STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 152591			A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/10/2021	
	ROVIDER OR SUPPLIER	E TERRE HAUTE SOUTH		315 E S	ADDRESS, CITY, STATE, ZIP COD SPRINGHILL DR HAUTE, IN 47802			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)		IATE	(X5) COMPLETION DATE	
E 0000	REGELITORI GR	ESC IDENTIFY THOU IN ORDER THON		1710			BITTE	
Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62  Survey Dates: 11/5/2021-11/10/2021  Facility Number: 004839  Census = 22 in-center hemodialysis No home hemodialysis No home peritoneal dialysis  At this Emergency Preparedness survey, Fresenius Medical Care Terre Haute North was found not in compliance with Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, 42 CFR 494.62		E 00	000				
	QR Completed 11/2	2/2021 A4						
E 0028 Bldg. 00	494.62(b)(9) Dialysis Emergency Equipment §494.62(b)(9) Condition for Coverage: [(b) Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:]							

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.

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		152591	B. WI	NG	<del>_</del>	11/10	/2021
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
-D-0-N		- TEDDE !!!!TE 00!!T!!			SPRINGHILL DR		
FRESEN	IUS MEDICAL CAF	RE TERRE HAUTE SOUTH		IERRE	HAUTE, IN 47802		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	that emergency ed limited to, oxygen defibrillator or auto artificial resuscitat are on the premis immediately availated Based on observation	comated external defibrillator, stor, and emergency drugs, es at all times and able.	E 00	028	On November 23, 2021, the C Manager held a staff meeting	and	12/09/2021
	interview, the facility failed to maintain emergency medication and supplies according to manufacturer instructions for 1 of 1 crash carts				reinforced the expectations an responsibilities of the facility so on policy:		
	observed; and failed	d to maintain emergency			· Emergency Medication,		
	supplies according	to manufacturer instructions			Equipment and Supplies		
	for 1 of 1 emergence	ey evacuation box observed.			Emphasis was placed on:  Ensuring emergency		
	Findings include:				supplies are immediately avail		
	Medication, Equipr provided by the Cli separate licensed di 1:10 p.m. The polito, "Emergency car be: Checked mor Items approaching and replaced prior t Emergency Evacua expiration must be the actual expiration 2. During the flash at 9:10 a.m., two be Calcium Chloride 1 an expiration date 1 crash cart emergence set MPC 125 with a luer lock cap set M.	2020 policy titled, "Emergency ment and Supplies" was nic Manager of Entity 2, a alysis facility, on 11/8/2021 at cy indicated, but was not limited t The emergency cart must of the			for use including but not limite Calcium Chloride 10%-1 gram ml, luer lock cap sets MPC 12 Yankauer suction instruments micron disk filters, and Providone-lodine medium prep pads.  Utilization of the emerger supply monthly checklist to identify all contents in the emergency cart.  Include the expiration day supplies on the monthly checkly Items approaching expira must be reordered and replace prior to the actual expiration de Effective November 29, 2021, Clinic Manager or designee wi conduct an emergency supply audit weekly for one month utilizing the Emergency Cart Checklist. The focus will be or	/10 5, , 0.2 p ncy te of dist. ation ed ate. the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLE	
		152591	B. W	ING		11/10/2	2021
NAME OF B			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	t .		315 E S	SPRINGHILL DR		
FRESEN	IUS MEDICAL CAF	RE TERRE HAUTE SOUTH		TERRE	HAUTE, IN 47802		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	The state of the s	inkauer suction instrument			removing expired supplies and		
	-	late 11/21/20, and two, 0.2			ensuring all emergency suppli		
		with an expiration date 2/2017			are immediately available for u	use.	
		e second drawer from the top box of Providone-Iodine			Once 100% compliance is		
					sustained, monitoring will be		
		with an expiration date of ed in the emergency			completed per the Quality Assessment and Performance		
	evacuation box.	ed in the emergency					
	evacuation dox.				Improvement (QAI) calendar v	VILII	
	3 During on intern	iew on 11/5/2021 at 3:45 p.m.,			oversight from the Governing Body.		
	•	of Entity 2 was made aware of			The Medical Director will revie		
	_	ion and supplies and no			the results of audits each mon		
	additional informati				at the QAI Committee meeting		
	additional informat	ion was provided.			monthly. The Clinic Manager	· I	
					responsible to review, analyze		
					trend all data and Monitor/Aug		
					results as related to this Plan		
					Correction prior to presenting		
					the QAI Committee monthly.		
					Director of Operations is		
					responsible to present the star	tus	
					of the Plan of Correction and a		
					other actions taken toward the		
					resolution of the deficiencies a		
					each Governing Body meeting		
					through to the sustained resol	· I	
					of all identified issues. The QA		
					Committee is responsible to		
					provide oversight, review findi	ngs,	
					and take actions as appropria	-	
					The Governing Body is respor	nsible	
					to provide oversight to ensure	the	
					Plan of Correction, as written	to	
					address the issues identified b	у	
					the Statement of Deficiency, is	s	
					effective and is providing reso	lution	
					of the issues.		
					Documentation of education,		
					monitoring, QAI, and Governir	ng	
					Body is available for review.		

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  152591		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/10/2021	
NAME OF I	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP COD	•	
FRESEN	IUS MEDICAL CAR	RE TERRE HAUTE SOUTH	315 E SPRINGHILL DR TERRE HAUTE, IN 47802				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	1	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU	REGULATORY OF	LSC IDENTIFTING INFORMATION		TAU	The Clinic Manager is respons for overall compliance. Date of Completion: December 2021		DATE
V 0000							'
Bldg. 00							
	1	a federal ESRD recertification a Covid-19 infection control	V 0	000			
	Survey Dates. 11/3/	2021-11/10/2021					
	Facility Number: 00	)4839					
		er hemodialysis nemodialysis itoneal dialysis					
V 0113	494.30(a)(1)	S/HAND HYGIENE					
Bldg. 00	Wear disposable of patient or touching the dialysis station	gloves when caring for the graph the patient's equipment at an arrangement. Staff must remove gloves between each patient or					
	interview, the facili hygiene was perform medication preparate observations (RN B Findings include:	on, record review, and ty failed to ensure hand med effectively for 2 of 3 tion and administration s).	VO	113	On November 23, 2021, the C Manager held a staff meeting reinforced the expectations an responsibilities of the facility son policies:  Medication Preparation a Administration Hand Hygiene Education emphasis was place on:	and nd taff und	12/09/2021
	"Medication Prepar	ation and Administration" was nic Manager of Entity 2, a			Perform hand hygiene pr to handling vials and preparing		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		152591	B. W	ING		11/10/	/2021
				CTREET	ADDRESS SITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
FDFOFN	UIO MEDIONI ONE	DE TERRE LIALITE COLUTI			SPRINGHILL DR		
FRESEN	IUS MEDICAL CAP	RE TERRE HAUTE SOUTH		TERRE	HAUTE, IN 47802		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	·-	DATE
	separate licensed di	alysis facility, on 11/8/2021 at			administering medications.		
	1:10 p.m. The poli	cy indicated, but was not limited			Practice hand hygiene		
	to, "Infection Contr	ol. The following steps must			between each patient and stat	ion	
	be taken to ensure i	nfection control. Perform			to prevent cross-contamination		
	hand hygiene prior	to handling vials and			Effective November 29, 2021,		
		istering medications"			Clinic Manager or designee wi		
		_			conduct infection control audit		
	2. During an obser	vation on 11/8/2021 at 9:45			five times weekly for one mon		
	_	o perform hand hygiene prior to			then two times weekly for one		
		et (lowers calcium) tablets into			month, then weekly for one mo		
	two medication cup	os for patient #10 and #11			utilizing the Infection Control		
	during medication	preparation. RN B failed to			Monitoring Tool. The focus wi	ll be	
		ene, took both medication cups			on practicing hand hygiene du		
	containing Cincalce	et tablets into dialysis station 7,			medication prep and	Ü	
	sat the medication of	cup on the chairside table for			administration to improve infe	ction	
	patient #10, failed t	o perform hand hygiene, and			control. Once 100% complian		
	took the second me	dication cup into dialysis			is sustained, monitoring will be		
	station 8, and sat th	e medication cup on the			completed per the Quality		
	chairside table for p	patient #11.			Assessment and Performance	)	
					Improvement (QAI) calendar v	vith	
	3. During an obser	vation on 11/8/2021 at 10:36			oversight from the Governing		
	a.m., RN B failed to	o perform hand hygiene prior to			Body.		
	Hecterol (lowers pa	rathyroid hormone) multi-dose			The Medical Director will revie	W	
	vial medication pre	paration.			the results of audits each mon	th	
					at the QAI Committee meeting	J	
	4. During an interv	riew on 11/8/2021 at 3:54 p.m.,			monthly. The Clinical Manager	r is	
	the Clinic Manager	of Entity 2 was made aware of			responsible to review, analyze	and	
	the observations an	d indicated hand hygiene			trend all data and Monitor/Aud	lit	
	should be performe	d before medication			results as related to this Plan	of	
	preparation and adr	ninistration.			Correction prior to presenting	to	
					the QAI Committee monthly. T	he	
					Director of Operations is		
					responsible to present the stat	tus	
					of the Plan of Correction and a	all	
					other actions taken toward the	•	
					resolution of the deficiencies a	nt	
					each Governing Body meeting	J	
					through to the sustained resolu		
					of all identified issues. The QA		
					Committee is responsible to		

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 152591	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE S COMPL 11/10/	ETED
	ROVIDER OR SUPPLIER	E TERRE HAUTE SOUTH	315 E S	ADDRESS, CITY, STATE, ZIP CO SPRINGHILL DR E HAUTE, IN 47802	DD	_
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE PPROPRIATE	(X5) COMPLETION DATE
V 0117 Bldg. 00	COMMON CARTS Clean areas shoul the preparation, he medications and u equipment. Clean separated from co used supplies and Do not handle and supplies in the san that where used e are handled.  When multiple dos used (including via prepare individual (centralized) area and deliver separa carry multiple dos station to station.	MED PREP AREA;NO d be clearly designated for andling and storage of nused supplies and areas should be clearly ntaminated areas where equipment are handled. I store medications or clean ne or an adjacent area to quipment or blood samples se medication vials are als containing diluents), patient doses in a clean away from dialysis stations ately to each patient. Do not be medication vials from		provide oversight, revie and take actions as app. The Governing Body is to provide oversight to open Plan of Correction, as we address the issues ider the Statement of Deficit effective and is providing of the issues.  Documentation of educt monitoring, QAI, and G Body is available for restriction The Clinic Manager is restricted for overall compliance. Completion Date: Dece 2021	propriate. responsible ensure the vritten to ntified by ency, is ng resolution ation, overning view. esponsible	

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Event ID:

XVBG11

Facility ID: 004839

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		152591	B. WI	NG		11/10/	/2021
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			SPRINGHILL DR		
FRESEN	IUS MEDICAL CAR	RE TERRE HAUTE SOUTH			E HAUTE, IN 47802		
				121111			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		ns to patients. If trays are					
	used to deliver medications to individual patients, they must be cleaned between						
	patients.						10/00/004
	D 1 1	1	V 0	117	On November 23, 2021, the C		12/09/2021
		on, record review, and			Manager held a staff meeting		
		ity failed to ensure medications			reinforced the expectations ar		
	_	arately to each patient for 1 of 3			responsibilities of the facility s	тап	
	inedication adminis	stration observations (RN B).			on policy:	and.	
	Eindings in abida.				Medication Preparation and		
	Findings include:				Administration	ad	
	1 A rayinad Mayor	mber 1, 2021 policy titled,			Education emphasis was place	eu	
		ration and Administration" was			on:  Ensure medications are		
	_	nic Manager of Entity 2, a			delivered separately to each		
		ialysis facility, on 11/8/2021 at			patient.		
	_	cy indicated, but was not limited			patient.		
		all be delivered separately			Effective November 29, 2021,	the	
	to each patient"	air se derivered separatery			Clinic Manager or designee w		
	te cuen punchum				conduct infection control audit		
	2. During an obser	vation on 11/8/2021 at 9:45			five times weekly for one mon		
	_	o medication cups containing			then two times weekly for one		
		or patient #10 and #11, into			month, then weekly for one m		
		at one medication cup on the			utilizing the Infection Control		
	1	patient #10, and took the			Monitoring Tool. The focus w	ill be	
	_	on cup for patient # 11 into			on delivering medications to e		
		nd sat it on the chairside table.			patient separately per policy.		
					Once 100% compliance is		
	3. During an interv	view on 11/8/2021 at 3:54 p.m.,			sustained, monitoring will be		
	the Clinic Manager	of Entity 2 was made aware of			completed per the Quality		
	the observation and	l indicated oral medications for			Assessment and Performance	)	
	different patients sh	nould be taken into the dialysis			Improvement (QAI) calendar v	vith	
	station separately a	nd not together.			oversight from the Governing		
					Body.		
					The Medical Director will revie	w	
					the results of audits each mor		
					at the QAI Committee meeting	3	
					monthly. The Clinical Manage		
					responsible to review, analyze	and	
					trend all data and Monitor/Aud	lit	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 152591		· ′	JILDING	onstruction  00	(X3) DATE SURVEY COMPLETED 11/10/2021		
	PROVIDER OR SUPPLIER	RE TERRE HAUTE SOUTH		315 E S	ADDRESS, CITY, STATE, ZIP COD SPRINGHILL DR HAUTE, IN 47802		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
					results as related to this Plan Correction prior to presenting the QAI Committee monthly. Director of Operations is responsible to present the state of the Plan of Correction and other actions taken toward the resolution of the deficiencies a each Governing Body meeting through to the sustained resolution of all identified issues. The QAC Committee is responsible to provide oversight, review find and take actions as appropria The Governing Body is responsible to provide oversight to ensure Plan of Correction, as written address the issues identified the Statement of Deficiency, i effective and is providing resolution of the issues.  Documentation of education, monitoring, QAI, and Governing Body is available for review. The Clinic Manager is responsion overall compliance.  Completion Date: December 2021	to The  tus all e at g lution Al ings, te. nsible tto by s solution	
V 0122 Bldg. 00	494.30(a)(4)(ii) IC-DISINFECT SU PROTOCOL	JRFACES/EQUIP/WRITTEN					
3.00	[The facility must of standard infection implementing- (4) And maintaining accordance with a laws and accepted for the-]	demonstrate that it follows control precautions by  g procedures, in pplicable State and local d public health procedures,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		152591	B. W	ING		11/10/	2021
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t			SPRINGHILL DR		
FRESEN	IUS MEDICAL CAR	RE TERRE HAUTE SOUTH			E HAUTE, IN 47802		
					T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	surraces, medical	devices, and equipment.	17.0	100	On November 02 2024 "	1:-:-	12/00/2021
	D11		\ \ 0	122	On November 23, 2021, the C		12/09/2021
		on, record review, and ty failed to follow applicable			Manager held a staff meeting		
		ocedures when cleaning and			reinforced the expectations ar		
	-	inated surfaces for 1 of 2			responsibilities of the facility s on policy:	ıali	
		ng cleaned (Station # 6).			Cleaning and Disinfection	n of	
	arary sis stations bei	ng creatica (Station ii 0).			the Dialysis Station	1 01	
	Findings include:				Education emphasis was plac	ed	
	- manage merade.				on:	-u	
	A revised Nover	mber 2, 2020 policy titled,			Cleaning and disinfected	d all	
		enfection of the Dialysis			work surfaces within the	=	
	-	led by the Clinic Manager of			hemodialysis station with 1:10	0	
	_	licensed dialysis facility, on			bleach solution after completion		
	11/8/2021 at 1:10 p	.m. The policy indicated, but			procedures; including but not		
	was not limited to,	"General Cleaning. The			limited to the back chase cour	nter	
	dialysis station coul	d become contaminated with			and television.		
	blood and other boo	ly fluids during treatment.			· Ensure the surfaces are		
		isposable equipment must			glistening wet and allow to air	dry	
		1:100 bleach Work Surface			before placing the next patient	t into	
	-	fection w/out Visible Blood			the hemodialysis station.		
	-	ons. All work surfaces shall					
		nfected with 1:100 bleach			Effective November 29, 2021,		
	solution after comp	letion of procedures"			Clinic Manager or designee w		
	2.5. 1	. 11/0/2021 - 11 22			conduct infection control audit		
	-	vation on 11/8/2021 at 11:33			five times weekly for one mon		
		ng and disinfection of the			then two times weekly for one		
	•	T C failed to disinfect the			month, then weekly for one me	บทเท	
	station.	tertop behind the dialysis			utilizing the Infection Control	ill bo	
	station.				Monitoring Tool. The focus with cleaning all work surfaces with		
	3 During an interv	iew on 11/8/2021 at 3:54 p.m.,			the hemodialysis station with	111 1	
	-	of Entity 2 was made aware of			1:100 bleach solution per police	~V	
	_	ne Clinic Manager indicated			Once 100% compliance is	Эу.	
		nd the dialysis station was			sustained, monitoring will be		
	_	area an should be disinfected			completed per the Quality		
	after each patient. No additional information was				Assessment and Performance	<del>)</del>	
	provided.				Improvement (QAI) calendar v		
	*				oversight from the Governing	== =	
					Body.		

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	ROVIDER OR SUPPLIER	STREET A 315 E S TERRE			
(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 APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE	
			The Medical Director will reviet the results of audits each monat the QAI Committee meeting monthly. The Clinical Manager responsible to review, analyzer trend all data and Monitor/Auditesults as related to this Plant Correction prior to presenting the QAI Committee monthly. The Director of Operations is responsible to present the state of the Plant of Correction and a 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 finding and take actions as appropriated The Governing Body is responsible to provide oversight to ensure Plant of Correction, as written the Statement of Deficiency, is effective and is providing resolution of the issues.  Documentation of education, monitoring, QAI, and Governing Body is available for review. The Clinic Manager is responsion overall compliance.  Completion Date: December 12021	th  If r is  If and  If the control of the control	
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				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 11/10/2021 152591 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 315 E SPRINGHILL DR FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH TERRE HAUTE, IN 47802 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE when dispensing and administering intravenous medications from vials and ampules; and V 0143 12/09/2021 On November 23, 2021, the Clinic Based on observation, record review, and Manager held a staff meeting and interview, the facility failed to label opened, reinforced the expectations and multi-dose vials and opened medication bottles responsibilities of the facility staff for 1 of 1 medication preparation room on policies: observations; and failed to ensure a new, sterile Medication Preparation and syringe and needle was used to enter a multi-dose Administration vial for 1 of 3 medication preparation observations Education emphasis was placed (RN B). on: Expiration dates for all stored medications are to be Findings include: monitored on a monthly basis. Expired medications will be 1. A revised November 1, 2021 policy titled, discarded promptly. "Medication Preparation and Administration" was The person opening provided by the Clinic Manager of Entity 2, a medication bottles and vials is separate licensed dialysis facility, on 11/8/2021 at responsible to initial and date at 1:10 p.m. The policy indicated, but was not limited the time of opening. Always use a new sterile to, "Labeling Vials. When preparing medications if the vial is not used immediately in its entirety, syringe and needle when entering the nurse ... must place the date and time the vial a vial or ampule. was opened on the mediation label along with Effective November 29, 2021, the their initials. Note: To ensure all open vials are Clinic Manager or designee will properly marked, the nurse must never walk away conduct infection control audits from an opened, multi-dose vial without writing five times weekly for one month, the date and time the vial was opened. Label any then two times weekly for one open multi-dose vial that is not used immediately month, then weekly for one month ... Infection Control. The following steps must be utilizing the Infection Control taken to ensure infection control.... Always use a Monitoring Tool. The focus will be sterile syringe and needle when entering a vial.... on correct labeling of the If either vial is multi-use a different syringe must medication bottles & vials when be used for entry into each vial...." opened, ensuring expired medications are discarded, and 2. During the flash tour observation on 11/5/2021 single syringe usage per vial per at 9:10 a.m., an opened, unlabeled, multi-dose vial policy. Once 100% compliance is of Hecterol (reduces parathyroid hormone) 4 mcg sustained, monitoring will be (microgram)/2 ml (milliliters), lot # BRM063, completed per the Quality

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		152591	B. W	ING		11/10/	/2021
			1	STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			SPRINGHILL DR		
FRESEN	ILIS MEDICAL CAE	RE TERRE HAUTE SOUTH			HAUTE, IN 47802		
				LININE	T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1 ^	023, was observed on the			Assessment and Performance		
	countertop in the locked medication preparation				Improvement (QAI) calendar v	vith	
	room. Opened, unlabeled bottles of Cincalcet				oversight from the Governing		
	(lowers calcium)60 mg tablets, lot # PB00721 with				Body.		
	an expiration date 8/22, lot # PB00722 with an				The Medical Director will revie		
	expiration date of 8/22, and an opened bottle of				the results of audits each mon		
	Acetaminophen (pain reliever) 325 mg tablets, lot				at the QAI Committee meeting	•	
		expiration date 10/22, were			monthly. The Clinical Manage		
		ttom shelf of the cabinet			responsible to review, analyze		
		ns" in the locked medication			trend all data and Monitor/Auc		
	preparation room.				results as related to this Plan		
					Correction prior to presenting		
		v on 11/5/2021 at 12:00 p.m., RN			the QAI Committee monthly. T	he	
		en, multi-dose vials should be			Director of Operations is		
		s, date, and time on the label.			responsible to present the sta		
		she forgot to label Hecterol			of the Plan of Correction and a		
		d the vial. RN B indicated			other actions taken toward the		
		thout labels must be discarded			resolution of the deficiencies a		
	and cannot be reuse	ed.			each Governing Body meeting		
					through to the sustained resol		
	_	v on 11/5/2021 at 3:45 p.m., the			of all identified issues. The QA	AI .	
	_	Entity 2 was made aware of the			Committee is responsible to		
		dicated open bottles of			provide oversight, review findi	-	
		lti-dose vials should be			and take actions as appropria		
	initialed, dated, and	I timed when opened.			The Governing Body is respor		
	2.5				to provide oversight to ensure		
	_	vation on 11/5/2021 at 12:00			Plan of Correction, as written		
	1 *	served to withdraw Hecterol			address the issues identified b	-	
	_	ulti-dose vial using a new,			the Statement of Deficiency, is		
		needle. RNB opened a new			effective and is providing reso	iution	
		Hecterol and used the same			of the issues.		
		filled with mediation from the			Documentation of education,		
	1 -	vial to withdraw and add			monitoring, QAI, and Governing	ng	
	medication from the	e new multi-dose vial.			Body is available for review.	.:	
	Daning C. C.				The Clinic Manager is respons	elais	
	During an interview on 11/5/2021 at 3:45 p.m., the				for overall compliance.	0	
	Clinic Manager of Entity 2 was made aware of the observation and indicated a different syringe				Completion Date: December	9,	
					2021		
		each of the multi-dose vials.					
	The Clinic Manage	r of Entity 2 indicated					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		152591	B. W	ING		11/10/	2021
	ROVIDER OR SUPPLIER	E TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP COD 315 E SPRINGHILL DR TERRE HAUTE, IN 47802				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	l		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	IE	DATE
		e multi-dose vials should be arate syringes and not					
	combined into one.						
V 0250	494.40(a) DIALYS PROPOR	RT-MONITOR					
Bldg. 00	PH/CONDUCTIVI						
J	5.6 Dialysate prop pH/conductivity						
	It is necessary for	the operator to follow the structions regarding					
		vity and to measure					
	-	ith an independent method					
	before starting the treatment of the next						
	patient.						
			V 0	250	On November 23, 2021, the C	linic	12/09/2021
		on, record review, and			Manager held a staff meeting		
		ty failed to ensure staff were			reinforced the expectations an		
	-	et limits for allowable pH			responsibilities of the facility s	taff	
	variability for 1 of 2	2 pH test observations.			on policy: Checking Conductivity ar	ad	
	Findings include:				pH of Final Dialysate	iu	
	1. A revised Augus	t 2, 2020 policy titled,			Education emphasis was plac	ed	
	_	ivity and pH of Final			on:		
		vided by the Clinic Manager of			<ul> <li>Ensure proper proportion</li> </ul>	ing	
		licensed dialysis facility, on			of acid concentrate, bicarbona		
	•	.m. The policy indicated, but			concentrate, and treated wate		
		'Conductivity and pH of			The dialysate range mus	t be	
	_	rements used to verify proper d concentrate, bicarbonate			verified with an instrument at which the test method can dis	nlov	
		ated water Responsibility.			pH values within the Associati		
		are (FKC) Staff In dialysis,			for the Advancement of Medic		
		tinely monitored for pH as a			Instrumentation (AAMI)	ui.	
	-	nt Dialysate pH Range. The			recommendation for dialysate	рН	
	range at which the t	est method can display pH			of 6.9-7.6.	-	
	values within the A				· The final dialysate pH mu	ust	
	Advancement of Medical Instrumentation			be tested prior to each patient			
		dation for dialysate pH of			treatment to verify the value is	;	
	6.9-7.6 The final	pH must be tested prior to			within the set parameters.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 152591		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/10/2021	
	PROVIDER OR SUPPLIER	RE TERRE HAUTE SOUTH	315 E	ADDRESS, CITY, STATE, ZIP COD SPRINGHILL DR E HAUTE, IN 47802	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
TAG	each patient's treatm scenarios occurs the and reported to the team leader The equal to 6.9 to 7.6  2. During an observa.m., PCT D was obwith the Phoenix marea did not contain remind staff of the answer of the answer of the answer of the staff of the answer of	vation on 11/8/2021 at 10:40 beserved to test the dialysate pH eter for station 14. The test signs or information to allowable pH variability.  iew on 11/8/2021 at 10:43 a.m., to verbalize the allowable pH CT D stated, "[BioMed] is who PCT D indicated the facility ed the pH range but PCT D	TAG	If the dialysate pH is not within or equal to the set parameters of 6.9-7.6, the reamust be investigated and repto the clinical manager, charginurse, team leader.  Staff must verbalize the expected pH range and ensuipatient safety prior to initiating dialysis.  Effective November 29, 2021 Clinical Manager or designee conduct dialysate pH audits of for one week, then five times weekly for one month, then to times weekly for one month utilizing Patient Safety Monitoring Too The focus will be on verifying dialysate pH per policy. Once 100% compliance is sustaine monitoring will be completed the Quality Assessment and Performance Improvement (Calendar with oversight from a Governing Body.  The Medical Director will review the results of audits each monat the QAI Committee meetin monthly. The Clinical Manager responsible to review, analyzatrend all data and Monitor/Aurresults as related to this Plan Correction prior to presenting the QAI Committee monthly. Director of Operations is responsible to present the state of the Plan of Correction and other actions taken toward the resolution of the deficiencies	ason orted lee  re g) , the laily wo hen y the ol. e d, per Al) the ew hth g er is e and dit of to The utus all e

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 152591	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 11/10/2021
	PROVIDER OR SUPPLIER	RE TERRE HAUTE SOUTH	315 E	ADDRESS, CITY, STATE, ZIP COD SPRINGHILL DR E HAUTE, IN 47802	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				each Governing Body meetin through to the sustained reso of all identified issues. The Quantities is responsible to provide oversight, review find and take actions as appropriated The Governing Body is responsible to provide oversight to ensure Plan of Correction, as written address the issues identified the Statement of Deficiency, if effective and is providing reso of the issues.  Documentation of education, monitoring, QAI, and Governi Body is available for review. The Clinic Manager is responsion overall compliance.  Completion Date: December 2021	lution AI ings, ate. nsible e the to by is blution  ng sible
V 0543 Bldg. 00	limited to, the follo (1) Dose of dialysi team must provide services to manag	nust address, but not be			
	failed to follow their (patient care technic of BP (blood pressu	riew and interview, the facility r policy and ensure the PCT cian) notified a licensed nurse re) not within parameters for 4 reviewed (Patients #5, 7, 12, &	V 0543	On November 23, 2021, the Clinical Manager will hold a s meeting and reinforced the expectations and responsibility of the facility staff on the follo policy:  Patient Assessment and Monitoring Education emphasis was place	ties wing

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	T 7 T T T	
i é companya di managana d	(X3) DATE SURVEY	
	COMPLETED	
152591 B. WING 11/10/202	21	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP COD		
315 E SPRINGHILL DR		
FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH TERRE HAUTE, IN 47802		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COLUMN	OMPLETION	
	DATE	
on:		
1. A September 29, 2018 policy titled, "Patient Ensuring vital signs and		
Assessment and Monitoring" was provided by treatment status of the patient are		
the Clinic Manager of Entity 2, a separate licensed monitored every 30 minutes or		
dialysis facility, on 11/9/2021 at 11:24 a.m. The more frequently if indicated during		
policy indicated, but was not limited to, dialysis treatment and obtaining		
"Monitoring During Treatment Blood manual Blood Pressures (BPs)		
Pressure Report to the nurse: Systolic [top when needed.		
number] blood pressure greater than 180 mm/Hg		
[millimeters of Mercury]. Diastolic [bottom (PCT) is required to notify the RN		
number] blood pressure greater than 100 mm/Hg. for Diastolic Blood Pressure (DPB)		
Blood pressure less than or equal to 100 mm/Hg  greater than 100 mm/Hg and		
systolic"  Systolic Blood Pressure (SBP)		
greater than 180 mm/Hg.		
2. The complete clinical record for patient # 5 was  The PCT is required to notify		
reviewed on 11/9/2021, included 7 treatment the Registered Nurse (RN) for a		
• The RN is responsible to		
A 11/1/2021 treatment sheet indicated a BP (blood document in the medical record of		
pressure) reading of 92/49 at 11:03 a.m., noted by  BPs out of parameters with an		
PCT C. At 11:28 a.m., the BP was 96/51, noted by assessment and intervention when		
PCT C. At 11:45 a.m., the BP was 98/47, noted by indicated.		
PCT D. At 12:03 p.m., the BP was 94/49, noted by  Effective November 29, 2021, the		
PCT D. At 12:22 p.m., the BP was 91/43, noted by  Clinic Manager or designee will		
PCT D. At 12:43 p.m., the BP was 83/44, noted by conduct hemodialysis treatment		
PCT C. At 1:07 p.m., the BP was 89/43, noted by sheet audits on a minimum of ten		
PCT D. At 1:30 p.m., the BP was 89/43, noted by patient records daily for two		
PCT C, and the comments indicated, "Green AMP weeks, then weekly for four		
Light; Denies Complaints; Access Visible; pt weeks, then every two weeks for		
states [he/she] feels fine/normal avls." [sic] At one month utilizing the Patient		
2:02 p.m., the BP was 96/49, noted by PCT D.  Treatment Sheet Monitoring Tool.		
There was no indication the licensed nurse was  The focus will be on PCT		
notified of systolic blood pressures less than 100 notification and RN assessments		
mm/Hg. and interventions for BPs outside		
of set parameters. Once 100%		
A 11/5/2021 treatment sheet indicated a BP compliance is sustained,		
reading of 87/46 at 1:43 p.m., noted by PCT C. At monitoring will be completed per		
1:44 p.m., the BP was 90/45, noted by PCT C, and the Quality Assessment and		
the comments indicated, "Green AMP Light; Performance Improvement (QAI)		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 00 COMPLETE			ETED
		152591	B. W	ING _		11/10/	/2021
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			SPRINGHILL DR		
FRESEN	ILIS MEDICAL CAR	RE TERRE HAUTE SOUTH			HAUTE, IN 47802		
	ISS WEDIOAL OAL	L LINE III OIL OOIII		LLININE	. 17.01L, III 77.00Z		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	-	Access Visible." At 1:59 p.m.,			calendar with oversight from the	ne	
		noted by PCT C. There was no			Governing Body.		
		sed nurse was notified of			The Medical Director will revie		
	systolic blood press	sures less than 100 mm/Hg.			the results of audits each mon		
	2 TI 1 1				at the QAI Committee meeting	•	
	-	inical record for patient # 7 was			monthly. The Clinical Manage		
		021, included 7 treatment			responsible to review, analyze		
		2021 to 11/5/2021, and			trend all data and Monitor/Aud		
	evidenced the follo	wing:			results as related to this Plan		
	A 10/25/2021 to 1	mont about indicated - DD			Correction prior to presenting		
		ment sheet indicated a BP			the QAI Committee monthly. T	ne	
	_	6:42 a.m., noted by PCT C. ation the licensed nurse was			Director of Operations is	h	
					responsible to present the state		
	•	lic blood pressure less than			of the Plan of Correction and a		
	100 mm/Hg.				other actions taken toward the		
	A 10/27/2021 two ata	ment sheet indicated a BP			resolution of the deficiencies a		
					each Governing Body meeting		
	-	7:05 a.m., noted by PCT D. At vas 86/44, noted by PCT D. At			through to the sustained resol		
		vas 88/44, noted by PCT D. At			of all identified issues. The QA	<b>₹I</b>	
		ras 99/48, noted by PCT D. At			Committee is responsible to	222	
		vas 93/45, noted by PCT D. At			provide oversight, review findi	_	
		ation the licensed nurse was			and take actions as appropriate		
		blood pressures less than 100			The Governing Body is respor to provide oversight to ensure		
	mm/Hg.	orood pressures less than 100			Plan of Correction, as written		
	111111 11g.				address the issues identified b		
	A 11/3/2021 treatm	ent sheet indicated a BP			the Statement of Deficiency, is	-	
		9:02 a.m., noted by PCT D.			effective and is providing reso		
		ation the licensed nurse was			of the issues.	iduoii	
		olic blood pressure less than			Documentation of education,		
	100 mm/Hg.	stock pressure tess man			monitoring, QAI, and Governir	na	
	100 1111111115.				Body is available for review.	יש	
	4. The complete of	inical record for patient # 12			The Clinic Manager is respons	sible	
	_	1/9/2021, included 7 treatment			for overall compliance.		
		2021 to 11/8/2021, and			Completion Date: December	9	
	evidenced the follow				2021	<b>.</b> ,	
	criacine a me folio	··· <del>····</del> 5·			2021		
	A 10/25/2021 treats	nent sheet indicated a BP					
		at 12:05 p.m., noted by PCT D.					
	-	SP was 97/58 noted by PCT D					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				ETED
		152591	B. W	ING		11/10/2021	
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			PRINGHILL DR		
FRESEN	IUS MEDICAL CAF	RE TERRE HAUTE SOUTH			HAUTE, IN 47802		
			<del></del>		,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	TE	COMPLETION
IAG		R LSC IDENTIFYING INFORMATION P was 86/48, noted by PCT D.		TAG	DEFICIENCE!		DATE
		P was 95/53, noted by PCT D.					
	* ′	P was 99/60, noted by PCT C.					
	* .	P was 91/52, noted by PCT D.					
	* .	ation the licensed nurse was					
		blood pressure greater than					
		stolic blood pressures less than					
	100 mm/Hg.	*					
	_						
	A 11/8/2021 treatm	ent sheet indicated a BP					
	_	at 12:03 p.m., noted by PCT D.					
	-	BP was 185/105, noted by PCT					
		dication the licensed nurse					
		tolic blood pressures greater					
	than 180 mm/Hg.						
	5 TEL 1 4 15	1 10					
	•	inical record for patient # 14					
		1/9/2021, included 3 treatment 021 to 11/5/2021, and					
	evidenced the follow						
	evidenced the follow	wing.					
	A 11/1/2021 treatm	ent sheet indicated a BP					
		11:48 a.m., noted by PCT D. At					
	-	was 98/63, noted by PCT C. At					
	_	vas 98/56, noted by PCT C.					
	There was no indica	ation the licensed nurse was					
	notified of systolic	blood pressures less than 100					
	mm/Hg.						
		ent sheet indicated a BP					
	_	7:22 a.m., noted by PCT D. At					
	· ·	vas 95/51, noted by PCT D. At					
	· ·	vas 95/55, noted by PCT C. At					
		vas 88/50, noted by PCT C, and					
		ated, "Access Visible; yellow					
		of leg pain and back pain; rn					
		21 a.m., the BP was 84/55, noted					
		vas no indication the licensed					
	less than 100 mm/H	of systolic blood pressures					
	1688 uian 100 mm/f.	ıg.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING O  COMPLETE					
		152591	B. WING		11/10/	2021	
	ROVIDER OR SUPPLIER	E TERRE HAUTE SOUTH		STREET ADDRESS, CITY, STATE, ZIP COD 315 E SPRINGHILL DR TERRE HAUTE, IN 47802			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
V 0676	the Clinic Manager the patient record re additional informati 494.130						
Bldg. 00	The dialysis facility available, laborator tissue pathology a meet the needs of laboratory services pathology and hist furnished by or ob meets the requirer services specified	tocompatibility must be tained from, a facility that ments for laboratory in part 493 of this chapter.	W.O.		On November 22, 2021, the C	lini a	12/00/2021
	failed to ensure lab specimens from dial for 1 of 1 facility.  Findings include:  1. A revised July 6, Medication, Equipm provided by the Clin separate licensed dial:10 p.m. The policito, "Items approach reordered and replace expiration date"  2. During the flash at 9:10 a.m., 80, 3.5 collection tubes) wi	on and interview, the facility supplies used to collect lysis patients were not expired  2020 policy titled, "Emergency ment and Supplies" was nic Manager of Entity 2, a alysis facility, on 11/8/2021 at ey indicated, but was not limited ing expiration must be need prior to the actual  tour observation on 11/5/2021 ml BD vacutainer SST (blood than expiration date  8.5 ml BD vacutainer SST with		On November 23, 2021, the Clinic Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policies:  Emergency Medication, Equipment and Supplies  Laboratory Testing Education emphasis was placed on:  Items approaching expiration must be reordered and replaced prior to the actual expiration date.  Ensure lab supplies used to collect specimens from dialysis patients are not expired.  Effective November 29, 2021, the Clinic Manager or designee will conduct a lab supply audit weekly for one month utilizing the Patient		12/09/2021	
	an expiration date 1	0/31/2021 were observed in the at the nurse's station.			Safety Monitoring Tool. The fo will be on removing expired supplies and ensuring all lab		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLE			ETED	
		152591	B. W	ING		11/10/2021	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			SPRINGHILL DR		
FRESEN	ILIS MEDICAL CAE	RE TERRE HAUTE SOUTH			HAUTE, IN 47802		
TRESEN	100 MEDICAL CAP	AL ILIMETIAGTE SOUTH		ILKKE	11701L, IN 4700Z		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	iew on 11/5/2021 at 3:45 p.m.,			supplies are immediately avail		
	_	of Entity 2 was made aware of			for use. Once 100% complian		
		plies and no additional			is sustained, monitoring will be	9	
	information was pro	ovided.			completed per the Quality		
					Assessment and Performance		
	-	iew on 11/8/2021 at 2:43 p.m.,			Improvement (QAI) calendar v	vith	
	_	of Entity 2 indicated there was			oversight from the Governing		
		al expired supplies, and general			Body.		
		dates would fall under the			The Medical Director will revie		
	_	mergency Medications,			the results of audits each mon		
	Equipment and Sup	pplies policy.			at the QAI Committee meeting		
					monthly. The Clinical Manage		
					responsible to review, analyze		
					trend all data and Monitor/Aud		
					results as related to this Plan		
					Correction prior to presenting		
					the QAI Committee monthly. T	he	
					Director of Operations is		
					responsible to present the state		
					of the Plan of Correction and a		
					other actions taken toward the		
					resolution of the deficiencies a		
					each Governing Body meeting		
					through to the sustained resol		
					of all identified issues. The QA	NI .	
					Committee is responsible to	200	
					provide oversight, review findi	•	
					and take actions as appropriate		
					The Governing Body is respon		
					to provide oversight to ensure Plan of Correction, as written		
					address the issues identified b		
					the Statement of Deficiency, is	-	
					effective and is providing reso		
					of the issues.	iuliOH	
					Documentation of education,		
					monitoring, QAI, and Governir	na	
						iy	
					Body is available for review.	siblo	
					The Clinic Manager is respons	sini <del>c</del>	
			1		for overall compliance.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		152591	B. WI	NG		11/10/2021	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u></u>	
NAME OF I	PROVIDER OR SUPPLIE	R			SPRINGHILL DR		
FRESEN	ILIS MEDICAL CAR	RE TERRE HAUTE SOUTH			E HAUTE, IN 47802		
TIVEOLIV	TOO WEDIONE ON	TE TERRETINGTE GOOTTI	ı	ILIVIVE	117.012, 114 47.002		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	I	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
					Completion Date: December	9,	
					2021		
V 0715	404.450(-)(0)(:)						
V 0715	494.150(c)(2)(i)	DE ALL ADUEDE TO DAD					
Dida 00		RE ALL ADHERE TO P&P					
Bldg. 00	The medical direct	ctor must-					
	(2) Ensure that-	l procedures relative to					
	, ,	d procedures relative to s, patient care, infection					
		ry are adhered to by all					
		reat patients in the facility,					
	including attendin	· · · · · · · · · · · · · · · · · · ·					
	nonphysician pro						
	i nonpriyatalar pro	videre,	$V_0$	715	On November 23, 2021, the C	Clinic 12/09/2021	
	Based on observati	on, record review, and	• •	/13	Manager held a staff meeting		
		ical Director failed to ensure all			reinforced the expectations ar	I	
		dures relative to patient care,			responsibilities of the facility s		
		nd safety were adhered to by			on policies:	tan	
		treated patients in the facility.			· Emergency Medication,		
	un mun numb min	walled pulled in the fueling.			Equipment and Supplies		
	Findings include:				Medication Preparation a	and	
	8				Administration		
	The Medical Di	rector failed to ensure			· Cleaning and Disinfectio	n of	
		es and procedures for staff			the Dialysis Station		
	hand hygiene (see	-			Patient Assessment and		
		-			Monitoring		
	2. The Medical Dir	rector failed to ensure adherence			· Laboratory Testing		
	to policies and prod	cedures to ensure medications			Education emphasis was place	ed	
	were delivered sepa	arately to each patient (see tag			on:		
	V117).						
					· Ensuring all policies and		
	3. The Medical Di	rector failed to ensure			procedures relative to patient		
	adherence to polici	es and procedures for cleaning			admissions, patient care, infe	ction	
	_	alysis treatment stations (see			control, and safety are adhere	ed to	
	tag V122).				by all individuals who treat		
					patients in the facility, including	ıg	
		rector failed to ensure			attending physicians and		
	_	es and procedures for			non-physician providers.		
		ling opened medications (see			Effective November 29, 2021,		
1	tag V143).				Clinic Manager or designee w	ill	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 152591		 JILDING	ONSTRUCTION  00	(X3) DATE : COMPL 11/10/	ETED	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD SPRINGHILL DR		
FRESEN	IUS MEDICAL CAR	RE TERRE HAUTE SOUTH		HAUTE, IN 47802		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	5. The Medical Director policies and procurse of BP (blood parameters (see tag)  6. The Medical Director adherence to policies lab supplies used to	ector failed to ensure adherence edures for notifying a licensed pressure) not within		conduct infection control audit five times weekly for one month then two times weekly for one month, then weekly for one month, then weekly for one mutilizing the Infection Control Monitoring Tool. The focus won practicing hand hygiene dumedication prep and administration; correct labeling the medication bottles & vials when opened, ensuring expire medications are discarded, ar single syringe usage per vial; cleaning all work surfaces with the hemodialysis station with 1:100 bleach solution; deliver medications to each patient separately.  Effective November 29, 2021, Clinic Manager or designee word conduct hemodialysis treatments heet audits on a minimum of patient records daily for two weeks, then every two weeks one month utilizing the Patien Treatment Sheet Monitoring The focus will be on PCT notification and RN assessment and interventions for BPs outs of set parameters.  Effective November 29, 2021, Clinic Manager or designee word conduct a lab supply audit we for one month utilizing the Patien Safety Monitoring Tool. The fowll be on removing expired	ts th, onth ill be uring g of ed and min ng the ill ent ten for t cool. ents side the ill ekly cient	
				supplies and ensuring all lab supplies are immediately avai	lable	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 152591	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction  00	(X3) DATE SURVEY COMPLETED 11/10/2021
	ROVIDER OR SUPPLIER	RE TERRE HAUTE SOUTH	315 E \$	ADDRESS, CITY, STATE, ZIP COI SPRINGHILL DR E HAUTE, IN 47802	D
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLETION DATE
				Once 100% compliance sustained, monitoring wi completed per the Qualit Assessment and Perform Improvement (QAI) caled oversight from the Gover Body.  The Medical Director will the results of audits each at the QAI Committee monthly. The Clinical Maresponsible to review, ar trend all data and Monitor results as related to this Correction prior to prese the QAI Committee mon Director of Operations is responsible to present the Operations of the Plan of Correction other actions taken toware resolution of the deficient each Governing Body must through to the sustained of all identified issues. To Committee is responsible provide oversight, review and take actions as apportant to provide oversight to explain of Correction, as we address the issues ident the Statement of Deficient effective and is providing of the issues.  Documentation of education monitoring, QAI, and Go Body is available for review and the Clinic Manager is refor overall compliance.  Completion Date: December 1997.	Il be ty mance mance mance mance mance mance mance month mon

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		152591	B. WING			11/10/2021	
NAME OF BROWNER OF GUIDNIER				STREET ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER				315 E S	PRINGHILL DR		
FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH				TERRE	HAUTE. IN 47802		
TREGEN	100 WEDIO/ (E O/ (I ·	E TERRETINOTE GOOTT		I LI (I (L	17.012, 114 17.002		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)				DATE
					2021		
			İ				
	l						1

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