STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152582	A. BUILDING 00 B. WING	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE SPENCER	11 CRANE AVE SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62 Survey Dates: 11/17/2021-11/22/2021 Facility Number: 010328 Census = 31 in-center hemodialysis 0 home hemodialysis 0 home peritoneal dialysis At this Emergency Preparedness survey, Fresenius Medical Care Spencer was found not in compliance with Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, 42 CFR 494.62. QR completed 11/30/2021 A4	E 0000		
E 0028 Bldg. 00	494.62(b)(9) Dialysis Emergency Equipment §494.62(b)(9) Condition for Coverage: [(b) Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:]			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152582	A. BUILDING 00 B. WING	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE SPENCER	11 CRANE AVE SPENCER, IN 47460

(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
	(9) A process by which the staff can confirm that emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, are on the premises at all times and immediately available. Based on observation, record review, and interview, the facility failed to maintain emergency supplies according to manufacturer instructions for 1 of 1 emergency evacuation box observed. Findings include: 1. A revised July 6, 2020 policy titled, "Emergency Medication, Equipment and Supplies" was provided by the Clinic Manager on 11/18/2021 at 8:25 a.m. The policy indicated, but was not limited to, "Emergency Evacuation Box ... Items approaching expiration must be reordered and replaced prior to the actual expiration date...." 2. During the flash tour observation on 11/17/2021 at 9:00 a.m., seven BD vacutainer safety-lok blood collection set 23 gauge x 3/4" x 12", lot # 7J3091, with an expiration date of 9/30/2020, and two, SafeDay IV (intravenous) administration set with universal spike, SafeDay IV valve and spin lock connector 15 drops/ml (milliliter), lot # 0061632683, with an expiration date of 7/31/2021, were observed in the emergency evacuation box. 3. During an interview on 11/17/2021 at 9:42 a.m., the Clinic Manager confirmed the expiration dates of the expired supplies, and no additional information was provided.	E 0028	On December 3, 2021, the Clinic Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy: · Emergency Medication, Equipment and Supplies Emphasis was placed on: · Ensuring emergency supplies are immediately available for use including but not limited to BD vacutainer safety-lok blood collection sets, SafeDay IV (intravenous) administration sets with universal spike, and SafeDay IV valve and spin lock connectors 15 drops/ml (milliliter). · Utilization of the emergency supply monthly checklist to identify all contents in the emergency cart. · Include the expiration date of supplies on the monthly checklist. · Items approaching expiration must be reordered and replaced prior to the actual expiration date. Effective December 6, 2021, the Clinic Manager or designee will conduct an emergency supply audit weekly for one month utilizing the Emergency Cart Checklist. The focus will be on removing expired supplies and	12/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152582	A. BUILDING 00 B. WING	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE SPENCER	11 CRANE AVE SPENCER, IN 47460

(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
			ensuring all emergency supplies are immediately available for use. Once 100% compliance is sustained, monitoring will be completed per the Quality Assessment and Performance Improvement (QAI) calendar with oversight from the Governing Body. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Clinic 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 Body is available for review. The Clinic Manager is responsible	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152582	A. BUILDING 00 B. WING	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE SPENCER	11 CRANE AVE SPENCER, IN 47460

(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
			for overall compliance. Date of Completion: December 21, 2021	
V 0000 Bldg. 00		V 0000		
	This survey was for a federal ESRD recertification in conjunction with a Covid-19 infection control survey. Survey Dates: 11/17/2021-11/22/2021 Facility Number: 010328 Census: 31 in-center hemodialysis 0 home hemodialysis 0 home peritoneal dialysis			
V 0118 Bldg. 00	494.30(a)(1)(i) IC-SINGLE USE VIALS Intravenous medication vials labeled for single use, including erythropoietin, should not be punctured more than once. Based on observation, record review, and interview, the facility failed to ensure single dose vials were not punctured more than once for 1 of 2 medication preparation observations (RN H). Findings include: 1. A revised November 1, 2021 policy titled, "Medication Preparation and Administration" was provided by the Clinic Manager on 11/18/2021 at 8:25 a.m. The policy indicated, but was not limited to, "Infection Control. The following steps must be taken to ensure infection control.... Always use a sterile needle and syringe when entering a vial....	V 0118	On December 3, 2021, the Clinic Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policies: · Medication Preparation and Administration Education emphasis was placed on: · Never puncture single dose vials twice. · Always use a new sterile syringe and needle when entering a vial or ampule. Effective December 6, 2021, the	12/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152582	A. BUILDING 00 B. WING	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE SPENCER	11 CRANE AVE SPENCER, IN 47460

(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
	For single dose vials, never puncture the vial twice...." 2. During an observation on 11/18/2021 at 10:34 a.m., RN H was observed preparing Venofer (iron replacement) from a single dose vial. RN H withdrew the needle and syringe from the single dose vial of Venofer, removed the needle and placed a new one on the syringe, inserted the needle into the same, single dose vial of Venofer, puncturing the vial a second time, and withdrew medication into the syringe that already contained Venofer. 3. During an interview on 11/19/2021 at 3:05 p.m., the Clinic Manager and Director of Operations were made aware of the observation. The Clinic Manager indicated he/she was unsure of the single dose vial policy and if single dose vials could be punctured with a needle more than once. The Clinic Manager indicated single dose vial meant the vial can only be used on one patient, and multi-dose vials meant the vial can be used on more than one patient. The Director of Operations was unsure of the policy and indicated he/she would have to follow-up regarding correct single dose vial preparation procedure. 4. During an interview on 11/22/2021 at 8:48 a.m., the Clinic Manager indicated single dose vials should only be punctured once per facility policy and procedure.		Clinic Manager or designee will conduct infection control audits five times weekly for one month, then two times weekly for one month, then weekly for one month utilizing the Infection Control Monitoring Tool. The focus will be on medication prep and administration per policy. Once 100% compliance is sustained, monitoring will be completed per the Quality Assessment and Performance Improvement (QAI) calendar with oversight from the Governing Body. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152582	A. BUILDING 00 B. WING	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE SPENCER	11 CRANE AVE SPENCER, IN 47460

(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
			effective and is providing resolution of the issues. Documentation of education, monitoring, QAI, and Governing Body is available for review. The Clinic Manager is responsible for overall compliance. Completion Date: December 21, 2021	
V 0122 Bldg. 00	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. Based on observation, record review, and interview, the facility failed to follow applicable infection control procedures when cleaning and disinfecting contaminated surfaces for 1 of 2 dialysis stations being cleaned (Station #2). Findings include: 1. A revised November 4, 2019 policy titled, "Cleaning and Disinfection of the Dialysis Station Procedure" was provided by the Clinic Manager on 11/18/2021 at 8:25 a.m. The policy indicated, but was not limited to, "Follow the steps below to disinfect the dialysis station after each dialysis.... 4. Clean all surfaces.... 5. Give special attention to the cleaning ... other surfaces that are ... potentially contaminated with patient's blood	V 0122	On December 3, 2021, the Clinic Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy: · Cleaning and Disinfection of the Dialysis Station Education emphasis was placed on: · Cleaning and disinfected all work surfaces within the hemodialysis station with 1:100 bleach solution after completion of procedures; including but not limited to the back chase counter. · Ensure the surfaces are glistening wet and allow to air dry before placing the next patient into	12/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152582	A. BUILDING 00 B. WING	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE SPENCER	11 CRANE AVE SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and/or body fluids...." 2. A revised November 2, 2020 policy titled, "Cleaning and Disinfection of the Dialysis Station" was provided by the Clinic Manager on 11/18/2021 at 8:56 a.m. The policy indicated, but was not limited to, "Work Surface Cleaning and Disinfection w/out Visible Blood using Bleach Solutions. All work surfaces shall be cleaned and disinfected with 1:100 bleach solution after completion of procedures...." 3. During an observation on 11/17/2021 at 10:47 a.m., during cleaning and disinfection of the dialysis station, PCT C failed to disinfect the countertop behind the dialysis station. 4. During an interview on 11/17/2021 at 3:02 p.m., the Clinic Manager and Director of Operations were made aware of the observation. The Clinic Manager and Director of Operations both indicated the countertop behind the dialysis station was considered a dirty area and should be cleaned after each patient.		the hemodialysis station. Effective December 6, 2021, the Clinic Manager or designee will conduct infection control audits five times weekly for one month, then two times weekly for one month, then weekly for one month utilizing the Infection Control Monitoring Tool. The focus will be cleaning all work surfaces within the hemodialysis station with 1:100 bleach solution per policy. Once 100% compliance is sustained, monitoring will be completed per the Quality Assessment and Performance Improvement (QAI) calendar with oversight from the Governing Body. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152582	A. BUILDING 00 B. WING	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE SPENCER	11 CRANE AVE SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. Documentation of education, monitoring, QAI, and Governing Body is available for review. The Clinic Manager is responsible for overall compliance. Completion Date: December 21, 2021	
V 0143 Bldg. 00	494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and Based on observation, record review, and interview, the facility failed to discard expired Nepro with Carbsteady nutritional supplement for 1 of 1 medication preparation area refrigerator observations. Findings include: 1. A revised November 1, 2021 policy titled, "Medication Preparation and Administration" was provided by the Clinic Manager on 11/18/2021 at 8:25 a.m. The policy indicated, but was not limited to, "Monitoring Medications Stored in the Refrigerator. Medication refrigerators are designated for the storage of medications. If necessary, nutritional supplements may be kept in	V 0143	On December 3, 2021, the Clinic Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policies: · Medication Preparation and Administration Education emphasis was placed on: · Expiration dates for all stored medications and nutritional supplements stored within the medication preparation area refrigerator are to be monitored on a monthly basis. · Expired medications and nutritional supplements will be	12/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152582	A. BUILDING 00 B. WING	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE SPENCER	11 CRANE AVE SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the medication refrigerator.... Follow manufacturer's recommendation regarding retention or disposal...." 2. During the flash tour observation on 11/17/2021 at 9:00 a.m., ten Nepro with Carbsteady, 8 fluid ounce containers with an expiration date of 1 Sep 2021, were observed in the medication preparation area refrigerator. 3. During an interview on 11/17/2021 at 9:42 a.m., the Clinic Manager confirmed the expiration dates of the expired nutritional supplement, and no additional information was provided.		discarded promptly per manufacturer's recommendation for disposal. · The person administering nutritional supplements must verify the product has not exceeded the expiration date. Effective December 6, 2021, the Clinic Manager or designee will conduct infection control audits five times weekly for one month, then two times weekly for one month, then weekly for one month utilizing the Infection Control Monitoring Tool. The focus will be on ensuring expired nutritional supplements are discarded per policy. Once 100% compliance is sustained, monitoring will be completed per the Quality Assessment and Performance Improvement (QAI) calendar with oversight from the Governing Body. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152582	A. BUILDING 00 B. WING	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE SPENCER	11 CRANE AVE SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			of 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 Body is available for review. The Clinic Manager is responsible for overall compliance. Completion Date: December 21, 2021	
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 record review and interview, the facility failed to follow physician orders and ensure the physician was notified of diastolic blood pressure not within parameters for 6 of 7 patient treatment records reviewed for Patient # 7. Findings include: 1. A July 4, 2012 policy titled, "Determination of Blood Pressure" was provided by the Clinic Manager on 11/19/2021 at 1:52 p.m. The policy indicated, but was not limited to, "Upper and	V 0543	On December 3, 2021, the Clinical Manager will hold a staff meeting and reinforced the expectations and responsibilities of the facility staff on the following policy: · Determination of Blood Pressure Education emphasis was placed on: · The Medical Director in conjunction with the Clinic Manager will determine what the blood pressure upper and lower	12/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152582	A. BUILDING 00 B. WING	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE SPENCER	11 CRANE AVE SPENCER, IN 47460

(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
	Lower Blood Pressure Parameters.... The Medical Director in conjunction with the Clinic Manager will determine what the blood pressure upper and lower range parameters will be for the facility. The parameters can also be modified by the nephrologist for individual patients that may require modifications based on their comorbid conditions...." 2. The complete clinical record for patient # 7 was reviewed on 11/19/2021, included 7 treatment sheets dated 11/3/2021 to 11/17/2021, and evidenced the following: The patient transfer sheet indicated a Special Attentions order with a start date of 2/10/2021, and a stop date of 2/9/2022. The order indicated, "Special Attention: Call MD [medical doctor] if pt [patient] symptomatic or if sbp [systolic blood pressure-top number] drops below 80 SBP or 40 DBP [diastolic blood pressure-bottom number]." An 11/3/2021 treatment sheet indicated a BP (blood pressure) reading of 106/33 at 7:04 a.m. At 7:31 a.m., the BP was 108/33, and 83/33 at 9:36 a.m. The treatment sheet did not indicate notification of the physician for diastolic blood pressure readings less than 40. An 11/8/2021 treatment sheet indicated a BP reading of 122/39 at 6:34 a.m. At 9:27 a.m., the BP was 102/33, and 95/38 at 9:53 a.m. The treatment sheet did not indicate notification of the physician for diastolic blood pressure readings less than 40. An 11/10/2021 treatment sheet indicated a BP reading of 112/30 at 6:27 a.m. At 6:36 a.m., the BP was 104/36, and 138/35 at 8:03 a.m. At 9:12 a.m., the BP was 130/38, and 139/25 at 9:36 a.m. The treatment sheet did not indicate notification of the		range parameters will be for the facility. · The RN is responsible to document in the medical record of BPs out of parameters with an assessment and intervention when indicated. · The RN will notify the physician as ordered and ensure the physician is notified of diastolic blood pressure not within parameters. Effective December 6, 2021, the Clinic Manager or designee will conduct hemodialysis treatment sheet audits on a minimum of ten patient records daily for two weeks, then weekly for four weeks, then every two weeks for one month utilizing the Patient Treatment Sheet Monitoring Tool. The focus will be on RN assessments, interventions, and physician notification for BPs outside of set parameters. Once 100% compliance is sustained, monitoring will be completed per the Quality Assessment and Performance Improvement (QAI) calendar with oversight from the Governing Body. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152582	A. BUILDING 00 B. WING	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE SPENCER	11 CRANE AVE SPENCER, IN 47460

(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
	physician for diastolic blood pressure readings less than 40. An 11/12/2021 treatment sheet indicated a BP reading of 134/38 at 8:33 a.m. The treatment sheet did not indicate notification of the physician for the diastolic blood pressure reading less than 40. An 11/15/2021 treatment sheet indicated a BP reading of 85/36 at 7:05 a.m. At 7:06 a.m., the BP was 99/35, and 96/37 at 7:38 a.m. At 9:36 a.m., the BP was 84/24, and 86/29 at 10:01 a.m. The treatment sheet did not indicate notification of the physician for diastolic blood pressure readings less than 40. An 11/17/2021 treatment sheet indicated a BP reading of 101/31 at 9:02 a.m. At 9:32 a.m., the BP was 101/39. The treatment sheet did not indicate notification of the physician for diastolic blood pressure readings less than 40. 3. During an interview on 11/19/2021 at 1:41 p.m., the Special Attentions order for patient # 7 was reviewed with the Clinic Manager, and the Clinic Manager indicated he/she had never read the order past notifying the physician for systolic blood pressure less than 80, and was unaware of the order to notify the physician for diastolic blood pressure less than 40. The Clinic Manager indicated if the physician had been notified of diastolic blood pressures less than 40, the communication would be documented within the patient's treatment record.		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 Body is available for review. The Clinic Manager is responsible for overall compliance. Completion Date: December 21, 2021	
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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152582	A. BUILDING 00 B. WING	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE SPENCER	11 CRANE AVE SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers; Based on observation, record review, and interview, the Medical Director failed to ensure the facility followed their own policy regarding medications being secured and under supervision of a licensed nurse during 1 of 1 medication preparation area observations. Findings include: 1. A revised November 1, 2021 policy titled, "Medication Preparation and Administration" was provided by the Clinic Manager on 11/18/2021 at 8:25 a.m. The policy indicated, but was not limited to, "Securement. The following steps must be taken for the securement: All medications will be kept in a locked cabinet except when in use. One key to the medication cabinet will be kept by the charge nurse/team leader.... When the charge nurse/team leader leaves the treatment area, the key will be left in the possession of other qualified, licensed personnel...." 2. During the flash tour observation on 11/17/2021 at 9:00 a.m., the medication cabinet in the medication preparation area was not locked, or equipped with a lock. 3. During an observation on 11/18/2021 at 9:57 a.m., the Clinic Manager was observed to place a chain and padlock on the medication cabinet. 4. During an observation on 11/18/2021 at 10:13 a.m., PCT J was observed to shout across the dialysis treatment floor while patients were being	V 0715	On December 3, 2021, the Clinic Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy: · Medication Preparation and Administration Education emphasis was placed on: · Ensuring 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 non-physician providers. · All medications will be kept in a locked cabinet except when in use. · When the charge nurse/team leader leaves the treatment area, the key will be left in the possession of other qualified, licensed personnel. Effective December 6, 2021, the Clinic Manager or designee will conduct medication securement audits five times weekly for one month, then two times weekly for one month, then weekly for one month utilizing the Physical Environment Monitoring Tool. The focus will be on ensuring	12/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152582	A. BUILDING 00 B. WING	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE SPENCER	11 CRANE AVE SPENCER, IN 47460

(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
	treated, "hey, where's the key for this?" while holding the chain and padlock for the medication cabinet in his/her hand. PCT C was observed to shout back across the treatment floor to PCT J, "it's in the drawer." PCT J was observed to remove the key from the drawer below the medication cabinet, hold it up, and shout back to PCT C, "this one?" PCT J was then observed to use the key to unlock the padlock and remove the chain from the medication cabinet. 5. During an interview on 11/18/2021 at 8:50 a.m., the Clinic Manager confirmed that medications are not stored in a locked cabinet, and the medication cabinet does not have the ability to lock. The Clinic Manager indicated the previous lock on the medication cabinet had jammed and was cut off, and a new one was ordered. 6. During an interview on 11/18/2021 at 2:57 p.m., the Director of Operations indicated a new keypad lock for the medication cabinet was ordered and it required installation by a special company. The Clinic Manager again indicated the previous lock on the medication cabinet had jammed and was cut off.		medication storage areas are locked. Once 100% compliance is sustained, monitoring will be completed per the Quality Assessment and Performance Improvement (QAI) calendar with oversight from the Governing Body. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. 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 Body is available for review. The Clinic Manager is responsible for overall compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152582	A. BUILDING 00 B. WING	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE SPENCER	11 CRANE AVE SPENCER, IN 47460

(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
			Completion Date: December 21, 2021	