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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152623	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIBERTY DIALYSIS-HAMMOND LLC	7214 CALUMET AVE HAMMOND, IN 46324

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E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62. Survey Dates: 9/12/2023 Census: 72 At this Emergency Preparedness survey, Liberty Dialysis, was found to have been in compliance with the Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, including staffing and the implementation of staffing during a pandemic at 42 CFR 494.62.	E 0000	10/12/23	
V 0000 Bldg. 00	This visit was a post-condition revisit survey for an ESRD recertification survey dated 8/03/23. An Immediate Jeopardy was cited at 42 CFR 494.80, Patient Assessment that began on 6/13/23. A review of a patient record identified the provider had failed to implement their policy when they failed to notify the physician of the patient being below their dry weight, with nausea and vomiting prior to being dialyzed. The Facility Administrator was notified of the Immediate Jeopardy on 8/02/23 at 3:40 PM. An acceptable Immediate Jeopardy removal plan was submitted and the Immediate Jeopardy was removed prior to exit on 8/03/23. Liberty Dialysis was found to be out of compliance with 42 CFR 498.80 Patient	V 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Geralyn Vogel	Sr. Regulatory Manager	10/10/2023

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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	Assessment and 42 CFR 494.30 Infection Control. Survey date: 9/12/23 Census by Service Type: In-Center Hemodialysis: 60 Home Peritoneal: 7 Home Hemodialysis: 5 Total Census: 72 Isolation Room/Waiver: No During this Post Condition Revisit Survey, 2 conditions and 5 standard deficiencies were removed and 4 standard deficiencies were recited. QR:9/27/23 Area 2			
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 3 of 10 handwashing observations completed by Patient Care Technician (PCT) 1. The findings include: 1. An agency policy titled "Hand Hygiene,"	V 0113	On 10/5/23, the Clinical Manager held a staff meeting to review, re-educate, and reinforce the expectations and responsibilities of the facility staff on policies: Personal Protective Equipment version 5 Emphasis was placed on: Remove gloves and wash hands after contact with each patient, and after exposure to	10/12/2023

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	revised 11/4/2019 stated " ... Hands will be washed with antimicrobial soap and water when hands are visibly dirty or contaminated with proteinaceous [containing, resembling, or being protein] material, blood, or other bodily fluids ... decontaminated using alcohol-based hand rub or by washing hands with antimicrobial soap and water before and after direct contact with patients ... Immediately after removing gloves. After contact with bodily fluids or excretion, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled. When moving from a contaminated body site to a clean body site of the same patient." 2. An agency procedure titled "Hand Hygiene," revised 9/26/2018 stated, "Procedure for Washing Hands with Soap and Water: 1. If gloves are worn remove and discard in appropriate waste container ... 2. Turn on warm running water ... 3. Wet hands with running water. Water is needed to lather soap. 4. Apply soap to hands using the amount recommended by the product manufacturer ... 5. Rub hands together vigorously. Cover all surfaces of the hands and fingers ... Duration of the entire procedure 40-60 seconds. 6. Rinse hands with running water and dry thoroughly with a disposable towel ... Turn of water faucet by using a hands-free control or by touching the sink with wrist blades with a clean single use paper towel." 3. During an observation on 9/12/2023 at 10:41 AM, PCT 1 was observed washing her hands with soap and water. PCT 1 scrubbed with soap and water for 10 seconds, and failed to wash for a minimum of 40 seconds. 4. During an observation on 9/12/2023 at 10:50 AM, PCT 1 was observed initiating dialysis		blood and body fluids. If hands are not visibly soiled, use of a waterless antiseptic hand rub is acceptable. *Hand hygiene must always be performed after glove removal.* Hands will be: *Washed with antimicrobial soap and water for 40-60 seconds*: Hands are visibly dirty or contaminated with proteinaceous material, blood, or other body fluids Before eating After using a restroom Anthrax or C-difficile exposure Decontaminated using alcohol-based hand rub or by washing hands with antimicrobial soap and water for 20-30 seconds, allowing the alcohol to completely dry: Before and after direct contact with patients Entering and leaving the treatment area Before performing any invasive procedure such as vascular access cannulation or administration of parenteral medications *Immediately after removing gloves* After contact with body fluids or excretion, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled After contact with inanimate objects near the patient	

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	through a Central Venous Catheter (CVC) (an indwelling device inserted into a large, central vein) at station #10. PCT 1 removed Patient #8's dressing that covered the CVC exit site. PCT 1 removed her gloves and donned new gloves; PCT 1 failed to sanitize their hands prior to donning new gloves. PCT 1 cleaned the exit site, removed her gloves and donned new gloves; PCT 1 failed to sanitize hands prior to donning the new gloves. 5. During an observation on 9/12/2023 at 11:06 AM, PCT 1 was observed washing their hands with soap and water; PCT 1 scrubbed with soap and water for 11 seconds and failed to wash for a minimum of 40 seconds. 6. During an interview on 9/12/2023 at 5:02 PM, the Facility Administrator indicated the staff should sanitize their hands prior to donning gloves; when washing their hands with soap and water, their hands should be scrubbed for a minimum of 40 seconds.		When moving from a contaminated body site to a clean body site of the same patient After contact with the dialysis wall box, concentrate, drain, or water lines After contact with other objects within the patient station or treatment space Effective 10/9/2023, Clinical Manager will conduct weekly infection control audits with specific focus on ensuring 100% of all staff complete appropriate hand hygiene according to policy and procedure utilizing Infection Control Audit Tool for 4 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 QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at	

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			each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing 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 QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic.	
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 dialysis facility failed to ensure patient pre/post and intradialytic blood pressure were being assessed and managed in 1 of 6 in-center hemodialysis treatment records reviewed. (Patient #1)	V 0504	On 10/5/2023, the Clinical Manager held a staff meeting to review, re-educate, and reinforce the expectations and responsibilities of the facility staff on policies: ·Patient Assessment and Monitoring version 4	10/12/2023

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	The findings include: 1. An agency document titled "Patient Assessment and Monitoring," published 9/29/2019, stated, " ... If the PCT/LPN [patient care technician/licensed practical nurse] notes any changes or abnormal findings in the patient's condition, the patient care technician must report the findings to the registered nurse [RN] who will further assess the patient. An abnormal finding confirmed by the RN will be reported to the attending physician ... Report to the nurse systolic blood pressures greater than 180 and/or diastolic blood pressures greater than 100 systolic pressures less than or equal to 100 during treatment ... Report to the nurse patients whose heart rates have dropped below 60 or have risen above 100 ... An abnormal finding confirmed by the RN will be reported to the attending physician if necessary." 2. An agency policy titled "Volume Management in ESRD [End Stage Renal Disease] Patients on Hemodialysis" published 9/7/2021 stated, "If any of the following patient clinical conditions occur refer to the volume algorithm if applicable or consult with the physician for appropriate fluid interventions: Pre-treatment hypervolemia Pre-treatment sitting systolic BP is greater than 160 mmHg and prior treatment post dialysis sitting systolic BP is greater than 140 mmHg Pre-treatment signs or symptoms of hypervolemia." 3. An agency policy titled "Nursing Supervision and Delegation," published 5/1/2023, stated, "The following can be used as a guideline for the PCT/ LPN or RN to refer the patient to the charge nurse for further assessment The charge nurse will determine any clinical interventions needed ... A		·Volume Management in ESRD Patients on Hemodialysis version 1 ·Nursing Supervision and Delegation version 6 Emphasis was placed on: ·Direct patient care staff may collect pre-treatment, intradialytic, and post treatment data such as weight, BP, pulse, respirations, temperature, general observations, access, and complaints reported by the patient. *·Report to the nurse:* *·Systolic blood pressures greater than 180 mm/Hg* *·Diastolic blood pressure greater than 100 mm/Hg* *·Blood Pressure less than or equal to 100 mm/hg systolic* ·If the PCT/LPN note any changes or abnormal findings in the patient's condition or vascular access are observed or reported by the patient, or the patient was hospitalized, the registered nurse must assess the patient. *·The RN will notify the patient's physician/physician extender of any abnormal findings, if necessary, based on clinical judgment for additional instruction*. Effective 10/9/2023, Clinical Manager will conduct weekly treatment sheet audits on 10% of completed treatments with specific focus on ensuring patient	

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	systolic blood pressure greater than 180 and/or diastolic blood pressure greater than 100 at anytime before, during or after the treatment. If B/P [blood pressure] less than 100 systolic during treatment. A systolic blood pressure less than 100 post-treatment when standing. A drop in systolic BP of 20 between sitting and standing." 4. The clinical record for Patient #1 indicated an admit date of 8/08/2023 and included a review of the dialysis treatment sheets dated 8/19/2023 through 9/9/2023 and evidenced the following: The treatment sheet dated 8/24/2023 documented Patient's blood pressure (BP) at 2:10 PM was 200/98; at 2:35 PM, the BP was 190/98; at 3:01 PM, the BP was 196/96, and at 3:35 PM, the BP was 184/93. The documentation failed to evidence the Physician was notified of Patient #1's blood pressure. The treatment sheet dated 9/07/2023 documented Patien's pre-treatment BP was 188/84 at 12:32 PM; the BP was 180/101; at 1:31 PM, the BP was 183/93. The documentation failed to evidence the Physician was notified of Patient #1's blood pressure. The treatment sheet dated 9/09/2023 documented Patient's BP was 184/91 at 2:00 PM. The documentation failed to evidence the Physician was notified of Patient #1's blood pressure. 5. During an interview on 9/12/2023 at 4:25 PM, the Facility Administrator indicated the Physician should be notified of patient's high blood pressure.		pre, post and intradialytic blood pressures are assessed and managed utilizing Treatment Sheet Audit Tool for 4 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 QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure	

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			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 QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic.	
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 observation, record review, and interview the facility failed to ensure patient blood pressures were monitored per policy in 2 of 6 in-center hemodialysis patients clinical records reviewed. (Patient #3 and #4) The findings include: 1. An agency policy titled "Volume Management in ESRD [End Stage Renal Disease] Patients on Hemodialysis" published 9/7/2021 stated "If any of the following patient clinical conditions occur refer to the volume algorithm if applicable or consult with the physician for appropriate fluid interventions:... Pre-treatment weight is less than or equal to EDW .... EDW order should be updated post treatment adjustments and patient fluid status ... the clinical care team must be diligent in determining the EDW and routinely assess and adjust this metric ... EDW order should be updated post treatment to reflect	V 0543	On 10/5/2023, the Clinical Manager held a staff meeting to review, re-educate, and reinforce the expectations and responsibilities of the facility staff on policies: ·Patient Assessment and Monitoring version 4 ·Volume Management in ESRD Patients on Hemodialysis version 1 Emphasis was placed on: ·Obtain blood pressure and pulse rate every 30 minutes or more as needed but not to exceed 45 minutes or per state regulations. Effective 10/9/2023, Clinical Manager will conduct weekly treatment sheet audits on 10% of	10/12/2023

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	treatment adjustments and patient fluid status ... The assessment of EDW remains a clinical judgment of a clinical judgment of a clinician and clinical care team ... Obtain blood pressure and pulse at least every 30 minutes or more often as needed. " 2. An agency policy titled "Patient Assessment and Monitoring" published 9/29/2018 stated, "If the PCT/LPN note any changes or abnormal findings in the patient's condition or vascular access are observed or reported by the patient, or if the patient was hospitalized, the patient care technician MUST report the changes to a registered nurse Any abnormal finding confirmed by the RN [registered nurse] will be reported to the attending physician ... Maintain the patient post-treatment weight and ensure the post weight is consistent with the goal set of the machine ... Obtain blood pressure and pulse rate every 30 minutes or more as needed but not to exceed 45 minutes per state regulations." 3. The clinical record for Patient #3, with admit date 3/01/2023, included a review of the dialysis treatment sheets dated 8/21/2023 through 9/11/2023 and evidenced the following: The treatment sheet dated 8/30/2023 documented Patient #3's blood pressure (BP) was monitored at 11:36 AM and not again until 12:34 PM. The agency failed to ensure Patient #3 was monitored per policy. 4. Clinical record review on 9/12/2023 for Patient #4, admit date 3/26/2019, included a review of the dialysis treatment sheets from 8/19/2023 through 9/9/2023 and evidenced the following: The treatment sheet dated 8/24/2023 documented		completed treatments with specific focus on ensuring patient blood pressures are monitored every 30 minutes, not to exceed 45 minutes, as required utilizing Treatment Sheet Audit Tool for 4 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 QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly.	

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	Patient #4's BP was monitored at 9:03 AM and not again until 10:00 AM. The agency failed to ensure Patient #4 was monitored per policy. The treatment sheet dated 9/2/2023 documented Patient #4's BP was monitored at 9:05 AM and not again until 10:01 AM. The agency failed to ensure Patient #4 was monitored per policy. 5. During an interview on 9/12/2023 at 5:05 PM, the Facility Administrator indicated the staff should be monitored every 30 minutes during treatment.		The Governing Body is responsible for providing 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 QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic.	
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 observation, record review, and interview, the facility failed to ensure patient dialysis prescription orders were verified and adhered to in order to achieve and sustain the prescribed dose of dialysis to meet the adequacy of dialysis in 3 out of 6 incenter hemodialysis records reviewed. (Patient #1 #2, and #3) The findings include: 1. An agency policy titled "Patient Assessment and Monitoring, " published 9/29/2018, stated " ... 3. Check the machine settings and measurements, check the prescribed blood flow rate is being achieved or reason in the medical record if unable to meet the prescribed flow rate. Check dialysate flow rate setting is correct the prescribed flow is	V 0544	On 10/5/2023, the Clinical Manager held a staff meeting to review, re-educate and reinforce the expectations and responsibilities of the facility staff on policies: ·Patient Assessment and Monitoring version 4 Emphasis was placed on: ·Document machine parameters and safety checks every 30 minutes or more often as needed but not to exceed 45 minutes or per state regulations. ·Check machine settings and measurements: ·Check prescribed blood flow is being achieved or reason is	10/12/2023

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	being delivered." 2. A clinical record review for Patient #1, with admit date 8/08/23, included a review of the dialysis treatment records dated 8/19/23 through 9/9/23 and evidenced the following: The record evidenced Patient's ordered dialysate flow rate (DFR) was 800 milliliter / minute (ml/min) on 8/31/23. The treatment record dated 8/31/23 through 9/09/23 evidenced Patient's DFR during these treatments was 500 and failed to evidence Patient received their prescribed treatment. The treatment sheet dated 8/31/23 documented Patient #1's ordered blood flow rate (BFR) was 800 ml/min; the treatment record evidenced Patient's BFR during treatment was 500. The documentation failed to evidence Patient received their prescribed treatment. 3. The clinical record for Patient #2 was reviewed on 9/12/23, included a review of the dialysis treatment records dated 8/21/23 through 9/11/23 and evidenced the following: The treatment record dated 9/11/23 documented Patient #2's ordered DFR was 500 ml/min; the Patient's DFR during treatment was 800. The documentation failed to evidence why Patient #2 did not get their prescribed treatment. 4. The clinical record for Patient # 3, was reviewed on 9/12/23, evidenced an admit date of 3/01/23, included a review of the dialysis treatment records dated 8/21/23 through 9/11/23 and evidenced the following:		documented in medical record if unable to meet prescribed blood flow. ·Check dialysate flow rate setting is correct, and the prescribed flow is being delivered. Effective 10/9/2023, Clinical Manager will conduct weekly treatment sheet audits on 10% of completed treatments with specific focus on ensuring the blood flow rate (BFR) and dialysate flow rate (DFR) is achieved and maintained throughout the dialysis treatment or justification documented utilizing Treatment Sheet Audit Tool for 4 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 QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The treatment records dated 8/23/23, 8/25/23, 8/28/23, and 9/6/23 documented Patient #3's ordered DFR was 600 ml/min; Patient's DFR during these treatments was 800. The documentation failed to evidence why Patient #3 did not get their prescribed treatment. The treatment records dated 9/04/23 and 9/06/23 documented Patient #3's ordered BFR was 400 ml/min; Patient's BFR during these treatments was 375. The documentation failed to evidence why Patient #3 did not receive their prescribed treatment. 4. During an interview on 8/3/23 at 2:25 PM, the Facility Administrator indicated if the patient cannot dialyze at their prescribed BFR or DFR there should be documentation of why he/she did not get the prescribed treatment.		resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing 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 QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic.	