

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012500	(X3) Date Survey Completed 09/16/2021
Name of Provider or Supplier Fmc Capitol City	Street Address, City, State 255 South Jackson Street, Montgomery, AL	
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)
V0452	<p>PR-RESPECT & DIGNITY CFR(s): 494.70(a)(1)</p> <p>The patient has the right to- (1) Respect, dignity, and recognition of his or her individuality and personal needs, and sensitivity to his or her psychological needs and ability to cope with ESRD</p> <p>This STANDARD is not met as evidenced by: Based on review of the medical record (MR), facility policy, and interviews with the staff it was determined the facility failed to ensure the staff treated the patient with respect and dignity. This affected 1 of 3 MR's reviewed and did affect Patient Identifier (PI) #1 and had the potential to negatively affect all patients served by the facility. Findings include: Facility Policy: Patient Rights and Responsibilities No Policy Number Published: 4/4/12 Version: 2 Purpose: To comply with Federal Regulations that require dialysis facilities to: Educate staff regarding the rights of dialysis patients. Inform and educate all dialysis patients about their rights ad responsibilities as a patient at the dialysis facility. Ensure patient's rights are respected and protected by the facility. Conditions for Coverage: Patients' Rights: ...Patients' Rights require dialysis facilities to inform patients or their representatives of their rights (including their privacy rights) and responsibilities when they begin their treatment and must protect and provide for the exercise of those rights. The patient has the right to: 1. Respect, dignity and recognition of his or hers individuality and personal needs... 5. Be informed about and participate if desired, in all aspects of his or her care, and be informed of the right to refuse treatment and to discontinue treatment... Policy: All patients and/or their representatives will be informed of their rights (including privacy rights) and responsibilities. Patient rights and the ability to exercise these rights must be protected by the facility. FMCNA (Fresenius Medical Care North America) Patient Rights Form You Have The Right To: Care that is Respectful: Be protected from discrimination and harassment... Be treated with</p>

dignity, consideration, respect and full recognition of your individuality and personal needs... Help Make Decisions About Your Care: Accept, refuse or stop any treatment that is prescribed for you. PI # 1 was admitted to the facility on 5/12/18 with an admitting diagnosis of End Stage Renal Disease. Review of the Treatment Sheet dated 5/13/21 revealed documentation by the RN (Registered Nurse), "Pt (patient) very belligerent during Dr. (doctor) visit. Patient demanded the he/she didn't see physician. Pt had covers over head entire TX (treatment)". Review of the physician rounding note dated 5/13/21 revealed Employee Identifier (EI) # 6, Medical Doctor, documented pt belligerent and agitated, refused exam, yelling and cursing with the team present. Explained that she was a provider with the practice and was assuming care with the practice. Review of the Provider Rounding Note dated 5/18/21 revealed EI # 7, Nurse Practitioner (NP), documented PI # 1 more reasonable demeanor today than last week. Patient continues to express that he/she does not want to be seen by EI # 6. Review of the MR revealed a letter dated 5/20/21 to PI # 1 from the Doctors of Renal Associates stating they will no longer be able to serve as your doctors effective 6/20/21 due to behavior toward staff. Review of the Treatment Flow Sheets dated 6/8/21 to 7/6/21 revealed no documentation by the staff concerning the patient's behavior nor was there documentation of PI # 1 having the covers over his/her head during the treatments. Review of the MR revealed a letter dated 6/22/21 with an original date of 6/16/21 which had been crossed through and re-dated with 6/22/21 stating Notice of Discharge and signed by EI # 2, Clinic Manager, and EI # 5, Medical Director. The letter stated Fresenius Kidney Care, Capital City will no longer be able to provide medical care or dialysis treatments to PI # 1 effective 7/22/21 with original date of 7/16/21 which had been crossed through and re-dated 7/22/21. Review of the Physician Order Sheet dated 6/22/21 revealed the following order: Involuntary discharge due to no Physician effective date 7/22/21. Review of the Involuntary Discharge (IVD) Patient Review Worksheet dated 7/3/21 revealed a potential discharge date of 7/16/21 revealed a summary stating due to past incidents of what Pt felt was disrespect made toward him by Dr. (Name), he has expressed that he does not want him/her to provide him with care. Since that time, Pt has avoided the doctor by shortening his/her treatments when he/she was rounding in the clinic. On 5/13/21, Pt was asleep during MD rounds and MD shook patient to wake him in order to discuss his labs. This angered the Pt, who began yelling at the MD. MD informed Renal Associates of Montgomery, with whom he/she was employed, of the incident. Renal Associates of Montgomery made the decision to discharge Pt from their services. Clinic was not made aware of discharge until Pt informed staff that he/she received a termination letter from Renal Associates of Montgomery. Further review of the IVD revealed the signatures of the Medical Director, Social Worker and Dietitian and documented below the signatures dated 7/3/21 was written by hand transferred to a non-FKC (Fresenius Kidney Care) facility and signed per the Clinic Manager. Review of the Patient Discharge Assessment dated 7/8/21 revealed under remarks patient informed by Director of Operations that involuntary discharge was being withdrawn. Patient elected to transfer to non-FMC (Fresenius Medical Care) clinic. Review of the Clinical Note Report dated 7/8/21 revealed documentation the patient was discharged to another dialysis facility. RD (Registered Dietitian) will no longer follow. An interview was conducted on 9/14/21 at 3:30 PM with PI # 1 who stated EI # 6, Medical Doctor, "has an ego or something. I cover my face with the blanket all the time and all the time the staff tells me to uncover it. One day (PI # 1 was asked the date but was not sure), (EI # 6) came up and ripped the covers off and I had a cap on my head which fell to the floor". PI # 1 said something to the physician and he/she introduced his/herself and PI # 1 asked if he/she was going to say he/she was sorry or pick up his hat. PI # 1 stated he/she started yelling, "Help Help", because he/she would not leave when PI # 1 asked him/her too. "I signed off early three times after

that because the physician is overbearing and rude". The patient went on to state that again this year the physician made rounds and the patient was asleep with the covers over his head. The patient stated he/she felt someone between his/her chair and the dialysis machine and thought it was a technician (tech). The patient stated then he/she heard someone barking at him/her about the covers and then felt someone bump his/her arm. PI # 1 stated he/she pulled the covers down and the physician was yelling at him/her about the covers, The patient stated the Social Worker, the Dietitian and the Nurse Practitioner (NP) were also there but a ways away from the chair. The patient stated he/she said hi to the NP and the NP replied "Oh don't get me involved." PI # 1 stated he/she asked the physician to leave and he/she stated he cursed at the physician and asked her/him again to leave and the physician stated "that's all I needed." That was the end of that, then I was discharged. The patient stated "he/she would always disrespect me and I don't know why." The patient stated he/she would always sign off early so the patient did not have to deal with the physician but this time the patient was asleep so the patient not see the physician coming. An interview was conducted on 9/15/21 at 8:50 AM with EI # 2, Clinical Manager. When asked if EI # 2 recalled PI # 1 he/she stated yes that some days PI # 1 was calm and nice but other days would just fly off the handle. When asked what caused the conflict between the patient and the physician, EI # 2 stated the patient would have the covers over his/her head the physician would come and pull the covers off and the patient would be startled. The physician told the patient he/she was making rounds and there to do the patient's assessment. The patient then said "No I do not want you touching me." When EI # 2 was asked when the last incident occurred EI # 2 stated "my best guess would be it occurred on 6/17/21." EI # 2 was asked what occurred on 6/17/21. EI # 2 stated they went to the patient's station to review the patient's labs and the physician woke him up by I think shaking him and maybe calling his name. The patient removed the covers and said "I don't want you any where near me. The physician said that was fine but he/she was going to review the labs with him and if he did not want him/her to assess him that was fine also and the physician started reviewing the lab work. The patient then got loud and said " your a rapist and you are raping me" EI # 2 was asked how the patient got discharged and not involuntarily discharged. EI # 2 stated the Medical Director stopped the Involuntary Discharge and the patient could stay and EI # 1, Director of Operations, talked to the patient and explained this to him/her. The patient then asked what guarantee this will not happen again and he was told there was no guarantee so the patient asked to be transferred. An interview was conducted on 9/15/21 at 9:00 AM with EI # 3, Registered Dietitian. During the interview EI # 3 was asked if he/she remembered the incident which took place between the physician and PI # 1 and he/she stated yes. EI # 3 was asked to explain what took place that day during rounds with the physician. EI # 3 stated PI # 1's section was the last section to round on. EI # 3 stated the patient usually signs off early when the physician is making rounds so there must be something that happened prior to this incident. EI # 3 stated patient had the covers over his/her head and was asleep. EI # 3 stated the physician approached the patient's chair and he/she always wakes the patient up. EI # 3 was unsure how the physician woke the patient up this time. Once the patient pulled the covers down and saw it was the physician the patient said over and over "I do not want to talk to you." The physician told the patient they needed to review his/her labs and started reading the lab results to the patient. EI # 3 then stated the patient said "I keep telling you I don't want to talk to you but you won't leave. I'm saying no, you must be a rapist because you won't stop you are raping me." An interview was conducted on 9/15/21 at 9:50 AM with EI # 4, Social Worker. EI # 4 was asked if he/she remembered the incident which occurred between the patient and the physician. He/she stated yes and explained. EI # 4 stated they were making round with the physician and the patient had the covers over his/her head and did not know they were

on the dialysis floor. EI # 4 stated physician removed the covers from patient's head and patient became irate. The patient immediately said "Oh man bitch I told you to leave me alone" He continued by stating he/she told the physician he/she did not want to talk to him/her at all and he/she was fine till he/she (EI #6) showed up. The physician stayed there and finished rounds with the patient even though the patient kept on and on telling the physician to leave. The physician finally walked away and physician said the patient was being immature. Upon the completion of the interview with EI # 4, this surveyor asked if EI # 4 had documented the incident. EI # 4 replied with a yes and a copy of the documentation was requested. EI # 4 approached the surveyor after looking for the documentation and no documentation could be found in the MR. An interview was conducted on 9/15/21 at 10:42 AM with EI # 1, Director of Operations. EI # 1 reported an incident occurred sometime in June with the patient and EI # 6. "I was in the clinic that day and the patient told me that (he/she) informed the staff if PI # 6 arrived at the clinic the staff was to tell (him/her) so (he/she) could leave the clinic. I went over to (his/her) chair and was going to wake the patient up because the physician arrived at the clinic. I was told by the staff if you wake the patient up he/she will leave. I decided not to wake the patient up". EI # 1 stated when he/she went out the the floor the whole team was surrounding the patient at chairside. The patient was saying I told you not to touch me and I don't want you to talk to me and then he/she started yelling and screaming and calling her/him (EI # 6) a rapist. When the doctor walked off the floor she/he asked EI # 1 to come back there where he /she was and stated "something needs to be done." I then went out to the floor to speak with the patient and he/she calmed down but did leave the clinic. When the physician came back on second shift for rounds he/she said he/she wants the patient fired from their services. I said FMC was not discharging the patient and that we would get another group to pick the patient up. At that time the physician did not like that. EI # 1 stated he/she received a call from the Medical Director who stated Network was contacted and the involuntary discharge was discussed. EI # 1 stated "much later" (time undetermined) he/she received another call from the Medical Director stating the discharge was to be canceled and to notify the patient of the cancellation of the discharge. During this interview with EI # 1 the surveyor asked if EI # 1 had documentation of the incident in the MR. EI # 1 stated he/she did. On 9/15/21 at 11:30 EI # 1 was asked for his/her documentation on the incident and responded by stating he/she knows it was documented but can not find it in the computer system but will keep searching. At the conclusion of the day prior to leaving the facility the surveyor again asked for the documentation and none was provided. An interview was conducted on 9/15/21 at 12:10 PM with EI # 5, Medical Director, by phone and was asked if EI # 5 recalled an incident which occurred on the dialysis floor with PI # 1. EI # 5 stated he/she recalled being told about the incident but was not present. EI # 5 stated the physician which was rounding had some issues with the patient several months ago but no other associates witnessed this incident. After this incident with the patient the physician (EI # 6) came to the group and demanded PI # 1 be discharged. At that time this physician did not see the patient anymore. EI # 5 was asked if the patient was involuntarily discharged and EI # 5 stated they (associate group) initiated the involuntary discharge and EI # 5 signed it and a letter had been sent to the patient. EI # 5 stated he/she received a call from Network 8 who discussed with him concerns about the involuntary discharge and the letter. EI # 5 stated we decided at that time we did not need to disrupt things. EI # 5 stated about a week later the area manager informed him/her the patient had been accepted to another facility. An interview was conducted on 9/15/21 at 2:25 PM with EI # 6, Medical Doctor. EI # 6 was asked if he /she recalled PI # 1 and stated the physician had only met the patient 2-3 times so probably could not describe the patient very well. EI # 6 was asked to describe what had recently occurred with the patient. EI # 6 stated the most recent incident occurred

when they made rounds. EI # 6 was asked when this occurred and EI # 6 continued to state what happened. EI # 6 stated he/she had awoken the patient and the patient became instantly angry. He/she spoke some obscenities and told me to keep moving. EI # 6 stated he/she told the patient they were going to go over some lab work and the patient stated the physician will not be his/her physician. EI # 6 stated he/she told the patient they were a team of 6 and were to provide him/her with care and he/she will be seen by any one of the 6 providers. EI # 6 then stated the patient was told EI # 6 was reviewing the labs with the team and the patient became louder and started calling the physician a rapist. EI # 6 stated they as a team did review his/her labs. EI # 6 stated after the incident the associate group all met and he/she discussed the patient's behavior with the group and as far as he/she knew a letter was sent to the patient to discharge him/her from the associate group and as far as he/she knew the patient went to another dialysis center.