

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/03/2025
NAME OF PROVIDER OR SUPPLIER  Complete Care at Kimberly Hall-South		STREET ADDRESS, CITY, STATE, ZIP CODE  1 Emerson Drive Windsor, CT 06095	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0698</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47491</b></p> <p>Based on clinical record review, interviews, and review of facility documentation for one (1) of three (3) residents (Resident #1) reviewed for dialysis, the facility failed to adequately assess an Arteriovenous Fistula (AVF) (a surgical connection made between an artery and a vein accessed by needles to administer hemodialysis treatment) dialysis access site that was bleeding status post hemodialysis treatment to ensure bleeding had stopped, subsequently the resident had a significant bleed and was sent to the hospital and diagnosed with hemorrhagic shock requiring four (4) units of blood resulting in a finding of Immediate Jeopardy.</p> <p>The findings included:</p> <p>Resident #1's diagnoses included end stage renal disease and Type 2 diabetes mellitus.</p> <p>Review of Resident #1's Care Plan dated [DATE] identified the risk for injury or risk of complications related to renal dialysis with interventions that directed to observe for active bleeding and monitor hemodialysis access site for excessive redness, swelling, pain at site, signs and symptoms of infection, and excessive bleeding from the site, and to report to physician as indicated.</p> <p>Review of the quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of twelve (12), indicative of moderately impaired cognition. The MDS further identified Resident #1 required substantial assistance with bathing and personal hygiene and received hemodialysis treatments.</p> <p>A physician's order dated [DATE] at 4:39 PM identified that the resident attends dialysis three (3) times weekly at 8:30 AM. The order directed to monitor the AVF site for signs and symptoms of infection, edema, bleeding and upon return from dialysis; to notify the primary care physician and dialysis unit if there are signs and symptoms of infection, and if the AVF site is bleeding, to apply pressure for fifteen (15) minutes and notify MD/Physician if bleeding does not stop.</p> <p>Review of nurse's notes dated [DATE] at 11:01 PM identified LPN #1 was alerted that Resident #1's left upper arm AVF was bleeding by the Nurse Aide (NA), the supervisor was then notified and assisted with applying a pressure dressing. The note further identified the bleeding had become worse around 9:30 PM, a call was made to the supervisor who assisted in sending the resident to the hospital, and 911 was called. Emergency Medical Technician's (EMT's) applied a more effective pressure dressing and took the resident via stretcher to the hospital.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 075237	If continuation sheet Page 1 of 7

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<p>F 0698</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of an ambulance run sheet date [DATE] at 9:45 PM identified that upon entry into Resident #1's room the resident was noted with several layers of bandages on the arm, all soaked with blood. The soaked bandages were removed and direct pressure was applied and the bleeding was controlled. The resident was being wheeled to the ambulance from the facility when a sudden change in mental status was noted and the resident became apneic (lack of breathing), and pulseless. The cardiac pads were applied and two (2) compressions were given and on the third (3rd) compression the resident yelled out, the resident returned to a normal sinus rhythm (normal cardiac rhythm).</p> <p>Review of hospital discharge records dated [DATE] identified Resident #1 arrived at the hospital in hemorrhagic shock (acute decrease in the body's supply of blood) with a blood pressure of ,d+[DATE] (normal blood pressure ,d+[DATE]) and received four (4) units of packed red blood cells and one (1) unit of frozen fresh plasma (FFP)(a blood transfusion).</p> <p>Interview with the Certified Clinical Hemodialysis Technician (CCHT) on [DATE] 1:52 PM identified that Resident #1 completed dialysis treatment at 3:06 PM, the AVF had clotted and there was no bleeding prior to the discharge back to the Skilled Nursing Facility.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on [DATE] at 11:07 AM identified that when the resident returned from hemodialysis sometime after 3:00 PM, he looked at the dressed AVF site and no visible signs of bleeding were evident. Around 8:00 PM Nurse Aide (NA) #1 informed him that Resident #1's AVF was bleeding. LPN #1 identified that he requested RN #1's assistance with the resident, and assisted RN #1 by holding the bandages in place as RN #1 secured the dressing to the resident's arm. LPN #1 identified that no additional pressure (manual) was applied to the access, that they just let the absorbent pads do the job. LPN #1 further identified that bleeding had ceased after the dressing was changed, and after performing two (2) ten (10) minute checks on the resident, LPN #1 had determined the bleeding had stopped as the dressing remained clean, dry and intact. However, LPN #1 indicated he/she didn't check the access site under the dressing to ensure the bleeding had actually stopped as he/she did not want to disturb the area and cause it to bleed again. LPN #1 indicated the standard of practice for access bleeds was to apply a pressure dressing to the access site without applying additional pressure to the area and that if the bandage applied was tight enough it should be sufficient to stop the bleeding. LPN #1 further identified he/she was notified at approximately 9:30 PM that Resident #1's access was noted to be bleeding through the dressing. LPN #1 informed RN #1 of the situation, and indicated the bandages were soaked with blood, that the resident had blood dripping down his arm, and that blood was on the bedsheet (approximately the size of a one (1) dollar bill). LPN #1 further identified RN #1 had assisted with Resident #1's had placed manual pressure on the access area until emergency medical technicians arrived. (This interview was read back to LPN #1 on [DATE] at 12:00 PM and verified to be accurate).</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview with RN #1 on [DATE] at 11:39 PM identified he/she was informed after dinner that Resident #1's access was bleeding and observed Resident #1's bandages were somewhat bloodied , but not saturated. RN #1 indicated he/she removed the dressing from dialysis from earlier in the day which were soaked in blood, and placed an Abdominal Pad (ABD pad- a long, thick and absorbent (multi layered) dressing used to cover wounds) dressing vertically over the wrapped gauze around it and the arm to secure the dressing, and applied tape to hold the gauze in place. RN #1 further identified he/she did not apply manual pressure to the access and that the gauze itself acted as a pressure dressing. RN #1 indicated he/she checked on Resident #1 twenty (20) minutes after the pressure dressing was applied and determined that the bleeding had stopped, because the dressing and tape were clean, dry and intact. She did not check under the dressings bandage and visualize the access site to ensure the bleeding had stopped. Around 30 minutes after she last checked the resident she was informed Resident #1's access site was again bleeding, she saw that the dressing was soaked with blood. RN #1 applied additional 4x4 gauze pads and an ABD pad on top of the previous dressing, secured them in place, applied a towel on top of the dressing and applied manual pressure to the access site until emergency medical technicians arrived. (Interview read back to RN #1 at the conclusion of the interview on [DATE] and verified as accurate).</p> <p>An untimed written statement provided by the facility dated [DATE] (2 weeks after the incident) written by RN #1 identified that RN #1 was notified by LPN #1 that the resident was bleeding at the AVF site. She placed three (3) four (4) by four (4) dressings and an ABD pad over the dressings placed at hemodialysis early in the day and wrapped the area in cling wrap. She applied manual pressure for 10 minutes, and at the end of 10 minutes she lifted up the end of the tape and didn't see any bleeding so she informed the charge nurse the bleeding had stopped and left the unit. She returned twenty (20) minutes later and the dressing was free from breakthrough bleeding. Thirty (30) minutes later she was called to the unit because LPN#1 had noted some blood on the dressing, however, it was not saturated. RN #1 placed ,d+[DATE] gauze dressings on the area and held pressure until emergency services arrived.</p> <p>Interview with Emergency Medical Technician (EMT) #1 on [DATE] at 10:23 AM identified he/she entered Resident #1's room as three (3) staff members were changing his/her sheets, and that Resident #1 had a big, bulky bandage on his/her left upper arm that was saturated with blood. EMT #1 indicated he/she removed the bloody dressing and applied a new pressure dressing to the access site and noted the arterial (lower cannulation site) was bleeding and the venous (upper cannulation site) was scabbed over. EMT #1 further identified the bleeding stopped once the pressure dressing was applied and that the dressing remained clean, dry, and intact throughout transport to the hospital.</p> <p>Interview with the Medical Director (MD) on [DATE] at 3:27 PM identified if an AVF access starts to bleed at the facility, staff is to apply pressure with gauze over the access site for five (5) to seven (7) minutes and may leave the resident unattended for a few minutes if the bleed was small, a breakthrough bleed. However, if the access failed to clot, the MD indicated the resident should be sent out to the hospital for further evaluation. The MD further indicated to properly assess if the access (AVF) bleeding has stopped, the nurse should remove the dressing to check the actual needle (puncture) insertion sites rather than assess by the cleanliness of the dressing to see if the access site is still bleeding.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview with the Director of Nurses (DNS) on [DATE] at 12:20 PM identified that there are currently 47 residents in the facility receiving hemodialysis treatment. The DNS further identified that it was inappropriate for staff to leave Resident #1 after applying the first pressure dressing, that staff should have removed the dressings and checked the access site to ensure the bleeding had stopped prior to leaving the resident. Further, the physician should have been called when the resident's access first bled on evening of [DATE], approximately five (5) hours after he/she returned from dialysis treatment.</p> <p>Interview with the Staff Development Nurse (SDN) on [DATE] at 12:45 PM identified the facility does not provide dialysis access training during the nurse's orientation, however the nurse could receive training while precepted if there was an actual bleeding event while he/she was working. The SDN further identified the facility did not have a specific guideline, timeframe, or training checklist to ensure staff receives training on what to do for bleeding hemodialysis accesses.</p> <p>Review of the hemodialysis policy identified the facility will provide the necessary care and treatment, consistent with professional standards of practice, physician's orders, the comprehensive person-centered care plans, and resident's goals and preferences to meet the special medical nursing, mental and psychosocial needs of residents receiving hemodialysis.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32738</b></p> <p>Based on clinical record review, facility documentation, polic review and interviews the facility failed to ensure that staff was educated and aware of what to do when a hemodialysis resident with an Ateriovenous Fistula (AVF) was noted to be bleeding from the AVF.</p> <p>The findings include:</p> <p>Resident #1's diagnoses included end stage renal disease and Type 2 diabetes mellitus.</p> <p>Review of Resident #1's Care Plan dated [DATE] identified the risk for injury or risk of complications related to renal dialysis with interventions that directed to observe for active bleeding and monitor hemodialysis access site for excessive redness, swelling, pain at site, signs and symptoms of infection, and excessive bleeding from the site, and to report to physician as indicated.</p> <p>Review of the quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of twelve (12), indicative of moderately impaired cognition. The MDS further identified Resident #1 required substantial assistance with bathing and personal hygiene and received hemodialysis treatments.</p> <p>A physician's order dated [DATE] at 4:39 PM identified that the resident attends dialysis three (3) times weekly at 8:30 AM. The order directed to monitor the AVF site for signs and symptoms of infection, edema, bleeding and upon return from dialysis; to notify the primary care physician and dialysis unit if there are signs and symptoms of infection, and if the AVF site is bleeding, to apply pressure for fifteen (15) minutes and notify MD/Physician if bleeding does not stop.</p> <p>Review of nurse's notes dated [DATE] at 11:01 PM identified LPN #1 was alerted that Resident #1's left upper arm AVF was bleeding by the Nurse Aide (NA), the supervisor was then notified and assisted with applying a pressure dressing. The note further identified the bleeding had become worse around 9:30 PM, a call was made to the supervisor who assisted in sending the resident to the hospital, and 911 was called. Emergency Medical Technician's (EMT's) applied a more effective pressure dressing and took the resident via stretcher to the hospital.</p> <p>Review of an ambulance run sheet date [DATE] at 9:45 PM identified that upon entry into Resident #1's room the resident was noted with several layers of bandages on the arm, all soaked with blood. The soaked bandages were removed and direct pressure was applied and the bleeding was controlled. The resident was being wheeled to the ambulance from the facility when a sudden change in mental status was noted and the resident became apneic (lack of breathing), and pulseless. The cardiac pads were applied and two (2) compressions were given and on the third (3rd) compression the resident yelled out, the resident returned to a normal sinus rhythm (normal cardiac rhythm).</p> <p>Review of hospital discharge records dated [DATE] identified Resident #1 arrived at the hospital in hemorrhagic shock (acute decrease in the body's supply of blood) with a blood pressure of ,d+[DATE] (normal blood pressure ,d+[DATE]) and received four (4) units of packed red blood cells and one (1) unit of frozen fresh plasma (FFP)(a blood transfusion).</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Licensed Practical Nurse (LPN) #1 on [DATE] at 11:07 AM identified that when the resident returned from hemodialysis sometime after 3:00 PM, he looked at the dressed AVF site and no visible signs of bleeding were evident. Around 8:00 PM Nurse Aide (NA) #1 informed him that Resident #1's AVF was bleeding. LPN #1 identified that he requested RN #1's assistance with the resident, and assisted RN #1 by holding the bandages in place as RN #1 secured the dressing to the resident's arm. LPN #1 identified that no additional pressure (manual) was applied to the access, that they just let the absorbent pads do the job. LPN #1 further identified that bleeding had ceased after the dressing was changed, and after performing two (2) ten (10) minute checks on the resident, LPN #1 had determined the bleeding had stopped as the dressing remained clean, dry and intact. However, LPN #1 indicated he/she didn't check the access site under the dressing to ensure the bleeding had actually stopped as he/she did not want to disturb the area and cause it to bleed again. LPN #1 indicated the standard of practice for access bleeds was to apply a pressure dressing to the access site without applying additional pressure to the area and that if the bandage applied was tight enough it should be sufficient to stop the bleeding. LPN #1 further identified he/she was notified at approximately 9:30 PM that Resident #1's access was noted to be bleeding through the dressing. LPN #1 informed RN #1 of the situation, and indicated the bandages were soaked with blood, that the resident had blood dripping down his arm, and that blood was on the bedsheet (approximately the size of a one (1) dollar bill). LPN #1 further identified RN #1 had assisted with Resident #1's had placed manual pressure on the access area until emergency medical technicians arrived. (This interview was read back to LPN #1 on [DATE] at 12:00 PM and verified to be accurate).</p> <p>Interview with RN #1 on [DATE] at 11:39 PM identified he/she was informed after dinner that Resident #1's access was bleeding and observed Resident #1's bandages were somewhat bloodied , but not saturated. RN #1 indicated he/she removed the dressing from dialysis from earlier in the day which were soaked in blood, and placed an Abdominal Pad (ABD pad- a long, thick and absorbent (multi layered) dressing used to cover wounds) dressing vertically over the wrapped gauze around it and the arm to secure the dressing, and applied tape to hold the gauze in place. RN #1 further identified he/she did not apply manual pressure to the access and that the gauze itself acted as a pressure dressing. RN #1 indicated he/she checked on Resident #1 twenty (20) minutes after the pressure dressing was applied and determined that the bleeding had stopped, because the dressing and tape were clean, dry and intact. She did not check under the dressings bandage and visualize the access site to ensure the bleeding had stopped. Around 30 minutes after she last checked the resident she was informed Resident #1's access site was again bleeding, she saw that the dressing was soaked with blood. RN #1 applied additional 4x4 gauze pads and an ABD pad on top of the previous dressing, secured them in place, applied a towel on top of the dressing and applied manual pressure to the access site until emergency medical technicians arrived. (Interview read back to RN #1 at the conclusion of the interview on [DATE] and verified as accurate).</p> <p>An untimed written statement provided by the facility dated [DATE] (2 weeks after the incident) written by RN #1 identified that RN #1 was notified by LPN #1 that the resident was bleeding at the AVF site. She placed three (3) four (4) by four (4) dressings and an ABD pad over the dressings placed at hemodialysis early in the day and wrapped the area in cling wrap. She applied manual pressure for 10 minutes, and at the end of 10 minutes she lifted up the end of the tape and didn't see any bleeding so she informed the charge nurse the bleeding had stopped and left the unit. She returned twenty (20) minutes later and the dressing was free from breakthrough bleeding. Thirty (30) minutes later she was called to the unit because LPN#1 had noted some blood on the dressing, however, it was not saturated. RN #1 placed ,d+[DATE] gauze dressings on the area and held pressure until emergency services arrived.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with LPN #2 on [DATE] at 12:30 PM failed to identify when asked what to do when a dialysis resident had a bleeding AVF. LPN #2 indicated that he/she was to apply a clamp and dressing to an arteriovenous fistula (located in the resident's arm) if it was bleeding, and when questioned about the process of applying the clamp and dressing to the bleeding AVF, LPN #2 identified he/she was unsure of what to do. Of further note, LPN #2 was the only nurse working on the F wing during first shift that housed twenty (20) residents receiving dialysis, seven (7) of which had AVF accesses.</p> <p>Interview with the Staff Development Nurse (SDN) on [DATE] at 12:45 PM identified that there are 47 hemodialysis patients that reside in the skilled nursing facility, as there is a dialysis den. The standard of practice for a bleeding AVF access was for nurses to reinforce the current dressing, apply no additional manual pressure to the access site, to notify dialysis staff if the clinic was still open, and then notify the APRN (Advanced Practice Registered Nurse) and Medical Director of the issue. The SDN failed to provide training documents to verify staff received training on what to do for bleeding dialysis accesses/sites, however indicated staff was to follow first-aid instructions and place a reinforcement bandage over the access and secure with a stretch bandage. The SDN indicated the facility does not provide dialysis access training during the nurse's orientation, however the nurse could receive training while precepted if there was an actual bleeding event while he/she was working. The SDN further identified the facility did not have a specific guideline, timeframe, or training checklist to ensure staff receives training on what to do for bleeding accesses.</p> <p>Review of the hemodialysis policy identified the facility will provide the necessary care and treatment, consistent with professional standards of practice, physician's orders, the comprehensive person-centered care plans, and resident's goals and preferences to meet the special medical nursing, mental and psychosocial needs of residents receiving hemodialysis.</p>		