STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152501	A. BUILDING 00 B. WING	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE GARY	3290 GRANT ST GARY, IN 46408

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V 0765 Bldg. 00	494.180(e) GOV-INTERNAL GRIEVANCE SYS ID/IMPLEMENTED Based on record review and interview, the dialysis clinic failed to evidence they implemented and followed their internal grievance process, failed to review the grievance within a reasonable timeframe, and failed to inform the patient of the steps taken to resolve the grievance in 2 of 2 complaints documented in October of 2024 relatec to Quality of Care /Treatment and Patient Rights (Patient #3 and Patient #4) and in 1 of 2 discharged clinical records reviewed Patient #2). Findings include: 1. The policy dated 01/02/2014 and titled, "Patient Grievance," indicated a meeting with the patient would occur within 5 days to discuss the grievance, to resolve it as quickly as possible and provide updates to the patient. The actions taken are to be documented in the Patient Grievance Status Report. The policy indicated a grievance was any complaint or concern raised by a patient. 2. A policy dated 06/28/2018, titled, "Patient Rights and Responsibility List," indicated the patient would be treated with dignity, consideration, respect and include sensitivity to the psychological needs and ability to cope with ESRD, the right to be informed about treatment options available to the patient, the patient can make a complaint and receive a response without fear or concern that services would be affected. The patient had the right to speak up to help protect their health and safety. The patient had the right to tell the staff if something didn't feel or look safe, and the patient would behave appropriately and not act in a way that made other people in the clinic uncomfortable or afraid for their safety such as threatening, cursing, or yelling.	V 0765	**V765** - On 12/23/2024, the Director of Operations met with staff, elicited input, and reinforced the expectations and responsibilities of the facility staff on the Policy. Patient Grievance Patient Rights and Responsibilities List Emphasis will be placed on: **Grievance** is any complaint or concern raised by the patient or the patient's representative. All facility staff Promptly acknowledging the patient/family members concern and reporting any patient grievances to the Nurse in Charge or the Team Leader. Assisting in assessing and resolving patient grievances as appropriate. Nurse in Charge or Team Leader Meeting with the patient/representative within 72 hours of being notified of a grievance. Assisting in assessing and resolving patient grievances as appropriate. Completing as many fields as possible on the Patient Grievance Status Report.	01/02/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Wennikkia Booker	CM	12/27/2024

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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	3. The clinics' complaint log evidenced a complaint from Patient #3, dated 10/10/2024. Patient #3's voiced concern that he/she was not able to tolerate their dialysis treatment, and they disliked the clinic and wanted to transfer. The complaint failed to evidence documented communication with Patient #3 or documentation of a resolution. 4. During an interview on 11/25/2024, beginning a 3:24 PM, Patient #3 indicated they had filed a complaint with the dietician regarding the amount of fluid being taken off during hemodialysis (a process to filter the blood of a person whose kidneys do not work normally) and felt sick during their treatment. Patient #3 indicated there was no follow up regarding their complaint. A. During an interview on 11/27/2024 beginning a 11:30 AM, the registered dietician [RD] indicated she did document Patient #3's concerns and did notify the social worker, CM, and the administrator through a TEAM'S message; no further information was provided regarding this grievance by survey exit. B. During an interview on 11/25/2024, beginning at 9:40 AM, the SW indicated they had yet to document or follow up with Patient #3 regarding their grievance reported to and filed by the RD. C. During an interview on 11/25/2024, beginning at 11:30 AM, Administrator 4 indicated she had not touched base with Patient #3 since the grievance was written. 5. The complaint log evidenced a complaint from Patient #4, dated 10/15/2024, which indicated Patient reported being treated rudely by an unnamed RN and a PCT. Patient reported he/she felt disrespected and did not want to return to the clinic. The grievance failed to evidence documentation of follow up / communication with Patient #4 and of a resolution. A. During an interview on 11/25/2024, beginning		Clinical Manager (CM) will review the Patient Grievance Status Report daily. Meeting with the patient/representative within 5 days to discuss the grievance, resolve it as quickly as possible, and provide periodic updates to the patient. Documenting actions taken on the Patient Grievance Status Report and reporting this information to the Quality Assessment and Performance Improvement (QAI) Committee. Escalating unresolved grievances to the attention of the Director of Operations /Area Manager. Ensuring the facility is adhering to the Patient Grievance Policy. Director of Operations (DO)/Area Manager (AM) will mee with the patient/representative within 5 days to discuss the grievance, resolve it as quickly as possible, and provide periodic updates to the patient. Escalating unresolved grievances to the attention of the Regional Vice President. Ensuring the facility has posted all of the required information outlined in this policy and updating these postings as applicable. Ensuring that all patient grievances are reported to the QA Committee and to the Governing Body. Ensuring the facility is adhering	

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	at 9:40 AM, the SW indicated she was involved with Patient #4's complaint of disrespectful behavior of the dialysis staff and Patient did not want to return to the clinic. The SW indicated Administrator 4 was to discuss Patient 4's concerns with the staff involved. B. During an interview on 11/25/2024, beginning at 3:20 PM, Patient #4 indicated he/she threw up while on the treatment floor and felt bad, feelings were hurt when the staff said "eww." Patient #4 indicated a complaint was made to SW and indicated he/she had not yet received a follow up from the facility. 6. During an interview on 11/26/2024, beginning a 11:37 AM, the facility Administrator indicated she had begun as the Administrator position on 10/14/2024; she indicated she and Administrator 4 were to address complaints during the transition. The Administrator indicated she had not addressed the complaints voiced by Patient #3 nor Patient #4. 7. During an interview on 11/25/2024, beginning a 11:30 AM, Administrator 4 indicated a complaint should be addressed within 24 hours and further indicated follow-up with complainant and any grievance should be addressed, and the resolution should be documented. Administrator 4 indicated she was not involved with Patient #4's complaint and had not touched base with Patient #3 since the grievance was written. 8. During a follow up interview on 11/26/2024, beginning at 10:50 AM, Administrator 4 indicated the current Administrator took over the role on 10/14/2024 and she had left the Administrator position as of 09/28/2024. She indicated Corporate Staff 1 covered as the facility Administrator from 09/28/2024 to 10/14/2024. Administrator 4 indicated Corporate Staff 1 and herself were to cover complaints when the clinic was without a designated clinical manager in		to the Patient Grievance Policy. Regional Vice President (RVP) will contact the patient/representative within 10 days to discuss the grievance and resolve as quickly as possible as possible. Reporting escalated patient Grievances to the Governing Body and documenting any issues identified and resolution in the minutes. Ensuring that there is a culture of caring conducive to collaborativ problem solving. Assuming responsibility for DO/AM vacancies in regard to the grievance process. (QAI) Committee Reviewing and trending patient grievance investigations as a means to identify opportunities to improve care. Governing Body Establishing an internal grievance process. Ensuring the facility's grievance process is implemented so that the patient may file an oral or written grievance with the facility without reprisal or denial of services and addressing any issues identified. Patient rights include being treated with dignity, consideration, respect and full recognition of the patient's individual and personal needs. This includes sensitivity to your psychological needs and	

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	October 2024. 9. During an interview on 11/25/2024, beginning a 11:05 AM, the CM indicated she began in her position on 10/14/2024, though did not enter the facility until 10/21/2024. The CM indicated she was not involved with the complaints by Patient #3 or Patient #4. 10. During an interview on 11/22/2024, beginning at 7:35 PM, Patient #2 indicated PCT 4 and PCT 1 wrote on their personal protective gowns, phrases included "tell the truth," "TikTok," and "elderly abuse" on 10/23/2024; Patient relayed they felt the writing was retaliation towards him/her. A, A review of the grievance documented within the clinics Complaint Log, through 11/22/2024 failed to evidence documentation of Patient #2's complaint related to PCTs' writing on their personal protective gown(s). B. During an interview on 11/25/2024, beginning a 11:05 AM, the CM indicated the SW informed her of Patient #2's complaint of staff who wrote on their gowns on 10/23/2024. The CM relayed she went to the floor and PCT 2 and PCT 10 had written on their gowns; the CM relayed the words written were related to domestic violence and TikTok. The CM relayed Patient #2 indicated they believed the words on the PCT's gowns were directed towards him/her. C. During a follow up interview on 11/26/2024, beginning at 12:01 PM, the CM indicated the SW notified her that Patient #2 was weepy and upset over the words written on the personal protective gown worn by PCT 10. The CM indicated she did not write a grievance related to Patient #2's complaint and there was no documented follow up regarding Patient #2's grievance. The CM indicated there was an in-service that was held regarding professionalism on 10/31/2024. D. During an interview on 11/26/2024, beginning at 11:00 AM, the SW indicated she was notified of		ability to cope with ESRD. Be informed about the treatment options available to you and the right to change your treatment option after discussion with your physician. Make a complaint and receive a response. Be informed about how to make a complaint through the facility, the ESRD Network or State Survey Agency. Make a complaint, verbally or in writing. A patient has a right to make a complaint themselves, anonymously or through a representative of their choice, through the Grievance Procedure without fear or concern that services will be affected. The patient has a right to speak up to help protect their health and safety. The patient has a right to tell the staff if something doesn't feel or look safe, or right. The patient has a responsibility to behave appropriately. This means not acting in a way that makes other people in the clinic uncomfortable or afraid for their safety, such as threatening, cursing, yelling, using sexually suggestive words, or inappropriate touching. By 12/27/2024, the Clinical Manager will review the patient grievance status report, provide patient(s) with update on their	

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	Patient #2's concern about the PCTs writing on their personal protective gowns; the SW indicated she did not write a grievance about Patient #2's concern, and she did not document a follow up regarding the grievance.		concerns, and document all intervention for resolution on grievance report per policy. The Clinical Manager will review all patients' concerns or grievances ir the facility's next scheduled QAI. Effective 12/27/2024, the Clinical Manager will conduct daily audits utilizing patient grievance status report with a focus on ensuring all patient grievances are documented and provide patient with updates on resolution for (2) weeks, then weekly (2) times per week for (4) additional weeks. Once compliance is sustained at 100%, the Governing Body will decrease frequency to monthly to resume regularly scheduled audits based on the QAPI calendar. Monitoring will be done through the patient grievance status report status report. The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly. The Clinica Manager is responsible to review, analyze anc 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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			other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolutior 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 responsibl 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 resolutio of the issues. The QAPI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic.	
V 0767 Bldg. 00	494.180(f)(4) GOV-INVOL DISCHARGE PROCESS REQUIREMENTS Based on record review and interview, the facility failed to evidence documentation of their intervention(s), reassessment(s) to resolve Patients' behaviors and ongoing problems, the documentation of Patient's behaviors that seriously impaired the facility's ability to operate, and documentation of their attempts to avert the IVD, prior to implementing, for 1 of 1 clinical	V 0767	**V767** On 12/23/2024, the Director of Operations met with staff, elicited input, and reinforced the expectations and responsibilities of the facility staff on the Policy. ·Disruptive Patient Behavior and Use of Behavioral Agreement Emphasis will be placed on:	01/02/2025

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	record reviewed of an IVD (Patient #2). Findings include: 1. The policy dated 04/04/2012 and titled, "Disruptive Patient Behavior and Use of Behavioral Agreement [BA]," indicated the POC should be revised or adjusted to demonstrate interventions or resources, agreed upon by the patient, and IDT to resolve barriers or other issues contributing to disruptive behavior. The patient's disruptive behavior, all interventions to defuse the patient's behavior, and the outcome of those efforts should be documented; the policy indicated the BA should be individualized to the behaviors the patient exhibited that are considered disruptive or dangerous to the safety of the patient, other patients, and / or the staff. The policy indicated the BA should define the responsibilities of the IDT in working with the patient to achieve success. The policy indicated the SW's role was to work with the patient, counsel or teach more effective coping and communication skills, to have regular contact with the patient to support, review the progress, contacts should be documented in a progress note, and updates provided to the IDT. The SW would collaborate with the CM to determine the need for staff meeting(s) or an in-service to ensure staff, who care for the patient, understand the BA and their role in supporting a positive outcome. 2. The policy titled, "Immediate and Non-Immediate Involuntary Patient Discharge" dated 11/04/2024, defined an IVD when patients were discharged, from the facility, against their will. The policy indicated the IVD would be based on escalating behavior, when there was no physician, the clinic was unable to meet the patient's medical needs or lack of payment. The policy indicated the Medical Director would ensure no patient was involuntary discharged		Any patient at risk for transfer or discharge must be considered “unstable” and reassessed by the interdisciplinary team. The plan of care should be revised or adjusted, as indicated, to demonstrate interventions or resources agreed upon by the patient or determined necessary by the interdisciplinary team to resolve barriers or other issues contributing to the disruptive behavior. Behavioral Agreements should be individualized to the particular behaviors that the patient is exhibiting that are considered disruptive or potentially dangerous to the safety of the patient, other patients, staff or the facility. The Behavioral Agreement should define what responsibilities or expectations the patient will need to meet to continue to receive services in the facility. Consequences of continued disruptive behavior should be spelled out, for example, possible change of shift or chair to a different time or location, temporary transfer to another FKC facility, reporting of behavior to police, possible discharge, etc. Responsibilities of the interdisciplinary team in working with the patient to achieve success such as weekly meetings with the MSW, consultation with outside counselors, monthly	

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	from the facility unless the patient's behavior was deemed disruptive and abusive to the extent that the delivery of care to the patient or the ability of the facility to operate was seriously impaired. The policy indicated the IDT was required to document their assessments, the ongoing behavior concerns, their efforts to resolve the problem(s), and the IDTs' efforts to resolve conflict and psychological issues, contributing to the behavior(s) in the patient's medical record. 3. A copy of Patient #2's Discharge Letter, dated 09/23/2024 indicated Patient would be discharged after their 10/23/2024's hemodialysis (process to filter the blood of a person whose kidneys do not work properly) treatment. The letter relayed the determination to discharge was based on behaviors that were disruptive and abusive to the extent it impaired the delivery of care and the ability to operate effectively was seriously impaired. The letter indicated the facility held multiple POC meetings to address Patient's concerns, indicated assistance would be provided for transfer to another dialysis facility. If a transfer to another dialysis provider was not found, Patient was to seek medical attention at Entity 6, a hospital for further HD. The letter included a list of dialysis facilities to contact. During an interview on 12/03/2024 at 12 PM, corporate person 2 indicated the verbiage used in the IVD notice was incorrect; the POC meetings were not held with the Patient. 4. Patients' clinical record evidence that the most recent KDQOL (quality of life survey for dialysis patients) was assessed in February of 2024. The mental health component indicated Patients' current score was 37.5, the previous annual assessment score was 60.5, with an average range of 40.8 to 61.5. The assessment indicated all scores were below average. Additional comments		meetings with the team to review progress, etc., should be included in the Behavioral Agreement as well. The Social Worker's role in reducing disruptive patient behavior or conflict is to work therapeutically with the patient to counsel on or teach more effective coping and communication skills. The Social Worker shall monitor the progress of adherence to the Behavioral Agreement and involve the Clinical Manager and Medical Director or Attending Nephrologist as necessary. Once a Behavioral Agreemen is implemented, regular contact with the patient to counsel, support and review progress should be made by the Social Worker. These contacts should be documented in a progress note in the medical record and updates provided to the interdisciplinary team. The social worker will collaborate with the Clinical Manager in determining the need for a staff meeting or in-service to ensure that staff who routinely care for the patient understand the Behavioral Agreement and their role in supporting a positive outcome. Involuntary Discharge: Involuntary discharge is when patients are discharged from the facility against their will. Non-Immediate Involuntary	

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	indicated incidents at the clinic have caused her stress, Patient is listed as unstable, and under a BA, Patient declines attendance or review of POC to resurvey in one year. 5. A review of Patient #2's clinical record failed tc evidence the IDT updated Patients' POC with the specific behaviors identified as abusive, disruptive, and / or impeding other patients' care, interventions to resolve the issues, reassessments and measurable goals to determine resolution of the disruptive behavior(s). A. The POC dated 07/31/2024 indicated for the goal for Patient's emotional/mental health was to improve their KDQOL scores, disruptive behaviors would be minimized, the SW and IDT would continue to monitor unspecified behaviors, the need of a behavior plan and indicated there were no bothersome symptoms during the review period. The POC included as an area of focus for modality, was education related to home dialysis and indicated the intervention was to educate Patient on their treatment options. The plan indicated there were no issues in adherence to treatment, they were monitoring unspecific behaviors. B. A Comprehensive RN Assessment dated 08/14/2024 indicated failed to evidence documentation regarding Patients' behaviors. The assessment indicated Patient adhered to their prescribed treatment, the treatment prescription was adequate, and goals were met. C. A Psychosocial Progress note for Patient #2 dated 08/16/2024 indicated Patient #2 reported no changes since previous month, patient's mood appeared stable, and the patient did not complain about the staff just stated that things were the		Discharge (30-day Discharge): Patient is notified in person and by letter that effective in 30 days, their current FKC clinic is no longer able to provide them with medical care or dialysis treatments. This is based on the following CMS Criteria for a 30-Day NonImmediate Involuntary Discharge (Escalating behavior, nc physician, unable to meet medical needs, lack of payment). The clinic team is responsible for attempting to place the patient in another facility during this 30-day timeline. The Medical Director shall ensure that no patient is involuntarily discharged from the facility unless: 1. The patient or payer no longer reimburses the facility for the ordered services, the payer materially reduces its established reimbursement to the facility, which the facility deems nonpayment for the ordered services, or the facility is unable tc verify the actual rate of payment with the patient's commercial payer prior to the patient's admission and the payer subsequently reimburses the Facility at an insufficient rate relative to historical commercial insurer payment rate. 2. The facility ceases to operate. 3. The transfer is necessary for the patient's welfare because the facility can no longer meet the patient's documented medical	

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	same. D. The record included an 08/16/2024 POC Meeting invitation, for meeting date 08/23/2024, which was declined by Patient. E. A Psychosocial Progress note dated 08/28/2024, indicated Patient #2 was disrespectful to the RN, the nurse practitioner spoke to Patient to address Patient's concerns, and the social worker encouraged the RN to call the human resource/compliance line. F. The POC dated 08/30/2024 indicated the goal was for Patients KDQOL score to improve to an undefined goal, indicated unspecified disruptive behaviors would be minimized, and the IDT would continue to monitor the need of a behavior plan for unspecified behaviors. The POC included as intervention(s) to help Patient identify the most bothersome symptom(s) and the SW was to monitor the undefined symptoms and or behavior(s), and as an intervention to provide crisis intervention as needed. The POC noted there were no needs at the time the POC was reviewed. The POC indicated there were no issues with adherence and Patient was compliant with treatment. The POC indicated Patient was aware of modality treatment options and would continue to educate and monitor. The POC was signed by RN 2, dated 09/23/2024, and indicated Patient chose not to sign the POC. G. The record included an undated POC Meeting invitation, for meeting date of 09/23/2024; documentation indicated Patient declined to attend. H. An ESRD Comprehensive SW Assessment, dated 09/20/2024, indicated there was no other required support needed or desired. I. A Psychosocial Progress note dated 09/23/2024		needs. 4. The patient's behavior is deemed disruptive and abusive to the extent that the delivery of care to the patient or the ability of the facility to operate effectively is seriously impaired. 5. The patient's behavior is an immediate and severe threat that is deemed dangerous to the health and safety of others (Examples: A patient with a gun or knife or who is making credible threats of physical harm). 6. The patient's attending physician or physician group has notified the patient that medical services are being terminated and there is no other attending physician at the facility available or willing to accept the patient. The medical director must be informed of and approve an involuntary discharge of a patient. In the event of a disagreement between the medical director and attending physician, contact the Regional Vice President. Patients shall be informed of discharge and transfer policies and procedures as part of the patient education process and as necessary. The facility's Governing Body shall ensure that all staff follow the facility's discharge and transfer policies and procedures. Except when a patient's behavior is a severe and immediate threat to the health and safety of others, a patient who is at risk for involuntary discharge	

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	indicated a patient informed the staff that Patient #2 informed him/her that one of the Patient Care Technicians (PCT) murdered a patient and another PCT tried to assault the patient. The SW note indicated that Patient understood the statements were a violation of Patient's behavioral agreement. The Psychosocial note failed to indicate the clinical manager, and the social worker met with the Patient as described in the behavior agreement to discuss concerns. J. The POC dated 09/23/2024 indicated behavior monitoring was in progress and Patient's behavior had not changed; undefined what behavior(s) were unchanged within the POC. The POC included under the area of focus of emotional/mental health, indicated Patient's goal included for their KDQOL score to improve, indicated disruptive behaviors would be minimized, and SW to monitor. An area of focus was treatment adherence, with the goal of improving adherence, identifying barriers leading to missed or shortened treatments, and indicated the facility was "in progress" of providing education. Under the area of focus for dialysis adequacy issues, indicated Patient adhered to their treatment. K. The Comprehensive RN Assessment dated 09/23/2024 indicated under any mental or neurological concerns: not applicable and failed to evidence behavior concerning documentation. The assessment indicated Patient adhered to prescribed treatment, the treatment prescription was adequate, and goals were met. L. The POC dated 10/23/2024 indicated Patient was compliant with treatment, and Patient's menta status and behaviors had not changed, and indicated Patient was to be involuntarily discharged on 10/23/2024. M. Plans of care dated 07/31/2024, 08/30/2024		must be considered unstable and reassessed by the interdisciplinary team (IDT). The IDT must document in the patient's medical record the reassessments, ongoing problems(s), and effort(s) made to resolve the problem(s). A written order, signed by the attending physician and the medical director, must be in the patient's medical record for the facility to involuntarily discharge or transfer patient. Effective 12/27/2024, the Clinical Manager will conduct daily audits utilizing patient grievance status report with a focus on ensuring the IDT members document their intervention, and reassessment to resolve patients ongoing problems per policy for (2) weeks, then weekly (2) times per week for (4) additional weeks. Once compliance is sustained at 100%, the Governing Body will decrease frequency to monthly to resume regularly scheduled audits based on the QAPI calendar. Monitoring will be done through the patient grievance status report status report. The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly.	

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	152501	A. BUILDING 00 B. WING	12/03/2024

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	09/23/2024 and 10/23/2024 failed to evidence documentation of why Patient was not a candidate for home dialysis nor progress towards an evaluation. N. The clinical record included Patients' KDQOL Scores Report, dated 02/28/2024; the record failed to evidence further KDQOL Scores Report were documented. O. A Rounding Note dated 08/30/2024 failed to evidence documentation of identified Patient behaviors. The Note indicated Patient insisted on having 4 liters ultrafiltration (amount of fluid take off during dialysis) despite having low blood pressure and an adjustment in dry weight. The note indicated the medical director discussed with Patient their concern of hypovolemia (low fluid in the body) and increased ultrafiltration. The Rounding Nurse Practitioner notes dated 08/26/2024, 09/11/2024, and 09/20/2024 failed to evidence notation regarding negative behaviors exhibited by Patient #2 or reported. P. A Comprehensive Physician Assessment dated 09/23/2024, authored by the Medical Director, indicated Patient was "threatening to staff," was "noncompliant with orders" and exhibited disruptive behavior; the clinical record failed to evidence the specific behaviors that threatened staff, was disruptive, and or documentation of interventions, successful and unsuccessful, related to the disruptive behavior which the provider was requesting to cease. 6. During an interview on 11/25/2024, beginning a 1:15 PM, the Medical Director indicated a behavior contract was given to Patient #2 due to disruptive behavior beginning in February 2024. They indicated Patient #2 had placed flyers in hospitals with Patient's Tik Tok site, that named and described the dialysis clinic and the medical director as poor providers of care. The Medical Director indicated Patient #2 did tell other		The Clinica Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the 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 resolutior 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 responsibl 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 resolutio of the issues. The QAPI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic.	

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	patients, in their clinic lobby, that he/she was not treated right, was abused, and had inadequate care. The Medical Director indicated Patient #2's IVD was based on Patient's treatment of the staff, indicated Patient's verbal abusive behaviors towards the physician and staff. When asked about Patient's non-compliance with orders, the Medical Director indicated Patient would want to take off more fluid during dialysis than was recommended and prescribed. 7. The BA dated 02/12/2024 indicated Patient to be considerate of other patients and staff, respect the personal rights of other patients and staff, follow the rules of the facility, Patient would not use swear words, threat, foul language to degrade, hurt or be disrespectful to staff or other patients, would act appropriately which included not acting in a way that would make other people in the clini uncomfortable or afraid for their safety such as kicking, hitting, threatening cursing and yelling, Patient would bring to the attention of the team any concerns, issues, or complaints in order to discuss. If Patient used vulgar, degrading, or inappropriate language towards a staff member or another patient, Patient would be verbally reminded of the terms of the BA and if the behavior continued, Patient's treatment would be ended and would be asked to leave. If Patient declined to leave the facility, the police would be called. Prior to the next treatment, Patient would have a meeting with the clinical manager and the SW. If Patient was physically violent towards a patient or staff member, the police would be called, and Patient would be immediately discharged from the clinic; Patient declined to sign the BA. 8. During an interview on 11/22/2024 beginning at 7:35 PM, Patient #2 indicated they received a discharge notice letter on 9/23/2024, from the SW; the letter notified him/her of their IVD with a			

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	30-day notice and discharge date. Patient indicated they did not know they would be discharged, indicated they were informed he/she had exhibited abusive and disruptive behavior that impaired the facility's ability to function. Patient indicated they said nothing and would sit in their corner chair. Patient indicated they did not seek further information of a home dialysis program. 9. During an interview on 11/25/2024, beginning a 9:40 AM, the SW indicated Patient #2 was inappropriate, relayed they felt harassed by the staff, and felt threatened and would bring up an incident from February 2024 with Administrator 4 a time when Patient and the facility called the police. The SW indicated some of the clinic staff received an injunction letter from an Attorney General, in September of 2024, related to a formal complaint filed, and that was why the facility decided to do an IVD. 10. During an interview 11/25/2024, beginning at 9:40 AM, SW indicated she monitored Patient's behavior by reports from staff; if the staff notified the SW of Patient #2's behavior she would make a note of it in her head to see if Patient's behaviors' continued. The social worker indicated they did not complete KDQOL on unstable patients, indicated KDQOL were completed annually, and indicated Patient's #2's last KDQOL was from February 2024. The SW indicated she did not adjust Patients goals monthly; the SW indicated she should have adjusted Patients' goals and have made them more specific to Patient. The SW indicated she did not attempt a temporary transfer to another in network dialysis facility because Patient #2 did not want to go to a facility where Administrator 4 worked. 11. During an interview on 11/25/2024, beginning at 11:30 AM, Administrator 4 indicated she was the facility's Administrator until 09/28/2024,			

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	indicated during the last week of September the IDT met regarding Patient #2 violation of the behavior contract when Patient #2 told other patients about how a PCT murdered a patient and another PCT abused him/her. Administrator 4 indicated interventions provided by the facility for Patient #2 was that Patient was advised behavior was not appropriate by telling patients about abuse and murder at the facility. 12. During a follow up interview on 11/26/2024, beginning at 10:50 AM, Administrator 4 indicated the alternate Administrator had approved the involuntary discharge. Administrator 4 indicated she was not aware of Patient #2 being offered a temporary transfer to another in-network dialysis facility because Patient did not want to be at any facility the Administrator 4 was at so that they excluded Patient from other in-network facilities. 13. During an interview on 11/26/2024, beginning at 12:23 PM, SW 2 indicated she did present the involuntary discharge letter to Patient #2; she indicated she read the letter to Patient related to Patient's disruptive behavior and that Patient shared with other patients in the lobby. SW 2 relayed Patient relayed to other patients a PCT killed a patient and another PCT assaulted Patient #2. SW 2 indicated there was no staff in-service training between 02/21/2024 and 10/31/2024 training documented. SW 2 indicated the facility's social worker should have documented regular interactions with Patient and assessment team during the POC meetings. SW 2 indicated the facility's SW should have had meetings with Patient #2 regularly to assess barriers and offer counseling resources and this is not documented within Patients' clinical record. SW 2 indicated Patient #2 was listed as unstable and the POC should have been addressed monthly, adjusted to reevaluate with a timeline, should have utilized documentation to document interventions and			

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	patient interactions. When asked, SW2 could not clearly identify the measurable goals within the POC. SW2 indicated the facility's SW should have looked at documentation to see if behavior interventions should have been adjusted if Patient #2 was not meeting behavior goals and the social worker should have made notes as to why the goals were adjusted. 14. During a follow up interview on 12/02/2024, beginning at 9:10 AM, Administrator 4 indicated Patient #2 was disrupting other patients' care due to Patient #2 required a lot of time and other patients would start dialysis late however, she did not have documentation of other patients' dialysis treatments being affected. Administrator 4 indicated she could not provide documentation of the interventions implemented to resolve Patient #2's behavior due to the social worker would have verbal communication with Patient and the social worker should have addressed. 15. During an interview on 12/02/2024, beginning at 10:05 AM, RN 2 indicated Patient #2 did not have escalating behaviors, she would adjust the POC if needed and indicated no other patients' care was delayed or impaired due to providing care to Patient #2. 16. During a follow up interview on 12/02/2024 beginning at 3:00 PM, the SW indicated Patient #2 was offered home hemodialysis and home peritoneal dialysis options, however Patient did not want to burden Family Member 1. SW failed t evidence documentation of the home program options. The SW indicated Patient was offered counseling but was refused. Documentation of the counseling and home program options offered was not provided by survey exit. 17. When evidence of staff training was requested, Staff in service training dated 02/20/2024 and 10/31/2024 was provided; no further documentation of staff in-service			

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	/meeting(s) /huddles were provided by survey exit.			