication not available.</p> <p>On 07/30/2025, at 3:15 PM, the FA indicated the medication was not given on the second treatment day on 06/18/2025, because the medication was not available. The FA stated, "If a medication isn't available, I can't give it. That's not a medication error; it's a supply issue."</p> <p>A Dialysis Order Report dated 07/21/2025 indicated the Patient's dialysate flow rate (DFR) was 500. A Treatment Sheet dated 07/25/2025 indicated the DFR was 600 beginning at 10:31 AM until the end of treatment at 1:55 PM. The record failed to evidence an order to increase the DFR to 600.</p> <p>On 07/30/2025, at 3:15 PM, RN 2 indicated the DFR should not be higher than what is ordered and indicated there was no order to increase the DFR to 600.</p> <p>2. A clinical record review for Patient #4 evidenced a Treatment Flow Sheet dated</p>		<p>Flow Rate (DFR) (See attached in-service record). Per policy IC08 Monitoring & Documentation of Patient Care During Treatment "4. The following must be documented before "starting" the patient's treatment in the electronic documentation system: Machine checks, Pre-treatment vital signs, Treatment RX – indicating caregiver review and verification of all patient treatment data and machine set-up information, Orders. 10. Data that must be documented ...at least every 30 minutes and PRN depending on patient's condition includes but is not limited to: Blood flow rate (BFR), Dialysate flow rate (DFR). Also, per the policy "15. Information that must be entered manually includes but is not limited to: If the patient's prescription was not met for any reason (A detailed progress note must be entered explaining why the prescription was not met and actions taken to address the situation." It was stressed during the in-service that every part of the dialysis prescription must be supported by a physician order or justified in writing the reason the order could not be achieved, and the charge nurse notified. This includes orders for , BFR, and/or the DFR. It was also stressed that 30-minute checks must be conducted to ensure the treatment is progressing safely and to note</p>	

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	<p>07/08/2025 which indicated the blood flow rate (BFR) was ordered at 350, the treatment was initiated with a BFR of 400. The record failed to evidence an order for a BFR increase to 400.</p> <p>On 07/31/2025, at 3:44 PM, the FA indicated the BFR must have been initiated incorrectly and indicated there was no order for a BFR increase to 400.</p> <p>3. A clinical record review for Patient #6 evidenced a Treatment Flow Sheet dated 07/28/2025 which indicated the BFR was ordered at 400, the treatment was initiated with a BFR of 450. The record failed to evidence an order for a BFR increase to 450.</p> <p>On 07/31/2025, at 1:41 PM, the FA indicated the treatment must have been started incorrectly with a BFR of 450.</p>		<p>any changes (e.g. patients not meeting BFR and/or DFR). If the prescription order cannot be achieved as ordered, the DPC staff member must document on the treatment sheet the reason that the prescribed orders could not be attained, and the charge nurse notified. The nurse in charge must perform and document an assessment of why the order cannot be achieved, and the physician notified. If any patient is continuously unable to achieve their dialysis prescription, as ordered, the IDT must document this on the Comprehensive Assessment and Plan of Care (CA/POC) and document action taken to achieve prescribed orders with a goal and target dates indicated when the goal will be achieved. Additionally, the Clinic Manager must evaluate any issues with receiving medications, such as , to ensure enough stock is being ordered by the Bio-Medical Technician to have available for patient administration on the dates the medication is ordered. The Charge Nurse (CN) will round on all patients shifts to verify that treatment orders are followed, including the correct dosage and schedule for , and the BFR and/or DFR, on all patients and there is documentation on the treatment sheet as to why the order cannot be attained (See attached CN rounding tool). The</p>	

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			<p>CM will review the treatment flow sheets weekly, daily for 1 week until 100% compliance is achieved, and the weekly for 12 weeks until 100% compliance is achieved, to ensure all treatment orders are followed per physician order and there is documentation by the DPC staff on the treatment sheet that the CN was notified if orders cannot be obtained and if trends are identified in patient not being able to meet their prescribed treatment orders the information is included in the Comprehensive Assessment and that plans are formulated with reasonable timelines to ensure the patient meets their prescribed treatment orders. Additionally, the CM will review the medication stock weekly ongoing with the BT to ensure there is enough medication to administer to patient as ordered (See attached CM monitoring tool). The CM will ensure compliance by direct review of the treatment records and through review of the charge nurse rounding tool. The findings from the CM monitoring tool and the CN rounding tool will be reviewed at the monthly Quality Assessment & Performance Improvement (QAPI) meeting, of which the medical director is a member, where additional action will be taken by the committee such as continuing the weekly CM monitoring, further education,</p>	

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			and/or disciplinary action.¿ Training Date(s) Training Location Hammond Dialysis Center Facilitator(s) Name Qualifications of Facilitator(s) Patient Rights – V 463 (Condition V 450) Per policy IC08 Monitoring & Documentation of Patient Care During Treatment “4. The following must be documented before “starting” the patient’s treatment in the electronic documentation system: Machine checks, Pre-treatment vital signs, Treatment RX – indicating caregiver review and verification of all patient treatment data and machine set-up information, Orders. 10. Data that must be documented ...at least every 30 minutes and PRN depending on patient’s condition includes but is not limited to: Blood flow rate (BFR), Dialysate flow rate (DFR). Also, per the policy “15. Information that must be entered manually includes but is not limited to: If the patient’s prescription was not met for any reason (A detailed progress note must be entered explaining why the prescription was not met and actions taken to address the situation.” Every part of the dialysis prescription must be supported by a physician order or justified in writing the reason the order could not be achieved, and the charge nurse notified. This includes orders for Mircera, BFR,	

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			and/or the DFR. 30-minute checks must be conducted to ensure the treatment is progressing safely and to note any changes (e.g. patients not meeting BFR and/or DFR). If the prescription order cannot be achieved as ordered, the DPC staff member must document on the treatment sheet the reason that the prescribed orders could not be attained, and the charge nurse notified. The nurse in charge must perform and document an assessment of why the order cannot be achieved, and the physician notified. If any patient is continuously unable to achieve their dialysis prescription, as ordered, the IDT must document this on the Comprehensive Assessment and Plan of Care (CA/POC) and document action taken to achieve prescribed orders with a goal and target dates indicated when the goal will be achieved. Additionally, the Clinic Manager must evaluate any issues with receiving medications, such as Mircera, to ensure that enough stock is being ordered by the Bio-Medical Technician to have available for patient administration on the dates the medication is ordered. The Charge Nurse (CN) will round on all patients shifts to verify that treatment orders are followed, including the correct dosage and schedule for Mircera, and the BFR	

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			and/or DFR, on all patients and there is documentation on the treatment sheet as to why the order cannot be attained. The CM will review the treatment flow sheets weekly, daily for 1 week until 100% compliance is achieved, and the weekly for 12 weeks until 100% compliance is achieved, to ensure all treatment orders are followed per physician order and there is documentation by the DPC staff on the treatment sheet that the CN was notified if orders cannot be obtained and if trends are identified in patient not being able to meet their prescribed treatment orders the information is included in the Comprehensive Assessment and that plans are formulated with reasonable timelines to ensure the patient meets their prescribed treatment orders. Additionally, the CM will review the Mircera medication stock weekly ongoing with the BT to ensure there is enough medication to administer to patient as ordered. The CM will ensure compliance by direct review of the treatment records and through review of the charge nurse rounding tool. The findings from the CM monitoring tool and the CN rounding tool will be reviewed at the monthly Quality Assessment & Performance Improvement (QAPI) meeting. Review CN rounding tool/ Review CM monitoring tool. div=""	

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			<div style="font-family: monospace; font-size: small;"> <div>div="" div="" div="" div="" div=""</div> <div>p="" paraid="1365276615"</div> <div>paraeid="{87ea21ae-e16c-4cc3-b411-419949c9cc2b}{141}"></div> <div>Hammond Dialysis Center</div> <div>Clinic Manager Tracking Tool</div> <div>To be brought to the monthly</div> <div>QAPI meeting</div> <div>Daily x 1 weeks</div> <div>ItemDate:</div> <div>Date:</div> <div>Date:</div> <div>Date:</div> <div>Date:</div> </div> <p>V 463 - Review CN rounding tool and treatment flow sheet to ensure all treatment orders are followed, including the BFR/DFR, and Mircera as administered as ordered. If ordered is not attained DPC document the reason on treatment flow sheet and the CN is notified. Any patient not meeting treatment goals are referred to IDT.</p> <p>Meet with BT to ensure the correct amount of Mircera is ordered and available for administration. Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p>	

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			<p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>CM Initials / Date Weekly x 12 weeks Item Week of: Week of: Week of: of: Week of: Week of: Week of: V 463 - Review CN rounding tool and treatment flow sheet to ensure all treatment orders are followed, including the BFR/DFR, and Mircera as administered as ordered. If ordered is not attained DPC document the reason on treatment flow sheet and the CN is notified. Any patient not meeting treatment goals are referred to IDT. Meet with BT to ensure the correct amount of Mircera is ordered and available for administration. Discrepancies Noted:</p>	

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			<p>amount of Mircera is ordered and available for administration. Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>CM Initials / Date CM Monitoring Tool and all indicated documents were reviewed at the monthly QAPI Meeting Held on _____.</p> <p>Clinic Manager Signature: _____</p> <p>Date: _____</p>	

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V 0506 Bldg. 00	<p>494.80(a)(3) PA-IMMUNIZATION/MEDICATION HISTORY</p> <p>Based on record review and interview, the facility failed to administer the pneumonia (a contagious infection) vaccine after patient consent was obtained in 1 of 1 clinical record review for a patient with an admission to the facility in the past 90 days in a total sample of 6 clinical records reviewed. (Patient #4)</p> <p>The findings include:</p> <p>A clinical record for Patient #4 evidenced a Patient Vaccination Consent form signed and dated by the Patient on 05/20/2025 which indicated the Patient consented to receiving the pneumonia vaccine, and the record failed to evidence the facility administered the pneumonia vaccine.</p> <p>On 07/31/2025, at 2:56 PM, the FA indicated the facility had not yet administered the pneumonia vaccine due to an oversight.</p>	V 0506	<p>TRAINING/INSERVICE DOCUMENTATION FORM</p> <p>V 506 An in-service was initiated to all nursing staff by the Clinic Manager (CM) regarding the Vaccine policy (See attached in-service record). Per G 50 Vaccines policy "7. Prior to receiving each dose of vaccine, the nurse will provide the patient with the most recent VIS (available from the CDC website) for the vaccine being administered. The patient must receive the information and sign the Vaccine Consent/Denial VIS Acknowledgement form prior to receiving the dose of vaccine." It was stressed during the in-service that vaccines should be offered to all patient and administered per physician orders. Once the patient has consented to the vaccine it should be administered as soon as possible. The immunization nurse is responsible for documenting and tracking the immunization status on all patients, including ensuring the vaccines, such as the pneumonia</p>	08/31/2025

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			vaccines, is administered as soon as possible after the patient has consented to the vaccine. Documentation of the administration of the vaccine must be documented in the patient medical record and tracked on the Immunization & TB Tracking Log. Patient #4 pneumonia vaccine August 1, 2025. All patient records reviewed to ensure their vaccine information is current and all patients have received their vaccines (as consented). The clinic manager will also monitor all new admissions weekly for the next 3 months until 100% compliance is achieved, to ensure all new admissions have been offered vaccines and if the patient has consented to any vaccines, they have been administered in a timely manner (See attached CM monitoring tool). The CM will ensure compliance through review of all new admissions, the active patient records and review of the Immunization and TB tracking log monthly, prior to the QAPI meeting. The Immunization and TB tracking log and the CM monitoring tool will be reviewed at the QAPI Meeting, of which the medical director is a member, where additional action will be taken as deemed appropriate by the committee such as, further education, additional monitoring, or disciplinary action. Hammond Dialysis Center	

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			<p>Clinic Manager Tracking Tool To be brought to the monthly QAPI meeting Monthly (x 3 months) Item Aug-25 Sep-25 Oct-25 V 715 - Review all new admissions to ensure each new patient has an initial nursing assessment prior to starting the first dialysis treatment in the facility. Discrepancies Noted: Discrepancies Noted: Discrepancies Noted: V 506 - Review all new admission records to ensure all new patients have been offered vaccines and if the patient consents the vaccine is administered in a timely manner. Discrepancies Noted: Discrepancies Noted: Discrepancies Noted: CM Initials / Date CM Monitoring Tool and all indicated documents were reviewed at the monthly QAPI Meeting Held on _____.</p> <p>Clinic Manager Signature: _____ Date: _____</p> <p>TRAINING/INSERVICE DOCUMENTATION FORM</p> <p>Training Date(s) Training Location Hammond Dialysis Center Facilitator(s) Name Qualifications of Facilitator(s) Patient Assessment</p>	

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			<p>– V 506 Per G 50 Vaccines policy “7. Prior to receiving each dose of vaccine, the nurse will provide the patient with the most recent VIS (available from the CDC website) for the vaccine being administered. The patient must receive the information and sign the Vaccine Consent/Denial VIS Acknowledgement form prior to receiving the dose of vaccine.” Vaccines should be offered to all patient and administered per physician orders. Once the patient has consented to the vaccine it should be administered as soon as possible. The immunization nurse is responsible for documenting and tracking the immunization status on all patients, including ensuring the vaccines, such as the pneumonia vaccines, is administered as soon as possible after the patient has consented to the vaccine. Documentation of the administration of the vaccine must be documented in the patient medical record and tracked on the Immunization & TB Tracking Log. Patient #4 must be offered and have the pneumonia vaccine administered with a new consent. All patient records must be reviewed to ensure their vaccine information is current and all patients have received their vaccines (as consented). The clinic manager will also monitor all new admissions weekly for the</p>	

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V 0543 Bldg. 00	<p>494.90(a)(1) POC-MANAGE VOLUME STATUS</p> <p>Based on record review and interview, the facility failed to follow agency policy and obtain a standing blood pressure prior to the initiation of hemodialysis (HD, the process to filter the blood when the kidneys do not function properly) to manage the patient's volume status in 3 of 6 clinical records reviewed. (Patient #1, 4, 6)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. A policy revised May 2022 titled "Ongoing Patient Monitoring" indicated the facility would obtain a standing blood pressure before initiation of HD for all ambulatory patients. 2. A clinical record review for Patient #1 evidenced Treatment Flowsheets dated 07/07/2025, 07/09/2025, 07/11/2025, 07/14/2025, 07/25/2025, and 07/28/2025 which failed to 	V 0543	<p>next 3 months until 100% compliance is achieved, to ensure all new admissions have been offered vaccines and if the patient has consented to any vaccines, they have been administered in a timely manner. The CM will ensure compliance through review of all new admissions, the active patient records and review of the Immunization and TB tracking log monthly, prior to the QAPI meeting. The Immunization and TB tracking log and the CM monitoring tool will be reviewed at the QAPI Meeting. Review CM monitoring tool.</p> <p>V 543 An in-service was initiated to all Direct Patient Care (DPC) staff by the Clinic Manager (CM) emphasizing that all policies and procedures must be followed, including ensuring a standing blood pressures is obtained on all ambulatory patients (See attached in-service record). During the in-service policy IC07 Patient Assessment: Pre & Post Dialysis states "2. Vital signs will include pre and post dialysis weight, temperature, heart rate and sitting blood pressures on all patients. Standing blood pressure is also done on all ambulatory patients." It was stressed that patients who</p>	08/31/2025

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	<p>evidence a standing blood pressure prior to initiation of HD.</p> <p>On 07/28/2025, at 11:00 AM, Patient #1 indicated the staff didn't typically obtain a standing blood pressure.</p> <p>On 07/30/2025, beginning at 2:20 PM, RN 2 indicated Patient #1 was ambulatory with a walker and was not sure why the standing blood pressure was not obtained prior to treatment.</p> <p>3. A clinical record review for Patient #4 evidenced Treatment Flowsheets dated 07/08/2025, 07/10/2025, 07/12/2025, 07/17/2025, 07/19/2025, 07/22/2025, 07/25/2025, and 07/28/2025 which failed to evidence a standing blood pressure prior to initiation of HD.</p> <p>On 07/31/2025, at 3:42 PM, the FA indicated the Patient is ambulatory and the standing blood pressure was not documented prior to initiation of treatment.</p> <p>4. A clinical record review for Patient #6 evidenced Treatment Flowsheets dated 07/03/2025, 07/12/2025, and 07/19/2025 which failed to evidence a standing blood pressure prior to initiation of HD.</p> <p>On 07/31/2025, at 1:39 PM, the FA indicated the Patient was ambulatory and the standing blood pressure was not documented.</p>		<p>are able to ambulate must have pre and post blood pressure. The CM will observe the treatment floor/treatment flow sheets daily for 1 week until 100% compliance is achieved, and then weekly thereafter, for 12 weeks until 100% compliance achieved, to ensure all ambulatory patient have a pre and post sitting blood pressure (See attached CM monitoring tool). The clinic manager will ensure compliance by direct review of the treatment records and through use of the CM monitoring tool. The findings from the CM monitoring tool will be reviewed at the monthly QAPI meeting, of which the medical director is a member, where additional action will be taken by the committee such as continuing the weekly CM monitoring, further education, and/or disciplinary action.ζ Hammond Dialysis Center Clinic Manager Tracking Tool To be brought to the monthly QAPI meeting Daily x 1 weeks ItemDate: Date: Date: Date: Date: Date:</p> <p>V 543 - Review the treatment floor and treatment flow sheets to ensure all ambulatory patients have a standing pre and post</p>	

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			<p>blood pressure. Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>CM Initials / Date Weekly x 12 weeks Item Week of: Week of: Week of: of: Week of: Week of: Week of: V 543 - Review the treatment floor and treatment flow sheets to ensure all ambulatory patients have a standing pre and post blood pressure. Discrepancies Noted:</p>	

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			<p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>CM Initials / Date CM Monitoring Tool and all indicated documents were reviewed at the monthly QAPI Meeting Held on _____.</p> <p>Clinic Manager Signature: _____</p> <p>Date: _____</p> <p>p paraid="376766537" paraeid="{ca367ad9-e957-421c-af2f-6237473bc82a}{19}" > TRAINING/INSERVICE DOCUMENTATION FORM</p>	

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			<div class="TableCellContent SCXW175894563 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;"> Training Date(s) </div> <div class="TableCellContent SCXW175894563 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;"> Training Location Hammond Dialysis Center </div> <div class="TableCellContent SCXW175894563 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;"> Facilitator(s) Name </div> <div class="TableCellContent SCXW175894563 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;"> Qualifications of Facilitator(s) </div>	

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			<p>-webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;"</p> <p>Plan of Care – V 543</p> <p>div class="TableCellContent SCXW175894563 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;"</p> <p>·p paraid="1833855113" paraeid="{ca367ad9-e957-421c-af2f-6237473bc82a}{102}" >Per policy IC07 Patient Assessment: Pre & Post Dialysis states "2. Vital signs will include pre and post dialysis weight, temperature, heart rate and sitting blood pressures on all patients. Standing blood pressure is also done on all ambulatory patients."</p> <p>Patients who are able to ambulate must have pre and post blood pressure. The CM will observe the treatment flow sheets daily for 1 week until 100% compliance is achieved, and then weekly thereafter, for 12 weeks until 100% compliance is achieved, to ensure all ambulatory have and post sitting blood pressure. The clinic manager will ensure compliance by direct review of the treatment records and through use of the CM monitoring tool. The findings from the CM monitoring tool will be</p>	

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V 0559 Bldg. 00	<p>494.90(b)(3) POC-OUTCOME NOT ACHIEVED-ADJUST POC</p> <p>Based on record review and interview, the facility failed to ensure the interdisciplinary team adjusted the plan of care when the expected outcome was not achieved and failed to identify and document the potential causes of patient non-adherence and efforts to address those causes in 1 of 1 unstable clinical record reviewed in a total sample of 6 clinical records reviewed. (Patient #6)</p> <p>The findings include:</p> <p>A revised policy dated May 2022 titled "Treatment Plans" indicated the treatment plan would be adjusted if the treatment outcomes were not met and indicated the interdisciplinary team would document the reasons why the goals were not met.</p> <p>A clinical record review for Patient #6 evidenced a POC dated 02/03/2025 which failed to evidence any concerns with the Patient's ability to meet the goal for hemodialysis (HD, the process to filter the blood when the kidneys do not function properly) related to the Patient's compliance with the HD treatment schedule.</p> <p>Review of the Quality Assurance and Performance Improvement (QAPI) program indicated the Patient had the following number of missed HD treatment visits: January 2025: 1, February 2025: 0, March 2025: 5, April 2025: 4, May 2025: 5, June 2025: 3, and July 2025: 2.</p>	V 0559	<p>reviewed at the monthly QAPI meeting. Review CM monitoring tool.¿</p> <p>V 559 An in-service was initiated to all DPC staff and the Interdisciplinary Team (IDT), which includes the Clinic Manager (CM) by the Regional Clinical and Regulatory Manager (CRM) regarding ensuring all patients are meeting their individualized goals per the Comprehensive Assessment and Plan of Care (CA/POC) (See attached in service record).¿ Per policy G 35 Comprehensive Assessment, Plan of Care "1. The treatment plan is individualized for each patient and addresses all criteria outlined in the current Conditions for Coverage 2. The treatment plan will also: specify services necessary to address the patient's needs as identified by the comprehensive patient assessment. Include measurable and expected outcomes and estimated time frame to achieve outcomes. Be adjusted if treatment outcomes are not met...11. If the expected outcome is not achieved, the interdisciplinary teams must adjust the treatment plan to achieve the specified goals, When a patient is unable to achieve the</p>	08/31/2025

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	<p>A Social Work Quarterly Review document dated 04/24/2025 indicated the Patient received ongoing education regarding compliance and was offered the option to reschedule treatments as needed.</p> <p>A Progress Note completed by the MSW on 05/15/2025 indicated the Patient did not feel safe at the facility and wanted to transfer to another facility. The note indicated the Patient was unsure if he would be able to transfer due to past behaviors at other dialysis facilities so did not want to pursue a transfer to another facility. A Progress Note completed by the MSW on 07/01/2025 indicated the Patient's barriers to compliance with treatment were related to diarrhea and waking up late. The record failed to evidence the POC was revised with interventions to address the identified barriers to treatment.</p> <p>A Nursing Monthly Progress Note dated 06/18/2025 completed by the FA indicated the Patient's compliance with treatment was poor, indicated the Patient had erratic behavior and generally missed one HD treatment per week, and failed to evidence any interventions to encourage Patient compliance. A Nursing Monthly Progress Note dated 07/21/2025 completed by the FA indicated the Patient's treatment compliance was poor and failed to evidence any reasons for the poor compliance and any interventions to encourage Patient compliance.</p> <p>During an interview on 07/29/2025, at 12:37 PM, the MSW indicated the Patient did not feel safe at the facility, because the Patient did not like the physician. The MSW indicated the facility did not provide a referral to or contact information for another physician.</p> <p>On 07/31/2025, at 1:35 PM, the FA indicated since</p>		<p>desired outcomes, the team must: Adjust the treatment plan to reflect the patients current condition, document in the record the reasons why the patient was unable to achieve the goals, and implement the treatment plan changes to address the issued identified." It was stressed during the in-service that any time a patient is not meeting their individualized goal, such as missing treatments, the IDT must meet to discuss barriers to patients not meeting their goals and adjust the plan of care to assist patient in achieving their specified goals. Evidence of this must be documented in the medical record along with the root cause and the goals established to help the patient meet their individualized goals. The IDT will meet to review patient #6 current care plan of care by August 28, to address their missed treatments and establish a new plan for to meet their treatment goals. All active patient records will be reviewed to ensure each patient is meeting their goals, and if not, the patient will be referred to the IDT for review through the CA/POC process. The Charge Nurse (CN) will notify the CM daily of all patients missed treatments and the CM and/or CN will contact patients to identify for missed treatment and to reschedule the patient treatment and notify the</p>	

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	the Patient was made unstable effective 07/01/2025 due to missed treatments and indicated there was no documented communication with the Patient regarding the Patient's missed treatments and inability to reach the Patient for rescheduling efforts. The FA indicated there was no documented efforts to reach the Patient through alternate means of communication to reschedule the Patient and indicated there were no revised interventions to address the Patient's continued noncompliance with attending ordered HD treatments.		physician. This information will be documented in the medical record. The CM will review the missed treatment report, daily for 1 week until 100% compliance is achieved, and then weekly for 12 weeks until 100% compliance is achieved, to ensure all patients are meeting their individualized treatment goals (e.g. treatment schedule) and if trends are identified in patient not being able to meet their goals, the patient will be referred to the IDT for further review in the CA/POC process (See attached CM monitoring tool). The clinic manager will ensure compliance by direct review of the treatment records and through review of the missed treatment report. The findings from the CM monitoring tool and missed treatment report will be reviewed at the monthly Quality Assessment & Performance Improvement (QAPI) meeting, of which the medical director is a member, where additional action will be taken by the committee such as continuing the weekly CM monitoring, further education, and/or disciplinary action.¿ Training Date(s) Training Location Hammond Dialysis Center Facilitator(s) Name Qualifications of Facilitator(s) Plan of Care – V 559 Per policy G 35 Comprehensive Assessment, Plan		

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			of Care "1. The treatment plan is individualized for each patient and addresses all criteria outlined in the current Conditions for Coverage 2. The treatment plan will also: specify services necessary to address the patient's needs as identified by the comprehensive patient assessment. Include measurable and expected outcomes and estimated time frame to achieve outcomes. Be adjusted if treatment outcomes are not met... 11. If the expected outcome is not achieved, the interdisciplinary teams must adjust the treatment plan to achieve the specified goals, When a patient is unable to achieve the desired outcomes, the team must: Adjust the treatment plan to reflect the patients current condition, document in the record the reasons why the patient was unable to achieve the goals, and implement the treatment plan changes to address the issued identified." Any time a patient is not meeting their individualized goal, such as missing treatments, the IDT must meet to discuss barriers to patients not meeting their goals and adjust the plan of care to assist patient in achieving their specified goals. Evidence of this must be documented in the medical record along with the root cause and the goals established to help the patient meet their	

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			individualized goals. The IDT must meet to review patient #6 current care plan of care to address their missed treatments and establish a new plan for to meet their treatment goals. All active patient records will be reviewed to ensure each patient is meeting their goals, and if not, the patient will be referred to the IDT for review through the CA/POC process. The Charge Nurse (CN) will notify the CM daily of all patients missed treatments and the CM and/or CN will contact patients to identify for missed treatment and to reschedule the patient treatment and notify the physician. This information will be documented in the medical record. The CM will review the missed treatment report, daily for 1 week until 100% compliance is achieved, and then weekly for 12 weeks until 100% compliance is achieved, to ensure all patients are meeting their individualized treatment goals (e.g. treatment schedule) and if trends are identified in patient not being able to meet their goals, the patient will be referred to the IDT for further review in the CA/POC process. The clinic manager will ensure compliance by direct review of the treatment records and through review of the missed treatment report. The findings from the CM monitoring tool and missed treatment report will be	

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			<p>reviewed at the monthly Quality Assessment & Performance Improvement (QAPI) meeting. Review CM monitoring tool.¿</p> <p>TRAINING/INSERVICE DOCUMENTATION FORM</p> <p>div class="TableCellContent SCXW94229439 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" Training Date(s)</p> <p>div class="TableCellContent SCXW94229439 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;" Training Location Hammond Dialysis Center div class="TableCellContent SCXW94229439 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;"</p>	

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			<p>Facilitator(s) Name div class="TableCellContent SCXW94229439 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;"</p> <p>Qualifications of Facilitator(s) div class="TableCellContent SCXW94229439 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;"</p> <p>Plan of Care – V 559 div class="TableCellContent SCXW94229439 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;"</p> <p>·p paraid="872687646" paraeid="{666fe0b6-608a-4c1f-a736-f86480da7b70}{135}" >Per policy G 35 Comprehensive Assessment, Plan of Care "1. The treatment plan is individualized for each patient and addresses all criteria outlined in the current Conditions for Coverage 2. The treatment plan will also: specify services necessary to address the patient's needs as identified by the comprehensive patient assessment. Include measurable and expected outcomes and estimated time frame to achieve</p>	

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			<p>paraeid="{fd11087a-c308-468b-b838-4c9670480f92}{135}"> Hammond Dialysis Center Clinic Manager Tracking Tool To be brought to the monthly QAPI meeting Daily x 1 weeks ItemDate: Date: Date: Date: Date: Date:</p> <p>V 559 - Review the missed treatment report in the EMR to ensure all patients are meeting their individualized treatment goals, including no missed treatments, and if trends are identified in patient not being able to meet their goals, the patient will be referred to the IDT for further review in the CA/POC process. Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p>	

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NAME OF PROVIDER OR SUPPLIER HAMMOND DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7 SIBLEY STREET HAMMOND, IN 46320
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			<p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>ItemWeek of:Week of:Week of:Week of:Week of:Week of: V 559 - Review the missed treatment report in the EMR to ensure all patients are meeting their individualized treatment goals, including no missed treatments, and if trends are identified in patient not being able to meet their goals, the patient will be referred to the IDT for further review in the CA/POC process.</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p>	

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V 0628 Bldg. 00	494.110(a)(2) QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS Based on record review and interview, the dialysis facility's Quality Assessment and Performance Improvement (QAPI) Program failed to monitor,	V 0628	Discrepancies Noted: Discrepancies Noted: CM Initials / Date CM Monitoring Tool and all indicated documents were reviewed at the monthly QAPI Meeting Held on _____. Clinic Manager Signature: _____ Date: _____ p="" paraid="376766537" paraeid="{fd11087a-c308-468b-b838-4c9670480f92}{50}"> TRAINING/INSERVICE DOCUMENTATION FORM	08/31/2025

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	<p>analyze, and track personnel qualifications and issues in 1 of 1 facility.</p> <p>The findings include:</p> <p>A revised policy, dated 01/13/2025, titled "G09 Quality Assurance and Performance Improvement (QAPI)", indicated that the QAPI program must continually look at indicators for patients and associates as they are available, develop an improvement plan when indicated by the data, and monitor the effectiveness of the plan.</p> <p>During an interview on 07/31/2025, beginning at 7:55 AM, the FA indicated that the facility does not monitor personnel qualifications and personnel issues during QAPI meetings.</p>		<p>will with the members of the Quality Assessment Performance Improvement (QAPI) team, of which includes the Clinic Manager (CM) and Medical Director (MD), to review the requirements of the team addressing all root causes related to outcomes including monitoring, analyzing, and tracking personnel qualifications (See attached in-service record). Per policy G09 Quality Assessment & Performance Improvement "9. The QAPI meeting minutes and the IRC QAPI reporting tools will be used to: define the methods used to obtain the data used for review. Document ongoing measurement, analysis, and tracking of aggregate quality indicators and other aspects of center performance. Allow for identification, prevention, and reduction of medical errors, mortality and morbidity. 10. The QAPI program must: Continually look at indicators for patients and associates as they are available." It was stressed during the in-service that the QAPI process includes tracking, analyzing, and trending quality indicators and identifying concerns that may contribute to poor clinical outcomes, such as personnel qualifications. If trends are root cause must be determined with action plans formulated, tracked, analyzed, and trended until</p>		

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			<p>improvement is noted and this documented in the QAPI minutes. The QAPI committee will meet by August 28, 2025. to review personnel qualifications and if any trends are identified an action plan will be developed based on the root cause. The action plan will be tracked and trended in QAPI until all goals established by the QAPI committee are met. The root cause and action plan information, including all reports, will be documented in the QAPI meeting minutes. To ensure compliance the QAPI minutes will be reviewed by the Regional Clinical and Regulatory manager, monthly for 3 months until 100% compliance is achieved, to ensure the facility is trending and analyzing all personnel qualifications and that a root cause is determined with an action plan developed if any issues are determined and this is monitored until the goal is met (See attached CRM monitoring tool). Additionally, the Regional Vice President, and/or the Corporate Clinical and Regulatory manager will attend (in person or via phone) the QAPI meetings for the next three months to ensure all areas are being addressed Hammond Dialysis Center Clinic Regulatory Manager Tracking Tool To be brought to the monthly QAPI meeting</p>	

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			<p>Monthly x 3 months Item Aug-25 Sep-25 Oct-25 Review QAPI minutes to ensure:</p> <ol style="list-style-type: none"> V 452 - All grievance reports are reviewed, resolution is given to patient within 15 working days. QAPI tracks and trends all grievances. V 628 - QAPI is trending and analyzing all personnel qualifications and root cause is determined with an action plan developed if any issues are determined that qualifications led to poor facility outcomes. V 634 - Facility staff are completing the incident reports and all incidents are reviewed, tracked, trended, and action plans developed if indicated. <p>TRAINING/INSERVICE DOCUMENTATION FORM</p> <p>div class="TableCellContent SCXW143173104 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;"</p>	

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			<p>Training Date(s) div class="TableCellContent SCXW143173104 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;"</p> <p>Training Location Hammond Dialysis Center div class="TableCellContent SCXW143173104 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;"</p> <p>Facilitator(s) Name div class="TableCellContent SCXW143173104 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;"</p> <p>Qualifications of Facilitator(s) div class="TableCellContent SCXW143173104 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text; overflow: visible;"</p> <p>QAPI – V 628 div class="TableCellContent SCXW143173104 BCX0" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 2px; user-select: text;</p>	

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			<p>overflow: visible;" ·p paraid="790833650" paraeid="{e80af7e4-a6ac-4569-a748-624070f62c1b}{109}" >Per policy G09 Quality Assessment & Performance Improvement "9. The QAPI meeting minutes and the IRC QAPI reporting tools will be used to: define the methods used to obtain the data used for review. Document ongoing measurement, analysis, and tracking of aggregate quality indicators and other aspects of center performance. Allow for identification, prevention, and reduction of medical errors, mortality and morbidity. 10. The QAPI program must: Continually look at indicators for patients and associates as they are available."</p> <p>The QAPI process includes tracking, analyzing, and trending quality indicators and identifying concerns that may contribute to poor clinical outcomes, such as personnel qualifications. If trends are identified, a root cause must be determined with action plans formulated, tracked, analyzed, and trended until improvement is noted and this documented in the QAPI minutes. The QAPI committee must meet to review personnel qualifications and if any trends are identified an action plan will be developed based on the root</p>	

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			<p>cause. The action plan will be tracked and trended in QAPI until all goals established by the QAPI committee are met. The root cause and action plan information, including all reports, will be documented in the QAPI meeting minutes. To ensure compliance the QAPI minutes will be reviewed by the Regional Clinical and Regulatory manager, monthly for 3 months until 100% compliance is achieved, to ensure the facility is trending and analyzing all personnel qualifications and that a root cause is determined with an action plan developed if any issues are determined and this is monitored until the goal is met. Additionally, the Regional Vice President, and/or the Corporate Clinical and Regulatory manager will attend (in person or via phone) the QAPI meetings for the next three months to ensure all areas are being addressed.</p> <p>Discrepancies Noted:Discrepancies Noted:Discrepancies Noted: CRM Initials / Date CRM Monitoring Tool and all indicated documents were reviewed at the monthly QAPI Meeting Held on _____.</p> <p>Clinic Manager Signature: _____</p> <p>Date: _____</p>	

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V 0634 Bldg. 00	<p>494.110(a)(2)(vi) QAPI-INDICATOR-MEDICAL INJURIES/ERRORS</p> <p>Based on record review and interview, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) program identified and addressed medical errors in 1 of 1 clinical record reviewed with a missed medication (Patient #1) and identified and addressed infiltrated (the leaking of fluid out of the blood vessel and into the surrounding tissues) hemodialysis (HD, the process to filter the blood when the kidneys do not function properly) lines in 1 of 1 clinical record reviewed with an infiltration (Patient #6) in a total sample of 6 clinical records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. A policy revised 05/2022 titled "Incident/Event Reporting" identified a medication omission and an infiltration requiring treatment as events/incidents requiring an incident report to be completed which was to be reviewed by the FA and Medical Director and reviewed at the QAPI meeting. 2. A clinical record review for Patient #1 evidenced a Treatment Flowsheet dated 06/18/2025 (Wednesday) which indicated the Patient's treatment days were Monday, Wednesday, and Friday and indicated the facility was to administer Mircera (medication to treat low red blood cells) during the second treatment weekly. The record failed to evidence the facility administered Mircera on the second treatment day 	V 0634	<p>V 634</p> <p>An in-service was initiated to all Direct Patient Care (DPC) staff and the Quality Assurance Performance Improvement (QAPI) Committee, which includes the Clinic Manager and Medical Director by the Regional Clinical and Regulatory Manager (CRM) to review the reporting requirements for incidents and monitoring in QAPI (See attached in-service record). Per policy G09 Quality Assurance & Performance Improvement "9. The QAPI meeting minutes and the IRC QAPI reporting tools will be used to: document ongoing measurement, analysis, and tracking of aggregate quality indicators and other aspects of the center performance. Allow for identification, prevention, and reduction of medical errors, mortality and morbidity. 11. At minimum, the QAPI program must include... Medical injuries and error identification." Also, RM300 Incident/Event Reporting was reviewed during the in-service with emphasis on what types of events to report such as infiltration requiring treatment and Medication</p>	08/31/2025

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	<p>of the week on 06/18/2025.</p> <p>A review of the facility's incidents/adverse events failed to evidence an incident/adverse event report for the missed medication.</p> <p>On 07/28/2025, at 11:00 AM, Patient #1 indicated the facility did not administer Mircera several weeks ago due to "a shipment didn't come in." The Patient indicated she informed the nurse practitioner that the medication was not given on the scheduled day.</p> <p>On 07/30/2025, at 2:20 PM, RN 2 indicated Mircera was supposed to be given on the second treatment day of the week, but if the medication was not available, the medication would be given on the third treatment day. RN 2 indicated the staff was instructed by the FA to document the medication as "not due" instead of medication not available.</p> <p>On 07/30/2025, at 3:15 PM, the FA indicated the medication was not given on the second treatment day on 06/18/2025, because the medication was not available. The FA stated, "If a medication isn't available, I can't give it. That's not a medication error; it's a supply issue."</p> <p>On 07/31/2025, at 12:53 PM, the FA indicated a medication that is not available at the time the medication is ordered to be administered is not an adverse event if the medication can be given at the next treatment day.</p> <p>3. A clinical record for Patient #6 evidenced a Treatment Flowsheet dated 07/10/2025 which indicated the Patient's arterial line infiltrated for which the Patient stopped treatment 1 hour and 47 minutes early.</p>		<p>errors related to incorrect dosage, drug time, route or omission. It was stressed during the in-service that all incidents must be documented in the incident report application system as soon as possible. All incidents must also be reported to the Clinic Manager, Attending Physician, Medical Director, and Regional Clinical Regulatory Manager. Once the notifications are completed, the Clinic Manager will gather comprehensive data regarding the incident and review findings with the QAPI committee members during the monthly QAP meeting. The QAPI committee will further review the incident and determine root cause analysis and action plans to reduce further incidents. All incidents will be analyzed and trended during the QAPI meeting to identify problems and for process improvement to improve clinical outcomes and patient safety. An incident report will be completed for #1 for the omission doses of and for #6 Infiltration (7/10/2025) on August 24, 2025. and this will be reviewed in the facilities next QAPI meeting. To ensure compliance the clinic manager (CM) will review 100% of all treatment sheets daily for one week until 100% compliance is achieved and then once a week for a minimum of 12 weeks until 100% compliance is achieved, to identify occurrences that require a</p>	

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	<p>A review of the facility's incidents/adverse events failed to evidence an incident/adverse event report for the infiltration.</p> <p>On 07/31/2025, beginning at 12:53 PM, the FA indicated an arterial line infiltration should have been an adverse event/incident and indicated there was no incident reporting for the adverse event.</p>		<p>documented incident report and to ensure the incident report is documented in the incident reporting application and this information is reviewed during the monthly QAPI meetings. (See attached CM monitoring tool). The Clinic Manager will ensure compliance through completion of the CM monitoring tool and all findings will be addressed at the monthly QAPI meeting, of which the medical director is a member, and where additional action will be taken as deemed appropriate by the committee, such as further education, continuing the CM monitoring and/or disciplinary action. To ensure further compliance, the QAPI minutes will be reviewed by the Regional Clinical and Regulatory Manager monthly to ensure the facility is completing the review of all incidents, and this is tracked, trended, and action plans developed, if indicated. Evidence of this review will be documented on the CRM monitoring tool for the next 3 months (See attached CRM Monitoring tool). Lastly, the Regional Vice President, and/or the Corporate Clinical and Regulatory manager will attend (in person or via phone) the QAPI meetings for the next three months to ensure all areas are being addressed.</p> <p>Training Date(s) Training Location Hammond Dialysis</p>	

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			Center Facilitator(s) Name Qualifications of Facilitator(s) QAPI – V 634 Per policy G09 Quality Assurance & Performance Improvement “9. The QAPI meeting minutes and the IRC QAPI reporting tools will be used to: document ongoing measurement, analysis, and tracking of aggregate quality indicators and other aspects of the center performance. Allow for identification, prevention, and reduction of medical errors, mortality and morbidity. 11. At minimum, the QAPI program must include... Medical injuries and error identification.” Review policy RM300 Incident/Event Reporting (with emphasis on what types of events to report such as infiltration requiring treatment and Medication errors related to incorrect dosage, drug time, route or omission). All incidents must be documented in the incident report application system as soon as possible. All incidents must also be reported to the Clinic Manager, Attending Physician, Medical Director, and Regional Clinical Regulatory Manager. Once the notifications are completed, the Clinic Manager will gather comprehensive data regarding the incident and review findings with the QAPI committee members during the monthly QAP meeting. The QAPI committee will further review the incident and determine root cause analysis and	

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			<p>action plans to reduce further incidents. All incidents will be analyzed and trended during the QAPI meeting to identify problems and for process improvement to improve clinical outcomes and patient safety. An incident report must be completed for #1 for the omission doses of and for #6 Infiltration this will be reviewed in the facilities next QAPI meeting. To ensure compliance the clinic manager (CM) will review 100% of all treatment sheets daily for one week until 100% compliance is achieved and then once a week for a minimum of 12 weeks until 100% compliance is achieved, to identify occurrences that require a documented incident report and to ensure the incident report is documented in the incident reporting application and this information is reviewed during the monthly QAPI meetings. The Clinic Manager will ensure compliance through completion of the CM monitoring tool and all findings will be addressed at the monthly QAPI meeting. To ensure further compliance, the QAPI minutes will be reviewed by the Regional Clinical and Regulatory Manager monthly to ensure the facility is completing the review of all incidents, and this is tracked, trended, and action plans developed, if indicated. Evidence of this review will be documented on the CRM monitoring tool for the</p>	

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			<p>next 3 months. Lastly, the Regional Vice President, and/or the Corporate Clinical and Regulatory manager will attend (in person or via phone) the QAPI meetings for the next three months to ensure all areas are being addressed. Review CRM monitoring tool.</p> <p>Hammond Dialysis Center Clinic Regulatory Manager Tracking Tool</p> <p>To be brought to the monthly QAPI meeting</p> <p>Monthly x 3 months</p> <p>ItemAug-25Sep-25Oct-25</p> <p>Review QAPI minutes to ensure:</p> <ol style="list-style-type: none"> V 452 - All grievance reports are reviewed, resolution is given to patient within 15 working days. QAPI tracks and trends all grievances. V 628 - QAPI is trending and analyzing all personnel qualifications and root cause is determined with an action plan developed if any issues are determined that qualifications led to poor facility outcomes. V 634 - Facility staff are completing the incident reports and all incidents are reviewed, tracked, trended, and action plans developed if indicated. <p>Discrepancies Noted:Discrepancies Noted:Discrepancies Noted:</p> <p>CRM Initials / Date</p> <p>CRM Monitoring Tool and all indicated documents were</p>	

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			<p>reviewed at the monthly QAPI Meeting Held on _____.</p> <p>Clinic Manager Signature: _____</p> <p>Date: _____</p> <p>div="" div="" div="" div="" div="" div="" p="" paraid="2057700146" paraeid="{f6c4331b-5296-4205-b278-9c21a8b796d9}{155}"> Hammond Dialysis Center Clinic Manager Tracking Tool To be brought to the monthly QAPI meeting Daily x 1 weeks ItemDate: Date: Date: Date: Date: Date:</p> <p>V 634 - Review treatment flow sheets to identify any occurrences that require a documented incident report and to ensure the incident is documented in the incident reporting applications and all notifications conducted. All incidents reviewed in QAPI.Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p>	

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			<p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>CM Initials / Date Weekly x 12 weeks ItemWeek of:Week of:Week of:Week of:Week of:Week of: V 634 - Review treatment flow sheets to identify any occurrences that require a documented incident report and to ensure the incident is documented in the incident reporting applications and all notifications conducted. All incidents reviewed in QAPI.Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2025
FORM APPROVED
OMB NO. 0938-039

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V 0715 Bldg. 00	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P	V 0715	<p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>Discrepancies Noted:</p> <p>CM Initials / Date CM Monitoring Tool and all indicated documents were reviewed at the monthly QAPI Meeting Held on _____.</p> <p>Clinic Manager Signature: _____</p> <p>Date: _____</p> <p>p="" paraid="376766537" paraeid="{f6c4331b-5296-4205-b278-9c21a8b796d9}{72}"> TRAINING/INSERVICE DOCUMENTATION FORM</p>	08/31/2025

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	<p>Based on record review and interview, the dialysis facility failed to ensure policies and procedures were followed in regards to patients leaving treatment early against medical advice (AMA) in 4 of 6 clinical records reviewed (Patient 1, 2, 4, 6) and in regards to the new patient assessments in 1 of 1 clinical record reviewed with an admission date in the last 90 days (Patient #4) in a total sample of 6 clinical records reviewed.</p> <p>Findings include:</p> <p>1. A revised policy, dated 01/13/2025, titled "G26 Against Medical Advice", indicated that when a patient decides to leave AMA, a detailed progress note must be entered on the patient's treatment sheet that explains the situation each time it occurs and that each note must provide details of patient counseling of the potential risks to the patient of not following medical orders/advice and the patient's response, and notification of the patient's physician.</p> <p>2. During a clinical record review on 07/31/2025, HD Treatment Flow Sheets for Patient 2 indicated the following:</p> <p>A. On 07/04/25, Patient 2 requested to leave AMA. No detailed explanation of the situation, counseling of potential risks, patient response, or MD notification was documented.</p> <p>B. On 07/07/2025, Patient 2 requested to leave AMA. No counseling of potential risks, patient response, or MD notification was documented.</p> <p>C. On 07/11/2025, Patient 2 requested to leave AMA. No detailed explanation of the situation, counseling of potential risks, patient response, or MD notification was documented.</p>		<p>paraeid="{092a1ae3-2c8b-457c-b0d0-6321b524ca93}{152}">addressed. V 715 An in-service was initiated to the Direct Patient Care (DPC) staff and the Clinic Manager (CM) by the Regional Clinical and Regulatory Manager (CRM) reinforcing the policy for patients requesting to shorten treatment and the requirement of an Initial Nursing Assessment on all new patients (See attached in-service record). During the in-service G26 Against Medical Advice was reviewed and states "3. The AMA process should NOT be used to document patient non-adherence for matters that are not likely to cause serious or immediate harm to the patient or others, such as the patient insisting on regularly signing treatment early. In these cases, there must be a detailed progress note entered in the patient's medical record that explains the situation each time it occurs. Each note must provide details of patient counseling of the potential risks to the patient of not following medical orders/advice and patient's response, and notification of the patient's physician as applicable." Also, per policy G04 Admission & Discharge of patients it states "9. Prior to the initiation of any patient's first treatment at the facility, an initial Nursing Assessment will be completed</p>	

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	<p>D. On 07/14/2025, Patient 2 requested to leave AMA. No detailed explanation of the situation, counseling of potential risks, or MD notification was documented.</p> <p>E. On 07/16/2025, Patient 2 requested to leave AMA. No detailed explanation of the situation, counseling of potential risks, patient response, or MD notification was documented.</p> <p>F. On 07/18/2025, Patient 2 requested to leave AMA. No counseling of potential risks, patient response, or MD notification was documented.</p> <p>3. During an interview on 07/31/2025, beginning at 1:50 PM, the Facility Administrator [FA] indicated that she was unaware that the AMA policy states that patients should be counseled about risks of leaving AMA, or that the MD should be notified. The FA indicated that the MD is only notified when the patient leaves AMA when it involves the patient leaving via EMS/911.</p> <p>4. A clinical record review for Patient #6 evidenced the Patient's HD treatment time was ordered for 4 hours. The Treatment Flowsheets evidenced: treatment ended 1 hour and 50 minutes early on 07/28/2025 and failed to evidence patient education on the risks of not following treatment orders; treatment ended 31 minutes early on 07/26/2026 and failed to evidence documentation for the reason why treatment ended early; treatment ended 1 hour and 46 minutes early on 07/10/2025 and failed to evidence patient education on the risks of not following treatment orders; and treatment ended 1 hour and 30 minutes early on 07/03/2025 and failed to evidence patient education on the risks of not following treatment orders.</p>		<p>and documented in the patient's medical record." The following was stressed during the in-service: All treatment orders must be followed, including the ordered treatment time. If the treatment time is shortened for any reason, the physician must be notified, and a detailed progress note and education on risk of shortening treatment must be documented. Additionally, whenever trends are noted with patients not meeting their treatment goals, including not completing their full treatment time, the IDT must be notified, and a Comprehensive Assessment and Plan of Care (CA/POC) must be initiated to determine the root cause of the patient not completing their treatment time. All new patients admitted to the facility must have an initial nursing assessment completed prior to the start of the first treatment in the facility. This assessment should be documented on the initial assessment page under the Nurse Evaluation tab in the EMR. The IDT will meet with patients 1, 2, 4, and 6 by August 31, to address any barriers to the patients not completing their full prescribed treatment time. If warranted, a CA/POC addressing all shortened treatments will be initiated to establish a plan and develop goals with reasonable</p>	

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	<p>On 07/31/2025, at 1:38 PM, the FA indicated the reasons for early termination were not documented.</p> <p>5. A clinical record review for Patient #4, start of care 05/20/2025, evidenced an initial Treatment Flowsheet dated 05/20/2025 which indicated treatment was initiated at 6:04 AM. The Nursing Initial Assessment dated 05/20/2025 indicated the assessment was at 7:00 AM and failed to evidence the assessment was completed before the initiation of treatment.</p> <p>On 07/31/2025, at 3:46 PM, the FA indicated the initial assessment for a new patient had to be completed within a couple of days of the initial treatment. The FA indicated the new patient did not necessarily get a different assessment than an established patient.</p> <p>The Treatment Flowsheets evidenced the Patient's HD treatment time was ordered for 3 hours and 30 minutes and evidenced: treatment ended 22 minutes early on 07/17/2025 and failed to evidence patient education on the risks of not following treatment orders; treatment ended 18 minutes early on 07/19/2025 and failed to evidence patient education on the risks of not following treatment orders; treatment ended 30 minutes early on 07/22/2025 and failed to evidence the reason treatment ended early and the patient education on the risks of not following treatment orders; and treatment ended 40 minutes early on 07/28/2025 and failed to evidence patient education on the risks of not following treatment orders.</p> <p>6. During an observation on 7/28/2025, at 10:30 AM, Patient #1 was heard telling staff that he/she would not be staying late since the staff started his/her treatment late and to end his/her treatment</p>		<p>timeframes for the patient to achieve goals in completing their full treatment time. The charge nurse (CN), after each shift of patient is on dialysis, is to round on each patient to ensure the patient is receiving the correct dialysis treatment order, including treatment times. Any issues with patient not being able to reach their ordered treatment time will be reported to the patient physician and a detailed progress note will be documented on the reason the treatment was not completed and education provided to the patient on risk of shortened treatments. The CN will also review the treatment records at the end of the day to ensure that the treatment time was achieved and if not, a progress note is documented and follow up education provided (See attached CN rounding tool). The Clinic Manager will ensure compliance by reviewing the treatment records daily for one week until 100% compliance is achieved, and then one day of treatment records, weekly for 12 weeks until 100% compliance is achieved, to ensure that the treatment time is being completed as ordered and there are no shortened treatments. The CM will review the progress notes on any patients with shortened treatment to ensure there is a detailed note, the physician was notified, and patient educated.</p>	

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	<p>at the normal time.</p> <p>During an interview on 7/28/2025, at 11:00 AM, Patient #1 indicated he/she arrived at the facility early and was scheduled to begin treatment at 10:15 AM. Patient #1 indicated he/she was not called back for treatment until 10:20 AM and treatment was not started until 10:35 AM. Patient #1 indicated his/her ride was already arranged, and he/she could not stay longer to get the full treatment time. Patient #1 indicated his/her treatment was delayed, because staff was doing things that were not typically done when the surveyors were not present such as having the patients wash their hands and taking standing blood pressures prior to beginning treatment.</p> <p>A review of the Treatment Flowsheet dated 07/28/2025 indicated the Patient was to receive dialysis treatment for 3 hours and 30 minutes but ended treatment 27 minutes early. The record failed to evidence the staff indicated the reason for why treatment was ended early and the education provided to the patient on the risks of not following treatment orders.</p> <p>On 07/30/2025, at 3:18 PM, RN 2 indicated the treatment sheet did not include the reason for why treatment ended early.</p> <p>7. On 07/31/2025, at 1:46 PM, the FA indicated the risk of ending treatment early was "the patient dies." When queried if the risk of ending treatment early was educated to the patients, the FA indicated the patient should be educated to limit fluids and watch potassium intake.</p>		<p>(See attached CM Monitoring Tool). Additionally, the CM will review all new patient treatment records monthly for 3 months, until 100% compliance is achieved, to ensure each new patient has an initial nursing assessment prior to starting the first dialysis treatment in the facility (See attached CM monitoring tool). The CM will ensure compliance through direct observation, use of the CM monitoring tool, and review of the CN rounding tool. All results from these tools will be brought to the monthly Quality Assurance Performance Improvement (QAPI) meeting, of which the medical director is a member, and additional action will be taken as deemed appropriate by the committee, including additional training, continuing the CM weekly monitoring, or if trends are identified disciplinary action. Hammond Dialysis Center Clinic Manager Tracking Tool To be brought to the monthly QAPI meeting Monthly (x 3 months) ItemAug-25Sep-25Oct-25 V 715 - Review all new admissions to ensure each new patient has an initial nursing assessment prior to starting the first dialysis treatment in the facility.Discrepancies Noted:Discrepancies Noted:Discrepancies Noted: V 506 - Review all new admission</p>		

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			<p>records to ensure all new patients have been offered vaccines and if the patient consents the vaccine is administered in a timely manner. Discrepancies Noted: Discrepancies Noted: Discrepancies Noted: CM Initials / Date CM Monitoring Tool and all indicated documents were reviewed at the monthly QAPI Meeting Held on _____.</p> <p>Clinic Manager Signature: _____</p> <p>Date: _____ Dialysis Center Clinic Manager Tracking Tool To be brought to the monthly QAPI meeting Monthly (x 3 months) Item Aug-25 Sep-25 Oct-25 V 715 - Review all new admissions to ensure each new patient has an initial nursing assessment prior to starting the first dialysis treatment in the facility. Discrepancies Noted: Discrepancies Noted: Discrepancies Noted: V 506 - Review all new admission records to ensure all new patients have been offered vaccines and if the patient consents the vaccine is administered in a timely manner. Discrepancies Noted: Discrepancies Noted: Discrepancies Noted: CM Initials / Date CM Monitoring Tool and all indicated documents were</p>	

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			<p>reviewed at the monthly QAPI Meeting Held on _____.</p> <p>Clinic Manager Signature: _____</p> <p>Date: _____</p> <p>TRAINING/INSERVICE DOCUMENTATION FORM</p> <p style="text-align: right;">Training</p> <p>Date(s) Training Location Hammond Dialysis Center Facilitator(s) Name Qualifications of Facilitator(s) Medical Director Responsibility – V 715 Per policy G26 Against Medical Advice states “3. The AMA process should NOT be used to document patient non-adherence for matters that are not likely to cause serious or immediate harm to the patient or others, such as the patient insisting on regularly signing treatment early. In these cases, there must be a detailed progress note entered in the patient’s medical record that explains the situation each time it occurs. Each note must provide details of patient counseling of the potential risks to the patient of not following medical orders/advice and patient’s response, and notification of the patient’s physician as applicable.” Also, per policy G04 Admission & Discharge of patients it states “9. Prior to the initiation of any</p>	

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			<p>patient's first treatment at the facility, an initial Nursing Assessment will be completed and documented in the patient's medical record." All treatment orders must be followed, including the ordered treatment time. If the treatment time is shortened for any reason, the physician must be notified, and a detailed progress note and education on risk of shortening treatment must be documented. Additionally, whenever trends are noted with patients not meeting their treatment goals, including not completing their full treatment time, the IDT must be notified, and a Comprehensive Assessment and Plan of Care (CA/POC) must be initiated to determine the root cause of the patient not completing their treatment time. All new patients admitted to the facility must have an initial nursing assessment completed prior to the start of the first treatment in the facility. This assessment should be documented on the initial assessment page under the Nurse Evaluation tab in the EMR. The IDT must meet with patients 1, 2, 4, and 6 to address any barriers to the patients not completing their full prescribed treatment time. If warranted, a CA/POC addressing all shortened treatments will be initiated to establish a plan and develop goals with reasonable</p>	

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			<p>timeframes for the patient to achieve goals in completing their full treatment time. The charge nurse (CN), after each shift of patient is on dialysis, is to round on each patient to ensure the patient is receiving the correct dialysis treatment order, including treatment times. Any issues with patient not being able to reach their ordered treatment time will be reported to the patient physician and a detailed progress note will be documented on the reason the treatment was not completed and education provided to the patient on risk of shortened treatments. The CN will also review the treatment records at the end of the day to ensure that the treatment time was achieved and if not, a progress note is documented and follow up education provided. The Clinic Manager will ensure compliance by reviewing the treatment records daily for one week until 100% compliance is achieved, and then one day of treatment records, weekly for 12 weeks until 100% compliance is achieved, to ensure that the treatment time is being completed as ordered and there are no shortened treatments. The CM will review the progress notes on any patients with shortened treatment to ensure there is a detailed note, the physician was notified, and patient educated. Additionally, the CM will</p>	

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V 0761 Bldg. 00	<p>494.180(b)(4) GOV-STAFF HAVE ACCESS TO CONTINUING ED</p> <p>Based on record review and interview, the administration failed to provide evidence they provided an opportunity for continuing education of their staff.</p> <p>The findings include:</p> <p>A policy revised 12/22/2023 titled "Associates Training [and] In-Services" indicated the FA will identify in-service needs and establish a plan to address the needs.</p> <p>On 07/31/2025, at 12:53 PM, the FA indicated the staff did not report all the incidents, because staff did not want to get each other "in trouble". The FA indicated she had not provided any additional training/in-service to staff on the reporting of</p>	V 0761	<p>review all new patient treatment records monthly for 3 months, until 100% compliance is achieved, to ensure each new patient has an initial nursing assessment prior to starting the first dialysis treatment in the facility. The CM will ensure compliance through direct observation, use of the CM monitoring tool, and review of the CN rounding tool. All results from these tools will be brought to the monthly Quality Assurance Performance Improvement (QAPI) meeting for review. Review CN rounding tool. Review CM monitoring tool.</p> <p>V 761 The Regional Clinical and Regulatory Manager (CRM) met with the members of the Governing Body (GB), which include the Clinic Manager (CM) and Medical Director (MD) to discuss the responsibilities of (See attached In-service record). Per policy G 03 Governing Body "4. The Administrator, by and through the Governing Body, shall exercise the following responsibilities for the management of the facility and the provision of all dialysis services: Adequate associates training (including orientation to the facility and their work</p>	08/31/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	incidents.		responsibilities as well as making available continuing education and related development ." It was stressed during the in-service that the GB members are responsible for ensuring all policy and procedures are adhered to by all staff members, including ensuring staff are knowledgeable in policy RM 300 Incident/Event Reporting, specifically on which incidents to report, how to report, notifications, and monitoring of incidents in the monthly QAPI meetings. All staff were in- on policy RM 300 on August 28, 2025. As members of the GB and QAPI committee the Medical Director and Clinic Manager will ensure that the policy related to incident reporting is followed by all staff of the facility and anytime there is an issue identified by staff not following the policy, further education will be provided by the Clinic Manager on the issues and this reported to the QAPI and GB members for further determination of the root cause and monitoring, tracking and trending, in the monthly QAPI until all goals are met and sustained improvement is noted. To ensure compliance, the governing body of the facility will meet monthly for 6 months to review the QAPI activity on reporting all incident reporting (See attached CM monitoring tool). Additional action will be taken as deemed appropriate by the committee, including	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2025
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			<p>additional training, continuing all monitoring tools and monthly GB meetings until 100% compliance is achieved, or if tends are identified, disciplinary action.</p> <p>TRAINING/INSERVICE DOCUMENTATION FORM</p> <p style="text-align: center;">Training</p> <p>Date(s) Training Location Hammond Dialysis Center Facilitator(s) Name Qualifications of Facilitator(s) Governing Body – V 761 Per policy G 03 Governing Body “4. The Administrator, by and through the Governing Body, shall exercise the following responsibilities for the management of the facility and the provision of all dialysis services: Adequate associates training (including orientation to the facility and their work responsibilities as well as making available continuing education and related development .” The GB members are responsible for ensuring all policy and procedures are adhered to by all staff members, including ensuring staff are knowledgeable in policy RM 300 Incident/Event Reporting, specifically on which incidents to report, how to report, notifications, and monitoring of incidents in the monthly QAPI meetings. All staff must be in- on policy RM 300. As members of the GB and QAPI committee the</p>	

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			Medical Director and Clinic Manager will ensure that the policy related to incident reporting is followed by all staff of the facility and anytime there is an issue identified by staff not following the policy, further education will be provided by the Clinic Manager on the issues and this reported to the QAPI and GB members for further determination of the root cause and monitoring, tracking and trending, in the monthly QAPI until all goals are met and sustained improvement is noted. To ensure compliance, the governing body of the facility will meet monthly for 6 months to review the QAPI committees' activity on reporting all incident reporting. Additional action will be taken as deemed appropriate by the committee, including additional training, continuing all monitoring tools and monthly GB meetings until 100% compliance is achieved. Review CM monitoring tool.	