STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152648	A. BUILDING 00 B. WING	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE WEST DIALYSIS	4916 ILLINOIS RD STE 118 FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 494.62 Survey Dates: 03/19/2025, 03/20/2025, and 03/21/2025 Total Census: 58 During this Emergency Preparedness survey, Fort Wayne West Dialysis was found to be in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, at 42 CFR 494.62. QR: A1 3/25/2025	E 0000		
V 0000 Bldg. 00	This visit was for a CORE federal recertification of an ESRD Provider. Provider requested to add in center peritoneal dialysis. Survey Dates: 03/19/2025, 03/20/2025, and 03/21/2025 CCN: 152648 Census by Service Type: In-Center Hemodialysis: 48 Home Peritoneal Dialysis: 9	V 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chip Koltash	Facility Administrator	04/10/2025

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

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	Home Hemodialysis: 1 Total Census: 58 1 Isolation Room Home Training Rooms: 2 Service added: In-center peritoneal dialysis. The abbreviations used in this survey would include RN for registered nurse and PCT for patient care technician. QR: A1, 3/25/2025			
V 0113 Bldg. 00	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Based on observation, record review, and interview, the dialysis facility failed to ensure PCT 1, PCT 3, and RN 1 performed hand hygiene, hand sanitizing with an alcohol based antiseptic or hand washing, after glove removal, between patients, when moving between patients' hemodialysis [HD] (a process to filter the blood of a patient whose kidneys do not work normally) stations, in of 5 of 10 observations of PCT 1 and PCT 3 and in 1 of 1 observations of RN 1 Patient care observed and failed to ensure PCT 1 and PCT 6 performed hand hygiene when central venous catheter [CVC] (large catheter into vein) care was provided and failed to perform hand hygiene/glove change when moving from a dirty area to perform CVC care in 2 of 2 CVC initiations observed (Patient #12, Patient #15). Findings include:	V 0113	The Facility Administrator or Registered Nurse will in-service all clinical teammates on Policy 1-05-01 “Infection Control For Dialysis Facilities” and Policy 1-04-02 “Central Venous Catheter (CVC) With TEGO Connectors Or CVC End Caps Procedure”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1)	04/19/2025

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	1. A revised policy, dated April 2023, titled, "Infection Control For Dialysis Facilities," indicated hand hygiene would be performed by staff upon entering and exiting the patient treatment area, prior to gloving and immediately after glove removal, after patient and dialysis delivery system contact, between patients even if contact was casual, after contamination with blood or infectious material, and before touching clean areas such as supplies and chairside keyboard/mouse. The policy indicated gloves would be changed when moving from a contaminated body site to a clean body site of the same patient, and after touching one patient or their dialysis delivery system and before arriving to care for another patient or touch another patient's dialysis delivery system. 2. A revised policy, dated October 2024, titled, "Central Venous Catheter [CVC] With Tego Connectors or CVC End Caps Procedure," indicated when performing CVC care remove the old dressing and discard from the CVC site, clean each CVC limb, remove gloves and perform hand hygiene and place sterile 2 x 2 gauze over the catheter exit site. 3. During an observation of HD Station cleaning on 03/19/2025, beginning at 12:15 PM, PCT 3 completed cleaning of HD Station #9, removed their gloves and without performing hand hygiene, PCT 3 typed on the computer keyboard, then walked to the center prep area, without hand hygiene removed their gown and exited the observation floor without performing hand hygiene. 4. During an observation, on 03/19/2025 beginning at 12:45 PM, RN 1 entered station #3 without hand		All teammates…will perform hand hygiene: upon entering and exiting the patient treatment area, prior to gloving and immediately after removal of gloves…after patient and dialysis delivery system contact…between patients even if the contact is casual…after contamination with blood or other infectious material…before touching clean areas such as supplies, supply cart and chairside keyboard/ mouse. 2) Gloves should be changed when:… When moving from a contaminated body site to a clean body site of the same patient…After touching one patient or their dialysis delivery system and before arriving to care for another patient or touch another patient's dialysis delivery system. 3) Remove old dressing and discard. 4) Clean each CVC limb…5) Remove gloves and discard, perform hand hygiene…6) Place sterile 2x2 gauze over the catheter exit site…The Facility Administrator or Registered Nurse or Patient Care Technician will conduct	

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	hygiene or donning gloves, RN 1 touched the buttons on Patient #10's HD machine, then exited station #3, without performing hand hygiene, and entered station #2 with Patient #2. Without hand hygiene or donning gloves, RN 1 typed on the computer keyboard and exited Station #2. Without performing hand hygiene, RN 1 entered station #1, with Patient #8, and then exited station #1, without performing hand hygiene, and entered station #10. 5. During an observation, on 03/19/2025 beginning at 1:00 PM, PCT 1 was in station #5 with Patient #21. PCT 1 was observed typing on the computer keyboard with gloves on, PCT 1 then removed her gloves, she failed to perform hand hygiene, and exited station #3 and entered the center prep area, wrote on paper and donned new gloves. 6. During an observation, on 03/19/2025 beginning at 1:20 PM, PCT 3 was at station #9 with Patient #20. During the observation, PCT 3 auscultated Patient's Arteriovenous fistulas [AVF] and removed her right glove, did not perform hand hygiene, exited station #9, went to the center prep area, retrieved a tourniquet, entered station #9, then PCT 3 donned a new right glove and inserted the 1st line of Patient's access. 7. During an observation, on 03/19/2025 beginning at 1:25 PM, PCT 1 was at station #5, with Patient #21. During the observation, PCT 1 removed her gloves and used a thermometer to take Patient's temperature, PCT 1 did not perform hand hygiene and exited station #5, went to the center prep area, retrieved a clamp and bag with supplies, entered station #5 and PCT 1 donned new gloves. During the observation, PCT 1 began CVC exit site care by removing Patient's dressing to the access site did not change gloves or perform hand hygiene		observational infection control audits for hand hygiene, glove usage, CVC care daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal infection control audit. Instances of noncompliance will be addressed. The Facility Administrator will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	

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	and cleaned the site with an alcohol prep pad, PCT 1 removed her right hand glove typed on computer keyboard and without performing hand hygiene donned a new right hand glove and began to clean the lines of Patient's CVC. 8. During an observation, on 03/20/2025, beginning at 10:00 AM, PCT 1 had gloves on at Station #9, PCT 1 exited Station #9, removed gloves, did not perform hand hygiene, entered Station #12, donned gloves and applied gauze to Patient #22's AVF site. 9. During an observation, on 03/20/2025, beginning at 10:30 AM, PCT 6 was at station #7, with Patient #18. During the observation, PCT 6, while wearing gloves, extended the legs of the dialysis chair and touched the base of the chair near Patient's feet, PCT 6 did not change gloves or perform hand hygiene and removed the gauze to Patient's right CVC access site. 10. During an interview on 03/19/2025, beginning at 2:00 PM, PCT 3 indicated hand hygiene should be performed in between patients and HD machines and when entering and exiting the dialysis floor. 11. During an interview on 03/19/2025, beginning at 2:15 PM, PCT 1 indicated hand hygiene should be performed when performing CVC exit site care after the dressing was removed, hand sanitizing should be completed after removal of gloves, and between patients and stations. 12. During an interview on 03/21/2025, beginning at 1:00 PM, RN 1 indicated hand hygiene and glove changes should be performed when going between patients or stations or when the HD machine was touched.			

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V 0470 Bldg. 00	494.70(c) PR-RIGHTS POSTED,STATE/NW ONTACT INFO Based on observation, and interview, the dialysis facility failed to ensure Patients' Rights were posted where it could be easily seen and read by all patients in 1 of 1 facility. Findings include: 1. During an observation upon entrance to the dialysis facility, on 03/19/2025, beginning at 11:30 AM, the lobby failed to evidence posting of Patient's Rights. 2. During an observation, on 03/19/2025 beginning at 2:45 PM, patient home training room #1 and #2 failed to evidence Patient's Rights were posted. 3. During an interview on 03/19/2025, beginning at 5:30 PM, the Facility Administrator, Administrative Staff 1, indicated the patient's rights were not posted in the lobby and indicated the Patient's Rights should be posted so as all patients would have access.	V 0470	The Facility Administrator or Registered Nurse will inservice all clinical teammates on Policy 4-01-07A "Patient Rights And Patients' Standards Of Conduct, Responsibilities, An Facility Rules". Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) PURPOSE: To fully inform and educate patients regarding the rights to which they are entitled as well as the responsibilities incumbent upon them as patients within all DaVita facilities. 2) The facility will prominently display a copy of the patient rights in the facility, including the current State agency and ESRD Network mailing addresses and telephone complaint numbers. On 3/19/25, the Facility Administrator posted a copy of the Patient Rights and the current State agency and ESRD Network mailing address and telephone compliant numbers in a prominent area in	04/19/2025

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			the facility's lobby. The Facility Administrator or Administrative Assistant will conduct observational audits five (5) days a week x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly. Instances of non-compliance will be addressed. The Facility Administrator will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0504	494.80(a)(2) PA-ASSESS B/P, FLUID MANAGEMENT			

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Bldg. 00	NEEDS Based on record review and interview, the dialysis facility failed to evidence that the licensed nurse evaluated the elevated blood pressure prior to the initiation of hemodialysis [HD] (a process to filter the blood of a patient whose kidneys do not function normally) in 1 of 1 in-center HD clinical record reviewed with pre-treatment systolic blood pressure of 180 or higher (Patient #3). Findings include: 1. A revised policy, dated April 2024, titled "Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment" indicated that any abnormal findings discovered during pre-treatment data collection will be documented and immediately reported to the licensed nurse and the nurse will assess the patient prior to the initiation of dialysis. Pre-dialysis blood pressure abnormal findings include systolic blood pressure greater than 180 or less than 90, or diastolic greater than or equal to 100 or less than 50. 2. A Treatment Flow Sheet, dated 03/06/2025, for Patient 3 indicated HD treatment was started at 6:27AM and evidenced the following: A. Pre-treatment blood pressure was 183/99 without RN notification documented. B. PCT 1 initiated HD treatment at 6:27AM with a blood pressure of 184/100 without RN notification documented. C. RN 2 performed pre-treatment assessment at 6:32AM, after treatment initiation. 3. A Treatment Flow Sheet, dated 03/11/2025, for Patient 3 indicated HD treatment was started at 6:24 AM and evidenced the following:	V 0504	The Facility Administrator or Registered Nurse will in-service all clinical teammates on Policy 1-08-01 “Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) Any abnormal findings or findings outside of any patient specific physician ordered parameters discovered during pre-treatment data collection will be documented and immediately reported to the licensed nurse…2) If an abnormal finding is reported to the licensed nurse pre-treatment, the nurse will assess the patient prior to the initiation of dialysis. 3) ABNORMAL FINDINGS: Blood pressure: Pre-dialysis: Systolic greater than 180 mm/Hg or less than 90 mm/Hg • Diastolic greater than or equal to	04/10/2025

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	A. Pre-treatment blood pressure was 174/102 without RN notification documented. B. PCT 7 initiated HD treatment at 6:24 AM with a blood pressure of 180/102 without RN notification documented. C. RN 2 performed pre-treatment assessment at 6:46 AM, after treatment initiation. 4. During an interview on 03/21/2025, beginning at 11:43 AM, PCT 7 indicated that the RN should be notified when a patient has a systolic blood pressure of greater than 150 and that the RN should then assess patient prior to the initiation of HD. 5. During an interview of 03/21/2025, beginning at 11:57 AM, RN 1 indicated that RN should be notified by the PCT if systolic blood pressure is greater than 200 or less than 100, and a full assessment should be completed by the RN prior to initiation of HD treatment.		100 mm/Hg or less than 50 mm/Hg. The Facility Administrator or Registered Nurse will audit twenty-five percent (25%) of treatment detail reports daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified with ten percent (10%) of treatment detail reports audited monthly x 3 months during the internal medical record audit. Instances of noncompliance will be addressed. The Facility Administrator will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved.	

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			Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0511 Bldg. 00	494.80(a)(8) PA-DIALYSIS ACCESS TYPE & MAINTENANCE Based on observation, record review, and interview, the dialysis facility failed to ensure arteriovenous fistula [AVF](access for hemodialysis) [a process to filter the blood of a patient whose kidneys do not work normally] and arteriovenous graft [AVG](access for hemodialysis) cannulations (insertion of needles) were implemented by PCT 2 to prevent AVF/AVG site infections in 1 of 2 AVF/AVG cannulations observed (Patient #12). Findings include: 1. A revised policy, dated October 2024, titled, "AV Fistula or Graft Cannulation with JMS Sysloc Mini Safety Fistula Needles and Administration of Heparin Loading Dose," indicated the access site would be assessed for a thrill (vibration felt over fistula) and bruit (sound heard by stethoscope of blood flow in the fistula), the access site would be cleaned and the access site should not be palpated (touched) after the area had been prepped. 2. During an observation on 03/19/2025, beginning at 1:00 PM, PCT 2 was initiating HD treatment via Patient #12's AVF/AVG, at station #7. During the	V 0511	The Facility Administrator or Registered Nurse will in-service all clinical teammates on Policy 1-04-01D “AV Fistula Or Graft Cannulation With JMS SYSLOC Mini Safety Fistula Needles (SFN) And Administration Of Heparin Loading Dose”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) Perform inspection, auscultation and palpation on entire length of access. 2) Determine presence of bruit and thrill. 3) While maintaining aseptic technique, cleanse the sites by applying skin	04/19/2025

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	observation, PCT 2 cleaned the access site, repalpated the site, sprayed cryo spray (numbing spray) and inserted the 1st line, PCT 2 then repalpated the access site sprayed cryo spray and inserted the 2nd line. 3. During an interview on 03/19/2025, beginning at 2:00 PM, PCT 2 indicated an AVF/AVG site should be cleaned with an alcohol prep pad for 60 seconds and the site should not be touched after cleaning was performed.		antiseptic using a circular rubbing motion, moving from the center out and allow to dry. 4) Do not palpate insertion site once area has been prepped. The Facility Administrator or Registered Nurse or Access Manager will conduct observational audits of AV fistula or graft cannulation daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly x 3 months. Instances of non-compliance will be addressed. The Facility Administrator will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when	

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			needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0544 Bldg. 00	494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Based on record review and interview, the dialysis failed to ensure the prescribed blood flow rate (BFR), dialysate flow rate (DFR), and prescribed time were provided to the hemodialysis [HD] (process of filtering blood for a patient whose kidneys do not work normally) patient as ordered in 2 of 4 in-center HD clinical records reviewed (Patient #2 and Patient #6) and failed to adhere to prescribed HD orders to meet dialysis adequacy in 1 of 1 unstable in center HD patient clinical record reviewed (Patient #4). Findings include: 1. A revised policy, dated April 2024, titled, "Pre-Intra-Post Data Collection, Monitoring and Nursing Assessment," indicated a nursing assessment would include but not limited to verification of HD prescription. 2. An Incenter HD PCT job description, dated 04/2023, indicated the PCT duties and responsibilities would include but not limited to review of the dialysis prescription and initiation of dialysis.	V 0544	The Facility Administrator or Registered Nurse will in-service all clinical teammates on Policy 1-08-01 “Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment” and Policy 1-01-09 “Prescribed Treatment Time Not Met”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) The Nursing assessment will be performed and documented by a licensed nurse; specifically, a Registered Nurse (RN) or if performance of a nursing assessment is permitted by state	04/19/2025

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	3. A revised policy, dated April 2024, titled "Pre-Intra-Post Treatment Data Collection, Monitoring, and Nursing Assessment" indicated that if the dialysis prescription is not being met (including inability to obtain prescribed blood flow rate) the reason will be documented and the licensed nurse informed. All findings of interventions and patient responses will be documented in patient's medical record. 4. A Patient HD Order, dated 02/17/2025, for Patient #2 indicated in center HD treatment time was 240 minutes (4 hours). A. A Treatment Details Report, dated 02/24/2025, indicated HD treatment was initiated at 2:47 PM and terminated at 6:21 PM (214 minutes). The Report failed to evidence documentation of the reason Patient did not receive their full treatment time prescribed. B. A Treatment Details Report, dated 03/12/2025, indicated HD treatment was initiated at 2:52 PM and terminated at 6:29 PM (217 minutes); the Report failed to evidence documentation of the reason Patient did not receive their full treatment time prescribed. C. During an interview on 03/21/2025, beginning at 1:00 PM, RN 1 indicated there should be documentation of the reason Patient #2 did not receive their full treatment time and there was no documentation. RN 1 indicated HD treatment was started late and an Against Medical Advice Form should have been completed by Patient when prescribed treatment time was not completed. 5. A Patient HD Order, dated 02/08/2025 and 02/12/2025, for Patient #6, indicated the in-center HD treatment prescribed dialysate flow rate [DFR]		law, a Licensed Practical Nurse (LPN) / Licensed Vocational Nurse (LVN). 2) The assessment includes the following components: Review of patient reports, data collection, complaints and response to treatment; Verification that machine safety checks have been completed and documented; Verification of prescription including machine parameters; Verification that the patient access is visible and face is not covered. 3) Patient identity, prescription and machine settings are verified by teammate prior to initiation of treatment with the exception of blood flow rate which is verified and documented when the ordered rate is obtained after onset of treatment. 4) If the dialysis prescription is not being met (including dialysis flow rate or change to /inability to obtain prescribed blood flow rate) the reason will be documented and the licensed nurse informed. 5) . All findings, interventions and patient	

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	152648	A. BUILDING 00 B. WING	03/21/2025

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	(rate the cleansing fluid flows through the dialyzer) was 600 milliliters/min [ml/min] and the blood flow rate [BFR] was 350 ml/min. A. A Treatment Details Report, dated 02/08/2025, indicated Patient's DFR was initiated and remained at 500 ml/min from 5:56 AM until end of treatment at 9:54 AM. The Report failed to evidence documentation of the reason Patient did not receive the prescribed DFR. B. A Treatment Details Report, dated 02/15/2025, indicated Patient's DFR was initiated and remained at 500 ml/min from start of treatment at 5:38 AM until end of treatment at 9:47 AM. The Report failed to evidence the reason Patient did not receive the prescribed DFR. The Report indicated Patient's BFR was initiated at 350 ml/min at 5:38 AM and at 6:01 AM until the end of treatment at 9:47 AM the BFR was at 250 ml/min. The Report failed to evidence the reason Patient did not receive the prescribed BFR. C. A Treatment Details Report, dated 02/22/2025, indicated Patient's DFR was initiated and remained at 500 ml/min from start of treatment at 6:35 AM until end of treatment at 10:04 AM. The Report failed to evidence the reason Patient did not receive the prescribed DFR. D. During an interview on 03/21/2025, beginning at 1:00 PM, RN 1 indicated Patient #6's DFR on 02/08/2025 and 02/22/2025 should have been at 600 ml/min instead of 500 ml/min, the BFR on 02/15/2025 should have been 350 ml/min instead of 250 ml/min and there was not documentation of the reason why Patient did not receive the prescribed HD treatment. RN 1 indicated the DFR was not to be adjusted without a physician order and the BFR could be adjusted based on the		response will be documented in the patient's medical record. 6) The Registered Nurse (RN) will verify that a patient signs the Early Termination of Treatment Against Medical Advice form any time the patient requests to terminate their treatment earlier than the prescribed run time. 7) If a patient's treatment is shortened/early terminated, the RN will document the event in the patient's electronic health record. 8) The licensed nurse notifies the physician (or NPP if applicable) as needed of changes in patient status. 9) f shortened/early termination of treatment time exceeds 30 or more minutes, the RN will notify the patient's attending nephrologist…The Facility Administrator or Registered Nurse will audit twenty-five percent (25%) of treatment detail reports daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified with ten percent	

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	venous/arterial pressure with physician notification. 6. A Treatment Flowsheet, dated 02/24/2025, indicated that Patient 4's blood flow rate [BFR] was to be 450 milliliters/minute [ml/min] and evidenced the following: A. The BFR was 415ml /min from 6:24AM - 7:31AM, and 250ml/ min from 7:46AM - 8:31AM B. At 6:24 AM, PCT 2 initiated treatment with a BFR at 415ml/min. PCT 2 failed to document the reason for the change of BFR from the dialysis prescription, nor was there documentation of the RN notified. C. At 7:01AM, PCT 6 documented the BFR was set at 415ml/min due to patient request. PCT 6 failed to notify the RN. D. At 7:46AM, PCT 2 documented a BFR of 250ml/min. PCT 2 failed to document the reason why there was a change in BFR, and failed to notify RN of the change in BFR. E.At 6:31AM, RN 2 verified that Patient 4's prescription matched what was being delivered during the dialysis treatment. 7. A Treatment Flowsheet, dated 02/28/2025, indicated Patient 4's BFR was to be 450 ml/min and evidenced the following: A. BFR was 415ml/min from 6:24AM - 8:45AM. B. At 6:24 AM, PCT 6 initiated treatment with a BFR at 415ml/min. PCT 6 failed to document the reason for the change of BFR from the dialysis prescription, nor was there documentation of the RN notified. C. At 6:30 AM, PCT 6 documented that BFR was set at 415ml/min due to patient request. PCT 6 failed to notify RN that BFR was not given per dialysis prescription. D. At 6:32AM, RN1 verified that Patient 4's		(10%) of treatment detail reports audited monthly x 3 months during the internal medical record audit. Instances of non-compliance will be addressed. The Facility Administrator will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	

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	prescription matched what was being delivered during the dialysis treatment. 8. During an interview on 03/21/2025, beginning at 11:30AM, PCT 6 indicated that the only reason she would change a BFR would be due to increased arterial pressure, and if the BFR needed to be changed, the RN should be notified and event should be documented. 9. During an interview on 03/21/2025, beginning at 11:57AM, RN 1 indicated that BFR should only be changed due to increased arterial pressure, however, PCT should notify RN, RN should notify MD, and all should be documented. RN 1 indicated that documentation was not completed, nor was MD notified of specific instances.			