STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152610	A. BUILDING 00 B. WING	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIBERTY DIALYSIS LEBANON LLC	2485 LEBANON ST LEBANON, IN 46052

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V 0000 Bldg. 00	This visit was for a Federal Complaint survey of an ESRD provider. Survey Dates: 02/17/2025 Complaint: IN00452400 was investigated, related deficiencies were cited. Census by Service Type: In-Center Hemodialysis: 40 Home Hemodialysis: 1 Peritoneal Dialysis: 4 Total Census: 45 Isolation: Waiver - Built Prior to 02/2008 Abbreviations RN Registered Nurse ICHD In-Center Hemodialysis PCT Patient Care Technician HHD Home Hemodialysis FA Facility Administrator PD Peritoneal Dialysis MD Medical Doctor CVC Central Venous Catheter RD Registered Dietician CM Clinical Manager MSW Masters Social Worker CCHT Certified Clinical Hemodialysis Technician QR completed 2-24-2025.	V 0000		
V 0117 Bldg. 00	494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Based on observation, record review, and interview, the facility failed to ensure the proper storage of supplies in 2 of 2 observations of the treatment floor. Findings Include: 1. A review of a Fresenius Kidney Care policy dated 04/05/2021, titled "General Cleanliness and Infection Control Guidelines," indicated but was not limited to, " ... The purpose of this policy is to provide guidance for the FKC staff on preventing the spread of infectious disease and maintaining a clean, safe, and aesthetically pleasant environment for patients, staff, and visitors ... Supplies or patient's belongings should not be kept or stored behind the machine at the patient station ... " 2. On 02/17/2025 at 9:30 AM, the following treatment floor observations were made: An observation of a patient coat stored on the wall unit shelf behind Station #3. An observation of a patient coat on the wall unit shelf behind Station #4. An observation of a blue cord and television remote on the wall unit shelf behind Station #5. An observation of a television remote on the wall box behind Station #6. An observation of a patient coat on the wall unit shelf behind Station #8. During an interview on 02/17/2025 at 10:23 AM, PCT 1 indicated nothing should be stored on the wall box unit3. During an observation with the	V 0117	**V-117** On 3/4/2025, the Facility administrator held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the Policy. General Cleanliness and Infection Control Guidelines Emphasis will be 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, water/supply room and offices. Walkways must be kept clear of debris and free of clutter. Supplies or patient's belongings should not be kept or stored behind the machine at the patient station. Effective 3/10/2025, the Facility Administrator will conduct bi-weekly audits utilizing specific plan of correction audit tool for 2 weeks, and then weekly for an additional 2 weeks or until 100% compliance is achieved. With a focus on ensuring the facility provides and maintains a clean, safe, aesthetically pleasant environment for patients, staff, and visitors. All areas will be kept clean and organized, including but	03/19/2025

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	Facility Administrator (FA) on 02/17/2025 at 1:35 PM, the following treatment observation was made: A patient's jacket was found on the wall box behind Station 5 and 6. 4. During an interview with the FA on 02/17/2025 at 1:35 PM, they indicated nothing was supposed to be on the wall boxes.		not limited to the treatment area, water/supply room and offices. Supplies or patient's belongings will not be kept or stored behind the machine at the patient station. Once compliance is sustained at 100%, the Governing Body will decrease frequency to monthly then resume regularly scheduled audits based on the QAPI calendar. Monitoring will be done through the specific plan of correction audit tool. The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly. The Facility Administrator 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 QAPI 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 QAPI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to	

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			develop the Plan of Correction. The Plan of correction is reviewed in QAPI monthly. The Governing Body is responsible to provide 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 QAPI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic.	
V 0402 Bldg. 00	494.60(a) PE-BUILDING-CONSTRUCT/MAINTAIN FOR SAFETY Based on observation, record review, and interview, the facility failed to ensure the building was maintained to ensure the safety of patients and staff in 1 of 1 stand-alone dialysis treatment centers. Findings Include: 1. A review of a Fresenius Kidney Care policy dated 11/04/2024, 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 on ... maintaining a clean, safe, and aesthetically pleasant environment for patients ... All areas must be kept clean and organized ..." 2. On 02/17/2025 at 10:00 AM, the following treatment floor observations were made:	V 0402	V 402 On 3/4/2025, the Facility administrator held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the Policy. GGeneral Cleanliness and Infection Control Guidelines EEquipment Installation-Operations-Maintenanc e -Repair-And Disposal Emphasis will be 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	03/19/2025

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	An observation of a white and brown substance covering 75% of the cabinet base located beneath the clean sink next to Station #9 and the crash cart. An observation of an electrical outlet with exposed metal beneath the clean sink next to Station #9 and the crash cart. An observation of the discolored uneven countertop associated with the clean sink next to Station #9 and the crash cart. An observation of a tan brown discoloration covering 75% of a ceiling tile located between Station #1, Station #2, and the nurses station. An observation of an approximately one inch crack on wall box counter behind Station #8. During an interview on 02/17/2025 at 10:23 AM, PCT 1 indicated the cabinet beneath the clean sink between Station #9 and the crash was not used and was unaware of how long the white and brown substance was present. When queried about the electrical outlet with the exposed metal, they indicated they were unaware there was an outlet located in the cabinet beneath the clean sink. During an interview on 02/17/2025 at 3:16 PM, Biomed 1 indicated the electrical outlet with exposed metal beneath the clean sink next to Station #9 and the crash cart was a problem. Biomed 1 indicated they were slowly trying change all of the electrical outlets to GFCI (Ground Fault Circuit Interrupter, a safety device that protects against electrical shocks, typically found in areas where water and electricity are close together). Biomed 1 indicated the discolored		limited to the treatment area, water/supply room and offices. Walkways must be kept clear of debris and free of clutter. The physical plant of the facility should be in good working condition. Any equipment or device that is not fully functioning in accordance with IFU or company policy, must be repaired or replaced as soon as reasonably possible. If the faulty equipment poses a risk to the patient or staff, the device will be immediately removed from service. Identified issues may include fluid leaks; nonfunctional, broken, or misadjusted parts and components; or aesthetic damages. Any equipment awaiting repair must be tagged in accordance with the use of Hemodialysis and Ancillary Machine Repair/Return Tag Policy. If any water is identified on the floor, clean and dry the affected area or immediately place If water reappears, obtain, and place a “wet floor” sign in the immediate area and to notify the CM or nurse in charge. On 2/17/25 the Area Technical Operations Manager (ATOM) spoke with the contractor regarding the scope of work needed. On 2/24/25 the facility received a quote for repairs	

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	uneven countertop associated with the clean sink next to Station #9 and the crash cart needs to be replaced to a material that can handle the chemicals. 3. During the flash tour on 02/17/2025 at 9:31 AM, the following treatment observations were made: Observed under the dirty sink in between Stations 4 and 5 white and brown crystals and brown fleck particles about the size of the cotton on a cotton swab and covering about 50 percent of the cabinet base. An outlet was observed under the dirty sink and the top outlet was black and brown. The sink next to Station 6, with the sign indicating no one was to wash their hands at the sink, evidenced white and brown particles under the sink about the size of the cotton on a cotton swab and covering about 50 percent of the cabinet base. A baseboard behind Station 6 was observed coming off the wall. Under the sink with the emergency eye wash station evidenced yellow and brown stains and crusty particles and a white sponge. Observed the wall box in between Stations 5 and 6 and a chip of the counter had been taken out of the counter exposing the brown layer beneath the counter. The Patient Care Technicians (PCT) station had multiple chips on the wood surrounding the station. The desk at the station had a crack and chip with tape over it, causing the counter to be lifted up at an angle, next to the computer. The clean sink next to the lobby door had a white		needed from the contractor. Work to start on week of 3/31/25 by the contractor, depending on material availability will include: ATOM has created a work order 3603979103, 3603979096, 3603979096, 3/3/2025 to replace or repair all listed below: Under sink next to station #9 changed to GFCI (Ground Fault Circuit Interrupter). Discolored and uneven countertop next to station #9 replaced with a material that can withstand the chemicals it is exposed to without deterioration. Baseboard behind station 6 reattached to the wall or replaced. Replace all discolored ceiling tiles. Wall box in between station 5 and 6 replaced. Wood surrounding the patient care technician station fixed so that there are no chips, the crack in the desk will be fixed so the counter is not up at an angle. Fix the leaking sink next to the lobby door and fix the bubble in the floor. Effective 3/10/2025, the Facility Administrator will conduct weekly audits, with focus on ensuring the	

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	and yellow liquid substance around the handle for the hot water. The liquid leaked down from the handle into the sink and caused a brown streak from the handle to the drain. 4. During an observation on 02/17/2025 at 11:52 PM, the following treatment floor observations were made: Observed under the sink next to the door to the lobby, evidenced the floor was lifted up next to the wall and caused a bubble, around a foot long, to form in the floor under the sink. 5. During an interview with the Facility Administrator (FA) on 02/17/2025 at 1:29 PM, they indicated nothing was to be under the sinks and kept clean. The explained how the outlets were to have their lines aligned appropriately, so the electrical was not exposed, and they indicated they would have to have Biomed look into the outlet with the black outlet plug because it was a potential safety hazard. They explained how they would have to looking into what was the cause of the ceiling stain. They revealed they would need to find the cause of the leaking sink by the lobby door and fix it, along with the floor under it because it was an infection risk and a problem. They indicated the baseboard coming off the wall would need to be fixed. They indicated the chipped wall boxes and PCT station desk and wood counter would need to be corrected too because of the infection risk associated with them. They explained if the staff saw physical environment concerns, they were to report them to the FA or Biomed Technician.		safety and functionality of the facility is maintained for patients and facility staff utilizing Building Interior Physical Environment Inspection Audit for four weeks or until 100% compliance is achieved. 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 Tool per QAI calendar. The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly. The Facility Administrator 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 QAPI 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 QAPI Committee is responsible to provide oversight, review findings, and take actions	

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			as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAPI monthly. The Governing Body is responsible to provide 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 QAPI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic.	
V 0519 Bldg. 00	494.80(d)(1) PA-FREQUENCY REASSESSMENT-STABLE 1X/YR Based on record review and interview, the facility failed to ensure the plan of care was revised annually for 1 of 3 active clinical records reviewed of stable patients. (Patient #4). Findings Include: 1. A review of a Fresenius Kidney Care policy dated 07/03/2023, titled "Comprehensive Interdisciplinary Assessment and Plan of Care" indicated but was not limited to, "The purpose of this policy is to provide guidance on the requirements for the ... the patient Plan of Care ... and then reassessed annually thereafter on all stable patients ..." 2. A review of the clinical record for Patient #4 revealed a document titled, "Plan of Care" and	V 0519	On 3/4/2025, the Facility administrator held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the Policy. Comprehensive Interdisciplinary Assessment and Plan of Care Emphasis will be placed on: Comprehensive interdisciplinary assessments and modifications to the Plan of Care must be conducted 12 months after the completion of the 3 month assessment and then	03/19/2025

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	was approved by the Medical Director 01/26/2024. The POC evidenced the patient was admitted 10/24/2022, the patient status was stable, and the next POC meeting would be 01/25/2025. The clinical record failed to evidence a revised POC for 2025. During an interview on 02/17/2025 at 5:00 PM, the FA indicated there was no up to date POC in the clinical record. During an interview on 02/17/2025 at 6:03 PM, the FA indicated the POC is completed at initial admission, 90 days from admission, and then annually if the patient is stable.		reassessed annually thereafter on all stable patients. The Plan of Care must be implemented within 15 days of the reassessment. Effective 3/10/25, the Facility administrator will conduct bi-weekly audits utilizing specific plan of correction audit tool for 3 weeks, and then monthly for an additional 3 months or until 100% compliance is achieved. With a focus on ensuring all patients have their Comprehensive Assessments and Plan of Care conducted annually after the completion of the 3 month assessment. The Plan of Care will be completed within 15 days of the comprehensive assessments. Once compliance is sustained at 100%, the Governing Body will decrease frequency to monthly then resume regularly scheduled audits based on the QAPI calendar. Monitoring will be done through the specific plan of correction audit tool. The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly. The Facility Administrator is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to	

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			the QAPI 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 QAPI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAPI monthly. The Governing Body is responsible to provide 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 QAPI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic.	
V 0520 Bldg. 00	494.80(d)(2) PA-FREQUENCY REASSESSMENT-UNSTABLE Q MO Based on record review and interview, the agency failed to update the Plan of Care (POC) monthly for 1 of 1 patient clinical record reviewed of an unstable patient. (Patient #9)	V 0520	On 3/4/2025, the Facility administrator held a staff meeting, elicited input, and reinforced the expectations and responsibilities	03/19/2025

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	Findings Include: 1. A Fresenius Kidney Care policy dated 07/03/2023 titled "Comprehensive Interdisciplinary (IDT) Assessment and Plan of Care" indicated but was not limited to, " ... Unstable patients must be reassessed by the IDT monthly. Monthly reassessment and any POC updated related to the reason the patient is considered "unstable" must be documented ..." A review of Patient #9's clinical record evidenced a POC with a meeting date of 11/22/2024. The "Patient Notes" section indicated the patient was to be listed as unstable due to hospitalizations dated 10/30/2024. Patient #9's clinical record failed to evidence failed to evidence care plan meetings since 11/22/2024. The Facility Administrator (FA) provided a document and it indicated the Interdisciplinary Team had been unable to meet for a POC meeting because of the patient's hospitalizations and the team having trouble gathering together to conduct the meeting. The document revealed the next IDT meeting was 02/28/2025. During an interview with FA at 02/17/2025 at 5:15 PM, they explained for unstable patients, the IDT meeting was supposed to meet monthly to reassess the patient and update the POC. They indicated it was difficult to find a time for the IDT meeting to happen with the patient being unavailable and explained it was hard to get the whole IDT together.		of the facility staff on the Policy. Comprehensive Interdisciplinary (IDT) Assessment and Plan of Care Emphasis will be placed on: Unstable patients will be reassessed by the IDT monthly. Monthly reassessment and any POC updated related to the reason the patient is considered "unstable" must be documented until the issues have been resolved or the IDT (including the patient if possible) determines that the condition is chronic. Effective 3/10/2025, the Facility administrator will conduct bi-weekly audits utilizing specific plan of correction audit tool for 3 weeks, and then monthly for an additional 3 months or until 100% compliance is achieved. With a focus on ensuring all unstable patients are reassessed by the IDT monthly in the comprehensive assessment and the Plan of Care will be updated monthly with any changes related to the reason the patient is considered unstable. This must be documented monthly until the issues have been resolved or the IDT (including the patient if possible) determines that the condition is chronic. Once compliance is sustained at 100%, the Governing Body will decrease	

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			frequency to monthly then resume regularly scheduled audits based on the QAPI calendar. Monitoring will be done through the specific plan of correction audit tool. The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly. The Facility Administrator 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 QAPI 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 QAPI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAPI monthly. The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by	

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			the Statement of Deficiency, is effective and is providing resolution of the issues. The QAPI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic.	
V 0543 Bldg. 00	494.90(a)(1) POC-MANAGE VOLUME STATUS Based on record review and interview, the facility failed to ensure direct patient care staff monitored the patients during their dialysis treatment in 4 of 4 active clinical records reviewed. (Patients #4, #5, #7, and #9) Findings Include: 1. A review of Patient #9's clinical record contained treatment sheets from 01/30/2025 through 02/15/2025 evidenced the following: The treatment sheet dated 01/31/2025 evidenced a blood pressure, pulse, Blood Flow Rate (BFR), Dialysis Flow Rate (DFR), and safety checks were completed at 11:00 AM by Patient Care Technician (PCT) 1. RN 3 performed a safety check, took the blood pressure, pulse, BFR, and DFR at 12:34 PM. The treatment sheet dated 02/04/2025 evidenced a blood pressure, pulse, BFR, DFR, and safety check were completed at 1:05 PM and again at 2:10 PM by PCT 4. The treatment sheet dated 02/10/2025 evidenced a blood pressure, pulse, BFR, DFR, and safety check were completed at 11:35 AM and again at	V 0543	On 3/4/2025, the Facility administrator held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the Policy. Patient Assessment and Monitoring Emphasis will be placed on: Staff will obtain blood pressure and pulse rate every 30 minutes or more as needed but not to exceed 45 minutes or per state regulations. Staff will document machine parameters and safety checks every 30 or more often as needed but not to exceed 45 minutes or per state regulations. Check prescribed blood flow is being achieved or reason is documented in medical record if unable to meet prescribed blood flow. Check dialysate flow rate setting is correct, and the prescribed flow is being delivered.	03/19/2025

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	152610	A. BUILDING 00 B. WING	02/17/2025

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	12:34 PM by PCT 1. RN 5 completed the next safety blood pressure, pulse, BFR, DFR, and safety check at 12:48 PM and PCT 1 completed the treatment with post-treatment vitals at 1:40 PM. The treatment sheet dated 02/11/2025 evidenced the first safety check was completed at 10:47 AM and again at 12:05 PM by PCT 4. The treatment sheet dated 02/13/2025 evidenced a safety check was completed at 12:33 PM and again at 1:40 PM by RN 6. During an interview with PCT 4 on 02/07/2025 at 5:33 PM, they indicated safety checks and blood pressure checks were to be completed every 30 minutes to ensure there were no issues with the patient.2. A review of the inactive medical record for Patient #5 contained treatment sheets from 01/27/2025 to 02/17/2025 evidenced the following: Treatment sheet dated 02/12/2025 evidenced a blood pressure, pulse, BFR, DFR, and safety checks were completed at 8:34 AM by PCT 3. PCT 4 completed the next blood pressure, pulse, BFR, DFR, and safety check at 10:09 AM. Treatment sheet dated 02/17/2025 evidenced a blood pressure, pulse, BFR, DFR, and safety checks were completed at 8:33 AM by PCT 2. RN 1 completed the next blood pressure, pulse, BFR, DFR, and safety check at 9:44 AM. During an interview on 02/17/2025 at 4:05 PM, the FA confirmed the safety checks were reviewed and noted they had not completed the safety checks according to policy, every 30-45 minutes. The FA further indicated all staff, including the travel staff who care for Patient #5 during their dialysis treatments, had received training on the		Effective 3/10/2025, the Facility administrator will conduct weekly, 3 days per week on 10 treatment sheets, audits utilizing treatment sheet audit tool for 2 weeks, and then weekly on 10% of completed treatments for an additional 2 weeks or until 100% compliance is achieved. With a focus on ensuring staff are obtaining blood pressure, pulse rates BFR, DFR, and safety checks every 30 minutes or more as needed but not to exceed 45 minutes or per state regulations. Once compliance is sustained at 100%, the Governing Body will decrease frequency to monthly then resume regularly scheduled audits based on the QAPI calendar. Monitoring will be done through the Treatment Sheet audit tool. The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly. The Facility Administrator 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 QAPI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all	

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	safety check protocols. 3. A review of Patient #4's active medical record contained treatment sheets from 01/27/2025 through 02/17/2025, which evidence the following: The treatment sheet dated 01/27/2025, indicate RN 4 measured a blood pressure and pulse and performed a safety check at 7:35 AM. At 9:06 AM, PCT 3 measured a blood pressure and pulse, performed a safety check, and discontinued treatment. The treatment sheet dated 02/10/2025, indicate PCT 3 took a blood pressure and pulse and performed a safety check at 5:35 AM. At 6:22 AM, PCT 3 measured a blood pressure and pulse. The treatment sheet dated 02/12/2025, indicate PCT 4 took a blood pressure and pulse and performed a safety check at 5:52 AM. At 7:05 AM, PCT 3 measured a blood pressure and pulse and performed a safety check. The treatment sheet dated 02/14/2025, indicate PCT 5 took a blood pressure and pulse and performed a safety check at 8:32 AM. At 9:30 AM, RN 3 performed a safety check. At 9:43 AM, RN 3 measured a blood pressure and pulse. The treatment sheet dated 02/17/2025, indicate PCT 2 took a blood pressure and pulse and performed a safety check at 8:32 AM. At 9:37 AM, PCT 2 measured a blood pressure and pulse and performed a safety check. The treatment sheets dated 01/27/2025, 02/10/2025, 02/12/2025, 02/14/2025, and 02/17/2025 failed to evidence Patient #4's blood pressure and pulse measurements and safety checks were performed every 30 minutes.		other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAPI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAPI monthly. The Governing Body is responsible to provide 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 QAPI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic.	

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	4. A review of Patient #7's active medical record contained treatment sheets from 01/24/2025 through 02/14/2025, which evidence the following: The treatment sheet dated 01/24/2025, indicate PCT 1 measured a blood pressure and pulse and performed a safety check at 1:07 PM. At 4:05 PM, PCT 1 measured a blood pressure and pulse and performed a safety check. The treatment sheet dated 01/27/2025, indicate RN 4 measured a blood pressure and pulse and performed a safety check at 2:01 PM. At 3:01 PM, PCT 1 measured a blood pressure and pulse and performed a safety check. The treatment sheet dated 01/29/2025, indicate PCT 4 measured a blood pressure and pulse and performed a safety check at 12:06 PM. At 1:05 PM, PCT 4 measured a blood pressure and pulse and performed a safety check. The treatment sheet dated 01/31/2025, indicate PCT 1 measured a blood pressure and pulse and performed a safety check at 1:00 PM. At 2:00 PM, PCT 1 measured a blood pressure and pulse and performed a safety check. At 3:05 PM, PCT 1 measured a blood pressure and pulse and performed a safety check. The treatment sheet dated 02/07/2025, indicate PCT 6 measured a blood pressure and pulse and performed a safety check at 2:04 PM. At 3:13 PM, PCT 4 measured a blood pressure and pulse and performed a safety check. The treatment sheet dated 02/10/2025, indicate PCT 1 measured a blood pressure and pulse and performed a safety check at 12:33 PM. At 1:35 PM,			

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	PCT 1 measured a blood pressure and pulse and performed a safety check. At 2:10 PM, RN 5 measured a blood pressure and pulse and performed a safety check. At 2:37 PM, RN 5 measured a blood pressure and pulse and performed a safety check. At 3: 34 PM, PCT 1 measured a blood pressure and pulse and performed a safety check. The treatment sheet dated 02/14/2025, indicate PCT 4 measured a blood pressure and pulse and performed a safety check at 12:07 PM. At 1:05 PM, PCT 4 measured a blood pressure and pulse and performed a safety check. At 1:50 PM, PCT 4 measured a blood pressure and pulse, and performed a safety check. The treatment sheets dated 01/24/2025, 01/27/2025, 01/29/2025, 01/31/2025, 02/07/2025, 02/10/2025, and 02/14/2025 failed to evidence Patient #7's blood pressure and pulse measurements, and safety checks were performed every 30 minutes.			
V 0726 Bldg. 00	494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE Based on record review and interview the facility failed to maintain a complete and accurate medical record by not obtaining and retaining a completed Against Medical Advice (AMA) Form for 2 of 2 active clinical records reviewed (Patient #4 & Patient #7) with patients ending treatment early. Findings Include: 1. A review of a Fresenius Kidney Care policy dated 11/07/2022, titled "Early Termination or Arriving Late for Treatment" indicated but was not limited to, "The purpose of this policy is to	V 0726	On 3/4/2025, the Facility administrator held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the Policy. Early Termination or Arriving Late for Treatment Emphasis will be placed on: The RN who evaluates the patient that has requested to end	03/19/2025

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	provide guidelines for staff when patients ... request early termination of treatment ... The RN who evaluates the patient must document the rational for early termination ... The RN is responsible to notify the physician, and document on the "AMA", or Against Medical Advice form ... Against Medical Advice forms are signed by the patient and witnessed by the supervising nurse ... Signed with each early termination event and filed in the patient's medical record ..." 2. A review of the clinical record for Patient #4 revealed a document titled, "Order Summary Report". The order indicated but was not limited to, "In Ctr HD, MonWedFri, 4 hrs 0 min". A review of Patient #4's clinical record evidenced a treatment sheet dated 01/29/2025 and signed by RN 3. The treatment sheet evidence treatment was initiated at 5:45 AM, ended at 8:59 AM, and "Treatment completed without complications". Patient #4's actual treatment duration was 3 hours and 14 minutes. The clinical record failed to evidence an Against Medical Advice form and documentation of the rational for ending the treatment early. A review of Patient #4's clinical record evidenced a treatment sheet dated 02/12/2025 and signed by RN 3. The treatment sheet evidence treatment was initiated at 5:53 AM, ended at 9:12 AM, and "Treatment completed without complications". Patient #4's actual treatment duration was 3 hours and 19 minutes. The clinical record failed to evidence a signed Against Medical Advice form and documentation of the rational for ending the treatment early.		treatment early, will document the rational for early termination. The RN is responsible to notify the physician, and document on the "AMA", or Against Medical Advice form. Against Medical Advice forms will be signed by the patient and witnessed by the supervising nurse, signed with each early termination event and filed in the patient's medical record. Effective 3/10/2025, the Facility administrator will conduct weekly, 3 days per week on 10 treatment sheets, audits utilizing treatment sheet audit tool for 2 weeks, and then weekly on 10% of completed treatments for an additional 2 weeks or until 100% compliance is achieved. With a focus on ensuring the RN who evaluates the patient that has requested to end treatment early, will document the rational for early termination. The RN is responsible to notify the physician, and document on the "AMA", or Against Medical Advice form. Against Medical Advice forms will be signed by the patient and witnessed by the supervising nurse, signed with each early termination event and filed in the patient's medical record. Once compliance is sustained at 100%, the Governing Body will decrease frequency to monthly then resume regularly scheduled audits based	

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	3. A review of the clinical record for Patient #7 revealed a document titled, "Order Summary Report". The order indicated but was not limited to, "In Ctr HD, MonWedFri, 4 hrs 0 min" A review of Patient #7's clinical record evidenced a treatment sheet dated 02/03/2025 and signed by RN 3. The treatment sheet evidence treatment was initiated at 11:56 AM, ended at 15:16 AM, and "Treatment completed without complications". Patient #4's actual treatment duration was 2 hours and 23 minutes. The clinical record failed to evidence an Against Medical Advice form and documentation of the rational for ending the treatment early. 4. During an interview on 02/17/2025 at 5:44 PM, the FA indicated there was no AMA forms in the clinical records of Patient #4 and Patient #7. 5. During an interview on 02/17/2025 at 6:03 PM, the FA indicated Patient #4 and Patient #7's clinical record did not have any documentation regarding treatments ending early. When queried about the early termination of treatment, the FA indicated the patient should be educated, document the reason why they want to stop treatment early, and notify the physician. When queried if there is any additional steps to the process, the DO indicated signing the AMA form.		on the QAPI calendar. Monitoring will be done through the specific plan of correction audit tool. The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly. The Facility Administrator 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 QAPI 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 QAPI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAPI monthly. The Governing Body is responsible to provide 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	

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			of the issues. The QAPI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic.	
V 0765 Bldg. 00	494.180(e) GOV-INTERNAL GRIEVANCE SYS ID/IMPLEMENTED Based on record review and interview the facility failed to document an internal grievance for 1 of 1 patient complaints (Patient #4). Findings Include: 1. A review of a Fresenius Kidney Care policy dated 04/04/2014, titled "Patient Grievance Procedure" indicated but was not limited to, " ... Follow the steps below when a patient or patient representative has a grievance: ... The CM ensure the following details are completed in the Quality Assessment and Performance Improvement (QAI) Patient Grievance Status Report: Date grievance received ... Intake Person, Patient Initials, Nature of the grievance, Findings of the investigation ... Resolution and any corrective actions taken ... Note: Even if a patient's grievance is resolved quickly, the CM must document the complaint and the actions taken to resolve it ..." 2. A review of the Patient Grievance Report dated 02/17/2024 to 02/17/2025 failed to evidence the complaint made by Patient #4 to MSW 2 on 01/20/2025. The facility failed to ensure all complaints were investigated, documented, discussed with all team members, and a resolution was determined.	V 0765	On 3/4/2025, the Facility administrator held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the Policy. Patient Grievance Procedure Emphasis will be placed on: Within the first 6 treatments after admission to the facility, ands any time as needed the Facility Social Worker (MSW) will provide “What to Do if You Have a Concern” and “Important Numbers” handouts to the patient or patient representative. Note: A Registered Nurse (RN) may assume the responsibility for informing patients if designated by the Clinical Manager (CM) After review of the grievance process, MSW will ask the patient to sign the Acknowledgement of Patient Grievance Procedure and file in the patient’s medical record. FKC Staff will promptly	03/19/2025

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	3. During an interview on 02/17/2025 at 9:35 AM, Patient #4 indicated the facility was having difficulty calculating their dry weight (a patient's weight without excess fluid in their body). When queried why there was an issue calculating their dry weight, Patient #4 indicated the scale was malfunctioning. When queried if they mentioned the problem to staff, Patient #4 indicated they have complained to staff and was informed it would take 3-6 months for a new scale to be delivered. 4. During an interview on 02/17/2025 at 12:44 PM, the Medical Director indicated they were aware of a complaint made in January regarding the scale. When queried who made the complaint, the Medical Director indicated Patient #4. 5. During an interview on 02/17/2025 at 4:03 PM, MSW 1 indicated the grievance process is: take in any grievance a patient or anyone has, document in the workbook, share the complaint with the team, if needed escalate to RVP, find a resolution, and close out the grievance once a satisfactory resolution is made. When queried if the MSW 1 heard any complaints, they indicated there was a concern with the scale that MSW 1's "counterpart", MSW 2, encountered during care planning. When queried who had the concern about the scale, MSW 1 indicated Patient #4 made the complaint. 6. During an interview on 02/17/2025 at 4:21 PM, MSW 2 indicated they spoke to Patient #4 about any concerns on 01/20/2025. When queried what concerns Patient #4 reported, MSW 2 indicated Patient #4 had concerns that their weight was not accurate before or after treatment. When queried what happened after Patient #4 made the complaint, MSW 2 indicated they emailed MSW 1,		acknowledge and report all patient grievances to the Nurse in Charge (or Team Leader) as soon as possible. The Nurse in Charge (or Team Leader) will meet with the patient to gather information, and complete as many fields as possible on the Patient Grievance Status Report within 72 hours of being notified and will inform the CM. The Facility Administrator (FA) will review the Patient Grievance Status Report daily. For any new grievances, FA will meet with the patient within 5 business days to acknowledge, investigate and address the grievance. Note: MSW or other staff may also assist in assessing and resolving patient grievances, as appropriate. The FA will report back to the patient when a resolution is attained or considered attained by the facility. Note: When the grievance cannot be immediately resolved, the FA must provide the patient/representative with updates periodically on progress. The FA will ensure the following details are completed in the Quality Assessment and Performance Improvement (QAI) Patient Grievance Status Report: Date grievance received Mode of grievance (i.e. meeting, phone call, email, letter, fax) Intake Person Patient Initials	

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	the Medical Director, the FA, and included their direct managers. When queried what the grievance process is, MSW 2 indicated they file the complaint in QAI, fill in all the complaint details, the complaint would go up to leadership, once concerns are addressed, resolve the issue within the system. 7. During an interview with the Facility Administrator (FA) on 02/17/2025 at 1:29 PM, they indicated a complaint can be made to any of the staff and it would follow the chain of command. The FA explained they would investigate the complaint and attempt to find a resolution and keep the patient informed. They revealed they had a complaint about the scale not being accurate from Patient #4 in the middle of January. They indicated they thought they had included the complaint on the complaint log, but explained it was not on the complaint log. They revealed they had discussed the complaint at their Quality Assurance meeting on 01/24/2025. They indicated they obtained a replacement scale while the permanent scale was being replaced.		Nature of the grievance Findings of the investigation Grievance referred to (if any) Resolution and any corrective actions taken Any follow-up related to the grievance Note: Even if a patient's grievance is resolved quickly, the CM must document the complaint and the actions taken to resolve it. The FA will ensure that all patient grievances are reported to the QAI Committee. Effective 3/10/2025, the Facility Administrator will conduct bi-weekly audits utilizing specific plan of correction audit tool for 2 weeks, and then weekly for an additional 4 weeks or until 100% compliance is achieved. With a focus on ensuring all patients grievances are documented and FKC policy and procedure is adhere to with all staff. The DO will ensure the Grievance procedure listed above will be followed, monitored and reported in QAI. Once compliance is sustained at 100%, the Governing Body will decrease frequency to monthly then resume regularly scheduled audits based on the QAPI calendar. Monitoring will be done through the specific plan of correction audit tool. The Medical Director will review	

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			the results of audits each month at the QAPI Committee meeting monthly. The Facility Administrator 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 QAPI 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 QAPI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAPI monthly. The Governing Body is responsible to provide 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 QAPI and Governing Body minutes, education and monitoring documentation, are available for	

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			review at the clinic.	