STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152635	A. BUILDING _____ B. WING _____	07/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
US RENAL CARE LAFAYETTE DIALYSIS	915 MEZZANINE DR LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A Recertification (CORE) and COVID-19 Focused Infection Control Survey was conducted by Healthcare Management Solutions, LLC on behalf of Centers for Medicare and Medicaid Services (CMS). An unannounced on-site Recertification (CORE) and COVID-19 Focused Infection Control Survey (ASPEN #1YF611) conducted at the above-named End Stage Renal Disease (ESRD) facility from 07/28/21 to 07/30/21 resulted in a finding of no deficiencies respective to the Emergency Preparedness Program Condition for Coverage under 42 CFR 494.62. Survey Dates: 07/28/21 - 07/30/21 Total Facility Census: 61 In-Center Hemodialysis: 61 Home Hemodialysis (HHD): 0 Peritoneal Dialysis (PD): 0 Nocturnal: 0 Pediatrics: 0 Sample Size: 9 Supplemental Sample: 9 Network 9 was contacted after entrance	E 000		
V 000	INITIAL COMMENTS A Recertification (CORE) and COVID-19 Focused Infection Control survey was conducted by Healthcare Management Solutions, LLC on behalf of Centers for Medicare and Medicaid Services (CMS). An unannounced on-site Recertification (CORE) and COVID-19 Focused Infection Control survey (ASPEN #1YF611) conducted at the above-named End Stage Renal Disease (ESRD) facility from 07/28/21 to 07/30/21 resulted in noncompliance with one Condition for Coverage	V 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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V 000	Continued From page 1 (CfC) (Infection Control) respective to applicable CfC under 42 CFR 494, Subpart A through D and the following standard-level deficiencies listed below. Total Facility Census: 61 In-Center Hemodialysis: 61 Home Hemodialysis (HHD): 0 Peritoneal Dialysis (PD): 0 Nocturnal: 0 Pediatrics: 0 Sample Size: 9 Supplemental Sample: 9 Network 9 was contacted after entrance.	V 000		
V 110	CFC-INFECTION CONTROL CFR(s): 494.30 This Condition is not met as evidenced by: Based on observation, staff interview, and review of the facility's policies and procedures, the facility failed to meet the Condition for Coverage (CfC) for Infection Control when they failed to ensure 1) staff and patients correctly performed hand hygiene, 2) staff correctly performed disinfection of the dialysis station, equipment, and commonly used surfaces, and 3) staff correctly performed care of a Central Venous Catheter (CVC/a device surgically implanted in a vein near the heart and exiting through the patient's chest wall ending in two tubes used for dialysis treatments). The pervasive non-compliance with correct infection control procedures had the potential for cross contamination of blood borne pathogens to all 61 patients receiving in-center hemodialysis at this facility, as well as their family members. This also had the potential for causing blood stream infections for all 17 patients using a CVC for their treatments at this facility, placing the patients at	V 110		

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V 110	Continued From page 2 risk for serious harm up to or including death. Findings include: 1. The facility failed to ensure appropriate hand hygiene was completed by staff when moving from dirty to clean tasks, when moving from one patient station to another, and after removal of soiled gloves for three of three observation days, (Patient (P)7, P8, and P17). The facility also failed to ensure patients performed hand hygiene after glove removal following the patient holding pressure to their own access site for three of three observations of patients holding pressure to their sites (P16, P17, P18). (Refer to V113). 2. The facility failed to ensure the staff thoroughly disinfected all surfaces of the dialysis machines, grab bar near the patient scales, and stethoscopes between patient uses during two of four days of observations of the disinfection process. (Refer to V122). 3. The facility failed to ensure proper procedure for CVC care for three of three observations of catheter care (Patient (P) 7, P9, and P16). (Refer to V147)	V 110		
V 113	IC-WEAR GLOVES/HAND HYGIENE CFR(s): 494.30(a)(1) Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. This Standard is not met as evidenced by: Based on observation, interview, and review of facility policy, the facility failed to ensure	V 113		

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V 113	Continued From page 3	V 113		

appropriate hand hygiene was completed by staff when moving from dirty to clean tasks, when moving from one patient station to another, and after removal of soiled gloves for three of three observation days, (Patient (P)7, P8, and P17). The facility also failed to ensure patients performed hand hygiene after glove removal following the patient holding pressure to their own access site for three of three observations of patients holding pressure to their sites (P16, P17, P18). Failure to correctly perform hand hygiene can lead to cross contamination of other surfaces, patients, and family members, and potentially place all 61 patients receiving in-center hemodialysis treatments at risk of infections.

Findings include:

Observations in the Patient Treatment Area on 07/28/21:

At 1:40 PM, during the Flash Tour, the Patient Treatment Area was noted to have multiple boxes of gloves available at centralized counters, multiple containers of alcohol-based hand rub (ABHR) solution available at centralized counters, ABHR canisters in holders attached to each dialysis machine, and multiple clean hand-washing sinks with soap available to staff.

At 2:25 PM Patient Care Technician (PCT) 7 cleaned the dialysis machine at Station 7, and, using the same gloves, prepared the machine at that station. PCT 7 then doffed the gloves and, without performing hand hygiene, donned new gloves and went to Station 8 to remove a white pressure clamp and add tape to P17's dressing. P17 then removed his/her own soiled gloves after holding pressure to the access site. PCT 7 then removed trash from the station and collected the

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V 113	Continued From page 4	V 113		

patient's belongings while still wearing the same gloves used to add tape to P17's dressing. PCT 7 then doffed and donned new gloves with no hand hygiene and escorted the P17 to the scales. P17 then left the facility with no hand hygiene or instructions to perform hand hygiene by PCT7.

At 2:30 PM, PCT7, still wearing same gloves donned at end of previous observation began disinfection of Station 5. After completing disinfection of the station PCT7 then began preparing machine with new supplies for next patient while wearing those same gloves.

At 2:40 PM, PCT7, still wearing same gloves as previous observation, touched machine being prepared for patient use at Station 8, removed gloves and with no hand hygiene, donned new gloves.

At 2:55 PM, PCT7, wearing same gloves as previous observation, set up clean supplies for P7 for CVC care. PCT7 removed gloves and, without hand hygiene, donned new gloves, then picked up BP cord from floor to attach to BP cuff, attached blood tubing connectors to the machine, then entered data into machine keyboard. PCT 7 then removed gloves and, without hand hygiene, donned new gloves. Following a dressing change for P7, PCT7 doffed gloves, performed hand hygiene and donned new gloves. PCT7 obtained lab samples from Patient 7's central venous catheter tube (CVC/tubing surgically implanted in a patient's vein near the heart and exiting at the chest wall, used for treatments), placed blood tubes into a rack at the lab area, doffed the soiled gloves and, without hand hygiene, donned new gloves. PCT7 then manipulated and cleaned open tubing on the P7's catheter in order to initiate treatment. PCT7 then collected trash from

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V 113	Continued From page 5	V 113		

the bedside table, handed P7 the T.V. remote, removed gloves and picked up patient belongings from the floor to hand to patient with bare hands, then donned new gloves with no hand hygiene.

At 3:05 PM, PCT7, wearing the same gloves as the previous observation, discarded blood-filled tubing from vacated machine at Station 8, then opened the bleach solution box and cleaned the machine at Station 7. Using the same gloves, PCT7 then closed a clean reclined clean chair at Station 7, and, using the same gloves, prepped the machine for use at Station 8.

During an interview with PCT7 on 07/28/21 at 3:05 PM, when asked if staff at the facility had received training related to hand hygiene following glove removal, PCT7 stated, "No. I changed my gloves."

At 3:40 PM, PCT8 removed blood-soaked gauze from the access site of P8 at Station 4, removed gloves and without performing hand hygiene donned new gloves, moved a biohazard trash can near Station 4, cleaned spilled fluid from the floor with a gauze pad, disposed of the gauze, removed gloves and without performing hand hygiene, donned new gloves.

Observations in the Patient Treatment Area on 07/30/21:

At 8:55 AM, P18 held pressure to his/her own access site with gloved fingers following removal of the treatment needles. After stabilization of the site, PCT8 applied a dressing to the site and P18 removed the soiled glove. PCT8 then escorted P18 to the scale and P18 left the facility with no hand hygiene and no instructions to perform hand hygiene by PCT8.

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V 113	Continued From page 6 At 9:50 AM, P16 held pressure to his/her own access site with gloved fingers following removal of the treatment needles. After stabilization of the site, PCT8 applied a dressing to the site and P16 removed the soiled glove. PCT8 then escorted P16 to the scale and P16 left the facility with no hand hygiene and no instructions to perform hand hygiene by PCT8. During a joint interview with the Facility Administrator and the Group Facility Administrator (GFA) on 07/28/21 at 4:40 PM and a follow-up interview with the same staff on 07/30/21 at 12:45 PM, the above observations were reviewed. The Facility Administrator stated the failure to perform hand hygiene as expected by facility policy was, "Completely unacceptable." Both agreed the facility expectation was for staff and patients to perform hand hygiene after removal of gloves, and for staff to perform hand hygiene and use of clean gloves when moving from dirty to clean task, and when moving between patient stations. Review of the facility's policy titled, "Hand Hygiene," last revision date 08/2020, revealed, "Hand Hygiene will be performed ... Before and after touching a patient... Prior to contact with vascular access site (the site where needles are inserted for treatment or CVC tubes exit the body) ... Before clean/aseptic procedure. After body fluid exposure (e.g., contact with contaminated fluids, handling used extracorporeal circuits (blood tubing). After touching patient surroundings (e.g., dialysis machine, any items in the dialysis area or chairside computers). After gloves are removed ...After contact with inanimate objects, including medical equipment or environmental surfaces at the patient station ...After handling biohazardous waste."	V 113		

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V 122	Continued From page 7	V 122		
V 122	IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL CFR(s): 494.30(a)(4)(ii) [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. This Standard is not met as evidenced by: Based on observation, staff interview, and review of the facility's policy and procedure, the facility failed to ensure the staff thoroughly disinfected all surfaces of the dialysis machines, grab bar near the patient scales, and stethoscopes between patient uses during two of four days of observations of the disinfection process. The failure to thoroughly disinfect dialysis stations, equipment, and commonly used surfaces has the potential to transmit blood borne pathogens and infections, and negatively impact all 61 patients receiving inpatient hemodialysis at the facility. Findings include: Observations of the Patient Treatment Area conducted on 07/28/21 revealed the following: At 2:25 PM at Station 7, Patient Care Technician (PCT) 7 cleaned the dialysis station (which includes the patient chair and dialysis machine) with bleach solution after it was vacated by an unsampled patient. PCT7 failed to wipe the Hansen connectors (used to connect the tubing that allows the flow of the dialysis fluid into and	V 122		

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V 122	Continued From page 8 out of the dialyzer), the tubing attached to the Hansen connectors and failed to wipe the interior of the intravenous (IV) pole. At 2:30 PM at Station 5, PCT7 cleaned the dialysis station with bleach solution after it was vacated by an unsampled patient. PCT7 failed to wipe the Hansen connectors or the attached tubing and failed to wipe the IV pole. At 3:05 PM at Station 8, PCT7 cleaned the dialysis station with bleach solution after it was vacated by an unsampled patient. PCT9 failed to wipe the Hansen connectors or the attached tubing and failed to wipe the IV pole. Observations of the Patient Treatment Area conducted on 07/30/21 revealed the following: At 9:05 AM, and unsampled patient removed a soiled glove after holding pressure to his/her own access site after decannulation (removal of the needles used during treatment), walked to the patient floor scale to obtain a post-treatment weight, held the mounted grab bar with his/her hands, and placed a carry bag of belongings on top of the grab bar. After leaving the facility, staff left the area without disinfecting the grab bar. At 9:23 AM, Registered Nurse (RN)10 used a stethoscope to assess an unsampled patient at Station 2, then, without disinfecting the stethoscope, conducted an assessment on another unsampled patient at Station 7. At 10:12 AM, RN 10 used a stethoscope to assess an unsampled patient at Station 8, then, without disinfecting the stethoscope, conducted an assessment on P14 at Station 3. Also at this time, an unsampled patient used the grab bar at	V 122		

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V 122	Continued From page 9 the patient scale, then left the facility. Staff left the area without disinfecting the grab bar. During an interview with P10 on 07/29/21 at 10:00 AM, P10 stated, "I sit here and watch for hours during my treatment, and nobody disinfects the grab bar above the scale." During a joint interview with the Facility Administrator and Group Facility Administrator (GFA) on 07/30/12:45 PM, the above observations were reviewed. Both agreed that facility policy and expectation is for all parts of the dialysis station, all contaminated surfaces and all non-disposable equipment should be disinfected after patient use. Review of the facility's policy titled, "Disinfection and Cleaning of Dialysis Machine Equipment," last revision date 07/20, revealed, "Clean all external surfaces of the dialysis machine to include top, sides, front and back, blood pressure cuffs and basket; dialysate connectors and lines; hand sanitizer and holder; IV pole, items hanging on pole ...Disinfect non-disposable medical equipment (e.g., scissors, hemostats and clamps.)"	V 122		
V 147	IC-STAFF EDUCATION-CATHETERS/CATHETER CARE CFR(s): 494.30(a)(2) Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who	V 147		

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V 147	Continued From page 10 manage intravascular catheters. II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections]. This Standard is not met as evidenced by: Based on observation, staff interview, and review of the facility's policies, the facility failed to ensure proper procedure for Central Venous Catheter (CVC, a tube surgically implanted in a vein near the heart and exiting through the patient's chest wall ending in two tubes for use in dialysis treatments) care for three of three observations of catheter care (Patient (P) 7, P9, and P16). This had the potential to negatively impact the 17 patients with CVC access receiving in-center hemodialysis treatments at this facility. Findings include: On 07/28/21 at 2:55 PM, an observation of a CVC dressing change and initiation of dialysis	V 147		

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V 147	Continued From page 11	V 147		

treatment for P7 at Station 6 revealed Patient Care Technician (PCT)7 doffed gloves used to disinfect a dialysis machine at another station and, without performing hand hygiene (washing hands with either soap and water or alcohol-based hand rub/ABHR), donned new gloves. PCT7 then set up clean supplies for the CVC dressing change on the chairside table at Station 6. PCT7 then picked up blood pressure cord and patient belongings from the floor, doffed the gloves and, without performing hand hygiene, donned new gloves, which were then used to remove the old dressing from the patient's exit site (the place on the patient's chest where the tubes come out of the skin).

On 07/29/21 at 11:30 AM, an observation of a CVC dressing change and initiation of dialysis treatment for P9 at Station 3 revealed PCT11 removed the old dressing from the exit site, doffed the soiled gloves, and without performing hand hygiene, donned new gloves, then placed a clean drape under the catheter tubes and cleaned the exit site with a prep swab.

On 07/30/21 at 9:55 AM, an observation of a CVC dressing change and initiation of dialysis treatment for P16 at Station 1, PCT8 removed the old dressing from the exit site without securing the P16's shirt away from the exposed site. After PCT8 cleaned the exit site, P16's shirt fell back on top of the site, contaminating the site prior to PCT8 covering the site with a new dressing.

During a joint interview with the Facility Administrator and the Group Facility Administrator on 07/07/30/21 at 12:45 PM, the above observation was reviewed. Both agreed facility policy and expectation is for hand hygiene to be

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V 147	Continued From page 12 performed and clean gloves donned prior to starting CVC care and any time gloves become soiled, and that the patient's clothing should be secured during CVC care, so that the clothing does not touch the insertion site. Review of the facility's policy titled, "Dialysis Catheter Dressing Change Procedure," last revision date 01/20, revealed, " ...perform hand hygiene and don clean gloves. Secure clothing away from dressing/exit site ...Remove and discard old dressing. Remove gloves, perform hand hygiene and don clean gloves ...using aseptic (clean) technique, cleanse the skin surrounding the exit site." Review of the facility's policy titled, "Accessing and De-Accessing the Dialysis Catheter," last revision date 02/20, revealed, " ...Remove gloves, perform hand hygiene and don clean gloves. Place the underpad beneath the catheter lumens (tubes)."	V 147		
V 184	ENVIRONMENT-SECURE & RESTRICTED CFR(s): 494.40(a) 8 Environment: secure & restricted The water purification and storage system should be located in a secure area that is readily accessible to authorized users. The location should be chosen with a view to minimizing the length and complexity of the distribution system. Access to the purification system should be restricted to those individuals responsible for monitoring and maintenance of the system. This Standard is not met as evidenced by: Based on observation, staff interview, document review, and review facility policy, the facility failed to ensure the water treatment room was secure and restricted to only those employees who had	V 184		

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V 184	Continued From page 13	V 184		

been trained and responsible for monitoring and maintaining the water system. Permitting unqualified personnel access to the water treatment room had the potential to affect the quality of the water and jeopardize the safety of all 61 hemodialysis patients receiving treatment at this facility.

Findings include:

Observation of the facility on 07/28/21 at 1:30 PM, in the presence of the Facility Administrator revealed the water treatment room was located, without a door, inside the Storage Room. The Storage Room was accessed using a keyless combination lock.

During an interview with the Facility Administrator on 07/28/21 at 1:30 PM, the Facility Administrator stated that all but one of the facility doors used the same combination for entry, and that all staff had this combination.

During a joint interview with the Facility Administrator and Biomedical Supervisor (Biomed) on 07/28/21 at 1:35 PM, both agreed that staff untrained in water maintenance, including the facility dietician and social worker, had access to the water room through the Storage Room entry.

During an interview with the facility Social Worker (SW) on 07/28/21 at 2:10 PM, the SW confirmed he/she was able to access the water room through the Storage Room and agreed that he/she was not trained in water maintenance.

Review of the "ESRD Core Survey Facility Worksheet: Personnel File," completed on 07/29/21, indicated the facility had two

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	152635	A. BUILDING _____ B. WING _____	07/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
US RENAL CARE LAFAYETTE DIALYSIS	915 MEZZANINE DR LAFAYETTE, IN 47905

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V 184	Continued From page 14 employees, the SW and the RD who had not been trained on how to monitor and treat the water in the water treatment room. Review of the facility's policy titled, "Facility Space/Design and Safety Requirements," last revision date 09/20, revealed, "Treatment, storage and business areas of facilities will be protected from general public access by the use of locks ...No doors, including the rear doors, fire doors, water treatment doors ...will be propped open at any time."	V 184		
V 401	PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT CFR(s): 494.60 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. This Standard is not met as evidenced by: Based on observation, staff interview, and review of the facility's policy, the facility failed to maintain a safe environment by not removing expired medications from the facility inventory. Failure to remove expired items provided the potential for staff to use medications that were no longer viable or were deemed unusable by the manufacturer and had the potential to negatively affect the care of all 61 in-center patients at this facility. Findings include: Observation in the Patient Treatment Area on 07/28/21 revealed the following: At 1:50 PM in the Medication Preparation Area,	V 401		

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V 401	Continued From page 15 review of the contents of a medication cupboard revealed five vials of Sodium Citrate Injection (a medication sometimes used to prevent kidney stones) with expiration dates of 02/02/21. At 1:55 PM in the Medication Preparation Area, review of the contents of the medication refrigerator revealed one vial of Tuberculin Purified Protein Derivative (used to conduct skin tests for Tuberculosis), marked with an "opened" date of 12/17/20. Review of the manufacturer's medication label revealed, "Discard opened product after 30 days." During an interview with Registered Nurse (RN)10 on 07/28/21 at 1:55 PM, the above expired medications were verified and RN10 stated the medications needed to be discarded. During a joint interview with the Facility Administrator and Group Facility Administrator (GFA) on 07/28/21 at 4:40 PM, the above observations were reviewed. The Facility Administrator and GFA agreed that facility policy and expectation is for expired medications to be discarded. Review of the facility's policy titled, "Guidelines for Administration of Medication," last revision date 11/20, revealed, "Record and monitor expiration date for all medications in inventory on a monthly basis. This ensures that medication is replaced prior to expiration date ...Opened multi-dose vials may be used until the manufacturer's expiration date noted on each individual vial. For medications with no specific manufacturer's instructions regarding expiration of opened multi-dose vials, discard at the end of 28 days."	V 401		
V 503	PA-APPROPRIATENESS OF DIALYSIS RX CFR(s): 494.80(a)(2)	V 503		

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V 503	Continued From page 16 The patient's comprehensive assessment must include, but is not limited to, the following: (2) Evaluation of the appropriateness of the dialysis prescription, This Standard is not met as evidenced by: Based on review of medical records, interview, and policy review, it was determined the facility failed to ensure the staff follow physician's orders for Blood Flow Rate (BFR) and/or Dialysis Flow Rate (DFR) for three of six sampled patients (Patient (P)1, P2, and P3). Failure to follow the medical provider's dialysis prescription could negatively impact the effectiveness of the treatment for all 61 patients receiving in-center hemodialysis treatment at the facility. Findings include: 1. Review of the electronic medical record (EMR) for P1 revealed the physician's order, dated 06/22/21, for a BFR of 450 milliliters per minute (ml/min) and a DFR of 800 ml/min. Review of six "Hemodialysis Flowsheets," dated 07/14/21 through 07/26/21, revealed the BFR was not administered as ordered for one of six treatments, as evidenced by the following: 07/16/21 - Treatment was initiated at 3:05 PM with a BFR of 365 until the treatment ended at 7:01 PM. No documentation was found to indicate the rationale for the change from the physician's order. 2. Review of the EMR for P2 revealed the physician's order, dated 06/22/21, for a BFR of	V 503		

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V 503	Continued From page 17 450 ml/min. Review of six "Hemodialysis Flowsheets," dated 07/14/21 through 07/28/21, revealed the BFR was not administered as ordered for one of six treatments, as evidenced by the following: 07/23/21 - Treatment was initiated at 4:32 PM with a BFR of 425 ml/min. At 5:33 PM, the BFR was decreased to 400 ml/min. until the treatment ended at 8:25 PM. No documentation was found to indicate the rationale for the change from the physician's order. 3. Review of the EMR for P3 revealed the physician's order, dated 07/26/21, for a BFR of 400 ml/min and a DFR of 800 ml/min. Review of six "Hemodialysis Flowsheets," dated 07/16/21 through 07/28/21, revealed the BFR was not administered as ordered for one of six treatments and the DFR was not administered as ordered for one of six treatments, as evidenced by the following: a. 07/16/21 - Treatment was initiated at 4:02 PM with a BFR of 400 ml/min. At 5:01 PM, the BFR was decreased to 350 ml/min. until the treatment ended at 7:58 PM. No documentation was found to indicate the rationale for the change from the physician's order. b. 07/23/21 - Treatment was initiated at 4:01 PM with a DFR of 600 ml/min. until the treatment ended at 8:04 PM. No documentation was found to indicate the rationale for the change from the physician's order. During an interview with the Facility Administrator on 07/29/21 at 2:45 PM, the above documentation was reviewed and confirmed. The Facility Administrator stated that facility policy and	V 503		

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V 503	Continued From page 18 expectation is for staff to document the reason for any change in treatment from the physician's prescribed orders. Review of the facility policy titled, "Intradialytic Monitoring of Patient," last revision date 09/20, revealed, "Direct patient care staff will monitor the following parameters during each dialysis treatment ...Blood flow rate. Dialysis flow rate ...Modify the treatment plan based on the patient's response, which must be documented by the charge nurse."	V 503		