STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152556	A. BUILDING 00 B. WING	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE NOBLESVILLE	165 SHERIDAN RD NOBLESVILLE, IN 46060

(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 0000 Bldg. 00	This visit was for a Federal Complaint Survey of an ESRD provider. Survey Dates: January 13th & 14th of 2025 Complaint: IN 00448906 with related Federal deficiencies cited. Facility ID: 010516 CCN #: 152556 Stations: 12 No isolation waiver required, grandfathered. Census by Service Type: In-Center Hemodialysis: 41 Peritoneal Dialysis: 24 Home Hemodialysis: 7 Abbreviations: RN Registered Nurse PCT Patient Care Technician RD Registered Dietician MSW Masters Social Worker CM Clinical Manager CVC Central Venous Catheter IDT Interdisciplinary Team QR Completed 01/20/2025 by A4	V 0000		
V 0757 Bldg. 00	494.180(b)(1) GOV-STAFF # & RATIO MEET PT NEEDS Based on observation and interview, the facility failed to ensure adequate monitoring of In-center Hemodialysis treatments in 1 of 1 facility	V 0757	**V757** On 1/30/2025, the Director of	02/12/2025

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

Kerrey Thornton | Director of Operations | 01/30/2025

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.

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	reviewed. Findings Include: 1. During an observation of the treatment floor on 01/13/2025 at 12:42 PM, RN 3 was observed assisting a patient receiving treatment. During this time another patient's machine began alarming and the phone was began ringing. RN 3 appeared overwhelmed with the tasks that needed to be completed. When asked where the scheduled PCT's were RN 3 shrugged her shoulders, turned and quickly walked away to attend to the alarming machine and answer the phone. RN 3 was the only staff member on the treatment floor attending to the 10 dialysis patients receiving treatment. 2. During an interview on 01/14/2025 at 11:13 AM, Patient #1 indicated that staff frequently group lunches together leaving the RN on the floor alone to tend to all the patients. He/she indicated having one staff member to care for all of the patients is unsafe. 3. During an interview on 01/13/2025 at 2:00 PM, RN 3 indicated that when surveyor was on the treatment floor earlier today, she was the only staff member taking care of patients. RN 3 indicated she thought PCT 2 was back from lunch, so PCT 3 was sent to start her lunch break. Staff lunches are rotated to ensure patient safety. 4. During an interview on 01/13/2025 at 1:40 AM, PCT 2 indicated the facility is frequently short staffed and cannot always meet the patient's needs. Fully staffed to him/her is one RN, and 3 PCT's, however frequently works with just one RN and 2 PCT's indicating that is not enough. He/she indicated feeling stressed and overworked. PCT 2 indicated that lunches are often rotated and does		Operations, and Clinical Manager held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on the Policy. Medical Director Compliance Guidelines ·Governing Body Emphasis will be placed on: The Medical Director is required to ensure adequate supervision of dialysis operations by medical and patient care staff through proper scheduling of medical personnel, direct patient care personnel, supervisory personnel, and emergency coverage. Governing Body duties (generally in conjunction with the Medical Director) include but are not limited to: Fiscal management Medical staff appointments, coverage, and compliance with facility policies Facility professional staff appointments Regulatory Compliance to include: Routine quarterly review of regulatory approval letters to determine if the numbers of stations and modalities of dialysis being delivered is exactly consistent with what is stated in	

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	not know why both PCT's were off the treatment floor at the same time for lunch. 5. During an interview on 01/13/2025 at 12:45, the Administrative Assistant indicated the RN tends to count her as someone on the floor during lunches even though he/she is not a PCT. At times PCT's do go to lunch together leaving the RN on the floor alone. The Administrative Assistant indicated that this is a concern that needs to be addressed.		the most recent CMS/Medicare approval letter, state certificate of need (if applicable) and state license (if applicable). Review of each statement of deficiency resulting from an internal or external facility survey, as well as review of the development and implementation of any related plans of correction Training and educating staff Ensuring adequate staff coverage Operation of Quality Assessment and Improvement Program Directing and overseeing the facility's internal grievance process and issues Ensuring involuntary patient discharges are carried out in compliance with regulations and facility policy and procedure Ensuring that facility emergency coverage and facility backup plans are in place and effective Ensuring that requisite data is submitted timely and accurately to ESRD Network and/or CMS, as required Maintaining the facility's relationship with the ESRD Network Maintaining compliance and adherence to federal healthcare program requirements/state regulations including staffing. Effective 1/31/2025, the Director of Operations will conduct monthly	

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			audit with focus on ensuring adequate number of qualified and trained staff are present whenever patients are undergoing dialysis to meet the patient needs, utilizing Schedule Wise Staffing Tool for 3 months and then an additional 3 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. The Medical Director will review the results of audits each month at the QAPI Committee meeting monthly. The Clinical manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the 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	

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			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 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: 02/12/2025.	