STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62. Survey Dates: March 12, 13, 14, 15, 18, 19, 20, 21, 2024 Active Census: 97 At this Emergency Preparedness survey, Fresenius Medical Care Fort Wayne Jefferson was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62.	E 0000		
V 0000 Bldg. 00	This visit was for a Federal complaint survey of an ESRD provider. Survey dates: March 12, 13, 14, 15, 18, 19, 20, 21, 2024 Complaint IN00430123 was investigated with related and unrelated findings. A full Federal survey was announced to Administrator and Clinic Manager on 3/14/24 at 2:20 PM. Census by Service Type: In-Center Hemodialysis: 56 Home Hemodialysis: 9	V 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Taylor Gage	Director of Operations	04/26/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	Home Peritoneal dialysis: 32 Total Active Census: 97 Isolation Room/Waiver: 1 During this Federal complaint survey, Fresenius Medical Care Fort Wayne Jefferson was found out of compliance with Conditions for Coverage 42 CFR 494.70 Patients' rights and 494.100 Care at home. QR A2 4/2/2024			
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, policy review, and interview, the dialysis facility failed to ensure staff performed hand hygiene according to facility policies and procedures during 1 of 1 day of in-center hemodialysis (ICHD) treatment floor observations (Patient Care Technician (PCT) 4, 5, Charge Nurse 4). Findings include: 1. The review of facility policy #47664 titled "Hand Hygiene," dated 11/06/23, indicated hand hygiene should be performed before and after direct contact with patients, when entering and leaving the treatment area, and immediately after removing gloves. 2. The review of facility policy #45178 titled	V 0113	V113 IC-Wear gloves/hand hygiene On or before 04/10/2024, the Facility Administrator will hold a staff meeting, elicit input, and reinforce the expectations and responsibilities of the facility staff on Policies & Procedures. Please see the list of Policies and procedures or processes reviewed at the bottom of the plan. Emphasis will be placed on: Hand hygiene is required after contact with patients. Hand hygiene is required after assessing the AV Fistula prior to disinfection. Glove removal and hand hygiene is required after contact with blood or body fluid. Glove removal and hand hygiene is required prior to	04/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	"Access Assessment and Cannulation," dated 7/05/22, indicated after assessing a fistula site, staff should remove their gloves, perform hand hygiene, and don new gloves. The policy indicated staff should then disinfect the fistula sites. 3. During an observation of the ICHD treatment floor on 3/15/24, from 6:05 AM - 10:30 AM, evidenced the following: a. At 6:40 AM, Patient Care Technician (PCT) 5 was observed entering Station #20 while Patient #13 was receiving dialysis. PCT 5 had a glove on his/her right hand only. The technician touched Patient #13 with his/her ungloved left hand then donned a glove to the left hand. b. At 7:05 AM, PCT 5 was observed in Station #15 initiating Patient #12's dialysis through an arteriovenous fistula. After the technician assessed the fistula site, he/she failed to change gloves and perform hand hygiene prior to disinfecting the site. After PCT 5 completed cannulation of the fistula and connected the dialysis lines, he/she failed to change gloves and perform hand hygiene prior to documenting on the dialysis machine. During an interview with PCT 5 on 3/15/24 beginning at 7:55 AM, the technician reported staff should change gloves and perform hand hygiene in between assessing a fistula site and disinfecting the site. PCT 5 also reported staff should perform hand hygiene prior to donning gloves. c. At 9:15 AM, PCT 4 was observed in Station #17 disconnecting Patient #20 from dialysis and performing post-dialysis access care to Patient's		obtaining clean supplies. Effective 04/11/2024, the Facility Administrator or Charge Nurse will conduct daily audits with a focus on staff performing hand hygiene per facility policy and procedure utilizing the plan of correction monitoring tool for 2 weeks. Once compliance is sustained, the Governing Body will decrease frequency to weekly for 2 weeks then resume regularly scheduled audits based on the QAPI calendar. Monitoring will be done through the Clinic Audit Checklist. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	fistula. After the technician replaced bloodied gauze with clean gauze over Patient's cannulation sites, the technician failed to change gloves and perform hand hygiene prior to assisting Patient with collecting his/her belongings and walking Patient to the lobby. While walking Patient to ICHD lobby, PCT 4 picked up a bottle of hand sanitizer, put a pump-full of sanitizer into Patient's hands, and pressed the handicap door button with his/her gloved hands. During an interview with PCT 4 on 2/15/24 beginning at 2:56 PM, the technician reported staff should change gloves and perform hand hygiene after handling bloodied gauze. d. At 9:47 AM, Charge Nurse 4 was observed cleaning Station #10. The nurse failed to change gloves and perform hand hygiene after leaving the station to empty the prime waste bucket. Charge Nurse 4 then reached to grab a garbage can within the station and pulled it closer to the machine. The nurse failed to change gloves or perform hand hygiene after reaching into the dirty trash can. Charge Nurse 4 left the station to obtain bleach cloths to clean the station, and upon return, failed to change gloves or hand hygiene. During an interview on 3/15/24 at 2:15 PM, Charge Nurse 4 indicated if additional bleach cloths were needed, they were located outside of the station. Charge Nurse 4 indicated gloves should be removed and hand hygiene performed before retrieving them. 4. During an interview with Clinic Manager and Administrator on 3/15/24 beginning at 3:45 PM, Clinic Manager 1 reported staff should perform hand hygiene in between glove changes. Staff should change their gloves and perform hand hygiene if gloves are soiled and after grabbing a		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. Hand Hygiene Access Assessment and Cannulation Completion Date: 4/20/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	garbage can. Clinic Manager 1 also reported staff did not need to change gloves and perform hand hygiene in between assessing and disinfecting a fistula site.			
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, policy review, and interview, the dialysis facility failed to ensure staff completed disinfection of dialysis stations according to facility policies and procedures and best practice in 3 of 3 observations of staff disinfecting a dialysis station (Patient Care Technician (PCT) 5, 6; Charge Nurse 4). Findings include: 1. The review of facility policy #47806 titled "Cleaning and Disinfecting the Dialysis Station," dated 09/05/23, indicated when disinfecting a dialysis station, staff should open the side panels of a treatment chair to disinfect all chair surfaces. "Special attention" should be paid to cleaning the control panel on the dialysis machine "and other surfaces that are frequently touched and potentially contaminated with patients' blood / bodily fluids." The policy indicated all the surfaces of the machine, including "the air detector chamber, blood pump casing, IV pole, and wherever the extracorporeal circuit was in	V 0122	V122 IC-Disinfect surfaces/equip/written protocols On or before 04/10/2024, the Facility Administrator will hold a staff meeting, elicit input, and reinforce the expectations and responsibilities of the facility staff on Policies and Procedures. Please see the list of Policies and procedures or processes reviewed at the bottom of the plan. Emphasis will be placed on: All surfaces of machine (air detector & IV pole) and blood pressure cuff should be disinfected and allowed to air dry. All items in the station should be cleaned with 1:100 bleach, be visibly wet and allowed to air dry. Effective 04/11/2024, the Facility Administrator or Charge Nurse will conduct daily audits with a focus on ensuring staff disinfect the dialysis station	04/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	contact with the machine" should be disinfected. The policy also indicated staff should allow all surfaces to air dry. 2. During an observation on 3/15/24 beginning at 9:10 AM, PCT 5 was observed cleaning Station #13. The technician failed to clean the inside of the air detector chamber and IV pole. After wiping the blood pressure cuff, PCT 5 rolled the cuff tight and placed it in a basket connected to the machine, failing to allow the cuff to air dry. The technician was observed using the same bleach wipe to clean both the machine and the treatment chair. During an interview with PCT 5 on 3/15/24 beginning at 1:52 PM, the technician reported when cleaning a dialysis station, the technician would clean the front and back of the machine, including the air detector chamber and IV pole. PCT 5 stated he/she would "loosely" roll the blood pressure cuff up after wiping it with bleach. The technician reported he/she would use different bleach wipes when cleaning the machine and treatment chair. 3. During an observation on 3/15/24 beginning at 9:35 AM, PCT 6 was observed cleaning Station #23. The technician wiped the left side panel of the treatment chair then immediately closed it, failing to allow the side panel to air dry. The technician also failed to clean all surfaces of the blood pressure cuff. 4. During an observation on 3/15/24 beginning at 9:47 AM, Charge Nurse 4 was observed cleaning Station #10. The nurse failed to ensure the station was visibly wet with bleach while cleaning. 5. During an interview with Clinic Manager 1 and Administrator on 3/15/24 beginning at 3:45 PM,		according to facility policy and procedure utilizing the plan of correction monitoring tool for 2 weeks. Once compliance is sustained, the Governing Body will decrease frequency to weekly, then resume regularly scheduled audits based on the QAPI calendar. Monitoring will be done through the Clinic Audit Checklist. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	Clinic Manager 1 reported when cleaning a dialysis station, staff should wipe all surfaces of the station, including the air detector chamber, IV pole, and the blood pressure cuff. The surfaces should be visibly wet and should be allowed to air dry.		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. Cleaning and Disinfection of the Blood Pressure Cuff Procedure Cleaning and Disinfection of the Dialysis Station Procedure Completion Date: 4/20/24	
V 0142 Bldg. 00	494.30(b)(1) IC-O-SIGHT-MONITOR ACTIVITY/IMPLEMENT P&P The facility must- (1) Monitor and implement biohazard and infection control policies and activities within the dialysis unit; Based on record review and interview, the dialysis facility failed to ensure all staff performing direct patient care received a 2-step tuberculosis (TB, an infectious respiratory disease) test and were offered a Hepatitis B vaccine upon hire for 3 of 3 personnel files reviewed of employees hired in 2023 for direct patient care roles in the home therapy clinic, which had the potential to affect all home therapy patients (Employees A, B, C). Findings include: 1. A review of facility policy #47630 titled "Employee Tuberculosis Testing" indicated a two-step tuberculin skin test (TST, a screening test for TB, which is done by injecting an inactive form of TB under the skin on 2 separate occasions and assessed for a reaction) would be performed on hire. 2. A review of facility policy titled "Employee	V 0142	V142 IC-O'sight: monitor activities & implement P&P On or before 04/09/2024, the Director of Operations will meet with the Home Therapy Program Manager and reinforce the expectations and responsibilities of the facility staff on Policies & Procedures. Please see the list of Policies and procedures or processes reviewed at the bottom of the plan. Emphasis will be placed on: New employees will have a two-step tuberculin skin test. New employees will be offered Hepatitis B vaccine upon hire. Effective 04/11/2024, the Home Therapy Program Manager will audit the personnel files for the two-step tuberculin skin test and	04/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	Requirements for Testing and Vaccination for Hepatitis B" indicated all employees should be offered the Hepatitis B vaccine series upon hire. If the employee declined the vaccine series, "a signed declination must be maintained in the employee file." 3. A review of the facility's personnel files evidenced the following: a. Employee A's hire date was 10/16/23. The employee was hired in a direct patient care role for the facility's home therapy clinic. The file failed to evidence a two-step TST was completed upon hire. The file indicated Employee A completed a Hepatitis B vaccine declination form on 3/15/24. b. Employee B's hire date was 12/11/23. The employee was hired in a direct patient care role for the facility's home therapy clinic. The file failed to evidence a two-step TST was completed upon hire. The file indicated Employee A completed a Hepatitis B vaccine declination form on 3/15/24. c. Employee C's hire date was 11/13/23. The employee was hired in a direct patient care role for the facility's home therapy clinic. The file failed to evidence a two-step TST was completed upon hire. The file indicated Employee A completed a Hepatitis B vaccine declination form on 3/15/24. 4. During an interview with Home Therapy Manager 6 on 3/21/24 beginning at 1:30 PM, the manager reported when the manager completed the personnel worksheet as part of the survey process, he/she discovered Employees A, B, and C did not have a 2-step TST upon hire.		Hepatitis B vaccine. Any employee found lacking will have the testing or vaccine status documented by 4/20/24. The audit will be documented on the Personnel Tracking tool. The Director of Operations will review the Personnel tracking tool monthly for 3 months and then resume regularly scheduled audits based on the QAPI calendar. The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly. The Home Therapy Program 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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
			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. Employee Requirements for Testing and Vaccination for Hepatitis B Employee Tuberculosis Testing Completion Date: 4/20/24	
V 0450 Bldg. 00	494.70 CFC-PATIENTS- RIGHTS Based on record review and interview, the dialysis facility failed to follow its policies and procedures regarding involuntary discharge and behavioral agreements, including clearly identifying patient actions and/or behaviors which would lead to an involuntary discharge and providing the patient written notification of a pending involuntary discharge 30 days prior (See Tag V469). The severity of this deficiency evidenced the facility did not promote and protect all patient rights, which led to Fresenius Medical Care Fort Wayne Jefferson being found out of compliance with Condition for Coverage 42 CFR 494.70 Patients' rights.	V 0450	V450 - CfC: 494.70 Patients' Rights 494.70 Patients' Rights The Governing Body on, 04/08/2024, reviewed the Statement of Deficiencies and developed the following Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The Governing Body began meeting weekly beginning 04/12/2024, to review the results of the progress on the Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The Governing Body will determine when the frequency of these	04/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
			meetings may be reduced to the regular quarterly schedule. Effective immediately: The Facility Administrator will analyze and trend all data and monitor/audit results as related to this Plan of Correction prior to presenting the monthly data to the QAPI Committee. A specific plan of action encompassing the citations as cited in the Statement of Deficiency has been added to the facility's monthly QAPI (Quality Assessment and Performance Improvement) agenda. The QAPI Committee is responsible to review and evaluate the Plan of Correction to ensure it is effective and is providing resolution of the issues. The Director of Operations (DO) will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The Governing Body, at its meeting of 04/08/2024, designated the Director of Operations (DO)to serve as Plan of Correction Monitor and provide additional oversight. They will participate in QAPI and Governing Body meetings. This additional oversight is to ensure the ongoing correction of deficiencies cited in the Statement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
			of Deficiency through to resolution as well as ensure the Governance of the Facility is presented current and complete data to enhance their governance oversight role. Minutes of the Governing Body and QAPI meetings, as well as monitoring forms and educational documentation will provide evidence of these actions, the Governing Body's direction and oversight and the QAPI Committees ongoing monitoring of facility activities. These are available for review at the facility. The responses provided for V469 describe, in detail, the processes and monitoring steps taken to ensure that all deficiencies as cited within this Condition are corrected to ensure ongoing compliance. Completion Date: 4/20/24	
V 0469 Bldg. 00	494.70(b)(2) PR-RECEIVE WRITTEN NOTICE 30 DAYS PRE IVD The patient has the right to- (2) Receive written notice 30 days in advance of an involuntary discharge, after the facility follows the involuntary discharge procedures described in §494.180(f)(4). In the case of immediate threats to the health and safety of others, an abbreviated discharge procedure may be allowed. Based on record review and interview, the dialysis facility failed to follow its policies and procedures	V 0469	V469 PR-Receive written notice 30 days pre IVD On 04/10/2024, the Facility	04/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	regarding involuntary discharge and behavioral agreements, including clearly identifying patient actions and/or behaviors which would lead to an involuntary discharge and providing the patient written notification of a pending involuntary discharge 30 days prior, for 1 of 1 record reviewed of a patient who had been involuntarily discharged in March 2024 (Patient #5). Findings include: The review of facility policy titled "Routine and Involuntary Patient Discharge," dated 9/04/19, indicated the Medical Director was to ensure no patient was involuntarily discharged unless "the facility can no longer meet the patient's documented medical needs ... 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." The policy indicated a patient at risk for involuntary discharge must be reassessed by the interdisciplinary team (IDT) and the IDT should document in the patient's medical record "the reassessments, ongoing problem(s), and effort(s) made to resolve the problem(s)." For involuntary discharges due to disruptive or abusive behavior, the facility should consult the "Disruptive Patient Behavior and Use of Behavioral Agreement" policy "at the first sign of disruptive or abusive behavior that does not rise to the level of a severe and immediate threat to the health and safety of others." The policy indicated prior to an involuntary discharge, "there must be evidence in the patient's medical record of the IDT's efforts to help the patient resolve any conflict or psychological issues contributing to the behavior." For involuntary discharges due to the facility's inability to meet the patient's needs, the facility should consider "all reasonable		Administrator will hold a staff meeting, elicit input, and reinforce the expectations and responsibilities of the facility staff on (Policies & Procedures). Please see the list of Policies and procedures or processes reviewed at the bottom of the plan. In addition, the Director of Operations will meet with the Interdisciplinary team to review the Policy and expectations. Emphasis will be placed on: Documentation of inappropriate/abusive language should be in the patient's medical record. Patients should be informed of risk of involuntary discharge. Written notification should be provided and verified that patient received for involuntary discharge. Effective 04/11/2024, the Facility Administrator or Charge Nurse will conduct monthly audits of any patient at risk for Involuntary Discharge for adequate documentation utilizing the Medical Record Audit tool. Medical Records are completed monthly per the QAPI 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	alternatives for continuing to provide care to the patient in the facility." The facility should conduct a meeting between the IDT and the patient and/or patient's representative "to discuss the patient's current status and barriers to providing a safe treatment environment for the patient" and discuss other treatment modalities and other locations that provide dialysis, such as a nursing home. The patient's medical record should include "documentation of all efforts to manage the patient's care and outcomes as well as all discussions with the patient and his/her representative." The policy indicated the "patient must receive notification at least 30 days prior to the non-immediate involuntary discharge ...." The review of facility policy titled "Disruptive Patient Behavior and Use of Behavioral Agreement," dated 4/04/12, indicated a patient at risk for involuntary discharge must be considered "unstable'" and reassessed by the IDT. The patient's plan of care should be revised "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." The behavioral agreement should "define what responsibilities or expectations the patient will need to meet to continue to receive services in the facility" and should indicate "consequences of continued disruptive behavior," including "possible discharge." The policy indicated once a behavioral agreement was implemented, the IDT would review the "progress of a patient's Behavioral Agreements on a monthly basis until the patient's behavior is either resolved, stabilized, or worsens to the extent that involuntary discharge is considered." The policy defined verbal abuse as "use of words, written or spoken, that demean, insult, belittle or degrade a		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. Routine and Involuntary Patient Discharge Procedure Routine and Involuntary Patient Discharge Disruptive Patient Behavior and Use of Behavioral Agreement Disruptive Patient Behavior and Use of Behavioral Agreement Procedure Disruptive Patient Behavior Guidelines for Completing Behavioral Agreement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	person." The review of the facility's grievance log included a grievance made by Patient #23 and logged by Clinic Manager (CM) 1 on 7/04/23. The log indicated Patient #23 reported "frustration with [Patient #5] over tone towards staff, including yelling at staff and making inappropriate demands." CM 1 documented when he/she met with Patient #23 to discuss the grievance, the patient reported he/she "at times feels uncomfortable during treatment [due to Patient #5's] outbursts." The log included a grievance made by Patient #26 and logged by CM 1 on 7/06/23. The log indicated Patient #26 "verbalized to staff that [he/she] was uncomfortable with [Patient #5's] outbursts, anger, and frustration towards staff." The log included a grievance made by Patient #4 and logged by Clinic Manager 1 on 8/08/23. Patient #4 reported Patient #5 was "constantly yelling and screaming at staff ... [Patient #5 was] rude and mean to staff and [Patient #4 was] tired of hearing it ... [Patient #5 was] disruptive and constantly yelling to get off treatment when [Patient #5] knows the staff are taking [Patient #4] or another patient off treatment." The review of Patient #5's clinical record indicated an admission date of 2/10/18. The record included a Clinical Note, dated 11/02/23 by CM 1, which indicated Patient was upset about his/her treatment time and the clocks on the treatment floor showing different times. Patient "got angry" and threw his/her belongings on the floor when obtaining his/her post treatment weight. When CM 1 offered to provide Patient with a treatment flowsheet to evidence the treatment times, Patient		Completion Date: 4/20/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	stated "those lie and so do your machines." Clinic Manager 1 responded "Ok [Patient], whatever you think" and walked away from Patient. The manager documented Receptionist 1 overheard Patient call CM 1 a "bitch" after the manager walked away. The review of personal statements from facility staff evidenced the following incidents were reported as occurring on 12/14/23: a. An undated personal statement, signed by Secretary 1, indicated the employee was assisting Patient #23 at the facility's "kidney cash patient cabinet" ("Dialysis Dollars" cabinet, where the facility stored various items used as part of its patient incentive program). Patient #5 came up to the cabinet, took 2 crossword puzzle books, then left the facility. The employee documented Patient #5 did not "pay" (using "cash" earned through the incentive program) for the books. Secretary 1 documented Patient #24 reported Patient #5 had accused staff of being racist. Secretary 1 also noted Patient Care Technician (PCT) 4 recounted an incident where Patient #5 had a blood spill at his/her station. When PCT 4 went to clean the station, Patient #5 told PCT 4 to "scrub the floor slave ([Patient] did not use the word slave, [he/she] used a racial slur) do this slave do that slave [sic], see [other staff] treat you [PCT 4] like their slave while all the white people are just sitting on their ass." b. An undated and unsigned personal statement, reported by Clinic Manager 1 as being written by PCT 4, indicated the technician was assigned to Patient #5 and there was a blood spill during his/her treatment. When PCT 4 went to clean up the spill, he/she documented Patient "quietly made a comment to [the employee] that contained			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	a racial slur." c. A personal statement from Registered Nurse (RN) 3, dated 12/21/23, indicated while the nurse was working on the treatment floor, Patient #5 was "yelling about the fact that the three Black patients were all on the same side of the room and all the white patients were on the other and insisted that [the facility was] doing that for a reason ... [Patient #5] began saying that the staff was racist and we do not care for the black folks the same way we care for the white folks." RN 3 documented Patient #5 also "made fun of my religion and would not quit talking about the fact that I choose the religion I choose [sic] ...." The nurse documented he/she "ignored" Patient's comments, however Patient "continued to be rude and disrespectful to the staff." d. A personal statement from PCT 8, dated 1/02/24, indicated while the technician was working on the treatment floor, Patient #5 told the technician that the in-center hemodialysis (ICHD) patients were divided based on their skin color, with black patients sitting on one side of the room and white patients sitting on the opposite side. Patient #5's record included a Progress Note, documented on 12/19/23 by Medical Social Worker (MSW) 1, which indicated the social worker met with Patient to discuss his/her "concerns and recently presented grievances." The note indicated Patient was frustrated with a "lack of communication both timely and in detail" with Medical Director and nursing staff regarding his/her "health status, lab values, and what is being done to address [his/her] medical concerns," which included "repetitive blood clotting causing machine issues." MSW 1 documented Patient "appeared emotionally stable and much calmer" at the end of their meeting.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	The record included 4 Clinical Notes documented on 12/21/23 by multiple staff members. These included: a. A note documented by Charge Nurse 4 which indicated the nurse reviewed with Patient the need to have an angiogram performed to assess his/her fistula access. Patient told the nurse to "handle it." Charge Nurse 4 discovered the procedure was already scheduled and returned to Patient's chairside to update him/her. The nurse documented Patient "yelled in a loud voice 'What have you been doing for 6 weeks that this has all been going on? Nothing! So why are you in my face right now?'." Charge Nurse 4 responded "in a stern voice, 'Did you just ask me why am I in your face? You do not need to talk to me that way ...'." Patient reportedly told the nurse "you don't need to yell at me," to which the nurse responded, "if you are so unhappy with your care here, there are other clinics we can refer you to." Charge Nurse 4 documented he/she then left Patient's station and Patient was "still yelling." b. A note documented by PCT 6 which indicated Patient's ICHD treatment ended 13 minutes early due to Patient "feeling mistreated." Charge Nurse 4 had gone to Patient's chairside to discuss Patient needing a fistulagram and Patient began "talking mean" to the nurse. Patient was upset and stated "nothing was done for 6 weeks, why yell at [Patient] now. Patient was constantly telling [Charge Nurse 4] to quit yelling at [him/her] and get out of [his/her] face." Charge Nurse 4 had moved on to speak with another patient, yet Patient continued to be "very rude and disrespectful." PCT 6 documented Patient stated he/she "had enough of this clinic today and demanded off" treatment. The technician documented he/she overheard Patient talking to a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	nearby patient "about how terrible [facility staff] are." c. A note documented by Clinic Manager 1 which indicated the manager had received "several calls ... regarding [Patient's] outburst and racial slurs." CM 1 notified Administrator and MSW 1 of the incident and planned to speak with Patient the next week to "set up a meeting." d. A note documented by RN 3 which indicated the nurse overheard Patient telling another patient that staff "always run to take care of" white patients. RN 3 documented Patient was "consistently bullying staff and making racial slurs." The review of a personal statement from PCT 7, dated 12/23/23, indicated Patient #4 wanted to file a grievance regarding Patient #5's inappropriate behaviors. Patient #4 reportedly told PCT 7 that Patient #5's "outbursts are too much" and Patient #4 was considering transferring to another facility because he/she felt they could not "deal with this shit every day." The facility's grievance log included a grievance from Patient #4 logged on 12/28/23 by Clinic Manager 1. The manager indicated Patient #4 gave the employee a written personal statement "regarding concerns about [Patient #5] treating staff poorly and being disruptive in clinic." The review of an undated personal statement from Patient #4 recounted the interaction between Patient #5 and Charge Nurse 4 on 12/21/23. Patient #4 wrote Patient #5 made [him/her] "sick! Every time I come to dialysis, I'm scared [Patient #5 will] start yelling about something ... All [Patient #5] does is complain ... [he/she] would talk smack the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	whole time. I don't wanna [sic] move anywhere. But I also don't want to have to listen to [Patient #5]. I've been thinking of moving to a different [dialysis facility] ...." Patient #5's clinical record included 3 Clinical Notes documented on 1/11/24 by multiple staff members. These included: a. A note documented by PCT 2 which indicated the technician overheard Patient #5 saying to another patient "the [technicians] always have a reason to be on the other side of the [treatment] floor when it's my time to [come off treatment]." b. A note documented by Clinic Manager 1 which indicated the manager asked to speak with Patient as he/she was leaving the facility. When Patient queried as to the reason the manager wanted to speak, CM 1 stated it was to "address some of your concerns." Patient responded "no" but was agreeable to meeting on 1/18/24. c. A note documented by Secretary 1 which indicated the employee overheard the above conversation between Patient and Clinic Manager 1. Patient then sat in the facility's lobby for "over 10 minutes" speaking with another patient. Secretary 1 overheard Patient #5 telling the other patient that he/she "did have time to talk to [Clinic Manager 1] but [he/she] wasn't going to," nor was Patient #5 planning to talk to CM 1 during the 1/18/24 scheduled meeting. Patient reportedly stated "why should I talk to [CM 1] about concerns when [the manager] doesn't give a damn about me ... I'm not wasting my time talking to that white girl." The record included a Clinical Note, documented on 1/18/24 by CM 1, which indicated the manager,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	MSW 1, and Patient #5 met after Patient's treatment. The manager's goals for the meeting were to review Patient's recent concerns, the facility's concerns with Patient's inappropriate behaviors, and initiate a behavioral agreement for Patient. During the meeting, Patient voiced concerns regarding the "length of time it took" to get an appointment with a hematologist, which Medical Director had previously suggested due to Patient's elevated Hemoglobin and several instances of clotting while on dialysis. CM 1 documented Patient "did not want to listen" when the manager attempted to explain the reason for the perceived delay in scheduling. The manager told Patient the facility staff wanted to "discuss concerns from staff and other patients about the way [Patient] is talking to and treating staff." Patient reportedly "became angry and began to get loud. Patient did not want to listen and would not stop talking." The manager asked to discuss the clinic's concerns and Patient's rights and responsibilities, however Patient reportedly stated, "Your 5 [minutes] are up, I have to leave." CM 1 documented Patient then sat in the lobby for 10 minutes "complaining about [the facility] to another patient" before leaving. The record included a Progress Note, documented on 1/18/24 by MSW 1, which recounted the above meeting with Patient, the social worker, and CM 1 on 1/18/24. The social worker documented Patient left the meeting prior to staff presenting or reviewing Patient's behavioral agreement. MSW 1 documented the behavioral agreement was to be mailed to Patient using certified delivery. The record included a "Behavioral Agreement," dated 1/18/24, which indicated Patient was instructed "the following areas are in need of improvement: Appropriate communication of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	presented concerns. No loud (above a conversational tone) verbal communication. No abusive, threatening, or derogatory verbal or physical communication." The behavioral agreement indicated to prevent further behaviors or circumstances, the facility would implement the following interventions: a. Patient would be "given a warning that [his/her] behavior/communication is inappropriate" and would be given an opportunity to re-phrase his/her communication. If Patient's inappropriate behavior and/or communication persisted despite the warning, his/her "dialysis treatment will be terminated, and [Patient] will be taken off the machine." b. The facility would complete an unstable care plan for Patient and "progress/concerns will be evaluated during the care plan process for 3 months." c. Patient would be referred for outpatient mental health counseling. The behavioral agreement indicated if "none of these actions are taken to prevent the disruptive behavior and another incident occurs, the following will happen: If your behavior results in 3 or more instances of staff having to end your treatment, your behavior will be evaluated for further interventions up to and including discharge" from the dialysis facility. The behavioral agreement indicated it was a part of Patient's plan of care and would be reviewed with Patient in 30 days. Clinic Manager 1 signed the document and indicated Patient refused to sign. The record included a Progress Note, documented on 1/23/24 by MSW 1, which indicated the social			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	worker met with Patient to complete the social worker portion of Patient's comprehensive assessment and follow up from the 1/18/24 meeting with Patient and Clinic Manager 1. MSW 1 documented he/she assessed Patient's mental health status and Patient "firmly denied" being depressed. Patient reported to MSW 1 that he/she was having "increased anxiety" regarding his/her medical issues and was receptive to speaking with his/her primary care provider (PCP) about starting anti-anxiety medication. During the meeting with MSW 1, Patient requested a meeting with Medical Director to discuss concerns with his/her medical care. During an interview with Secretary 1 on 3/13/24 beginning at 8:25 AM, the secretary reported Patient #5 was observed via security camera taking 1 jar of petroleum jelly and a word search book from the Dialysis Dollars cabinet on 1/23/24. Patient's clinical record failed to evidence this observation nor facility staff's attempts to discuss the stealing with Patient. The record included a Progress Note, dated 1/25/24 by MSW 1, which indicated the social worker met with Patient. During the meeting, Patient reported he/she made an appointment with his/her PCP "to discuss getting on anti-anxiety medications." MSW 1 documented he/she had scheduled an appointment with Patient and Medical Director for 2/01/24. The review of a certified mail receipt indicated Patient received the mailed behavioral agreement on 1/25/24. The review of Patient's in-center treatment flowsheets between 1/18/24 - 2/01/24 failed to evidence Patient was given a warning by staff nor			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	was Patient's treatment terminated early for inappropriate behaviors and/or communication. The record included a Clinical Note, documented on 1/30/24 by PCT 7, which indicated Patient asked if the technician was supposed to fold Patient's blankets. PCT 7 responded "if you ask or want me to." Patient then stated "So I'm the only one who has to ask? Nobody else has to ask?" PCT 7 documented he/she packed Patient's belonging then Patient "ripped" the bag from the technician. The facility's Grievance Log included a grievance from Patient #25 documented as received on 1/30/24 by Charge Nurse 4. Patient #25 reported he/she was "tired of hearing [Patient #5] complain and be so mean to staff." Clinic Manager 1 documented he/she spoke with Patient #25 regarding the grievance on 2/02/24, and Patient #25 stated "all [Patient #5] does is make everyone miserable including me and other patients ... I would really like to be moved away from [Patient #5]. I like it here and your staff, but I can't listen to this anymore." The clinic manager documented Patient #25 was initially moved to a chair on the other side of the treatment floor, then changed to a different treatment schedule starting 2/09/24. Patient #5's clinical record included a Progress Note, documented on 2/01/24 by Medical Director, which indicated the physician and Patient met to discuss Patient's concerns with his/her medical care. The record failed to evidence Physician discussed Patient's progress with the behavioral agreement nor potential for involuntary discharge if inappropriate behaviors continued. The record included a Clinical Note, documented on 2/01/24 by Secretary 1, which indicated as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	Patient was leaving the facility, he/she called the employee a "stupid white bitch." The secretary notified Clinic Manager 1, Administrator, and Medical Director during the facility's Quality Assurance and Performance Improvement (QAPI) meeting. The record indicated the facility's IDG updated Patient's plan of care (POC) on 2/01/24 due to Patient being on a behavioral agreement. Prior to this POC meeting, Patient's POC had last been updated on 3/28/23. The plan of care evidenced the following: a. Within the focus area "Change in Mental Status," Charge Nurse 4 documented on 1/31/24 "[Patient] has become increasingly more agitated and vocal with staff." The facility's intervention for this focus area was to refer Patient to the social worker. During an interview with Charge Nurse 4 on 3/13/24 beginning at 2:46 PM, the nurse reported the above note was regarding Patient's increasing agitation and behaviors over the several months prior to the plan of care meeting held on 2/01/24. The nurse reported Patient did not have any instances of inappropriate behaviors or communication requiring his/her treatment to be terminated either prior to or after the behavioral agreement was initiated, however Patient did continue to "verbally insult" staff. b. Within the focus area "Emotional/Mental Health," MSW 1 documented a goal on 1/23/24 for Patient's KDQOL scores to "improve and/or mental health symptoms and/or disruptive behaviors will be minimized." The facility's interventions for this focus area included "Patient already followed by psychiatry or PCP for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	depression symptoms, IDT will continue to monitor ... Provide short term counseling ... Monitor and assist to modify disruptive behavior ...." MSW 1 documented a "patient meeting to discuss concerns and behavioral contract" was held on 1/18/24. c. Within the focus area "Coping Adjusting to Dialysis Issues," facility interventions included but were not limited to referring Patient "for other mental health services." MSW 1 documented counseling referrals were "sent" with Patient's behavioral agreement and the social worker discussed anti-anxiety medication with Patient during his/her comprehensive assessment. During an interview with Clinic Manager 1 on 3/12/24 beginning at 2:34 PM, the manager reported Patient was designated as "unstable" after Patient had a behavioral agreement initiated 1/18/24. Patient had not been designated as "unstable" due to inappropriate behaviors prior to January 2024. CM 1 confirmed the POC updated 2/01/24 was the first update to the POC after Patient had a behavioral agreement enacted and Patient was designated unstable. The record included a Clinical Note, documented by Administrator on 2/01/24, which indicated "in-depth" discussions were held with Medical Director and the IDT regarding "Patient's behavior ... behavior contract, lobby instances, and [other] patient grievances regarding [Patient #5]." The Medical Director gave a verbal order for Patient to be involuntarily discharged to due "behavior." The review of the minutes for the facility's Governing Body meeting held 2/01/24 evidenced Medical Director, Administrator, Clinic Manager 1, and Home Therapy Manager 6 were present for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	the meeting. The Governing Body discussed Patient #5's behavioral agreement along with "new [involuntary discharge] recommendation." The minutes indicated the Governing Body agreed to the involuntary discharge of Patient #5 based on "several patient complaints and stealing from clinic." The record included a "Patient Discharge Letter," dated 2/02/24, which indicated Patient was to be involuntarily discharged from the facility and would be unable to received dialysis treatment after 3/03/24. The discharge letter indicated Patient was being discharged due to exhibiting "behavior that is disruptive and abusive to the extent that it impairs the delivery of care to you or the ability of the facility to operate effectively; the facility can no longer meet your documented medical needs." The discharge letter indicated Patient had been "given the opportunity to rephrase [his/her] communication appropriately to staff ... offered mental health services, and ... given the opportunity to meet with the clinic leaders to express your concerns." The discharge letter indicated these interventions had "not been utilized" and Patient had continued to "use inappropriate/threatening language on the treatment floor." The continued behaviors resulted in other patients and employees feeling "uncomfortable." The letter also indicated Patient had also been found on camera "taking things" from the Dialysis Dollars cabinet "without staff assistance." The record included a Progress Note, dated 2/02/24 by MSW Manager 5, which indicated the discharge letter was sent by certified mail to Patient on 2/02/24. A copy of the outgoing certified mail receipt indicated the letter was postmarked by a local post office on 2/07/24. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	record failed to evidence the facility received confirmation the discharge letter was delivered to Patient, nor was Patient informed by facility staff of the involuntary discharge. The record included a Clinical Note, dated 2/16/24 by Clinical Manager 1, which evidenced CM 1 offered to assist Patient with transferring to another dialysis clinic. This was the first documented attempt by facility staff to offer such assistance. The record indicated Patient's last dialysis treatment at the facility was on 3/02/24. During an interview with Clinic Manager 1 and Administrator on 3/12/24 beginning at 12:25 PM, the clinic manager reported Patient #5 had a history of inappropriate behaviors, including swearing, name calling, and making accusations of staff being racist, since starting at the facility. Patient's behaviors were directed towards facility staff. CM 1 reported staff had been "dealing" with Patient's behaviors, but recently, the facility had begun to receive complaints from other patients regarding Patient #5's behaviors. One of the complainants, Patient #4, reported he/she would leave the facility if nothing was done regarding Patient #5's behaviors. The facility enacted a behavioral agreement for Patient #5 due to the inappropriate behaviors, but Patient refused to review nor sign the agreement with the manager. Around the same time, the clinic's lobby was vandalized, and security cameras were installed. Approximately 1 week after cameras were installed, Patient #5 was seen via security camera "stealing" crossword puzzle books from the Dialysis Dollars cabinet. Clinic Manager 1 reported he/she attempted to speak with Patient #5 after the alleged stealing, however Patient			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	became angry and left the facility. During an interview with Medical Director on 3/13/24 beginning at 9:27 AM, the physician reported the facility had received multiple reports about Patient's inappropriate behavior and being verbally abusive towards staff. The behavior had gotten worse over the last year and was interrupting the care of other patients. Medical Director reported Patient was given a behavioral agreement "weeks" before the involuntary discharge. The physician reported he/she did not review the behavioral agreement. Medical Director could not recall any instances where Patient's dialysis treatment was terminated early due to behaviors occurring during treatment. Medical Director reported during his/her meeting with Patient #5 on 2/01/24, the physician reviewed Patient's multiple complaints against the facility but did not discuss Patient's behavioral agreement nor potential for involuntary discharge if behaviors continued. After the meeting with Patient, Medical Director reported he/she attended the facility's QAPI meeting, and Patient's continued behaviors were discussed, including Patient being heard calling staff "bitches" and seen stealing from the Dialysis Dollars cabinet. Medical Director reported the facility staff discussed involuntary discharge, but a final decision was not made until later that day, when Clinic Manager 1 informed Medical Director that Administrator and corporate staff had "demanded" Patient be involuntarily discharged. Medical Director reported Patient was involuntarily discharged due to reports of continued inappropriate behaviors, continued complaints from other patients, and evidence of Patient stealing from the facility. During an interview with PCT 2 on 3/13/24			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	beginning at 3:14 PM, the technician reported he/she was instructed by the facility's administrative staff to terminate Patient #5's treatment early if Patient became "aggressive." PCT 2 reported he/she did not have any instances where this occurred. The technician reported Patient's inappropriate behaviors tended to happen while Patient was being taken off dialysis, so the technician felt this intervention within the behavioral agreement was counterproductive. During an interview with RN 1 on 3/13/24 beginning at 3:27 PM, the nurse reported he/she was instructed by the facility's administrative staff to terminate Patient #5's treatment early if Patient "became loud." RN 1 reported he/she did not have any instances where this occurred. The nurse stated Patient's behavior remained "the same" until the "last few weeks," after which Patient became "quiet." During an interview with PCT 3 on 3/13/24 beginning at 3:31 PM, the technician reported he/she was instructed by the facility's administrative staff to terminate Patient #5's treatment early if Patient became "combative." The technician was not aware of any instances where this occurred. During an interview with RN 2 on 3/13/24 beginning at 3:34 PM, the nurse reported he/she was instructed by the facility's administrative staff to give Patient #5 a warning if he/she was "yelling out," and if the behavior "escalated," he/she would terminate Patient #5's treatment early. The nurse reported Patient was "pleasant" after the behavioral agreement was initiated. During a follow-up interview with CM 1 and Administrator on 3/13/24 beginning at 3:54 PM,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	the clinic manager reported after Patient #5's behavioral agreement was initiated, floor staff were advised if Patient #5 had an "outburst" during treatment, staff were to attempt to redirect Patient and give a warning. If Patient's behavior continued, he/she was to be taken off treatment early. CM 1 reported this was the same procedure staff were to follow with any patient who exhibited inappropriate behaviors during treatment. Staff were also advised to document all of Patient #5's inappropriate behaviors and/or communication. CM 1 reported after Patient was mailed the behavioral agreement, Patient became quieter and there were no instances of Patient's treatment ending early due to behaviors. The manager reported patient continued to "make comments" when walking out of the treatment area and when speaking to other patients, including calling staff names and accusing them of being racist. CM 1 reported on 2/01/24, Patient had his/her treatment, met with Medical Director, then left the facility. The IDT team, including Medical Director, CM 1, Administrator, Charge Nurse 4, and MSW Manager 5, conducted a plan of care meeting. The facility's QAPI committee and Governing Body then held a meeting during which the employees present discussed Patient's inappropriate behaviors had continued. Patient was continuing to "scream" in the lobby and call staff names. Patient had also been seen on security camera stealing items from the Dialysis Dollars cabinet. Administrator reported because of these behaviors, the administrative staff felt patient had "violated" his/her behavioral agreemen t, and decided to involuntarily discharge Patient. CM 1 reported Patient's plan of care and/or behavioral agreement were not revised to reflect the facility's concerns with theft and/or patient's inappropriate			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	communication/behaviors with other patients and in the lobby. Administrator reported Patient was not informed of the involuntary discharge in person due to Patient's history of "explosive" behaviors. The administrative staff decided to notify Patient of the involuntary discharge via a discharge letter sent through certified mail on 2/03/24. The facility did not receive confirmation the letter was delivered. CM 1 reported the facility staff "assumed" Patient received the discharge letter because Patient was overheard telling another patient that the facility was "kicking [him/her] out" and was afraid he/she would not have another clinic to go to. CM 1 reported after Patient was overheard mentioning the discharge on 2/16/24, the manager offered to assist Patient with finding another dialysis clinic. During a second follow-up interview with Clinic Manager 1 and Administrator on 3/14/24 beginning at 1:41 PM, CM 1 reported Patient did not have a history of inappropriate behaviors or communication occurring during treatment which required Patient to have his/her treatment ended early. The facility staff was concerned once Patient received the behavioral agreement, he/she would have worsening behaviors while on treatment, so the facility included the interventions regarding Patient's treatment being ended early if inappropriate			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	behaviors were observed during treatment. When queried how the facility informed Patient that name calling, swearing, and accusations of racism in areas outside of the treatment floor and when interacting with other patients, as well as stealing from the facility, could lead to involuntary discharge, Administrator reported the behavioral agreement indicated this in the section which began "if none of these actions are taken to prevent the disruptive behavior and another incident occurs, the following will happen ...."During an interview with MSW 1 on 3/14/24 beginning at 7:30 AM, the social worker reported Patient #5 had a long history of "dissatisfaction" with the facility. Patient's issues began to become more frequent and staff were unable to resolve them, which led to Patient becoming verbally abusive towards staff and disruptive on the treatment floor. The facility initiated a behavioral agreement so the allegations against Patient were not a "he-said, she-said" and there were "consequences" if Patient's behaviors continued. MSW 1 reported during his/her visit with Patient on 1/23/24, the social worker attempted to discuss the 1/18/24 meeting, however Patient continued to express multiple complaints about his/her care, so the social worker allowed Patient to "vent." MSW 1 reported Patient was agreeable to speaking			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	with his/her PCP about starting anti-anxiety medication, and the social worker thought Patient had made an appointment with his/her PCP for the end of March. MSW 1 reported he/she did not discuss Patient's behaviors or the behavioral contract with Patient after the 1/18/24 meeting because he/she wanted things to "cool down" for "a week or 2." MSW 1 reported he/she did not hear any reports of Patient exhibiting any inappropriate behaviors after Patient's behavioral agreement was initiated. The social worker had a leave of absence from the facility between 1/26/24 - 2/28/24 and was not involved in Patient's involuntary discharge. During an interview with MSW Manager 5 on 3/13/24 beginning at 4:20 PM, the social work manager reported he/she did not have any direct interaction with Patient #5. The manager reported he/she did not have access to Patient's record, so the events recalled were based off his/her memory. MSW Manager 5 stated on 1/23/24, Patient was found stealing items from the Dialysis Dollars cabinet. Patient also had a history of making "derogatory" comments, swearing, and being "negative" on the treatment floor. MSW Manager 5 reported after Patient was observed stealing from the facility, a behavioral agreement was implemented. The social work manager reported "1-2 weeks" later, the facility			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	received additional grievances from other patients regarding Patient #5's language on the treatment floor. MSW Manager 5 reported the facility had a meeting on 2/01/24 to discuss Patient's behaviors, during which staff discussed that Patient had "broke" his/her behavioral agreement due to stealing and using derogatory language towards staff and peers. The facility then decided to move forward with an involuntary discharge. MSW Manager 5 reported he/she was not present for the meeting when the facility decided to involuntarily discharge Patient. Corporate Employee 2, who was MSW Manager 5's supervisor, was reportedly present for this meeting. The social work manager reported a discharge letter was sent via certified mail to Patient, but it was returned, so the facility provided Patient with a hard copy of the discharge letter. During an interview with Patient #5 on 3/13/24 beginning at 10:12 AM, the patient reported he/she had a meeting with Clinic Manager 1 and was given a "warning" due to other patients feeling threatened by Patient's behaviors. Patient reported he/she was not informed by the facility that he/she was at risk of being involuntarily discharged. Patient reported Medical Director did not discuss Patient's behaviors nor potential for involuntary discharge during their meeting held 2/01/24. Patient reported several days			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	after his/her meeting with Medical Director, he/she received a letter in the mail informing Patient that Medical Director and his/her practicing partners would no longer be managing Patient's dialysis care due to Patient being "rude ... disrespectful." Patient reported he/she was not notified directly by the dialysis facility of the involuntary discharge. Patient stated he/she was unable to establish with a new dialysis clinic prior to his/her last dialysis treatment at Fresenius Medical Care Fort Wayne Jefferson. Patient reported he/she continued to search for a new dialysis clinic after 3/02/24, but was unsuccessful, and missed 2 dialysis treatments. Patient reported due to missing 2 treatments and not having a dialysis clinic, he/she went to Entity A, a local Emergency Department and hospital, on 3/07/24 to request dialysis. Patient reported he/she had to be admitted to Entity A in order to receive dialysis. The review of Patient #5's medical record from Entity A indicated Patient presented to Entity A's Emergency Department on 3/07/24 requesting to receive dialysis. Patient reported he/she had not received dialysis since 3/02/24 and had missed 2 treatments. The record indicated Patient was admitted to Entity A's hospital, received dialysis, and was discharged on 3/08/24.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
V 0544 Bldg. 00	494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. Based on record review and interview, the dialysis facility failed to ensure the in-center hemodialysis (ICHD) patient's prescribed blood flow rate (BFR) was followed during treatment for 1 of 6 ICHD records reviewed (Patient #3). Findings include: The review of Patient #3's clinical record included a dialysis prescription order, dated 2/09/24, which indicated Patient's BFR was to be 350 milliliters per minute (ml/min). The record included a treatment flowsheet for Patient's treatment on 3/15/24 which indicated Patient Care Technician 1 and Registered Nurse (RN) 2 confirmed Patient's dialysis settings. The flowsheet evidenced Patient's BFR during his/her treatment was 400 ml/min. The flowsheet failed to evidence staff obtained an order to change Patient's BFR. During an interview with Registered Nurse (RN) 2 on 3/18/24 beginning at 3:35 PM, the nurse confirmed he/she was Patient #3's nurse during the 3/15/24 treatment and Patient's ordered BFR was 350 ml/min. The nurse was unsure why Patient's BFR during his/her treatment on 3/15/24 was 400 ml/min and stated this was a "mistake." During an interview with Clinic Manager 1 and Administrator on 3/18/24 beginning at 3:50 PM, the clinic manager reported the ICHD patient's	V 0544	V544 POC-Achieve adequate clearance On or before 04/10/2024, the Facility Administrator will hold a staff meeting, elicit input, and reinforce the expectations and responsibilities of the facility staff on Policies & Procedures. Please see the list of Policies and procedures or processes reviewed at the bottom of the plan. Emphasis will be placed on: Ensuring prescription is set per physician order or documented rationale for variance from prescription (Blood Flow Rate) Effective 04/11/2024, the Facility Administrator or Charge Nurse will conduct daily audits of 10% of treatment sheets utilizing Medical Records Audit tool for 2 weeks. Once compliance is sustained, the Governing Body will decrease frequency to weekly for 2 weeks then resume regularly scheduled audits based on the QAPI calendar. Monitoring will be done through the Medical Records Audit. The Medical Director will review the results of audits each month	04/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	BFR should adhere to the Patient's orders.		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 review at the clinic. Patient Assessment and Monitoring Initiation of Treatment Using a Central Venous Catheter and Optiflux Single Use Ebeam	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
			Dialyzer Initiation of Treatment Using a Arteriovenous Graft or Fistula and Optiflux Single Use Ebeam Dialyzer Completion Date: 4/20/24	
V 0547 Bldg. 00	494.90(a)(4) POC-MANAGE ANEMIA/H/H MEASURED Q MO The interdisciplinary team must provide the necessary care and services to achieve and sustain the clinically appropriate hemoglobin/hematocrit level. The patient's hemoglobin/hematocrit must be measured at least monthly. The dialysis facility must conduct an evaluation of the patient's anemia management needs. Based on record review and interview, the dialysis facility staff failed to ensure staff followed its anemia management algorithm when adjusting a patient's Mircera dosage for 1 of 3 in-center hemodialysis (ICDH) records reviewed for anemia management (Patient #4). Findings include: The review of the facility policy titled "Corporate MAB Recommended Anemia [CMAB] Algorithm - Mircera IVP [IV push] Administration (In Center Only) Version 4.0," revised 09/07/17, indicated Mircera (an erythropoiesis-stimulating agent (ESA) medication used to treat anemia) would be dosed according to the patient's hemoglobin level (blood test used to assess the number of red blood cells). The policy indicated the facility nurse was to consult with the physician and/or nurse practitioner "when nurse believes that,	V 0547	V547 POC-Manage anemia/H/H measured q mo On 04/10/2024, the Facility Administrator will hold a nursing meeting, elicit input, and reinforce the expectations and responsibilities of the facility staff on Anemia Management processes. Please see the list of Policies and procedures or processes reviewed at the bottom of the plan. Emphasis will be placed on: Timely adjustments/restarts to Mircera dosing dependent on hemoglobin results. Effective 04/11/2024, the Facility Administrator or Charge Nurse will conduct weekly audits utilizing the Anemia Facility Summary Report for 4 weeks.	04/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	based on assessment of the patient's condition, it may not be appropriate to follow the algorithm" If a patient's hemoglobin was greater than 11.2, staff were to hold the Mircera and check the patient's hemoglobin weekly. The Mircera was to be restarted if the patient's hemoglobin fell less than or equal to 11.1. The policy also indicated if a patient was hospitalized, the Mircera was to be discontinued. Once the patient returned from his/her hospitalization, the patient's hemoglobin level should be checked and the Mircera resumed according to the algorithm's dosing chart. The review of Patient #4's clinical record evidenced an order for facility staff to adjust Patient's Mircera dose according to the facility's "CMAB Recommended Anemia Algorithm for Mircera." The record evidenced the following: a. On 1/23/24, Patient's hemoglobin level was 12.1 and the facility placed Patient's Mircera on hold according to the Mircera algorithm. b. On 1/30/24, 2/06/24, and 2/22/24, Patient's hemoglobin was 12.1 or greater. c. On 2/27/24, Patient's hemoglobin level was 12.2. d. On 3/05/24, Patient's hemoglobin level decreased to 10.5. The record failed to evidence Patient's Mircera was restarted according to the algorithm. e. On 3/09/24, Patient's hemoglobin was 10.8. The record indicated Patient's Mircera continued to be held. f. On 3/12/24, Patient's hemoglobin was 9.8. g. On 3/14/24, Patient's Mircera was ordered to be		Once compliance is sustained, the Governing Body will decrease frequency to resume regularly scheduled audits based on the QAPI calendar. Monitoring will be done through the Anemia Facility Summary Report. 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 of the issues.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	resumed and the medication was administered on 3/16/24. The review of the facility's log of treatment absences and hospitalizations from 3/12/23 - 3/12/24 evidenced Patient #4 was absent due to hospitalization on 2/20/24. The record failed to evidence any further absences in February or March 2024 for Patient. During an interview with Clinic Manager 1 on 3/21/24 beginning at 10:20 AM, the clinic manager reported he/she was responsible for reviewing ICHD patients' hemoglobin levels and adjusting the Mircera dosage according to the facility's Mircera algorithm. Clinic Manager 1 reported he/she did not resume Patient's Mircera on 3/05/24 because Patient's hemoglobin "runs high" and he/she was above the facility's goal hemoglobin level of 10. The manager reported Patient had also recently been discharged from an inpatient stay on 2/17/24. The nurse reported he/she obtained an order from the physician or nurse practitioner to continue to hold Patient's Mircera on 3/05/24. Clinic Manager 1 could not produce documentation of the order.		The QAPI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic. Corporate MAB Recommended Anemia Algorithm Mircera IVP Administration (InCenter Only) Version 4.0 Mircera® Algorithm InCenter 4.0 Quick Reference Guide Completion Date: 4/20/24	
V 0580 Bldg. 00	Based on record review and interview, the dialysis facility failed to ensure the patient and/or primary caregiver had completed his/her training on home hemodialysis prior to performing dialysis without nursing supervision (See Tag V582), failed to ensure staff noted and discussed with the patient and/or caregiver any non-adherence to the dialysis prescription (see Tag V587), and failed to develop and periodically review the home therapy	V 0580	V580 - CfC: 494.100 Care at Home 494.100 Care at Home The Governing Body on, 04/08/2024, reviewed the Statement of Deficiencies and developed the following Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution.	04/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	patient's individualized plan of care, ensuring it specified the services necessary to address the patient's needs (see Tag V591). Based on record review and interview, the home therapy registered nurse failed to coordinate the home dialysis patient's care specific to timely notifying the patient's physician and social worker of concerns with poor sanitary conditions in the patient's home (See Tag V590). Based on record review and interview, the dialysis facility's interdisciplinary team (IDT) failed to oversee and manage the home peritoneal dialysis (PD) patient's care, specific to assessing the patient for appropriateness of home therapy and addressing poor sanitary conditions and non-compliance with the dialysis treatment plan, which resulted in the patient being at increased risk of developing peritonitis, for 1 of 2 records reviewed of home PD patients who developed peritonitis (Patient #7). Due to the scope and the severity of the findings, Fresenius Medical Care Fort Wayne Jefferson failed to administer and manage the home dialysis patient's care, which resulted in the facility being found out of compliance with Condition for Coverage 42 CFR 494.100 Care at home. Findings include: The review of a facility policy titled "Home Peritoneal Patient Selection and Assessment Criteria," dated 7/01/19, indicated prior to acceptance into the facility's home dialysis training program, "the home therapies team with the patient's physician will evaluate the patient and/or patient's care partner to ensure there are no medical problems that would make dialysis at		The Governing Body began meeting weekly beginning 04/12/2024, to review the results of the progress on the Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The Governing Body will determine when the frequency of these meetings may be reduced to the regular quarterly schedule. Effective immediately: The Home Therapy Program Manager will analyze and trend all data and monitor/audit results as related to this Plan of Correction prior to presenting the monthly data to the QAPI Committee. A specific plan of action encompassing the citations as cited in the Statement of Deficiency has been added to the facility's monthly QAPI (Quality Assessment and Performance Improvement) agenda. The QAPI Committee is responsible to review and evaluate the Plan of Correction to ensure it is effective and is providing resolution of the issues. The Director of Operations (DO) will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	home a poor choice for this patient. The evaluation will include assessment of stability (medically, physically, psychologically, mentally, emotionally, etc.) and suitability (medically, physically, psychologically, mentally, emotionally, etc.) to perform dialysis safely and effectively at home. Factors which staff were to evaluate "for transition to home peritoneal dialysis" included but were not limited to "visual acuity." Criteria to be included in the evaluation of suitability of a patient for home peritoneal dialysis included but were not limited to "an appropriate place to do the treatments in the home setting ... a stable home environment: medical, physical, psychological, emotional. Results of the home visit ...." The policy referenced facility policy titled "Home Visits for Home Peritoneal Dialysis" for information regarding home visit requirements. The review of facility policy #23561 titled "Home Visits for Home Dialysis Patients," dated 7/03/23, indicated "conducting a home visit early in the home referral, admission, or training process can be helpful to identify and address barriers to success that could be resolved prior to the initiation of home dialysis." A home visit was required to be completed at the "initiation" of home peritoneal dialysis "to assess the home environment and verify adaption to home therapy." A home visit to "assess the home environment, evaluate safety, and identify possible changes needed to accommodate home dialysis may be conducted at any time during the patient's home dialysis tenure ...." The policy indicated "concerns or problems noted during a home visit should be reported" by the home therapy nurse "as appropriate to the physician." The review of facility policy #48409 titled "Home Therapies Patient Non-Adherence," dated 9/06/21,		The Governing Body, at its meeting of 04/08/2024, designated the Director of Operations (DO)to serve as Plan of Correction Monitor and provide additional oversight. They will participate in QAPI and Governing Body meetings. This additional oversight is to ensure the ongoing correction of deficiencies cited in the Statement of Deficiency through to resolution as well as ensure the Governance of the Facility is presented current and complete data to enhance their governance oversight role. Minutes of the Governing Body and QAPI meetings, as well as monitoring forms and educational documentation will provide evidence of these actions, the Governing Body's direction and oversight and the QAPI Committees ongoing monitoring of facility activities. These are available for review at the facility. The responses provided for V582, V587, V591, and V590 describe, in detail, the processes and monitoring steps taken to ensure that all deficiencies as cited within this Condition are corrected to ensure ongoing compliance. Completion Date: 4/20/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	indicated due to a home therapy patient's responsibility "for carrying out much of their own dialysis treatment plan, non-adherence to components of the plan may limit its effectiveness and create safety concerns." The policy indicated the interdisciplinary team (IDT)'s clinical assessment should include a review of the patient's adherence to the prescribed home dialysis treatment plan. This review should include an "evaluation of the patient's demonstrated behaviors in the following components: Completing the prescribed frequency and duration of dialysis treatments ... Performing dialysis related tasks as trained ... Taking medications as prescribed." The policy defined "complex non-adherence" as "isolated, intermittent, or repeated behavior(s) ... [which] produces a real or potential safety concern in which the patient's ability to safely remain on their current home modality requires review." Examples of complex non-adherence included but were not limited to "Disregard for performing required steps or safety checks ... Failure to perform all or a significant portion of their prescribed treatment(s) ... Refusing to meet with the IDT ...." The policy indicated if patient behaviors rose to the level of complex non-adherence "despite efforts by the IDT to engage the patient ... in education, counseling, support, and interventions," the facility was to follow its procedure titled "Home Therapies Escalation Ladder Guide to Addressing Non-adherent Behavior." The review of facility procedure #60495 titled "Home Therapy Non-Adherence Escalation Ladder," dated 9/06/21, indicated the procedure was to be started when a home therapy patient's non-adherent behavior persisted "despite efforts made by the IDT to engage, educate, and counsel the patient ...." The patient's nephrologist was to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	be consulted regarding the non-adherent behavior and the IDT was to "collaborate to evaluate patient trends." The patient and facility staff, including physician, registered nurse, social worker, dietician, and home therapy manager, were to set up an IDT meeting to review the concerns with the patient. The meeting should include reviewing the patient's signed "home responsibility consent form" with the patient, "identify root causes and safety concerns," and consider "back-up for respite, if appropriate." The review of Patient #7's clinical record indicated an admission date of 12/12/23. Prior to admission, Patient received in-center hemodialysis at a sister dialysis facility and expressed interest in changing to home peritoneal dialysis. Patient had a Tenckhoff catheter (tube surgically placed in the lower abdomen used for PD) and began his/her PD training at the Fresenius Medical Care Fort Wayne Jefferson home therapy clinic on 12/12/23. The record indicated Patient lived alone, was his/her own caregiver, and had a left below-the-knee amputation. The record included a Comprehensive SW (Social Work) Assessment, dated 10/19/23 and completed by Medical Social Worker (MSW) 1 while Patient was receiving ICHD at a sister dialysis clinic. The assessment indicated Patient was "in [the] process" of getting set up with home health care" through Medicaid waiver services. The record failed to evidence an assessment of Patient's appropriateness for home therapy was conducted by Fresenius Medical Care Fort Wayne Jefferson staff prior to Patient transferring to the clinic. The record included a Clinical Note, dated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	12/20/23 and documented by Home Therapy Registered Nurse (HT RN) 4, which indicated HT RNs 4 and 5 completed an initial home visit with Patient #7 on 12/20/23. This was after Patient had completed 4 days of PD training in the dialysis home therapy clinic. The clinical note failed to evidence the home therapy nurses observed any concerns with Patient's home environment. The record included a "Patient Home Environment Evaluation," signed by HT RN 4 and Patient on 12/21/23. The evaluation form failed to evidence the home therapy nurse documented any concerns with Patient's home environment. The record included a Clinical Note, dated 1/19/24 and documented by HT RN 4, which indicated the nurse completed a home visit with Patient as part of a skills evaluation on automated peritoneal dialysis (APD, a type of peritoneal dialysis where a machine called a "cycler" is used to perform the dialysis exchanges). HT RN 4 documented Patient's home was "a concern. Patient has limited sight and mobility. Patient uses a bed toilet at night and empties in the AM. [The nurse] found used toilet paper on the boxes of [dialysate] solution. Stool on floor ...." HT RN 4 indicated he/she would "speak with social worker to see if any help can be provided to help patient take care of [his/her] house." The record included a Comprehensive SW Assessment, completed on 1/22/24 by MSW 2, which indicated Patient lived alone and his/her living situation was not a "barrier to treatment outcomes." The social worker indicated Patient had neuropathy and had applied to move to a nearby city "for greater family support," but the waitlist for the new apartment "may extend into May." MSW 2 documented Patient wanted to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	"regain" his/her Medicaid insurance. The record included a Clinical Note, dated 1/24/24 and documented by HT RN 4, which indicated the nurse notified Medical Social Worker (MSW) 2 of his/her "concerns regarding patient's living conditions ... patient has feces on the floor of [his/her] apartment, trash everywhere and food on the counter tops." MSW 2 reportedly stated Patient was in the process of getting his/her Medicaid "reinstated" and once this was completed, the patient would contact his/her case manager for waiver services. These services could include home health services, but Patient was "not eligible" until his/her Medicaid was reinstated. The social worker reported Patient might also qualify for services from League for the Blind-Disabled ("The League"). MSW 2 had provided Patient with contact information for The League. HT RN 4 documented MSW 2 stated "we'll try this first and if we can't get anywhere, I'll check with [Adult Protective Services (APS)] to see if they can provide some support more quickly." The record included a Progress Note, dated 1/24/24 and documented by MSW 2, which indicated the social worker was notified by a facility nurse of his/her concern "for cleanliness issues of patient's apartment due to low vision and limited mobility and lack of assistance. RN concerned patient is at risk for peritonitis [an infection of the lining of the abdomen]." MSW 2 noted Patient was currently reapplying for Medicaid "to be able to reinstate [his/her] Medicaid waiver homemaker services again." The social worker spoke with The League and provided Patient with instructions on how to apply for services.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	The record included a Progress Note, dated 1/29/24 and documented by MSW 2, which indicated Patient reported he/she had an appointment with The League to be evaluated for service eligibility. Patient had not yet received determination if he/she was eligible for Medicaid. The record included a Rounding Note, dated 1/29/24 and documented by Medical Director, which indicated the physician conducted a telehealth visit with Patient. The visit note failed to evidence the physician reviewed the poor sanitary conditions in Patient's home and his/her increased infection risk. The record included a Plan of Care (POC) dated 1/29/24. The POC included the following: a. An "Area of Focus" of "Infection / Recurring Fever." HT RN 4 documented on 1/26/24 that Patient was "aware of the signs and symptoms of peritonitis." The facility's goal within this focus area was to "prevent recurring infection/fever," with one intervention to "administer antibiotic" per physician order. The POC failed to evidence the IDT discussed and addressed Patient's poor living conditions and related increased infection risk. b. An "Area of Focus" of "Diabetes management." HT RN 4 documented Patient was "compliant with checking/taking insulin." The record included a Progress Note, dated 1/31/24 and documented by MSW 2, which indicated Patient was approved for services through The League and was going to have a visit "for next steps in setting up services." MSW 2 documented he/she educated Patient on assisted living options.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	The record included a Clinical Note, dated 2/01/24 and documented by HT RN 4, which Patient was "approved" for home care by The League "once [Patient] gets [his/her] insurance." The record included a Rounding Note, dated 2/08/24 and documented by Medical Director. The note indicated Patient's blood sugars had been high and his/her Primary Care Provider (PCP) increased Patient's insulin dose. Medical Director instructed Patient to add 2 units of insulin when using 2.5 % Dextrose dialysate and add 4 units of insulin when using 4.25% Dextrose dialysate. The visit note failed to evidence the physician reviewed the poor sanitary conditions in Patient's home and his/her increased infection risk. The record included a Clinical Note, dated 2/08/24 and documented by MSW 2, which indicated Patient had not yet had his/her follow-up visit from The League nor was Patient's Medicaid reinstated. The record included a Clinical Note, dated 2/13/24 and documented by HT RN 4, which indicated on 2/12/24, Patient informed HT RN 5 that over the previous weekend, he/she "had to reuse the same cap two or three times and twice drained [his/her PD fluid out] in a bucket." The record included a Clinical Note, dated 2/14/24 and documented by HT RN 4, which indicated on 2/13/24, Patient reported to the nurse that he/she began having trouble draining his/her effluent (fluid removed from the perineum during PD), mild abdominal pain, and fibrin (protein buildup) was noted in the effluent. Patient was instructed to begin taking oral antibiotics due to the potential of peritonitis.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	The record included a second Clinical Note, dated 2/14/24 and documented by HT RN 4, which indicated Patient reported "mild abdominal pain" and Patient's effluent was cloudy. HT RN 4 observed Patient perform a dialysis exchange and noted Patient had difficulty with a portion of the procedure due to "poor sight." The nurse documented he/she "again discussed the need to clean [Patients] treatment area daily ...." The record included a Clinical Note, dated 2/15/24 and documented by HT RN 4, which indicated Patient reported he/she was 6 kilograms (kg) above his/her target weight. Patient reported he/she was only using 1.5% Dextrose solution due to concerns over his/her blood sugar getting high if he/she used 2.5% or 4.25% Dextrose solution. HT RN 4 documented he/she thought Patient "has 100% understanding [of] how to choose solution bags for treatment. Unfortunately, Patient believes [he/she] knows better and does [his/her] own thing." The record included a Progress Note, dated 2/16/24 and documented by MSW 2, which indicated Patient had peritonitis and "concerns for cleanliness" of his/her home. Patient reported The League was unable to provide any services due to lack of availability. The social worker noted Patient called his/her former case worker for Medicaid waiver services, who stated "they are now working on getting [his/her] Medicaid waiver application started again." MSW 2 documented he/she reviewed with Patient how to clean his/her floor. Patient reported interest in other housing options, as he/she was still waitlisted. The record failed to evidence further notes regarding the status of Patient's attempts to obtain home health assistance.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	The record included a Clinical Note, dated 2/19/24 and documented by HT RN 4, which indicated the following: a. On 2/16/24, HT RN 4 went to Patient's home and found his/her dialysis treatment area "has trash all over the place." The nurse assisted Patient in cleaning and sanitizing his/her work area. b. On 2/17/24, HT RN 4 went to Patient's home again. The nurse reported Patient's dialysis treatment area was "better." The record included a second Clinical Note, dated 2/19/24 and documented by HT RN 4, which indicated Patient's effluent cultures had shown growth of staphylococcus haemolyticus (a bacteria commonly found on the skin), which indicated peritonitis. The record evidenced HT RN 4 completed a home visit with Patient on 2/19/24 but failed to evidence the condition of Patient's home. The record failed to evidence any further home visits were conducted after 2/19/24. The record included a Clinical Note, dated 2/20/24 by HT RN 4, which indicated Patient was "attempting to get blood sugar under control. [Medical Director] increased insulin sliding scale [dosing system where the amount of insulin administered depends on Patient's blood sugar and/or percentage of dextrose in the dialysate fluid used] according to dialysate strength. Patient not compliant with insulin ...." The record included a Clinical Note, dated 3/06/24 and documented by HT RN 4, which indicated Patient was not following his/her dialysis prescription, "performing different number of manuals [exchanges] and different hours on the cycler." When the nurse attempted to speak with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	Patient regarding not following the dialysis prescription, Patient reportedly stated "I can do whatever I want to do." The nurse documented Patient refused to listen to re-education and ended the call. The record included a Clinical Note, dated 3/08/24 by HT RN 4, which indicated the nurse spoke with Patient regarding elevated blood sugar levels. Patient reported he/she took Toujeo (a long-acting insulin) "12-16 units" twice a day and was unable to explain how he/she determined the dose to administer. Patient reported "I just twist [the insulin pen] and give [the medication]." HT RN 4 instructed Patient to administer Toujeo 16 units twice a day "until [his/her] blood sugar is stable," however Patient refused and stated he/she would "continue to give [the] dose as [he/she] sees fit." Patient also reported he/she was not adhering to the sliding scale insulin as prescribed by Medical Director. HT RN 4 instructed Patient the clinic was unable to test Patient's dialysis adequacy due to Patient not adhering to his/her dialysis prescription. The nurse documented Patient stated he/she would do "what [he/she] wants to do." The record included a Clinical Note, dated 3/11/24 by HT RN 4, which indicated Patient's peritonitis had resolved. When the nurse queried how Patient decided what treatment he/she was going to perform, Patient responded "Whatever is in my way, I use that particular box." The record included treatment flowsheets for Patient's home PD treatments, which evidenced the following blood sugars and dialysate - a. On 2/02/24 - Blood sugar 237			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	b. On 2/03/24 - Blood sugar 266 c. On 2/04/24 - Blood sugar 258 d. On 2/05/24 - Blood sugar 257 - Dextrose 2.5% dialysate used. e. On 2/06/24 - Blood sugar 348 - Dextrose 2.5% dialysate used. f. On 2/07/24 - Blood sugar 292 - Dextrose 2.5% dialysate used. g. On 2/08/24 - Blood sugar 305 - Dextrose 2.5% dialysate used. h. On 2/09/24 - Blood sugar 320 - Dextrose 2.5% dialysate used. i. On 2/10/24 - Blood sugar 292 - Dextrose 2.5% dialysate used. j. On 2/11/24 - Blood sugar 245 - Dextrose 2.5% dialysate used. k. On 2/12/24 - Blood sugar 225 - Dextrose 2.5% dialysate used. l. On 2/14/24 - Blood sugar 209 - Dextrose 2.5% dialysate used. m. On 2/15/24 - Blood sugar 204 - Dextrose 2.5% dialysate used. n. On 2/16/24 - Blood sugar 245 - Dextrose 2.5% dialysate used. o. On 2/17/24 - Blood sugar 233 - Dextrose 2.5% and 4.25% dialysate used.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	p. On 2/18/24 - Blood sugar 315 - Dextrose 2.5% dialysate used. q. On 2/19/24 - Blood sugar 332 - Dextrose 2.5% dialysate used. r. On 2/20/24 - Blood sugar 332 - Dextrose 2.5% dialysate used. s. On 2/21/24 - Blood sugar 343 - Dextrose 2.5% dialysate used. t. On 2/22/24 - Blood sugar 248 - Dextrose 2.5% dialysate used. u. On 2/23/24 - Blood sugar 248 - Dextrose 2.5% dialysate used. v. On 2/24/24 - Blood sugar 422 - Dextrose 2.5% dialysate used. w. On 2/25/24 - Blood sugar 266 - Dextrose 2.5% dialysate used. x. On 2/26/24 - Blood sugar 308 - Dextrose 2.5% dialysate used. y. On 2/27/24 - Blood sugar 316 z. On 2/28/24 - Blood sugar 307 - Dextrose 2.5% dialysate used. aa. On 2/29/24 - Blood sugar 302 - Dextrose 2.5% dialysate used. bb. On 3/01/24 - Blood sugar 305 - Dextrose 2.5% dialysate used. cc. On 3/02/24 - Blood sugar 312 - Dextrose 2.5% dialysate used.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	dd. On 3/03/24 - Blood sugar 303 - Dextrose 2.5% dialysate used. ee. On 3/04/24 - Blood sugar 299 ff. On 3/05/24 - Blood sugar 195 - Dextrose 2.5% dialysate used. gg. On 3/06/24 - Blood sugar 204 - Dextrose 2.5% dialysate used. hh. On 3/07/24 - Blood sugar 208 - Dextrose 2.5% dialysate used. ii. On 3/09/24 - Blood sugar 244 - Dextrose 2.5% dialysate used. jj. On 3/10/24 - Blood sugar 210 During an interview with HT RN 5 on 3/19/24 beginning at 8:37 AM, when queried how Patient developed peritonitis, the nurse reported Patient's home was "filthy," had a bad odor, and there was feces on the floor by Patient's bedside commode. HT RN 5 observed the poor living conditions when conducting Patient's home evaluation with HT RN 4 on 12/20/23. The nurse reported HT RN 4 had been Patient's primary nurse and he/she had attempted to educate Patient on cleanliness, but Patient had become "resistant" to the nurse's care. HT RN 4 had reportedly gone back to Patient's home, but there was no improvement in the conditions. HT RN 5 reported Patient did not measure out his/her insulin prior to administering and would give "whatever [he/she] pulls up." Patient was scheduled for a routine clinic visit with the IDT on 3/26/24. During an interview with HT RN 4 on 3/19/24			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	beginning at 12:58 PM, the nurse reported he/she completed an initial home evaluation for Patient #7 on 12/20/23. HT RN 5 was also present for the evaluation. During the visit, Patient was observed performing dialysis in his/her living room. The nurse reported the living room and Patient's bathroom both appeared in good condition and there were no concerns on cleanliness. The nurse reported he/she did not assess other areas of the home, including Patient's bedroom, as the Patient would not be performing dialysis there. HT RN 4 reported he/she conducted a second home evaluation on 1/19/24 as part of a check off due to Patient changing to APD. Patient would now be performing the dialysis in his/her bedroom. The nurse reported when he/she went to Patient's bedroom, a bedside commode was observed "full of stool," there were feces "all over the carpet going in to the bathroom," and used toilet paper was sitting on dialysis supply boxes. HT RN 4 initially stated he/she notified MSW 2 "the next day" and Medical Director "within a couple of days" of the poor sanitary conditions. After reviewing the record, HT RN 4 confirmed he/she documented notification of MSW 2 regarding the poor sanitary conditions on 2/24/24. The nurse stated he/she initially thought Patient's home conditions would improve after the nurse spoke with Patient, but later "realized it wasn't fine" and informed MSW 2 of his/her concerns. The nurse reported he/she notified Medical Director of the poor home conditions via text message on 2/21/24 after Patient had developed peritonitis. HT RN 4 reported he/she "generally" spoke with Medical Director regarding the home conditions while Patient was in the dialysis clinic but could not provide documentation of this notification. The nurse reported the IDT did not discuss the concerns regarding the poor sanitary conditions during the 1/29/24 POC meeting because the nurse			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	had not yet observed Patient's bedroom. The nurse reported after the initial home visit and staff education, Patient's home conditions were "the same ... didn't improve a lot." HT RN 4 reported he/she thought Patient remained at a high risk for peritonitis due to the poor sanitary conditions in his/her home. During an interview with MSW 2 on 3/19/24 beginning at 1:33 PM, the social worker reported the assessment of Patient #7's appropriateness for home therapy was the responsibility of the sister facility who transferred Patient to Fresenius Medical Care Fort Wayne Jefferson. The social worker reported this sister facility did not have a home therapy program so Patient transferred to Fresenius Medical Care Fort Wane Jefferson to start home dialysis. When Patient #7 transferred to home therapy, he/she had lost Medicaid insurance and was working to get it reinstated. The social worker reported he/she was first informed of the poor sanitary conditions of Patient's home by HT RN 4 on 1/24/24. The nurse reportedly stated Patient needed "additional home support for cleaning." The social worker reported the IDT did not discuss Patient's home conditions during Patient's POC meeting. MSW 2 reported his/her last contact with Patient was on 2/19/24 and he/she had been on leave for the past 10 days. The social worker's first day back was 3/19/24. During an interview with Patient #7 on 3/19/24 beginning at 2:41 PM, Patient reported he/she was still working on getting Medicaid waiver services reinstated. Patient reported he had previously hired caregivers through private pay to assist with housework but did not currently have this set up. Patient did not have home health services through Medicaid waiver prior to losing his/her Medicaid			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	insurance. Patient reported he/she could not always see when there were feces on the floor due to his/her poor vision and was unable to bend over to clean the floor due to his/her amputation. During an interview with Administrator and HT Manager 6 on 3/19/24 beginning at 3:27 PM, the Administrator reported the facility's policy indicated a home evaluation was required prior to Patient beginning dialysis in his/her home independently. HT Manager 6 reported the IDT was planning to discuss the concerns with Patient's home conditions when Patient came in for his/her visit on 3/26/24. This was the first visit after Patient was diagnosed and treated for peritonitis. During an interview with Medical Director on 3/19/24 beginning at 4:30 PM, the physician reported he/she did not evaluate Patient's appropriateness for home therapy prior to Patient having a Tenckhoff catheter placed and transferring to the facility. The physician was shown pictures of Patient #6's home condition which evidenced used toilet paper on the floor. The physician stated that based on the report of the poor sanitary conditions in Patient's home, he/she was at high risk of developing peritonitis. Medical Director reported he/she had not discussed the facility's concerns with Patient nor the IDT as he/she was not informed of the home conditions until after Patient's last clinic visit (2/08/24). When queried how the IDT was addressing the unsanitary conditions, the physician reported the facility could only recommend Patient relocate to another home and educate Patient on infection control policies and procedures, unless Patient wanted to switch to a different dialysis modality. Medical Director reported the facility would discuss a potential			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	need for change in dialysis modality if Patient was unable to continue PD safely due to a medical condition such as arthritis, Patient developed "recurrent" peritonitis, and/or Patient was not meeting dialysis adequacy despite following his/her dialysis prescription. Medical Director also reported Patient did not adhere to his/her dialysis prescription and "does what [he/she] wants" regarding how much insulin he/she administers. During a follow-up interview with HT RN 4 on 3/20/24 beginning at 9:17 AM, the nurse reported Patient had discussed hiring private pay home care, however the nurse recommended Patient not do this as MSW 2 was working on getting Patient set up with home care through Medicaid. HT RN 4 reported after informing MSW 2 of his/her concerns regarding Patient's home conditions, he/she did not speak with the social worker further to follow-up. HT RN 4 reported he/she last visited Patient's home on 2/17/24. The nurse had assisted Patient in cleaning his/her home on the day prior (2/16/24) and the home remained clean when the nurse visited on 2/17/24. During a follow-up interview with Home Therapy (HT) Manager 6 on 3/20/24 beginning at 9:40 AM, the manager reported the facility had not been routinely conducting home visit evaluations prior to the home therapy patient beginning training. The manager reported this was because issues identified during the evaluation rarely impacted the decision to initiate patient on home dialysis. HT Manager 6 reported the facility would attempt to address issues discovered during a home evaluation after patient began home dialysis rather than delaying the start of home therapy to address the home evaluation concerns. HT Manager 6 reported when an in-center hemodialysis patient expressed interest in home			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	therapy, Corporate Employee 3, a "kidney care advocate," would speak with the patient and/or primary caregiver to educate on the different home therapy modalities. Corporate Employee 3 had a background as a patient care technician. The facility would then attempt to have a one-on-one meeting between a home therapy nurse and the patient, prior to the patient beginning home therapy training, in order for the nurse to assess the patient and provide additional education on home therapy modalities. The home therapy manager reported this 1-on-1 meeting was not required prior to the patient beginning home therapy training. HT Manager 6 reported he/she could not find documentation of Corporate Employee's meeting with Patient #7 prior to Patient initiating home therapy. During a follow-up interview with MSW 2 on 3/20/24 beginning at 1:18 PM, the social worker reported he/she did not discuss private pay home care options with Patient as he/she did not expect Patient to be able to afford these services. MSW 2 reported there was a rotation of social workers covering him/her while the social worker was on leave. The social worker did not leave any report or instructions to follow-up with Patient while MSW 2 was on leave as the Patient was waiting on his/her Medicaid waiver to be reinstated and social worker was planning on following-up with Patient at his/her next clinic visit.			
V 0582 Bldg. 00	494.100(a) H-IDT OVERSEES HOME TRAINING The interdisciplinary team must oversee training of the home dialysis patient, the designated caregiver, or self-dialysis patient before the initiation of home dialysis or self-dialysis (as defined in §494.10) and when the home dialysis caregiver or home dialysis			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	modality changes. Based on record review and interview, the dialysis facility failed to ensure the patient and/or primary caregiver had completed his/her training on home hemodialysis prior to performing dialysis without nursing supervision for 1 of 1 record reviewed of a patient receiving home hemodialysis (Patient #8). Findings include: The review of facility policy #23561 titled "Home Visits for Home Dialysis Patients," dated 7/03/23, indicated a home visit must be conducted "at the initiation of home hemodialysis to ... verify adaption to home therapy. The patient and/or care partner must be validated as competent to perform home dialysis before they are allowed to function independently." The review of Patient #8's clinical record indicated an admission date of 9/18/23. Prior to admission, Patient received in-center hemodialysis at a sister dialysis facility and expressed interest in changing to home hemodialysis (HHD). Patient and Person B, the primary caregiver, began training at the Fresenius Medical Care Fort Wayne Jefferson home therapy clinic on 9/18/23. Patient and Person B completed 4 weeks of training in the dialysis clinic. The record included a Clinical Note, dated 10/17/23 by Home Therapy Registered Nurse (HT RN) 5, which indicated the nurse went to Patient's home for the first day of at-home HHD training. Patient's primary caregiver cannulated Patient's fistula and initiated Patient's dialysis, however within minutes Patient reported pain at the venous cannulation site and Patient's venous pressures were "elevated." HT RN 5 stopped the treatment	V 0582	V582 H-IDT oversees home training On 04/10/2024, the Home Therapy Program Manager will hold a Home Therapy staff meeting, elicit input, and reinforce the expectations and responsibilities of the facility staff on Policies & Procedures. Please see the list of Policies and procedures or processes reviewed at the bottom of the plan. Emphasis will be placed on: A home visit must be conducted at the initiation of home hemodialysis to assess the home environment and verify adaptation to home therapy. The patient and/or care partner must be validated as competent to perform home dialysis before they are allowed to function independently. Effective 04/11/2024, the Home Therapy Program Manager will conduct monthly audits utilizing Home Therapy Medical Record Audit Tool for 3 months on all new Home Hemodialysis patients. Once compliance is sustained, the Governing Body will resume regularly scheduled audits based on the QAPI calendar. Monitoring will be done through the Medical Records Audit. The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly.	04/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	and noted Patient's fistula had a "small infiltrate" (needle dislodged from inside a vein). The nurse instructed Person B to connect the venous dialysis line to Patient's central venous catheter (CVC, a long IV placed in a large vein for dialysis) and the dialysis treatment was resumed. HT RN 5 documented Patient and Person B stated "they felt comfortable with monitoring treatment and ending treatment themselves." The record indicated HT RN 5 left Patient's home prior to the end of treatment. The record included a Clinical Note, dated 10/18/23 by HT RN 5, which indicated the nurse went to Patient's home for the second day of at-home HHD training. Patient's primary caregiver cannulated Patient's fistula and initiated Patient's dialysis. HT RN 5 documented Patient and Person B stated "they felt comfortable with monitoring treatment and ending treatment themselves." The record indicated HT RN 5 left Patient's home prior to the end of treatment. The record included a Clinical Note, dated 10/19/23 by HT RN 5, which indicated the nurse went to Patient's home for the third day of at-home HHD training. Patient's primary caregiver had begun setting up the dialysis prior to nurse's arrival. Person B cannulated Patient's fistula and initiated Patient's dialysis. HT RN 5 documented Patient and Person B stated "they felt comfortable with monitoring treatment and ending treatment themselves." The record indicated HT RN 5 left Patient's home prior to the end of treatment. After the nurse left the home, Person B called the nurse twice, the first time regarding elevated arterial pressures and the second time regarding the dialysis machine "running out of dialysate." During the second call, HT RN 5 recommended the treatment be ended early "and instructed		The Home Therapy Program 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 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. Home Visits for Home Dialysis Patients Completion Date: 4/20/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	[Person B] on [the] process." The record included a Clinical Note, dated 10/20/23 by HT RN 5, which indicated the nurse went to Patient's home for the fourth day of at-home HHD training. Patient's primary caregiver had begun setting up the dialysis prior to nurse's arrival. Person B and nurse were both unable to cannulate Patient's fistula. The dialysis was initiated using Patient's CVC. Patient and Person B informed the nurse they were comfortable with performing dialysis independently going forward and HT RN 5 left the home. During an interview with HT RN 5 on 3/19/24 beginning at 8:37 AM, the nurse reported Person B performed Patient #8's HHD as Patient was unable to perform due to multiple medical conditions. HT RN 5 reported Patient and his/her caregiver's last day of HHD training was 10/20/24. During a follow-up interview with HT RN 5 on 3/21/24 beginning at 1:14 PM, the nurse reported after a patient and/or primary caregiver completed HHD training in the clinic, they would perform a "skills check-off" in their home, which lasted 3 days - 1 week. The nurse stated he/she did not always stay in the home for the complete dialysis treatment, depending on how competent the patient and/or caregiver were with the process. During an interview with Home Therapy (HT) Manager 6 on 3/21/24 beginning at 1:30 PM, the manager reported if the patient and/or primary caregiver had not completed their dialysis training, they could not perform the dialysis without a staff member present in the home.			
V 0587	494.100(b)(2),(3) H-FAC RECEIVE/REVIEW PT RECORDS Q			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
Bldg. 00	2 MONTHS The dialysis facility must - (2) Retrieve and review complete self-monitoring data and other information from self-care patients or their designated caregiver(s) at least every 2 months; and (3) Maintain this information in the patient ' s medical record. Based on record review and interview, the dialysis facility failed to ensure staff noted and discussed with the patient and/or caregiver any non-adherence to the dialysis prescription for 1 of 1 record reviewed of a patient receiving home hemodialysis (Patient #8). Findings include: The review of Patient #8's clinical record indicated an admission date of 9/18/24 and Patient's modality was home hemodialysis. Patient's dialysis prescription, dated 12/11/23, indicated Patient's blood flow rate was to be 450 milliliters per minute (ml/min). Patient's self-reported treatment flowsheets for treatments performed between 2/12/24 - 3/11/24 evidenced Patient's blood flow rate during treatment was as follows: a. 2/12/24 - 400 b. 2/13/24 - 390 c. 2/15/24 - 380 d. 2/19/24 - 380 e. 2/20/24 - 400	V 0587	V587 H-Fac get/review pt records q 2 mo On or before 04/10/2024, the Home Therapy Program Manager will hold a Home Therapy staff meeting, elicit input, and reinforce the expectations and responsibilities of the facility staff on Policies & Procedures. Please see the list of Policies and procedures or processes reviewed at the bottom of the plan. Emphasis will be placed on: Review of Home Record compliance to prescription should be documented in the medical record. Patient reeducation should occur and be documented when variance to prescription identified. Follow up communication with the patient, including interventions or instructions as needed, will be documented in the patient's medical record. Effective 04/11/2024, the Home Therapy Program Manager will conduct monthly audits with a focus on staff documenting discussion with patient and/or caregiver any non-adherence to the dialysis prescription by utilizing the Home Therapy Medical Records Audit tool for 3 months. Once	04/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	f. 2/21/24 - 380 g. 2/22/24 - 400 h. 2/26/24 - 380 i. 2/27/24 - 350 j. 2/28/24 - 380 k. 2/29/24 - 390 l. 3/04/24 -380 m. 3/05/24 - 400 n. 3/06/24 - 380 o. 3/07/24 - 400 p. 3/11/24 - 400 The record indicated Home Therapy Registered Nurse (HT RN) 5 reviewed Patient's treatment flowsheets on 2/13/24, 2/14/24, 2/20/24, 2/22/24, 2/28/24, 3/08/24, and 3/12/24. The record failed to evidence HT RN 5 noted Patient was not adhering to the ordered blood flow rate. The record included a Clinical Note, dated 3/13/24 and documented by Home Therapy Licensed Practical Nurse (HT LPN) 6, which indicated Patient had a clinic visit with the home therapy nurse. The record failed to evidence during the visit the home therapy nurse discussed Patient not adhering to the ordered blood flow rate. The record included a Clinical Note, dated 3/15/24 and documented by HT RN 5, which indicated Patient was not meeting his/her dialysis adequacy		compliance is sustained, the Governing Body will then resume regularly scheduled audits based on the QAPI calendar. Monitoring will be done through the Medical Records Audit. The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly. The Home Therapy Program 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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	(Kt/V, a lab test used to assess if a patient's dialysis prescription is effective). The nurse reported he/she informed Patient of the lab result and discussed with Patient his/her non-adherence to the ordered treatment frequency. The record failed to evidence HT RN 5 discussed Patient not adhering to the ordered blood flow rate. During an interview with HT RN 5 on 3/21/24 beginning at 1:30 PM, the nurse was unsure of the reason Patient did not adhere to the ordered blood flow rate. HT RN 5 reported the home hemodialysis patient's blood flow rate could be between 400 - 450, however the facility did not have a way to enter this range into the patient's orders. During an interview with Home Therapy (HT) Manager 6, the manager reported Patient #8's most recent Kt/V lab value was 1.7. The facility's goal for all home hemodialysis patients was a Kt/V of 2.0 or higher.		documentation, are available for review at the clinic. Home Therapies Patient Treatment Record Keeping Review and Documentation of Home Therapies Patient Health Data Completion Date: 4/20/24	
V 0590 Bldg. 00	494.100(c)(1)(ii) H-COORDINATION OF CARE BY MEMBER OF IDT Services include, but are not limited to, the following: (ii) Coordination of the home patient's care by a member of the dialysis facility's interdisciplinary team. Based on record review and interview, the home therapy registered nurse (HT RN) failed to coordinate the home dialysis patient's care specific to timely notifying the patient's physician and social worker of concerns with poor sanitary conditions in the patient's home for 1 of 2 records reviewed of a home peritoneal dialysis (PD) patient who developed peritonitis (Patient #7).	V 0590	V590 H-Coordination of care by member of IDT On 04/10/2024, the Home Therapy Program Manager will hold a Home Therapy staff meeting (inclusive of the Interdisciplinary Team (IDT), elicit input, and reinforce the expectations and responsibilities of the facility staff on Policies &	04/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	Findings include: The review of Patient #7's clinical record indicated an admission date of 12/12/23. Prior to admission, Patient received in-center hemodialysis at a sister dialysis facility and expressed interest in changing to home peritoneal dialysis. Patient had a Tenckhoff catheter (tube surgically placed in the lower abdomen used for PD) and began his/her PD training at the Fresenius Medical Care Fort Wayne Jefferson home therapy clinic on 12/12/23. The record indicated Patient lived alone, was his/her own caregiver, and had a left below-the-knee amputation. The record included a Comprehensive SW (Social Work) Assessment, dated 10/19/23 and completed by Medical Social Worker (MSW) 1 while Patient was receiving ICHD at a sister dialysis clinic. The assessment indicated Patient was "in [the] process" of getting set up with home health care through Medicaid waiver services. The record included a Clinical Note, dated 12/20/23 and documented by HT RN 4, which indicated HT RNs 4 and 5 completed an initial home visit with Patient #7 on 12/20/23. The clinical note failed to evidence the home therapy nurses observed any concerns with Patient's home environment. The record included a "Patient Home Environment Evaluation," signed by HT RN 4 and Patient on 12/21/23. The evaluation form failed to evidence the home therapy nurse documented any concerns with Patient's home environment. The record included a Clinical Note, dated 1/19/24 and documented by HT RN 4, which indicated the		Procedures. Please see the list of Policies and procedures or processes reviewed at the bottom of the plan. Emphasis will be placed on: A home visit is a means to ensure that safety of the environment necessary for successful home dialysis is in place at the beginning of home dialysis and remains in place throughout the patient's home dialysis tenure. The home therapies nurse will communicate concerns as appropriate to the physician or physician extender and document in the medical record. Plan of Care should reflect IDT discussion of living conditions if related to increased infection risk. Patient #7 will have the Plan of Care updated by 4/20/24 to reflect the current status of the patient. 100% of Plans of Care will be audited by 4/20/24 to verify they accurately reflect the status of each individual patient. Any care plan found to insufficient reflect the current status will be updated at the next scheduled Care Plan meeting. Effective 04/11/2024, the Home Therapy Program Manager will conduct monthly audits with focus on each patient reviewed for any barries identified by any memeber of the IDT that would interfere with the ability to continue a home modality by utilizing Home Therapy Medical Record Audit tool for 3 months. Once compliance is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	nurse completed a home visit with Patient as part of a skills evaluation on automated peritoneal dialysis (APD, a type of peritoneal dialysis where a machine called a "cycler" is used to perform the dialysis exchanges). HT RN 4 documented Patient's home was "a concern. Patient has limited sight and mobility. Patient uses a bed toilet at night and empties in the AM. [The nurse] found used toilet paper on the boxes of [dialysate] solution. Stool on floor ...." HT RN 4 indicated he/she would "speak with social worker to see if any help can be provided to help patient take care of [his/her] house." The record included a Comprehensive SW Assessment, completed on 1/22/24 by MSW 2, which indicated Patient lived alone and his/her living situation was not a "barrier to treatment outcomes." The social worker indicated Patient had neuropathy and had applied to move to a nearby city "for greater family support," but the waitlist for the new apartment "may extend into May." MSW 2 documented Patient wanted to "regain" his/her Medicaid insurance. The record included a Clinical Note, dated 1/24/24 and documented by HT RN 4, which indicated the nurse notified Medical Social Worker (MSW) 2 of his/her "concerns regarding patient's living conditions ... patient has feces on the floor of [his/her] apartment, trash everywhere and food on the counter tops." MSW 2 reportedly stated Patient was in the process of getting his/her Medicaid "reinstated" and once this was completed, the patient would contact his/her case manager for waiver services. These services could include home health services, but Patient was "not eligible" until his/her Medicaid was reinstated. The social worker reported Patient might also qualify for services from League for the		sustained, the Governing Body will then resume regularly scheduled audits based on the QAPI calendar. Monitoring will be done through the Medical Records Audit. The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly. The Home Therapy Program 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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	Blind-Disabled ("The League"). MSW 2 had provided Patient with contact information for The League. HT RN 4 documented MSW 2 stated "we'll try this first and if we can't get anywhere, I'll check with [Adult Protective Services (APS)] to see if they can provide some support more quickly." The record included a Progress Note, dated 1/24/24 and documented by MSW 2, which indicated the social worker was notified by a facility nurse of his/her concern "for cleanliness issues of patient's apartment due to low vision and limited mobility and lack of assistance. RN concerned patient is at risk for peritonitis [an infection of the lining of the abdomen]." MSW 2 noted Patient was currently reapplying for Medicaid "to be able to reinstate [his/her] Medicaid waiver homemaker services again." The social worker spoke with The League and provided Patient with instructions on how to apply for services. The record included a Plan of Care (POC) dated 1/29/24. The POC included an "Area of Focus" of "Infection / Recurring Fever." HT RN 4 documented on 1/26/24 that Patient was "aware of the signs and symptoms of peritonitis." The facility's goal within this focus area was to "prevent recurring infection/fever," with one intervention to "administer antibiotic" per physician order. The POC failed to evidence the IDT discussed and addressed Patient's poor living conditions and related increased infection risk. The record included a Clinical Note, dated 2/14/24 and documented by HT RN 4, which indicated on 2/13/24, Patient reported to the nurse that he/she began experiencing difficulty draining his/her effluent (fluid removed from the perineum during PD), mild abdominal pain, and fibrin (protein		review at the clinic. Comprehensive Interdisciplinary Assessment and Plan of Care Home Hemodialysis Home Setting Guidelines Completion Date: 4/20/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	buildup) was noted in the effluent. Patient was instructed to begin taking oral antibiotics due to the potential of peritonitis. The record included a Clinical Note, dated 2/19/24 and documented by HT RN 4, which indicated Patient's effluent cultures had shown growth of staphylococcus haemolyticus (a bacteria commonly found on the skin), which indicated peritonitis. During an interview with HT RN 5 on 3/19/24 beginning at 8:37 AM, when queried how Patient developed peritonitis, the nurse reported Patient's home was "filthy," had a bad odor, and there were feces on the floor by Patient's bedside commode. HT RN 5 observed the poor living conditions when conducting Patient's home evaluation with HT RN 4 on 12/20/23. During an interview with HT RN 4 on 3/19/24 beginning at 12:58 PM, the nurse reported he/she completed an initial home evaluation for Patient #7 on 12/20/23. HT RN 5 was also present for the evaluation. During the visit, Patient was observed performing dialysis in his/her living room. The nurse reported the living room and Patient's bathroom both appeared in good condition and there were no concerns on cleanliness. The nurse reported he/she did not assess other areas of the home, including Patient's bedroom, as the Patient would not be performing dialysis there. HT RN 4 reported he/she conducted a second home evaluation on 1/19/24 as part of a check off due to Patient changing to APD. Patient would now be performing the dialysis in his/her bedroom. The nurse reported when he/she went to Patient's bedroom, a bedside commode was observed "full of stool," there were feces "all over the carpet going in to the bathroom," and used toilet paper			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	was sitting on dialysis supply boxes. HT RN 4 initially stated he/she notified MSW 2 "the next day" and Medical Director "within a couple of days" of the poor sanitary conditions. After reviewing the record, HT RN 4 confirmed he/she documented notification of MSW 2 regarding the poor sanitary conditions on 2/24/24. The nurse stated he/she initially thought Patient's home conditions would improve after the nurse spoke with Patient, but later "realized it wasn't fine" and informed MSW 2 of his/her concerns. The nurse reported he/she notified Medical Director of the poor home conditions via text message on 2/21/24 after Patient had developed peritonitis. HT RN 4 reported he/she "generally" spoke with Medical Director regarding the home conditions while Patient was in the dialysis clinic but could not provide documentation of this notification. The nurse reported the IDT did not discuss the concerns regarding the poor sanitary conditions during the 1/29/24 POC meeting because the nurse had not yet observed Patient's bedroom. The nurse reported after the initial home visit and staff education, Patient's home conditions were "the same ... didn't improve a lot." HT RN 4 reported he/she thought Patient remained at a high risk for peritonitis due to the poor sanitary conditions in his/her home. During an interview with MSW 2 on 3/19/24 beginning at 1:33 PM, the social worker reported he/she was first informed of the poor sanitary conditions of Patient's home by HT RN 4 on 1/24/24. The nurse reportedly stated Patient needed "additional home support for cleaning." The social worker reported the IDT did not discuss Patient's home conditions during Patient's POC meeting. During an interview with Patient #7 on 3/19/24			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	beginning at 2:41 PM, Patient reported he/she was still working on getting his/her Medicaid waiver services initiated. During an interview with Medical Director on 3/19/24 beginning at 4:30 PM, the physician stated that based on the report of the poor sanitary conditions in Patient's home, he/she was at high risk of developing peritonitis. Medical Director reported he/she had not discussed the facility's concerns with Patient nor the IDT as he/she was not informed of the home conditions until after Patient's last clinic visit (2/08/24).			
V 0591 Bldg. 00	494.100(b)(1)(iii) H-HOME PT PLAN OF CARE DEV/UPDATED Services include, but are not limited to, the following: (iii) Development and periodic review of the patient's individualized comprehensive plan of care that specifies the services necessary to address the patient's needs and meets the measurable and expected outcomes as specified in §494.90 of this part. Based on record review and interview, the dialysis facility failed to develop and periodically review the home therapy patient's individualized plan of care, ensuring it specified the services necessary to address the patient's needs, for 1 of 2 records reviewed of a home peritoneal dialysis (PD) patient who developed peritonitis (Patient #7). Findings include: The review of Patient #7's clinical record indicated an admission date of 12/12/23. Prior to admission, Patient received in-center hemodialysis at a sister dialysis facility and expressed interest in changing	V 0591	V591 H-Home pt plan of care dev/updated On 04/10/2024, the Home Therapy Program Manager will hold a Home Therapy staff meeting (inclusive of the IDT), elicit input, and reinforce the expectations and responsibilities of the facility staff on Policies & Procedures. Please see the list of Policies and procedures or processes reviewed at the bottom of the plan. Emphasis will be placed on: The patient plan of care will be	04/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	to home peritoneal dialysis (PD). Patient had a Tenckhoff catheter (tube surgically placed in the lower abdomen used for PD) and began his/her PD training at the Fresenius Medical Care Fort Wayne Jefferson home therapy clinic on 12/12/23. The record indicated Patient lived alone, was his/her own caregiver, and had a left below-the-knee amputation. The record included a Comprehensive SW (Social Work) Assessment, dated 10/19/23 and completed by Medical Social Worker (MSW) 1 while Patient was receiving ICHD at a sister dialysis clinic. The assessment indicated Patient was "in [the] process" of getting set up with home health care through Medicaid waiver services. The record included a Clinical Note, dated 12/20/23 and documented by Home Therapy Registered Nurse (HT RN) 4, which indicated HT RNs 4 and 5 completed an initial home visit with Patient #7 on 12/20/23. The clinical note failed to evidence the home therapy nurses observed any concerns with Patient's home environment. The record included a "Patient Home Environment Evaluation," signed by HT RN 4 and Patient on 12/21/23. The evaluation form failed to evidence the home therapy nurse documented any concerns with Patient's home environment. The record included a Clinical Note, dated 1/19/24 and documented by HT RN 4, which indicated the nurse completed a home visit with Patient as part of a skills evaluation on automated peritoneal dialysis (APD, a type of peritoneal dialysis where a machine called a "cycler" is used to perform the dialysis exchanges). HT RN 4 documented Patient's home was "a concern. Patient has limited sight and mobility. Patient uses a bed toilet at		developed from the findings gathered in the comprehensive assessment. The IDT members are expected to interact and share information from the comprehensive assessment to facilitate the development of an individualized plan of care. Plan of Care should be completed within 30 days of change in modality. Patient #7 will have the Plan of Care updated by 4/20/24 to reflect the current status of the patient. 100% of Plans of Care will be audited by 4/20/24 to verify they accurately reflect the status of each individual patient. Any care plan found to insufficient reflect the current status will be updated at the next scheduled Care Plan meeting. Effective 04/11/2024, the Home Therapy Program Manager will conduct monthly audits utilizing the Home Therapy Medical Records Audit tool for 3 months. Once compliance is sustained, the Governing Body will then resume regularly scheduled audits based on the QAPI calendar. Monitoring will be done through the Medical Records Audit. The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly. The Home Therapy Program Manager is responsible to review, analyze and trend all data and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	night and empties in the AM. [The nurse] found used toilet paper on the boxes of [dialysate] solution. Stool on floor ...." HT RN 4 indicated he/she would "speak with social worker to see if any help can be provided to help patient take care of [his/her] house." The record included a Comprehensive SW Assessment, completed on 1/22/24 by MSW 2, which indicated Patient lived alone and his/her living situation was not a "barrier to treatment outcomes." The social worker indicated Patient had neuropathy and had applied to move to a nearby city "for greater family support," but the waitlist for the new apartment "may extend into May." MSW 2 documented Patient wanted to "regain" his/her Medicaid insurance. The record included a Clinical Note, dated 1/24/24 and documented by HT RN 4, which indicated the nurse notified Medical Social Worker (MSW) 2 of his/her "concerns regarding patient's living conditions ... patient has feces on the floor of [his/her] apartment, trash everywhere and food on the counter tops." MSW 2 reportedly stated Patient was in the process of getting his/her Medicaid "reinstated" and once this was completed, the patient would contact his/her case manager for waiver services. These services could include home health services, but Patient was "not eligible" until his/her Medicaid was reinstated. The social worker reported Patient might also qualify for services from League for the Blind-Disabled ("The League"). MSW 2 had provided Patient with contact information for The League. HT RN 4 documented MSW 2 stated "we'll try this first and if we can't get anywhere, I'll check with [Adult Protective Services (APS)] to see if they can provide some support more quickly."		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 review at the clinic. Comprehensive Interdisciplinary Assessment and Plan of Care Completion Date: 4/20/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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

The record included a Progress Note, dated 1/24/24 and documented by MSW 2, which indicated the social worker was notified by a facility nurse of his/her concern "for cleanliness issues of patient's apartment due to low vision and limited mobility and lack of assistance. RN concerned patient is at risk for peritonitis [an infection of the lining of the abdomen]." MSW 2 noted Patient was currently reapplying for Medicaid "to be able to reinstate [his/her] Medicaid waiver homemaker services again." The social worker spoke with The League and provided Patient with instructions on how to apply for services.

The record included a Progress Note, dated 1/29/24 and documented by MSW 2, which indicated Patient reported he/she had an appointment with The League to be evaluated for service eligibility. Patient had not yet received determination if he/she was eligible for Medicaid.

The record included a Plan of Care (POC) dated 1/29/24. The POC included an "Area of Focus" of "Infection / Recurring Fever." HT RN 4 documented on 1/26/24 that Patient was "aware of the signs and symptoms of peritonitis." The facility's goal within this focus area was to "prevent recurring infection/fever," with one intervention to "administer antibiotic" per physician order. The POC failed to evidence the IDT discussed and addressed Patient's poor living conditions and related increased infection risk.
The record included a Clinical Note, dated 2/14/24 and documented by HT RN 4, which indicated on 2/13/24, Patient reported to the nurse that he/she began experiencing difficulty draining his/her effluent (fluid removed from the perineum during PD), mild abdominal pain, and fibrin (protein

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	buildup) was noted in the effluent. Patient was instructed to begin taking oral antibiotics due to the potential of peritonitis. The record included a Clinical Note, dated 2/19/24 and documented by HT RN 4, which indicated Patient's effluent cultures had shown growth of staphylococcus haemolyticus (a bacteria commonly found on the skin), which indicated peritonitis. During an interview with HT RN 5 on 3/19/24 beginning at 8:37 AM, when queried how Patient developed peritonitis, the nurse reported Patient's home was "filthy," had a bad odor, and there were feces on the floor by Patient's bedside commode. HT RN 5 observed the poor living conditions when conducting Patient's home evaluation with HT RN 4 on 12/20/23. During an interview with HT RN 4 on 3/19/24 beginning at 12:58 PM, the nurse reported he/she completed an initial home evaluation for Patient #7 on 12/20/23. HT RN 5 was also present for the evaluation. During the visit, Patient was observed performing dialysis in his/her living room. The nurse reported the living room and Patient's bathroom both appeared in good condition and there were no concerns on cleanliness. The nurse reported he/she did not assess other areas of the home, including Patient's bedroom, as the Patient would not be performing dialysis there. HT RN 4 reported he/she conducted a second home evaluation on 1/19/24 as part of a check off due to Patient changing to APD. Patient would now be performing the dialysis in his/her bedroom. The nurse reported when he/she went to Patient's bedroom, a bedside commode was observed "full of stool," there were feces "all over the carpet going in to the bathroom," and used toilet paper			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	was sitting on dialysis supply boxes. HT RN 4 initially stated he/she notified MSW 2 "the next day" and Medical Director "within a couple of days" of the poor sanitary conditions. After reviewing the record, HT RN 4 confirmed he/she documented notification of MSW 2 regarding the poor sanitary conditions on 2/24/24. The nurse stated he/she initially thought Patient's home conditions would improve after the nurse spoke with Patient, but later "realized it wasn't fine" and informed MSW 2 of his/her concerns. The nurse reported he/she notified Medical Director of the poor home conditions via text message on 2/21/24 after Patient had developed peritonitis. HT RN 4 reported he/she "generally" spoke with Medical Director regarding the home conditions while Patient was in the dialysis clinic but could not provide documentation of this notification. The nurse reported the IDT did not discuss the concerns regarding the poor sanitary conditions during the 1/29/24 POC meeting because the nurse had not yet observed Patient's bedroom. The nurse reported after the initial home visit and staff education, Patient's home conditions were "the same ... didn't improve a lot." HT RN 4 reported he/she thought Patient remained at a high risk for peritonitis due to the poor sanitary conditions in his/her home. During an interview with MSW 2 on 3/19/24 beginning at 1:33 PM, the social worker reported he/she was first informed of the poor sanitary conditions of Patient's home by HT RN 4 on 1/24/24. The nurse reportedly stated Patient needed "additional home support for cleaning." The social worker reported the IDT did not discuss Patient's home conditions during Patient's POC meeting. During an interview with Patient #7 on 3/19/24			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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
	beginning at 2:41 PM, Patient reported he/she could not always see when there were feces on the floor due to his/her poor vision and was unable to bend over to clean the floor due to his/her amputation. During an interview with Administrator and HT Manager 6 on 3/19/24 beginning at 3:27 PM, the home therapy manager reported the IDT was planning to discuss the concerns with Patient's home conditions when Patient came in for his/her visit on 3/26/24. This was the first visit after Patient was diagnosed and treated for peritonitis. During an interview with Medical Director on 3/19/24 beginning at 4:30 PM, the physician reported he/she was shown pictures of Patient #6's home condition by HT RN 4 which evidenced used toilet paper on the floor. The physician stated that based on the report of the poor sanitary conditions in Patient's home, he/she was at high risk of developing peritonitis. Medical Director reported he/she had not discussed the facility's concerns with Patient nor the IDT as he/she was not informed of the home conditions until after Patient's last clinic visit (2/08/24).			