

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  012306	<b>(X3) Date Survey Completed</b>  02/27/2025
<b>Name of Provider or Supplier</b>  Childrens Hospital Of Alabama Esrd	<b>Street Address, City, State</b>  1600 7th Avenue South, Birmingham, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

<b>(X4) ID Prefix Tag</b>	<b>Summary Statement of Deficiencies</b>  (Each deficiency should be preceded by full regulatory or LSC identifying information)
<b>E0000</b>	An on-site recertification survey was conducted on 2/25/25-2/27/25 at Children's Hospital of Alabama ESRD (End Stage Renal Disease). The facility was found to be in substantial compliance with the Conditions of Participation for Emergency Preparedness. 30952
<b>V0000</b>	"CORE" An on-site recertification survey was conducted 2/25/25 to 2/27/25 at Children's Hospital of Alabama ESRD (End Stage Renal Disease), a six (6) station hemodialysis facility with one (1) peritoneal dialysis training and support room, and one (1) home hemodialysis training and support room. Standard level deficiencies were cited which will require a plan of correction.
<b>V0113</b>	<p><b>IC-WEAR GLOVES/HAND HYGIENE</b> CFR(s): 494.30(a)(1)</p> <p>Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.</p> <p>This STANDARD is not met as evidenced by: Based on review of facility policy, observations, and staff interview, it was determined the facility failed to ensure staff followed policies related to infection prevention and control which could result in transmission of bacteria and poor patient outcomes. This affected Patient Identifier (PI) # 9, in one of two observations of discontinuation of dialysis with a Central Venous Catheter (CVC), in one of two observations of cleaning and disinfection of the dialysis station, one of two medication preparation and administration observations, which included PI # 8, and one of two observations for preparation of the hemodialysis (HD) machine. This had the potential to negatively affect the 17 incenter patients dialyzing at the facility, staff, and visitors. Findings include: Facility Policy: Hand Hygiene Policy Number: 12020</p>

Revision: 9 Date Published: Not listed Purpose: Hands are the most common way in which microorganisms might be transported and cause infection. When to Perform Hand Hygiene: Before and after patient contact, even if the patient's skin is intact. Before and after touching any items in the patient's room... Before and after wearing gloves. Before and after handling dressings, body secretions and body excretions. After entering and/or working in an area that is likely to be highly contaminated, i.e. patient room... Hand Hygiene Technique: ...Alcohol-Based Instant Hand Sanitizer ... The efficacy of alcohol-based products depends on the technique of the user. If not enough product is dispensed or...not applied to all parts of the hand...efficacy may be limited. I. Put hands together spreading the...sanitizer onto fingertips, cuticles, and nails up to wrists. Rub palms against each other. II. Rub...sanitizer into back of hand, into the web spaces between fingers and on both thumbs. Repeat procedure for the other hand. III. Rub hand surfaces together UNTIL THEY ARE DRY... 1. An observation was conducted on 2/25/25 at 10:37 AM with Employee Identifier (EI) # 3, Registered Nurse (RN), performing discontinuation of dialysis with a CVC for PI # 9 at station 3. EI # 3 entered the patient station, and without performing hand hygiene, retrieved clean gloves from the box of clean gloves, and donned them. EI # 3 then removed one glove, exited the patient station, retrieved clean supplies from the drawer at the supply cabinet, re-entered the patient station, and without performing hand hygiene, retrieved a glove from the box of clean gloves, and donned it. After reinfusing the extracorporeal circuit, EI # 3 failed to remove his/her gloves and perform hand hygiene. An interview was conducted on 2/27/25 at 12:19 PM with EI # 1, Director of Nursing, who confirmed staff failed to perform hand hygiene per facility policy. 2. An observation was conducted on 2/25/25 at 10:56 AM with EI # 5, Unit Support Specialist, cleaning and disinfecting dialysis station 3. After emptying the prime waste container, EI # 5 failed to remove gloves and perform hand hygiene before completing the disinfection of the station. An interview was conducted on 2/27/25 at 12:19 PM with EI # 1, who confirmed staff failed to perform hand hygiene per facility policy. 30952 3. An observation of medication preparation and administration was conducted on 2/25/25 at 11:20 AM with EI # 4, RN, in the medication room, and at station 6, for PI # 8. During the observation, EI # 4 performed hand hygiene using hand sanitizer on multiple occasions for less than 4 seconds before donning gloves. EI # 4 failed rub hands together briskly until dry. An interview was conducted on 2/27/25 at 12:18 PM with EI # 1 who confirmed staff must apply adequate amount of product, briskly rub hands together, an allow sanitizer to dry before donning clean gloves. 4. An observation of care was conducted on 2/25/27 at 11:55 AM at station 4, with EI # 3, for preparation of the HD machine for treatment for an unsampled patient. EI # 3, gloved, placed saline solution bag, dialyzer, and bloodlines on the HD machine. EI # 3 removed gloves but failed to perform hand hygiene after glove removal. An interview was conducted on 2/27/25 at 12:18 PM with EI # 1 who confirmed staff must perform hand hygiene after glove removal.

**V0114**

IC-SINKS AVAILABLE  
CFR(s): 494.30(a)(1)(i)

A sufficient number of sinks with warm water and soap should be available to facilitate hand washing.

This STANDARD is not met as evidenced by:  
Based on review of facility policy, observation, and staff interview, it was determined the facility failed to ensure staff followed the facility policy for dedicated clean sinks. This deficient practice affected one of two observations of cleaning and disinfection

of the dialysis station and had the potential to negatively affect the 17 incenter patients dialyzing at the facility. Findings include: Facility Policy: Infection Control of Dialysis Equipment Policy Number: 18640 Date Published: Not listed ...VII. Procedure ...3. Sinks in the patient care area are designated as clean sinks for patients and staff. 4. There are designated areas considered "Dirty" for cleaning and disinfecting of equipment, discarding used bicarb, acids, and/or dialysate sampling fluids. ...b. The hopper in the Soiled Utility room is designated for disposal and handling of waste products (dialysate,...) 1. An observation was conducted on 2/25/25 at 10:56 AM with Employee Identifier (EI) # 5, Unit Support Specialist, cleaning dialysis station 3. EI # 5 emptied the prime waste container and the remaining acid in the used acid jug in the designated clean sink in the patient care area. An interview was conducted on 2/27/25 at 12:19 PM with EI # 1, Director of Nursing, who confirmed staff failed to use the hopper in the soiled utility room for disposal of waste products.

**V0115**

**IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK**  
CFR(s): 494.30(a)(1)(i)

Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory.

This STANDARD is not met as evidenced by:  
Based on review of facility policies, observations, and staff interview, it was determined the facility failed to ensure staff donned Personal Protective Equipment per facility policy. This did affect two of two observations of cleaning and disinfection of the dialysis station, Patient Identifier (PI) # 10 in one of two observations of access of the Arteriovenous Fistula/Arteriovenous Graft (AVF/AVG) for initiation of dialysis, and PI # 9 in one of two observations of discontinuation of dialysis with a Central Venous Catheter (CVC) and had the potential to negatively affect the 17 incenter patients dialyzing at the facility and staff performing care. Findings include: Facility Policy: Infection Control of Dialysis Equipment Policy Number: 18640 Date Published: Not Listed Purpose: The purpose of this policy is to provide current infection prevention and control guidelines regarding cleaning and disinfecting of patient care equipment and surrounding environment to prevent cross-contamination between patients and care providers: Precautions: All personnel will follow Standard Precautions for all...chemicals. Barriers will be selected based on likelihood of exposure. Appropriate personal protective equipment (PPE) utilized based on exposure risk may include gloves, gown...goggles or face shields. Facility Policy: Dialysis Catheter CVL Maintenance and Dressing Change Policy Number: 18388 Revision: 1 Date Published: Not Listed Precautions: All personnel will follow Standard Precautions for all patient specimens... Barriers will be selected based on likelihood of exposure. Appropriate personal protective equipment utilized based on exposure risk may include gloves, gown...goggles or face shields. 1. An observation was conducted on 2/25/25 at 10:37 AM with Employee Identifier (EI) # 3, Registered Nurse (RN), performing discontinuation of dialysis with a CVC for PI # 9 at station 3. EI # 3 failed to don a face shield while discontinuing the dialysis treatment. An interview was conducted on 2/27/25 at 12:19 PM with EI # 1, Director of Nursing, who confirmed staff failed to don a face shield per facility policy. 2. An observation was conducted on 2/25/25 at 10:56 AM with EI # 5, Unit Support Specialist, cleaning

and disinfecting dialysis station 3. EI # 5 failed to don a face shield while cleaning and disinfecting the dialysis station. An interview was conducted on 2/27/25 at 12:19 PM with EI # 1, who confirmed staff failed to don a face shield per facility policy. 3. An observation was conducted on 2/26/25 at 11:05 AM with EI # 5, during cleaning of dialysis station 5. EI # 5 failed to don a face shield while cleaning and disinfecting the dialysis station. An interview was conducted on 2/27/25 at 12:18 PM with EI # 1, who confirmed staff failed to follow the facility infection control policy during dialysis station disinfection. 4. An observation was conducted on 2/25/25 at 1:30 PM with EI # 7 accessing the Arteriovenous Graft (AVG) for PI # 10 at station 5. EI # 7 failed to don a face shield while accessing the AVG. An interview was conducted on 2/27/25 at 12:19 PM with EI # 1, who confirmed staff failed to don a face shield based on exposure risk per facility policy. 30952

**V0116**

IC-IF TO STATION=DISP/DEDICATE OR DISINFECT  
CFR(s): 494.30(a)(1)(i)

Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient. -- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient. -- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients.

This STANDARD is not met as evidenced by:  
Based on review of facility policy, observations, and staff interview, it was determined the facility failed to ensure the Phoenix XL Meter (used for testing the pH and conductivity of the dialysate) was disinfected after each use per facility policy. This affected two of two observations of preparation of the hemodialysis machine and extracorporeal circuit and had the potential to negatively affect the 17 incenter patients dialyzing at the facility. Findings include: Facility Policy: Phoenix Meter XL Dialysate Testing Policy Number: 18372 Date Published: Not listed Procedure: The conductivity and pH of dialysate will be checked before every dialysis treatment and before using a different composition of acid concentrate during the same treatment. ... 6. Once testing is complete... 7. Clean Phoenix XL meter with appropriate disinfectant wipe. 1. An observation was conducted on 2/25/25 at 11:40 AM with Employee Identifier (EI) # 7, Registered Nurse (RN), preparing the hemodialysis machine at station 5. After checking the pH and conductivity of the dialysate, EI # 7 returned the Phoenix XL meter to the countertop in the common area without wiping the meter with the appropriate disinfectant wipe. An interview was conducted on 2/25/25 at 12:50 PM with EI # 1, Director of Nursing, who confirmed staff failed to clean the Phoenix XL meter with the appropriate disinfectant wipe after use per facility policy. 30952 2. An observation was made on 2/25/25 at 12:27 PM with EI # 1, at station 4, to test the conductivity and pH of the dialysate with the Phoenix XL meter for an unsampled patient. After testing the dialysate, EI # 1 placed the meter on the counter at station 4, and exited the station. EI # 1 failed to disinfect the meter after use per facility policy. An interview was conducted on 2/27/25 at 12:18 PM with EI # 1, who confirmed staff failed to follow the policy and disinfect the Phoenix XL meter after use.

**V0122**

IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL

CFR(s): 494.30(a)(4)(ii)

[The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.

This STANDARD is not met as evidenced by:

Based on review of facility policy, observations, and staff interview, it was determined the facility failed to ensure staff failed to follow infection prevention and control guidelines and facility policy regarding cleaning and disinfection of patient care equipment and surrounding environment in two of two observations of cleaning and disinfection of the dialysis station. This deficient practice had the potential to negatively affect the 17 incenter patients dialyzing at the facility. Findings include: Facility Policy: Infection Control of Dialysis Equipment Policy Number: 18640 Date Published: Not listed ...IV. Equipment 1. Each dialysis station is cleaned and disinfected prior to each patient's use. This includes, but is not limited to: Chair fully reclined, tables, TV, computers, dialysis machine, critline, containers, patient's blood pressure cuff, used clamps, Phoenix meter, acid wands, Hemachron Elite, and machine log clipboard. a. The exterior surfaces of the dialysis machine, care equipment and care area will be disinfected with a hospital approved germicidal disposable wipe. 1. An observation was conducted on 2/26/25 at 10:56 AM with Employee Identifier (EI) # 5, Unit Support Specialist, cleaning dialysis station 3. EI # 5 failed to disinfect all exterior surfaces of the dialysis machine, including all sides of the machine, basket, IV pole, Hansen Connectors, prime waste container, reusable clamps, and blood pressure cuff cord. EI # 5 failed to disinfect all surfaces in the patient care area, including the TV, wall behind the dialysis machine, sharps container, and chair used by the family during the dialysis treatment. An interview was conducted on 2/27/25 at 12:19 PM with EI # 1, Director of Nursing, who confirmed staff failed to clean and disinfect the dialysis station and surrounding areas per facility policy. 30952 2. An observation was conducted on 2/26/25 at 11:05 AM with EI # 5, during cleaning of dialysis station 5. EI # 5 failed to disinfect all exterior surfaces of the dialysis machine, including all sides of the machine, the IV pole, reusable clamps, and clip board on the pole. EI # 5 removed and emptied the prime waste container but failed to disinfect the inside and outside surfaces of the container before replacing the container onto the dialysis machine. EI # 5 failed to disinfect all surfaces in the patient care area, including the TV, and chair used by the family during the dialysis treatment. An interview was conducted on 2/27/25 at 12:18 PM with EI # 1, who confirmed staff failed to clean and disinfect the dialysis station and surrounding areas per facility policy.

**V0147**

IC-STAFF EDUCATION-CATHETERS/CATHETER CARE

CFR(s): 494.30(a)(2)

Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters. II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of

the site. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].

This STANDARD is not met as evidenced by:

Based on review of facility policy, observation, and staff interview, it was determined the facility failed to ensure staff performed Central Venous Catheter (CVC) exit site care per facility policy. This affected Patient Identifier # 7 in one of two observations of CVC exit site care and had the potential to negatively affect all patients dialyzing with a CVC at this facility. Findings Include: Facility Policy: Dialysis Catheter CVL Maintenance and Dressing Change Policy Number: 18388 Revision: 1 Date Published: Not listed CVL dressing change with a dialysis catheter ...3. Procedure ...p. With the Chlorhexidine (CHG) sponge, scrub the exit site for 30 seconds. Use a gentle back and forth diagonal motion when you scrub. 1. An observation was conducted on 2/27/25 at 9:58 AM with Employee Identifier (EI) # 6, Registered Nurse, performing CVC exit site care for PI # 7 at station 4. EI # 6 failed to scrub the exit site in a back-and-forth motion. An interview was conducted on 2/27/25 at 12:19 PM with EI # 1, Director of Nursing, who confirmed staff failed to perform CVC exit site care per facility policy.

**V0403**

PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU  
CFR(s): 494.60(b)

The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations.

This STANDARD is not met as evidenced by:

Based on observations, review of facility policy, and staff interview, it was determined the facility failed to ensure staff followed the policy for use of the Phoenix XL Meter when testing dialysate during two of two observations for preparation of the hemodialysis machine. This had the potential to negatively affect the 17 incenter patients dialyzing at this facility. Findings include: Facility Policy: Phoenix XL Meter Dialysate Testing: Policy Number: 18372 Date Published: Not listed Purpose: The purpose is to serve as a guide for dialysis nurses to use the Phoenix meter to check for accurate dialysate conductivity and potential of Hydrogen (pH) on the hemodialysis machine to ensure patient safety during treatment. ...Precautions: ...3. Keep fluid of syringe cell filled with fluid at all times ...Procedure: ...6. Once testing is complete; discard the used solution... ...8. Rinse the meter cell and syringe interior thoroughly with RO water (water that has been purified using Reverse Osmosis) after use. 9. Keep cell filled with RO water during use to preserve the integrity of the cell. 1. An observation was made on 2/25/25 at 11:40 AM with Employee Identifier (EI) # 7, Registered Nurse, using the Phoenix XL meter to test the conductivity and pH of the dialysate at station 5. After discarding the dialysate that was tested, EI # 7 failed to rinse the Phoenix meter with RO water and fill the cell with RO water to preserve the integrity of the cell. An interview was conducted on 2/27/25 at 12:18 PM with EI # 1, Director of Nursing, who confirmed staff failed to follow the policy for use of the Phoenix XL meter when testing the dialysate. 30952 2. An observation was made on 2/25/25 at 12:27 PM with EI # 1, at station 4, to test the conductivity and pH of the

dialysate with the Phoenix XL meter. After testing the dialysate, EI # 1 placed the meter on the counter at station 4, and exited the station. EI # 1 failed to rinse the Phoenix meter with RO water and fill the cell with RO water to preserve the integrity of the cell. An interview was conducted on 2/27/25 at 12:18 PM with EI # 1, who confirmed staff failed to follow the policy for use of the Phoenix XL meter when testing the dialysate.

**V0550**

**POC-VASCULAR ACCESS-MONITOR/REFERRALS**  
CFR(s): 494.90(a)(5)

The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement.

This STANDARD is not met as evidenced by:

Based on review of facility procedure, observations, and staff interview, it was determined the facility failed to ensure staff performed Arteriovenous Fistula /Arteriovenous Graft (AVF/AVG) site preparation for cannulation according to facility procedure in two of two observations of accessing the AVF/AVG for initiation of dialysis. This affected Patient Identifier (PI) # 10, and PI # 12, and had the potential to negatively affect all patients dialyzing with an AVF/AVG at this facility. Findings include: Facility Procedure: AV (Arteriovenous Fistula)-Assessment, Cannulation, Decannulation and Lab Draw Procedure Number: 18335 Date Published: Not listed ...

The purpose of this procedure is to provide guidelines for routine AVF/AVG cannulation... 5. Cannulation of a New AVF/AVG ...b. Procedure ...vii. Prep (prepare) site ...II. Scrub site with chloraprep (Chlorhexidine Gluconate 2% and isopropyl alcohol 70%, a topical skin antiseptic solution used to disinfect the skin before surgical and medical procedures) for 30 seconds and allow to air dry... 1. An observation was conducted on 2/25/25 at 1:30 PM with Employee Identifier (EI) # 7, Registered Nurse (RN), accessing the AVG and initiating dialysis for PI # 10 at station 5. EI # 7 failed to scrub the arterial and venous cannulation sites for 30 seconds each prior to cannulation. An interview was conducted on 2/27/25 at 12:19 PM with EI # 1, Director of Nursing, who confirmed staff failed to perform site preparation for AVF/AVG cannulation per facility procedure. 30952 2. An observation was conducted on 2/26/25 at 7:30 AM with EI # 2, RN, to prepare, cannulate, and initiate dialysis for PI # 12 at station 6. EI # 2 used a Chloraprep sponge, and scrubbed access site one for 20 seconds, scrubbed access site two for 5 (five) seconds, allowed both sites to dry, and cannulated the sites. EI # 2 failed to scrub the access cannulation sites for 30 seconds each prior to cannulation. An interview was conducted on 2/27/25 at 12:18 PM with EI # 1, who confirmed staff failed to follow the facility procedure for AVF/AVG assessment, and cannulation.

**V0726**

**MR-COMPLETE, ACCURATE, ACCESSIBLE**  
CFR(s): 494.170

The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility.

This STANDARD is not met as evidenced by:

Based on medical record (MR) reviews, facility policy, and interviews with staff, it was determined the facility failed to ensure staff adjusted heparin infusions as ordered and documented heparin dosages adjustments in the patient MR. This affected Patient Identifier (PI) # 4, PI # 2, in two of two incenter hemodialysis (HD) record reviews, and had the potential to affect all patients treated at the facility. Findings include: Facility Policy: Documentation Multidisciplinary Procedure No. (Number) 2.04 Date Published: None Listed I. Purpose To provide a record of patient care... III. Policy A.... to ensure accurate patient medical records thorough, accurate documentation... Findings include: 1. PI # 4 was admitted to the facility on 8/1/22 with a diagnosis of End Stage Renal Disease (ESRD). Record review revealed a Normal Heparin Infusion Sliding Scale Standing Order dated 11/21/24 which revealed the following: ACT (activated clotting time test, a rapid blood test used to monitor heparin therapy, assessing how long it takes blood to clot, and is often used during procedures requiring blood clot prevention) Greater than 200 Decrease Infusion Adjustment by 4 units/kg/hr (units/kilogram/hour) 180-200 Decrease Infusion Adjustment by 2 units/kg/hr 160-180 (optimum range) No Change 140-160 Increase by 2 units/kg/hr Less than 140 Increase by 4 units/kg/hr MR review included incenter HD Treatment documentation dated 2/12/25, 2/14/25, 2/17/25, 2/19/25, 2/24/25, which revealed the ACTs results met the Normal Heparin Infusion Sliding Scale criteria for dosage adjustments. There was no documentation heparin dosages were adjusted per the heparin sliding scale standing order. An interview was conducted on 2/27/25 at 11:47 AM, with Employee Identifier (EI) # 1, Director of Nurses, who confirmed the MR documentation did not include heparin sliding scale dosage adjustments. 2. PI # 2 was admitted to the facility on 1/24/25 with a diagnosis of ESRD. Record review revealed a Normal Heparin Infusion Sliding Scale Standing Order dated 1/23/25 (before admission) and an order reprint requisition dated 2/12/25 which revealed the following: ACT Greater than 200 Decrease Infusion Adjustment by 4 units/kg/hr 180-200 Decrease Infusion Adjustment by 2 units/kg/hr 160-180 (optimum range) No Change 140-160 Increase by 2 units/kg/hr Less than 140 Increase by 4 units/kg/hr MR review included incenter HD Treatment documentation dated 2/12/25, 2/14/25, 2/17/25, 2/19/25, 2/21/25, 2/24/25 which revealed the ACTs results met the Normal Heparin Infusion Sliding Scale criteria for dosage adjustments. There was no documentation heparin dosages were adjusted per the heparin infusion sliding scale standing order. An interview was conducted on 2/27/25 at 12:50 PM, with EI # 1, who confirmed the MR documentation did not include heparin sliding scale dosage adjustments.