STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	12/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714

(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		E 0000		
	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 494.62. Survey Dates: 11/30/2021-12/3/2021 Facility Number: 002562 Census: 82 In-Center HD 52 Home PD 6 Home HD At this Emergency Preparedness Survey, East Evansville Dialysis was found to be in compliance with the Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers 42 CFR 494.62. QR Completed 12/16/2021 A4			
V 0000 Bldg. 00		V 0000		
	This visit was for a Federal ESRD (Core) recertification in conjunction with an Infection Control focused survey. Survey Dates: 11/30/2021-12/3/2021 Facility Number: 002562 Census: 82 In-Center Hemodialysis 52 Home Peritoneal Dialysis 6 Home Hemodialysis >3x/week			

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

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

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V 0222 Bldg. 00	494.40(a) ACID BULK STORAGE TANKS-SAFETY CONTROLS 5.4 Concentrate preparation 5.4.3 Bulk storage tanks (acid concentrate): safety controls Procedures should be in place to control the transfer of the acid concentrate from the delivery container to the storage tank to prevent the inadvertent mixing of different concentrate formulations. If possible, the tank and associated plumbing should form an integral system to prevent contamination of the acid concentrate. The storage tanks and inlet and outlet connections, if remote from the tank, should be secure and labeled clearly. Based on observation, record review, and interview, the facility failed to date and time the acid concentrate mixer for 1 of 1 water room observations. Findings include: An April 2019 policy titled Acid Concentrate System, Incoming Acid Concentrate and Supply Log and Use of Acid Gallon Concentrate Containers was provided by the FA (facility administrator) on 12/2/2021 at 10:10 a.m. The policy indicated, but was not limited to, "13. All dialysate delivery systems, all concentrate ports, ... will be labeled." During the flash tour of the water room along BioMed H on 11/30/2021 at 8:45 a.m. observed the label on an acid concentrate mixer. The label date and time was left blank. At that time BioMed H indicated staff should have filled in the date and time on the mixer, but indicated staff recorded the	V 0222	V222 100% of teammates will be in-serviced on Policy 2-07-05 "ACID CONCENTRATE SYSTEM, INCOMING ACID CONCENTRATE AND SUPPLY LOG AND USE OF ACID GALLON CONCENTRATE CONTAINERS. Verification of attendance is evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) All dialysate delivery systems, all concentrate ports…will be labeled. The Facility Administrator (FA) or designee will conduct observational audits daily x 2 weeks and then 1x week x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly x 3 months. The FA will review audit results with the Medical	01/27/2022

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	date and time of the acid mixer in a book next to the mixer.		Director during monthly Quality Assurance Performance Improvement (QAPI), known as Facility Health Meeting (FHM). The FA is responsible for ongoing compliance with the plan of Correction.	
V 0250 Bldg. 00	494.40(a) DIALYS PROPORT-MONITOR PH/CONDUCTIVITY 5.6 Dialysate proportioning: monitor pH/conductivity It is necessary for the operator to follow the manufacturer's instructions regarding dialysate conductivity and to measure approximate pH with an independent method before starting the treatment of the next patient. Based on observation, record review, and interview, the facility failed to ensure accurate pH and conductivity testing of dialysate solution was performed prior to each patient treatment related to the use of expired testing solutions to calibrate a Myron L (D-2) (water quality) meter creating the potential for harm affecting all 82 in-center dialysis patients. Findings include: An April 2019 policy titled Testing Dialysate Conductivity with Dual Range Myron L Meter (D-2) was provided by the MCS (Manger of Clinical Services) on 12/1/2021 at 2:00 p.m. The policy indicated, but was not limited to, "Dialysis quality water obtained fresh daily... Fresh dialysis quality water should be used for rinsing the D-2 meter cell." On 12/1/2/021 at 9:45 a.m. observed a bottle of RO	V 0250	V250 100% of teammates will be in-serviced on Policy 2-08-01E “TESTING DIALYSATE CONDUCTIVITY WITH DUAL RANGE MYRON L METER (D-2)”. Verification of attendance is evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Dialysis quality water is obtained fresh daily. 2) Fresh dialysis quality water should be used for rinsing the D-2 meter cell. The Facility Administrator (FA) or designee will conduct observational audits daily x 2 weeks and then weekly x 2 weeks to verify compliance with facility policy. The FA will review audit	01/27/2022

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	(reverse osmosis) solution dated 11/30/2021, time 4:30 a.m.. At that time, RN (registered nurse) E indicated the RO solution was expired and should be changed daily. During an interview on 12/1/2021 at 4:00 p.m. the FA (Facility Administrator) confirmed the RO solution should be changed daily.		results with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI), known as Facility Health Meeting (FHM). The FA is responsible for ongoing compliance with the plan of Correction.	
V 0506 Bldg. 00	494.80(a)(3) PA-IMMUNIZATION/MEDICATION HISTORY The patient's comprehensive assessment must include, but is not limited to, the following: Immunization history, and medication history. Based on record review and interview, the facility failed to complete the immunization history timely for 1 of 1 new patient record review. (Patient 5) Findings include: An October 2019 policy titled Vaccinations for Adult Hemodialysis Patient was provided by the MCS (Manager of Clinical Services) on 12/3/2021 at 12:00 p.m. The policy indicated, but was not limited to, "7. Refusal will be documented on the consent form. 8. The consent from must be completed and filed in the patient's medical record." The complete clinical record for patient 5 was reviewed on 12/3/2021. Patient 5 was admitted to dialysis on 9/28/2021, hospitalized on 10/27/2021, and passed away on 12/2/2021. The facility failed to ensure a copy of the consent form for hepatitis B and pneumococcal vaccines were completed and in the record. During an interview on 12/3/2021 at 11:00 a.m. the	V 0506	V506 100% of clinical teammates will be in-serviced on Policy 1-06-08 “VACCINATIONS FOR ADULT HEMODIALYSIS PATIENTS’. Verification of attendance is evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Refusal will be documented on the consent form. 2) The consent form must be completed and filed in the patient’s medical record. A consent/declination form for hepatitis B and pneumonia will be completed for Patient # 5 and will be maintained in the patient’s medical record. The Facility Administrator or designee will audit 100% of facility patient’s records to verify compliance with facility policy. A consent/	01/27/2022

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	FA confirmed the signed consents were not in the record and was unable to confirm if the patient was offered the vaccines. At 12:00 p.m. the MCS indicated a reasonable time frame to offer the vaccines would be one month.		declination form will be completed for any patient without documentation of vaccination consent/declination in the medical record. Ongoing compliance will be verified with 10% of medical records audited monthly during the medical record audit. The FA will review audit results with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI), known as Facility Health Meeting (FHM). The FA is responsible for ongoing compliance with the plan of Correction.	
V 0543 Bldg. 00	494.90(a)(1) POC-MANAGE VOLUME STATUS 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; Based on observation, record review, and interview, the facility failed to follow their policy and ensure the PCT (patient care technician) notified a licensed nurse of BP (blood pressure) of rates not within parameters for 2 of 8 in-center records reviewed (Patient 2, 10); failed to ensure patients received heparin as ordered by the physician for 1 of 4 in-center patients receiving heparin by pump (Patient 16); failed to ensure patients' blood pressures were within a desired range pre/intradialytic/post dialysis treatment for 5 of 8 in-center patient records reviewed. (Patient 2, 5, 7, 8, 10); and failed to ensure the nurse verified machine set-up timely for 3 of 8 in-center patient records reviewed. (Patient 1, 2, 3)	V 0543	V543 100% of teammates will be in-serviced on Policy 1-03-08 “PRE-INTRA-POST TREATMENT DATA COLLECTION, MONITORING AND NURSING ASSESSMENT” and Policy 1-06-01 “Medication Policy”, and Policy 1-06-02 “Anticoagulation”. Verification of attendance is evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) …the prescription components are	01/27/2022

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	Findings include: 1. An April 2021 policy titled Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment was provided by the MCS (Manager of Clinical Services) on 12/1/2021 at 2:00 p.m. The policy indicated, but was not limited to, "3. ... The prescription components are confirmed by a licensed nurse within one (1) hour of treatment initiation along with the nursing assessment ... "9. Vital signs and treatment monitoring i. For non-nocturnal treatments is completed at least every thirty (30) minutes ... 11. Abnormal findings or findings outside of any patient specific physician ordered parameters will be reported to the licensed nurse immediately ... 13. All findings, interventions and patient response will be documented in the patient's medical record ... 16. If an abnormal finding(s) or concern is identified post treatment, this needs to be reported to the licensed nurse. The licensed nurse will assess the patient prior to discharge. ... Abnormal Findings ... the following are considered abnormal findings and should be reported to the licensed nurse and documented in the patient's medical record ... the teammate who is observing or collecting information should report to the licensed nurse whenever there is concern for the patient's condition or potential safety of initiating dialysis, even in the absence of specific abnormal findings. ... Fluid Status: ... Post-treatment If patient is above or below 1 kg from the target weight Blood Pressure: Pre-dialysis: Systolic greater than 180 mm/Hg or less than 90 mm/Hg * Diastolic greater than or equal to 100 mm/Hg ... Blood Press-Intradialytic: Difference of 20 mm/Hg increase or decrease from patient's last intradialytic treatment BP [blood pressure] reading ... Blood Pressure Post		confirmed by a licensed nurse within one (1) hour of treatment initiation along with the nursing assessment…2) Vital signs and treatment monitoring: For non-nocturnal treatment is completed at least every thirty (3) minutes. 3) Abnormal findings or findings outside of any patient specific physician ordered parameters will be reported to the licensed nurse immediately…4) All findings, interventions and patient response will be documented in the patient's medical record. 5) If an abnormal finding(s) or concern is identified post treatment, this needs to be reported to the licensed nurse. 6) The licensed nurse will assess the patient prior to discharge. 7) ABNORMAL FINDINGS: …the following are considered abnormal findings and should be reported to the licensed nurse and documented in the patient' medical record…8) …the teammate who is observing or collecting information should report to the licensed nurse whenever there is concern for the patient's condition or potential safety of initiating dialysis, even in the absence of specific abnormal findings…9) FLUID STATUS: Post-treatment: If patient is above or below 1 kg from the target weight. 10) BLOOD PRESSURE: Pre dialysis: Systolic greater than 180 mm/Hg or less than 90	

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	Treatment: ... * If the patient can stand: Standing systolic: B/P greater than 140 mm/Hg or less than 90 mm/Hg * Standing diastolic: BP greater than 90 mm/Hg or less than 50 mm/Hg * Sitting BP for patients that cannot stand: Sitting systolic BP greater than 140 mm/Hg or less than 90 mm/Hg * Sitting diastolic BP greater than 90 mm/Hg or less than 50 mm/Hg ... Vascular Access: ... bleeding ... " 2. An April 2021 policy titled Medication Policy was provided by the MCS on 12/2/2021 at 10:10 a.m. The policy indicated, but was not limited to, "9. Medications are administered as prescribed and then documented in the patient's medical record. ... 36. ... Examples of medication errors include: ... · A prescribed medication not administered to the patient ... A prescribed medication administered by an incorrect infusion rate." 3. An October 2020 policy titled Anticoagulation was provided by the MCS on 12/3/2021 at 12:00 p.m. The policy indicated, but was not limited to, "3. Heparin is administered per physician's order. ... 15. It is recommended that the heparin hourly infusion be discontinued 60 minutes prior to end of treatment for patients with arterio-venous (AV) fistulas and / or AV grafts per physician order. It is recommended that the heparin hourly infusion be continued for the entire treatment for patients with CVCs. ... 16. Post treatment, the following is documented; · Total amount of heparin administered · Comments reflecting problems or changes in coagulation status including excessive bleeding ..." 4. The Centers for Medicare and Medicaid Services (CMS) Measures Assessment Tool (MAT) identifies the desired pre-Blood Pressure		mm/Hg. Diastolic greater than or equal to 100 mm/Hg. Blood Pressure-Intradialytic: Difference of 20 mm/Hg increase or decrease from patient's last intradialytic treatment BP reading…Blood Pressure-Post Treatment: If the patient can stand: Standing systolic BP greater than 140 mm/Hg or less than 90 mm/Hg; Standing diastolic BP greater than 90 mm/Hg or less than 50 mm/Hg; Sitting BP for patient's that cannot stand: Sitting systolic BP greater than 140 mm/ Hg or less than 90 mm/Hg; Sitting diastolic BP greater than 90 mm/Hg or less than 50 mm/Hg. VASCULAR ACCESS: …bleeding…11) Medications are administered as prescribed and then documented in the patient's medical record. 12) …Examples of medication errors include: …A prescribed medication not administered to the patient…A prescribed medication administered by an incorrect infusion rate. 13) Heparin is administered per physician's order. 14) It is recommended that the heparin hourly infusion be discontinued 60 minutes prior to end of treatment for patients with arterio-venous (AV) fistulas and/or AV grafts per physician order. It is recommended that the heparin hourly infusion be continued for the entire treatment for patients with CVC. 15) Post treatment, the following is documented: Total	

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	(B/P) <140/90; post (B/P) <130/80 (adult). 5. The complete clinical record for patient 1 was reviewed on 12/1/2021. Review of patient 1's Intradialytic record dated 11/9/2021 indicated dialysis treatment was initiated at 10:01 a.m. RN T verified machine prescription components at 11:47 a.m. Review of Intradialytic record dated 11/11/2021 indicate dialysis treatment was initiated at 10:09 a.m. RN T verified machine prescription components at 11:37 a.m. Review of Intradialytic record dated 11/13/2021 indicated dialysis treatment was initiated at 10:04 a.m. RN N verified machine components at 11:21 a.m. The facility failed to confirm prescription components with in 1 (one) hour of treatment initiation. 6. The complete clinical record for patient 2 was reviewed on 12/2/2021. Review of patient 2's Intradialytic record dated 11/13/2021 indicated dialysis treatment was initiated at 11:10 a.m. RN N verified machine prescription components at 12:44 p.m. The facility failed to confirm prescription components within 1 hour of treatment initiation. Review of patient 2's 11/8/2021 Pre-treatment Vitals indicated a sitting B/P (blood pressure) of 154/101, standing B/P of 152/97. Post-Treatment Vitals indicated a sitting B/P of 148/111, standing B/P of 156/100. No documentation that a prescribed prn (as needed) Clonidine (high blood pressure medication) pill was given or offered for patient 2's high B/P prior to leaving the facility. The facility failed to ensure the patient met a desired pre-Blood Pressure (B/P) <140/90; post (B/P) <130/80 (adult). Review of patient 2's 11/15/2021 Pre-treatment Vitals indicated a sitting B/P of 154/103, standing B/P of 190/109. Post-Treatment Vitals indicated a		amount of heparin administered; Comments reflecting problems or changes in coagulation status including excessive bleeding…The Facility Administrator or designee will audit twenty-five percent (25%) of post treatment records daily x2 weeks and then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified with ten percent (10%) of post treatment records audited monthly x 3 months. The FA will review audit results with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI), known as Facility Health Meeting (FHM). The FA is responsible for ongoing compliance with the plan of Correction.	

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	sitting B/P of 207/120, standing B/P of 197/113. Review of the Intradialytic record for 11/15/2021 indicated the following B/Ps: B/P of 154/103 at 8:45 a.m., by PCT K; B/P of 145/121 at 9:01 a.m., by RN N; B/P of 172/103 at 9:31 a.m., by RN N; B/P of 166/105 at 10:01 a.m., by RN N; B/P of 160/101 at 10:31 a.m., by PCT DD; B/P of 156/133 at 11:01 a.m., by RN N; B/P of 171/118 at 11:32 a.m., by RN N; B/P of 198/103 at 12:01 p.m., by PCT DD; B/P of 151/112 at 12:32 p.m., by PCT DD; and ending B/P of 207/120 at 1:02 p.m. by PCT DD. No documentation that a prescribed prn Clonidine pill was given or offered for patient 2's high B/P prior to leaving the facility. The facility failed to ensure the patient met a desired pre-Blood Pressure (B/P) <140/90; post (B/P) <130/80 (adult). Review of patient 2's 11/12/2021 Intradialytic record indicated a B/P of 162/84 at 12:02 p.m., by PCT S and an ending sequential B/P of 158/39 at 12:28 p.m., by PCT S. The PCT failed to report a drop of B/P greater than 20 mm/Hg to a licensed nurse. 7. The complete clinical record for patient 3 was reviewed on 12/3/2021. Review of patient 3's Intradialytic record dated 11/24/2021 indicated dialysis treatment was initiated at 10:45 a.m. RN E verified machine prescription components at 12:24 p.m. The facility failed to confirm prescription components within 1 hour of treatment initiation. 8 The complete clinical record for patient 5 was reviewed on 12/2/2021. Review of patient 2's Kardex prn (as needed) orders indicated Clonidine 0.10 mg (milligram) pill by mouth as needed for high blood pressure. Review of patient 5's 10/12/2021 Pre-Treatment Vitals indicated a sitting B/P (blood pressure) of			

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	169/101 and a standing B/P of 187/105. Review of the Intradialytic record dated 10/12/2021 indicated a B/P of 169/101 at 11:18 a.m., by PCT (patient care technician) L; B/P of 183/104 at 11:35 a.m. by PCT L; B/P of 152/123 at 12:08 p.m., by PCT L; B/P of 169/109 at 12:10 p.m., by PCT BB; B/P of 185/100 at 12:26 p.m., by PCT BB. The PCTs failed to notify the licensed nurse of a high blood pressure throughout dialysis treatment. The Post Treatment Vitals indicated patient 2 left the facility with a B/P of 185/100. The facility failed to document whether a prn Clonidine was offered or refused. The facility failed to ensure the patient met a desired pre-Blood Pressure (B/P) <140/90; post (B/P) <130/80 (adult). Review of patient 5's 10/14/2021 Pre-Treatment Vitals indicated a sitting B/P of 174/105 and a standing B/P of 198/103. Review of the Intradialytic record dated 10/14/2021 indicated a B/P of 174/105 at 11:15 a.m., by PCT CC; B/P of 191/104 at 11:36 a.m., by PCT DD; B/P of 197/108 at 12:06 p.m., by RN T; B/P of 207/108 at 12:36 p.m., by RN T; B/P of 201/116 at 1:06 p.m., by PCT CC; B/P of 189/107 at 1:36 p.m., by PCT CC; B/P of 213/111 at 2:06 p.m., by PCT CC; B/P of 192/103 at 2:36 p.m., by RN T; and ending B/P of 202/111 at 2:43 p.m. The Post Treatment Vitals indicated patient 2 left the facility with a B/P of 202/111. The facility failed to document whether a prn Clonidine was offered or refused. The facility failed to ensure the patient met a desired pre-Blood Pressure (B/P) <140/90; post (B/P) <130/80 (adult). Review of patient 5's 10/232021 Pre-Treatment Vitals indicated a sitting B/P of 185/102 and a standing B/P of 201/104. Review of the Intradialytic record dated 10/23/2021 indicated a B/P of 185/102 at 11:58 a.m., by PCT DD; B/P of 164/86 at 12:05 p.m., by PCT DD; B/P of 187/105 at			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12:35 p.m., by RN E; B/P of 207/116 at 1:05 p.m., by PCT BB; B/P of 174/107 at 1:35 p.m., by PCT BB; B/P of 181/134 at 2:05 p.m., by PCT BB; B/P of 163/104 at 2:35 p.m., by RN E; and ending B/P of 187/111 at 2:44 p.m., by PCT BB. The Post-Treatment Vitals indicated patient 5 left the facility with a B/P of 187/111. The facility failed to document whether a prn Clonidine was offered or refused. The facility failed to ensure the patient met a desired pre-Blood Pressure (B/P) <140/90; post (B/P) <130/80 (adult). 9. The complete clinical record for patient 7 was reviewed on 11/30/2021. Review of patient 7's Kardex prn orders indicated an order for Clonidine 0.10 mg 1 tab by mouth as needed for high blood pressure. Review of patient 7's 11/9/2021 Pre-Treatment Vitals indicated a sitting B/P of 205/141 and a standing B/P of 222/155. Review of the Intradialytic record dated 11/9/2021 indicated a B/P of 205/141 at 6:28 a.m., by PCT DD; B/P of 195/137 at 6:59 a.m., by PCT CC; B/P of 191/130 at 7:29 a.m., by PCT DD; B/P of 216/137 at 7:59 a.m., by PCT CC; B/P of 227/132 at 8:29 a.m., by PCT CC; B/P of 216/154 at 8:59 a.m., by PCT CC; B/P of 228/150 at 9:30 a.m., by RN T; B/P of 202/135 at 10:00 a.m., not noted by staff; B/P of 233/152 at 10:02 a.m., by PCT DD. The Post-Treatment Vitals indicated patient 7 left the facility with a sitting B/P of 202/135 and a standing B/P of 233/152. The facility failed to document whether a prn Clonidine was offered or refused. The facility failed to ensure the patient met a desired pre-Blood Pressure (B/P) <140/90; post (B/P) <130/80 (adult). Review of patient 7's 11/10/2021 Pre-Treatment Vitals indicated a sitting B/P of 193/132 and a standing B/P of 110/76. Review of the Intradialytic			

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	152569	A. BUILDING 00 B. WING	12/03/2021

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	record dated 11/10/2021 indicated a B/P of 193/132 at 6:26 a.m., by PCT CC; B/P of 188/128 at 6:31 a.m., by RN E; B/P of 178/126 at 7:01 a.m., by RN N; B/P of 199/131 at 7:31 a.m., by RN N; B/P 171/110 at 8:01 a.m., by RN N; B/P of 184/114 at 8:31 a.m., by PCT L; B/P of 172/113 at 9:01 a.m., by RN N; B/P of 188/128 at 9:16 a.m., by RN N. The Post-Treatment Vitals indicated patient 7 left the facility with a sitting B/P of 188/128 and a standing B/P of 195/129. The facility failed to document whether a prn Clonidine was offered or refused. The facility failed to ensure the patient met a desired pre-Blood Pressure (B/P) <140/90; post (B/P) <130/80 (adult). 10. The complete clinical record for patient 8 was reviewed on 12/2/2021. Review of patient 2's Kardex prn orders indicated an order for Clonidine 0.10 mg 1 tab by mouth as needed for high blood pressure. Review of patient 8's 11/15/2021 Pre-Treatment Vitals indicated a sitting B/P of 216/61. Review of the Intradialytic record dated 11/15/2021 indicated a B/P of 248/99 at 7:09 a.m., by PCT K; B/P of 216/81 at 7:11 a.m., by PCT K; B/P of 234/91 at 7:32 a.m., by PCT K; B/P of 211/88 at 8:02 a.m., by RN N; B/P of 206/78 at 8:32 a.m., by PCT DD; B/P of 126/56 at 9:02 a.m., by PCT DD; B/P of 192/83 at 9:32 a.m., by PCT DD; B/P of 197/177 at 10:01 a.m., by PCT DD; B/P of 212/83 at 10:03 a.m., by PCT DD; B/P of 195/145 at 10:31 a.m., by RN N; and ending B/P of 206/149 at 10:45 a.m. The Post Treatment Vitals indicated patient 8 left the facility with a B/P of 206/149. The PCT failed to notify the licensed nurse of a rise or drop of 20 mm/Hg in blood pressure. The facility failed to document whether a prn Clonidine was offered or refused. The facility failed to ensure the patient met a desired pre-Blood Pressure (B/P) <140/90; post			

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	(B/P) <130/80 (adult). Review of patient 8's 12/1/2021 Pre-Treatment Vitals indicated a sitting B/P of 182/73 and a standing B/P of 205/81. Review of The Post Treatment Vitals indicated patient 8 left the facility with a B/P of 131/113. The facility failed to document whether a prn Clonidine was offered or refused. 11. The complete clinical record for patient 10 was reviewed on 11/30/2021. Review of patient 10's Kardex prn orders indicated an order for Clonidine 0.10 mg 1 tab by mouth as needed for high blood pressure. Review of patient 10's 11/9/2021 Pre-Treatment Vitals indicated a sitting B/P of 152/98 and a standing B/P of 162/105. Review of the Intradialytic record dated 11/9/2021 indicated a B/P of 168/104 at 12:01 p.m., by PCT L and a sequential B/P of 152/101 at 12:05, by PCT L. The Post-Treatment Vitals indicated patient 10 left the facility with a sitting B/P of 152/101 and a standing B/P of 142/92. The facility failed to document whether a prn Clonidine was offered or refused. The facility failed to ensure the patient met a desired pre-Blood Pressure (B/P) <140/90; post (B/P) <130/80 (adult). Review of patient 10's 11/20/2021 Pre-Treatment Vitals indicated a sitting B/P of 163/90 and a standing B/P of 170/105. Review of the Intradialytic record dated 11/20/2021 indicated a B/P of 176/108 at 11:02 a.m., by PCT BB; B/P of 177/119 at 11:32 a.m., by PCT L; B/P of 153/108 at 11:56 a.m., by PCT L. The Post-Treatment Vitals indicated patient 10 left the facility with a sitting B/P of 153/108 and a standing B/P of 167/108. The facility failed to document whether a prn Clonidine			

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	was offered or refused. The facility failed to ensure the patient met a desired pre-Blood Pressure (B/P) <140/90; post (B/P) <130/80 (adult). Review of patient 10's 11/22/2021 Pre-Treatment Vitals indicated a sitting B/P of 165/104 and a standing B/P of 149/104. Review of the Intradialytic record dated 11/22/2021 indicated a B/P of 165/104 at 8:15 a.m., by PCT CC; B/P of 161/108 at 8:31 a.m., by RN D; B/P of 170/100 at 9:01 a.m., by RN E; 158/98 at 10:01 a.m., by PCT K; B/P of 180/107 at 10:31 a.m., by PCT K; B/P of 172/106 at 11:01 a.m., by PCT K; B/P of 158/107 at 11:31 a.m.., by PCT CC; B/P of 191/104 at 12:01 p.m., by PCT K. The Post-Treatment Vitals indicated patient 10 left the facility with a sitting B/P of 191/104 and a standing B/P of 187/98. The PCTs failed to report a rise or drop of 20 mm/Hg in blood pressure. The facility failed to document whether a prn Clonidine was offered or refused. The facility failed to ensure the patient met a desired pre-Blood Pressure (B/P) <140/90; post (B/P) <130/80 (adult). Review of patient 10's 11/24/2021 Post-Treatment Vitals indicated patient 10 left the facility with a pulse of 116. No documentation that the patient was symptomatic or if the physician was notified of a heart rate greater than 110 as ordered. 12. The complete clinical record for patient 16 was reviewed on 12/2/2021. Review of patient 16's Prescription Information dated 11/22/2021 and 11/24/2021 indicated Heparin Dose of 600 units/hour was to stop 60 minutes before the end of dialysis. Review of patient 16's Intradialytic record dated 11/22/2021 indicated Heparin was stopped at 1:02 p.m., and the treatment ended at 1:32 p.m. The			

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	facility failed to stop Heparin 60 minutes before the end of treatment. Review of patient 16's Intradialytic record dated 11/24/2021 indicated Heparin was not given the entire treatment. At 12:21 p.m. RN E documented "heparin set did not start". The facility failed to ensure patient 16 received the prescribed Heparin and failed to notify the physician of the missed Heparin. 13. During an interview on 12/2/2021 at 7:50 a.m. the Medical Director was asked what his/her expectations are for staff to do for someone with a high blood pressure during dialysis and after treatment. The Medical Director indicated staff are to adhere to facility policies and address the high blood pressure during and after treatment by offering a prn (as needed) blood pressure pill and document the response or refusal. The Medical Director or physician should be made aware. 14. During an interview on 12/3/2021 at 10:45 a.m. the FA confirmed that heparin was stopped short and not given for patient 16. The FA indicated the machines are old and they would be getting new machines. The FA was unable to provide additional information as to why a back-up machine was not used if the machine was unable to deliver the prescribed Heparin and why the physician was not notified of the missed Heparin.			
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.			

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	Based on record review and interview, the facility failed to ensure facility policy was followed that a licensed nurse was notified the prescribed BFR's (blood flow rate) was achieved and maintained throughout dialysis treatments for 1 of 1 records reviewed of an unstable patient. (Patient 2) Findings include: A revised April 2021 policy titled Pre-Intra-Post Treatment Data Collection Monitoring and Nursing Assessment was provided by the MCS (Manager of Clinical Services) on 12/1/2021 at 2:00 p.m. The policy indicated, but was not limited to, "10. If the dialysis prescription is not being met (including dialysis flow rate or change to / inability to obtain prescribed blood flow flow rate) the reason will be documented and the licensed nurse informed.)" The complete clinical record for patient 2 was reviewed on 12/2/2021. Review of patient 2's Prescription Information indicated orders for a BFR of 400 ML/min. for the following treatment sheets reviewed: Review of the Intradialytic record dated 11/8/2021 indicated a BFR of 350 for the following times: 9:01 a.m., by PCT BB; 9:31 a.m., by PCT BB; 10:01 a.m., by PCT BB; 10:31 a.m., by PCT L; 11:01 a.m., PCT P; 11:31 a.m., PCT BB; and a BFR of 250 at 11:33 a.m., by PCT BB. The PCTs failed to follow facility policy by notifying the nurse and documenting a reason the BFR was not met for patient 2. Review of the Intradialytic record dated 11/10/2021 indicated a BFR of 350 for the following times: 11:01 a.m., by PCT L; 11:31 a.m. by PCT L. The BFR was lowered to 300 for the	V 0544	V544 100% of teammates will be in-serviced on policy 1-03-08 “PRE-INTRA-POST TREATMENT DATA COLLECTION, MONITORING AND NURSING ASSESSMENT”. Verification of attendance is evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) If the dialysis prescription is not being met (including dialysis flow rate or change to/inability to obtain prescribed blood flow rate) the reason will be documented and the licensed nurse informed. The Facility Administrator (FA) or designee will audit twenty-five (25%) of post treatment records daily x 2 weeks and then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified with 10% of post treatment records audited monthly x 3 months. The FA will review audit results with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI), known as Facility Health Meeting (FHM). The FA is responsible for ongoing compliance with the plan of Correction.	01/27/2022

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	following times: 12:02 p.m., by PCT L; 12:31 p.m., by PCT L; 1:01 p.m., by RN N; 1:31 p.m., by PCT CC; 1:47 p.m., by PCT CC. The PCT failed to inform and document the licensed nurse as to why the BFR was lowered. At 2:02 p.m. RN N documented "Ran well on prescuirbed [sic] FBR [sic]" RN N failed to accurately document the BFR delivered for patient 2. Review of Intradialytic record dated 11/15/2021 indicated a BFR of 300 for the following times: 9:31 a.m., by RN N; 9:31 a.m., by RN N; 10:01 a.m., by RN N; 10:31 a.m., by PCT DD; 11:01 a.m., by RN N; 11:32 a.m., RN N; 12:01 p.m., PCT DD; 12:32 p.m., by PCT DD; 1:02 p.m., by PCT DD. At 1:54 p.m. RN N documented "Ranw [sic] ell [sic] on prescuirbed [sic] FBR [sic]" RN N failed to accurately document the BFR delivered for patient 2. The facility failed to indicate a reason the BFR was not delivered as prescribed. Review of Intradialytic record dated 11/19/2021 indicated a BFR of 350 for the following times: 9:31 a.m., by RN N; 10:08 a.m., by RN N; 10:31 a.m., by PCT S; 11:02 a.m., by PCT S; 11:31 a.m., by PCT S. The BFR was lowered to 300 for the following times: 12:02 p.m., by PCT CC; 12:12 p.m., by RN N. At 12:15 p.m. RN N documented "Ranw [sic] ell [sic] on prescribed FBR [sic]" The facility failed to indicate a reason the BFR was not delivered as prescribed. Review of Intradialytic record dated 11/27/2021 indicated a BFR of 300 for the following times: 11:32 a.m., by PCT S; 11:35 a.m., BFR decreased to 300 [due to] high [arterial pressure], by PCT S; 12:02 p.m., by PCT S; 12:32 p.m., by RN N; 1:03 p.m., by RN N; 1:32 p.m., by PCT EE; 1:34 p.m., PCT EE. At 1:49 p.m. RN N documented "Ranw [sic] ell [sic] on prescirbe BFR" RN N failed to			

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	accurately document the BFR delivered for patient 2. Review of Intradialytic record dated 12/1/2021 indicated a BFR of 350 for the following times: 10:03 a.m., by RN E; 10:33 a.m., by RN E; 11:03 a.m., by RN E; 11:33 a.m., by PCT FF; 12:03 p.m., by PCT FF; 12:34 p.m., by PCT FF; 12:37 p.m., by PCT FF. The facility failed to ensure the BFR was met as prescribed. During a interview on 12/3/2021 at 12:00 p.m. the MCS confirmed the BFR was not met and the RN documented that it was. The MCS indicated the RN was educated on documenting the correct BFR in the notes but was unsure of the date he/she spoke to the RN.			
V 0628 Bldg. 00	494.110(a)(2) QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves. Based on record review and interview, the facility failed to collect information about patient deaths, conduct analysis of individual patient deaths and recognize trends in causes and contributory factors to deaths for 1 of 1 QAPI (quality assessment performance improvement) review. Findings include: A 2021 policy titled Continuous Quality	V 0628	V628 100% of Continuous Quality Improvement(CQI) committee members will be in-serviced on Policy 1-14-06 “CONTINUOUS QUALITY IMPROVEMENT PROGRAM”. Verification of attendance is evidenced by a signature sheet. CQI committee members will be instructed using surveyor observations as examples with emphasis on, but	01/27/2022

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	Improvement Program was provided by the MCS (Manager of Clinical Services) on 12/3/2021 at 12:00 p.m. The policy indicated, but was not limited to, "2. Facility Administrators (FAs) conduct periodic Facility Health Meetings (FHM) (also known as QAPI in the CMS Conditions for Coverage) ... FHMs are conducted monthly. ... The facility will measure, analyze, and track quality indicators or to the aspects of performance ... Mortality - review of deaths ... 8. Continuous monitoring of the above indicators will be reflected in the meeting minutes. Any area identified as underperforming will be reviewed to identify root causes for underperformance, will have an action plan identified that will result in performance improvement, and will track this change in performance over time to verify improvements are sustained." During an interview on 12/3/2021 at 9:30 a.m. the FHM (also known as QAPI in the CMS Conditions for Coverage) was reviewed along with RN C. The FHM data sheet indicated no available information regarding facility deaths. The facility failed to collect information about patient deaths, conduct an analysis of individual patient deaths, and recognize trends in causes and contributory factors to deaths when asked. At 11:00 a.m. the FA confirmed the facility did not have available information about facility deaths and was not monitored monthly.		not limited to the following: 1) Facility Administrators (FAs) conduct periodic Facility Health Meetings (FHM) (also known as QAPI in the CMS Conditions for Coverage) with the CQI committee members to review issues and indicators regarding facility's management and performance. 2) FHMs are conducted monthly. 3) The facility will measure, analyze, and track quality indicator or other aspects of performance. 4) The program must include, but not be limited to…: Mortality – review of deaths…5) Continuous monitoring of the above indicators will be reflected in the meeting minutes. 6) Any area identified as underperforming will be reviewed to identify root causes for underperformance, will have an action plan identified that will result in performance improvement, and will track this change in performance over time to verify improvements are sustained. The FA will review all patient deaths with the Medical Director and CQI committee monthly during Quality Improvement Performance (QAPI), known as Facility Health Meeting (FHM). The CQI committee will analyze and track patient deaths and develop action plans as needed. The GB will meet monthly for 3 months to review FHM minutes documenting the trending of patient mortality in compliance	

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			with facility policy. The FA is responsible for ongoing compliance with this plan of care.	
V 0632 Bldg. 00	494.110(a)(2)(iv) QAPI-INDICATOR-ANEMIA MANAGEMENT The program must include, but not be limited to, the following: (iv) Anemia management. Based on record review and interview, the facility failed to ensure anemia management was tracked monthly for 1 of 1 QAPI (quality assessment performance improvement) review. Findings include: A 2021 policy titled Continuous Quality Improvement Program was provided by the MCS (Manager of Clinical Services) on 12/3/2021 at 12:00 p.m. The policy indicated, but was not limited to, "2. Facility Administrators (FAs) conduct periodic Facility Health Meetings (FHM) (also known as QAPI in the CMS Conditions for Coverage) ... FHMs are conducted monthly. ... The facility will measure, analyze, and track quality indicators or to the aspects of performance ... Anemia Management ... Mortality - review of deaths ... 8. Continuous monitoring of the above indicators will be reflected in the meeting minutes. Any area identified as underperforming will be reviewed to identify root causes for underperformance, will have an action plan identified that will result in performance improvement, and will track this change in performance over time to verify improvements are sustained." During entrance conference on 11/30/2021 at 10:16 a.m. the data core worksheet was reviewed along with the FA. The review indicated anemia was a	V 0632	V632 100% of Continuous Quality Improvement (CQI) committee members will be in-serviced on Policy 1-14-06 “CONTINUOUS QUALITY IMPROVEMENT PROGRAM”. Verification of attendance is evidenced by a signature sheet. CQI committee members will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Facility Administrators (FAs) conduct periodic Facility Health Meetings (FHM) (also known as QAPI in the CMS Conditions for Coverage) with the CQI committee members to review issues and indicators regarding facility’s management and performance. 2) FHMs are conducted monthly. 3) The facility will measure, analyze, and track quality indicator or other aspects of performance. 4) The program must include, but not be limited to…Anemia Management…5) Continuous monitoring of the above indicators will be reflected in the meeting minutes. 6) Any area identified as underperforming will be reviewed to	01/27/2022

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	focus area for the survey. The ESRD Core Survey Data Worksheet completed by the FA indicated 16 in-center patients with a hemoglobin less than 10 g/dL. The FA agreed anemia was as outlier and was an area of focus for the recertification survey. During an interview on 12/3/2021 at 9:30 a.m. the FHM was reviewed along with RN C. The facility failed to measure, analyze, and track quality indicators of anemia management. The facility failed to keep meeting minutes that would identify root causes for under performance and an action plan for the last 6 months. At 11:00 a.m. the FA confirmed anemia was not monitored monthly. At 12:00 p.m. the MCS indicated the facility should have tracked anemia management in the FHM.		identify root causes for underperformance, will have an action plan identified that will result in performance improvement, and will track this change in performance over time to verify improvements are sustained. The FA will review anemia management data for facility patients with a hemoglobin less than 10 g/dl with the Medical Director and CQI committee during monthly Quality Improvement Performance (QAPI), known as Facility Health Meeting (FHM). The CQI committee will analyze anemia data to identify root causes for underperformance and identify action plans to improve performance and track over time to verify improvement for anemia management is sustained. The GB will meet monthly for 3 months to review FHM minutes documenting the trending of patient mortality in compliance with facility policy. The FA is responsible for ongoing compliance with this plan of care.	
V 0715 Bldg. 00	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	12/03/2021

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	nonphysician providers; Based on observation, interview, and record review, the Medical Director failed to ensure adherence to policies and procedures for chlorine test strip bottle without a cap in place and tightly secured for 1 of 1 chlorine test strip observation in the isolation room. Findings include: A March 2015 policy titled Daily Water System Total Chlorine Monitoring was provided by the MCS on 12/1/2021 at 2:00 p.m. The policy indicated, but was not limited to "8. Verify cap is in place and tightly secured both pre and post use of test strips." During a flash tour observation of the isolation room on 11/30/2021 at 9:30 a.m. 1 bottle of chlorine test strips was sitting a counter without the cap in place and tightly secured. At that time, RN E was interviewed and indicated the bottle should have a cap on it.	V 0715	V715 The Governing Body will meet and review surveyor findings and Policy COMP-DD-017 "Medical Director Qualifications and Responsibilities" with the Medical Director with emphasis on: 1) Medical Director responsibilities include, but are not limited to…Oversight of policies and procedures relative to…safety are adhered to by all individuals who treat patients in the facility… Verification of attendance is evidenced by the Medial Director's signature on the policy. 100% facility teammates will be in-serviced on Policy 2-05-02 "DAILY WATER SYSTEM TOTAL CHLORINE MONITORING". Verification of attendance is evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Verify cap is in place and tightly secured both pre and post use of test strips. The Facility Administrator (FA) or designee will conduct observational audits daily x2 weeks and then weekly x 2 weeks to verify compliance with facility policy. The FA will review audit results with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI), known as Facility Health Meeting (FHM). The FA is responsible for	01/27/2022

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			ongoing compliance with the plan of Correction.	