STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152515	A. BUILDING 00 B. WING	12/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE FORT WAYNE JEFFERSON	7836 W JEFFERSON BLVD STE LL10 FORT WAYNE, IN 46804

(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: December 26, 27, and 30, 2024. Active Census: 90. At this Emergency Preparedness survey, FMC Fort Wayne Jefferson was not found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62.	E 0000		
E 0039 Bldg. 00	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to test the EP plan every two years with participation in a full-scale community-based EP exercise, facility-based functional exercise or an actual emergency of activation of the EP plan for 1 of 1 agency. Findings include: 1. Review of a facility policy titled "Guidelines for Emergency Preparedness" indicated annually the facility must participate in a community-based disaster drill and if unable to participate should coordinate a dialysis facility area-based drill. 2. Review of the facility's EP testing indicated participation in a tabletop exercise on 05/08/2023 and a tabletop exercise on 03/15/2024 presented by the state Healthcare Coalition. The EP testing	E 0039	On 1/10/2025 the Facility Administrator held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the Policy. Guidelines for Emergency Preparedness Emphasis will be placed on: Annually, each facility must participate in a community-based disaster drill. If unable to participate, document who you contacted in the community and why the clinic was unable to participate on the Facility Specific Disaster Safety Plan form. If the	01/29/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Allison Cruea	Director of Operations	02/03/2025

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	failed to evidence facility participation in a full-scale community-based exercise, facility-based functional exercise, or an actual emergency activation exercise for the past two years. 3. During an interview on 12/30/2024 at 4:10 PM, the FA indicated the facility had not participated in community, facility, or actual EP exercise in the past two years.		EOC or similar agency has not performed a community-based drill, or it was missed for a particular year, the DO should coordinate a dialysis facility area-based drill. The Governing Body will: Review and approve the Facility Specific Disaster Safety plan initially and annually. Review the FKC Facility Emergency Information Directory is complete and current. By 1/16/2025 the Facility Administrator will conduct a facility Drill on “Blizzard”, with an after-action review for all staff. Materials with signature page will be located at facility and available for review upon request. By 4/30/2025 the Facility Administrator and Director of Operations will participate in a community wide drill on Prom Mock Crash Event in Adams County Indiana. An after Action Review will be completed and reviewed with all Fort Wayne Jefferson Staff by 5/16/2025 (See attached minutes for details) Effective 1/10/2025, the Facility Administrator will conduct monthly audits utilizing specific plan of correction audit tool for 3 months, and then an additional 3 months or until 100% compliance is achieved. Once compliance is	

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			sustained at 100%, the Governing Body will decrease frequency to monthly then resume regularly scheduled audits based on the QAPI calendar. Monitoring will be done through the specific plan of correction audit tool. The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly. The Facility Administrator 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. 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 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. The Governing Body is responsible to provide oversight to ensure the	

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			Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAPI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic. Completion Date: 01/29/2025.	
V 0000 Bldg. 00	This visit was for a CORE Federal recertification survey of an ESRD provider. Survey dates: December 26, 27, and 30, 2024. Census by Service Type: In-Center Hemodialysis: 54 Home Hemodialysis: 8 Home Peritoneal Dialysis: 28 Total Active Census: 90 Isolation Room/Waiver: 0 Abbreviations: EP Emergency Preparedness FA Facility Administrator HHD Home Hemodialysis ICHD Incenter Hemodialysis IV Intravenous PCT Patient Care Technician POC Plan of Care RN Registered Nurse	V 0000		

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V 0114 Bldg. 00	QR 1/6/2025 by A2 494.30(a)(1)(i) IC-SINKS AVAILABLE Based on record review, observation and interview, the agency failed to ensure that soap was available for staff to wash hands at hand washing sink in the ICHD area and at clean sinks in the medication area during 2 of 2 days of observation. Findings include: 1. Review of an agency policy titled "Hand Hygiene" indicated hand hygiene includes washing hands with soap and water and soap must be available at hand washing sinks. 2. During the flash tour of the ICHD room on 12/26/2024 beginning at 9:15 AM, observed a sink labeled, hand wash sink, located across from Station 12 with no soap in the dispenser. 3. During an observation period on 12/27/2024 beginning at 8:20 AM, observed the hand wash sink, same as observed on 12/26/2024, located across from Station 12 with no soap in the dispenser. 4. During an interview on 12/27/2024 at 1:45 PM, when asked why there was no soap at the hand wash sink located across from Station 12, the FA indicated the batteries were dead in the soap dispenser.	V 0114	On 1/10/2025 Facility Administrator, and Charge Nurse held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the Policy. Hand Hygiene Emphasis will be placed on: A sufficient number of sinks with soap and plumbed with both hot and cold water shall be available to facilitate hand washing. The hand washing sinks may be used for both staff and patients. Soap and a supply of paper towels protected from contamination must be available at each sink. Hand washing sinks should be dedicated for hand washing only and should remain clean. Used items should not be placed, cleaned or drained in the hand washing sink. Sinks will be properly labeled for use. By 1/29/2025 the Facility Administrator will label sinks per usage, new signage will be posted for “medication sinks”. Effective 1/10/2025, Facility Administrator will conduct 3 days per week audits with focus on ensuring soap is available at all	01/29/2025

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			clean sinks, proper usage/signage of sinks are displayed, and all sinks are functioning per policy, as required, utilizing Infection Control Audit Tool 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. The Facility Administrator 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. 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 QAPI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to	

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			develop the Plan of Correction. The Plan of correction is reviewed in QAPI monthly. 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. The QAPI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic. Completion Date: 01/29/2025.	