

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

PRINTED: 03/28/2025

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152585	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  03/12/2025
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NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE SHADELAND STATION	STREET ADDRESS, CITY, STATE, ZIP COD 7155 SHADELAND STATION STE 130 INDIANAPOLIS, IN 46256
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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: 03/10/2025, 03/11/2025, and 03/12/2025  Active Census: 79  At this Emergency Preparedness survey, FMC Shadeland Station was not found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62.  Abbreviations RN Registered Nurse ICHD In-Center Hemodialysis PCT Patient Care Technician HHD Home Hemodialysis FA Facility Administrator PD Peritoneal Dialysis MD Medical Doctor CVC Central Venous Catheter RD Registered Dietician CM Clinical Manager MSW Masters Social Worker LPN Licensed Practical Nurse CCHT Certified Clinical Hemodialysis Technician  QR by A3 on 3-13-2025	E 0000		
E 0018  Bldg. 00	403.748(b)(2), 416.54(b)(1), 418.113(b)( Procedures for Tracking of Staff and Patients  Based on record review and interview, the facility	E 0018	<b>E-018 PROCEDURES FOR</b>	04/11/2025

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.

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	<p>failed to ensure they had a current list of all patient prescriptions and contact information for 2 of 2 Emergency Evacuation box reviewed on the incenter treatment floor.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>1. A review of a Fresenius Kidney Care policy dated 08/02/2017 titled "Emergency and Disaster Responsibility Guidelines" indicated but was not limited to, " ... Maintain current listings of patients and staff including local contact, emergency contact and evacuation contact information ..."</li> <li>2. A review of the Emergency Evacuation box on 03/10/2025 at 9:40 AM, on the incenter treatment floor in front of Stations #1-12, evidenced patient contact information dated 01/27/2025. The facility failed to ensure the patient information was up-to-date.</li> <li>3. A review of the Emergency Evacuation box on 03/10/2025 at 9:46 AM, on the incenter treatment floor next to Stations #13 - 24, evidenced patient contact information dated 01/27/2025. The facility failed to ensure the patient information was up-to-date.</li> <li>4. During an interview with the Clinical Manager (CM) on 03/10/2025 at 9:46 AM, they indicated the Administrative Assistant reviewed the Emergency Evacuation box monthly and was supposed to update the patient information monthly.</li> <li>5. During an interview with the Administrative Assistant on 03/10/2025 at 10:15 AM, they indicated they checked the Emergency Evacuation box monthly to ensure everything was updated.</li> </ol>		<p><b>TRACKING OF STAFF AND PATIENTS CFR(S): 494.62(B)(1)</b></p> <p>On 03/25/2025 the Clinical Manager, held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the Policy.</p> <p>Emergency and Disaster Responsibility Guidelines</p> <p>Emphasis will be placed on:</p> <p>An emergency evacuation box must:</p> <ul style="list-style-type: none"> <li>Be available to grab in case of fire or the immediate need to evacuate the clinic.</li> <li>Contain all patient and staff emergency contact information.</li> <li>Be checked monthly or after use for contents, expiration dates and cleanliness.</li> </ul> <p>On 03/10/2025, the Clinical Manager placed the updated patient contact information in the evacuation boxes between Stations #13-24 and Stations #1-12.</p> <p>Effective 04/01/2025, the Clinical Manager will conduct monthly audits with focus on ensuring the Emergency Evacuation Box has updated patient emergency contacts, as required, utilizing the facility specific Audit Tool for 3</p>	

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			<p>months or until 100% compliance is achieved. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar.</p> <p>The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly.</p> <p>The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAPI Committee monthly.</p> <p>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.</p> <p>The QAPI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAPI monthly.</p> <p>The Governing Body is responsible</p>	

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E 0028  Bldg. 00	<p>494.62(b)(9) Dialysis Emergency Equipment</p> <p>Based on observation, record review, and interview, the facility failed to ensure all expired emergency medication and supplies were removed for 2 of 2 Emergency Evacuation box reviewed on the incenter treatment floor.</p> <p>Findings Include:</p> <p>1. A review of a Fresenius Kidney Care policy dated 02/03/2025 titled "Emergency Medications, Equipment and Supplies" indicated but was not limited to, " ... An emergency evacuation box must ... Be checked monthly or after use for contents, expiration dates ..."</p> <p>2. A review of a Fresenius Kidney Care document located in the emergency preparedness tote dated 2025 titled "Evacuation Box Checklist" indicated but was not limited to, " ... Nitrile Gloves (L) 2 boxes in Jan and 1 box in Feb ..."</p> <p>The document failed to evidence the expiration date of 1 box of size large non-sterile exam gloves,</p>	E 0028	<p>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.</p> <p>The QAPI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic.</p> <p>Completion Date: 04/11/2025.</p> <p><b>E028 DIALYSIS EMERGENCY EQUIPMENT CFR(S): 494.62(B) (9)</b></p> <p>On 03/25/2025, the Clinical Manager held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the Policy. Emergency Medications, Equipment and Supplies Emphasis will be placed on: The emergency cart must be checked monthly or after use for contents, expiration dates, cleanliness, and proper functioning of all equipment.</p> <p>On DATE, the Clinical Manager removed all expired supplies from the evacuation boxes between Stations # 1-12 and Stations #13-24.</p>	04/11/2025

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	<p>and the presence and expiration date of 1 box of size medium non-sterile exam gloves, 1 box of small non-sterile exam gloves, and 2 AV Fistula 16 G x 1" needle sets.</p> <p>3. During a flash tour of the facility on 03/10/2025 at 9:46 AM, the following observations were made:</p> <p>An observation of the emergency preparedness tote on the left side of the treatment room floor, with Stations #13 - 24, evidenced 1 box of size small non-sterile exam gloves with an expiration date of 08/2022, 1 box of size medium non-sterile exam gloves with an expiration date of 07/2022, 1 box of size large non-sterile exam gloves with an expiration date of 05/2022, 2 - AV Fistula (Arteriovenous Fistula, connection between an artery and vein used for dialysis) 15 G x 1" Needle Sets.</p> <p>4. During the flash tour of the facility on 03/10/2025 at 9:40 AM, the Emergency Evacuation box in the treatment room, on the side with Stations #1-12, evidenced a box of small gloves and a box of medium gloves with an expiration date of 03/2023 and a box of large gloves with an expiration date of 01/2023.</p> <p>A review of the "Evacuation Box Checklist" evidenced 1 box of gloves was accounted for in January and February. The checklist failed to include the expiration dates for the exam gloves.</p> <p>5. During an interview with the Clinical Manager on 03/10/2025 at 9:46 AM, when queried regarding the Emergency Evacuation box, they indicated the Administrative Assistant was in charge of the Emergency Evacuation box and checked it monthly. They explained the Administrative Assistant only included how many gloves were in</p>		<p>Effective 03/31/2025, Clinical Manager will conduct 3 days per week audits, utilizing the facility specific audit tool for 2 weeks, with a focus on ensuring there are no expired supplies in the evacuation box, then weekly for an additional 2 weeks or until 100% compliance is achieved. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly.</p> <p>The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAPI Committee monthly.</p> <p>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.</p> <p>The QAPI Committee is responsible to provide oversight, review findings, and take actions</p>	

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V 0000  Bldg. 00	<p>the tote and not the date of their expiration. The Clinical Manager confirmed the fistulas and the gloves were not removed when they expired.</p> <p>6. During an interview with the Administrative Assistant on 03/10/2025 at 10:15 AM, they indicated they checked the Emergency Evacuation box monthly using the checklist to determine if any of the supplies need updating and remove the expired items and items about to expire.</p> <p>This visit was for a CORE Federal Recertification survey of an ESRD provider.</p> <p>Survey Dates: 03/10, 03/11, 03/12/2025</p> <p>Census by Service Type:</p> <p>In-Center Hemodialysis: 78 Home Hemodialysis: 0 Peritoneal Dialysis: 1 Total Census: 79</p> <p>Isolation: None- established prior to 2009</p> <p>Abbreviations RN Registered Nurse ICHD</p>	V 0000	<p>as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAPI monthly.</p> <p>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.</p> <p>The QAPI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic.</p> <p>Completion Date: 04/11/2025.</p>	

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V 0117 Bldg. 00	<p>In-Center Hemodialysis PCT Patient Care Technician HHD Home Hemodialysis FA Facility Administrator PD Peritoneal Dialysis MD Medical Doctor CVC Central Venous Catheter RD Registered Dietician CM Clinical Manager MSW Masters Social Worker LPN Licensed Practical Nurse CCHT Certified Clinical Hemodialysis Technician</p> <p>QR by A3 on 3-13-2025.</p> <p>494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS</p> <p>Based on observation, record review, and interview, the facility failed to ensure the proper storage of supplies for 4 of 4 observations of the treatment room dialysis machines and wall boxes.</p> <p>Findings Include:</p> <p>1. A review of a Fresenius Kidney Care policy dated 11/04/2024, titled "General Cleanliness and Infection Control Guidelines," indicated but was not limited to, " ... The purpose of this policy is to provide guidance for the FKC staff on preventing the spread of infectious disease and maintaining a clean, safe, and aesthetically pleasant environment for patients, staff, and visitors ... Supplies or patient's belongings should not be kept or stored behind the machine at the patient station ... "</p> <p>2. During the flash tour on 03/10/2025 at 9:40 AM, the following treatment floor observations were</p>	V 0117	<p><b>V117 IC-CLEAN/DIRTY; MED PREP AREA; NO COMMON CARTS CFR(S): 494.30(a)(1)(i)</b></p> <p>On 03/25/2025, the Clinical Manager held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the Policy.</p> <p>General Cleanliness and Infection Control Guidelines Emphasis will be placed on:</p> <p>All areas must be kept clean and organized, including but not limited to treatment areas, water/supply rooms and offices. Walkways must be kept clear of debris and free of clutter.</p> <p>Supplies or patient's belongings should not be kept or stored behind the machine at the patient station.</p>	04/11/2025

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	<p>made:</p> <p>An observation between Stations 7 and 8 evidenced a box of extra-large gloves on the wall box.</p> <p>An observation between Stations 3 and 4 evidenced a box of small gloves, tissue box, and at least three loose gloves on the wall box.</p> <p>An observation between Stations 23 and 24 evidenced a single glove on the wall box.</p> <p>An observation between Stations 15 and 16 evidenced a box of small gloves and an analog clock on the wall box.</p> <p>3. An observation of the wall box in between Stations 11 and 12 evidenced a sign evidencing the following direction, "DO NOT PLACE ANY ITEMS ON BACK COUNTER".</p> <p>4. On 03/10/2025 at 11:24 AM, the following treatment floor observations were made:</p> <p>An observation of Station 8 evidenced a blue pad on top of the dialysis machine.</p> <p>An observation between Stations 6 and 7 evidenced an arm rest on the wall box.</p> <p>5. On 03/10/2025 at 3:10 PM, the following treatment floor observations were made:</p> <p>An observation at Station 10 evidenced a patient's large grocery bag behind the chair, on the wall box.</p> <p>An observation at Station 10 evidenced a blue pad on top of the dialysis machine.</p>		<p>Effective 03/31/2025, Clinical Manager will conduct 3 days per week audits, utilizing the facility specific audit tool, with focus on ensuring the facility is clean, organized and free of debris and clutter, and that no supplies or patient items are stored on machine or behind on chaise/wall box, for 2 weeks and then weekly for an additional 2 weeks or until 100% compliance is achieved. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly.</p> <p>The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAPI Committee monthly.</p> <p>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.</p>	

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V 0143 Bldg. 00	<p>An observation at Station 12 evidenced a blue pad on top of the dialysis machine.</p> <p>6. On 03/11/2025 at 10:20 AM, the following treatment floor observations were made:</p> <p>An observation between Stations 3 and 4 evidenced a tissue box on the wall box.</p> <p>An observation between Stations 5 and 6 evidenced a tissue box on the wall box.</p> <p>An observation at Station 9 evidenced a patient's bag behind the chair on the wall box.</p> <p>An observation between Stations 9 and 10 evidenced a box of gloves on the wall box.</p> <p>During an interview with PCT 3 on 03/10/2025 at 3:55 PM, they indicated nothing was supposed to be on the wall boxes or the dialysis machines.</p> <p>During an interview on 03/11/2025 at 3:15 PM, PCT 7 indicated nothing should be placed on the wall box.</p> <p>7. During an interview with the Area Technician Operations Manager, CM, and the Director of Operations on 03/12/2025 at 1:41 PM, they explained nothing was supposed to be on the wall boxes or dialysis machines.</p> <p>494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS</p> <p>Based on observations, record review, and interviews, the facility failed to ensure all expired medications and supplies were removed from 1 of 1 standalone dialysis facilities.</p>	V 0143	<p>The QAPI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAPI monthly.</p> <p>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.</p> <p>The QAPI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic.</p> <p>Completion Date: 04/11/2025.</p>	04/11/2025		<p><b>V143 IC: ASEPTIC TECHNIQUES FOR IV MEDS CFR(S): 494.30(b) (2)</b></p>	

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	<p>Findings Include:</p> <p>1. A review of a Fresenius Kidney Care policy dated 02/06/2023 titled "Medication Preparation and Administration" indicated but was not limited to, " ... Monitoring Expired Medications: Expiration dates for all stored medications are to be monitored on a monthly basis. Expired medications are to be discarded ..."</p> <p>2. A review of a Fresenius Kidney Care policy dated 04/05/2021 titled "Storage of Supplies" indicated but was not limited to, " ... Proper storage conditions are necessary to provide a safe environment and to ensure supplies are not expired ..."</p> <p>3. On 03/10/2025 11:39 AM, the following treatment floor observations were made:</p> <p>An observation of a drawer labeled "17 G (sic gauge) in the storage unit in front of Stations #1-12 evidenced six 15 G hemodialysis arteriovenous (AV) fistula needles (a needle inserted into a surgically connected vein and artery to remove waste and excess fluids when the kidneys no longer function appropriately) with an expiration date of 06/30/2024, one 14 G AV needle set with an expiration date of 07/2018, and six 17 G needle sets with clamps with an expiration date of 10/23/2024.</p> <p>During an interview with the CM on 03/10/2025 at 12:20 PM, they indicated the PCTs restocked the supplies daily and where to remove any expired items.</p> <p>4. A review of an undated facility document titled, "2024 Emergency Med Box," indicated by was not limited to, the medication box check in July</p>		<p>On 03/25/2025, the Clinical Manager held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the Policy.</p> <p>Medication Preparation and Administration Storage of Supplies Emphasis will be placed on: Supplies must be rotated First in-First Out (FIFO) to ensure products maintain quality and do not expire. Appropriately dispose of items that have reached the expiration date.</p> <p>Expiration dates for all stored medications are to be monitored on a monthly basis. Expired medications are to be discarded via Fresenius Kidney Care off-site return program or in accordance with local and/or state law.</p> <p>On 3/10/2025 Clinical Manager removed all expired medications from medication box.</p> <p>Effective 03/31/2025 Clinical Manager will conduct 3 days per week audits, for 2 weeks utilizing the facility specific audit tool, with focus on ensuring all supplies are monitored monthly and properly disposed of when they reach their expiration, and all medications are monitored monthly and properly disposed of when they reach their expiration, and then weekly for an additional 2 weeks or until 100% compliance is achieved. The</p>	

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	<p>evidence 4 vials of Solu-Medrol with an expiration date of 10/2024.</p> <p>The document failed to evidence the medication box was checked since September of 2024.</p> <p>5. During a flash tour of the facility on 03/10/2025 the following observations were made:</p> <p>An observation of the emergency medications on the ICHD treatment floor evidenced 4 - Solu Medrol 40 mg (milligram, measurement of mass in the metric system, one thousandths of a gram) vials with an expiration date of 10/2024.</p> <p>During an interview on 03/10/2025 at 10:09 AM, the CM indicated they were responsible for checking the emergency medication and should have completed the check prior to going on vacation.</p>		<p>Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly.</p> <p>The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAPI Committee monthly.</p> <p>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.</p> <p>The QAPI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAPI monthly.</p> <p>The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by</p>	

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V 0543 Bldg. 00	<p>494.90(a)(1) POC-MANAGE VOLUME STATUS</p> <p>Based on record review and interview, the facility failed to ensure direct patient care staff monitored the patients during their dialysis treatment in 6 of 6 active clinical records reviewed with patients receiving ICHD. (Patients #: 1, 10, 11, 12, 13, and 30)</p> <p>Findings Include:</p> <p>1. A review of a Fresenius Kidney Care policy dated 05/01/2023, titled "Patient Assessment and Monitoring" indicated but was not limited to "The purpose of this policy is to provide guidance ... direct care staff on assessment and monitoring patients before, during and after treatment ... During Treatment: Obtain blood pressure and pulse rate every 30 minutes or more as needed but not to exceed 45 minutes or per state regulations. Document machine parameters and safety checks every 30 minutes or more often as needed but not to exceed 45 minutes ..."</p> <p>2. A review of Patient #7's active medical record contained treatment sheets from 02/18/2025 through 03/08/2025, which evidence the following:</p>	V 0543	<p>the Statement of Deficiency, is effective and is providing resolution of the issues.</p> <p>The QAPI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic.</p> <p>Completion Date: 04/11/2025.</p> <p><b>V543 POC-MANAGE VOLUME STATUS CFR(s): 494.90(a)(1)</b> On 03/25/2025, the Clinical Manager held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the Policy. Patient Assessment and Monitoring Emphasis will be placed on: Obtain blood pressure and pulse rate every 30 minutes or more as needed but not to exceed 45 minutes or per state regulations. Document machine parameters and safety checks every 30 or more often as needed but not to exceed 45 minutes or per state regulations. Effective 03/31/2025 Clinical Manager will conduct 3 days per week audits for 2 weeks utilizing the facility specific audit tool, with focus on ensuring blood pressure checks and machine parameter</p>	04/11/2025

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	<p>The treatment sheet dated 02/18/2025, indicate PCT 3 measured a blood pressure and pulse, and performed a safety check at 9:34 AM. At 10:35 AM, PCT 3 measured a blood pressure and pulse, and performed a safety check.</p> <p>The treatment sheet dated 03/01/2025, indicate PCT 1 measured a blood pressure and pulse and performed a safety check at 9:30 AM. At 10:30 AM, PCT 3 measured a blood pressure and pulse, and performed a safety check.</p> <p>The treatment sheet dated 03/08/2025, indicate PCT 3 measured a blood pressure and pulse, and performed a safety check at 8:13 AM. At 9:00 AM, PCT 8 measured a blood pressure and pulse, and performed a safety check.</p> <p>The treatment sheets dated 02/18/2025, 03/01/2025, and 03/08/2025 failed to evidence Patient #7's blood pressure and pulse measurements and safety checks were performed every 30 minutes.</p> <p>3. A review of Patient #10's active medical record contained treatment sheets from 02/15/2025 through 03/08/2025, which evidence the following:</p> <p>The treatment sheet dated 03/04/2025, indicate PCT 9 measured a blood pressure and pulse, and performed a safety check at 5:53 AM. At 6:59 AM, PCT 9 measured a blood pressure and pulse, and performed a safety check.</p> <p>The treatment sheet dated 03/04/2025 failed to evidence Patient #10's blood pressure and pulse measurements and safety checks were performed every 30 minutes.</p> <p>4. A review of Patient #11's active medical record</p>		<p>checks are completed every 30 minutes but not to exceed 45 minutes, the audits will then go to weekly for an additional 2 weeks or until 100% compliance is achieved. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar.</p> <p>The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly.</p> <p>The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAPI Committee monthly.</p> <p>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.</p> <p>The QAPI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed</p>	

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	<p>contained treatment sheets from 02/18/2025 through 03/08/2025, which evidence the following:</p> <p>The treatment sheet dated 02/15/2025, indicate PCT 10 measured a blood pressure and pulse, and performed a safety check at 4:02 PM. At 4:30 PM, PCT 8 performed a safety check. At 4:49 PM, PCT 8 measured a blood pressure and pulse.</p> <p>The treatment sheet dated 02/22/2025, indicate PCT 8 measured a blood pressure and pulse, and performed a safety check at 11:23 AM. At 12:12 PM, RN 6 measured a blood pressure and pulse, and performed a safety check.</p> <p>The treatment sheet dated 03/04/2025, indicate RN 1 measured a blood pressure and pulse, and performed a safety check at 11:39 AM. At 12:19 PM, PCT 9 performed a safety check. At 12:32 PM, PCT 9 measured a blood pressure and pulse, and performed a safety check. At 2:00 PM, PCT 9 measured a blood pressure and pulse, and performed a safety check. At 3:03 PM, PCT 2 measured a blood pressure and pulse, and performed a safety check.</p> <p>The treatment sheet dated 03/08/2025, indicate PCT 9 measured a blood pressure and pulse, and performed a safety check at 12:00 PM. At 12:30 PM, PCT 9 performed a safety check. At 1:02 PM, PCT 9 measured a blood pressure and pulse, and performed a safety check.</p> <p>The treatment sheets dated 02/12/2025, 02/22/2025, 03/04/2025, and 03/08/2025 failed to evidence Patient #11's blood pressure and pulse measurements and safety checks were performed every 30 minutes.</p> <p>5. A review of Patient #13's active medical record</p>		<p>in QAPI monthly.</p> <p>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.</p> <p>The QAPI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic.</p> <p>Completion Date: 04/11/2025.</p>	

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	<p>contained treatment sheets from 02/13/2025 through 03/08/2025, which evidence the following:</p> <p>The treatment sheet dated 03/04/2025, indicate PCT 3 measured a blood pressure and pulse, and performed a safety check at 8:02 AM. At 9:02 AM, PCT 3 measured a blood pressure and pulse, and performed a safety check.</p> <p>The treatment sheet dated 03/04/2025 failed to evidence Patient #13's blood pressure and pulse measurements and safety checks were performed every 30 minutes.</p> <p>During an interview on 03/10/2025 at 3:20 PM, RN 1 indicated patients are monitored before treatment starts, during treatment, and after treatment. When queried about the frequency of monitoring during treatment, RN 1 indicated patients should be monitored every 30 minutes during treatment.</p> <p>During an interview on 03/11/2025 at 3:15 PM, PCT 7 indicated patients should be monitored every 30 minutes.6. A review of Patient #12's clinical record contained treatment sheets from 02/03/2025 through 03/03/2025 evidenced the following:</p> <p>The treatment sheet dated 03/03/2025 evidenced a blood pressure check was completed at 2:00 PM by PCT 4. PCT 5 completed a blood pressure check at 3:05 PM.</p> <p>The treatment sheet dated 02/28/2025 evidenced the Blood Flow Rate (BFR) and Dialysis Flow Rate (DFR) was completed at 2:01 PM by RN 7. The next BFR and DFR were completed at 2:52 PM by PCT 8. The BFR and DFR were completed at 4:07 PM by PCT 8 and was not checked for the</p>			

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	<p>remainder of the treatment, the treatment ended at 5:08 PM.</p> <p>The treatment sheet dated 02/24/2025 evidenced the blood pressure, BFR, DFR, and safety checks were completed at 3:36 PM by PCT 4, then checked by PCT 5 at 4:31 PM.</p> <p>The treatment sheet dated 02/12/2025 evidenced the treatment started at 1:11 PM and the first time the BFR and DFR were completed at 2:05 PM by PCT 3. The BFR and DFR were checked at 3:09 PM by RN 6 and again at 4:02 PM by PCT 3. The blood pressure was checked at 3:30 PM by RN 6 and was checked again at 4:32 PM by RN 6.</p> <p>The treatment sheet dated 02/03/2025 evidenced the blood pressure, BFR, DFR, and safety checks were completed at 1:32 PM by PCT 3. The next BFR, DFR, and safety checks were completed at 3:34 PM. The next blood pressure check was completed at 3:49 PM by PCT 3.</p> <p>7. A review of Patient #30's clinical record contained treatment sheets from 02/15/2025 through 03/08/2025 evidenced the following:</p> <p>The treatment sheet dated 03/06/2025 evidenced the BFR and DFR were completed at 9:31 AM by PCT 9 and again at 10:23 AM by PCT 2.</p> <p>The treatment sheet dated 03/04/2025 evidenced the blood pressure was checked at 6:00 AM by PCT 2 and again at 7:02 AM. The BFR and DFR were checked at 6:09 AM by PCT 2 and again at 6:58 AM by PCT 9. The blood pressure was checked at 8:03 AM by PCT 9 and again at 9:03 AM.</p> <p>The treatment sheet dated 02/27/2025 evidenced</p>			

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	<p>the BFR and DFR were checked at 6:04 AM and again at 7:00 AM by PCT 2. The blood pressure was completed at 9:00 AM and again at 10:03 AM by PCT 2.</p> <p>The treatment sheet dated 02/25/2025 evidenced the BFR and DFR were checked at 8:31 AM by RN 6 and again at 9:33 AM by PCT 7.</p> <p>The treatment sheet dated 02/20/2025 evidenced the BFR and DFR were checked at 9:31 AM by RN 6 and again at 10:30 AM by PCT 2.</p> <p>The treatment sheet dated 02/20/2025 evidenced the BFR and DFR were checked at 9:03 AM and again at 10:30 AM by PCT 3.</p> <p>8. During an interview with PCT 1 on 03/10/2025 at 3:17 PM, they indicated they were to verify the dialysis machine was running as ordered by the dialysis prescription, run the patient's blood pressure, and perform safety checks every 30 minutes.</p> <p>9. During an interview with PCT 4 on 03/11/2025 at 10:49 AM, they indicated they were to perform safety checks, take a blood pressure, and verify the prescription on the dialysis machine every half hour.</p> <p>10. During an interview with the CM on 03/12/2025 at 1:41 PM, they indicated the clinicians performed safety checks, blood pressures, and verified treatment orders every 30 to 45 minutes.</p>			