

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012502	(X3) Date Survey Completed 09/12/2023
Name of Provider or Supplier Tuscaloosa University Dialysis	Street Address, City, State 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.		

(X4) ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency should be preceded by full regulatory or LSC identifying information)
V0000	An onsite complaint survey was conducted 9/11/23 to 9/12/23 at Tuscaloosa University Dialysis to investigate complaint number AL00045436. The complaint was unsubstantiated with standard level deficiencies cited.
V0147	<p>IC-STAFF EDUCATION-CATHETERS/CATHETER CARE CFR(s): 494.30(a)(2)</p> <p>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].</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records, facility policy, and interviews, it was determined the facility failed to ensure staff documented the care provided to CVC (Central Venous Catheter) per policy. This affected two of two records reviewed with CVC accesses, and did affect Patient Identifier (PI) # 1, PI # 2, and had the potential to affect all patients dialyzing with CVC's. Findings include: Facility Policy: Central Venous Catheter Care Policy number: 1-04-02 Revision date: October 2022 Purpose: To reduce the risk of infection in the patient and to reduce trauma to the catheter and exit site while minimizing blood loss. Policy: 1. Only non-occlusive dressing, such as</p>

sterile gauze pads, will be used. ...2. Dressings are changed every dialysis treatment on: -Newly inserted cuffed catheters. -Cuffed catheter exit sites that are not well healed. -Exit sites with signs and symptoms of infection. -All CVCs not in use. ...4. Cuffed catheters with well-healed exit sites... still require examination and cleaning of exit site each treatment. 10. Acceptable germicidal/disinfectant solutions may include: a. Isopropyl alcohol b. Povidone iodine... c Hypochlorite...only for skin... d. Chlorhexidine Gluconate 2%...only for skin e. Alcavis 50...for CVC caps... 11. CVC capping devices include...Clearguard..end caps... ...15. Document findings and interventions in patient's medical record. 1. PI # 1 was admitted to the facility on 1/13 /23 with a primary diagnosis of End Stage Renal Disease (ESRD). Review of the IDT (Interdisciplinary Team) Rounding Worksheet revealed PI # 1 was allergic to Chlorhexidine. Review of the Treatment Detail Reports (TDR's) dated 8/18/23, 8/21 /23 and 8/25/23 revealed access type: CVC ...Dressing Change: Yes. There was no documentation of the disinfectant used for the CVC exit site care. An interview was conducted on 9/12/23 at 11:36 AM with Employee Identifier (EI) # 1, Facility Administrator, who confirmed there was no documentation of the disinfectant used for the CVC exit site care. 2. PI # 2 was admitted to the facility on 3/29/22 with a primary diagnosis of ESRD. Review of the IDT Rounding Worksheet revealed PI # 2 had no known allergies to disinfectant's. Review of the TDR's dated 8/31/23, 9/2/23 and 9/5 /23 revealed access type: CVC ...Dressing Change: Yes. There was no documentation of the disinfectant used for the CVC exit site care. An interview was conducted on 9 /12/23 at 11:45 AM with EI # 1, who confirmed there was no documentation of the disinfectant used for the CVC exit site care.

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 medical records (MR), facility policies and interviews with the staff it was determined the facility failed to ensure: 1. Normal Saline (NS) used for prime and post treatment rinse was documented. 2. Patient Care Technician (PCT) notified the nurse when blood pressure (BP) readings were abnormal, UF (Ultrafiltration) was decreased or turned off, and when NS was administered. 3. Vital signs were documented at least every 30 minutes. 4. The physician was notified of the patient leaving greater than 1.0 kg (kilograms) over the Target Weight (TW). This deficient practice affected three of three in-center hemodialysis records reviewed and did affect Patient Identifier (PI) # 1, PI # 2, PI # 3, and had the potential to negatively affect all patients dialyzing at this facility. Findings include: Facility Policy: Treatment Initiation Utilizing Fresenius 2008 Series Dialysis Delivery Systems With All Single Use Dialyzer Types and Streamline or Combiset or Nipro Blood Lines Policy#: 1-03-08F Date Revised: October 2021 ...5. Calculate and set ultrafiltration per procedure. Remember to include the priming volume and rinse back. Facility Policy: CWOW (Clinic Without Walls) Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment Policy: 1-03-08 Date Revised: April 2021 Purpose: To obtain...document baseline and ongoing information about the patient before, during and after the dialysis treatment through data collection and nursing assessment...reviewing the patient's response to the treatment and status prior to discharge. Policy: 1. Patient data will be obtained and documented...Measurement of

BP... 9. Intradialytic treatment monitoring...data collection may be performed by the PCT or licensed nurse... a. Vital signs and treatment monitoring: ... For non-nocturnal treatments is completed at least every thirty (30) minutes ... 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 notified the physician...as needed of changes in patient status. 13. All findings, interventions and patient response will be documented... Abnormal Findings Unless other abnormal parameters are established...the following are considered abnormal findings and should be reported to the license nurse and documented in the patient's medical record...the teammate who is observing or collecting information should report to the licensed nurse whenever there is concern for the patient's condition... Fluid Status: ...Post-treatment: If patient is above or below 1 kg (kilogram) from the target weight.

1. PI # 1 was admitted to the facility on 1/13/23 with a primary diagnosis of End Stage Renal Disease (ESRD). Review of the Treatment Detail Report (TDR) dated 8/18/23 revealed there was no documentation of the amount of NS used for the prime at the start of treatment and for the rinse back at the end of treatment. Review of the TDR's dated 8/21/23, 8/25/23 and 9/1/23 revealed there was no documentation of the amount of NS used for the prime at the start of treatment. An interview was conducted on 9/12/23 at 11:36 AM with Employee Identifier (EI) # 1, Facility Administrator, who confirmed the staff failed document the amount of NS given as prime or rinse back.

2. PI # 2 was admitted to the facility on 3/29/22 with a primary diagnosis of ESRD. Review of the TDR's dated 8/31/23, 9/2/23, and 9/5/23 revealed there was no documentation of the amount of NS used for the prime at the start of treatment. An interview was conducted on 9/12/23 at 11:45 AM with EI # 1, who confirmed the staff failed document the amount of NS given as prime at the start of treatment.

3. PI # 3 was admitted to the facility 6/17/11 with a primary diagnosis of ESRD. Review of the IDT (Interdisciplinary Team) Rounding Worksheet: Active Treatment Orders dated 8/22/23 revealed, "Target Weight: 115 kg (kilograms)." Review of the TDR dated 8/29/23 revealed documentation the treatment was started at 6:34 AM with a pretreatment weight of 121.9 kg and ended at 11:09 AM with a post treatment weight of 117.1 kg. There was no documentation the physician was notified of the patient post treatment weight of 2.1 kg over the ordered TW. Review of the TDR's dated 8/31/23 and 9/5/23 revealed there was no documentation of the amount of NS used for the prime at the start of treatment. Review of the TDR dated 9/2/23 revealed there was no documentation of the amount of NS used for the prime at the start of treatment and for the rinse back at the end of treatment. Review of the TDR dated 9/5/23 revealed documentation the treatment was started at 6:21 AM with a pretreatment weight of 121.1 kg and ended at 10:29 AM with a post treatment weight of 117.2 kg. There was no documentation the physician was notified of the patient post treatment weight of 2.2 kg over the ordered TW. Further review of the TDR dated 9/5/23 at 8:33 AM revealed, "BP low (95/64): UF goal decreased and at 9:03 AM UF turned off per pt (patient) request. BP improved (147/90). 200 cc (centimeters) NS. There was no documentation the staff notified the nurse of the low BP and UF decreased and turned off the per facility policy. There was no reason documented why the 200 cc NS was administered. Continued review of the 9/5/23 TDR revealed a BP and pulse documented at 9:03 AM. The next BP and pulse was documented at 10:26 AM, which was 83 minutes later. The staff failed to document vital signs every 30 minutes per facility policy. Review of the TDR dated 9/7/23 revealed documentation the treatment was started at 6:25 AM with a pretreatment weight of 121.4 kg and ended at 10:20 AM with a post treatment weight of 117.4 kg. There was no documentation the physician was notified of the patient post treatment weight of 2.4 kg over the ordered TW. Review of the TDR dated 9/9/23 revealed documentation the treatment was started at 6:24 AM with a pretreatment weight of 120.8 kg and ended at 10:53 AM

with a post treatment weight of 117.0 kg. There was no documentation the physician was notified of the patient post treatment weight of 2.0 kg over the ordered TW. An interview was conducted on 9/12/23 at 11:47 AM with EI # 1 who confirmed the staff failed to document the amount of NS given as prime or rinse back, document vital signs every 30 minutes, and notified the nurse when BP readings were abnormal, UF was decreased or turned off, and NS administered. EI # 1 also verified the staff failed to notify the physician of the patient leaving greater than 1.0 kg over the TW.

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 review of medical records, facility policy, and interviews with staff, it was determined the facility failed to ensure staff documented and reported early termination of treatments to the physician, per policy. This affected two of three in-center records reviewed including Patient Identifier (PI) # 1, PI # 3, and had the potential to negatively affect all patients dialyzing at this facility. Findings include: Facility Policy: CWOW (Clinic Without Walls) Prescribed Treatment Time Not Met Policy number: 1-01-09 Date revised: October 2022 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 1. The RN (Registered Nurse) will verify that a patient signs the Early Termination of Treatment Against Medical Advice form any time the patient requests to terminate their treatment earlier than the prescribed run time. ...3. The RN will obtain the patient's signature on the... form prior to the patient being rinsed back from their treatment... 4. A RN must countersign all... forms. A witness signature is required only if the patient refuses to sign the form... B. Prescribed Treatment Time Not Met 1. If shortened/ early termination of treatment time exceeds 30 or more minutes, the RN will notify the patient's attending nephrologist to discuss the appropriate interventions (if any)... 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 why the treatment was shortened; - Whether the patient's nephrologist was notified... - A copy of the Early Termination of Treatment Against Medical Advice form... ...5. The facility's FA (Facility Administrator) will verify that all shortened treatments are recorded and trended, and the FA shall verify that such records are reviewed and discussed at the Facility Health Meetings (FHM), as appropriate... 1. PI # 1 was admitted to the facility on 1/13/23 with a primary diagnosis of End Stage Renal Disease (ESRD). Review of the Treatment Detail Report (TDR) revealed the dialysis prescription for a treatment time of 3 hour 15 minutes. Review of the TDR dated 8/18/23 revealed the treatment start time was 2:30 PM and the end time was 4:32 PM (2 hours and 2 minutes). There was no documentation of an AMA form being obtained for early termination of treatment. There was no documentation the RN notified the physician, per policy. An interview was conducted on 9/12/23 at 11:36 AM with Employee Identifier (EI) # 1, FA, who confirmed the staff failed to document and report the early termination of treatment to the physician, per policy. 2. PI # 2 was admitted to the facility on 3/29/22 with a primary diagnosis of ESRD. Review of the IDT (Interdisciplinary Team) Rounding

Worksheet: Active Treatment Orders dated 8/22/23 revealed, "Tx (Treatment) Time: ... 270 mins (minutes)." Review of the TDR dated 9/7/23 revealed the treatment start time was 6:25 AM and the end time was 10:20 AM (235 minutes). There was no documentation of an AMA form being obtained for early termination of treatment. There was no documentation the RN notified the physician, per policy. An interview was conducted on 9/12/23 at 11:47 AM with EI # 1, who confirmed the staff failed to document and report the early termination of treatment to the physician, per policy.