

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  012502	<b>(X3) Date Survey Completed</b>  01/08/2020
<b>Name of Provider or Supplier</b>  Tuscaloosa University Dialysis	<b>Street Address, City, State</b>  220 15th Street, Tuscaloosa, 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>E0028</b>	<p><b>Dialysis Emergency Equipment</b></p> <p>494.62(b)(9) Condition for Coverage: [(b) Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (9) A process by which the staff can confirm that emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, are on the premises at all times and immediately available.</p> <p>This STANDARD is not met as evidenced by: Based on review of the AED (Automated External Defibrillator) Checklists, Emergency Equipment Checklists, policy and interview, it was determined the facility failed to ensure emergency equipment was checked per policy. This had the potential to affect all persons dialyzing at the facility. Findings include: Policy: Emergency Equipment Checks Policy Number: 1-02-08 Revision Date: April 2019 Purpose: To verify that emergency equipment is maintained in a ready-to-use condition. Policy: ... 2. The following equipment checks will be performed by a licensed nurse teammate to verify the designated equipment is available and functional: Daily: -Check Status Indicator light for Philips Heart Start... Break away lock is intact. Weekly: -Oxygen supply is adequate... ..Emergency cart (crash cart) is clean, operational and supplies have not expired. ...4. The emergency checklist will be developed by the facility based on Medical Director input as to the supplies needed on the emergency (crash) cart and will be used to verify that the cart has been checked. A review of the AED daily checklist for November 2019 revealed the following missing dates: 11/2/19 11/29/19 11/30/19 A review of the AED daily checklist for December 2019 revealed the</p>

following missing dates: 12/4/19 12/30/19 12/31/19 There was documentation the checklist was completed on 12/8/19, which was a Sunday, and the facility was closed. Review of the weekly Emergency Equipment Checklist for November and December of 2019 revealed the Emergency Cart information was left blank the week of 11/25/19. There was no documentation the week of 12/02/19 and the week of 12/30/19. An interview was conducted on 1/8/2020 at 12:18 PM with Employee Identifier # 1, Facility Administrator, who confirmed the missing dates.

**V0000**

(Core) A recertification survey was conducted on 1/6/2020 to 1/8/2020 with standard level deficiencies cited.

**V0111**

**IC-SANITARY ENVIRONMENT**  
CFR(s): 494.30

The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas.

This STANDARD is not met as evidenced by:  
Based on observation, review of facility policy and procedure and interviews, it was determined the facility failed to ensure the staff: a) Maintained a safe and sanitary environment for all patients and staff. b) Followed the facility policy for the initiation of a dialysis treatment with an arteriovenous fistula (AVF). This affected 1 of 2 observations conducted, 1 of 4 patients interviewed, and did affect PI (Patient Identifier) # 2, PI # 11 and had the potential to negatively affect all patients served by the facility. Findings include: Title: AV Fistula or Graft Cannulation With Nipro or Medisystems Safety Fistula Needles (SFN) and Administration of Heparin Loading Dose. Policy Number: 1-04-01E Revised Date: April 2019 Procedure: 8. Locate and palpate the needle cannulation sites prior to skin preparation... 10. While maintain aseptic technique, prep each planned needle site by applying a 70% alcohol prep pad to each site using a circular rubbing motion, center out... 13. Do not palpate insertion site once area has been prepped... Policy: Infection Control for Dialysis Facilities Policy Number: 1-05-01 Revision Date: October 2019 Purpose: To minimize the spread of infections or bloodborne pathogens in the dialysis facility environment. ... Wall Box and Drain/Water Line Care and Maintenance ...61. ...The presence of flies (drain flies, sink flies, filter flies or sewer gnats which are small true flies with short, hairy bodies and wings...) will prompt a report to the Facility Administrator and Biomedical Services for advanced drain care options. 1. During observations of care on 1/8/2020 from 10:00 AM to 2:00 PM, the surveyor observed gnats flying at station # 1, # 6, # 10, and near the treatment exit door. An interview was conducted on 1/8/2020 at 1:00 PM during observation of care with PI # 2 at station # 10. The surveyor asked PI # 2 if she/he had observed gnats in the facility before today. She/he answered, "Yes." During an interview on 1/8/2020 at 2:30 PM with Employee Identifier (EI) # 1, Facility Administrator, the surveyor requested an invoice from the pest control company's last visit. EI # 1 stated there was none, but provided the surveyor a copy of the bill received for December 2019 services, and a copy of the pest control contract. 2. During observations of care on 1/6/2020 at 10:25 AM the surveyor observed EI # 2, Certified Clinical Hemodialysis Technician, prepping the sites with an antiseptic for cannulation of PI # 11 at station # 14. After the sites were prepped EI # 2 then palpated/touched both sites with his/her fingers without repeating skin antiseptics before cannulation, thus leading to potential contamination. An interview was conducted on 1/8/2020 with EI # 1 at 12:22 PM who verified staff

failed to follow the facility policy for accessing of an AV Fistula. 3. During a flash tour of the Peritoneal Dialysis Room on 1/6/2020 at 1:15 PM the surveyor observed the 2 walls behind the dialysis chair with multiple stains, black marks and paint peeling. The rolling stool legs were completely covered with rust. An interview was conducted on 1/6/2020 at 1:23 PM with EI # 1 who verified the above findings, and stated, "We are aware of how it look's and we are told that we are due for an upgrade to the facility this year". 39098

**V0113**

IC-WEAR GLOVES/HAND HYGIENE  
CFR(s): 494.30(a)(1)

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.

This STANDARD is not met as evidenced by:

Based on observations, review of facility policies and procedures and interviews, it was determined the facility failed to ensure staff 1. Wore/changed gloves as directed per the facility policy. 2. Performed hand hygiene after removing gloves. This did affect 1 of 2 observations conducted for Discontinuation of Dialysis and Post Dialysis Access Care for AV (Atrioventricular) Fistula or Graft and 2 of 2 observations conducted for Parental Medication Preparation and Administration. This affected Patient Identifier (PI) # 12, PI # 13, PI # 14 and had the potential to negatively affect all patients served by the facility. Findings include: Policy: 1-05-01 Title: Infection Control For Dialysis Facilities Revision Date: October 2019 Purpose: To minimize the spread of infections or bloodborne pathogens in the dialysis facility environment. Teammate Hygiene 1. Hand hygiene is to be performed upon entering the patient treatment area, prior to gloving, after removal of gloves... after patient and dialysis delivery system contact...before touching clean areas such as supplies, and on exiting the patient treatment area. Teammate/Patient Safety 11. Teammates will wear gloves when caring for the patient or touching the patient's equipment at the dialysis station, and will remove gloves and wash hands or perform hand hygiene between each patient and/or station. 12. Gloves should be worn when: ...Administering medications, checking vital signs. Policy: 1-06-01 Title: Medication Policy Revision Date: April 2019 Purpose...To provide guidance for medication management...aspect technique for preparation of all medications. 8. All teammates administering medications must utilize aseptic technique... Procedure: 1-06-04A Title: Preparation and Administration of Intravenous Epogen With All Dialyzer Types Revision Date: April 2017 Preparation of Epogen dose ...2. Perform hand hygiene. Put on PPE (Personnel Protective Equipment). 3. Prior to each medication preparation, disinfect medication preparation surface area... Remove PPE. ...5. Perform hand hygiene prior to medication preparation. ...16. Distribute the medication to the patient station in an aseptic manner... Administration of Epogen ...3. Perform hand hygiene. Put on PPE. 1. During observation of Discontinuation of Dialysis and Post Dialysis Access Care for AV Fistula or Graft on 1/6/2020 at 10:07 AM, the surveyor observed Employee Identifier (EI) # 4, Certified Clinical Hemodialysis Technician (CCHT), removed the first needle from PI # 12, proceeded to the clean counter top, obtained a glove and the thermometer. Holding the thermometer with the glove, hand EI # 4 returned to station # 16 and assessed PI # 12's temperature. EI # 4 failed to apply gloves as directed per the facility policy. 2. During observation of Parenteral Medication Preparation and Administration on 1/6/2020 at 11:05 AM, the surveyor observed EI # 5, Registered Nurse (RN), prepare two (2) intravenous (IV) medication's for PI # 13. EI # 5

withdrew the medication into the syringe and removed his/her gloves without performing hand hygiene. 3. During observation of Parenteral Medication Preparation and Administration on 1/6/2020 at 12:15 PM, the surveyor observed EI # 3, RN, prepare and administer three (3) IV medication's, including Epogen, for PI # 14 at station # 11. EI # 3 withdrew the medications into the syringes and wearing the same gloves proceeded to station # 11. EI # 3, holding medications in 1 gloved hand retrieve a large sharps container located on the treatment floor and place the large sharps container in a rolling cart with the both gloved hands. EI # 3 then rolled the sharps container closer to station # 11 and proceeded to administer the IV medications, including Epogen, to PI # 14 without changing gloves and performing hand hygiene. An interview was conducted on 1/8/2020 12:05 PM with EI # 1, Facility Administrator, who confirmed the staff failed to follow facility infection control policies and procedures for gloving and hand hygiene.

**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 observations, review of facility policy and interviews, it was determined the facility failed to ensure the staff cleaned and disinfected equipment before returning it to a common clean area or being used on another patient. This did affect 1 of 2 observations conducted for Discontinuation of Dialysis and Post Dialysis Access Care for AV (Atrioventricular) Fistula or Graft, 1 of 2 observations conducted for Access of AV Fistula or Graft, and 1 of 2 observations for Center Venous Catheter (CVC) Exit Care and Initiation of Dialysis with CVC. This affected Patient Identifier (PI) # 12, PI # 11, PI # 16 and had the potential to negatively affect all patients served by the facility. Findings include: Policy: Infection Control for Dialysis Facilities Policy Number: 1-05-01 Date Revised: October 2019 Purpose: To minimize the spread of infections or bloodborne pathogens in the dialysis facility environment. ...Teammate /Patient Safety ...25. Non-disposable items are to be disinfected between patients. 26. Stethoscopes will be disinfected with 1:100 (one to one hundred) bleach solution. ... Dialysis Station Management ...65. Items taken into the dialysis station will be... cleaned and disinfected before taken to a common area or used on another patient... 66. Teammates will thoroughly wipe down all non-disposable items and equipment... with an appropriate disinfectant... 1. During observation of Discontinuation of Dialysis and Post Dialysis Access Care for AV Fistula or Graft on 1/6/2020 at 10:07 AM, the surveyor observed Employee Identifier (EI) # 4, Certified Clinical Hemodialysis Technician (CCHT), removed the first needle from PI # 12, proceeded to the clean counter top, retrieved the thermometer, returned to station # 16 and assessed PI # 12's temperature. EI # 4 then proceeded to the clean sink, wet a cleaning wipe with water and cleaned the thermometer and returned thermometer to clean counter top. EI # 4 failed to clean and disinfect the thermometer with an appropriate disinfectant as directed per the facility policy. An interview was conducted on 1/8

/2020 at 11:00 AM with EI # 4, who stated he/she failed to clean the thermometer with a disinfectant after use. 2. During observation of Access of AV Fistula or Graft for Initiation of Dialysis on 1/6/2020 at 10:25 AM, the surveyor observed EI # 2, CCHT, obtain cannulation supplies and thermometer from the clean counter top and proceed to station # 14 to assess PI # 11's temperature. EI # 2 then returned the thermometer to the clean counter top without first cleaning the thermometer. At 10:35 AM EI # 3, Registered Nurse, assessed PI # 11 with a stethoscope and hung the stethoscope around his/her neck. EI # 3 failed to disinfect the stethoscope after use. An interview was conducted on 1/8/2020 at 12:05 PM with EI # 2 and EI # 1, Facility Administrator who verified the staff failed to follow the facility policy for cleaning equipment after use. 39098 3. During observation of Initiation of Dialysis with CVC on 1/6/2020 at 11:35 AM on PI # 16, the surveyor observed EI # 6, CCHT, assess the patient's temperature. EI # 6 then returned the thermometer to the clean counter without first cleaning the thermometer. An interview was conducted on 1/8/2020 at 10:38 AM with EI # 6, who confirmed she/he failed to clean the thermometer per policy.

**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 3 of 3 observations of cleaning and disinfection of the hemodialysis stations, review of facility policy, Centers for Disease Control and Prevention (CDC) Checklist: Dialysis Station Routine Disinfection, and interviews it was determined, the facility failed to ensure staff cleaned and disinfected the dialysis station after patient treatments. This had the potential to negatively affect all patients in this facility. Findings Include: Policy: Infection Control for Dialysis Facility Policy Number: 1-05-01 Revision Date: October 2019 Purpose: To minimize the spread of infection or bloodborne pathogens in the dialysis facility environment. Facility Hygiene 44. Teammates will thoroughly wipe down all non-disposable items and equipment such as the blood pressure cuff, the inside and outside of the prime container, ... and the dialysis delivery systems, with appropriate disinfectant after every treatment... 46. Equipment including the dialysis delivery system, the interior and exterior of the prime container, the dialysis chair and side tables including opening the chair to reach crevices, blood pressure equipment, television arms and control knobs or remote control devices if accessible to patient and teammates...IV (Intravenous) poles, as well as work surfaces will be wiped clean with a bleach solution of the appropriate strength...before being used on another patient ..., and after each treatment. Dialysis Station Management 66. Teammates will thoroughly wipe down all non-disposable items and equipment such the blood pressure cuff, the inside and outside of the prime container, hemostats (blood line clamps), and the dialysis delivery systems, with an appropriate disinfectant after each treatment. CDC Checklist: Dialysis Station Routine Disinfection Part A: Before Beginning Routine Disinfection of the Dialysis Station Disconnect and takedown used blood tubing and dialyzer from the dialysis machine. Discard tubing and dialyzers in a leak-proof container Before Beginning Routine Disinfection of the Dialysis Station Disconnect and takedown used blood tubing and dialyzer from the dialysis machine. ...Discard all single-use supplies. Move any reusable supplies to an area where they will be cleaned

and disinfected before being stored or returned to a dialysis station. 1. During observations of care on 1/6/2020 at 10:50 AM the surveyor observed Employee Identifier (EI) # 2, Certified Clinical Hemodialysis Technician (CCHT), clean and disinfect dialysis station 15. EI # 2 failed to clean the entire dialysis machine to include the IV pole, hemostat, purple pouch, and clipboard. Further observation revealed EI # 2 failed to clean and disinfect underneath the chairside table tops and the exterior chair panels bilaterally. An interview was conducted with EI # 2 on 1/8/2020 at 12:07 PM who verified he/she failed to perform cleaning and disinfection of the dialysis station per policy. 39098 2. During observations of care on 1/6/2020 at 1:15 PM the surveyor observed EI # 8, CCHT, cleaning and disinfecting dialysis station # 10. EI # 8 cleaned the chair, then removed the blood lines from the dialysis machine. EI # 8 failed to remove all patient supplies from the dialysis station before starting the disinfection process. An interview was conducted on 1/8/2020 at 11:18 AM with EI # 8, who confirmed she/he did not follow the recommended guidelines for cleaning the dialysis station. 3. On 1/6/2020 at 2:00 PM the surveyor observed EI # 6, CCHT, cleaning and disinfecting station # 1. EI # 6 failed to clean the entire dialysis machine to include the IV pole, hemostat, purple pouch, and clipboard. An interview was conducted on 1/8/2020 at 10:38 AM with EI # 6, who confirmed she/he failed to clean the entire dialysis machine per policy.

**V0143**

**IC-ASEPTIC TECHNIQUES FOR IV MEDS**  
CFR(s): 494.30(b)(2)

[The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and

This STANDARD is not met as evidenced by:  
Based on review of policy and procedure, observation and interviews, it was determined the facility failed to ensure staff labeled opened multidose medication vials per policy. This affected 2 of 6 opened vials observed, and had the potential to affect all patients served by this facility. Findings include: Policy: Medication Policy Policy Number: 1-06-01 Revision Date: April 2019 Purpose: To provide guidance for medication management in the facility and to provide guidance for the safe and aseptic preparation of all medications. Policy: ...28. Medications containing a preservative must be discarded 28 days after opening or accessed... Each vial is labeled with the initials of the person opening the vial and the expiration date. 1. During observation of the medication preparation area on 1/6/2020 at 11:55 AM the surveyor observed 1 of 5 opened vials of Epogen 20,000 units/ 2 ml (milliliters) with no date or initials, and 1 of 1 opened vials of Hectoral 4 mcg (micrograms)/ 2 ml with no date or initials. Employee Identifier (EI) # 5, RN (Registered Nurse), who was present during the observation, confirmed the vials should have been labeled.

**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 observation, review of policy and procedure, and interview, it was determined the facility failed to ensure staff performed initiation of dialysis with a Central Venous Catheter (CVC) per policy. This affected 2 of 2 observations of initiation of dialysis with CVC, including Patient Identifiers (PI) # 15, PI # 16, and had the potential to affect all patients dialyzing at this facility. Findings include: Policy: Central Venous Catheter (CVC) Care Policy Number: 1-04-02 Revision Date: October 2019 Purpose: To reduce the risk of infection in the patient... Policy: Central Venous Catheter (CVC) Procedure Policy Number: 1-04-02A Revision Date: April 2019 ...21. Remove attached Curosur for TEGO Caps from each TEGO connector and discard. 22. Scrub CVC TEGO connectors or caps with LARGE alcohol prep pad, one (1) per TEGO connector or cap, for 60 seconds. 1. During observations of care on 1/6/2020 at 10:05 AM, the surveyor observed Employee Identifier (EI) # 5, RN (Registered Nurse), perform initiation of dialysis with a CVC on PI # 15. During disinfection of the CVC hubs, EI # 5 used an alcohol pad and wiped the threads of the blue port for 5 seconds, and the red port for 3 seconds. EI # 5 failed to scrub the connector caps for 60 seconds, per policy. 2. During observations of care on 1/6/2020 at 11:35 AM, the surveyor observed EI # 5, perform initiation of dialysis with a CVC on PI # 16. During disinfection of the CVC hubs, EI # 5 used an alcohol pad and wiped the threads of the blue port for 10 seconds, and the red port for 10 seconds. EI # 5 failed to scrub the connector caps for 60 seconds, per policy. An interview was conducted on 1/8/2020 at 11:35 AM with EI # 5, who confirmed she/he failed to clean the CVC hubs per policy.

**V0196**

**CARBON ADSORP-MONITOR, TEST FREQUENCY**  
CFR(s): 494.40(a)

6.2.5 Carbon adsorption: monitoring, testing freq Testing for free chlorine, chloramine, or total chlorine should be performed at the beginning of each treatment day prior to patients initiating treatment and again prior to the beginning of each patient shift. If there are no set patient shifts, testing should be performed approximately every 4 hours. Results of monitoring of free chlorine, chloramine, or total chlorine should be recorded in a log sheet. Testing for free chlorine, chloramine, or total chlorine can be accomplished using the N.N-diethyl-p-phenylene-diamine (DPD) based test kits or dip-and-read test strips. On-line monitors can be used to measure chloramine concentrations. Whichever test system is used, it must have sufficient sensitivity and specificity to resolve the maximum levels described in [AAMI] 4.1.1 (Table 1) [which is a maximum level of 0.1 mg/L]. Samples should be drawn when the system has been operating for at least 15 minutes. The analysis should be performed on-site, since chloramine levels will decrease if the sample is not assayed promptly.

This STANDARD is not met as evidenced by:

Based on observation, review of procedure, and interview, it was determined the

facility failed to ensure the CCHT (Certified Clinical Hemodialysis Technician) performed the Total Chlorine Test per policy. This had the potential to affect all patients dialyzing at the facility. Findings include: Procedure: Serim Hisense Ultra 0.1 Test for Total Chlorine in Feed or Rinse Water Procedure Number: 2-05-02G Revision Date: March 2015 Procedure: ...4. Remove test strip from the test water and shake to remove excess sample. Immediately compare reacted test strip to the color chart on Serim Hisense Ultra 0.1 test bottle. Rationale: Delaying comparison of the reacted test strip with the color chart may cause test results to be reported inaccurately. On 1/6/2020 at 12:00 PM the surveyor observed Employee Identifier (EI) # 2, CCHT (Certified Clinical Hemodialysis Technician), perform a total chlorine water test. The CCHT performed a chlorine test using the Serim Hisense Ultra test strip, and then discarded the strip and water sample. EI # 2 then stated she/he was going to do the test again to take to the treatment floor for the nurse to confirm results. EI # 2 obtained another sample and another test strip. After removing the test strip from the sample, EI # 2 proceeded to the treatment floor. Once inside door, EI # 2 took the strip and bottle to EI #9, RN (Registered Nurse) for verification of results, which was 45 seconds after the test was completed. An interview was conducted on 1/8/2020 at 1:45 PM with EI # 2, who confirmed she had verified the results.

**V0543**

**POC-MANAGE VOLUME STATUS**  
CFR(s): 494.90(a)(1)

The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status;

This STANDARD is not met as evidenced by:

Based on review of the medical records (MR), agency policy and procedure and interviews, it was determined the facility failed to: a) Ensure the staff performed and documented the amount of normal saline (NS) used for prime and/or rinse back. b) Achieve physician's orders for the patient's target weight at end of each treatment. c) Ensure staff administered antihypertensives and notified the physician of patient's hypertension or hypotension. This affected 8 of 9 incenter medical records reviewed including Patient Identifier (PI) # 2, PI # 6, PI # 3, PI # 1, PI # 5, PI # 7, PI # 8, PI # 9, and had the potential to negatively affect all patients served by the dialysis facility. Findings include: Policy: Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment Policy Number: 1-03-08 Revision Date: April 2017 Purpose: To obtain and document baseline and ongoing information about the patient before, during and after the dialysis treatment... Policy: ...Pre-Treatment Data Collection/ Assessment 4. Any abnormal findings or findings outside of any patient specific physician ordered parameters discovered during pre-treatment data collection will be documented and immediately reported to the licensed nurse. 5. The assessment is a nursing responsibility... 6. The licensed nurse will use his/her clinical judgement... The physician... will be notified of any concerns that may preclude the initiation of dialysis. ...Intradialytic Data Collection/ Assessment ...11. Abnormal findings or findings outside of any patient specific physician ordered parameters will be reported to the licensed nurse immediately... 12. The licensed nurse notifies the physician... as needed of changes in the patient status. 13. All findings, interventions and patient response will be documented in the patient's medical record. ...Post Treatment Data Collection/ Assessment 15. The PCT (Patient Care Technician) or licensed nurse will obtain and document basic data on each patient post dialysis and compare to pre dialysis findings. 16. If an abnormal finding or concern is identified post treatment,

this needs to be reported to the licensed nurse... 17. Licensed nurse will use his/her clinical judgement... to determine if any clinical interventions or notification of physician... is necessary prior to discharge of the patient from the facility. Abnormal Findings: ...Fluid Status: Post-treatment: If patient is above or below 1 kg (kilogram) from the target weight. Blood pressure- Pre dialysis: Systolic greater than 180 mm (millimeters)/ Hg (mercury) or less than 90 mm/ Hg. Diastolic greater than or equal to 100 mm/Hg. Blood pressure- Intradialytic: Difference of 20 mm/Hg increase or decrease from patient's last... BP (Blood Pressure) reading. Blood Pressure Post Treatment: If the patient can stand: Standing systolic BP greater than 140 mm/Hg or less than 90 mm/Hg. Standing diastolic BP greater than 90 mm/Hg or less than 50 mm/ Hg. Sitting BP for patient's that cannot stand: Sitting systolic BP greater than 140 mm/Hg or less than 90 mm/Hg. Sitting diastolic BP greater than 90 mm/Hg or less than 50 mm/ Hg. 1. PI # 2 was admitted to the facility on 8/2/19 with a primary diagnosis of Acute Kidney Injury. Review of the Treatment Sheet dated 12/27/19 revealed no documentation prime and rinse back fluids were given. Review of the Treatment Sheet dated 12/30/19 revealed no prime fluids were given. Review of the Treatment Sheet dated 1/1/2020 revealed no prime fluids were documented. Review of the Treatment Sheet dated 1/6/2020 revealed no documentation rinse back fluids were given. Interviews were conducted on 1/8/2020 at 11:46 AM with Employee Identifier (EI) # 10, RN (Registered Nurse), and at 12:16 PM with EI # 1, Facility Administrator (FA), who confirmed the fluids were not documented. 2. PI # 6 was admitted to the facility on 2/19/13 with a primary diagnosis of ESRD (End Stage Renal Disease). Review of the physician's orders dated 7/24/19 revealed a target weight of 125.0 kg, and a prn (as needed) order for Clonidine 0.10 mg (milligrams) PO (by mouth), give 1 tab (tablet) for systolic BP > (greater than)/ = (equal to) 180. May repeat 1 x (time). Review of Treatment Sheet dated 12/27/19 revealed a pre-treatment BP 199/114 sitting, and 210/108 standing. Review of the intradialytics revealed the following BP's: 9:02 AM: 196/103 9:32 AM: 190/110 10:02 AM: 192 /101 10:47 AM: 188/112 The post- treatment weight was 128.4 kg, which was 3.4 kg over the target weight. There was no documentation the patient received Clonidine, or that the physician was notified of the patient's hypertension and post-treatment weight. Review of the Treatment Sheet dated 12/30/19 revealed no documentation of rinse back fluids. Review of the Treatment Sheet dated 1/6/2020 revealed no documentation prime fluids were given. An interview was conducted on 1/8/2020 at 10:34 AM with EI # 6, CCHT (Certified Clinical Hemodialysis Technician), who confirmed she/he failed to document the prime and rinse back fluids, and in an interview at 11:52 AM with EI # 10, she/he confirmed there was no Clonidine given as ordered and no physician notification of the post-treatment weight. 3. PI # 3 was admitted to the facility on 12/4/95 with a primary diagnosis of ESRD. Review of the PRN Orders dated 3/19/07 revealed an order for Normal Saline Solution 0.9% NaCl (Sodium Chloride) 100 ml Intravenous, Give 100 ml NS IV PRN for hypotension. Review of the Treatment Sheet dated 12/21/19 revealed a pre-treatment BP 99/57 sitting, and 105/66 standing. Treatment was initiated at 11:37 AM. The following BP's were documented: 12:32 AM: 90/48 1:02 PM: 63/32 1:32 PM: 79/50 2:02 PM: 89/55 There was no documentation the CCHT notified the RN of the patient's hypotension, and no documentation NS was administered as ordered for hypotension. Review of the Treatment Sheet dated 12/26/19 revealed treatment was initiated at 12:05 PM. The intradialytic BP's were documented as follows: ...12:32 PM: 89/51 1:02 PM: 69/55 1:03 PM: 77/45 1:05 PM: 73/48 1:32 PM: 84/49... There was no documentation the CCHT notified the RN of the patient's hypotension, and no documentation NS was administered. Review of the Treatment Sheet dated 12/28/19 revealed no documentation of rinse back fluids. Review of the Treatment Sheet dated 12/31/19 revealed treatment was initiated at 11:29 AM, with a BP of 104/63. There were no

prime fluids documented. At 12:34 the BP was 74/57. There was no documentation the CCHT notified the RN or administered NS. At 2:21 PM the treatment was terminated, which was 38 minutes early. Review of the AMA form dated 12/31/19 revealed the CCHT documented the treatment was shortened by 45 minutes, not 38 as documented on the treatment sheet. The reason listed by the CCHT was, "...pt (patient) request pt cramping." Review of Treatment Sheet dated 1/2/2020 revealed the following intradialytic BPs: 1:02 PM: 114/65 1:33 PM: 71/50 2:03 PM: 100/69 2:32 PM 88/59 There was no documentation the CCHT notified the RN of the patient's drop in BP, or NS administered. Interviews were conducted on 1/8/2020 from 10:09 AM to 12:14 PM with EI # 11, CCHT, EI # 1, and EI # 8, CCHT, who confirmed fluids were not documented, or NS given as ordered for hypotension. 28327 4. PI # 1 was admitted to the facility on 10/17/19 with a primary diagnosis of ESRD. Review of the Treatment Sheet dated 12/26/19 revealed no documentation a rinse back was given at the end of treatment. Review of treatment sheet dated 12/28/19 revealed no documentation the prime fluids were given. Interview's were conducted on 1/8/2020 at 10:40 AM with EI # 6, CCHT, and 11:40 AM with EI # 10, RN who confirmed the fluids were not documented on the aforementioned dates. 5. PI # 5 was admitted to the facility on 5/6/10 with a primary diagnosis of ESRD. Review of the Treatment Sheet dated 12/24/19 revealed no documentation a rinse back was given at the end of treatment. Review of the Treatment Sheet dated 12/27/19 revealed no documentation the prime fluids or rinse back was given. Review of treatment sheet dated 12/30/19 revealed no documentation the prime fluids were given. Review of the Treatment Sheet dated 1/1/2020 revealed no documentation a rinse back was given at the end of treatment. Interviews were conducted on 1/8/2020 at 10:33 AM with EI # 6 and EI # 1 who confirmed the fluids were not documented. 6. PI # 7 was admitted to the facility on 7/6/18 with a primary diagnosis of ESRD. Review of the Treatment Sheet dated 12/23/19 revealed no documentation a rinse back was given at the end of treatment. Review of the Treatment Sheet dated 12/31/19 revealed no documentation the prime fluids or rinse back was given. An interview was conducted on 1/8/2020 at 10:28 AM with EI # 6 who confirmed the fluids were not documented. 7. PI # 8 was admitted to the facility on 4/16/19 with a primary diagnosis of ESRD. Review of the physician's orders dated 4/11/19 revealed a prn order for Clonidine 0.10 mg PO, give 1 tab for systolic BP > / = 180. May repeat 1 x. Further review of the physician's orders dated 8/14/19 revealed a target weight of 90.0 kg. Review of the Treatment Sheet dated 11/30/19 revealed no documentation the prime fluids was given. Review of Treatment Sheet dated 12/3/19 revealed a pre-treatment weight of 99.5 kg and a post treatment weight of "NA". Further review of the Treatment Sheet revealed, "Actual Target Removal: 5.00 kg", which was 4.5 kg over the target weight. There was no documentation the physician was notified of the patient's post-treatment weight. Review of the Treatment Sheet dated 12/5/19 a pre-treatment BP 220/105 sitting. Review of the intradialytics revealed the following BP's: 11:46 AM: 225/110 12:02 PM: 215/105 12:32 PM: 212/92 1:02 PM: 202/97 1:32 PM: 199/108 2:32 PM: 214/86 3:15 PM: 219/85 3:34 PM: 206/87 3:48 PM: 217/93 Post Treatment: 206/93 There was no documentation the licensed nurse was notified of PI # 8's elevated BP pre-treatment, during treatment or post treatment as directed per the facility policy. There was no documentation the patient received Clonidine, or that the physician was notified of the patient's hypertension. Review of the Treatment Sheet dated 12/12/19 revealed no documentation a rinse back was given at the end of treatment. Interviews were conducted on 1/8/2020 from 10:12 AM to 11:35 AM with EI # 11, EI # 5, RN and EI # 6. EI # 11 stated, "I should have notified the nurse of the patient's target weight". EI # 11 also stated, "I notified the nurse of the patient's BP, but I failed to document it". EI # 5 confirmed he/she failed to administer Clonidine as ordered and notify the physician of the patient's elevated BP. EI # 6 confirmed the fluids were not

documented. 8. PI # 9 was admitted to the facility on 12/9/11 with a primary diagnosis of ESRD. Review of the Treatment Sheet dated 12/24/19 revealed no documentation the prime fluids was given. An interview was conducted on 1/8/2020 with EI # 9 who confirmed the fluids were not documented.

**V0544**

**POC-ACHIEVE ADEQUATE CLEARANCE**

CFR(s): 494.90(a)(1)

Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis.

This STANDARD is not met as evidenced by:

Based on observations, review of facility policy and interviews with the staff it was determined the facility failed to ensure the staff: a) Followed the physician order for the Blood Flow Rates (BFR) and Dialysate Flow Rates (DFR). b) Completed an Against Medical Advice (AMA) Form for early termination of treatment as documented. This affected 6 of 9 incenter medical records reviewed and did affect Patient Identifier (PI) # 4, PI # 5, PI # 7, PI # 9, PI # 6, PI # 3 and had the potential to negatively affect all patients that dialyzed in this facility. Findings include: Facility Policy: Prescribed Treatment Time Not Met Policy #: 1-01-09 Revision Date: October 2019 Purpose: To provide requirements for teammates to follow when a patient's treatment is terminated early. Policy: "A. Completion of the Early Termination of Treatment Against Medical Advice Form. 3. The RN (Registered Nurse) will obtain the patient's signature on the Early Termination of Treatment Against Medical Advice form prior to the patient being rinsed back from their treatment. B. Prescribed Treatment Time Not Met 1. If shortened/early termination time exceeds 30 or more minutes, the RN will notify the patient's attending nephrologist to discuss the appropriate intervention ... 3. If a patient's treatment is shortened/early terminated, the RN will document the event in the patient's medical record. Documentation will include, as appropriate: The amount of time by which the treatment was shortened;... A description of all other interventions planned to address the shortened treatment, including recommendations to the patient; and A copy of the Early Termination of Treatment Against Medical Advice form signed by the patient, if shortened voluntarily by patient. 1. PI # 4 was admitted on 8/14/14 with a primary diagnosis of End Stage Renal Disease (ESRD). Review of the Hemo (Hemodialysis) Treatment Orders dated 6/16/19 revealed an order for the BFR to run at 450 and the DFR at 800. Review of the 12/23/19 and 12/26/19 Treatment Sheet's revealed the DFR was ran at 600 the entire treatment. There was no documentation why the DFR was not ran at physician's ordered rate of 800. Review of the Treatment Sheet dated 12/31/19 revealed the BFR was decreased to 400 at 6:32 AM and then decreased to 350 at 9:02 AM. There was no documentation why the BFR was decreased and not ran at the ordered rate of 450. Review of the Treatment Sheet dated 1/4/2020 revealed the DFR ran at 600 the entire treatment. There was no documentation why the DFR was not ran at physician's ordered rate of 800. Further review of the 1/4/2020 Treatment Sheet revealed the BFR was decreased to 350 at 8:02 AM and then decreased to 315 at 8:32 AM. There was no documentation why the BFR was decreased and not ran at the ordered rate of 450. Interviews were conducted on 1/8/2020 from 10:00 AM to 11:05 AM with Employee Identifier (EI) # 9, RN, EI # 4, Certified Clinical Hemodialysis Technician (CCHT), EI # 11, CCHT and EI # 8, CCHT, EI # 1, Facility Administrator, who confirmed there was no documentation why the BFR's and DFR's were not ran at the ordered rates on the aforementioned dates. 2. PI # 5 was admitted

to the facility on 5/6/10 with a primary diagnosis of ESRD. Review of the Hemo Treatment Orders dated 11/18/19 revealed an order for the BFR to run at 450. Review of the Treatment Sheet dated 12/24/19 revealed the BFR was decreased to 400 at 9:32 AM. There was no documentation why the BFR was decreased and not ran at the ordered rate of 450. Review of the Treatment Sheet dated 12/27/19 revealed the BFR was decreased to 325 at 9:32 AM and then decreased to 250 at 2:01 PM. There was no documentation why the BFR was decreased and not ran at the ordered rate of 450. Review of the Treatment Sheet dated 1/1/2020 at 10:59 AM revealed the BFR was ran at 350 and then decreased to 300 at 12:00 PM, 250 at 1:00 PM, 200 at 1:22 PM and at 2:00 PM the BFR was increased to 300. There was no documentation why the BFR was not ran at the ordered rate of 450. Review of the Treatment Sheet dated 1/3/2020 revealed the BFR was decreased to 400 at 12:10 PM. There was no documentation why the BFR was decreased and not ran at the ordered rate of 450. Review of the Treatment Sheet dated 1/6/2020 revealed the BFR ran the entire treatment at 400. There was no documentation why the BFR not ran at the ordered rate of 450. Interviews were conducted on 1/8/2020 from 10:33 AM to 12:15 PM with EI # 6, CCHT, EI # 8, EI # 11, CCHT, EI # 5, RN, and EI # 1 who confirmed there was no documentation why the BFR's were not ran at the ordered rates on the aforementioned dates. 3. PI # 7 was admitted to the facility on 7/6/18 with a primary diagnosis of ESRD. Review of the Hemo Treatment Orders dated 6/16/19 revealed an order for the BFR to run at 350. Review of the Treatment Sheet dated 12/23/19 revealed the BFR was decreased to 325 at 6:33 AM and then decreased to 300 at 7:00 AM. There was no documentation why the BFR not ran at the ordered rate of 350. Review of the Treatment Sheet dated 12/26/19 and 12/31/19 revealed the BFR's ran the entire treatment at 400. There was no documentation why the BFR not ran at the ordered rate of 350. Interviews were conducted on 1/8/2020 at 10:28 AM with EI # 6 and EI # 4 who confirmed there was no documentation why the BFR's were not ran at the ordered rates on the aforementioned dates. 4. PI # 9 was admitted to the facility on 12/9/11 with a primary diagnosis of ESRD. Review of the Hemo Treatment Orders dated 6/16/19 revealed an order for the DFR to run at 800 and a treatment time of 195 minutes. Review of the Treatment Sheet dated 12/30/19 revealed the DFR the entire treatment at 600. There was no documentation why the DFR not ran at the ordered rate of 800. Review of the Treatment Sheet dated 1/6/2020 revealed a duration of 160 minutes, which was 35 minutes less than ordered. There was no documentation the physician was notified per policy. The surveyor requested the AMA form signed by the patient. None was provided. Interviews were conducted on 1/8/2020 from 10:45 AM with EI # 4 and EI # 1. EI # 4 confirmed there was no documentation why the DFR was not ran at the ordered rate. EI # 1 confirmed there was no AMA form completed per policy. 39098 5. PI # 6 was admitted to the facility on 2/19/13 with a primary diagnosis of ESRD. Review of the Hemo Treatment Orders dated 7/24/19 revealed a treatment time of 240 minutes. Review of the Treatment Sheet dated 1/6/2020 revealed a duration of 187 minutes, which was 53 minutes less than ordered. There was no documentation the physician was notified per policy. The surveyor requested the AMA form signed by the patient. None was provided. An interview was conducted on 1/8/2020 at 10:36 AM with EI # 1, who confirmed an AMA form was not completed. 6. PI # 3 was admitted to the facility on 12/4/95 with a primary diagnosis of ESRD. Review of the Treatment Sheet dated 12/26/19 revealed an ordered treatment duration of 210 minutes. The duration documented for the treatment was 197, which was 13 minutes less than ordered. The surveyor requested the AMA form signed by the patient and none was provided. An interview was conducted on 1/8/20 at 10:11 AM with EI # 1, who confirmed there was no AMA form completed.

CFR(s): 494.110(a)(2)

The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves.

This STANDARD is not met as evidenced by:

Based on review of the FHR (Facility Health Record), Discharge Patient Census Report, Mortality Review Form, policy and staff interview, it was determined the Quality Improvement Committee failed to analyze and trend patient's mortality and causes. This had the potential to negatively affect all patients served by this facility. Findings include: Title: Continuous Quality Improvement Program Policy: 1-14-06 Revision Date: October 2017 Purpose: To improve patient safety and outcomes...in accordance with the Quality Assessment and Performance Improvement (QAPI) requirements in the CMS (Centers for Medicare and Medicaid Services) Conditions for Coverage. Policy 1. Each dialysis facility will have a Continuous Quality Improvement (CQI) Committee.... 2. ...the CQI committee to review issues and indicators regarding facility's management and performance... 3. Written documentation and plans of action will be documented... 4. The Facility Medical Director is responsible for promoting the execution as well as participation in the Quality Improvement program... 7. The facility will measure, analyze, and track quality indicators ...not limited to, the following ...Mortality- review of deaths... 8. Continuous monitoring of the above indicators will be reflected in the meeting minutes. Any area identified as underperforming will be reviewed to identify root causes... 1. Review of the FHR documentation for Mortality 2019 was conducted on 1/8/2020 at 12:40 PM with Employee Identifier (EI) # 1, Facility Administrator. Review of the Discharge Patient Census Report from 1/1/19 to 12/31/19 revealed the facility had 11 patient's "expired". Review of the facility Mortality Review Form's revealed the following: 3 Mortality death reviews completed 3 Mortality death review incomplete (2 items per form completed) 5 Mortality death reviews not performed The surveyor how the deaths were trended, and an analysis of any contributory factors was reviewed for all deaths. There was no documentation the facility staff conducted an analysis of individual deaths to recognize trends in causes and contributory factors of deaths and no documentation the CQI Committee discussed results of facility mortality reviews. An interview was conducted on 1/8/2020 at 1:00 PM, with EI # 1, who verified the facility failed to conduct an analysis of all deaths to recognize trends for 2019.

**V0634**

**QAPI-INDICATOR-MEDICAL INJURIES/ERRORS**

CFR(s): 494.110(a)(2)(vi)

The program must include, but not be limited to, the following: (vi) Medical injuries and medical errors identification.

This STANDARD is not met as evidenced by:

Based on review of medical record, observation and interview, it was determined staff failed to complete an adverse event report for a near miss, per policy. This affected 1 of 4 dialysate prescriptions confirmed during the flash tour of the facility. This near miss could have affected Patient Identifier (PI) # 2, and had the potential to affect all patients dialyzing at the facility. Findings include: Policy: Risk Event Reporting

Policy Policy Number: 13-01-02 Revision Date: April 2019 Purpose: To establish the process for handling and investigating Risk Event Management (REM) Reports.

Policy: A. Preparing a Risk Event Management Report (Event Report) 1. Any unexpected event that is inconsistent with the routine operation of a dialysis facility... may be a risk event. Such risk events include... personal injury or potential personal injury to a patient... or 'near miss' events... 2. All risk events will be promptly reported to the Facility Administrator... The teammate involved in the risk event or who witnessed the risk event firsthand will complete a REM Report. The teammate will complete the REM Report as soon after the occurrence as is reasonably possible, but no later than the completion of the teammates' shift during which the risk event happened. B. Handling of the Risk Event Management Report... ...3. RM Reports are to be trended and reviewed during the Facility Health Meeting. This includes "Near Miss" events. Any negative trend should result in a plan of action. ...Examples of Reportable Risk Events ...Dialysate Concentrate Issue ...Near Miss Events (use the appropriate adverse occurrence category) 1. PI # 2 was admitted to the facility on 8/2/19 with a primary diagnosis of Acute Kidney Injury. During the flash tour of the facility on 1/6/2020 at 9:43 AM the surveyor asked Employee Identifier (EI) # 7, RN (Registered Nurse) at station # 10 to confirm the dialysis orders and dialysate that the patient had connected. The dialysis machine was connected to the wall bath, which delivers a dialysate of K (Potassium): 2.00, Ca (Calcium): 2.50. Review of the physician's orders revealed the patient was ordered a dialysate of K: 2.00 and Ca: 2.00. The RN immediately retrieved a jug from the supply cart of the correct dialysate, and connected the tubing to the jug. During an interview on 1/8/2020 at 10:25 AM with Employee Identifier # 1, Facility Administrator, the surveyor requested any adverse event reports for PI # 2. EI # 1 stated there was none documented.