

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 852587	(X3) Date Survey Completed 02/07/2025
Name of Provider or Supplier Fresenius Kidney Care Richmond County	Street Address, City, State 2556 Tobacco Road Suite A, Hephzibah, GA	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

(X4) ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency should be preceded by full regulatory or LSC identifying information)
E0000	A Recertification survey was conducted at Fresenius Kidney Care Richmond County on February 5, 2025 through February 7, 2025. The recertification survey revealed that the facility was in substantial compliance with 42 CFR Part 494.62, Emergency Preparedness Plan for End Stage Renal Dialysis Facilities. A standard level deficiency was cited.
E0028	<p>Dialysis Emergency Equipment</p> <p>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:] (9) A process by which the staff can confirm that emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, are on the premises at all times and immediately available.</p> <p>This STANDARD is not met as evidenced by: Based on observation, a review of Food and Drug Administration (FDA) Guidelines, staff interview, a review of Centers for Disease Control and Prevention (CDC) Recommendations, and a review of facility Policies and Procedures (P&P), it was determined that the facility failed to ensure that two of two Registered Nurses, (RN), (RN AA and RN BB), who were responsible for administering medications, discarded and not made available for use, an opened and expired vial of Tuberculin Purified Protein Derivative (PPD Mantoux - a diagnostic antigen to aid in the detection of infection with Mycobacterium Tuberculosis) testing, in accordance with the manufacturer's set time frames for use, as well as other expired medications in one of</p>

one Medication Refrigerator, in one of one Emergency Cart, and in one of one Medication Cabinet. This failure had the potential to negatively affect the health and safety of 37 in-center hemodialysis patients who were under the care of this facility. Findings include: During a tour of the Patient Treatment Room with the Facility Administrator on 2/5/25 between 10:15 a.m. and , the following was revealed: In the Medication Refrigerator: - There was an opened and accessed vial of Tuberculin PPD Mantoux, which was dated as first opened on 2/23/24, (348 days since first opened). - A review of FDA guidelines stated: A vial of Tuberculin PPD (Mantoux) Tubersol, which has been entered and in use for 30 days should be discarded... Do not use after expiration date. In the Medication Cabinet of the Medication Room: - 24 bottles of Calcium Gluconate (for the treatment of low calcium), 100 milligrams [mg] per 10 milliLiters [mL] per bottle, expired 10/2024. - 10 vials of Cefepime (an antibiotic), 1gram [gm] per vial, expired 10/2024. - 16 bottles of Sodium Bicarbonate (used to treat or prevent excess acid in the blood or urine), 50 milliEquivalent [mEq] per 50 mg, expired 10/2024. In the Emergency Crash Cart: - Two vials of Benadryl (antihistamine), 50 mg/mL, expired 11/2024. The Facility Administrator stated on 2/5 /25 at 10:30 a.m. that the nurses should have caught this. - According to CDC Guidelines, multi-dose vials typically contain an antimicrobial preservative to help prevent the growth of bacteria. If a multi-dose vial has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. - A review of the facility's Policy: 47488, Version 9, titled, "Medication Preparation and Administration", with latest revision date of February 6, 2023 stated: - Expiration date for all stored medications are to be monitored on a monthly basis. Any open multi-dose vials must be discarded 28 days after opening or per manufacturer's expiration date.

V0000

A recertification survey was conducted at Fresenius Kidney Care Richmond County from February 5, 2025, through February 7. 2025. The survey revealed that the facility was not in compliance with 42 CFR 494.40 - Water and Dialysate Quality and 42 CFR 494.180 - Governance, for End-Stage Renal Disease Facilities. The following standard-level deficiencies were also cited, which resulted from the facility's noncompliance related to the survey:

V0175

CFC-WATER & DIALYSATE QUALITY
CFR(s): 494.40

This CONDITION is not met as evidenced by:
Based on observation, staff interviews, a review of the facility's Policy and Procedures (P&P), a review of the manufacturer's Directions for Use (DFU), and a review of the Association for the Advancement of Medical Instrumentation (AAMI) for "Dialysate for hemodialysis" (ANSI/AAMI RD52: 2004), it was determined that the facility failed to ensure that there was a safe environment for all patients, as evidenced by the failure of two of two Patient Care Technicians, (PCT AA and PCT BB) observed, to independently verify the hemodialysis machine's dialysate pH (potential of Hydrogen- a measurement that can determine the acidity or alkalinity of a solution), at Station (S), (S7), during preparation and initiation of hemodialysis treatments of two of two patients, (P), (P#5 and P#2), on 2/5/25 and 2/6/25, respectively. This deficient practice had the potential to negatively affect the health and safety of P#2, P#5 and the other 17 patients, (P#1, P#3, P#9, P#10, P#11, P#12, P#13, P#14, P#15, P#16, P#17, P#18, P#19, P#20, P#21, P#22, and P#23), whose dialysate or dialysis bath (the fluid that

the hemodialysis machine proportions from bicarbonate concentrate, acid concentrate and treated water used to exchange solutes with the blood in a dialysis filter), concentration prescriptions were different from the facility's standard dialysate, which was 2 Potassium / 2.5 Calcium. Complications as minor as nausea and fatigue or as severe as metabolic acidosis (a decrease in pH that could cause rapid breathing, confusion, dizziness, shortness of breath, and chest pain) could result if dialysate composition is incorrect. The facility census was 37. Cross Reference: V 250 - Failure of the facility to ensure that PCTs AA and BB, independently test the machine's dialysate pH when the dialysate concentration was changed and when the dialysate in a jug was replaced due to low contents.

V0250

DIALYS PROPORT-MONITOR PH/CONDUCTIVITY
CFR(s): 494.40(a)

5.6 Dialysate proportioning: monitor pH/conductivity It is necessary for the operator to follow the manufacturer's instructions regarding dialysate conductivity and to measure approximate pH with an independent method before starting the treatment of the next patient.

This STANDARD is not met as evidenced by:

Based on observation, staff interviews, a review of the facility's Policy and Procedures (P&P), a review of the manufacturer's Directions for Use (DFU), and a review of the Association for the Advancement of Medical Instrumentation (AAMI) for "Dialysate for hemodialysis" (ANSI/AAMI RD52: 2004), it was determined that the facility failed to ensure that there was a safe environment for all patients, as evidenced by the failure of two of two Patient Care Technicians, (PCT AA and PCT BB) observed, to independently verify the hemodialysis machine's dialysate pH (potential of Hydrogen- a measurement that can determine the acidity or alkalinity of a solution), at Station (S), (S7), during preparation and initiation of hemodialysis treatments of two of two patients, (P), (P#8 and P#2), on 2/5/25 and 2/6/25, respectively. This deficient practice had the potential to negatively affect the health and safety of P#2, P#8 and the other 17 patients, (P#1, P#3, P#9, P#10, P#11, P#12, P#13, P#14, P#15, P#16, P#17, P#18, P#19, P#20, P#21, P#22, and P#23), whose dialysate or dialysis bath (the fluid that the hemodialysis machine proportions from bicarbonate concentrate, acid concentrate and treated water used to exchange solutes with the blood in a dialysis filter), concentration prescriptions were different from the facility's standard dialysate, which was 2 Potassium / 2.5 Calcium. Complications as minor as nausea and fatigue or as severe as metabolic acidosis (a decrease in pH that could cause rapid breathing, confusion, dizziness, shortness of breath, and chest pain) could result if dialysate composition is incorrect. The facility census was 37. Findings include: During observation in the Patient Treatment Room on 2/5/25 between 10:50 a.m. and 11:00 a. m., the following was revealed: - At 10:50 a.m., PCT AA was observed (after P#8 had started hemodialysis treatment at Station [S] 7), pulling out the red wand (used to pull the acid concentrate) from the acid concentrate jug, then PCT AA plugged the red wand to the wall box. The dialysate concentration in the jug was 3 Potassium/2.5 Calcium, whereas, the dialysate concentration from the wall box was 2 Potassium and 2.5 Calcium. P#8's prescription was 2 Potassium/2.5 Calcium bath. The machine's dialysate conductivity dropped to 12 (acceptable range is 13.0 - 14.2 +/- 0.3 mS/cm - milliSiemen per centimeter), which caused the machine to alarm, then it stabilized to 13.8 at 10:54 a.m. PCT AA did not independently or manually re-test the machine dialysate's pH. The facility used Myron L D6 to manually test for pH and Conductivity. - At 10:55 a.m., PCT AA was asked by this surveyor why she did not

manually verify the dialysate pH after she changed the dialysate concentration (from jug to wall box). PCT AA stated that the dialysis machine did the testing of pH and conductivity and she added that no one ever told her that she needed to re-check the pH if the dialysate or bath was changed. - At 11:00 a.m., the Biomedical Technician (BMT) was notified of the above finding and the BMT stated that even though the dialysis machines were the new 2008T BlueStar Premium Dialysis Machines (with software 2.71 or higher will have the ability to have "Independent Conductivity/pH" selected as an option), the PCTs were made aware that the pH must be manually verified after a dialysate or bath was changed and when the conductivity dropped during dialysis treatment. During observation in the Patient Treatment Room on 2/6/25 between 10:45 a.m. and 11:00 a.m., the following was revealed: - At 10:45 a.m., P#2 was seated at S7 and his prescribed bath was 2 Potassium / 2 Calcium from a jug. The jug was almost empty which set the machine to alarm showing the conductivity dropped. PCT BB replaced the jug with the same bath concentration of 2 Potassium/2 Calcium). PCT BB did not manually/independently verify the machine's dialysate pH. - At 10:55 a.m., PCT BB was asked by this surveyor why she did not manually verify the machine's dialysate pH after replacing the jug. PCT BB stated that because she did not change the bath composition, there was no need to manually verify the machine's dialysate pH. PCT BB also stated that the BlueStar machines check the pH and Conductivity automatically. - On 2/6/25 at 11:00 a.m., the Facility Administrator was notified of the above findings. - A review of patients' dialysate prescriptions that were different from the facility's standard dialysate (2 Potassium/2.5 Calcium), revealed the following: - P#9, P#10, P#11, P#15, P#20, and P#22, had 2.0 Potassium/3.0 Calcium dialysate prescriptions. - P#1, P#12, P#13, P#14, P#16, P#17, P#18, P#19, P#21, and P#23, had 3.0 Potassium/2.5 Calcium dialysate prescriptions. - P#2 and P#3, had 2.0 Potassium/2.0 Calcium dialysate prescriptions. - A review of facility Policy, with reference number: 25912, titled, "Checking Conductivity and pH of Final Dialysate", version 12, and published: 02/03/2025, stated: BlueStar Machine - Fresenius 2008T machines with software 2.71 or higher will have the ability to have "Independent Conductivity/pH" selected as an option. If this feature is activated, the machine performs the Independent Conductivity measurement... The machine will perform the independent pH calculation only if it is equipped with BiBag (a single-use bag of dry sodium bicarbonate powder that is used in bicarbonate hemodialysis [sic]) and BiBag is actively in use. When replacing the concentrate to same or new formula or replacing bicarbonate (except is using BiBag), pH must be checked. BlueStar Requirements for Changing Concentrates: * Concentrate Changes During BlueStar Treatments: - Replace current acid concentrate with same catalog number (ex. 2251 to 2251). - Verify Concentrate Matches Selected in the Dialysate Screen. - Check pH with Meter or Strip after 10 minutes. - Replace current acid concentrate with the different catalog number (ex. 2251 to 3251). - Verify Concentrate Matches Selected in the Dialysate Screen. - Check pH with Meter or Strip after 10 minutes. - A review of Fresenius 2008T Hemodialysis BiBag System Operator's Instruction (English) 508213 Revision K -January 12, 2024 stated: Page 4. Warning! When changing concentration during treatments always verify the conductivity and approximate pH of the dialysate through independent means. Independent means could be by using an external conductivity meter, pH meter, pH paper or by using the machine independent conductivity test. The wrong concentrate composition, conductivity, or pH may cause serious injury or death. - According to AAMI RD52:2004, Section 5.6, "Dialysate Proportioning", it is necessary for the operator to follow the manufacturer's instructions regarding dialysate conductivity and to measure approximate pH with an independent method.

V0402

PE-BUILDING-CONSTRUCT/MAINTAIN FOR SAFETY

CFR(s): 494.60(a)

The building in which dialysis services are furnished must be constructed and maintained to ensure the safety of the patients, the staff and the public.

This STANDARD is not met as evidenced by:

Based on observation and staff interviews, and the recommendations of the Centers for Disease Control and Prevention (CDC), it was determined that the facility failed to maintain the integrity of the building to ensure the safety of the 37 patients who dialyzed at this facility. This failure could hinder effective cleaning and disinfection of the surfaces, thus the potential for microbial growth. This deficient practice was observed in one of one Dialysate Preparation Room and one of one Dialysis Treatment Room. Findings include: During a tour of the facility with the Facility Administrator on 2/5/25 at 10:00 a.m., the following was revealed: In the Dialysis Preparation Room: - There was a large, dead cockroach covered with dust, screws (3 small fasteners), and dirt particles on the floor in the corner next to the drain under the Aqua B Plus ring sample port; the same drain had greenish gold color fuzz substance on top of the drain, and around it. - Behind both carbon tanks, there were old RPC strips (used to test the water for chlorine and chloramine), strewn on the floor, mixed with dust and dirt particles. The drain line (PVC Piping) located behind the carbon tanks had a blackish gold fuzz around the piping where water drained out. In the Patient Treatment Room: - Inside the clean Utility closet, there were two ceiling tiles with rust-colored stains. - Two ceiling tiles over Station (S), (S7) had rust-colored stains. - Two ceiling tiles over clean sink #2 had rust-colored stains. - The wall boxes (frames recessed into the wall at each dialysis station that contain ports for the dialysis machine), at S1, S3, S7, S8, S9, and S10, had thick, white substance that covered each large black hose that was connected to the dialysis machines. The wall behind these stations was splattered with the same thick, white substance. On 2/5/25 at 10:20 a.m., the Facility Administrator acknowledged these findings and stated that the facility's sprinkler system malfunctioned, which got the ceiling tiles wet. - A review of CDC Recommendations stated, that due to the unique infection prevention and control challenges associated with wall boxes, the CDC recommends that staff receive proper education on the essential practices for cleaning, disinfecting, and maintaining these boxes. Cleaning inside and around the wall boxes is crucial to minimizing the risk of infections in patients, especially considering that wall boxes can be prone to contamination by microorganisms, which can then be transmitted to dialysis patients, a population particularly vulnerable to infections.

V0547

POC-MANAGE ANEMIA/H/H MEASURED Q MO

CFR(s): 494.90(a)(4)

The interdisciplinary team must provide the necessary care and services to achieve and sustain the clinically appropriate hemoglobin/hematocrit level. The patient's hemoglobin/hematocrit must be measured at least monthly. The dialysis facility must conduct an evaluation of the patient's anemia management needs.

This STANDARD is not met as evidenced by:

Based on a review of facility records and staff interview, it was determined that the interdisciplinary team (IDT) failed to investigate, develop, and implement a plan of care for patient's unique anemia management needs in order to attain and maintain appropriate blood levels of Hemoglobin (Hgb - protein in red blood cells that carries

oxygen), for one of one sampled patient (P#1), whose Hgb levels were below 10 g/dL (grams per deciliter) and continued to drastically drop or trended down from November 14, 2024 through January 28, 2025 (last Hgb result). Normal hemoglobin is 12-14 g/dL, with 10 g/dL being considered low for dialysis patients. Severe anemia in dialysis patients, like a Hgb of 6.0 g/dL, can lead to significant consequences including: extreme fatigue, reduced exercise tolerance, shortness of breath, increase risk of heart failure, left ventricular hypertrophy, poorer quality of life, higher mortality rate, and increased risk of cardiovascular events due to the body's struggle to deliver adequate oxygen to the tissues, potentially worsening their already compromised kidney function. Findings Include: A review of P#1's Hgb lab values, anemia management reports, and P#1's care plan revealed that her Hgb levels were below 10 g/dL and drastically trended down between November 14, 2024 through January 28, 2025 (last Hgb result). - On 11/14/24 - Hgb = 8.8 - On 11/21/24 Hgb = 8.2 - On 12/03/24- Hgb = 8.0 - On 12/12/24- Hgb = 8.7 - On 12/19/24 - Hgb = 8.0 - On 1/28/25 - Hgb = 6.0 A review of the facility's Mircera (a long-acting erythropoiesis-stimulating agent, [ESA], used for the treatment of anemia associated with chronic kidney disease) Algorithm In-Center 4.0, stated: Exception Criteria: Rapid Hgb Fall: Hgb falling greater than 1.0 g/dL over two weeks and dose not currently on hold - increase dose using column 1 of the Maintenance Dose Chart (Applicable only to patients receiving Mircera, not patients on hold). Hgb less than 8.0 g/dL: Consult Provider for orders. - A review of the "Providers Rounding Notes" dated 11/24/2024, revealed that: - On 8/27/24, P#1 received Mircera 30 micrograms (mcg) and on 9/19/24 P#1 received another dose of Mircera 30 mcg. - On this same "Providers Rounding Notes", dated 11/24/24, the Physician Assistant (PA AA) stated under "Anemia Assessment": Jehovah's Witness - does not accept blood products. Continue Anemia protocol but hold ESA until she gets clearance from OB/GYN (Obstetrician/Gynecologist) regarding potential adnexal mass (a growth or lump found in the female reproductive organs known as the adnexa) (sic). The appointment date to see OB/GYN: April 17, 2025. A review of facility records on 2/6/25 revealed no documented IDT progress notes of P#1 from 11/14/24 to 1/28/25. - P#1 was hospitalized on 1/3/25 with a diagnosis of fluid overload. - P#1 was hospitalized on 1/6/25 with a diagnosis of Right Pleural Effusion. Per hospital's H&P (History and Physical), it stated, "Epogen was increased to 20,000 units three times weekly". - P#1 was hospitalized again on 2/4/25 with shortness of breath (SOB). A review of P#1's "Treatment Sheet for Facility..." from 1/28/25 through 2/3/25 revealed no documented dose of Mircera or Epogen given during dialysis treatment. There was no documentary evidence that the nephrologist or medical director were notified of the above information regarding P#1's continued drop in the Hgb count or that P#1 was not receiving ESA. - On 2/5/25 Mircera 30 mcg was given after P#1's last hospitalization on 2/4/25. A review of P#1's Plan of Care dated 3/29/24 and was last updated by a Registered Nurse on 4/3/24, stated: - P#1's status was stable. Goal -Hgb 10-11g/dL. Goal due 7/28/2024. There were no new goals documented. Change ESA dose (per MD order/per algorithm). There was no new Plan of Care initiated by the IDT relative to P#1's worsening anemia. - During a discussion with the Facility Administrator on 2/5/25 at 3:00 p.m, she stated that P#1 is a Jehovah's Witness and refuses to take Epogen or Mircera. - A review of P#1's chart between 11/4/24 through 1/28/25, revealed no patient education regarding risk and benefits of Epogen or Mircera (ESA), and there was no documentary evidence that P#1 refused the Epogen or Mircera. - During a follow-up discussion with the Facility Administrator on 2/6/25 at 10:00 a.m., the Facility administrator was asked if she was aware of P#1's ESA being put on hold until April 17, 2025, after her appointment with OB/GYN, and P#1's current Hgb was 6.0g/dL. The Facility Administrator stated that P#1 just got out of the hospital and she was on Mircera 30 mcg every two weeks. - On 2/7/25 at 11:00

a.m., the Facility Administrator acknowledged the above findings and stated that P#1 should have been deemed unstable.

V0750

CFC-GOVERNANCE
CFR(s): 494.180

This CONDITION is not met as evidenced by:
Based on observations, staff interviews, a review of the manufacturer's Directions for Use (DFU) and a review of facility records including facility Policy and Procedures (P & P), it was determined that the Governing Body failed to demonstrate responsibility and accountability for the operations of the facility. This failure had the potential to negatively affect the health and safety of 37 in-center hemodialysis patients who dialyzed at this facility. Findings include: Cross References: V 250 - Failure of the facility to ensure that two of two Patient Care Technicians (PCT AA and PCT BB) observed, verified the machine's dialysate pH, according to the manufacturer's Directions For Use (DFU) and facility P&P. V757 - Failure of the Governing Body to ensure that the facility had adequate number of qualified staff to meet the needs of all patients and provide safe patient care; and to be in compliance with the minimum State required staffing ratios of one licensed and qualified nurse for every 12 patients who were receiving dialysis care and one qualified patient care giver for every four patients.

V0757

GOV-STAFF # & RATIO MEET PT NEEDS
CFR(s): 494.180(b)(1)

The governing body or designated person responsible must ensure that- (1) An adequate number of qualified personnel are present whenever patients are undergoing dialysis so that the patient/staff ratio is appropriate to the level of dialysis care given and meets the needs of patients;

This STANDARD is not met as evidenced by:
Based on a review of facility records, patient and staff interviews, and a review of minimum state required staffing ratios, it was determined that the Facility Administrator/Clinic Manager failed to ensure the facility employed an adequate number of qualified staff to meet the needs of all patients as evidenced by a lack of at least one licensed and qualified nurse (who was not counted as a dialysis care giver in the staff-to-patient ratio of one dialysis care giver to four patients), who was readily available to provide nursing care, take charge and deal with unexpected complications of dialysis, for every 12 patients receiving dialysis care and that each care giver was not assigned more than four patients at any given time. This deficient practice had the potential to cause a delay in monitoring patients for issues such as fluid overload (an excessive amount of fluid in the body), changes in vital signs, or problems with the dialysis equipment. Additionally, insufficient staffing could mean slower responses to alarms, delayed adjustments, or missed complications including but not limited to: intradialytic hypotension (sudden drops in blood pressure which can occur when fluid is removed too rapidly), arrhythmias (irregular heartbeat), and other medical issues and emergencies related to hemodialysis. Findings include: During observation in the Patient Treatment Room on 2/6/25 between 09:40 a.m. and 12:00 p.m., the following was revealed: - There were six patients who were undergoing hemodialysis treatment. - At 09:50 a.m., this surveyor observed that patient's (P), P#5's access sites were

covered with a blanket at Station (S) 9. This surveyor notified Registered Nurse (RN BB, who was at the Nurse's Station, sitting in front of her computer), that P#5's access sites were covered with a blanket. - At 10:50 a.m., this surveyor requested RN BB to show her P#5's prescription to verify if it matched the prescription on the machine. In addition, this surveyor observed that RN BB did not visit the patients at S9 and S10 between 9:40 a.m. and 11:40 a.m. When RN BB was asked how she monitored P#5 at S9 and P#6 at S10, RN BB stated that she can capture the patients' vital signs from her computer at the Nurse's station. - P#5 at S9 completed her hemodialysis treatment at 11:13 a.m., but was not rinsed back by Patient Care Technician (PCT BB) until 11:30 a.m. - P#6 at S10 completed his hemodialysis treatment at 11:18 a.m., but was not rinsed back until 11:40 a.m., by PCT BB. During interviews with PCT AA, PCT BB, RN BB, and the Facility Administrator/Clinic Manager on 2/6/25 between 12:00 p.m. and 3:00 p.m., this surveyor asked all four staff regarding who was assigned to S9 and S10: - At 12:00 p.m., PCT AA stated she was assigned to patients at S1, S2, S3, and S4 (four patients), per shift. - At 12:03 p.m., PCT BB stated she was responsible for patients at S5, S6, S7, and S8 and PCT BB also added that she was only responsible for four patients per shift and the nurse was responsible for patients at S9 and S10. - At 12:07 p.m., RN BB stated that the PCTs have five patients each per shift. RN BB also added that she was assigned to do patients' assessments, draw up and administer all medications, and ensure that the patients' treatments ran smoothly. - At 3:00 p.m., the Facility Administrator/Clinic Manager stated that the nurses were assigned to S9 and S10. She also added that the facility had no Charge Nurse because there were only 10 stations. She also stated that she was the Clinic Manager and the Nurse in Charge of Nursing services. - A review of the facility schedule from 1/22/25 through 2/5/25 revealed that a PCT was assigned to four patients at S1 - S4, and another PCT was assigned to S5 - S8. There was no assigned staff member to care for patients at S9 and S10. - A review of patients' "Treatment Sheet for Facility: ...", stated: P#3 - S10: - On 2/3/25, P#3's hemodialysis (HD) treatment started at 8:39 a.m., with vital signs (VS) and assessment comments documented at 8:43 a.m. by PCT CC. The intradialytic monitoring (the process of closely observing [at least every 30 minutes or more frequently], and measuring a patient's vital signs (VS) and other key parameters like blood pressure (BP), heart rate, blood volume to ensure their safety and adjust the dialysis settings as needed to prevent complications like sudden drops in BP which can occur when fluid is removed too rapidly), was performed between PCT CC and RN AA. There was a missing 30-minute check between 8:52 a.m. and 10:08 a.m. and another missing 30-minute check between 10:37 a.m. and 11:33 a.m. - On 2/5/25, P#3's HD treatment started at 8:19 a.m. and VS and assessment comments was documented at 8:24 a.m. The intradialytic monitoring was performed between PCT AA, PCT BB and RN AA. There was a missing 30-minute check between 10:05 a.m. and 11:00 a.m. and a late 30-minute check between 11:00 a.m. and 11:42 a.m. - On 2/7/25, P#3's HD treatment started at 8:00 a.m. The intradialytic monitoring was performed between PCT AA, PCT DD and RN CC. P#5 - S9: - On 2/4/25, P#5's HD treatment started at 7:45 a.m. and the intradialytic monitoring was performed between RN BB, PCTs BB and CC. - On 2/6/25, P#5's HD treatment started at 7:37 a.m. and VS / assessment comments by RN BB was at 8:00 a.m. At 9:32 a.m., 10:30 a.m., and 11:01 a.m., there were no assessment comments but signed by PCT BB. At 11:17 a.m., treatment was ended, but without VS nor assessment comments. P#6 - S10: - On 2/4/25, P#6's HD treatment started at 8:02, with VS and assessment comments at 8:23 a.m. The intradialytic monitoring was performed between RN BB, PCT BB and PCT CC. - On 2/6/25, P#6's HD treatment started at 8:01 a.m. with VS and assessment comments at 8:06 a.m., by PCT BB. Intradialytic monitoring were missing between 8:37 a.m. and 10:00 a.m., and a late 30-minute monitoring between 10:00 a.m. and 10:47 a.m. At 11:19 a.m., PCT BB's assessment comments showed, "UF on, access

visible, green AMP light, denies complaints, patient alert". There was no mention of ending patient treatment. At 11:42 a.m., there were no VS and no assessment comments but signed by PCT BB. At 11:47 a.m., RN BB documented, "Discharged to home". - During a telephonic interview with P#3 on 2/6/25 at 7:30 p.m., P#3 stated that there was nobody assigned to patients at S9 and S10. P#3 also added that the Clinic Manager was never there, and was never available when she needed to talk to her. P#3 also stated that last week, a PCT instructed her to stay in the lobby with another patient until the other PCT came back from her lunch break, then both PCTs put her and the other patient on their machines at the same time.