STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152543	A. BUILDING 00 B. WING	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE - NORTH HAMMOND	5454 HOHMAN AVE HAMMOND, IN 46320

(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 complaint survey of an ESRD provider. Survey dates: 8/23/2022 and 8/24/2022 Complaint #: IN00248738 -unsubstantiated. Census by Service Type: In-Center Hemodialysis: 86 Total Census: 86 Isolation Room/Waiver: yes Quality Review Completed 09/08/2022	V 0000		
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 and pulse were being assessed and managed in 4 of 5 in-center hemodialysis records reviewed. (Patient #1, #2, #3, #5) The findings include:	V 0504	On 09/09/22, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policies: · Patient Assessment and Monitoring version 3 Emphasis was placed on: · Pre Treatment:	10/08/2022

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

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	1. An agency policy 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. Record review on 8/23/2022, for patient #1, start of care 4/21/2022, evidenced an agency document titled, "Treatment Sheet for Facility," dated 8/19/2022. This document indicated patient #1's blood pressure at 11:31 AM, was 154/105 (normal blood pressure reading is 120/80), and at 1:03 PM, patient #1's pulse was 105 (normal pulse is 60 to 100). This document failed to evidence the nurse was notified of patient #1's high blood pressure and pulse. Record review evidenced an agency document titled, "Treatment Sheet for Facility," dated 8/22/2022. This document indicated patient #1's blood pressure at 11:04 AM, was 164/101, at 1:03 PM, patient #1's blood pressure was 174/102, and at 2:01 PM patient #1's blood pressure was 171/101. This document failed to evidence the nurse was notified of patient #1's high blood pressure.		o Direct patient care staff may collect pre-treatment weight, BP, pulse, respirations, temperature, general observations, access, and complaints reported by the patient. o If the PCT/LPN notes 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 patient care technician MUST report the changes in the patient condition to a registered nurse who will further assess the patient prior to initiation of the treatment. o An abnormal finding confirmed by the RN will be reported to the attending physician for assessment and intervention, if necessary, as determined by the clinical judgement of the registered nurse. · Monitoring During Treatment: o Obtain blood pressure and pulse rate every 30 minutes or more as needed but not to exceed 45 minutes or per state regulations. § Record blood pressure. · Recheck blood pressures after a drop that requires interventions such as administering normal saline. · Reposition electronic cuff or use a manual cuff for aberrant blood pressure readings. · Report to the nurse: o Systolic blood pressures	

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	3. Record review on 8/24/2022, for patient #2, start of care 10/2/2017, evidenced an agency document titled, "Treatment Sheet for Facility," dated 8/2/2022. This document indicated patient #2's blood pressure at 6:02 AM, was 164/103. This document failed to evidence the nurse was notified of patient #2's high blood pressure. Record review evidenced an agency document titled, "Treatment Sheet for Facility," dated 8/6/2022. This document indicated patient #2's blood pressure at 6:06 AM, was 168/109, and at 6:32 AM patient #2's blood pressure was 169/112. This document failed to evidence the nurse was notified of patient #2's high blood pressure. Record review evidenced an agency document titled, "Treatment Sheet for Facility," dated 8/2/2022. This document indicated patient #2's blood pressure at 6:02 AM, was 164/103. This document failed to evidence the nurse was notified of patient #2's high blood pressure. Record review evidenced an agency document titled, "Treatment Sheet for Facility," dated 8/11/2022. This document indicated patient #2's blood pressure at 10:04 AM, was 178/108, and at 11:02 AM, patient #2's blood pressure was 151/103. This document failed to evidence the nurse was notified of patient #2's high blood pressure. Record review evidenced an agency document titled, "Treatment Sheet for Facility," dated 8/13/2022. This document indicared patient #2's pulse at 12:36 PM, was 106 and at 2:00 PM, patient #2's pulse was 57. This document failed to evidence the nurse was notified of patient #2's pulse rates during treatment.		greater than 180 mm/Hg o Diastolic blood pressure greater than 100 mm/Hg · Blood Pressure less than or equal to 100 mm/hg systolic § Record pulse. · Verify pulses manually if automated readings display below 60 or greater than 100 beats per minute. · Report to the nurse patients whose heart rates have dropped below 60, risen above 100 or become irregular. · Post Treatment: o Non-licensed staff may collect post-treatment weight, BP, pulse, respirations, temperature, general observations, access, and complaints reported by the patient. o The staff member who collects the information and evaluates the patient post-treatment will document their findings on the hemodialysis treatment record. If any changes or abnormal findings in the patient's condition, vital signs, or vascular access are observed or reported by the patient, the PCT/LPN MUST report the changes in the patient condition to a registered nurse who will further assess the patient prior to discharge after the treatment. o An abnormal finding confirmed by the RN will be reported to the attending physician, if necessary, as determined by the clinical	

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	Record review evidenced an agency document titled, "Treatment Sheet for Facility," dated 8/16/2022. This document indicated patient #2's pulse at 12:47 PM, was 45 and at 1:18 PM, patient #2's pulse was 59. This document failed to evidence the nurse was notified of patient #2's pulse rates during treatment. Record review evidenced an agency document titled, "Treatment Sheet for Facility," dated 8/10/2022. This document indicated patient #2's blood pressure at 10:11 AM, was 154/114, and pulse was 59, at 10:38 AM, patient #2's blood pressure was 167/107, and pulse was 52, at 11:00 AM the patient's blood pressure was 163/105 and pulse was 51. This document failed to evidence the nurse was notified of patient #2's high blood pressure and low pulse readings during treatment. 4. Record review on 8/24/2022, for patient #3, start of care 7/23/2022, evidenced an agency document titled, "Treatment Sheet for Facility," dated 7/30/2022. This document indicated patient #3's blood pressure at 1:34 PM, was 97/52 and at 2:03 PM, patient #3's blood pressure was 98/58. This document failed to evidence the nurse was notified of patient #3's low blood pressure. Record review evidenced an agency document titled, "Treatment Sheet for Facility," dated 8/6/2022. This document indicated patient #3's blood pressure at 1:34 PM, was 88/29 and at 2:03 PM, patient #3's blood pressure was 75/34, and at 2:32 PM, patient #3's blood pressure was 95/55. This document failed to evidence the nurse was notified of patient #3's low blood pressure. Record review evidenced an agency document titled, "Treatment Sheet for Facility," dated 8/18/2022. This document indicated patient #3's		judgement of the registered nurse for assessment and intervention. The Registered Nurse will assess/re-assess any findings addressed pre-treatment prior to discharge Effective 9/12/22, Clinical Manager or designee will conduct weekly treatment sheet audits on 10% of completed treatments with focus on ensuring patient pre/post and intradialytic blood pressure and pulse 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.	

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	blood pressure at 1:33 PM, was 99/63. This document failed to evidence the nurse was notified of patient #3's low blood pressure. Record review evidenced an agency document titled, "Treatment Sheet for Facility," dated 8/20/2022. This document indicated patient #3's blood pressure at 2:04 PM, was 82/48 and at 2:07 PM, patient #3's blood pressure was 95/56. This document failed to evidence the nurse was notified of patient #3's low blood pressure. 5. Record review on 8/24/2022, for patient #5, start of care 12/1/2012, evidenced an agency document titled, "Treatment Sheet for Facility," dated 8/22/2022. This document indicated patient #5's blood pressure at 2:05 PM, was 93/61, at 3:18 PM, patient #5's blood pressure was 95/41 and at 3:42 PM patient #5's blood pressure was 98/36. This document failed to evidence the nurse was notified of patient #5's low blood pressure. 6. During an interview on 8/24/2022 at 2:02 PM, the clinical manager indicated the nurse should be notified of any blood pressure outside of parameters. She indicated any systolic blood pressure over 180 or less than 100 the nurse would need to be noticed. Any diastolic blood pressure less than 80 or greater than 100 the nurse should be notified. She also indicated a pulse over 100 or under 60 should prompt the staff to alert the nurse.		The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI 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 QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 10/8/22	
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			

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	status; Based on observation, record review, and interview the facility failed to ensure the physician was aware of the inability of the patient to achieve their dry weight to establish the appropriateness of the dialysis prescriptions in 1 of 5 in-center hemodialysis patients' clinical records reviewed. (patient #3) The findings include: 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 ... Overestimation of the EDW leads to chronic fluid overload, and the underestimation of EDW increases the risk of dialytic hypertension ...." Clinical record review on 8/24/2022, for patient #3, start of care 7/23/2022, evidenced an agency document titled "Treatment Sheet for Facility" dated 7/30/2022. This document indicated patient #3's dry weight [a weight without excess fluid] was 61 kilograms (kg). At the completion of treatment patient #3's weight was 62.1 kg. This document failed to evidence the physician was informed patient #3 failed to achieve her target dry weight. Clinical record review evidenced an agency document titled "Treatment Sheet for Facility" dated 8/2/2022. This document indicated patient #3's dry weight was 61 kg. At the completion of	V 0543	On 9/9/22, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policies: ·Volume Management in ESRD Patients on Hemodialysis Policy version 1 Emphasis was placed on: ·If any of the following patient clinical conditions occur refer to the volume algorithm if applicable or consult with provider for appropriate fluid interventions: ·Pre-treatment signs or symptoms of 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 hypovolemia · Unable to achieve EDW due to UF intolerance Effective 9/12/22, Clinical Manager or designee will conduct weekly treatment sheet audits on 10% of completed treatments with focus on ensuring the physician is aware of the inability of a patient to achieve their dry weight 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	10/08/2022

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	treatment patient #3's weight was 63.4 kg. This document failed to evidence the physician was informed patient #3 failed to achieve her target dry weight. Clinical record review evidenced an agency document titled "Treatment Sheet for Facility" dated 8/4/2022. This document indicated patient #3's dry weight was 61 kg. At the completion of treatment patient #3's weight was 62.1 kg. This document failed to evidence the physician was informed patient #3 failed to achieve her target dry weight. Clinical record review evidenced an agency document titled "Treatment Sheet for Facility" dated 8/6/2022. This document indicated patient #3's dry weight was 61 kg. At the completion of treatment patient #3's weight was 62.4 kg. This document failed to evidence the physician was informed patient #3 failed to achieve her target dry weight. Clinical record review evidenced an agency document titled "Treatment Sheet for Facility" dated 8/9/2022. This document indicated patient #3's dry weight was 61 kg. At the completion of treatment patient #3's weight was 64.1 kg. This document failed to evidence the physician was informed patient #3 failed to achieve her target dry weight. Clinical record review evidenced an agency document titled "Treatment Sheet for Facility" dated 8/11/2022. This document indicated patient #3's dry weight was 61 kg. At the completion of treatment patient #3's weight was 64 kg. This document failed to evidence the physician was informed patient #3 failed to achieve her target dry weight.		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 to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI 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 QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic.	

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	Clinical record review evidenced an agency document titled "Treatment Sheet for Facility" dated 8/13/2022. This document indicated patient #3's dry weight was 61 kg. At the completion of treatment patient #3's weight was 63.9 kg. This document failed to evidence the physician was informed patient #3 failed to achieve her target dry weight. Clinical record review evidenced an agency document titled "Treatment Sheet for Facility" dated 8/16/2022. This document indicated patient #3's dry weight was 61 kg. At the completion of treatment patient #3's weight was 63.9 kg. This document failed to evidence the physician was informed patient #3 failed to achieve her target dry weight. Clinical record review evidenced an agency document titled "Treatment Sheet for Facility" dated 8/18/2022. This document indicated patient #3's dry weight was 61 kg. At the completion of treatment patient #3's weight was 64.1 kg. This document failed to evidence the physician was informed patient #3 failed to achieve her target dry weight. During an interview on 8/24/2022 at 2:34 PM. The clinical manager indicated they were trying to challenge the patient's weight. She indicated the physician was aware of the patient's weight being higher than her dry weight the staff discussed it with him, it just was not documented in the chart.		Completion 10/8/22	
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			

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	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 orders were verified and adhered to in order to achieve and sustain the prescribed dose of dialysis to meet the adequacy of dialysis in 4 of 5 in-center hemodialysis records reviewed. (#2, #3, #4, #5) 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 being delivered...." 2. Clinical record review on 8/24/2022, for patient #2, start of care 10/20/2017, evidenced an agency document titled "Treatment Sheet for Facility" dated 8/2/2022. This document indicated the patient's prescribed BFR (blood flow rate) was 400 ml/min (milliliters/minute). During this treatment, patient #2's BFR was reduced to 350 ml/min. This document failed to evidence why patient #2 did not get her prescribed treatment. 3. Clinical record review on 8/24/2022, for patient #3, evidenced agency documents titled "Treatment Sheet for Facility" dated 8/4/2022, 8/9/2022, and 8/20/2022. These documents indicated the patient's prescribed BFR was 350 ml/min. During these treatments, patient #3's BFR was 400 ml/min. These documents failed to evidence why patient #3 did not get her	V 0544	On 9/9/22, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policies: ·Patient Assessment and Monitoring version 3 Emphasis was placed on: ·Document machine parameters and safety checks every 30 or more often as needed but not to exceed 45 minutes or per state regulations. ·Check prescribed blood flow is being achieved or reason is documented in medical record if unable to meet prescribed blood flow. Effective 9/12/22, Clinical Manager or designee will conduct weekly treatment sheet audits on 10% of completed treatments with focus on ensuring patient dialysis prescription orders are verified and adhered to achieve and sustain the prescribed dose of dialysis 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	10/08/2022

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	prescribed treatment. Clinical record review evidenced an agency document titled "Treatment Sheet for Facility" dated 8/16/2022. This document indicated the patient's prescribed BFR was 350 ml/min. During this treatment, patient #3's BFR was reduced to 300 ml/min. This document failed to evidence why patient #3 did not get her prescribed treatment. 4. Clinical record review on 8/24/2022, for patient #4, start of care 9/21/2018, evidenced agency documents titled "Treatment Sheet for Facility" dated 8/1/2022, and 8/22/2022. These documents indicated the patient's prescribed BFR was 450 ml/min. During these treatments, patient #4's BFR was 400 ml/min. These documents failed to evidence why patient #4 did not get his prescribed treatment. 5. Clinical record review on 8/24/2022, for patient #5, start of care 12/1/2012 evidenced an agency document titled "Treatment Sheet for Facility" dated 8/3/2022. This document indicated the patient's prescribed BFR was 400 ml/min. During this treatment, patient #5's BFR was reduced to 300 ml/min. This document failed to evidence why patient #5 did not get his prescribed treatment. Clinical record review evidenced agency documents titled "Treatment Sheet for Facility" dated 8/5/2022 and 8/19/2002. These documents indicated the patient's prescribed BFR was 400 ml/min. During these treatments, patient #5's BFR was reduced to 350 ml/min. These documents failed to evidence why patient #5 did not get his prescribed treatment. Clinical record review evidenced an agency document titled "Treatment Sheet for Facility"		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 to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI 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 QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 10/8/22	

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FRESENIUS MEDICAL CARE - NORTH HAMMOND	5454 HOHMAN AVE HAMMOND, IN 46320

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	dated 8/8/2022. This document indicated the patient's prescribed BFR was 400 ml/min. During this treatment, at 12:11 PM, patient #5's BFR was reduced to 350 ml/min and at 2:33 PM, patient #5's BFR was reduced to 300 ml/min. This document failed to evidence why patient #5 did not get his prescribed treatment. Clinical record review evidenced an agency document titled "Treatment Sheet for Facility" dated 8/10/2022. This document indicated the patient's prescribed BFR was 400 ml/min. During this treatment, at 12:03 PM, patient #5's BFR was reduced to 350 ml/min and at 12:31 PM, patient #5's BFR was reduced to 300 ml/min. This document failed to evidence why patient #5 did not get his prescribed treatment. Clinical record review evidenced an agency document titled "Treatment Sheet for Facility" dated 8/15/2022. This document indicated the patient's prescribed BFR was 400 ml/min. During this treatment, at 12:33 PM, patient #5's BFR was reduced to 300 ml/min and at 1:12 PM, patient #5's BFR was reduced to 280 ml/min. This document failed to evidence why patient #5 did not get his prescribed treatment. Clinical record review evidenced an agency document titled "Treatment Sheet for Facility" dated 8/22/2022. This document indicated the patient's prescribed BFR was 400 ml/min. During this treatment, patient #5's BFR was reduced to 345 ml/min. This document failed to evidence why patient #5 did not get his prescribed treatment. During an interview on 8/24/2022 at 2:25 PM, the clinical manager indicated if the patient cannot dialyze at the blood flow rate prescribed, staff should document the reason for the change, and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152543	A. BUILDING 00 B. WING	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE - NORTH HAMMOND	5454 HOHMAN AVE HAMMOND, IN 46320

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	the nurse was to be notified of the change.			