STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62. Survey Dates: June 18, 19, 20, and 23, 2025 Active Census: 105 At this Emergency Preparedness survey, Fort Wayne South Dialysis was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62. QR 7/2/25 A2	E 0000		
V 0000 Bldg. 00	This visit was for a CORE Federal recertification survey of an ESRD provider. Survey dates: June 18, 19, 20, and 23, 2025 Census by Service Type: In-Center Hemodialysis: 105 Total Active Census: 105 Isolation Room/Waiver: One Isolation Room Abbreviations: RN Registered Nurse PCT Patient Care Technician	V 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Drew Bercot	Facility Administrator	07/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 0111 Bldg. 00	ICHD In-Center Hemodialysis 494.30 IC-SANITARY ENVIRONMENT Based on observation, policy review, and interview, the dialysis facility failed to maintain a sanitary environment specific to the preparation of bleach solution for 1 of 1 observations of bleach solution mixing and failed to maintain a sanitary environment specific to bleach solution storage for 1 of 2 treatment floor observations in which bleach solution containers were observed, which had the potential to affect 105 active patients. Findings include: 1. Review of the Bleach Policy, revised October 2023, indicated " ... A 1:10 (one to ten) bleach solution is used to clean and decontaminate any environmental surfaces or non-disposable supplies which are visibly contaminated with blood or body fluids ... 1 part bleach is mixed with 9 parts water to prepare a 1:10 (one to ten) bleach solution ... A 1:100 (one to one hundred) bleach solution is used for routine disinfection procedures of environmental surfaces or non-disposable supplies which are not visibly contaminated with blood or bodily fluids ... 1 part bleach is mixed with 99 parts water to prepare a 1:100 (one to one hundred) bleach solution ... Bleach solution needs to be covered with a secure lid ... Without a secure lid, the bleach solution is open to air causing the solution to degrade over time and become less effective ... 2. During a flash tour observation on 06/18/2025 beginning at 10:19 AM, observed a 1:10 bleach solution container with the lid open on the	V 0111	The Facility Administrator, Clinical Coordinator, or Nurse will in-service all clinical teammates on Policy 1-05-08 “Bleach Policy”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) A 1:10 (one to ten) bleach solution is used to clean and decontaminate any environmental surfaces or non-disposable supplies which are visibly contaminated with blood or body fluids. 2) A 1:100 (one to one hundred) bleach solution is used for routine disinfection procedures of environmental surfaces or non-disposable supplies which are not visibly contaminated with blood or bodily fluids. 3) …1part bleach is mixed with 99 parts water to prepare a 1:100 (one to one hundred) bleach solution. 4) Bleach solution needs to be covered with a secure lid…NOTE: Without a secure lid, the bleach solution is open to air causing the solution to degrade over time and become less effective. The Facility Administrator, Clinical Coordinator, or Charge Nurse will conduct observational audits daily	07/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	treatment floor. The facility failed to ensure all bleach solution containers on the treatment floor remained closed when not in use. 3. During an observation on 06/19/2025 at 7:00 AM, PCT 4 mixed bleach solution to be used on the ICHD treatment floor. The nurse mixed 100 milliliters (mL) water and 1 mL of bleach into a container labeled 1:100 bleach solution. PCT 4 also mixed 100 mL water and 10 mL of bleach into one container labeled 1:10 bleach solution. The facility failed to ensure bleach solution was being mixed to the required concentration. 4. During an interview on 06/18/2025 at 11:53 AM, RN 1 indicated the 1:10 bleach solution container should not have been left open, and she would shut it. 5. During an interview on 06/20/2025 at 3:43 PM, the Alternate Administrator indicated bleach solution containers on the treatment floor should remain closed when not in use. 6. During an interview on 06/19/2025 at 7:02 AM, PCT 4 reported the 1:100 mL bleach solution was made with 100 mL water and 1 mL bleach. PCT 4 reported the 1:10 mL bleach solution was made with 100 mL water and 10 mL bleach. PCT 4 explained the solution was made with one part bleach to 100 parts water for the 1:100 solution and one part bleach to ten parts water for the 1:10 solution. 7. During an interview on 06/20/2025 at 3:43 PM, the Alternate Administrator indicated the 1:10 bleach solution should be mixed as one part bleach to nine parts water, and the 1:100 solution should be mixed as one part bleach to 99 parts water.		x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal infection control audit. Instances of non-compliance will be addressed. The Facility Administrator, Clinical Coordinator, or Charge Nurse will review audit results with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 0407 Bldg. 00	494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS Based on observation, policy review, and interview, the dialysis facility failed to ensure all patients' accesses remained uncovered during treatment for 2 of 4 treatment floor observations. Findings include: 1. Review of the Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment policy, revised April 2024, indicated " ... The vascular access site, blood line connections and the patient's face should be visible throughout the dialysis treatment ..." 2. A treatment floor observation was conducted on 06/18/2025 from 11:47 AM to 12:45 PM with the following observed: At 12:16 PM, Patients at Stations 12 and 20 had their accesses covered with a blanket. At 12:19 PM, the Patient at Station 20 still had their access covered with a blanket. At 12:33 PM, Patients at Stations 4 and 17 had their accesses covered with a blanket. At 12:40 PM, Patients at Stations 4 and 9 had their accesses covered with a blanket. Staff failed to ensure patients' accesses remained uncovered at all times during treatment. 3. A treatment floor observation was conducted on 06/19/2025 from 5:50 AM to 7:03 AM with the following observed: At 6:18 AM, Patients at Station 19 had their access covered with a blanket. At 6:23 AM, 6:27 AM, and 6:34 AM, Patients at	V 0407	The Facility Administrator, Clinical Coordinator, or Charge Nurse will in-service all clinical teammates on Policy 1-03-08 “Pre-Intra-Post Treatment Data Collection, Monitoring, And Nursing Assessment”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) The vascular access site, blood line connections and the patient’s face should be visible throughout the dialysis treatment. The Facility Administrator, Clinical Coordinator, or Charge Nurse will provide written education to all patients on the importance of having vascular access uncovered and in view during treatment. A copy of this patient education will be placed in each patient's medical record. Teammates will re-educate any patient that has his/ her face covered and uncover the face. Teammates will document in patient's medical record that education/re-education was given to the patient. The Facility Administrator, Clinical Coordinator, or Charge Nurse will conduct observational daily audits x 2 weeks, then weekly x 3 weeks to verify compliance with facility	07/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	Stations 4 and 19 had their accesses covered with a blanket. At 6:37 AM, 6:44 AM, and 6:58 AM, the Patient at Station 19 had their access covered with a blanket. Staff failed to ensure patients' accesses remained uncovered at all times during treatment. 4. During an interview on 06/18/2025 at 12:35 PM, PCT 2 indicated patients' accesses should never be covered during treatment. 5. During an interview on 06/18/2025 at 12:36 PM, RN 2 indicated patients' accesses should never be covered during treatment, and staff was to politely remind patients to uncover their accesses. 6. During an interview on 06/18/2025 at 12:39 PM, PCT 3 indicated patients' accesses should never be covered during treatment. 7. During an interview on 06/19/2025 at 6:32 AM, PCT 6 indicated patients' accesses should not ever be covered during treatment. 8. During an interview on 06/19/2025 at 6:36 AM, PCT 5 indicated patients' accesses should never be covered during treatment. 9. During an interview on 06/19/2025 at 6:42 AM, RN 3 indicated patients' faces and accesses should be visible at all times during treatment. 10. During an interview on 06/19/2025 at 6:39 AM, RN 4 indicated patients' accesses should never be covered during treatment.		policy. Instances of noncompliance will be addressed. The Facility Administrator, Clinical Coordinator, or Charge Nurse will review audit results with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0715 Bldg. 00	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	Based on observation, record review, and interview, the Medical Director failed to ensure policies & procedures were followed related to patients receiving dialysis treatment according to their physician-ordered dialysis prescription for 2 of 4 randomly chosen ICHD patients whose machine settings were compared to their prescriptions during treatment (Patient #3, 4) and for 9 of 11 ICHD patient records reviewed (Patient #3, 5, 6, 7, 8, 11, 12, 13, 14); failed to ensure policies and procedures were followed related to risk event reporting for 1 of 1 ICHD patient found to be receiving the wrong dialysate during treatment (Patient #3); failed to ensure policies and procedures were followed related to expired medications for 1 of 2 medication refrigerators (medication refrigerator #1); failed to ensure policies and procedures were followed related to patient blood pressure monitoring and reporting for 8 of 11 ICHD patient records reviewed (Patient #3, 6, 7, 9, 10, 11, 12, 13); and failed to ensure policies and procedures were followed related to as needed antihypertensive medications for 2 of 11 ICHD patient records reviewed (Patient #6 and 11). Findings include: 1. Review of the Medical Director Agreement indicated " ... Duties, Responsibilities and Conditions ... As Medical Director of Center, Medical Director shall have the duties and responsibilities set forth on Schedule 3.1 attached hereto ... Physician Duties ... Participate in development, implementation, review and approval of (and adherence by Center providers to) all Center policies and procedures including, but not limited to, those addressing ... Patient ...care ... Quality assessment and performance improvement ... Infection control and safety ..."	V 0715	A Governing Body meeting will be conducted to include Medical Director, Facility Administrator and Regional Operations Director for review of the results of the survey completed on 6/23/25. The Governing Body will review Policy COMP-DD-017 “Medical Director Qualifications and Responsibilities” with the Medical Director to include: 1) : 1) Medical Director responsibilities include, but are not limited to, the following…: Oversight of policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility….Verification of the Medical Director’s attendance and understanding is evidence by his/her signature on the policy. The Facility Administrator, Clinical Coordinator, or Charge nurse will in-service all clinical teammates on Policy 1-03-08 “Pre-Intra-Post Treatment Data Collection, Monitoring, And Nursing Assessment” and Policy 1-06-01 “Medication Policy”, and Policy 13-01-02 “Risk Event Reporting Policy (Non Teammate Related)”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) Intradialytic	07/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	2. Review of the Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment policy, revised April 2024, indicated " ... Intradialytic treatment monitoring and data collection which may be performed by the PCT or licensed nurse includes ... Vital signs and treatment monitoring ... Non-nocturnal treatments are completed at least every thirty (30) minutes ... At a minimum, obtain and document the following ... blood pressure ... Blood and dialysate flows, arterial and venous pressures ... If the dialysis prescription is not being met (including dialysis flow rate or change to/inability to obtain prescribed blood flow rate) the reason will be documented and the licensed nurse informed ... Abnormal findings or findings outside of any patient specific physician ordered parameters will be reported to the licensed nurse immediately ... All findings, interventions and patient response will be documented in the patient's medical record ... Unless other abnormal parameters are established by the facility Governing Body and documented in the Governing Body meeting minutes, the following are considered abnormal findings and should be reported to the licensed nurse and documented in the patient's medical record ... Blood pressure-Intradialytic ... Systolic greater than 180 ... or less than 90 ... Diastolic greater than or equal to 100 ... or less than 50 ..." 3. Review of the Medication policy, revised October 2023, indicated " ... The Facility Administrator/designee is responsible for supervising the handling, storing, disposing, administering, and controlling of medications and performs a monthly audit and inventory ..." 4. Review of the Risk Event Reporting Policy, revised October 2024, indicated " ... Any		treatment monitoring and data collection which may be performed by the PCT or licensed nurse includes: Vital signs and treatment monitoring… Nonnocturnal treatments are completed at least every thirty (30) minutes. 2) At a minimum, obtain and document the following: Blood pressure…Blood and dialysate flows, arterial and venous pressures…3) If the dialysis prescription is not being met (including dialysis flow rate or change to /inability to obtain prescribed blood flow rate) the reason will be documented and the licensed nurse informed. 4) Abnormal findings or findings outside of any patient specific physician ordered parameters will be reported to the licensed nurse immediately…5) All findings, interventions and patient response will be documented in the patient's medical record. 6) Unless other abnormal parameters are established by the facility Governing Body and documented in the Governing Body Meeting minutes, the following are considered abnormal findings and should be reported to the licensed nurse and documented in the patient's medical record. 7) Blood Pressure Intradialytic: Systolic greater than 180 mm/Hg or less than 90 mm/Hg • Diastolic greater than or equal to 100 mm/Hg or less than 50 mm/Hg. 8) The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	unexpected event that is inconsistent with the routine operation of a dialysis facility, routine provision of acute dialysis or ancillary renal-related services may be a risk event. Such risk events include, but are not limited to ... potential personal injury to a patient ... 'near miss' events ... The teammate will complete the Risk Event Management (REM) Report as soon after the occurrence as is reasonably possible, but no later than the completion of the teammates' shift during which the risk event happened ..." 5. During a treatment floor observation on 06/18/2025 at 12:28 PM, Patient #3's treatment was observed to be running with 3.0 potassium (K) dialysate rather than the prescribed 2.0K dialysate. Observed RN 1 changed the dialysate line from 3.0K dialysate to 2.0K. The facility failed to ensure all patients received their treatments with the correct dialysate. During an interview on 06/18/2025 at 12:28 PM, RN 1 indicated she needed to change that when it was brought to her attention Patient #3's dialysis treatment was running with 3.0K dialysate. During an interview on 06/20/2025 at 3:03 PM, RN 1 indicated an incident report should be completed for a wrong prescription. RN 1 relayed she did not document Patient #4 had been running with the incorrect dialysate before RN 1 corrected it on 06/18/2025. RN 1 further indicated she had not completed an incident report due to Patient #4 not receiving the correct dialysis prescription but could do it now. 6. During a treatment floor observation on 06/18/2025 at 12:09 PM, Patient #4's treatment was observed to be running at a blood flow rate (BFR) of 300 rather than the prescribed BFR of 350. The		Facility Administrator/designee is responsible for supervising the handling, storing, disposing, administering, and controlling of medications and performs a monthly audit and inventory. 9) Any unexpected event that is inconsistent with the routine operation of a dialysis facility, routine provision of acute dialysis or ancillary renal-related services may be a risk event. 10) Such risk events include, but are not limited to… potential personal injury to a patient…'near miss' events, 11) The teammate will complete the Risk Event Management (REM) Report as soon after the occurrence as is reasonably possible, but no later than the completion of the teammates' shift during which the risk event happened. The Facility Administrator, Clinical Coordinator, or Charge Nuse will audit twenty-five percent (25%) of treatment detail reports daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy for delivery of dialysis treatments in accordance with physicians' prescription orders, notification and documentation of abnormal patient findings. Ongoing compliance will be verified with ten percent (10%) of treatment detail reports audited monthly x 3 months during the internal medical record audit. The Facility Administrator, Clinical	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	facility failed to ensure all patients received their treatments at the prescribed BFR. During an interview on 06/18/2025 at 12:10 PM, PCT 2 relayed there were no notes in Patient #4's charting to indicate why Patient #4's treatment was running at a blood flow rate (BFR) of 300 instead of the prescribed BFR of 350. 7. During a flash tour observation of the treatment floor on 06/18/2025 beginning at 10:19 AM, observed two boxes of Flucelvax (an influenza vaccine), one unopened and one open and containing three vials, in medication refrigerator #1. The boxes included an expiration date of May 29, 2025. During an interview on 06/18/2025 12:30 PM, RN 1 confirmed the two packages of Flucelvax in medication refrigerator #2 were expired and would dispose of the medication in a sharps container. 8. Review of Patient #3's treatment sheets dated 05/30/2025 to 06/16/2025 included the following: 06/09/2025 PCT 12 recorded a blood pressure of 149/35 at 1:01 PM. The record failed to evidence the RN was notified of the diastolic less than 50. A blood pressure check was recorded at 12:01 PM with a follow up blood pressure check at 1:01 PM, one hour later. Staff failed to monitor Patient #3's blood pressure at least every 30 minutes during treatment.\ During a treatment floor observation on 06/18/2025 at 12:28 PM, Patient #3's treatment was observed to be running with 3.0 potassium (K) dialysate rather than the prescribed 2.0K dialysate. Observed RN 1 changed the dialysate		Coordinator, or Charge nurse will audit one hundred percent (100%) of risk event reports monthly x 3 months to verify compliance with facility policy. Ongoing compliance will be verified with ten percent of risk event reports audited monthly x 3 months during an internal audit. Instances of noncompliance will be addressed. The Facility Administrator, Clinical Coordinator, or Charge Nurse will review audit results with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	line from 3.0K dialysate to 2.0K. 06/18/2025 The record failed to evidence Patient #3 was receiving 3.0K dialysate rather than the ordered 2.0K dialysate from the start of treatment at 11:00 AM until 12:28 PM when RN 1 corrected the dialysate line after the Surveyor asked about it. RN 1 failed to document a prescription error in the treatment sheet. During an interview on 06/23/2025, PCT 12 indicated systolic blood pressures over 200 or below 100 and diastolic blood pressures over 80 or under 60 should be reported to the nurse. During an interview on 06/20/2025 at 9:07 AM, RN 3 indicated patients should be assessed before treatment, vital signs should be taken every 30 minutes during treatment, and patients should be assessed again before leaving the treatment floor. During an interview on 06/20/2025 at 3:03 PM, RN 1 relayed she did not document Patient #3 had been running with the incorrect dialysate before RN 1 corrected it on 06/18/2025. 9. Review of Patient #5's treatment sheets dated 05/30/2025 to 06/16/2025 included the following: 05/30/2025 The ultrafiltration rate for the treatment was 13.3 milliliters per kilogram per hour. Staff failed to ensure Patient #13's ultrafiltration rate did not exceed the ordered maximum of 13 milliliters per kilogram per hour. 06/06/2025 Treatment was started with a 600 dialysate flow rate (DFR) and ran at 600 DFR for the entire treatment. The treatment record failed to indicate a reason for running the treatment below the prescribed DFR of 800.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	06/11/2025 Treatment was started with a 600 DFR and ran at 600 DFR for the entire treatment. The treatment record failed to indicate a reason for running the treatment below the prescribed DFR of 800. 06/13/2025 Treatment was started at 1:32 PM with a 600 DFR and ran at 600 DFR until 2:42 PM when RN 1 changed it to 800 DFR per order. The treatment record failed to indicate a reason for starting the treatment below the prescribed DFR of 800. 06/16/2025 Treatment was started with a 600 DFR and ran at 600 DFR for the entire treatment. The treatment record failed to indicate a reason for running the treatment below the prescribed DFR of 800. During an interview on 06/23/2025 at 2:31 PM, PCT 12 indicated treatments should run at the prescribed settings, and if not, the reason should be documented in the patient's chart. During an interview on 06/23/2025 at 2:36 PM, RN 2 indicated the ultrafiltration rate should be no greater than 13 milligrams per kilogram per hour, and anything above that would require an extra order. During an interview on 06/20/2025 at 3:07 PM, RN 3 indicated patients' machine settings should run at what the doctor has on their orders. RN 3 further indicated if the patient's dialysis was running at different settings than prescribed, it should be documented and the physician notified. 10. Review of Patient #6's treatment sheets dated 05/30/2025 to 06/18/2025 included the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	06/04/2025 Treatment was started at 3:30 PM with a 450 blood flow rate (BFR) rather than the prescribed BFR of 500. Treatment ran at 450 BFR until 6:30 PM when it was reduced to 300 BFR without a documented reason. Treatment ran at 300 until 7:31 when it was reduced to 200 due to the machine would not stop alarming. The treatment record failed to indicate a reason for starting and running the treatment below the prescribed BFR. Treatment was started with a 600 dialysate flow rate (DFR) and ran at 600 DFR for the entire treatment. The treatment record failed to indicate a reason for running the treatment below the prescribed DFR of 800. PCT 14 recorded blood pressures of 173/100 at 3:30 PM and 200/108 at 4:00 PM. The record failed to evidence the RN was notified of the diastolic blood pressures greater than or equal to 100 or the systolic blood pressure greater than 180. 06/06/2025 Treatment was started at 3:15 PM with a 450 BFR rather than the prescribed BFR of 500 and continued at 450 BFR the entire treatment. The treatment record failed to indicate a reason for starting and running the treatment below the prescribed BFR. Treatment was started with a 600 DFR and ran at 600 DFR for the entire treatment. The treatment record failed to indicate a reason for running the treatment below the prescribed DFR of 800. PCT 6 recorded a blood pressure of 149/102 at 3:15 PM, and PCT 4 recorded a blood pressure of 148/111 at 7:01 PM. The record failed to evidence the RN was notified of the diastolic blood			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	pressures greater than 100. 06/09/2025 Treatment was started with a 600 DFR and ran at 600 DFR for the entire treatment. The treatment record failed to indicate a reason for running the treatment below the prescribed DFR of 800. PCT 11 recorded blood pressures of 181/103 at 2:32 PM and 162/100 at 4:01 PM, and PCT 13 recorded blood pressures of 148/106 at 6:01 PM and 158/109 at 6:30 PM. The record failed to evidence the RN was notified of the diastolic blood pressures greater than or equal to 100. 06/11/2025 Treatment was started at 2:47 PM with a 450 BFR rather than the prescribed BFR of 500. Treatment ran at 450 BFR until 4:00 PM when it was reduced to 400 BFR due to high venous pressure. Treatment ran at 400 until 5:01 PM when the Patient was switched to another machine due to machine malfunction. Treatment began at 6:05 PM at 350 BFR on the new machine and ran at 350 BFR the remainder of the treatment. The treatment record failed to indicate a reason for starting and running the treatment below the prescribed BFR. Treatment was started with a 600 DFR and ran at 600 DFR until 3:14 PM when the RN increased it to 800 DFR. At 4:00 PM and 4:30 PM, a 600 DFR was recorded. From 4:38 PM through the end of treatment, the treatment ran at 800 DFR. The treatment record failed to indicate a reason for starting the treatment below the prescribed DFR of 800 or for lowering it temporarily during treatment. PCT 6 recorded a blood pressure of 166/112 at 2:47 PM, PCT 10 recorded blood pressures of 152/100 at 5:01 PM and 149/104 at 6:05 PM, PCT 8			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	recorded blood pressures of 152/107 at 6:30 PM and 162/108 at 7:00 PM. The record failed to evidence the RN was notified of the diastolic blood pressures greater than or equal to 100. A blood pressure check was recorded at 5:01 PM with a follow up blood pressure check at 6:05 PM, one hour and four minutes later. Staff failed to monitor Patient #11's blood pressure at least every 30 minutes during treatment. 06/13/2025 Treatment was started at 2:25 PM with a 450 BFR rather than the prescribed BFR of 500 with an RN note that the BFR was running at 450 due to the Patient being cannulated with a 15-gauge needle. Treatment ran at 450 BFR until 4:30 PM when it was reduced to 440 BFR with no documented reason. Treatment then ran at 440 until the end of treatment. The treatment record failed to indicate a reason for running the treatment below the prescribed BFR. During an interview on 06/20/2025 at 10:43 AM, PCT 7 indicated patients are monitored before treatment, every half hour during treatment, and after treatment. During an interview on 06/23/2025 at 2:31 PM, PCT 12 indicated treatments should run at the prescribed settings, and if not, the reason should be documented in the patient's chart. During an interview on 06/23/2025 at 2:44 PM, PCT 11 indicated he would report to the nurse blood pressures under 100 or above 200 systolic or above 100 diastolic. PCT 11 indicated he didn't know of a specific lower diastolic blood pressure to report. During an interview on 06/23/2025 at 2:36 PM, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	2 indicated systolic blood pressures greater than 180 and less than 90 should be reported to the nurse. RN 2 relayed he couldn't remember the diastolic parameters off the top of his head. During an interview on 06/23/2025 at 2:57 PM, RN 3 indicated systolic blood pressures above 200 and below 100 should be reported to the nurse. RN 3 relayed he didn't think there was a policy regarding reporting diastolic blood pressures, but he asks PCTs to report diastolic blood pressures above 100 and below 60 to him. RN 3 also indicated the treatments should run at the prescribed settings, and if not running at the prescribed settings, the reason should be documented on the treatment run sheet. 11. Review of Patient #7's treatment sheets dated 05/30/2025 to 06/16/2025 included the following: 06/02/2025 Treatment was started at 2:46 PM with a 350 blood flow rate (BFR) rather than the prescribed BFR of 400 and ran at 350 BFR the entire treatment. The treatment record failed to indicate a reason for starting and running the treatment below the prescribed BFR. PCT 12 recorded blood pressures of 252/126 at 2:46 PM, 246/123 at 3:01 PM, 237/120 at 3:31 PM, 229/115 at 4:01 PM, and 234/111 at 4:31 PM. The record failed to evidence the RN was notified of the systolic blood pressures greater than 180 or the diastolic blood pressures greater than 100. PCT 1 recorded a blood pressure of 241/135 and indicated the RN was notified. The record failed to evidence Patient #7's prescribed, as needed Clonidine (a medication primarily used to treat high blood pressure) was offered.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	The ultrafiltration rate for the treatment was 13.2 milliliters per kilogram per hour. Staff failed to ensure Patient #13's ultrafiltration rate did not exceed the ordered maximum of 13 milliliters per kilogram per hour. 06/06/2025 Treatment was started at 3:22 PM with a 350 BFR rather than the prescribed BFR of 400 and ran at 350 BFR the entire treatment. The treatment record failed to indicate a reason for starting and running the treatment below the prescribed BFR. The ultrafiltration rate for the treatment was 14.8 milliliters per kilogram per hour. Staff failed to ensure Patient #13's ultrafiltration rate did not exceed the ordered maximum of 13 milliliters per kilogram per hour. 06/09/2025 Treatment was started at 2:46 PM with a 350 BFR rather than the prescribed BFR of 400 and ran at 350 BFR the entire treatment. The treatment record failed to indicate a reason for starting and running the treatment below the prescribed BFR. The ultrafiltration rate for the treatment was 14.9 milliliters per kilogram per hour. Staff failed to ensure Patient #13's ultrafiltration rate did not exceed the ordered maximum of 13 milliliters per kilogram per hour. 06/11/2025 Treatment was started with a 600 dialysis flow rate (DFR) and ran at 600 DFR the entire treatment. The treatment record failed to indicate a reason for running the treatment below the prescribed DFR of 800. During an interview on 06/23/2025 at 2:31 PM, PCT 12 indicated treatments should run at the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	prescribed settings, and if not, the reason should be documented in the patient's chart. PCT 12 also indicated he would report systolic blood pressures greater than 200 or less than 100 and diastolic blood pressures greater than 80 or less than 60 to the nurse. PCT 12 reported nurse notification should be recorded in the vitals section of the patient's chart. During an interview on 06/23/2025 at 2:36 PM, RN 2 indicated systolic blood pressures greater than 180 and less than 90 should be reported to the nurse. RN 2 relayed he couldn't remember the diastolic parameters off the top of his head. RN further indicated if a patient's blood pressure was above parameters and as needed antihypertensives were not given, the reason should be noted in the treatment log. RN 2 further indicated the ultrafiltration rate should be no greater than 13 milligrams per kilogram per hour, and anything above that would require an extra order. During an interview on 06/23/2025 at 2:57 PM, RN 3 indicated systolic blood pressures above 200 and below 100 should be reported to the nurse. RN 3 relayed he didn't think there was a policy regarding reporting diastolic blood pressures, but he asks PCTs to report diastolic blood pressures above 100 and below 60 to him. RN 3 also indicated the treatments should run at the prescribed settings, and if not running at the prescribed settings, the reason should be documented on the treatment run sheet. RN 3 further indicated if the blood pressure parameters of 200 systolic were met and as needed Clonidine was prescribed, as needed Clonidine should be offered to the patient. RN 3 indicated there should be documentation on the treatment run sheet that as need Clonidine was given or offered and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	refused. 12. Review of Patient #8's treatment sheets dated 06/01/2025 to 06/12/2025 included the following: 06/05/2025 Treatment was started with a 600 dialysis flow rate (DFR) and ran at 600 DFR the entire treatment. The treatment record failed to indicate a reason for running the treatment below the prescribed DFR of 800. 06/07/2025 Treatment was started with a 600 DFR and ran at 600 DFR the entire treatment. The treatment record failed to indicate a reason for running the treatment below the prescribed DFR of 800. 06/10/2025 Treatment was started with a 600 DFR and ran at 600 DFR the entire treatment. The treatment record failed to indicate a reason for running the treatment below the prescribed DFR of 800. During an interview on 06/23/2025 at 2:31 PM, PCT 12 indicated treatments should run at the prescribed settings, and if not, the reason should be documented in the patient's chart. During an interview on 06/20/2025 at 3:07 PM, RN 3 indicated patients' machine settings should run at what the doctor has on their orders. RN 3 further indicated if the patient's dialysis was running at different settings than prescribed, it should be documented and the physician notified. 13. Review of Patient #9's treatment sheets dated 05/31/2025 to 06/16/2025 included the following: 06/02/2025 PCT 3 recorded blood pressures of 79/39 at 9:05 AM and 86/43 at 9:07 AM. The record failed to evidence the RN was notified of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	the diastolic blood pressures less than 50. 06/04/2025 PCT 7 recorded blood pressures of 124/45 at 7:31 AM, 74/51 at 9:02 AM and 79/49 at 9:04 AM. The record failed to evidence the RN was notified of the systolic blood pressure less than 90 or the diastolic blood pressures less than 50. 06/09/2025 PCT 7 recorded blood pressures of 88/52 at 9:05 AM, 85/46 at 9:06 AM, and 89/52 at 9:24 AM. The record failed to evidence the RN was notified of the systolic blood pressures less than 90 or the diastolic blood pressure less than 50. 06/11/2025 PCT 7 recorded blood pressures of 92/49 at 8:01 AM, 86/54 at 8:31 AM, 90/43 at 8:33 AM, 89/38 at 9:11 AM, and 79/52 at 9:17 AM. The record failed to evidence the RN was notified of the systolic blood pressures less than 90 or the diastolic blood pressures less than 50. 06/16/2025 PCT 3 recorded blood pressures of 96/51 at 8:32 AM, 72/37 at 9:16 AM, and 108/47 at 9:18 AM. The record failed to evidence the RN was notified of the systolic blood pressure less than 90 or the diastolic blood pressures less than 50. During an interview on 06/23/2025 at 2:51 PM, PCT 3 indicated blood pressures below 100 and above 200 systolic and less than 60 or greater than 100 diastolic should be reported to the nurse and the reporting documented in the treatment log. During an interview on 06/23/2025 at 2:36 PM, RN 2 indicated systolic blood pressures greater than 180 and less than 90 should be reported to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	nurse. RN 2 relayed he couldn't remember the diastolic parameters off the top of his head. During an interview on 06/23/2025 at 2:57 PM, RN 3 indicated systolic blood pressures above 200 and below 100 should be reported to the nurse. RN 3 relayed he didn't think there was a policy regarding reporting diastolic blood pressures, but he asks PCTs to report diastolic blood pressures above 100 and below 60 to him. 14. Review of Patient #10's treatment sheets dated 06/03/2025 to 06/18/2025 included the following: 06/05/2025 PCT 9 recorded blood pressures of 206/66 7:32 AM and 195/63 at 8:02 AM, and PCT 8 recorded a blood pressure of 192/71 at 9:31 AM. The record failed to evidence the RN was notified of the systolic blood pressures greater than 180. 06/12/2025 PCT 10 recorded blood pressures of 221/70 at 8:02 AM, 196/79 at 8:32 AM, 183/68 at 9:02 AM, 122/102 at 9:32 AM, and 187/66 at 9:43 AM. The record failed to evidence the RN was notified of the systolic blood pressures greater than 180. 06/16/2025 PCT 3 recorded blood pressures of 155/24 at 9:33 AM and 150/44 at 9:59 AM. The record failed to evidence the RN was notified of the diastolic blood pressures less than 50. 06/18/2025 PCT 9 recorded blood pressures of 182/72 at 7:31 AM and 202/76 at 8:01 AM. The record failed to evidence the RN was notified of the systolic blood pressure greater than 180. During an interview on 06/23/2025 at 2:51 PM, PCT 3 indicated blood pressures below 100 and above 200 systolic and less than 60 or greater			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	than 100 diastolic should be reported to the nurse and the reporting documented in the treatment log. During an interview on 06/23/2025 at 2:36 PM, RN 2 indicated systolic blood pressures greater than 180 and less than 90 should be reported to the nurse. RN 2 relayed he couldn't remember the diastolic parameters off the top of his head. During an interview on 06/23/2025 at 2:57 PM, RN 3 indicated systolic blood pressures above 200 and below 100 should be reported to the nurse. RN 3 relayed he didn't think there was a policy regarding reporting diastolic blood pressures, but he asks PCTs to report diastolic blood pressures above 100 and below 60 to him. 15. Review of Patient #11's treatment sheets dated 05/24/2025 to 06/17/2025 included the following: 05/24/2025 Treatment was started at 4:18 PM with a 400 blood flow rate (BFR) rather than the prescribed BFR of 450. Treatment ran at 400 BFR until 5:03 PM when it was reduced to 350 BFR due to high venous pressure. The treatment record failed to indicate a reason for starting treatment below the prescribed BFR. Treatment was started with a 600 dialysate flow rate (DFR) and ran at 600 DFR for the entire treatment. The treatment record failed to indicate a reason for running the treatment below the prescribed DFR of 800. 05/31/2025 Treatment was started with a 600 DFR and ran at 600 DFR for the entire treatment. The treatment record failed to indicate a reason for running the treatment below the prescribed DFR.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	A blood pressure check was recorded at 4:01 PM with a follow up blood pressure check at 4:48 PM, 47 minutes later. Staff failed to monitor Patient #11's blood pressure at least every 30 minutes during treatment. PCT 11 recorded a blood pressure of 186/117 at 2:51 PM, and PCT 4 recorded a blood pressure of 191/114 at 4:48 PM. The record failed to evidence the RN was notified of the systolic blood pressure greater than 180 or the diastolic blood pressures greater than 100. RN 2 recorded blood pressures of 170/104 at 3:01 PM, 181/102 at 3:31 PM, and 166/102 at 4:01 PM. The treatment record failed to indicate Patient #11 was offered as needed Clonidine for their high blood pressures. 06/03/2025 Treatment was started with a 600 DFR and ran at 600 DFR for the entire treatment. The treatment record failed to indicate a reason for running the treatment below the prescribed DFR. 06/05/2025 Treatment was started at 3:08 pm with a 400 BFR rather than the prescribed BFR of 450. Treatment ran at 400 BFR until 3:32 PM when it was reduced to 300 BFR due to difficult cannulation. The treatment record failed to indicate a reason for starting treatment below the prescribed BFR. Treatment was started with a 600 DFR and ran at 600 DFR for the entire treatment. The treatment record failed to indicate a reason for running the treatment below the prescribed DFR. A blood pressure check was recorded at 4:05 PM with a follow up blood pressure check at 5:02 PM, 57 minutes later. Staff failed to monitor Patient			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	#11's blood pressure at least every 30 minutes during treatment. 06/14/2025 Treatment was started at 4:42 pm with a 350 BFR rather than the prescribed BFR of 450. Treatment ran at 350 BFR until treatment ended. The treatment record failed to indicate a reason for starting and running the treatment below the prescribed BFR. PCT 12 recorded a blood pressure of 175/117 at 4:42 pm, and PCT 13 recorded blood pressures of 166/101 at 5:01 PM, 161/100 at 5:31 PM, and 184/109 at 6:26 PM. The record failed to indicate the RN was notified for the systolic blood pressure greater than 180 or the diastolic blood pressures greater than or equal to 100. 06/17/2025 Treatment was started at 4:23 PM with a 350 BFR and ran at 350 BFR until 6:31 PM when the BFR was lowered to 300. Treatment ran at 300 BFR until 7:00 PM when the BFR was changed to 350 and ran at 350 BFR until the end of treatment. The treatment record failed to indicate a reason for starting and running the treatment below the prescribed BFR. Treatment was started at 4:23 PM at 600 DFR and ran at 600 DFR until it was changed to 800 BFR at 4:30 PM. Treatment ran at 800 DFR until 6:30 PM when it was lowered to 600 DFR. The remainder of the treatment ran at 600 DFR. The treatment record failed to indicate a reason for starting and running the treatment below the prescribed DFR. PCT 12 recorded a blood pressure of 178/117 at 4:23 PM. PCT 13 recorded a blood pressure of 168/114 at 4:30 PM. PCT 4 recorded blood pressures of 210/130 at 5:31 PM, 173/123 at 6:01 PM, and 211/132 at 6:31 PM. The record failed to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	evidence the RN was notified of the systolic blood pressures greater than 180 or the diastolic blood pressures greater than 100. RN 3 recorded a blood pressure of 199/120 at 5:01 PM and 215/135 at 7:00 PM. RN 5 recorded a post-treatment blood pressure of 202/128 at 7:08 PM. RN 3 recorded the patient was stable, and they were removing lots of fluid at 7:00 PM. The record failed to indicated Patient #11 was offered their prescribed, as needed clonidine for their high blood pressures. The actual ultrafiltration rate was recorded as 18.6 milliliters per kilogram per hour. Staff failed to ensure the ultrafiltration rate remained equal to or below the prescribed maximum ultrafiltration rate of 15 milliliters per kilogram per hour. During an interview on 06/20/2025 at 10:43 AM, PCT 7 indicated patients are monitored before treatment, every half hour during treatment, and after treatment. During an interview on 06/23/2025 at 2:31 PM, PCT 12 indicated treatments should run at the prescribed settings, and if not, the reason should be documented in the patient's chart. PCT 12 also indicated he would report systolic blood pressures greater than 200 or less than 100 and diastolic blood pressures greater than 80 or less than 60 to the nurse. PCT 12 reported nurse notification should be recorded in the vitals section of the patient's chart. During an interview on 06/23/2025 at 2:51 PM, PCT 3 indicated blood pressures below 100 and above 200 systolic and less than 60 or greater than 100 diastolic should be reported to the nurse and the reporting documented in the treatment			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	log. PCT 3 also indicated a patient's treatment should run at the prescribed machine settings, and if not, the reason should be documented in the treatment log. PCT further indicated the ultrafiltration rate should be less than 13 milliliters per kilogram per hour. During an interview on 06/23/2025 at 2:36 PM, RN 2 indicated systolic blood pressures greater than 180 and less than 90 should be reported to the nurse. RN 2 relayed he couldn't remember the diastolic parameters off the top of his head. RN further indicated if a patient's blood pressure was above parameters and as needed antihypertensives were not given, the reason should be noted in the treatment log. RN 2 further indicated the ultrafiltration rate should be no greater than 13 milligrams per kilogram per hour, and anything above that would require an extra order. During an interview on 06/23/2025 at 2:57 PM, RN 3 indicated systolic blood pressures above 200 and below 100 should be reported to the nurse. RN 3 relayed he didn't think there was a policy regarding reporting diastolic blood pressures, but he asks PCTs to report diastolic blood pressures above 100 and below 60 to him. RN 3 also indicated the treatments should run at the prescribed settings, and if not running at the prescribed settings, the reason should be documented on the treatment run sheet. RN 3 further indicated if the blood pressure parameters of 200 systolic were met and as needed Clonidine was prescribed, as needed Clonidine should be offered to the patient. RN 3 indicated there should be documentation on the treatment run sheet that as need Clonidine was given or offered and refused.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	16. Review of Patient #12's treatment sheets dated 05/31/2025 to 06/17/2025 included the following: 06/03/2025 Treatment was started with a 600 dialysate flow rate (DFR) and ran at 600 DFR for the entire treatment. The treatment record failed to indicate a reason for running the treatment below the prescribed DFR of 700. 06/07/2025 PCT 4 recorded a blood pressure of 91/45 at 9:43 AM. The record failed to evidence the RN was notified of the diastolic blood pressure less than 50. 06/10/2025 A blood pressure check was recorded at 8:31 AM with a follow up blood pressure check at 9:32 AM, one hour and one minute later. Staff failed to monitor Patient #12's blood pressure at least every 30 minutes during treatment. PCT 7 recorded a blood pressure of 91/49 at 8:31 AM. The record faile d to evidence the RN was notified of the diastolic blood pressure less than 50.06/12/2025 PCT 4 recorded a blood pressure of 100/45 at 6:32 AM, and PCT 12 recorded a blood pressure of 82/54 at 8:34 AM. The record failed to evidence the RN was notified of the systolic blood pressure less than 90 or the diastolic blood pressure less than 50.06/13/2025 Treatment was started with a 600 dialysate flow rate (DFR) and ran at 600 DFR for the entire treatment. The treatment record failed to indicate a reason for running the treatment below the prescribed DFR of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	700.06/17/2025 PCT 7 recorded a blood pressure of 83/50 at 9:31 AM. The record failed to evidence the RN was notified of the systolic blood pressure less than 90.During an interview on 06/20/2025 at 10:43 AM, PCT 7 indicated patients are monitored before treatment, every half hour during treatment, and after treatment.During an interview on 06/23/2025 at 2:51 PM, PCT 3 indicated blood pressures below 100 and above 200 systolic and less than 60 or greater than 100 diastolic should be reported to the nurse and the reporting documented in the treatment log. During an interview on 06/23/2025 at 2:31 PM, PCT 12 indicated treatments should run at the prescribed settings, and if not, the reason should be documented in the patient's chart. PCT 12 also indicated he would report systolic blood pressures greater than 200 or less than 100 and diastolic blood pressures greater than 80 or less than 60 to the nurse. PCT 12 reported nurse notification should be recorded in the vitals section of the patient's chart.During an interview on 06/23/2025 at 2:36 PM, RN 2 indicated systolic blood pressures greater than 180 and less than 90 should be reported to the nurse. RN 2 relayed he couldn't remember the diastolic parameters off the top of his head.During an interview on 06/20/2025 at 3:07 PM, RN 3 indicated patients' machine			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	settings should run at what the doctor has on their orders. RN 3 further indicated if the patient's dialysis was running at different settings than prescribed, it should be documented and the physician notified.17. Review of Patient #13's treatment sheets dated 05/31/2025 to 06/17/2025 included the following:06/05/2025 PCT 7 recorded a blood pressure of 87/47 at 9:00 AM. The record failed to evidence the RN was notified of the systolic blood pressure less than 90 or the diastolic blood pressure less than 50.06/10/2025 The ultrafiltration rate for the treatment was 15.1 milliliters per kilogram per hour. Staff failed to ensure Patient #13's ultrafiltration rate did not exceed the ordered maximum of 13 milliliters per kilogram per hour.06/12/2025 The ultrafiltration rate for the treatment was 13.1 milliliters per kilogram per hour. Staff failed to ensure Patient #13's ultrafiltration rate did not exceed the ordered maximum of 13 milliliters per kilogram per hour.PCT 9 recorded a blood pressure of 126/45 at 9:00 AM. The record failed to evidence the RN was notified of the diastolic blood pressure less than 50.During an interview on 06/23/2025 at 2:51 PM, PCT 3 indicated blood pressures below 100 and above 200 systolic and less than 60 or greater than 100 diastolic should be reported to the nurse and the reporting documented in the treatment			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	log. During an interview on 06/23/2025 at 2:36 PM, RN 2 indicated systolic blood pressures greater than 180 and less than 90 should be reported to the nurse. RN 2 relayed he couldn't remember the diastolic parameters off the top of his head. RN 2 further indicated the ultrafiltration rate should be no greater than 13 milligrams per kilogram per hour, and anything above that would require an extra order.18. Review of Patient #14's treatment sheets dated 06/06/2025 to 06/18/2025 included the following:06/06/2025 Treatment was started with a 600 dialysate flow rate (DFR) and ran at 600 DFR for the entire treatment. The treatment record failed to indicate a reason for running the treatment below the prescribed DFR of 800.06/09/2025 Treatment was started with a 600 DFR and ran at 600 DFR for the entire treatment. The treatment record failed to indicate a reason for running the treatment below the prescribed DFR of 800.06/09/2025 Treatment was started at 5:59 AM with a 600 DFR and ran at 600 DFR until 6:30 when it was increased to 800 DFR. Treatment ran at 800 DFR until 9:00 AM when it was lowered to 600 DFR. Treatment ran at 600 DFR the rest of the treatment until 09:58 AM. The treatment record failed to indicate a reason for starting and finishing the treatment below the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152647	A. BUILDING 00 B. WING	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE FORT WAYNE, IN 46806

(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
	prescribed DFR of 800.During an interview on 06/23/2025 at 2:31 PM, PCT 12 indicated treatments should run at the prescribed settings, and if not, the reason should be documented in the patient's chart.During an interview on 06/20/2025 at 3:07 PM, RN 3 indicated patients' machine settings should run at what the doctor has on their orders. RN 3 further indicated if the patient's dialysis was running at different settings than prescribed, it should be documented and the physician notified.19. During an interview on 06/23/2025 at 4:47 PM, the Administrator indicated patients should be started on treatment at the prescribed BFR, and deviations should be recorded in the chart. The Administrator further indicated deviations from the prescribed BFR would require a physician order or parameters. The Administrator also indicated if there was an issue, they would fill out an incident report.20. During an interview on 06/23/2025 at 1:50 PM, the Medical Director indicated she was in charge of the whole clinic. She indicated she was responsible for policies and procedures when they come in and how to implement them. The Medical Director indicated she ensures all policies and procedures are followed by the staff by going over them with the FA who updates the staff regarding new policies and procedures.			