STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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, for a Medicare participating End Stage Renal Disease Supplier. Date of survey: 3/9/2022 to 3/15/2022 Facility #: 003230 CCN: 152581 Stations: 16 ICHD Patients: 56 PD Patients: 11 Total Census: 67 At this Emergency Preparedness survey, Merrillville Dialysis was found to be in compliance with the Emergency Preparedness Requirements for Medicare participating providers and suppliers, including staffing and implementation of staffing during a Pandemic, at 42 CFR 494.62.	E 0000		
V 0000 Bldg. 00	This survey was for a Federal Re-Certification and a Complaint of an ESRD provider. Complaint: IN00266082 - unsubstantiated with unrelated findings	V 0000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	Survey Dates: 3/9/2022 to 3/15/2022 Facility: 003230 Provider: 152581 Stations: 16 ICHD Patients: 56 PD Patients: 11 Total Census: 67 Quality Review Completed 03/25/2022			
V 0113 Bldg. 00	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. Based on observation, record review, and interview, the facility failed to ensure staff had completed appropriate hand hygiene according to hand hygiene policies and procedures in 9 of 10 handwashing observations completed. (PCT E, PCT F, PCT H) The findings include: 1. An agency policy titled "Infection Control for Dialysis Facilities" revised October 2021, stated "Purpose to minimize the spread of infection or bloodborne pathogens in the dialysis facilities environment ... 1. Hand hygiene is to be	V 0113	The Facility Administrator (FA) held mandatory in-service(s) for all clinical teammates on Policy 1-05-01 "Infection Control For Dialysis Facilities" and Policy 1-05-01B "Handwashing" starting on 3/9/2021. Verification of attendance is evidenced by a signature sheet for each in-service. Teammates were instructed using surveyor's observations as examples with emphasis on, but not limited to	04/08/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	performed upon entering the patient treatment area, prior to gloving, after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact, between patients even if the contact is casual, before touching clean areas such as supplies and on exiting the patient treatment area. Physicians, Non-Physician Practitioners (NPP), and all teammates are to follow the same requirements for glove use and hand hygiene. 2. If hands are not visibly contaminated, use of an alcohol-based hand rub may be substituted for handwashing ... Handwashing will be performed if hands are visibly contaminated with blood or body fluids ... 6. Alcohol-based hand rub may be used: -in the absence of sink/water - In the event of an emergency (i.e. emergency evacuation) -Before gloving and after glove removal ... 11. Teammates will wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis training room/station and will remove gloves and wash hands or perform hand hygiene between each patient and/or station. 12. Gloves should be worn when: -Potential for exposure to blood, dialysate, and other potentially infectious substances ... Administering medications, checking vital signs ... 13. Gloves should be changed when: -When soiled with blood, dialysate, or other body fluids -When going from a "dirty" area or task to a "clean" area or task - When moving from a contaminated body site to a clean body site of the same patient; and -After touching one patient or their dialysis delivery system and before arriving to care for another patient or touching other patients dialysis delivery system...." 2. An agency procedure titled "Handwashing" revised October 2020, stated, " ... Cover hands (palms back of hands, between fingers) and wrists		the following: 1) Purpose: To minimize the spread of infections or blood borne pathogens in the dialysis facility environment. 2) Hand hygiene is to be performed upon entering the patient treatment area, prior to gloving, after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact, between patients even if the contact is casual, before touching clean areas such as supplies and on exiting the patient treatment area. Physicians, Non-Physician Practitioners (NPP), and all teammates are to follow these same requirements for glove use and hand hygiene. 3) If hands are not visibly contaminated, use of an alcohol-based hand rub may be substituted for handwashing. 4) Hand washing will be performed if hands are visibly contaminated with blood or body fluids. 5) Alcohol-based hand rubs may be used: In the absence of sinks/water; In the event of an emergency (i.e., emergency evacuation); Before gloving and after glove removal. 6) Teammates will wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station, and will remove gloves and wash hands or perform hand hygiene between each patient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	with lather and wash vigorously for a minimum of 20 seconds...." 3. During an observation on 3/9/2022 at 11:44 AM, PCT (patient care technician) H was observed discontinuing dialysis for patient #4, at station #15. PCT H applied the sterile port caps, removed the glove from her left hand and obtained a roll of tape from the clean central supply, donned a new glove to her left hand, and taped a gauze 4 X 4 over the CVC [central venous catheter] ports. PCT H failed to remove both gloves and wash or sanitize her hands after removing her glove and donning a new glove. 4. During an observation on 3/9/2022 at 11:48 AM, PCT H was observed discontinuing dialysis for patient #11, at station #10. PCT H removed a pair of gloves and obtained a saline syringe and gauze from the central supply cabinet, failing to sanitize her hands after removing her gloves. PCT H re-infused the extracorporeal circuit removed her gloves, failing to sanitize her hands after removing her gloves. PCT H then donned gloves failing to sanitize her hands, removed patient #10 needles, removed her gloves, and was typing on the computer. PCT H failed to sanitize her hands after removing her gloves. 5. During an observation on 3/9/2022 at 12:07 PM, PCT F was observed cleaning station #11, machine #3. PCT F cleaned part of the chair with a bleach wipe then removed her gloves. PCT F donned new gloves failing to wash or sanitize her hands prior to donning new gloves. PCT F cleaned the blood pressure cuff, removed her gloves and donned new gloves failing to wash or sanitize her hands prior to donning new gloves. PCT F picked up trash from the floor by the chair, removed her gloves, and donned new gloves		and/or station. 7) Gloves should be worn when: Potential for exposure to blood, dialysate and other potentially infectious substances... 8) Gloves should be changed when: When soiled with blood, dialysate or other body fluids; When going from a “dirty” area or task to a “clean” area or task; When moving from a contaminated body site to a clean body site of the same patient; and After touching one patient or their dialysis delivery system and before arriving to care for another patient or touch another patient’s dialysis delivery system 9) Handwashing: Cover hands (palms, back of hands, between fingers) and wrists with lather and wash vigorously for a minimum of 20 seconds. The Facility Administrator or designee will conduct observational infection control audits daily for one (1) week and then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the infection control audit. Instances of non-compliance will be addressed immediately. The Facility Administrator will review results of all audits with TMs during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	failing to wash or sanitize her hands prior to donning new gloves. PCT F cleaned the IV [intravenous] pole, removed her gloves and donned new gloves failing to wash her hands prior to donning new gloves. 6. During an observation on 3/9/2022 at 2:40 PM, PCT F was observed discontinuing dialysis for patient #7, at station #13. PCT F re-infused the extracorporeal circuit, removed her gloves, failing to sanitize her hands after removing her gloves. 7. During an observation on 3/10/2022 at 9:45 AM, PCT E was observed accessing patient #10's fistula (an abnormal opening between a vein and an artery) at station #5. PCT E palpated the site, cleaned the area, and cleaned the site, failing to change gloves and sanitize her hands after palpating the site. 8. During an observation on 3/14/2022 at 10:04 AM, PCT E was observed performing exit site care for patient #2, at station #4. PCT E connected sterile syringes to both ports of the Central Venous Catheter and removed the dressing. PCT E removed her gloves and obtained gauze from the central clean supply on the counter, failing to wash or sanitize her hands after removing her gloves. PCT E donned new gloves, failed to wash her hands prior to donning the gloves and cleansed the area around the CVC exit site. 9. During an observation on 3/14/2022 at 10:03 AM, PCT E was observed washing her hands with soap and water. PCT E washed her hands for 7 seconds, failing to wash for a minimum of 20 seconds per agency policy. During an interview on 3/15/2022 at 12:10 PM, the facility administrator indicated teammates should		Facility Administrator is responsible for ongoing compliance with this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	wash or sanitize their hands whenever they are visibly soiled, before donning or removing gloves, and when entering and exiting the treatment floor. During an interview on 3/15/2022 at 12:13 PM, the facility administrator indicated the scrub time for teammates to wash their hands is 20 seconds.			
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 ensure staff had completed appropriate disinfection of dialysis stations in 4 of 4 disinfection of stations observed. (PCT E, PCT F, PCT H) The findings include: 1. An agency policy titled "Infection Control for Dialysis Facilities" revised October 2021, stated, " ... Equipment including the dialysis delivery system and work station, the interior and exterior of the prime container, the dialysis chair and side tables including opening the chair to reach crevices, blood pressure equipment, television arms and control knobs or remote control devices if accessible to patients and teammates, facility wheelchairs, outside of sharps containers, IV poles, as well as all work surfaces will be wiped clean with a bleach solution of the appropriate	V 0122	The Facility Administrator (FA) held mandatory in-service(s) for all clinical teammates on Policy 1-05-01 “Infection Control For Dialysis Facilities” starting on 3/9/2022. Verification of attendance is evidenced by a signature sheet for each in-service. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Equipment including the dialysis delivery system, the interior and exterior of the prime container, the dialysis chair and side tables, including opening the chair to reach crevices, blood pressure equipment, television arms and	04/08/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	strength after completion of procedures, before being used on another patient, after spills of blood, throughout the workday, and after each treatment...." 2. During an observation on 3/10/2022 at 10:05 AM, PCT (patient care technician) E was observed cleaning station #6. PCT E failed to recline the chair during the cleaning process to wipe all areas and failed to clean the television and the shelf behind the station. 3. During an observation on 3/14/2022 at 9:49 AM, PCT F was observed cleaning station #8, Machine 18. PCT F failed to ensure the previous patient left the station prior to cleaning the machine. PCT F failed to open the sides of the chair and failed to recline the chair during the cleaning process. PCT F also failed to clean the shelf behind the station. 4. During an observation on 3/9/2022 at 9:43 AM, PCT E was observed cleaning machine #18 at station #8. PCT E cleaned the machine while patient #8 was still sitting in the chair holding her needle sites. PCT E failed to ensure the station was vacated before cleaning machine #18. PCT E then cleaned the chair, failing to fully recline the chair for cleaning. PCT E also failed to clean the shelf behind the station. 5. During an observation on 3/9/2022 at 11:31 AM, PCT H was observed cleaning machine #14, at station #9. PCT H cleaned the machine while patient #12 was still sitting in the chair holding her needle sites. PCT H failed to ensure the station was vacated prior to cleaning machine #14. During an interview on 3/15/2022 at 12:16 PM, the facility administrator indicated the dialysis machines should be cleaned after the patient		control knobs or remote control devices if accessible to patients and teammates, facility wheel chairs, outside of sharps containers, IV poles, as well as all work surfaces will be wiped with a bleach solution of the appropriate strength after completion of procedures, before being used on another patient, after spills of blood, throughout the work day, and after each treatment. The Facility Administrator or designee will conduct observational infection control audits daily for one (1) week and then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal infection control audits to verify compliance. Instances of non-compliance will be addressed immediately. The Facility Administrator will review results of all audits with TMs during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The Facility Administrator is responsible for ongoing compliance with this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	leaves the station.			
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 ensure expired medications were removed from the medication refrigerator. The findings include: An agency policy titled "Medication Policy" revised April 2021, stated, " ... 1. The administrator/designee is responsible for supervising the handling, storing, disposing, administering, and controlling of medications and performs a monthly audit and inventory. ... 13. All open or unopened ampules and/or vials are stored according to the manufacturer's directions. Do not use any ampule or vial that has been stored improperly or has expired ... 29. Medications containing a preservative must be discarded in 28 days after opening or accessed (e.g., needle punctured) unless the manufacturer specifies a different (shorter or longer) date or as directed by the manufacturer ... All medications in the facility are checked monthly for expiration dates...." During an observation on 3/9/2022 at 9:24 AM, the contents of the medication refrigerator were checked. An open vial of Tuberculin (used to diagnose Tuberculosis) was observed with the expiration date of 2/22/2022. There was also an	V 0143	The Facility Administrator (FA) held mandatory in-service(s) for all clinical teammates on Procedure # 1-06-01 “Medication Policy”. Verification of attendance is evidenced by a signature sheet for each in-service. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) The Administrator/designee is responsible for supervising the handling, storing, disposing, administering, and controlling of medications and performs a monthly audit and inventory. 2) All open or unopened ampules and/or vials are stored according to the manufacturer’s directions. Do not use any ampule or vial that has been stored improperly or has expired. 3) Medications containing a preservative must be discarded 28 days after opening or accessed (e.g., needle punctured), unless the manufacturer specifies a different (shorter or longer) date or as directed by the manufacturer…4)	04/08/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	unopened vial of Daptomycin (for treatment of infections) which had an expiration date of 10/2021. During an interview on 3/10/2022 at 12:21 PM, the facility administrator indicated medications are checked monthly for expiration dates.		All medications are checked monthly for expiration dates. The expired open vial of Tuberculin with expiration date of 2/22/2022 and the unopened vial of Dapotomycin with expiration date of 10/2021 were removed from the refrigerator and discarded. The FA or designee will conduct observational audits daily for one (1) week and then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during internal medication audit. Instances of noncompliance will be addressed immediately. The Facility Administrator will review results of all audits with TMs during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The Facility Administrator is responsible for ongoing compliance with this plan of correction.	
V 0147 Bldg. 00	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters. II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].			
	Based on observations, record review, and interview, the agency failed to ensure staff followed dressing change policies in 1 of 2 observations of Central Venous Catheter (CVC) care. (PCT F) The findings include: An agency policy titled "Central Venous Catheter (CVC) Care" revised October 2019, stated " ... Dressings are changed every dialysis treatment ... Acceptable germicidal/disinfectant solutions may include: Chlorhexidine Gluconate 2%/Isopropyl Alcohol 70% (Chloraprep) only for skin including exit site cleaning Hypochlorite (ExSept Plus) only for skin cleaning including exit site cleaning,	V 0147	The Facility Administrator (FA) held mandatory in-service(s) for all clinical teammates on Policy 1-04-02 “Central Venous Catheter (CVC) Care” starting 3/11/2022. Verification of attendance is evidenced by a signature sheet for each in-service. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Dressings are changed every treatment…2) Acceptable germicidal/disinfectant solutions may include: Chlorhexidine Gluconate 2%/	04/08/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	Isopropyl 70% Alcohol. Use skin antiseptics in the above order. For patients who have a sensitivity or allergy to certain skin antiseptic document this condition in the medical record and then proceed to the next listed skin antiseptic on the list, per physician direction...." During an observation on 3/14/2022 at 10:04 AM, PCT (patient care technician) F was observed performing exit site care for patient #2. PCT F cleansed the site with a disinfecting swab and covered the area with a dressing. PCT F failed to allow the area to dry prior to applying the dressing. During an interview on 3/15/2022 at 12:30 PM, the facility administrator indicated the CVC exit site should be left to air dry prior to applying a dressing.		Isopropyl Alcohol 70% (Chloraprep) only for skin including exit site cleaning; Hypochlorite (Exsept Plus) only for skin including exit site cleaning; Isopropyl 70% alcohol; Note: Use skin antiseptics in the above order. For patients who have a sensitivity or allergy to a certain skin antiseptic, document this condition in the medical record and then proceed to the next listed skin antiseptic on the list, per physician direction. The Facility Administrator or designee will conduct observational audits for CVC care daily for one (1) week and then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal infection control audit. Instances of non-compliance will be addressed immediately. The Facility Administrator will review results of all audits with TMs during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The Facility Administrator is responsible for ongoing compliance with this plan of correction.	
V 0407 Bldg. 00	494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement). Based on observation, record review, and interview, the agency failed to ensure site access and patient faces were always visible for 3 of 12 observations. (patient #13, #14, #15) The findings include: 1. An agency policy titled "Pre-Intra-Posttreatment Data Collection, Monitoring and Nursing Assessment" revised April 2021, stated " ...The vascular access site, blood line connections, and the patient's face should always be visible throughout the dialysis treatment ...." 2. During an observation on 3/9/2022 at 9:40 AM, patient #13, at station #7, had his access site covered with a blanket, at 11:40 AM, patient #13's site was observed to still be covered. 2. During an observation on 3/11/2022 at 9:41 AM, patient #14, at station #15, had his access site covered with a blanket, at 11:40 AM, patient #15's site was observed to still be covered. 3. During an observation on 3/11/2022 at 11:05 AM, patient #15, at station #1, had his access site covered with a blanket, at 11:41 AM, patient #15's site was observed to still be covered. During an interview on 3/15/2022 at 12:35 PM, the facility administrator indicated access sites should remain uncovered at all times, for the duration of treatment.	V 0407	The Facility Administrator (FA) held mandatory in-service(s) for all clinical teammates on Policy 1-03-08 “Pre- Intra-Post Treatment Data Collection, Monitoring, and Nursing Assessment” starting 3/11/2022. Verification of attendance is evidenced by a signature sheet for each in-service. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Intradialytic treatment monitoring and data collection which may be performed by the PCT or licensed nurse includes: The vascular access site, blood line connections and the patient’s face should be visible throughout the dialysis treatment. The Facility Administrator or designee will conduct observational audits to verify vascular access sites, blood line connections and the patient’s face remain visible throughout the dialysis treatment daily for one (1) week and then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal infection control audit. Instances of non-compliance will be addressed immediately. The Facility	04/08/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
			Administrator will review results of all audits with TMs during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The Facility Administrator is responsible for ongoing compliance with this plan of correction.	
V 0504 Bldg. 00	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: Blood pressure, and fluid management needs. Based on observation, record review, and interview, the facility failed to ensure patient pre/post and intradialytic blood pressure and heart rates were being assessed and managed in 6 of 6 in-center hemodialysis records reviewed (Patient #2, #3, #4, #5, #6, #7). The findings include: 1. A policy titled "Pre-Intra-Post Data Collection, Monitoring, and Nursing Assessment" revised April 2021, stated, " ... The following are considered abnormal findings and should be reported to the licensed nurse and documented in the patient's medical record" ... "Blood pressure: Intradialytic: Difference of 20 mm/Hg increase or decrease from the patient's last intradialytic treatment BP reading" ... "Blood pressure Post Treatment: If a patient can stand: Standing	V 0504	The Facility Administrator (FA) held mandatory in-service(s) for all clinical teammates on Policy 1-03-08 “Pre- Intra-Post Treatment Data Collection, Monitoring, and Nursing Assessment” starting 4/1/2022. Verification of attendance is evidenced by a signature sheet for each in-service. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) …the following are considered abnormal findings and should be reported to the licensed nurse and documented in the patient’s medical record. 2) Members of the patient care team	04/08/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	systolic BP (blood pressure) greater than 140 mm/Hg or less than 90 mm/Hg. Standing diastolic BP greater than 90 mm/Hg or less than 50 mm/Hg. Sitting BP for patients that cannot stand: Sitting systolic BP greater than 140 mm/Hg or less than 90 mm/Hg. Sitting diastolic BP greater than 90 mm/Hg or less than 50 mm/Hg ... Heart or Pulse Rate Pre/Intra/Post Less than 60 beats per minute or greater than 100 beats per minute and/or an irregular heartbeat...." 2. Record review on 3/14/2022 for patient #2, start of care 9/17/2020, evidenced an agency document titled "Post Treatment" dated 2/16/2022. This document indicated patient #2's post-treatment sitting blood pressure was 128/42 [average blood pressure is 120/80]. This document failed to evidence documentation the nurse was notified of the patient's low diastolic blood pressure. Record review on 3/14/2022 for patient #2, evidenced an agency document titled "Post Treatment" dated 3/2/2022. This document indicated patient #2's blood pressure at 10:35 AM, was 123/49, and at 11:01 AM, the patient's blood pressure was 102/44. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #2, evidenced an agency document titled "Post Treatment" dated 3/2/2022. This document indicated patient #2's blood pressure at 10:55 AM, was 135/52, and at 11:25 AM, the patient's blood pressure was 114/55. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings.		should report ANY changes in patient conditions or concerns of patient well-being immediately to the licensed nurse at any time…3) Abnormal Findings: **Blood Pressure**: Pre-dialysis: Systolic greater than 180 mm/Hg or less than 90 mm/Hg – Diastolic greater than or equal to 100 mm/Hg…Blood Pressure-Intradialytic: Difference of 20 mm/Hg increase or decrease from patients last intradialytic treatment reading…Blood Pressure Post Treatment: Standing systolic BP greater than 140 mm/Hg or less than 90 mm/Hg - Standing diastolic BP greater than 90 mm/hg or less than 50 mm/Hg; Sitting systolic BP greater than 140 mm/Hg or less than 90 mm/Hg – Sitting diastolic greater than 90 mm/Hg or less than 50 mm/Hg…**Heart or Pulse Rate Pre/Intra/Post:** Less than 60 beats per minute or greater than 100 beats per minute and/or an irregular heart beat…The Facility Administrator or designee will audit twenty five (25%) of post treatment records daily for one (1) week and then twenty five (25%) of post treatment records weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified with ten percent (10%) of post treatment records audited monthly x 3 months. Instances of non-compliance will be addressed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	Record review on 3/14/2022 for patient #2, evidenced an agency document titled "Post Treatment" dated 3/4/2022. This document indicated patient #2's blood pressure at 10:38 AM, was 144/53, at 11:01 AM, the patient's blood pressure was 123/51, at 12:01 PM patient #2's blood pressure was 112/48, and at 12:31 PM the patient's blood pressure was 82/45. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #2, evidenced an agency document titled "Post Treatment" dated 3/7/2022. This document indicated patient #2's blood pressure at 10:44 AM, was 177/56, at 11:01 AM, the patient's blood pressure was 149/48, at 12:31 PM patient #2's blood pressure was 144/68, at 1:01 PM the patient's blood pressure was 91/61, at 1:31 PM patient #2's blood pressure was 97/62, and at 1:43 PM patient #4's blood pressure was 117/63. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. During an interview on 3/15/2022 at 1:25 PM, the facility administrator indicated the nurse should have been notified of the patient's blood pressure. 3. Record review on 3/14/2022 for patient #3, start of care 10/2/2019, evidenced an agency document titled "Post Treatment" dated 2/17/2022. This document indicated patient #3's blood pressure at 6:31 AM, was 159/78, at 7:01 AM, the patient's blood pressure was 134/68, at 7:31 AM, patient #3's blood pressure was 164/89, and at 8:01 AM patient #3's blood pressure was 111/72. This document failed to evidence documentation the nurse was notified of more than a 20-point change		immediately. The Facility Administrator will review results of all audits with TMs during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The Facility Administrator is responsible for ongoing compliance with this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	in blood pressure readings. Record review on 3/14/2022 for patient #3, evidenced an agency document titled "Post Treatment" dated 2/19/2022. This document indicated patient #3's blood pressure at 6:01 AM, was 161/80, at 6:31 AM, the patient's blood pressure was 141/76, at 8:01 AM patient #3's blood pressure was 147/58, and at 8:31 AM, patient #3's blood pressure was 85/47. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #3, evidenced an agency document titled "Post Treatment" dated 2/22/2022. This document indicated patient #3's blood pressure at 6:58 AM, was 143/83, at 7:28 AM, the patient's blood pressure was 115/65, at 7:58 AM, patient #3's blood pressure was 104/57, and at 8:18 AM, patient #3's blood pressure was 91/40. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #3, evidenced an agency document titled "Post Treatment" dated 2/24/2022. This document indicated patient #3's blood pressure at 6:27 AM, was 147/82, at 6:57 AM, the patient's blood pressure was 168/93, at 7:28 AM, patient #3's blood pressure was 146/76, at 7:57 AM, patient #3's blood pressure was 168/84, and at 8:28 AM, patient #3's blood pressure was 134/75. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #3,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	evidenced an agency document titled "Post Treatment" dated 2/26/2022. This document indicated patient #3's blood pressure at 4:58 AM, was 186/89, at 5:28 AM, the patient's blood pressure was 154/83, at 5:58 AM, patient #3's blood pressure was 128/66, at 7:29 AM, patient #3's blood pressure was 98/55, and at 7:42 AM, patient #3's blood pressure was 131/65. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #3, evidenced an agency document titled "Post Treatment" dated 3/1/2022. This document indicated patient #3's pretreatment blood pressure was 202/89. Patient #3's blood pressure at 4:59 AM, was 192/85, at 5:28 AM, the patient's blood pressure was 161/77, at 5:58 AM, patient #3's blood pressure was 126/72, at 8:01 AM, patient #3's blood pressure was 83/49, and at 8:23 AM, patient #3's blood pressure was 139/69. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings and notified of his pre-treatment blood pressure. Record review on 3/14/2022 for patient #3, evidenced an agency document titled "Post Treatment" dated 3/3/2022. This document indicated patient #3's blood pressure at 7:35 AM, was 111/69, and at 7:58 AM, patient #3's blood pressure was 130/73. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #3, evidenced an agency document titled "Post Treatment" dated 3/5/2022. This document			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	indicated patient #3's blood pressure at 6:28 AM, was 152/70, at 6:58 AM, the patient's blood pressure was 120/68, at 7:58 AM, patient #3's blood pressure was 116/88, at 8:28 AM, patient #3's blood pressure was 74/39, and at 8:54 AM, patient #3's blood pressure was 99/56. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #3, evidenced an agency document titled "Post Treatment" dated 3/8/2022. This document indicated patient #3's blood pressure at 4:58 AM, was 165/89, at 5:28 AM, the patient's blood pressure was 134/83, at 6:58 AM, patient #3's blood pressure was 112/71, and at 7:13 AM, patient #3's blood pressure was 152/80. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #3, evidenced an agency document titled "Post Treatment" dated 3/10/2022. This document indicated patient #3's blood pressure at 4:58 AM, was 181/85, at 5:28 AM, the patient's blood pressure was 159/80, at 7:28 AM, patient #3's blood pressure was 128/74, and at 7:58 AM, patient #3's blood pressure was 88/56. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. During an interview on 3/15/2022 at 1:25 PM, the facility administrator indicated the nurse should have been notified of the patient's blood pressure. 4. Record review on 3/14/2022 for patient #4, start of care 12/9/2021, evidenced an agency document			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	titled "Post Treatment" dated 2/16/2022. This document indicated patient #4's blood pressure at 8:20 AM, was 152/69, at 8:27 AM, the patient's blood pressure was 127/65, at 9:57 AM, patient #4's blood pressure was 137/64, and at 10:27 AM, patient #4's blood pressure was 112/63. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #4, evidenced an agency document titled "Post Treatment" dated 2/18/2022. This document indicated patient #4's blood pressure at 8:37 AM, was 136/82, at 8:57 AM, patient #4's blood pressure was 104/55, at 11:30 AM, patient #4's blood pressure was 115/65, and at 11:53 AM, the patient's blood pressure was 130/66. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #4, evidenced an agency document titled "Post Treatment" dated 2/21/2022. This document indicated patient #4's blood pressure at 8:44 AM, was 143/93, at 8:57 AM, the patient's blood pressure was 119/67, at 11:26 AM, patient #4's blood pressure was 102/67, and at 11:56 AM, patient #4's blood pressure was 130/71. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #4, evidenced an agency document titled "Post Treatment" dated 2/24/2022. This document indicated patient #4's blood pressure at 8:21 AM, was 140/68, at 8:26 AM, the patient's blood pressure was 99/77, at 8:55 AM, patient #4's blood			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	pressure was 122/67, at 9:26 AM, patient #4's blood pressure was 108/59, at 9:55 AM, patient #4's blood pressure was 137/72, and at 10:26 AM, the patient's blood pressure was 115/60. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #4, evidenced an agency document titled "Post Treatment" dated 2/28/2022. This document indicated patient #4's blood pressure at 8:29 AM, was 143/82, at 8:57 AM, patient #4's blood pressure was 116/64, at 11:27 AM, patient #4's blood pressure was 99/59, and at 11:46 AM, the patient's blood pressure was 124/60. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #4, evidenced an agency document titled "Post Treatment" dated 3/2/2022. This document indicated patient #4's blood pressure at 8:26 AM, was 167/103, at 8:57 AM, the patient's blood pressure was 143/64, at 11:26 AM, patient #4's blood pressure was 133/81, and at 11:39 AM, patient #4's blood pressure was 155/77. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #4, evidenced an agency document titled "Post Treatment" dated 3/4/2022. This document indicated patient #4's blood pressure at 8:07 AM, was 159/83, at 8:27 AM, the patient's blood pressure was 107/73, at 9:57 AM, patient #4's blood pressure was 113/55, and at 10:26 AM, patient #4's blood pressure was 134/62. This			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #4, evidenced an agency document titled "Post Treatment" dated 3/7/2022. This document indicated patient #4's blood pressure at 8:13 AM, was 158/110, and at 8:26 AM, the patient's blood pressure was 122/64. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #4, evidenced an agency document titled "Post Treatment" dated 3/9/2022. This document indicated patient #4's blood pressure at 11:25 AM, was 134/68, and at 11:41 AM, the patient's blood pressure was 112/61. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. During an interview on 3/15/2022 at 1:25 PM, the facility administrator indicated the nurse should have been notified of the patient's blood pressure. 5. Record review on 3/14/2022 for patient #5, start of care 2/11/2022, evidenced an agency document titled "Post Treatment" dated 2/19/2022. This document indicated patient #5's blood pressure at 11:56 AM, was 85/60, at 12:26 PM, the patient's blood pressure was 105/58, at 12:57 PM, patient #5's blood pressure was 93/64, and at 1:09 PM, the patient's blood pressure was 116/69. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	Record review on 3/14/2022 for patient #5, evidenced an agency document titled "Post Treatment" dated 2/22/2022. This document indicated patient #5's blood pressure at 10:05 AM, was 106/57, at 10:29 AM, the patient's blood pressure was 78/41, at 10:58 AM, patient #5's blood pressure was 114/72, at 12:28 PM, the patient's blood pressure was 137/73, and at 12:51 PM, the patient's blood pressure was 94/69. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #5, evidenced an agency document titled "Post Treatment" dated 2/28/2022. This document indicated patient #5's blood pressure at 10:41 AM, was 120/65, at 10:57 AM, the patient's blood pressure was 90/79, and at 10:31 AM, patient #5's blood pressure was 112/93. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #5, evidenced an agency document titled "Post Treatment" dated 3/2/2022. This document indicated patient #5's blood pressure at 8:44 AM, was 107/63, at 9:01 AM, the patient's blood pressure was 81/57, at 9:31 AM, patient #5's blood pressure was 69/53, and at 9:33 AM, the patient's blood pressure was 110/51. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure and notified of patient's low blood pressure readings. Record review on 3/14/2022 for patient #5, evidenced an agency document titled "Post Treatment" dated 3/4/2022. This document			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	indicated patient #5's blood pressure at 10:58 AM, was 117/60, at 11:57 AM, the patient's blood pressure was 95/59, at 12:27 PM, patient #5's blood pressure was 88/56, and at 12:57 PM, the patient's blood pressure was 111/62. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. During an interview on 3/15/2022 at 1:57 PM, the facility administrator indicated the nurse should have been notified of the changes in the patient's blood pressure. 6. Record review on 3/14/2022 for patient #6. start of care 7/1/2019, evidenced an agency document titled "Post Treatment" dated 6/10/2020. This document indicated patient #6's standing pre-treatment blood pressure was 147/101, and his sitting pre-treatment blood pressure was 137/101. This document failed to evidence documentation the nurse was notified of the patient's pre-treatment blood pressures. Record review on 3/14/2022 for patient #6, evidenced an agency document titled "Post Treatment" dated 6/12/2019. This document indicated patient #6's blood pressure at 5:06 AM, was 140/87, and at 5:10 AM, the patient's blood pressure was 118/82. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #6, evidenced an agency document titled "Post Treatment" dated 6/19/2019. This document indicated patient #6's blood pressure at 8:00 AM, was 116/81, and at 8:22 AM, the patient's blood pressure was 137/96. This document failed to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. 7. Record review on 3/14/2022 for patient #7, start of care 3/21/2021, evidenced an agency document titled "Post Treatment" dated 2/23/2022. This document indicated patient #7's blood pressure at 10:16 AM, was 160/98, at 10:26 AM, the patient's blood pressure was 131/91, at 12:26 PM, patient #7's blood pressure was 120/80, and at 1:36 PM, the patient's blood pressure was 150/86. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #7, evidenced an agency document titled "Post Treatment" dated 3/9/2022. This document indicated patient #7's blood pressure at 10:31 AM, was 141/98, and at 11:01 AM, the patient's blood pressure was 125/80. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. Record review on 3/14/2022 for patient #7, evidenced an agency document titled "Post Treatment" dated 3/2/2022. This document indicated patient #7's blood pressure at 1:25 PM, was 130/98, and at 1:55 PM, the patient's blood pressure was 155/94. This document failed to evidence documentation the nurse was notified of more than a 20-point change in blood pressure readings. During an interview on 3/15/2022 at 1:57 PM, the facility administrator indicated the nurse should have been notified of the changes in the patient's blood pressure.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
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 ensure patient blood pressures were monitored per policy in 2 of 5 in-center hemodialysis clinical records reviewed (#2, #7), and 1 of 1 closed clinical records reviewed. (#6) The findings include: 1. An agency policy titled "Pre-Intra-Posttreatment Data Collection, Monitoring and Nursing Assessment" revised April 2021, stated, " Vital signs and treatment monitoring for non-nocturnal treatments is completed at least every thirty minutes...." 2. Clinical record review on 3/14/2022 for patient #2, start of care 9/17/2020, evidenced an agency document titled "Post Treatment" dated 2/23/2022. This document indicated patient #2's blood pressure was monitored at 12:55 PM, and then at 1:55 PM. This document failed to evidence patient #2's blood pressure was monitored every 30 minutes per policy. 3. Clinical record review on 3/14/2022 for patient #6, start of care 7/1/2019, evidenced an agency document titled "Post Treatment" dated 6/1/2020. This document indicated patient #6's blood pressure was monitored at 4:33 AM, 5:30 AM, 6:00 AM, 6:30 AM, 7:00 AM, 8:00 AM, and 8:22 AM. This document failed to evidence patient #6's blood pressure was monitored every 30 minutes	V 0543	The Facility Administrator (FA) held mandatory in-service(s) for all clinical teammates on Policy 1-03-08 “Pre- Intra-Post Treatment Data Collection, Monitoring, and Nursing Assessment” starting 4/1/2022. Verification of attendance is evidenced by a signature sheet for each in-service. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Intradialytic treatment monitoring and data collection which may be performed by the PCT or licensed nurse includes: Vital signs and treatment monitoring for non-nocturnal treatments is completed at least every thirty (30) minutes. The Facility Administrator or designee will audit twenty five (25%) of post treatment records daily for one (1) week and then twenty five (25%) of post treatment records weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified with ten percent (10%) of post treatment records audited monthly x 3	04/08/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	per policy. During an interview on 3/15/2022 at 2:10 PM, the facility administrator indicated blood pressures should be monitored every 30 minutes, unless the nurse feels the patient should be monitored more often. 4. Clinical record review on 3/14/2022 for patient #7, start of care 3/21/2019, evidenced an agency document titled "Post Treatment" dated 3/3/2022. This document indicated patient #7's blood pressure was monitored at 10:25 AM, and then at 11:25 AM. This document failed to evidence patient #7's blood pressure was monitored every 30 minutes per policy. Clinical record review on 3/14/2022 for patient #7, evidenced an agency document titled "Post Treatment" dated 2/23/2022. This document indicated patient #7's blood pressure was monitored at 12:26 PM, and then at 1:26 PM. This document failed to evidence patient #7's blood pressure was monitored every 30 minutes per policy. During an interview on 3/15/2022 at 2:08 PM, the facility administrator indicated blood pressures should be monitored every 30 minutes.		months. Instances of non-compliance will be addressed immediately. The Facility Administrator will review results of all audits with TMs during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The Facility Administrator is responsible for ongoing compliance with this plan of correction.	
V 0544 Bldg. 00	494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. Based on record review and interview, the facility failed to ensure patient dialysis prescriptions	V 0544	The Facility Administrator (FA) held mandatory in-service(s) for all	04/08/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	orders were verified and adhered to in order to achieve and sustain the prescribed dose of dialysis to meet the adequacy of dialysis in 5 out of 5 in-center hemodialysis records reviewed (#2, #3, #4, #5, #7) and 1 of 1 closed in-center hemodialysis records reviewed. (#6) The findings include: 1. An agency policy titled "Pre-Intra-Posttreatment Data Collection, Monitoring and Nursing Assessment" revised April 2021, indicated " ... 2. The Nursing Assessment will be performed and documented ... a. The assessment includes the following components ... iii. Verification of prescription ... 3. Patient identity, prescription, and machine setting are verified by teammates prior to initiation of treatment with the exception of blood flow rate which is verified and documented when the ordered rate is obtained after onset of treatment. The prescription components are confirmed by a licensed nurse within one (1) hour of treatment initiation ... Prescription components include ... f. Blood flow rate g. Dialysate flow rate...." 2. Clinical record review on 3/14/2022 for patient #2, start of care 9/17/2020, evidenced an agency document titled "Post Treatment" dated 2/25/2022. This document indicated the patient's prescribed dialysate flow rate (DFR) was 500 ml/min (milliliters/minute). Patient #2's DFR was 600 ml/min for the first 15 minutes. This document failed to evidence documentation as to why patient #2's DFR was started higher than prescribed by the physician. Clinical record review on 3/14/2022 for patient #2, evidenced an agency document titled "Post Treatment" dated 2/28/2022. This document		clinical teammates on Policy 1-03-08 “Pre- Intra-Post Treatment Data Collection, Monitoring, and Nursing Assessment” starting 4/1/2022. Verification of attendance is evidenced by a signature sheet for each in-service. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) The Nursing assessment will be performed and documented by a licensed nurse… 2) The assessment includes the following components: Verification of prescription including machine parameters. 3) Patient identity, prescription and machine settings are verified by teammate prior to initiation of treatment with the exception of blood flow rate which is verified and documented when the ordered rate is obtained after onset of treatment. 4) The prescription components are confirmed by a licensed nurse within one (1) hour of treatment initiation. 5) Prescription components include but are not necessarily limited to: Blood flow rate and Dialysate flow rate. 6) If the dialysis prescription is not being met (including dialysis flow rate or change to /inability to obtain prescribed blood flow rate) the reason will be documented and the licensed nurse informed. The Facility Administrator or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	indicated the patient's prescribed blood flow rate (BFR) was 350 ml/min. During this treatment patient #2's BFR was 400 ml/min. This document failed to evidence documentation as to why patient #2 did not get her prescribed treatment. Clinical record review on 3/14/2022 for patient #2, evidenced an agency document titled "Post Treatment" dated 3/2/2022. This document indicated the patient's prescribed DFR was 500 ml/min. During this treatment patient #2's DFR was 600 ml/min. This document failed to evidence documentation as to why patient #2 did not get her prescribed treatment. Clinical record review on 3/14/2022 for patient #2, evidenced an agency document titled "Post Treatment" dated 3/7/2022. This document indicated the patient's prescribed DFR was 500 ml/min. Patient #2's DFR was 800 ml/min for the first 15 minutes. This document failed to evidence documentation as to why patient #2's DFR was started higher than prescribed by the physician. Clinical record review on 3/14/2022 for patient #2, evidenced an agency document titled "Post Treatment" dated 3/9/2022. This document indicated the patient's prescribed DFR was 500 ml/min. Patient #2's DFR was 600 ml/min for the first 13 minutes. This document failed to evidence documentation as to why patient #2's DFR was started higher than prescribed by the physician. During an interview on 3/15/2022 at 1:41 PM, the facility administrator indicated he was not sure why she was not ran at the prescribed rate. 3. Clinical record review on 3/14/2022 for patient #3, start of care 10/21/2019, evidenced an agency document titled "Post Treatment" dated 2/17/2022.		designee will audit twenty five (25%) of post treatment records daily for one (1) week and then twenty five (25%) of post treatment records weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified with ten percent (10%) of post treatment records audited monthly x 3 months. Instances of non-compliance will be addressed immediately. The Facility Administrator will review results of all audits with TMs during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The Facility Administrator is responsible for ongoing compliance with this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	This document indicated the patient's prescribed BFR was 400 ml/min. During this treatment, patient 3's BFR was 400 ml/min for the first 30 minutes of treatment 370 ml/min from 5:31 AM to 6:01 AM, 300 ml/min from 6:01 AM to 6:31 AM, and 305 ml/min from 6:31 AM until the completion of treatment at 8:23 AM. This document failed to evidence documentation as to why patient #3 did not get his prescribed treatment. Clinical record review on 3/14/2022 for patient #3, evidenced an agency document titled "Post Treatment" dated 3/1/2022. This document indicated the patient's prescribed BFR was 400 ml/min. During this treatment patient #3's BFR was 350 ml/min for the first 30 minutes of treatment 300 ml/min from 5:28 AM to 5:58 AM, and 290 ml/min from 5:58 AM, until the completion of treatment at 8:23 AM. This document failed to evidence documentation as to why patient #3 did not get his prescribed treatment. Clinical record review on 3/14/2022 for patient #3, evidenced an agency document titled "Post Treatment" dated 3/3/2022. This document indicated the patient's prescribed BFR was 400 ml/min. During this treatment patient #3's BFR was 300 ml/min. This document failed to evidence documentation as to why patient #3 did not get his prescribed treatment. Clinical record review on 3/14/2022 for patient #3, evidenced an agency document titled "Post Treatment" dated 3/5/2022. This document indicated the patient's prescribed BFR was 400 ml/min. During this treatment patient #3's BFR was 305 ml/min. This document failed to evidence documentation as to why patient #3 did not get his prescribed treatment.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	During an interview on 3/15/2022 at 1:01 PM, the facility administrator indicated staff was probably not able to run him at the prescribed rate. The administrator indicated his catheter was probably not working correctly and staff should have noted why he was not running at the prescribed rate. 4. Clinical record review on 3/14/2022 for patient #4, start of care 12/9/2021, evidenced an agency document titled "Post Treatment" dated 2/23/2022. This document indicated the patient's prescribed BFR was 350 ml/min. During this treatment patient #4's BFR was 400 ml/min. This document failed to evidence documentation as to why patient #4 did not get his prescribed treatment. Clinical record review on 3/14/2022 for patient #4, evidenced an agency document titled "Post Treatment" dated 3/2/2022. This document indicated the patient's prescribed DFR was 500 ml/min. During this treatment, patient #4s DFR was 600 ml/min. This document failed to evidence documentation as to why patient #4 did not get his prescribed treatment. Clinical record review on 3/14/2022 for patient #4, evidenced an agency document titled "Post Treatment" dated 3/4/2022. This document indicated the patient's prescribed BFR was 350 ml/min. During this treatment patient #4's BFR was 275 ml/min for the first hour of treatment. This document failed to evidence documentation as to why patient #4 did not get his prescribed treatment during the first hour of treatment. Clinical record review on 3/14/2022 for patient #4, evidenced an agency document titled "Post Treatment" dated 3/4/2022. This document indicated the patient's prescribed DFR 350 ml/min and his prescribed DFR was 500 ml/min. During			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	this treatment patient #4's BFR was 400 ml/min and DFR was 600 ml/min. This document failed to evidence documentation as to why patient #4 did not get his prescribed treatment. 5. Clinical record review on 3/14/2022 for patient #5, start of care 2/11/2022, evidenced agency documents titled "Post Treatment" dated 2/19/2022, 2/22/22, 2/23/2022, and 2/25/2022. These documents indicated the patient's prescribed BFR was 300 ml/min. During these treatments, patient #5's BFR was 400 ml/min. These documents failed to evidence documentation as to why patient #5 did not get his prescribed treatment. Clinical record review on 3/14/2022 for patient #5, evidenced agency documents titled "Post Treatment" dated 2/28/2022, 3/4/2022, and 3/9/2022. These documents indicated the patient's prescribed BFR was 300 ml/min. During these treatments, patient #5's BFR was 350 ml/min. These documents failed to evidence documentation as to why patient #5 did not get his prescribed treatment. 6. Clinical record review on 3/14/2022 for patient #6, start of care 9/17/2020, evidenced an agency document titled "Post Treatment" dated 6/1/2020. This document indicated the patient's prescribed BFR was 450 ml/min. During this treatment patient #6's BFR was 200 ml/min for the first hour of treatment. This document failed to evidence documentation as to why patient #6 did not get his prescribed treatment during the first hour. Clinical record review on 3/14/2022 for patient #6, evidenced an agency document titled "Post Treatment" dated 6/10/2020. This document indicated the patient's prescribed BFR was 450			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

(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
	ml/min. During this treatment patient #6's BFR was 200 ml/min for the first 41 minutes of treatment. This document failed to evidence documentation as to why patient #6 did not get his prescribed treatment at the beginning of his treatment. During an interview on 3/15/2022 at 2:14 PM, the facility administrator indicated the staff should have written why the blood flow rate was not as prescribed. 7. Clinical record review on 3/14/2022 for patient #7, start of care 3/21/2019, evidenced agency documents titled "Post Treatment" dated 2/23/2022, and 3/9/3022. These documents indicated the patient's prescribed BFR was 450 ml/min. During these treatments patient #7's BFR was 400 ml/min. These documents failed to evidence documentation as to why patient #7 did not get his prescribed treatment. During an interview on 3/15/2022 at 2:06 PM, the facility administrator indicated he was unsure why patient #7's BFR was not as prescribed.			