

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)
V0757	<p>GOV-STAFF # & RATIO MEET PT NEEDS CFR(s): 494.180(b)(1)</p> <p>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;</p> <p>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</p>

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.