STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152630	A. BUILDING 00 B. WING	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PORTAGE DIALYSIS	5823 US HWY 6 PORTAGE, IN 46368

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E 0000 Bldg. 00	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. Date of survey: 11/10/2021, 11/12/2021, 11/15/2021 to 11/17/2021 Facility #: 011896 CCN: 152630 Stations: 16 ICHD Patients: 41 Home Peritoneal Dialysis patients: 3 Home Hemodialysis patients: 6 Total Census: 50 At this Emergency Preparedness survey, Portage Dialysis, was found to have been in compliance with the requirements of Emergency Preparedness Requirements for Medicare participating providers and suppliers, including staffing and implementation of staffing during a Pandemic, at 42 CFR 494.62.	E 0000		
V 0000 Bldg. 00	This survey was a Federal Re-certification, and complaint survey. Complaint #: IN00273777: Complaint was	V 0000		

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

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	unsubstantiated. Complaint #: IN00356424: Complaint was unsubstantiated. Date of survey: 11/10/2021, 11/12/2021, 11/15/2021 to 11/17/2021 Facility #: 011896 CCN: 152630 ICHD Patients: 41 Home Peritoneal Dialysis patients: 3 Home Hemodialysis patients: 6 Total Census: 50 Quality Review Completed 12/1/21			
V 0113 Bldg. 00	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE 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. Based on observation, record review and interview, the facility failed to ensure staff had completed appropriate hand hygiene according to hand hygiene policies and procedures in 7 of 10 hand hygiene observations completed. (PCT [patient care technician] I, PCT J, PCT H, RN D) The findings include: 1. An agency policy titled "Infection Control for	V 0113	=”” span=””>4) Hand washing will be performed if hands are visibly contaminated with blood or body fluids. 5) Alcohol-based hand rubs may be used: In the absence of sinks/water; In the event of an emergency (i.e., emergency evacuation); Before gloving and after glove removal. 6) Teammates will wear	12/17/2021

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	Dialysis Facilities" revised October 2021, stated "Purpose to minimize the spread of infection or bloodborne pathogens in the dialysis facilities environment ... 1. Hand hygiene is to be performed upon entering the patient treatment area, prior to gloving, after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact, between patients even if the contact is casual, before touching clean areas such as supplies and on exiting the patient treatment area. Physicians, Non-Physician Practitioners (NPP) and all teammates are to follow the same requirements for glove use and hand hygiene. 2. If hands are not visibly contaminated, use of an alcohol-based hand rub may be substituted for handwashing ... Handwashing will be performed if hands are visibly contaminated with blood or body fluids ... 6. Alcohol-based hand rub maybe used: -in the absence of sink/water - In the event of an emergency (i.e. emergency evacuation) -Before gloving and after glove removal ... 11. Teammates will wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis training room/station, and will remove gloves and wash hands or perform hand hygiene between each patient and/or station. 12. Gloves should be worn when: -Potential for exposure to blood, dialysate and other potentially infectious substances ... Administering medications, checking vital signs ... 13. Gloves should be changed when: -When soiled with blood, dialysate or other body fluids -When going from a "dirty" area or task, to a "clean" area or task - When moving from a contaminated body site to a clean body site of the same patient; and -After touching one patient or their dialysis delivery system and before arriving to care for another patient or touching other patients dialysis delivery system...."		disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station, and will remove gloves and wash hands or perform hand hygiene between each patient and/or station. 7) Gloves should be worn when: Potential for exposure to blood, dialysate and other potentially infectious substances... 8) Gloves should be changed when: When soiled with blood, dialysate or other body fluids; When going from a “dirty” area or task to a “clean” area or task; When moving from a contaminated body site to a clean body site of the same patient; and After touching one patient or their dialysis delivery system and before arriving to care for another patient or touch another patient’s dialysis delivery system 9) Alcohol-Based Hand Rubs: Follow the manufacturer’s recommendations in regards to volume of product to be used. Apply product in palm of one (1) hand. Rub hands together covering all surfaces of hands and fingers until hand rub has evaporated and hands are dry. 10) Handwashing: Cover hands (palms, back of hands, between fingers) and wrists with lather and wash vigorously for a minimum of 20 seconds. The FA or designee will conduct observational infection control audits daily for one (1) week and then weekly for two (2)	

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	2. An agency procedure titled "Use of Alcohol-Based Hand Rubs," revised October 2019, stated "1. Follow the manufacturer's recommendations in regards to volume of product to be used 2. Apply the product in the palm of one hand. 3. Rub hands together covering all surfaces of hands and fingers until hand rub has evaporated and hands are dry." 3. An agency procedure titled "Handwashing" revised October 2020, stated " ... Cover hands (palms back of hands, between fingers) and wrists with lather and wash vigorously for a minimum of 20 seconds...." 4. During an observation on 11/10/2021 at 9:45 AM, PCT J was observed accessing a fistula (abnormal connection between an artery and a vein) for initiation of dialysis at station #1. PCT J cleansed patient #14's fistula and inserted the cannulation (place inside a vein) needles and taped the needles in place. PCT J removed his gloves and used alcohol based hand rub. PCT J failed to sanitized between his fingers with the alcohol based hand rub. 5. During an observation on 11/10/2021 at 12:06 PM, PCT H was observed performing exit site care for patient #11 at station #3. PCT H removed patient #3's dressing and removed her gloves. PCT H failed to wash or sanitize her hands after removing her gloves. PCT H cleansed the area around the CVC [central venous catheter] exit site, applied a sterile dressing and removed her gloves. PCT H failed to sanitize all surfaces of her hands with the alcohol based hand rub after removing her gloves. 6. During an observation on 11/10/2021 at 11:40		weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the infection control audit. Instances of non-compliance will be addressed immediately. The FA will review results of all audits with TMs during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The FA is responsible for ongoing compliance with this plan of correction. ="" p="">	

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	AM, PCT F was observed performing exit site care for patient #12 at station #9. PCT F applied gloves and failed to wash her hands prior to donning her gloves. PCT F then applied a sterile dressing to patient #9's catheter site. 7. During an observation on 11/10/2021 at 12:06 PM, PCT H was observed at station #3. PCT H initiated dialysis through patient #11's CVC. PCT H connected sterile syringes to both ports of the CVC, removed her gloves and performed hand hygiene using alcohol based hand rub. PCT H failed to sanitize all surfaces of her hands using the alcohol based hand rub. 8. During an observation on 11/10/2021 at 11:43 AM, PCT F was observed washing her hands prior to initiating dialysis for patient #12 at station #9. PCT F was observed washing her hands with soap and water for 10 seconds. PCT F failed to wash her hands for a minimum of 20 seconds prior to initiating patient #12's dialysis treatment. 9. During an observation on 11/10/2021 at 10:11 AM, PCT J was observed discontinuing dialysis for patient #15 at station 3. PCT J disconnected patient #15's blood lines removed his gloves and sanitized his hands with alcohol based hand rub. PCT J failed to sanitize all surfaces of his hands with the alcohol based hand rub. PCT J donned gloves and removed patient #15's cannulation needles. PCT J sanitized his hands with alcohol based hand rub, but failed to sanitize all surfaces of his hands. 10. During an observation on 11/10/2021 at 11:30 AM, PCT H was observed performing hand hygiene before discontinuing dialysis for patient #13 at station #5. PCT H sanitized her hands, but failed to ensure all surfaces of her hands were			

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	sanitized with the alcohol based hand rub. PCT H disconnected the blood lines for patient #13 and removed her gloves. PCT H donned a new pair of gloves removed the cannulation needles. PCT H removed her gloves and washed her hands with soap and water for 7 seconds. PCT H failed to wash her hands for a minimum of 20 seconds. During an interview on 11/12/2021 at 4:00 PM, the facility administrator indicated teammates should wash or sanitize their hands before and after gloving, before touching the computer, and when going from dirty to clean areas. During an interview on 11/17/2021 at 11:36 AM, the facility administrator indicated all surfaces of the hands should be sanitized using friction. During an interview on 11/17/2021 at 11:34 AM, the facility administrator indicated when washing hands with soap and water, hands should be washed for a minimum of 20 seconds. . 11. During an observation on 11/10/2021 at 12:16 PM, PCT I touched dialysis machine #5 at station #12, removed their gloves and face shield, and then walked off the treatment floor. PCT I failed to perform hand hygiene after removing their gloves. 12. During an observation on 11/10/2021 at 3:32 PM, PCT I touched dialysis machine #1 at station #3 while wearing only one glove, then donned another glove to perform care for patient #11 at station #3. PCT I failed to wear gloves on both			

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	hands while operating the dialysis machine. 13. During an observation on 11/10/2021 at 3:39 PM, RN [registered nurse] D donned gloves on both hands, adjusted the blood pressure cuff on patient #5's arm, touched the dialysis machine, removed and disposed of their gloves, then donned new gloves. RN D failed to perform hand hygiene after removing their gloves. 14. During an observation on 11/12/2021 at 11:20 AM, PCT H retrieved an item from patient #18's personal belonging bag and handed it to him/her while they were dialyzing at station #4. PCT H then placed alcohol-based hand rub in their hand, moved the garbage can and sharps container with his/her hands, and then rubbed the alcohol-based hand rub onto the top and palms of the hands. PCT H then walked to machine #15 at station #8, put one glove on and touched the dialysis machine. With the ungloved hand, PCT H retrieved supplies from the top of the dialysis machine and placed them at patient #19's chair side. PCT H failed to wear gloves when performing patient care and when touching the dialysis machine, and failed to cover the entire surface of their hands with alcohol-based hand rub when performing hand hygiene. During an interview on 11/12/2021 at 4:00 PM, the facility administrator indicated staff should be washing their hands before and after changing gloves and before and after touching the dialysis machine. During an interview on 11/17/2021 at 11:24 AM, the facility administrator indicated alcohol-based hand rub should be rubbed onto the top and bottom of hands and in between fingers.			

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V 0122 Bldg. 00	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [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. Based on observation, record review and interview, the facility failed to ensure staff had completed appropriate disinfection of dialysis stations in 1 of 2 disinfection of stations observed. (station #13) The findings include: An agency policy titled "Infection Control for Dilaysis Facilites" revised October 2021, stated " ... Equipment including the dialysis delivery system and work station, the interior and exterior of the prime container, the dialysis chair and side tables including opening the chair to reach crevices, blood pressure equipment, television arms and control knobs or remote control devices if accessible to patients and teammates, facility wheel chairs, outside of sharps containers, IV poles, as well as all work surfaces will be wiped clean with a bleach solution of the appropriate strength after completion of procedures, before being used on another patient, after spills of blood, throughout the work day, and after each treatment...." During an observation on 11/10/2021 at 3:15 PM, PCT [patient care technician] J was observed at station #13 cleaning the station after patient use.	V 0122	The Facility Administrator (FA) held mandatory in-service(s) for all clinical teammates on Policy 1-05-01 “Infection Control For Dialysis Facilities” starting on 11/16/2021. Verification of attendance is evidenced by a signature sheet for each in-service. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Equipment including the dialysis delivery system, the interior and exterior of the prime container, the dialysis chair and side tables, including opening the chair to reach crevices, blood pressure equipment, television arms and control knobs or remote control devices if accessible to patients and teammates, facility wheel chairs, outside of sharps containers, IV poles, as well as all work surfaces will be wiped with a bleach solution of the appropriate strength after completion of	12/17/2021

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	PCT J was observed cleaning the chair. During the cleaning process, PCT J cleaned the seat and the back of the chair and then reclined the chair. PCT J failed to clean the chair after it was reclined so the area where the back of the chair and seat meet could be fully cleaned. During an interview on 11/15/2021 at 11:22 AM, the facility administrator indicated teammates should clean all surfaces of the chair. The chair should be fully reclined and all crevices should be cleaned after the chair was reclined.		procedures, before being used on another patient, after spills of blood, throughout the work day, and after each treatment. The FA or designee will conduct observational infection control audits daily for one (1) week and then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal infection control audits to verify compliance. Instances of non-compliance will be addressed immediately. The FA will review results of all audits with TMs during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The FA is responsible for ongoing compliance with this plan of correction.	
V 0143 Bldg. 00	494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and Based on observation, record review, and interview, the dialysis facility failed to ensure the staff wiped stopper of a multi - dose medication vial with alcohol wipe for 1 of 2 observations of a medication withdrawal into a sterile syringe. (PCT J).	V 0143	The Facility Administrator (FA) held mandatory in-service(s) for all clinical teammates on Procedure # 1-06-01A, preparation and Administration of Parenteral Medications (Non-EPO,	12/17/2021

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	The findings include: An agency policy titled "PREPARATION AND ADMINISTRATION OF PARENTAL MEDICATIONS (NON-EPO, NON-PARSABIV) WITH ALL DIALYZER TYPES" revised April 2021 stated " ... 7. If the mediation is in a vial, remove the vial cap, and clean vial stopper with alcohol prep pad. A new alcohol prep pad is used prior to each time a vial is entered...." During an observation of a parenteral medication preparation and administration on 11/10/2021 at 9:45 AM, PCT (patient care technician) J, was observed to draw up Heparin [medication to prevent blood clotting] from a multi - dose vial. PCT J cleaned the rubber stopper with an alcohol pad and inserted the needle to withdraw the medication. PCT J inserted the second sterile needle into the stopper of the vial and withdrew the heparin medication into the second syringe. PCT H failed to wipe the opened heparin vial with an alcohol pad prior to inserting the second syringe needle into the vial. PCT H was then observed taking the syringes to station #1, machine #7 and administered the heparin into patient #14's intravenous tubing. During an interview on 11/17/2021 at 11:34 AM, Employee C (Manager of Clinical Services) indicated vials should always be cleaned prior to inserting each needle.		Non-Parsabiv) With All Dialyzer Types" starting on 11/16/2021. Verification of attendance is evidenced by a signature sheet for each in-service. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) If the medication is in a vial, remove the vial cap, and clean vial stopper with an alcohol prep pad. A new alcohol prep pad is used prior to each time vial is entered. The FA or designee will conduct observational audits daily for one (1) week and then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during internal medication audit. Instances of noncompliance will be addressed immediately. The FA will review results of all audits with TMs during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The FA is responsible for ongoing compliance with this plan of correction.	
V 0147 Bldg. 00	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of			

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	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 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].			
	Based on observations, record review, and interview, the agency failed to ensure staff followed infection control policies for 1 of 2 observations of Central Venous Catheter (CVC) care. (PCT [patient care technician] F) The findings include: An agency policy titled "Central Venous Catheter (CVC) Care" revised October 2019, stated " ... Dressings are changed every dialysis treatment ...	V 0147	The Facility Administrator (FA) held mandatory in-service(s) for all clinical teammates on Policy 1-04-02 “Central Venous Catheter (CVC) Care” and Procedure 1-04-02B: “Central Venous Catheter (CVC) With ClearGuard HD Antimicrobial End Caps Procedure”. Verification of attendance is evidenced by a signature sheet for each	12/17/2021

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	Acceptable germicidal/disinfectant solutions may include: Chlorhexidine Gluconate 2%/Isopropyl Alcohol 70% (Chloraprep) only for skin including exit site cleaning Hypochlorite (ExSept Plus) only for skin cleaning including exit site cleaning, Isopropyl 70% Alcohol. Use skin antiseptics in the above order. For patients who have a sensitivity or allergy to certain skin antiseptic document this condition in the medical record and the proceed to the next listed skin antiseptic on the list, per physician direction...." During an observation on 11/12/2021 at 11:40 AM, PCT F was observed performing CVC care on patient #12 at station #9. PCT F was observed removing the patient's CVC dressing. PCT F removed her gloves and donned new gloves. PCT F failed to perform hand hygiene before donning new gloves. PCT F applied a sterile dressing to the CVC exit site. PCT F failed to cleanse the area with antiseptic prior to applying the sterile dressing. During an interview on 11/17/2021 at 11:30 AM, the facility administrator indicated the CVC site should be cleaned with every dressing change.		in-service. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Dressings are changed every treatment…2) Acceptable germicidal/disinfectant solutions may include: Chlorhexidine Gluconate 2%/ Isopropyl Alcohol 70% (Chloraprep) only for skin including exit site cleaning; Hypochlorite (Exsept Plus) only for skin including exit site cleaning; Isopropyl 70% alcohol; Note: Use skin antiseptics in the above order. For patients who have a sensitivity or allergy to a certain skin antiseptic, document this condition in the medical record and then proceed to the next listed skin antiseptic on the list, per physician direction. 3) Remove old dressing and discard. Remove gloves and discard. Perform hand hygiene per procedure and re-glove. The FA or designee will conduct observational audits for CVC care daily for one (1) week and then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal infection control audit. Instances of non-compliance will be addressed immediately. The FA will review results of all audits with TMs during homeroom meetings and with the Medical Director during monthly Quality	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The FA is responsible for ongoing compliance with this plan of correction.	
V 0503 Bldg. 00	494.80(a)(2) PA-APPROPRIATENESS OF DIALYSIS RX The patient's comprehensive assessment must include, but is not limited to, the following: (2) Evaluation of the appropriateness of the dialysis prescription, Based on record review and interview the facility failed to ensure the physician was aware of changes to patient conditions, patient's blood flow rate and dialysate flow rates were followed, and ability of the patient to achieve their dry weigh to establish appropriateness of the dialysis prescriptions in 6 of 10 incenter hemodialysis patients. (patient #1, #3, #4, #6, #8, #9) The Findings include: 1. An agency document titled "Interdisciplinary Team (IDT) Patient Assessment and Plan of Care" revised October 2020, stated " ... In addition if the expected outcome is not achieved, the interdisciplinary team (or individual IDT member) will adjust the patient's plan of care to achieve the specific goal.... " 2. An agency document titled "Chest Pain/Angina" revised Aptil 2017, stated " ... Licensed nurse teammate assesses the patient. Decrease the blood flow rate to 150 mL/min [militers/minute] Decrease the ultafiltration rate (UFR) ... Notify physician for orders...."	V 0503	The Facility Administrator (FA) held mandatory in-service(s) for all Interdisciplinary Team (IDT) members on Policy 1-14-01 “Interdisciplinary Team (IDT) Patient Assessment and Plan of Care”, and all clinical teammates on Policy 1-10-02 “Chest Pain/Angina” and Policy 1-03-08 “Pre-Intra-Post Treatment Data Collection, Monitoring, and Nursing Assessment”. Verification of attendance is evidenced by a signature sheet for each in-service. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) In addition if the expected outcome is not achieved, the interdisciplinary team (or individual IDT member) will adjust the patient’s plan of care to achieve the specific goal...2) Licensed nurse	12/17/2021

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	152630	A. BUILDING 00 B. WING	11/17/2021

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	3. An agency document titled "Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment" revised April 2021, stated " ... Members of the patient care team should report ANY changes in patient conditions or concerns of patient well-being immediately to the nurse at any time .... Any weight loss from the last post weight ... removal goal not to exceed maximum Ordered by physician ... If patient is above or below 1 kg from the target weight...." 4. Clinical record review on 11/15/2021 for patient #4, start of care 8/3/2020, evidenced an agency document titled "Post Treatment" dated 10/25/2021. This document indicated patient #4 complained of chest pain, tingling of his lips and a headache during treatment. This document failed to evidence documentation the physician was notified of patient #4's chest pain, tingling of the lips and headache. Clinical record review evidenced an agency document titled "Post Treatment" dated 10/27/2021. This document indicated patient #4's dry weight [a weight without excess fluid] was 60 kg [kilogram]. At completion of treatment patient #4's weight was 61.5 kg. This document failed to evidence documentation the nurse and the physician were informed patient #4 failed to achieve his dry weight. Clinical record review evidenced an agency document titled "Post Treatment" dated 11/1/2021. This document indicated patient #4's dry weight was 60 kg. At completion of treatment patient #4's weight was 61.6 kg. This document failed to evidence documentation the nurse and the physician were informed patient #4 failed to achieve his dry weight.		teammate assesses the patient…Decrease the blood flow rate to 150 mL/min…Decrease the ultrafiltration rate (UFR) …Notify physician for orders..3) Members of the patient care team should report ANY changes in patient conditions or concerns of patient wellbeing immediately to the licensed nurse at any time. Fluid Status: Pre-treatment: Any weight loss from the last post weight…Post-treatment: removal goal not to exceed maximum ordered by physician…If patient is above or below 1 kg from the target weight. 4) If the dialysis prescription is not being met (including dialysis flow rate or change to/inability to obtain prescribed blood flow rate) the reasons will be documented and the licensed nurse informed. The FA or designee will audit twenty five (25%) of post treatment records daily for one (1) week and then twenty five (25%) of post treatment records weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified with ten percent (10%) of post treatment records audited monthly x 3 months. Instances of non-compliance will be addressed immediately. The FA will review results of all audits with TMs during homeroom meetings and with the Medical Director during monthly Quality Assurance	

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	During an interview on 11/17/2021 at 3:35 PM, the facility administrator indicated if the symptoms did not resolve the physician would have been notified. During an interview on 11/17/2021 at 3:44 PM, the facility administrator indicated he was not too worked up about the weight being over, when patients are continually over 3 kg then there would be cause for concern. 5. Clinical record review on 11/12/2021 for patient #3, start of care 10/16/2021, evidenced an agency document titled "Post Treatment" dated 11/11/2021. This document indicated patient #3's dry weight was 73 kg. At completion of treatment patient #3's weight was 74 kg. This document failed to evidence documentation the nurse and physician were informed patient #3 failed to achieve her dry weight. Clinical record review on 11/12/2021 for patient #3, start of care 10/16/2021, evidenced an agency document titled "Post Treatment" dated 10/23/2021. This document evidenced the patient's prescribed blood flow rate (BFR) was 350 ml/min (milliliters/minute). After 1 hour of treatment the patients BFR was changed to 300 ml/min. This document failed to evidence documentation as to why the BFR was reduced and why patient #3 did not get her prescribed treatment. During an interview on 11/17/2021 at 2:43 PM, the administrator indicated there should be a reason documented if the BFR was changed. 6. Clinical record review on 11/16/2021 for patient #1, start of care 10/16/2021, evidenced an agency document titled "Post Treatment" dated		Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The FA is responsible for ongoing compliance with this plan of correction.	

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	10/30/2021. This document indicated patient #1's dry weight was 66 kg. At completion of treatment patient #1's weight was 65 kg. This document failed to evidence documentation the nurse and physician were informed patient #1 failed to achieve her dry weight. During an interview on 11/17/2021 at 12:09 PM, the facility administrator indicated the patient's weight may not have been subtracted correctly during this treatment. Clinical record review evidenced an agency document titled "Post Treatment" dated 10/28/2021. This document evidenced the patient's prescribed blood flow rate was 350 ml/min. Patient #1's BFR during this treatment was 300 ml/min. This document failed to evidence documentation as to why the BFR was reduced. During an interview on 11/17/2021 at 2:43 PM, the administrator indicated there may have been something going on with the patient, so they had to run at a reduced rate. He indicated there should be a reason documented if the BFR was changed. 7. Clinical record review on 11/12/2021 for patient #6, admit date 2/16/2017, evidenced a facility document titled "Post Treatment" dated 11/10/2021, which failed to evidence the correct blood flow rate (BFR) of 400 mL/min prescribed by the physician. The facility document indicated the BFR was set at 350 mL/min from 10:31 AM until 11:01 AM. Then this document indicated the			

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	BFR was decreased to 345 mL/min from 11:01 AM until the end of treatment at 1:20 PM. The facility document failed to evidence a reason for the change to the patient's BFR prescription. During an interview on 11/17/2021 at 3:52 PM, the facility administrator indicated the BFR was incorrectly set at 345 mL/min. 8. Clinical record review on 11/16/2021 for patient #9, admit date 6/25/2019, evidenced a facility document titled "Post Treatment" dated 10/22/2021, which failed to evidence the correct blood flow rate (BFR) of 450 mL/min prescribed by the physician. The facility document indicated the BFR was set at 300 mL/min from 12:00 PM until 2:00 PM. The facility document failed to evidence a reason for the change to the patient's BFR prescription. During an interview on 11/17/2021 at 2:29 PM, the manager of clinical services indicated the RN [registered nurse]should have documented the reason for the BFR prescription changes. 9. Clinical record review on 11/15/2021 for patient #8, admit date 1/12/2021, evidenced a facility document titled "Post Treatment" dated 11/10/2021, which failed to evidence the correct blood flow rate (BFR) of 400 mL/min prescribed by the physician. The facility document indicated the BFR was set at 270 mL/min from 10:43 AM until 10:45 AM. Then this document indicated the BFR was decreased to 200 mL/min from 10:45 AM until 11:02 AM. Then this document indicated the BFR was increased to 250 ml/min from 11:02 AM until end of treatment at 14:01 PM. The facility document failed to evidence a reason for the changes to the patient's BFR prescription.			

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	Clinical record review on 11/15/2021 for patient #8, admit date 1/12/2021, evidenced a facility document titled "Post Treatment" dated 10/15/2021, which failed to evidence the correct dialysate flow rate (DFR) of 800 mL [milliliters]/min [minute] prescribed by the physician. The facility document indicated the DFR was set at 500 mL/min from 10:49 AM until the end of treatment at 2:00 PM. The facility document failed to evidence a reason for the change to the patient's DFR prescription. During an interview on 11/17/2021 at 2:55 PM, the facility administrator indicated the change in the patient's DFR prescription was an error.			
V 0504 Bldg. 00	494.80(a)(2) PA-ASSESS B/P, FLUID MANAGEMENT NEEDS The patient's comprehensive assessment must include, but is not limited to, the following: Blood pressure, and fluid management needs. Based on record review, and interview, the facility failed to ensure patient pre/post and intradialytic blood pressures were being assessed and managed in 2 of 8 incenter hemodialysis records reviewed (Patient #5, #7). The findings include: 1. An agency document titled "Hypotension" revised October 2017, stated " ... special considerations should be taken to prevent hypotensive events from occurring. Take vital signs, decrease or turn of the utrafiltration rate depending on the patient's condition. Administer	V 0504	The Facility Administrator (FA) held mandatory in-service(s) for all clinical teammates on Policy 1-09-01 Hypotension" and Policy 1-03-08 "Pre- Intra-Post Treatment Data Collection, Monitoring, and Nursing Assessment". Verification of attendance is evidenced by a signature sheet for each in-service. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Special	12/17/2021

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	normal saline bolus of 100-200 milliters for severe hypotensive symptoms, Patient care technician can administer up to 200 milliliter and will inform nurse of intervention. continue to monitoring the blood pressure, it the patient continue to show hypotension symptoms notify the physician...." 2. An agency document titled "Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment" revised April 2021, stated " ... Members of the patient care team should report ANY changes in patient conditions or concerns of patient well-being immediately to the nurse at any time .... removal goal not to exceed maximum Ordered by physician ... If patient is above or below 1 kg form the target weight .. systolic greater than 190 mm/Hg or less than 90 mm/Hg Diastolic greater than or equal to 100 mm/Hg Difference of 20 mm/Hg increase or decrease from patients last intradialytic treatment reading ... standing systolic BP (blood pressure) is greater than 140 mmHg or less than 90 mmHg standing diastolic BP is greater than 90 mmHg or less than 50 mmHg ... sitting systolic BP greater than 90 mmHg or less than 90 mmHg sitting diastolic BP greater than 90 mmHg or less than 50 mmHg...." 3. Record review on 11/16/2021 for patient #7, start of care 6/21/2011, evidenced an agency document titled "Post Treatment" dated 10/20/2021. This document evidenced the patient's blood pressure at the beginning of treatment was 194/97, during treatment patient #7's blood pressure was 212/106, at the end of treatment patient #7's blood pressure was 211/110. This document failed to evidence documentation the physician was notified of the patient's elevated blood pressures. Record review evidenced an agency document titled "Post Treatment" dated 10/25/2021. This		consideration should be taken to prevent hypotensive events from occurring. Take vital signs…Decrease ultrafiltration rate (UFR) or turn off UFR depending on patient's condition. Administer normal saline bolus of 100-200 ml for severe hypotensive symptoms. Patient Care Technician (PCT) may give up to 200ml, and will inform licensed nurse of intervention. Continued monitoring blood pressure. If patient continues to show signs and symptoms of hypotension, notify physician…2) Members of the patient care team should report ANY changes in patient conditions or concerns of patient well-being immediately to the licensed nurse at any time…Abnormal Findings: Fluid Status: Pre-treatment: Removal goal not to exceed maximum ordered by physician…Post treatment: If patient is above or below 1 kg from the target weight…Blood Pressure: Pre-dialysis: Systolic greater than 180 mm/Hg or less than 90 mm/Hg – Diastolic greater than or equal to 100 mm/Hg…Blood Pressure-Intradialytic: Difference of 20 mm/Hg increase or decrease from patients last intradialytic treatment reading…Blood Pressure Post Treatment: Standing systolic BP greater than 140 mm/Hg or less than 90 mm/Hg - Standing diastolic BP	

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	document evidenced the patient's blood pressure at the beginning of treatment was 211/98, during treatment patient #7's blood pressure was 188/106, at the end of treatment patient #7's blood pressure was 193/110. This document failed to evidence documentation the physician was notified of the patient's elevated blood pressures. Record review evidenced an agency document titled "Post Treatment" dated 10/27/2021. This document evidenced the patient's blood pressure at the beginning of treatment was 177/92, during treatment patient #7's blood pressure was 194/102, at the end of treatment patient #7's blood pressure was 171/92. This document failed to evidence documentation the physician was notified of the patient's elevated blood pressures. Record review evidenced an agency document titled "Post Treatment" dated 10/29/2021. This document evidenced the patient's blood pressure at the beginning of treatment was 176/98, during treatment patient #7's blood pressure was 190/103, at the end of treatment patient #7's blood pressure was 187/98. This document failed to evidence documentation the physician was notified of the patient's elevated blood pressures. Record review evidenced an agency document titled "Post Treatment" dated 11/1/2021. This document evidenced the patient's blood pressure at the beginning of treatment was 207/109, during treatment patient #7's blood pressure was 182/96, at the end of treatment patient #7's blood pressure was 178/97. This document failed to evidence documentation the physician was notified of the patient's elevated blood pressures. During an interview on 11/17/2021 at 2:20 PM, the administrator indicated a high blood pressures		greater than 90 mm/hg or less than 50 mm/Hg; Sitting systolic BP greater than 140 mm/Hg or less than 90 mm/Hg – Sitting diastolic greater than 90 mm/Hg or less than 50 mm/Hg…The FA or designee will audit twenty five (25%) of post treatment records daily for one (1) week and then twenty five (25%) of post treatment records weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified with ten percent (10%) of post treatment records audited monthly x 3 months. Instances of non-compliance will be addressed immediately. The FA will review results of all audits with TMs during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The FA is responsible for ongoing compliance with this plan of correction.	

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	could be the patient moving around. If it is consistently high the physician would have been notified. 4. Record review on 11/16/2021 for patient #5, start of care 11/1/2021, evidenced an agency document titled "Post Treatment" dated 11/12/2021. This document evidenced the patient's blood pressure at the beginning of treatment was 211/96, during treatment patient #5's blood pressure was 207/105, at the end of treatment patient #5's blood pressure was 174/70. This document failed to evidence documentation the physician was notified of the patient's elevated systolic blood pressures. During an interview on 11/17/2021 at 3:24 PM, the facility administrator indicated the nurse would be notified of a 20 point drop in blood pressure, the nurse would assess the patient and call the physician if needed.			