

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152691	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/20/2023
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NAME OF PROVIDER OR SUPPLIER  FRESENIUS KIDNEY CARE SOUTHPORT	STREET ADDRESS, CITY, STATE, ZIP CODE 6826 MADISON AVENUE INDIANAPOLIS, IN 46227
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E 0000  Bldg. 00	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62, for a Medicare participating End Stage Renal Disease Supplier.</p> <p>Dates of Survey: 12-18, 12-19, and 12-20-2023</p> <p>Facility #: 014304</p> <p>CCN: 152691</p> <p>Stations: 24, includes the 1 isolation room.</p> <p>Census by Service Type:</p> <p>In Center Hemodialysis Patients: 72 Home Hemodialysis Patients: 7 Home Peritoneal Dialysis Patients: 27 Total Census: 106</p> <p>At this Emergency Preparedness survey, Fresenius Kidney Care Southport was found not in compliance with Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, 42 CFR 494.62</p> <p>QR completed by Area 3 on 12-27-2023.</p>	E 0000		
E 0018  Bldg. 00	<p>403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6) (ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2),</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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	<p>§485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1).</p> <p>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]</p> <p>[(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.</p> <p>*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.</p> <p>*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.</p>			

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	<p>(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.</p> <p>(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.</p> <p>*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.</p> <p>*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.</p> <p>*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on observation, record review, and interview, the facility failed to ensure patient and staff information was current in the Emergency</p>	E 0018	p paraid="1314172410" paraeid="{6c6bbddf-b02b-4e6c-b0e d-01417a30cea1}{126}" >On	01/19/2024

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	<p>Preparedness tote for 1 of 1 stand alone in-center dialysis facilities.</p> <p>Findings Include:</p> <p>1. A review of a dated 07-03-2023, Fresenius Kidney Care policy titled, "Guidelines for Emergency Preparedness," indicated but was not limited to " ... Create and maintain staff, patient, and facility emergency information contact list ... "</p> <p>2. On 12-18-2023 at 9:45 AM, during a flash tour, the Emergency Evacuation box was reviewed. The Emergency Evacuation box failed to contain an updated list of the patient's and staff's emergency contact information.</p> <p>During an interview on 12-18-2023 at 9:45 AM, the Interim Clinical Manager, Admin 3, indicated the documents had fallen off the box and handed me the documents dated 09-23-2023. Admin 3 further confirmed the Emergency Evacuation box is audited monthly.</p> <p>3. During an interview on 12-18-2023 at 9:55 AM, the Director of Operations, Admin 1, confirmed the Emergency Evacuation box should have contained the updated list of the patient's and staff's emergency contact information.</p> <p>4. On 12-19-2023 at 11:11 AM, facility documents dated 05-14-2023 to 12-19-2023, titled, "Fresenius Kidney Care Clinical Log Readings Report" was provided by Admin 1. The documents indicated a review of the contents of the Emergency Evacuation box contents. The log was completed on 12-19-2023, and signed by Admin 3.</p>		<p>01/04/2024, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy:</p> <p>Guidelines for Emergency Preparedness</p> <p>Emphasis was placed on:</p> <p>The facility must develop a communication plan for all patients (in-center and home). This plan includes the following:</p> <p>Create and maintain staff, patient and facility emergency information contact lists:</p> <p>Quarterly, the Director of Operations/Area Manager or designee will review and update:</p> <p>The FKC Facility Emergency Information Directory</p> <p>Quarterly, the CM will review and update</p> <p>The Emergency and Disaster Staff Contact Information Sheet</p> <p>-The Emergency and Disaster Patient Contact Information Sheet</p> <p>A current copy of the emergency</p>	

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			<p>lists must:</p> <p>Be kept locked in the emergency supply boxes, or cart</p> <p>Effective 01/05/2024, the Clinical Manager will conduct monthly audits utilizing the Emergency Box Contents for Incenter and Emergency Box for Home Audit Tools for 4 weeks or until 100% compliance is achieved. Monitoring for continued compliance will be done monthly utilizing the Emergency Box Contents for Incenter and Emergency Box for Home Audit Tools for 4 weeks or until 100% compliance is achieved. The results from the audits will be reviewed each month in QAI with any non-compliance noted in the meeting minutes.</p> <p>The Medical Director will review the results of audits each month at the QAI Committee meeting monthly.</p> <p>The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. ζ</p> <p>The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the</p>	

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E 0028 Bldg. 00	494.62(b)(9) Dialysis Emergency Equipment §494.62(b)(9) Condition for Coverage: [(b) Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this		<p>resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.</p> <p>The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly.</p> <p>The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.</p> <p>The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic.</p> <p>Completion 01/19/2024</p>	

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	<p>section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:]</p> <p>(9) A process by which the staff can confirm that emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, are on the premises at all times and immediately available.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the Emergency Cart medications were checked for expiration dates for 1 of 2 Emergency Carts observed.</p> <p>Findings include:</p> <p>1. A review of a dated 05-01-2023, Fresenius Kidney Care policy titled, "Emergency Medications, Equipment, and Supplies" indicated but was not limited to, " ... The medications ... must be checked monthly or after use for contents, and expiration dates ... An itemized log must be kept indicating the contents and expiration dates of contents. Items approaching expiration must be reordered and replaced prior to the actual expiration date ...."</p> <p>2. During the flash tour observation on 12-18-2023 at 9:35 AM, 19 vials of Adrenaline (a medication used for emergency treatment of severe allergic reactions) 1milligram (mg)/milliliter (ml), and 2 vials of Calcium Chloride ( a medication used for treatment of low calcium levels) 1 gram/10 ml were</p>	E 0028	<p>p paraid="1857734888" paraeid="{178a7766-7a4a-45c6-9e9b-ec765d05d853}{130}" &gt;On 01/04/2024, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy:</p> <p>Emergency Medications, Equipment and Supplies</p> <p>Emphasis was placed on:</p> <p>The emergency cart must be:</p> <p>Checked monthly or after use for contents, expiration dates, cleanliness, and proper functioning of all equipment.</p> <p>An itemized log must be kept indicating the contents and expiration dates of contents. Items approaching expiration must be</p>	01/19/2024

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	<p>found in the Emergency Cart by the nurse's station of the in-center treatment floor.</p> <p>During an interview on 12-18-2023 at 9:45 AM, The Interim Clinical Manager, Admin 3, confirmed the medications had expired. Admin 3 further indicated the Emergency Cart is audited monthly.</p> <p>3. On 12-19-2023 at 11:11 AM, facility documents dated 05-14-203 to 12-19-2023, titled, "Fresenius Kidney Care Clinical Log Readings Report" was provided by Admin 1. The documents indicated a review of the contents of the Emergency Cart contents. The log was completed on 12-19-2023 and signed by Admin 3.</p>		<p>reordered and replaced prior to the actual expiration date.</p> <p>Effective 01/05/2024, the Clinical Manager will conduct monthly audits utilizing the Emergency Code Cart, Medications, and Machine Hand Crank Checklist for 4 weeks or until 100% compliance is achieved. Monitoring for continued compliance will be done monthly utilizing the Emergency Code Cart, Medications, and Machine Hand Crank Checklist. The results from the audits will be reviewed each month in QAI with any non-compliance noted in the meeting minutes.</p> <p>The Medical Director will review the results of audits each month at the QAI Committee meeting monthly.</p> <p>The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. ζ</p> <p>The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.</p>	

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V 0000  Bldg. 00	This visit was for a CORE Recertification Survey of an ESRD supplier.  Survey Dates: 12-18, 12-19, and 12-20-2023  CCN: 152691  Facility #: 014304  Census by Service Type:	V 0000	The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly.  The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.  The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic.  Completion 01/19/2024	

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V 0401 Bldg. 00	<p>In Center Hemodialysis: 72 Home Peritoneal Dialysis: 27 Home Hemodialysis: 7 Total: 106</p> <p>Stations: 24, including 1 isolation room QR completed by Area 3 on 12-27-2023.</p> <p>494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment. Based on observation, record review, and interview, the facility failed to provide the patients with a safe, aesthetically pleasant environment with treatment chairs free of torn and unstained upholstery to allow proper effective cleaning and disinfection for 1 of 1 stand alone dialysis in-center facilities.</p> <p>Findings include:</p> <p>1. A review of a dated 02-07-2022, Fresenius Kidney Care policy titled, "General Cleanliness and Infection Control Guidelines" indicated but was not limited to, " ... The purpose of this policy is to provide guidance for FKC staff ... maintaining a clean, safe, aesthetically pleasant environment for patients, staff, and visitors .... "</p> <p>2. During treatment room observations on 12-19-2023 from 8:30 AM to 1055 AM, observed the following on the treatment floor:</p> <p>A. Observed the isolation room patient's treatment</p>	V 0401	<p>On 01/04/2024, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policies: • General Cleanliness and Infection Control Guidelines Emphasis was placed on: • Facility to provide and maintain a clean, safe, aesthetically pleasant environment for patients, staff, and visitors. • All areas must be kept clean and organized, including but not limited to the treatment area (monitoring patient chairs &amp; hemodialysis machines for stains), water/supply room and offices. Walkways must be kept clear of debris and free of clutter. The Area Technical Manager placed an order for 2 new Hemodialysis Chairs on 12/29/2023, expected to arrive by 02/09/2024. The facility will place an order for the remaining 15</p>	01/19/2024

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	<p>chair with brown spots and splatters on the right arm tray and the base of the dialysate machine #4.</p> <p>B. Observed at Station #12 the patient's treatment chair with brown and yellow splatters on the right arm tray and armrest.</p> <p>C. Observed at Station #13 the patient's treatment chair with brown and yellow splatters on the right arm tray and armrest.</p> <p>D. Observed at Station #11 the patient's treatment chair with brown and yellow splatters on the right arm tray and the base of dialysis machine #16.</p> <p>E. Observed at Station #10 the patient's treatment chair with brown and yellow splatters on the right arm tray and the base of dialysis machine #10.</p> <p>F. Observed at Station #9 the patient's treatment chair with brown and yellow splatters on the right arm tray and the base of dialysis machine #14.</p> <p>G. Observed at Station #8 the patient's treatment chair with brown and yellow splatters on the right and left arm trays and the base of dialysis machine #18.</p> <p>H. Observed at Station #7 the patient's treatment chair with brown splatters on the right and left arm trays and the base of dialysis machine #2.</p> <p>I. Observed at Station #6 the patient's treatment chair with brown splatters on the right arm tray and the base of dialysis machine #5.</p> <p>J. Observed at Station #5 the patient's treatment chair with brown splatters on the right and left arm trays and yellow stains at the base of dialysis machine #27.</p>		<p>stained chairs, monthly, 2 per month until all replaced. On 01/05/2024, the facility staff cleaned the base of the 11 machines identified to remove all visible stains. Effective 01/08/2024, Clinical Manager will conduct weekly audits, 3 days per week, utilizing Plan of Correction Audit Tool for 2 weeks and then weekly for an additional 2 weeks or until 100% compliance is achieved. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Tool per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause</p>	

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	<p>K. Observed at Station #3 the patient's treatment chair with brown and yellow splatters on the right arm tray and the base of dialysis machine #11.</p> <p>L. Observed at Station #2 the patient's treatment chair with brown splatters on the right arm tray and yellow and brown stains at the base of dialysis machine #21.</p> <p>M. Observed at Station #1 the patient's treatment chair with brown splatters on the right arm tray and the base of dialysis machine #17.</p> <p>N. Observed at Station #23 the patient's treatment chair with brown splatters on the right and left arm trays and the base of dialysis machine #6.</p> <p>O. Observed at Station #22 the patient's treatment chair with brown splatters on the left and right arm trays and yellow and brown splatters on the base of dialysis machine #26.</p> <p>P. Observed at Station #19 the patient's treatment chair with brown splatters on the right armrest and arm tray and the base of dialysis machine #20.</p> <p>Q. Observed at Station #17 the patient's treatment chair with brown splatters on the left and right arm trays.</p> <p>During an interview on 12-18-2023 at 9:30 AM, the Patient Care Technicians, PCT 5 and PCT 7, when queried regarding the brown splatters and droplets on the patient's treatment chairs and machines, indicated the stains were betadine and would not come off.</p> <p>3. During an interview on 12-19-2023 at 3:20 PM, Patient #25 was receiving their dialysis at Station</p>		<p>analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. FKC Southport Plan of Correction (Medicare ESRD Recertification Survey 12/20/23) Page 4 The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 01/19/2024</p>	

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NAME OF PROVIDER OR SUPPLIER  FRESENIUS KIDNEY CARE SOUTHPORT	STREET ADDRESS, CITY, STATE, ZIP CODE 6826 MADISON AVENUE INDIANAPOLIS, IN 46227
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V 0543  Bldg. 00	<p>#18. Patient #25 confirmed the chairs looked worn and stained.</p> <p>4. During an interview on 12-19-2023 at 4:00 PM, the Director of Operations, Admin 1, when queried regarding the patient's treatment chairs and machines, indicated they would think they were dirty. Admin 1 confirmed the chairs were old and stained.</p> <p>494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; Based on record review and interview, the facility failed to ensure direct patient care staff monitored the patients according to the facility policy in 5 of 10 records reviewed. (Patients #1, 4, 5, 6, and 9)</p> <p>Findings Include:</p> <p>1. A review of a Fresenius Kidney Care policy dated 09-05-2023 titled "Patient Monitoring and Safety Checks During Hemodialysis Treatment" indicated but was not limited to, " ... Patient Monitoring: Monitor and document every 30 minutes or more frequently as needed but not to exceed 45 minutes ... Safety Check-Machine Checks ... DFR (sic Dialysis Flow Rate), BFR (Blood Flow Rate), and UFR (Ultrafiltration rate) is set and functioning per treating physician order ..."</p> <p>2. The clinical record of Patient #4 was reviewed with a total of 6 treatment records reviewed from 09-20-2023 to 10-02-2023. The treatment records</p>	V 0543	<p>p paraid="490135276" paraeid="{a5ab6d1d-9725-411b-9a79-a65c565a8313}{95}" &gt;On 01/04/2024, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policies:</p> <p>Patient Assessment and Monitoring</p> <p>p paraid="856561831" paraeid="{a5ab6d1d-9725-411b-9a79-a65c565a8313}{130}" &gt;Emphasis was placed on:</p> <p>Document machine parameters and safety checks every 30 or</p>	01/19/2024

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	<p>failed to evidence safety checks were performed every 30-45 minutes for the treatment records dated 09-20-2023 and 09-27-2023. The treatment document dated 09-20-2023 failed to evidence a safety check was performed in between the safety checks at 13:43 and at 15:03 and the safety checks at 15:03 and 16:32. The treatment document dated 09-27-2023 failed to evidence a safety check was performed in between the safety checks at 13:05 and 14:04 and the safety checks at 14:04 and 15:08.</p> <p>3. The clinical record of Patient #5 was reviewed with a total of 10 treatment records reviewed from 11-27-2023 to 12-18-2023. The treatment records failed to evidence safety checks were performed every 30-45 minutes for the treatment records dated 11-27-2023, 11-29-2023, 12-01-2023, 12-04-2023, and 12-06-2023. The treatment document dated 11-27-2023 failed to evidence a safety check was performed in between the safety checks at 15:10 and 16:15. The treatment document dated 11-29-2023 failed to evidence a safety check was performed in between the safety checks at 15:01 and 16:05. The treatment document dated 12-01-2023 failed to evidence a safety check was performed in between the safety checks at 14:05 and 15:02. The treatment document dated 12-04-2023 failed to evidence a safety check was performed in between the safety checks at 15:12 and 16:19. The treatment document dated 12-06-2023 failed to evidence a safety check was performed in between the safety checks at 14:36 and 16:53.</p> <p>The clinical record of Patient #5 evidenced treatment records from 11-27-2023 to 12-18-2023. The treatment records indicated the patient's BFR was ordered at 350. The treatment documents dated 12-01-2023, 12-04-2023, and 12-06-2023 evidenced the BFR was set at 400. The agency</p>		<p>more often as needed but not to exceed 45 minutes.</p> <p>Check machine settings and measurements:</p> <p>Check prescribed blood flow is being achieved or reason is documented in medical record if unable to meet prescribed blood flow.</p> <p>Obtain blood pressure and pulse rate every 30 minutes or more as needed but not to exceed 45 minutes.</p> <p>Effective 01/05/2024 the Clinical Manager will conduct 10 treatment sheets weekly, alternating shifts, for 3 days per week for 2 weeks and then weekly for an additional 2 weeks or until 100% compliance is achieved utilizing Treatment Sheet Audit Tool. Once compliance is sustained, the Governing Body will decrease frequency to resume regularly scheduled audits based on the QAI calendar. Monitoring will be done through the Clinic Audit Checklist with any non-compliance noted in the meeting minutes in</p> <p>The Medical Director will review the results of audits each month at the QAI Committee meeting monthly.</p>	

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	<p>failed to ensure the BFR was set according to the physician's orders for the 3 treatments.</p> <p>During an interview with the Director of Operations (DO) on 12-20-2023 at 2:00 PM, they indicated the staff had not looked at the orders to ensure the BFR was running at the physician-prescribed rate.</p> <p>4. The clinical record of Patient #6 was reviewed with a total of 12 treatment records reviewed from 11-22-2023 to 12-18-2023. The treatment records failed to evidence safety checks were performed every 30-45 minutes for the treatment record dated 12-15-2023. The treatment document failed to evidence a safety check was performed in between the safety checks at 07:30 and 09:04.</p> <p>During an interview with the DO on 12-20-2023 at 4:15 PM, they indicated the staff were to include why the BFR was changed in the treatment notes. The DO indicated they were unable to find any notes indicating why the BFR was not running at the prescribed rate.5. The medical record/treatment sheets for Patient #1 were reviewed on 12-19-2023. The treatment sheets from 11-27-2023 through 12-18-2023 evidenced the following:</p> <p>A. Treatment sheet dated 12-18-2023, a blood pressure, and pulse check at 10:00 AM by the Patient Care Technician (PCT). The following patient assessment was completed by the Registered Nurse (RN) at 11:43 AM.</p> <p>6. The medical record/treatment sheets for Patient #9 were reviewed on 12-19-2023. The treatment sheets from 11-27-2023 through 12-18-2023 evidenced the following:</p>		<p>The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. ζ</p> <p>The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.</p> <p>The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly.</p> <p>The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.</p> <p>The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic.</p> <p>Completion 01/19/2024</p>	

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	<p>A. Treatment sheet dated 11-27-2023, a blood pressure, and pulse check at 3:08 PM by the PCT. The PCT completed the following blood pressure, and pulse check at 4:15 PM.</p> <p>B. Treatment sheet dated 11-29-2023, a blood pressure, and pulse check at 3:00 PM by the PCT. The following patient assessment was completed by the RN at 4:03 PM.</p> <p>C. Treatment sheet dated 12-01-2023, a blood pressure, and pulse check at 2:03 PM by the PCT. The following blood pressure and pulse check was completed by the PCT at 3:00 PM.</p> <p>D. Treatment sheet dated 12-06-2023, a blood pressure, and pulse check at 12:42 PM by the PCT. The following patient assessment was completed by the PCT at 1:33 PM. The PCT completed a blood pressure, and pulse check at 3:02 PM, and then at 4:27 PM.</p> <p>E. Treatment sheet dated 12-08-2023, a blood pressure, and pulse check at 2:01 PM by the RN. The following blood pressure and pulse check was completed by the PCT at 3:03 PM, and then at 4:01 PM, by the PCT.</p> <p>F. Treatment sheet dated 12-11-2023, a blood pressure, and pulse check at 12:46 PM by the PCT. The following patient assessment was completed by the RN at 1:14 PM.</p> <p>G. Treatment sheet dated 12-13-2023, a blood pressure, and pulse check at 2:09 PM by the RN. The following blood pressure and pulse check was completed by the PCT at 3:05 PM.</p> <p>During an interview on 12-19-2023 at 1:00 PM, the Director of Operations, Admin 1, confirmed the</p>			

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

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	patients are to be monitored every 30 minutes with a maximum of 45 minutes during their dialysis treatment by the direct care staff.				