

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

PRINTED: 04/07/2022

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152595	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DUNELAND DIALYSIS COFFEE CREEK	STREET ADDRESS, CITY, STATE, ZIP COD 3100 VILLAGE POINT STE 101 CHESTERTON, IN 46304
--	--

(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	<p>An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62, for a Medicare participating End Stage Renal Disease Supplier.</p> <p>Date of survey: 3/22/2022 to 3/25/2022</p> <p>Facility # 011217</p> <p>CCN: 152595</p> <p>Stations: 19</p> <p>ICHD Patients: 35</p> <p>Home Peritoneal Dialysis patients: 10</p> <p>Home Hemodialysis Patients: 5</p> <p>Total Census: 50</p> <p>At this Emergency Preparedness survey, Duneland Dialysis-Coffee Creek, was found to have been in compliance with the requirements of Emergency Preparedness Requirements for Medicare participating providers and suppliers, including staffing and implementation of staffing during a Pandemic, at 42 CFR 494.62.</p>	E 0000		
V 0000  Bldg. 00	<p>This survey was for a Federal Re-Certification and a complaint of an ESRD provider.</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:  152595	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DUNELAND DIALYSIS COFFEE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 VILLAGE POINT STE 101 CHESTERTON, IN 46304
--	---

(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 0504 Bldg. 00	<p>Complaint: IN00266082 - unsubstantiated</p> <p>Survey Dates: 3/22/2022 to 3/25/2022</p> <p>Facility: 011217</p> <p>Provider: 152595</p> <p>Stations: 19</p> <p>ICHD Patients: 35</p> <p>PD Patients: 10</p> <p>HHD Patients: 5</p> <p>Total Census: 50</p> <p>Quality Review Completed 04/01/2022</p> <p>494.80(a)(2) PA-ASSESS B/P, FLUID MANAGEMENT NEEDS The patient's comprehensive assessment must include, but is not limited to, the following:</p> <p>Blood pressure, and fluid management needs. Based on observation, record review, and interview the dialysis facility failed to ensure patient pre/post and intradialytic blood pressure were being assessed and managed in 4 of 4 incenter hemodialysis records reviewed. (#1, #2, #3, #4).</p> <p>The findings include:</p> <p>1. An agency policy titled "Intradialytic</p>	V 0504	FA or designee will in-service all direct care staff on policies C-TP-0060: Post Dialysis Assessment of Patient and C-ID-0010: Intradialytic Monitoring of Patient; and Parameters Reportable to the Charge Nurse tool as it relates to ensuring all vital signs outside of clinic approved ranges. FA or designee	04/24/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152595	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DUNELAND DIALYSIS COFFEE CREEK	STREET ADDRESS, CITY, STATE, ZIP COD 3100 VILLAGE POINT STE 101 CHESTERTON, IN 46304
--	--

(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>Monitoring of Patient" revised 9/2020, stated "The patient will receive safe, effective and comfortable treatment. Vital signs: obtained and documented every 30 minutes and reported to the charge nurse if outside parameters ... Notify the patient's physician of any significant change or problem..."</p> <p>2. An agency policy titled "Vital Signs" revised 5/2021, stated, " ... Notify charge nurse and/or physician of BP (blood pressure) readings outside specific parameters ... Notify the patient's physician of any significant change or problem...."</p> <p>3. An undated agency policy, retrieved on 03/25/2022, titled "Parameters Reportable to the Charge Nurse stated, " ... Blood Pressure Systolic &gt; [greater than] 160 or &lt; [less than] 100 Diastolic &gt;100 or &lt; 40 ... Pulse &gt;100 or &lt; 60...."</p> <p>4. Record review on 3/24/2022 for patient #1, start of care 8/17/2020, evidenced an agency document titled "Hemodialysis Flowsheet " dated 1/26/2022. This document indicated patient #1's pulse at 6:05 AM, was 38, at 6:33 AM, patient #1's pulse was 41, at 9:03 AM, the patient's blood pressure was 127/79, and at 9:28 AM, her blood pressure was 147/79. This document failed to evidence documentation the nurse was notified of more than 20-point change in blood pressure readings and low pulse.</p> <p>Record review on 3/24/2022 for patient #1, evidenced an agency document titled "Hemodialysis Flowsheet " dated 1/28/2022. This document indicated patient #1's blood pressure at 9:03 AM, was 145/75 and at 9:33 AM, her blood pressure was 165/93. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure</p>		<p>will conduct Prescription audit for 25% of patients daily x2 weeks, weekly x4 and resume auditing per the Quality Management Workbook audit schedule. FA or designee will conduct Flow Sheet audit for 10% of patents daily x2 weeks, weekly x4 and resume monthly auditing per the Quality Management Workbook audit schedule.</p> <p>FA is responsible to review all education and audit results in the monthly QAPI and governing body (GB) meetings for tracking and trending. If compliance is not progressing in a favorable direction, the Plan of Correction (POC) will be re-evaluated, revisions made, re-education (if indicated), corrective action for staff (if indicated) and monitoring will continue until substantial compliance is met.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152595	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DUNELAND DIALYSIS COFFEE CREEK	STREET ADDRESS, CITY, STATE, ZIP COD 3100 VILLAGE POINT STE 101 CHESTERTON, IN 46304
--	--

(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>readings.</p> <p>Record review on 3/24/2022 for patient #1, evidenced an agency document titled "Hemodialysis Flowsheet " dated 2/4/2022. This document indicated patient #1's blood pressure at 6:02 AM, was 147/45 and at 6:36 AM, her blood pressure was 116/55. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings.</p> <p>Record review on 3/24/2022 for patient #1, evidenced an agency document titled "Hemodialysis Flowsheet " dated 2/7/2022. This document indicated patient #1's blood pressure at 6:02 AM, was 119/62 and at 6:33 AM, her blood pressure was 98/61. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings.</p> <p>Record review on 3/24/2022 for patient #1, evidenced an agency document titled "Hemodialysis Flowsheet " dated 2/9/2022. This document indicated patient #1's blood pressure at 6:33 AM, was 167/91, at 7:03 AM, her blood pressure was 184/62, at 7:33 AM, her blood pressure was 188/56, and at 8:03 AM, her blood pressure was 142/74. This document failed to evidence documentation the nurse was notified of more than 20-point changes in blood pressure readings.</p> <p>Record review on 3/24/2022 for patient #1, evidenced an agency document titled "Hemodialysis Flowsheet " dated 3/18/2022. This document indicated patient #1's blood pressure at 5:33 AM, was 174/102, at 5:49 AM, her blood pressure was 197/104, at 6:02 AM, her blood</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152595	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DUNELAND DIALYSIS COFFEE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 VILLAGE POINT STE 101 CHESTERTON, IN 46304
--	---

(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 was 213/112, at 6:32 AM, her blood pressure was 207/125 and at 6:34 AM, her blood pressure was 187/109. This document failed to evidence documentation the nurse and physician were notified of patient #1's high blood pressure.</p> <p>5. Record review on 3/24/2022 for patient #2, start of care 12/24/2021, evidenced an agency document titled "Hemodialysis Flowsheet " dated 1/17/2022. This document indicated patient #2's blood pressure at 1:03 PM, was 98/55, at 2:46 PM, her blood pressure was 90/40, and at 3:16 PM, her blood pressure was 84/47. This document failed to evidence documentation the nurse and physician were notified of patient #2's low blood pressure.</p> <p>Record review on 3/24/2022, for patient #2, evidenced an agency document titled "Hemodialysis Flowsheet " dated 1/17/2022 This document indicated patient #2's blood pressure at 1:04 PM, was 96/45, at 2:46 PM, her blood pressure was 90/40, and at 2:03 PM, her blood pressure was 92/41, at 2:33 PM, patient #2's blood pressure was 81/24. This document failed to evidence documentation the nurse and physician were notified of patient #2's low blood pressures.</p> <p>Record review on 3/24/2022, for patient #2, evidenced an agency document titled "Hemodialysis Flowsheet " dated 1/26/2022 This document indicated patient #2's blood pressure at 2:36 PM, was 140/43, at 2:49 PM, her blood pressure was 105/44. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings.</p> <p>Record review on 3/24/2022, for patient #2, evidenced an agency document titled "Hemodialysis Flowsheet " dated 2/7/2022. This</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152595	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DUNELAND DIALYSIS COFFEE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 VILLAGE POINT STE 101 CHESTERTON, IN 46304
--	---

(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>document indicated patient #2's blood pressure at 2:04 PM, was 131/49, at 2:33 PM, her blood pressure was 104/37, at 3:32 PM, patient #2's blood pressure was 140/55, and at 4:07 PM, her blood pressure was 112/55. This document failed to evidence documentation the nurse was notified of more than 20-point changes in blood pressure readings.</p> <p>Record review on 3/24/2022, for patient #2, evidenced an agency document titled "Hemodialysis Flowsheet " dated 2/9/2022 This document indicated patient #2's blood pressure at 12:15 PM, was 138/36, at 2:31 PM, her blood pressure was 157/47, and at 2:50 PM, patient #2's blood pressure was 91/42. This document failed to evidence documentation the nurse was notified of more than 20-point changes in blood pressure readings.</p> <p>6. Record review on 3/24/2022 for patient #3, start of care 4/25/2015, evidenced an agency document titled "Hemodialysis Flowsheet " dated 2/25/2022. This document indicated patient #3's blood pressure at 1:44 PM, was 124/58, at 2:04 PM, patient #3's blood pressure was 150/65, at 3:19 PM, the patient's blood pressure was 157/68, at 3:34 PM, patient #3's blood pressure was 125/61, and at 3:49 PM, patient #3's blood pressure was 156/71. This document failed to evidence documentation the nurse was notified of the more than 20-point changes in blood pressure.</p> <p>Record review on 3/24/2022, for patient #3, evidenced an agency document titled "Hemodialysis Flowsheet " dated 2/28/2022. This document indicated patient #3's blood pressure at 2:04 PM, was 111/34, at 3:34 PM, patient #3's blood pressure was 134/50, at 3:04 PM, patient #3's blood pressure was 141/49, and at 3:31 PM,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152595	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DUNELAND DIALYSIS COFFEE CREEK	STREET ADDRESS, CITY, STATE, ZIP COD 3100 VILLAGE POINT STE 101 CHESTERTON, IN 46304
--	--

(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>the patient's blood pressure was 169/69. This document failed to evidence documentation the nurse was notified of the more than 20-point changes in blood pressure.</p> <p>Record review on 3/24/2022, for patient #3, evidenced an agency document titled "Hemodialysis Flowsheet " dated 3/2/2022. This document indicated patient #3's blood pressure at 1:34 PM, was 129/54 and at 2:04 PM, patient #3's blood pressure was 156/49. This document failed to evidence documentation the nurse was notified of the more than 20-point changes in blood pressure.</p> <p>Record review on 3/24/2022, for patient #3, evidenced an agency document titled "Hemodialysis Flowsheet " dated 3/4/2022. This document indicated patient #3's blood pressure at 12:32 PM, was 122/77, at 1:05 PM, patient #3's blood pressure was 147/68, at 3:22 PM, patient #3's blood pressure was 167/57 and at 3:40 PM, patient #3's blood pressure was 132/50. This document failed to evidence documentation the nurse was notified of the more than 20-point changes in blood pressure.</p> <p>Record review on 3/24/2022, for patient #3, evidenced an agency document titled "Hemodialysis Flowsheet " dated 3/7/2022. This document indicated patient #3's blood pressure at 12:41 PM, was 132/76, at 12:48 PM, patient #3's blood pressure was 161/80, at 1:03 PM, patient #3's blood pressure was 148/48, at 1:22 PM, patient #3's blood pressure was 122/24, at 2:32 PM, patient #3's blood pressure was 154/53, at 3:02 PM, the patient's blood pressure was 132/53, at 3:32 PM, the patient's blood pressure was 118/74, and at 3:43 PM, patient #3's blood pressure was 130/58. This document failed to</p>			

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

PRINTED: 04/07/2022  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152595	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DUNELAND DIALYSIS COFFEE CREEK	STREET ADDRESS, CITY, STATE, ZIP COD 3100 VILLAGE POINT STE 101 CHESTERTON, IN 46304
--	--

(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>evidence documentation the nurse was notified of the more than 20-point changes in blood pressure.</p> <p>Record review on 3/24/2022, for patient #3, evidenced an agency document titled "Hemodialysis Flowsheet " dated 3/9/2022. This document indicated patient #3's blood pressure at 3:36 PM, was 124/58, at 3:44 PM, patient #3's blood pressure was 104/54, and at 4:11 PM, the patient's blood pressure was 140/64. This document failed to evidence documentation the nurse was notified of the more than 20-point changes in blood pressure.</p> <p>Record review on 3/24/2022, for patient #3, evidenced an agency document titled "Hemodialysis Flowsheet " dated 3/11/2022. This document indicated patient #3's blood pressure at 12:20 PM, was 134/62, at 12:33 PM, patient #3's blood pressure was 176/93, at 2:32 PM, the patient's blood pressure was 137/71, at 2:59 PM, patient #3's blood pressure was 121/69, and at 3:33 PM, the patient's blood pressure was 178/43. This document failed to evidence documentation the nurse was notified of the more than 20-point changes in blood pressure.</p> <p>Record review on 3/24/2022, for patient #3, evidenced an agency document titled "Hemodialysis Flowsheet " dated 3/14/2022. This document indicated patient #3's blood pressure at 12:33 PM, was 157/84, at 1:05 PM, patient #3's blood pressure was 136/65, at 3:31 PM, the patient's blood pressure was 109/62, and at 3:50 PM, patient #3's blood pressure was 130/57. This document failed to evidence documentation the nurse was notified of the more than 20-point changes in blood pressure.</p> <p>Record review on 3/24/2022 for patient #3,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152595	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DUNELAND DIALYSIS COFFEE CREEK	STREET ADDRESS, CITY, STATE, ZIP COD 3100 VILLAGE POINT STE 101 CHESTERTON, IN 46304
--	--

(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>evidenced an agency document titled "Hemodialysis Flowsheet " dated 3/31/2022. This document indicated patient #3's blood pressure at 12:33 PM, was 151/70 and at 1:03 PM, patient #3's blood pressure was 121/61. This document failed to evidence documentation the nurse was notified of the more than 20-point changes in blood pressure.</p> <p>7. Record review on 3/24/2022 for patient #4, start of care 1/13/2017, evidenced an agency document titled "Hemodialysis Flowsheet " dated 3/2/2022. This document indicated patient #4's blood pressure at 8:32 AM, was 127/60 and at 9:02 AM, patient #4's blood pressure was 152/68. This document failed to evidence documentation the nurse was notified of the more than 20-point changes in blood pressure.</p> <p>Record review on 3/24/2022 for patient #4, start of care 1/13/2017, evidenced an agency document titled "Hemodialysis Flowsheet " dated 3/4/2022. This document indicated patient #4's blood pressure at 8:04 AM, was 133/61 and at 8:33 AM, patient #4's blood pressure was 154/71. This document failed to evidence documentation the nurse was notified of the more than 20-point changes in blood pressure.</p> <p>Record review on 3/24/2022 for patient #4, start of care 1/13/2017, evidenced an agency document titled "Hemodialysis Flowsheet " dated 3/9/2022. This document indicated patient #4's blood pressure at 9:32 AM, was 152/79 and at 9:56 AM, patient #4's blood pressure was 130/64. This document failed to evidence documentation the nurse was notified of the more than 20-point changes in blood pressure.</p> <p>Record review on 3/24/2022 for patient #4, start of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152595	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DUNELAND DIALYSIS COFFEE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 VILLAGE POINT STE 101 CHESTERTON, IN 46304
--	---

(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 0543 Bldg. 00	<p>care 1/13/2017, evidenced an agency document titled "Hemodialysis Flowsheet " dated 3/16/2022. This document indicated patient #4's blood pressure at 7:03 AM, was 162/74, at 7:33 AM, patient #4's blood pressure was 132/66, at 9:04 AM, patient #4's blood pressure was 163/68 and at 9:34 AM, patient #4's blood pressure was 130/63. This document failed to evidence documentation the nurse was notified of the more than 20-point changes in blood pressure.</p> <p>During an interview on 3/25/2022 at 1:54 PM, the facility administrator indicated the nurse should be notified of a 20-point change in blood pressure during treatment or any blood pressures outside of normal parameters.</p> <p>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 record review and interview, the facility failed to ensure patients' volume status were maintained by being within 1 kilogram (kg) of their expected dry weight post-treatment and failed to notify the physician when post-treatment weight was greater than/less than 1 kilogram of the ordered dry weight for 3 of 4 in center hemodialysis records reviewed (#1, #2, #3,)  The findings include:  1. An agency policy titled "Weighing Patients" revised 4/2020, stated, "To ensure proper weight measurement is completed prior to every dialysis treatment. It is imperative to weigh dialysis</p>	V 0543	FA or designee will in-service all direct care staff on policies C-PT-0010: Pre-Treatment Assessment of Patient and C-TP-0060: Post Dialysis Assessment of Patient as it relates to monitoring estimated dry weights and documenting changes in medical record; notifying the patient's physician if not achieving the EDW post dialysis. FA or designee will conduct Flow Sheet audit of 10% of patients daily x2 weeks, weekly x4, and resume monthly auditing	04/24/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152595	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DUNELAND DIALYSIS COFFEE CREEK	STREET ADDRESS, CITY, STATE, ZIP COD 3100 VILLAGE POINT STE 101 CHESTERTON, IN 46304
--	--

(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>patients properly and accurately as the goals of the treatment involve removal of excess fluid weight...."</p> <p>2. An agency policy titled "Post Dialysis Assessment of Patient, " revised 1/2020, stated, " ... Evaluate post weight variance from EDW [estimated dry weight]. If the post weight is +/- 1 kg from EDW evaluate the patient's condition, document, and contact the physician if assessment deems necessary ... Per facility specific reportable parameters. Notify the patient's physician of any significant changes or problems...."</p> <p>3. An undated agency policy, retrieved on 03/25/2022, titled "Parameters Reportable to the Charge Nurse stated, " ... "Weight Post Dialysis &gt; [greater than] 1 kg above or below EDW [estimated dry weight]...."</p> <p>4. Clinical record review on 3/24/2022, for patient #1, start of care 8/17/2020, evidenced an agency document titled "Hemodialysis Flowsheet" dated 1/26/2022. This document indicated patient #1's dry weight [a weight without excess fluid] was 106 kilograms (kg). At the completion of treatment patient #1's weight was 107.4 kg. This document failed to evidence documentation the physician was informed patient #1 failed to achieve her target dry weight.</p> <p>Clinical record review on 3/24/2022, for patient #1, evidenced an agency document titled "Hemodialysis Flowsheet" dated 1/31/2022. This document indicated patient #1's dry weight was 106 kg. At the completion of treatment patient #1's weight was 109 kg. This document failed to evidence documentation the physician was informed patient #1 failed to achieve her target dry</p>		<p>per the Quality Management Workbook audit schedule. FA is responsible to review all education and audit results in the monthly QAPI and governing body (GB) meetings for tracking and trending. If compliance is not progressing in a favorable direction, the Plan of Correction (POC) will be re-evaluated, revisions made, re-education (if indicated), corrective action for staff (if indicated) and monitoring will continue until substantial compliance is met.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152595	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DUNELAND DIALYSIS COFFEE CREEK	STREET ADDRESS, CITY, STATE, ZIP COD 3100 VILLAGE POINT STE 101 CHESTERTON, IN 46304
--	--

(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>weight.</p> <p>5. Clinical record review on 3/24/2022, for patient #2, start of care 12/24/2021, evidenced an agency document titled "Hemodialysis Flowsheet" dated 1/17/2022. This document indicated patient #2's dry weight was 90 kg. At the completion of treatment patient #2's weight was 95.3 kg. This document failed to evidence documentation the physician was informed patient #4 failed to achieve her target dry weight.</p> <p>Clinical record review on 3/24/2022 for patient #2 evidenced an agency document titled "Hemodialysis Flowsheet" dated 1/21/2022. This document indicated patient #2's dry weight was 90 kg. At the completion of treatment patient #2's weight was 93.3 kg. This document failed to evidence documentation the physician was informed patient #2 failed to achieve her target dry weight.</p> <p>Clinical record review on 3/24/2022 for patient #2 evidenced an agency document titled "Hemodialysis Flowsheet" dated 1/24/2022. This document indicated patient #2's dry weight was 90 kg. At the completion of treatment patient #2's weight was 93.6 kg. This document failed to evidence documentation the physician was informed patient #2 failed to achieve her target dry weight.</p> <p>Clinical record review on 3/24/2022 for patient #2 evidenced an agency document titled "Hemodialysis Flowsheet" dated 1/26/2022. This document indicated patient #2's dry weight was 90 kg. At the completion of treatment patient #2's weight was 93.9 kg. This document failed to evidence documentation the physician was informed patient #2 failed to achieve her target dry</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152595	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DUNELAND DIALYSIS COFFEE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 VILLAGE POINT STE 101 CHESTERTON, IN 46304
--	---

(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>weight.</p> <p>Clinical record review on 3/24/2022 for patient #2 evidenced an agency document titled "Hemodialysis Flowsheet" dated 1/28/2022. This document indicated patient #2's dry weight was 90 kg. At the completion of treatment patient #2's weight was 93.6 kg. This document failed to evidence documentation the physician was informed patient #2 failed to achieve her target dry weight.</p> <p>Clinical record review on 3/24/2022 for patient #2 evidenced an agency document titled "Hemodialysis Flowsheet" dated 1/31/2022. This document indicated patient #2's dry weight was 90 kg. At the completion of treatment patient #2's weight was 94.9 kg. This document failed to evidence documentation the physician was informed patient #2 failed to achieve her target dry weight.</p> <p>Clinical record review on 3/24/2022 for patient #2 evidenced an agency document titled "Hemodialysis Flowsheet" dated 2/2/2022. This document indicated patient #2's dry weight was 90 kg. At the completion of treatment patient #2's weight was 92.6 kg. This document failed to evidence documentation the physician was informed patient #2 failed to achieve her target dry weight.</p> <p>Clinical record review on 3/24/2022 for patient #2 evidenced an agency document titled "Hemodialysis Flowsheet" dated 2/4/2022. This document indicated patient #2's dry weight was 90 kg. At the completion of treatment patient #2's weight was 93.2 kg. This document failed to evidence documentation the physician was informed patient #2 failed to achieve her target dry</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152595	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DUNELAND DIALYSIS COFFEE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 VILLAGE POINT STE 101 CHESTERTON, IN 46304
--	---

(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>weight.</p> <p>Clinical record review on 3/24/2022 for patient #2 evidenced an agency document titled "Hemodialysis Flowsheet" dated 2/7/2022. This document indicated patient #2's dry weight was 90 kg. At the completion of treatment patient #2's weight was 95.2 kg. This document failed to evidence documentation the physician was informed patient #2 failed to achieve her target dry weight.</p> <p>Clinical record review on 3/24/2022 for patient #2 evidenced an agency document titled "Hemodialysis Flowsheet" dated 2/9/2022. This document indicated patient #2's dry weight was 90 kg. At the completion of treatment patient #2's weight was 93.5 kg. This document failed to evidence documentation the physician was informed patient #2 failed to achieve her target dry weight.</p> <p>During an interview on 3/25/2022 at 2:50 PM. the facility administrator indicated she is always over her weight but her dry weight is correct and the physician is aware.</p> <p>6. Clinical record review on 3/24/2022, for patient #3, start of care 4/24/2015, evidenced an agency document titled "Hemodialysis Flowsheet" dated 2/25/2022. This document indicated patient #3's dry weight was 74 kg. At the completion of treatment patient #3's weight was 79 kg. This document failed to evidence documentation the physician was informed patient #3 failed to achieve her target dry weight.</p> <p>Clinical record review on 3/24/2022, for patient #3, evidenced an agency document titled "Hemodialysis Flowsheet" dated 2/28/2022. This</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152595	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DUNELAND DIALYSIS COFFEE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 VILLAGE POINT STE 101 CHESTERTON, IN 46304
--	---

(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 0544  Bldg. 00	<p>document indicated patient #3's dry weight was 74 kg. At the completion of treatment patient #3's weight was 77.6 kg. This document failed to evidence documentation the physician was informed patient #3 failed to achieve her target dry weight.</p> <p>Clinical record review on 3/24/2022, for patient #3, evidenced an agency document titled "Hemodialysis Flowsheet" dated 3/2/2022. This document indicated patient #3's dry weight was 74 kg. At the completion of treatment patient #1's weight was 75.5 kg. This document failed to evidence documentation the physician was informed patient #3 failed to achieve her target dry weight.</p> <p>Clinical record review on 3/24/2022, for patient #3, evidenced an agency document titled "Hemodialysis Flowsheet" dated 3/21/2022. This document indicated patient #3's dry weight was 74 kg. At the completion of treatment patient #1's weight was 75.2 kg. This document failed to evidence documentation the physician was informed patient #3 failed to achieve her target dry weight.</p> <p>During an interview on 3/25/2022 at 2:05 PM, the facility manager indicated patient #3's dry weight was correct. She indicated they can not always take off all the fluid from patient #3 due to cramping.</p> <p>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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152595	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DUNELAND DIALYSIS COFFEE CREEK	STREET ADDRESS, CITY, STATE, ZIP COD 3100 VILLAGE POINT STE 101 CHESTERTON, IN 46304
--	--

(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>practice standard for adequacy of dialysis. Based on record review and interview, the facility failed to ensure patient dialysis prescriptions orders were verified and adhered to in order to achieve and sustain the prescribed dose of dialysis to meet the adequacy of dialysis in 2 out of 4 in center hemodialysis records reviewed (#1, #3)</p> <p>The findings include:</p> <p>1. An agency policy titled, "Intradialytic Monitoring of Patient," revised 09/2020, stated, "Direct patient care staff will monitor the following parameters during each dialysis treatment ...Blood flow rate. Dialysis flow rate ...Modify the treatment plan based on the patient's response, which must be documented by the charge nurse."</p> <p>2. Clinical record review on 3/24/2022 for patient #1, start of care 8/17/2020, evidenced an agency document titled "Post Treatment" dated 1/31/2022. This document indicated the patient's prescribed blood flow rate (BFR) was 450 ml/ min (milliliters/minute). Patient #1's BFR was reduced to 400 ml/min during treatment. This document failed to evidence documentation as to why patient #1's BFR was reduced during treatment.</p> <p>During an interview on 3/25/2022 at 1:25 PM, the facility administrator indicated staff should have indicated why the patient's BFR was reduced.</p> <p>3. Clinical record review on 3/24/2022 for patient #3, start of care 4/25/2015, evidenced an agency document titled "Post Treatment" dated 3/9/2022. This document indicated the patient's prescribed BFR was 400 ml/ min. Patient #3's BFR during treatment was 350 ml/min This document failed to evidence documentation as to why patient #3 did</p>	V 0544	<p>FA or designee will in-service all direct care staff on policies C-TI-0010: Initiation of Dialysis; C-ID-0010: Intradialytic Monitoring of Patient as it relates to documentation of not achieving or any changes to prescribed BFR during the dialysis treatment. FA or designee will conduct Flow Sheet audit of 10% of patients daily x2 weeks, weekly x4, and resume monthly auditing per the Quality Management Workbook audit schedule.</p> <p>FA is responsible to review all education and audit results in the monthly QAPI and governing body (GB) meetings for tracking and trending. If compliance is not progressing in a favorable direction, the Plan of Correction (POC) will be re-evaluated, revisions made, re-education (if indicated), corrective action for staff (if indicated) and monitoring will continue until substantial compliance is met.</p>	04/24/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152595	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DUNELAND DIALYSIS COFFEE CREEK	STREET ADDRESS, CITY, STATE, ZIP COD 3100 VILLAGE POINT STE 101 CHESTERTON, IN 46304
--	--

(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>not get the prescribed BFR during treatment.</p> <p>Clinical record review on 3/24/2022, for patient #3, evidenced an agency document titled "Post Treatment" dated 3/11/2022. This document indicated the patient's prescribed BFR was 400 ml/min. Patient #3's BFR during treatment was 375 ml/min This document failed to evidence documentation as to why patient #3 did not get the prescribed BFR during treatment.</p> <p>During an interview on 3/25/2022 at 2:11 PM, the facility administrator indicated staff should have noted why the BFR was lower than prescribed.</p>			