Form Approved
OMB No. 0938-0391

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number	(X3) Date Survey Completed
	012500	09/16/2021
Name of Provider or Supplier	**Street Address, City, State**	
Fmc Capitol City	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)
V0540	CFC-PATIENT PLAN OF CARE CFR(s): 494.90 This CONDITION is not met as evidenced by: Based on review of medical records (MR), facility policies and interviews, it was determined the facility failed to ensure staff provided care according to facility policies and procedures, physician orders and the patient's Plan of Care (POC) during care delivery. This had the potential to negatively affect all patients who dialyzed at this facility. Refer to: V 542, V 543, V 544, V 545, V 550 and V 551.