

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/29/2021

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152504	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/05/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE SOUTHERN INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 810 EASTERN BOULEVARD CLARKSVILLE, IN 47129
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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	<p>An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 494.62.</p> <p>Survey Dates: March 2nd, 3rd, 4th and 5th of 2021.</p> <p>Facility Number: 005151</p> <p>Census: 100 in-center hemodialysis, 13 home peritoneal dialysis 5 home hemodialysis</p> <p>At this Emergency Preparedness survey, Fresenius Medical Care Southern Indiana, was found in compliance with Emergency Preparedness Requirements for Providers and Suppliers, 42 CFR 494.62.</p> <p>Quality Review completed on 3/16/2021 A4</p>	E 0000		
V 0000 Bldg. 00	<p>This visit was for a federal core ESRD recertification survey in conjunction with a COVID-19 infection control focused survey.</p> <p>Survey Dates: March 2nd, 3rd, 4th, and 5th of 2021.</p> <p>Facility Number: 005151</p> <p>Census: 100 in-center hemodialysis 13 home peritoneal dialysis 5 home hemodialysis.</p>	V 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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: 152504	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/05/2021
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE SOUTHERN INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 810 EASTERN BOULEVARD CLARKSVILLE, IN 47129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0184 Bldg. 00	<p>494.40(a) ENVIRONMENT-SECURE & RESTRICTED 8 Environment: secure & restricted The water purification and storage system should be located in a secure area that is readily accessible to authorized users. The location should be chosen with a view to minimizing the length and complexity of the distribution system. Access to the purification system should be restricted to those individuals responsible for monitoring and maintenance of the system. Based on observation and interview, the facility failed to ensure the water purification and storage system room access was restricted from unauthorized personnel and failed to ensure the doors were locked in 1 of 1 facilities reviewed.</p> <p>Findings include:</p> <p>Observation during the facility flash tour on 3/2/2021 at 1:22 p.m., revealed the water room gate was open with key located inside lock. Two access doors to the water purification and storage system room revealed both doors closed, but unlocked.</p> <p>During an observation on 3/3/2021 at 12:30 p.m., revealed the water room gate was open with key located inside lock. Two access doors to the water purification and storage system room revealed both doors closed, but unlocked.</p> <p>During an interview on 3/3/2021 at 12:30 p.m., employee X, Biomed Manager, stated the gate is left open and is not locked. Stated the "key is left in the door because it has been misplaced in the past, the water room has restricted access due to this being a locked facility," indicating the door locked from waiting room to treatment floor area.</p>	V 0184	<p>On or before 3/30/2021, the Clinical Manager will conduct a staff meeting to review the survey findings with all direct patient care staff, elicit input, and reinforce the expectations and responsibilities of the facility staff on the following FKC policy: Physical Security and Facility Access</p> <p>Emphasis placed on: Staff responsibility to ensure that all doors that allow access to the water treatment system storage room are maintained closed and locked at all times to restrict unauthorized access.</p> <p>On 3/5/2021, the Bio-Medical Technician installed punch locks on the two interior doors entering the water system storage room, thus restricting any unauthorized access to the water purification system.</p> <p>To ensure that the two interior</p>	04/12/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152504	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/05/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE SOUTHERN INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 810 EASTERN BOULEVARD CLARKSVILLE, IN 47129
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	Agreed with surveyor that patients and visitors, once on treatment floor, have access to water purification and storage system room through unlocked doors. Employee X, stated "I never thought of it like that, but that's true."		<p>doors entering the water system storage room are maintained closed and locked at all times, effective 4/1/2021, the Clinical Manager will be responsible to conduct random observational audits of the doors weekly x4 weeks. Once 100% compliance is determined by the Governing Body to be achieved and sustained, the facility will decrease audit frequency to resume routine monthly scheduled audits as based upon the QAI calendar.</p> <p>The Medical Director will review the results of the weekly observational audits at the next scheduled QAI Committee meeting.</p> <p>The Clinical 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 QAI 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 QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The Governing Body is responsible to provide oversight to ensure the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152504	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/05/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE SOUTHERN INDIANA	STREET ADDRESS, CITY, STATE, ZIP COD 810 EASTERN BOULEVARD CLARKSVILLE, IN 47129
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 0543 Bldg. 00	<p>494.90(a)(1) POC-MANAGE VOLUME STATUS</p> <p>The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status;</p> <p>Based on record review and interview, the facility failed to follow their policy and ensure the PCT (Patient Care Technician) notified the RN (Registered Nurse) of blood pressure and pulse rates not within parameters for 6 of 11 records reviewed (Patient 4, 10, 12, 13, and 16) and incorrect blood flow rates not documented in medical record when not achieved on 3 of 11 records reviewed (Patient 10, 12, and 16).</p> <p>Findings include:</p> <p>1. A policy published 9/29/2018, Version 3, was provided by the administrator on 3/3/2021 at 3:51 p.m. titled "Patient Assessment and Monitoring." The policy indicated, but was not limited to, "Pre-Treatment: Direct patient care staff may collect pre-treatment weight, BP [blood pressure], pulse, respirations, temperature, general</p>	V 0543	<p>Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.</p> <p>Documentation of education, monitoring, QAI, and Governing Body is available for review.</p> <p>The Clinic Manager is responsible for overall compliance.</p> <p>V543 POC-Manage volume status On or before 3/30/2021, the Clinical Manager will conduct a staff meeting to review the survey findings with all direct patient care staff, elicit input, and reinforce the expectations and responsibilities of the facility staff on the following FKC policy: Patient Assessment and Monitoring</p> <p>Emphasis placed on: The Patient Care Technician must report any changes in the patients condition or abnormal findings in the patients vital signs to the Registered Nurse including, but not limited to:</p>	04/12/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152504	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/05/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE SOUTHERN INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 810 EASTERN BOULEVARD CLARKSVILLE, IN 47129
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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>observations, access, and complaints reported by the patient. If the PCT/LPN notes any changes or abnormal findings in the patient's condition or vascular access are observed or reported by the patient, or the patient was hospitalized, the patient care technician MUST report the changes in the patient condition to a registered nurse who will further assess the patient prior to initiation of treatment. An abnormal finding confirmed by the RN will be reported to the attending physician for assessment and intervention if necessary, as determined by the clinical judgement of the registered nurse." ... "During Treatment: The Registered Nurse will assess/re-assess any findings addressed pre or during treatment as needed." ... "Post-Treatment: Non-licensed staff may collect post treatment weight, BP, pulse, respirations, temperature, general observations, access, and complaints reported by the patient. The staff member who collects the information and evaluates the patient post-treatment will document their findings on the hemodialysis treatment record. If any changes or abnormal findings in the patient's condition, vital signs, or vascular access are observed or reported by the patient, the PCT/LPN MUST report the changes in the patient condition to a registered nurse who will further assess the patient prior to discharge after the treatment. An abnormal finding confirmed by the RN will be reported to the attending physician if necessary, as determined by the clinical judgement of the registered nurse for assessment and intervention. The Registered Nurse will assess/re-assess any findings addressed pre-treatment prior to discharge." ... "Step 1, Action/Rationale: Blood Pressure: Record blood pressure. Record blood pressures after a drop that requires interventions such as administering normal saline. Reposition electronic cuff or use a manual cuff for aberrant blood</p>		<p>Systolic blood pressure greater than 180 and/or Diastolic blood pressure greater than 100mm/hg Systolic blood pressure less than or equal to 100mm/hg Pulse below 60 or greater than 100 beats per minute. Document irregular rhythms</p> <p>The Patient Care Technician must check that prescribed blood flow is being achieved and document reason in the medical record if patient is unable to meet prescribed blood flow rate.</p> <p>An abnormal finding confirmed by the RN will be reported to the attending physician if necessary as determined by the clinical judgment of the registered nurse for assessment and intervention.</p> <p>To monitor staff compliance to reporting of abnormal blood pressures and pulse rates to the Registered Nurse, and to ensure that, if the patient is unable to achieve the prescribed Blood Flow Rate during treatment, the reason is appropriately documented on the treatment sheet, effective 4/1/2021 the Clinical Manager or designated Registered Nurse be responsible to review 2% of patient treatment sheets daily. Once 100% compliance is achieved, the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152504	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/05/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE SOUTHERN INDIANA	STREET ADDRESS, CITY, STATE, ZIP COD 810 EASTERN BOULEVARD CLARKSVILLE, IN 47129
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>pressure readings. Report to the nurse: Systolic blood pressures greater than 180 mm/Hg. Diastolic blood pressures greater than 100 mm/Hg. Blood pressure less than or equal to 100 mm/hg systolic. Pulse: Record pulse. Verify pulses manually if automated readings display below 60 or greater than 100 beats per minute. Report to the nurse patients whose heart rates have dropped below 60, risen above 100 or become irregular." ... "Check prescribed blood flow is being achieved or reason is documented in the medical record if unable to meet prescribed blood flow rate."</p> <p>2. The clinical record for patient 4 was reviewed on 3/3/2021 for treatments dated 2/19/2021, 2/22/2021, 2/27/2021, and 3/1/2021 evidenced the following:</p> <p>On 2/19/2021 at 7:24 a.m. patient 4's treatment sheet evidenced a BP (blood pressure) of 204/91, 7:40 a.m. BP noted at 216/97, 8:08 a.m. BP noted at 204/92, 8:38 a.m. BP noted at 194/94, 9:04 a.m. BP noted at 193/97, 9:45 a.m. BP noted at 191/107, 10:06 a.m., BP noted at 182/107, by Employee I (PCT), and failed to notify a registered nurse of a systolic blood pressure greater than 180 mm/Hg and a diastolic blood pressure greater then 100 mm/Hg.</p> <p>On 2/22/2021 at 8:40 a.m., patient 4's treatment sheet evidenced a BP of 206/93 noted by Employee R, (PCT) during treatment and failed to notify a registered nurse of a systolic blood pressure greater than 180 mm/Hg.</p> <p>On 2/27/2021 at 3:37 p.m., patient 4's treatment sheet evidenced a BP of 198/82 during treatment, 4:01 p.m. BP noted at 190/92, 4:31 p.m. BP noted at 194/87, by Employee I (PCT), and failed to notify a registered nurse of a systolic blood pressure</p>		<p>Governing Body will decrease frequency to weekly x 4 weeks. Once 100% compliance is determined by the Governing Body to be sustained, the facility will resume regularly scheduled monthly audits based on QAI calendar. The Medical Director will review the results of the treatment sheet audits each month at the QAI Committee meeting. The Clinical 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 QAI 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 QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate. 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. Documentation of education, monitoring, QAI, and Governing</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152504	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/05/2021
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE SOUTHERN INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 810 EASTERN BOULEVARD CLARKSVILLE, IN 47129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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>greater than 180 mm/Hg.</p> <p>On 3/1/2021 at 7:41 a.m., patient 4's treatment sheet evidenced a BP of 212/101 during treatment, 8:36 a.m. a BP of 205/92 noted by Employee CC (PCT) and failed to notify a registered nurse of a systolic blood pressure greater than 180 mm/Hg and a diastolic BP greater than 100 mm/Hg.</p> <p>3. The clinical record for patient 10 was reviewed on 3/3/2021 for treatments dated 2/8/2021, 2/10/2021, 2/12/2021, 2/15/2021, 2/17/2021, 2/22/2021, 2/24/2021, 2/26/2021, and 3/1/2021 evidenced the following:</p> <p>On 2/8/2021 at 10:48 a.m., patient 10's treatment sheet evidenced a BP of 211/79 during treatment by Employee I, PCT. At 11:02 a.m., BP noted at 182/91, by Employee R (PCT). Employee I (PCT) and Employee R (PCT), failed to notify a registered nurse of a systolic blood pressure greater than 180 mm/Hg.</p> <p>On 2/10/2021 at 10:44 a.m., patient 10's treatment sheet evidenced a BP of 211/91, 11:03 a.m. BP noted at 207/92, 12:03 p.m. BP noted at 183/85 during treatment by Employee DD (PCT), failed to notify a registered nurse of a systolic blood pressure greater than 180 mm/Hg. Ordered BFR (blood flow rate) is 400, patient 10 ran treatment on incorrect BFR of 450 throughout treatment. PCT and RN failed to ensure patient was on correct BFR or to document reason for not achieving correct BFR.</p> <p>On 2/12/2021 patient 10's treatment sheet evidenced a BP of 244/97 standing and 258/116 sitting prior to treatment starting by Employee S (RN) Registered Nurse. At 11:37 a.m. BP of 238/91, 12:07 p.m. BP of 227/95, 12:35 BP of 234/77, 1:10</p>		<p>Body is available for review. The Clinic Manager is responsible for overall compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152504	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/05/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE SOUTHERN INDIANA	STREET ADDRESS, CITY, STATE, ZIP COD 810 EASTERN BOULEVARD CLARKSVILLE, IN 47129
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>p.m. BP of 235/105, 1:30 p.m. BP of 186/80. Employee S (RN), failed to document necessary interventions and/or notify the physician of increased BP. Ordered BFR (blood flow rate) is 400, patient 10 ran BFR of 450 throughout treatment. PCT and RN failed to ensure patient was on correct BFR or to document reason for not achieving correct BFR.</p> <p>On 2/15/20 patient 10's treatment sheet evidenced a BP of 223/84 at 10:53 a.m., 208/82 at 11:07 a.m., 184/70 at 11:30 a.m., all noted by Employee I (PCT) and failed to notify a registered nurse of a systolic blood pressure greater than 180 mm/Hg. Ordered BFR (blood flow rate) is 400, patient 10 ran BFR of 360 throughout treatment. PCT and RN failed to ensure patient was on correct BFR or to document reason for not achieving correct BFR.</p> <p>On 2/17/20 patient 10's treatment sheet evidenced a BP of 190/66 at 12:32 p.m. noted by Employee O, (PCT), and failed to notify a registered nurse of a systolic blood pressure greater than 180 mm/Hg. Ordered BFR (blood flow rate) is 400, patient 10 ran BFR of 450 throughout treatment. PCT and RN failed to ensure patient was on correct BFR or to document reason for not achieving correct BFR.</p> <p>On 2/22/20 patient 10's treatment sheet evidenced a BP of 224/91 at 10:50 a.m., 11:08 a.m. 214/87, 11:17 a.m. BP 217/89, 11:32 a.m. BP 216/99, 12:00 p.m. BP 226/107, 12:35 p.m. BP 200/65. BP readings noted by Employee A (PCT), and Employee I (PCT), both failed to notify a registered nurse of a systolic blood pressure greater than 180 mm/Hg.</p> <p>On 2/24/2021 patient 10's treatment sheet evidenced a BP of 191/84 at 10:39 a.m., 11:01 a.m. BP noted at 181/88, 11:33 a.m. BP noted at 184/74. Employee DD (PCT), and Employee L (PCT) noted</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152504	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/05/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE SOUTHERN INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 810 EASTERN BOULEVARD CLARKSVILLE, IN 47129
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>these findings and failed to notify a registered nurse of a systolic blood pressure greater than 180 mm/Hg. Ordered BFR (blood flow rate) is 400, patient 10 ran BFR of 350 throughout treatment. PCT and RN failed to ensure patient was on correct BFR or to document reason for not achieving correct BFR.</p> <p>On 2/26/2021 patient 10's treatment sheet evidenced a pulse rate of 37 noted by Employee O (PCT) and failed to document a recheck of pulse or obtaining a manual pulse and failed to notify registered nurse. Ordered BFR (blood flow rate) is 400, patient 10 ran BFR of 450 at 11:30 a.m. PCT and RN failed to ensure patient was on correct BFR or to document reason for not achieving correct BFR.</p> <p>On 3/1/2021 patient 10's treatment sheet evidenced a BP reading of 216/86 at 10:37 a.m., 11:02 a.m. BP noted at 208/85, 11:30 a.m. BP noted at 194/73 by Employee I (PCT) and failed to notify a registered nurse. Ordered BFR (blood flow rate) is 400, patient 10 ran BFR of 450 throughout treatment. PCT and RN failed to ensure patient was on correct BFR or to document reason for not achieving correct BFR.</p> <p>4. The clinical record for patient 12 was reviewed on 3/4/2021 for treatments dated 2/22/2021, 2/24/2021, and 2/26/2021 evidenced the following:</p> <p>On 2/24/2021 patient 12's treatment sheet evidenced a BP reading of 92/43 prior to treatment starting. At 8:31 a.m. BP 90/49, 9:01 a.m. BP at 93/54, 9:33 a.m. BP at 91/48, 10:34 BP at 92/55 noted by Employee K (PCT), Employee R (PCT), and Employee J (PCT). All three employees (PCT's) failed to notify registered nurse of systolic blood pressure less than 100 mm/Hg. Ordered</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152504	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/05/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE SOUTHERN INDIANA	STREET ADDRESS, CITY, STATE, ZIP COD 810 EASTERN BOULEVARD CLARKSVILLE, IN 47129
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>BFR (blood flow rate) is 400, patient 12 ran BFR of 420 throughout treatment. PCT and RN failed to ensure patient was on correct BFR or to document reason for not achieving correct BFR.</p> <p>On 2/26/2021 patient 12's treatment sheet evidenced a BP reading of 88/46 at 8:02 a.m., 8:31 a.m. BP of 96/45, 9:01 a.m. BP of 92/51, 9:32 a.m. BP of 84/71, 10:04 BP of 82/47, 10:32 a.m. BP of 94/68 noted by Employee P (PCT) and Employee R (PCT), both PCT's failed to notify the registered nurse of systolic blood pressure less than 100. Ordered BFR (blood flow rate) is 400, patient 12 ran BFR of 450 throughout treatment. PCT and RN failed to ensure patient was on correct BFR or to document reason for not achieving correct BFR.</p> <p>5. The clinical record for patient 13 was reviewed on 3/4/2021 for treatments dated 2/22/2021, 2/24/2021, and 3/1/2021 evidenced the following:</p> <p>On 2/22/2021 patient 13's treatment sheet evidenced a BP reading of 188/79 at 2:36 p.m., 3:02 p.m. BP of 194/80, and post treatment BP reading of 195/84 noted by Employee J (PCT) and Employee R (PCT), both PCT's failed to notify a registered nurse of a systolic blood pressure greater than 180 mm/Hg.</p> <p>On 2/24/2021 patient 13's treatment sheet evidenced a BP reading of 224/142 prior to starting treatment. Employee K (PCT) failed to notify the registered nurse of systolic BP greater than 180 mm/Hg and diastolic BP greater than 100 mm/Hg prior to starting treatment.</p> <p>On 3/1/2021 patient 13's treatment sheet evidenced a pulse (heart rate) of 39 and at end of treatment a BP reading of 188/89. Employee J (PCT) and Employee K (PCT) failed to notify the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152504	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/05/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE SOUTHERN INDIANA	STREET ADDRESS, CITY, STATE, ZIP COD 810 EASTERN BOULEVARD CLARKSVILLE, IN 47129
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>registered nurse of a pulse less than 60 and a systolic blood pressure greater than 180 mm/Hg.</p> <p>6. The clinical record for patient 16 was reviewed on 3/5/2021 for treatments dated 2/20/2021, 2/22/2021, 2/23/2021, and 2/25/2021 evidenced the following:</p> <p>On 2/20/2021 patient 16's treatment sheet evidenced a BP reading of 202/88 at 7:24 a.m., 8:11 a.m. BP reading of 199/81, 9:03 a.m. BP reading of 199/73, 9:33 a.m. BP reading of 208/71, 10:03 a.m. BP reading of 181/93, 10:32 a.m. BP reading of 182/85. Employee E (PCT) and Employee I (PCT) failed to notify the registered nurse of a systolic blood pressure greater than 180 mm/Hg.</p> <p>On 2/22/2021 patient 16's treatment sheet evidenced a BP reading of 211/78 prior to starting treatment. At 7:17 a.m. BP reading of 193/73, 7:33 a.m. BP reading of 192/98, 8:03 a.m. BP reading of 199/89, 8:32 a.m. BP reading of 205/100, 9:03 a.m. BP reading of 194/80, 9:34 a.m. BP reading of 190/66, and at end of treatment BP noted at 204/103 sitting, 186/88 standing. Employee I (PCT), Employee EE (PCT), Employee L (PCT) failed to notify the registered nurse of a systolic BP reading greater than 180 mm/Hg and a diastolic BP reading greater than 100 mm/Hg.</p> <p>On 2/23/2021 patient 16's treatment sheet evidenced a BP reading of 183/79 prior to treatment starting. At 7:16 a.m. BP reading of 211/97, 7:30 a.m. BP reading of 204/110, 8:01 a.m. BP reading of 209/95, 8:31 a.m. BP reading of 214/94, 9:02 a.m. BP reading of 198/107, 9:16 a.m. BP reading of 200/100 and at end of treatment BP reading of 214/99 sitting, 177/105 standing. Employee A (PCT), Employee FF (PCT) failed to notify the registered nurse of a systolic blood</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/29/2021

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152504	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/05/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE SOUTHERN INDIANA	STREET ADDRESS, CITY, STATE, ZIP COD 810 EASTERN BOULEVARD CLARKSVILLE, IN 47129
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>pressure greater than 180 mm/Hg and a diastolic pressure greater than 100 mm/Hg. Ordered BFR (blood flow rate) is 500, patient 16 ran BFR of 400 throughout treatment. PCT and RN failed to ensure patient was on correct BFR or to document reason for not achieving correct BFR.</p> <p>On 2/25/2021 patient 16's treatment sheet evidenced a BP reading of 202/106 at 8:06 a.m., 8:31 a.m. BP reading of 194/106, 10:03 a.m. BP reading of 193/88. Employee GG (PCT) and Employee T (PCT) failed to notify the registered nurse of systolic blood pressures greater than 180 mm/Hg and diastolic blood pressure greater than 100 mm/Hg.</p> <p>7. During an interview on 3/5/2021 at 11:39 a.m. with Employee V, Clinic Manager, she stated she was not sure why patients were running on incorrect BFR with no documentation and why out of range blood pressures were not being reported to the RN. Stated she would be holding an in-service with staff to address these identified problems.</p>			