

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  012505	<b>(X3) Date Survey Completed</b>  07/26/2018
<b>Name of Provider or Supplier</b>  Physicians Choice Dialysis-Montgomery	<b>Street Address, City, State</b>  1001 Forest Avenue, Montgomery, 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>	Based on the recertification survey conducted on 7/24/18 to 7/26/18, Physicians Choice Dialysis Montgomery was in substantial compliance with the Centers of Medicare Medicaid Services requirements for Emergency Preparedness.
<b>V0000</b>	"CORE" A recertification survey was completed on 7/26/18 at PCD-Montgomery. Condition level deficiencies were cited at 494.30, Infection Control, and other standard level deficiencies were cited.
<b>V0110</b>	CFC-INFECTION CONTROL CFR(s): 494.30  This CONDITION is not met as evidenced by: Based on observation, review of facility policies, Hepatitis B Report, Daily Patient Schedule, team staffing schedule, Centers for Medicare and Medicaid (CMS) ESRD (End Stage Renal Disease) CORE Survey Observations of Hemodialysis Care and Infection Control Practices worksheet, medical records and interview, it was determined the facility failed to ensure: 1. All dialysis treatment chairs were free from tears in the vinyl 2. All staff performed hand hygiene according to the facility policy and the CMS ESRD Core survey infection control practice worksheet. 3. All staff followed the policy for disinfection of the dialysis station. 4. All equipment used in the isolation room was designated and labeled for "isolation" only". 5. All teammates caring for confirmed or suspect hepatitis B surface antigen positive (HBsAg) positive patient (s) do not care for surface antibody negative (susceptible/ non-immune) patients simultaneously. Refer to V 111, V 113, V 122, V 130, V 131 for additional findings.
<b>V0111</b>	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 observations and interview, it was determined the facility staff failed to ensure all dialysis treatment chairs were free from tears in the vinyl. This affected all patients dialyzed in the isolation unit. Findings include: A tour of the isolation unit, station 15, was performed on 7/24/18 at 2:50 PM. The dialysis treatment chair had two tears in the vinyl on the right arm rest. The 2 tears would prevent the treatment chair from being properly disinfected between patients. An observation of care and interview was conducted on 7/25/18 at 10:30 AM with Employee Identifier (EI) # 8, Registered Nurse. Following disinfection of the isolation station, EI # 5 confirmed the treatment chair vinyl was torn in 2 places on the right arm rest. In an interview on 7/26/18 at 12:00 PM, EI # 1 Facility Administrator confirmed the aforementioned finding.

**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, facility policies and procedure for hand hygiene, the CMS (Centers for Medicare and Medicaid Services) ESRD (End Stage Renal Disease) Core Survey Hemodialysis Care and Infection Control Practices Worksheet and staff interview, it was determined the facility failed to ensure staff performed hand hygiene according to the facility policy and the CMS ESRD Core survey infection control worksheet requirements. This affected Patient Identifier (PI) # 4, which was 1 of 3 access cannulation's observed and this had the potential to negatively affect all patients who dialyzed at the facility. Findings include: Title: Infection Control for Dialysis Facilities Policy: 1-05-01 Revision Date: April 2018 "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 contamination with blood or other infectious material, after patient and dialysis delivery system contact, between patients even if the contact is casual, before touching clean areas such as supplies and on exiting the patient treatment area... Teammate / Patient Safety 11. Teammates will wear disposable 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... Title: Handwashing Procedure: 1-05-01B Revision Date: September 2016 Materials required: Antibacterial liquid soap Water Paper towels ...3. Cover hands...and wrists with later and wash vigorously... 4. Rinse well... 5. Dry hands thoroughly with paper towels. 6. If sink is not pedal operated operated, turn faucet off with elbows or paper towels..." CMS Core Survey Worksheet Version 1.5 Access of AV (arteriovenous) or Graft for Initiation of Dialysis ...Action ...Evaluate access: Locate/palpate cannulation site Hand Hygiene (remove gloves if worn); don clean gloves... \*\*\*\*\* During observations of care on 7/24/18 at 12:00 PM, Employee Identifier (EI) # 6, Certified Clinical Hemodialysis Technician (CCHT) evaluated the access site using the stethoscope,

then completed access site antiseptics and cannulation. EI # 6 failed to remove gloves and perform hand hygiene after access site evaluation. During observations of care conducted on 7/25/18 at 11:50 AM, EI # 4, CCHT performed hand hygiene at the clean sink across from station 2. EI # 4 turned the faucet off with bare hands. An interview was conducted on 7/26/18 at 12:00 PM with EI # 1, Facility Administrator, who verified EI # 5 failed to follow the facility hand hygiene policy and procedure.

**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 observation, facility policy and staff interview, the facility failed to ensure staff followed the policy for disinfection of the dialysis station. This had the potential to affect all patients who dialyzed at the facility. Findings include: Title: Infection Control For Dialysis Facilities Policy: 1-05-01 Revision Date: April 2018 "Purpose: To minimize the spread of infections 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 an appropriate disinfectant after every treatment. \*\*\*\* 1. During observations of care on 7/24/18 at 10:10 AM, the surveyor observed Employee Identifier (EI) # 4, Certified Clinical Hemodialysis Technician (CCHT), clean the hemodialysis (HD) machine at station # 7. EI # 4 failed to remove and disinfect the prime waste container that contained clear solution. EI # 4 retrieved and placed dialysis supplies on top of the HD machine, opened the saline solution and placed solution lines into the dirty prime container. The surveyor interviewed EI # 4 at 10:15 AM regarding the HD disinfection and prime container. EI # 4 removed the dirty prime container from the HD machine, emptied, cleaned, dried and replaced the clean container on the contaminated HD machine. EI # 4 then discarded the dialysis supplies, but EI # 4 failed to disinfect the HD machine after removing the dirty prime container. An interview was conducted on 7/24/18 at 10:55 AM with EI # 2, Clinical Nurse Manager, who verified the aforementioned findings. EI # 2 instructed EI # 4 to discard the dialysis supplies, disinfect the HD machine and prepare the station with new dialysis supplies. 2. Observations of care on 7/25/18 at 9:35 AM at station 15, the isolation unit was conducted with EI # 3, Registered Nurse. EI # 3 disinfected the dialysis station but failed to clean the blood pressure cuff/tubing, wire basket, call light, green supply bag and top of the sharps container. In an interview on 7/25/18 at 10:00 AM, EI # 3 confirmed the above findings.

**V0130**

**IC-HBV-ISOLATION-MACHINES/EQUIP/SUPPLIES**  
CFR(s): 494.30(a)(1)(i)

Isolation of HBV+ Patients To isolate HBsAg positive patients, ... dedicate machines, equipment, instruments, supplies, and medications that will not be used by HBV susceptible patients.

This STANDARD is not met as evidenced by:  
 Based on observation, review of facility policy, and interviews, it was determined the facility failed to ensure all equipment used in the isolation room was designated and labeled for "isolation" only. This had the potential to affect all Hepatitis B susceptible patients and staff at the facility. Findings include: Title: Infection Control and Isolation Measures for known or Suspected Hepatitis B Surface Antigen Positive Patients Policy #: 1-05-09 Revision Date: April 2017 Purpose: To provide additional infection control measures for care of the suspected or confirmed hepatitis B surface antigen (HBsAg) positive patient. Note: Policy will be followed at all times. In addition, teammates caring for the hepatitis B surface antigen positive (HBsAg) patient will observe the following precautions... Confirmed Hepatitis B Surface Antigen Positive "...2. Patients who are confirmed hepatitis B surface antigen positive (HBsAg) are dialyzed on a dialysis delivery system dedicated for use by surface antigen positive...patients only... 3. A dialysis delivery system dedicated for use only by Hepatitis B surface antigen positive (HB sAg) patients will be used. Establishing an Isolation Area/Room... 17. Ancillary supplies such as blood pressure cuffs, clamps, tourniquets, stethoscope, blood glucose meter, bicarb/dialysate jugs, bleach buckets, sharps container, thermometer, pens, centrifuge, and non-disposable items are designated for use by ... (HBsAg) positive patients only. Such supplies will be labeled "isolation" and will remain in the isolation room/area and be disinfected after every patient use with a 1:100 (one to one hundred) bleach solution..." 1. On 7/25/18 at 9:30 AM, following observations of care with Employee Identifier # 3, Registered Nurse, the isolation station equipment was inspected. There was no isolation label on the following equipment/supplies: Dialysis machine # 18 Patient treatment chair IV (intravenous) medication pump Centrifuge Glucometer Stethoscope Computer Terminal Sharps and and biohazard container Plastic dialysis supply container Bleach containers 1 Chair and 1 stool An interview conducted on 7/26/18 at 12:00 PM. EI # 1, Facility Administrator confirmed the findings above.

**V0131**

**IC-HBV-ISOLATION-STAFFING**  
 CFR(s): 494.30(a)(1)(i)

Isolation of HBV+ Patients Staff members caring for HBsAg positive patients should not care for HBV susceptible patients at the same time, including during the period when dialysis is terminated on one patient and initiated on another.

This STANDARD is not met as evidenced by:  
 Based on review of facility policy, the Hepatitis B Report, team staffing schedule, Patient Call Back Schedule, medical records and interviews with facility staff, it was determined the facility failed to follow the facility policy and ensure teammates caring for confirmed or suspect hepatitis B surface antigen positive (HBsAg) positive patient (s) do not care for surface antibody negative (susceptible/ non-immune) patients simultaneously. This affected 5 of 5 Hepatitis surface antibody negative (susceptible) patients, which included Patient Identifiers' (PI) # 14, 15, 16, 17 and 18 who dialyzed at the same time as HBsAg positive patients. This had the potential to negatively affect all susceptible (non-immune) patients and staff. Findings include: POLICY: 1-05-09 Title: Infection Control and Isolation Measures for Known or Suspected Hepatitis B Surface Antigen Positive Patients Revision Date: April 2017 Purpose: To provide additional infection control measures for care of the suspected or confirmed hepatitis B surface antigen (HBsAg) positive patient. "...Patient Seating and Teammate Assignments 33. Surface antibody positive (immune) patients are seated between the confirmed hepatitis B surface antigen (HBsAg) positive patient and the

susceptible patient to serve as a geographical buffer. 34. Teammates caring for confirmed or suspect hepatitis B surface antigen positive (HBsAg) positive patient(s) do not care for surface antibody negative (susceptible) patients simultaneously. 35. When preparing patient assignments, teammates who care for confirmed or suspected hepatitis B surface antigen (HBsAg) positive patient (s) will only be assigned to simultaneously care for surface positive (immune) patients. 39. It is recognized that some small facilities may only have one (1) nurse on duty per shift...In such cases... verify all other patients scheduled for treatment on the same shift as a HBsAG positive patient...are immune. Scheduling HBsAg positive patient at the end of the day...after ALL Susceptible patients have completed treatment AND exited the treatment area. 40. Facilities that are unable to meet there requirements above will make arrangements with another facility...to accept HBsAg + patients in accordance with CMS (Centers for Medicare and Medicaid Services)... " \*\*\*\* During the facility entrance conference on 7/24/18 at 8:15 AM, Employee Identifier (EI) # 2, Clinical Nurse Manager (CNM) reported the facility had an isolation unit with 1 HBsAg positive patient, Patient Identifier (PI) # 19 who dialyzed on Monday, Wednesday and Friday (M/W/F) on first shift and 1 HBsAg positive patient, PI # 20 who dialyzed on second shift. Observations of care on 7/24/18 from 8:30 AM to 12:40 PM revealed 1 Registered Nurse (RN), EI # 2, the CNM providing care for all facility patients. Review of the facility team staffing schedule for July submitted to the surveyor on 7/24/18 revealed 1 RN scheduled to work on Monday 7/2/18, on Wednesday 7/4/18, on Friday 7/14/18 and on Friday 7/27/18. Review of the Patient Call Back Schedule submitted to the surveyor on 7/24/18 revealed that on M/W/F, 1 HBsAg positive, PI # 19 scheduled for first shift and 2 HBV susceptible patients for first shift. On second shift, there was 1 HBsAg positive patient, PI # 20 and 3 HBV susceptible patients scheduled. In an interview conducted on 7/25/18 at 10:05 AM, EI # 2 reported there were not always 2 RN's to work on M/W/F, which was the days both HBV + patients dialyzed. EI # 2 verified one RN would care for both HBsAg positive and HBV susceptible patients at the same time. Review of the Hepatitis Report provided to the surveyor on 7/24/18 confirmed PI's # 14, # 15, # 16, # 17 and # 18 were HBsAg negative with hepatitis B antibodies less than 10, insufficient for protection against HBV. Review of facility post treatment report documentation on the following dates revealed EI # 3, RN and EI # 2, CNM provided care simultaneously to HBsAg positive and HBV susceptible: On 7/2/18 and 7/4/18 first shift, EI # 3 cared for HBsAg positive, PI # 19 and HBV susceptible patients, PI # 14 and PI # 15. On 7/2/18 and 7/4/18 second shift, EI # 3 cared for HBsAg positive PI # 20 and PI # 16 and # PI # 17, both susceptible. On 7/13/18 first shift, EI # 3 cared for PI # 19 HBsAg positive and PI # 14 and # 18, both HBV susceptible. On 7/13/18 second shift, EI # 3 and EI # 2 provided care to HBsAg positive patients and PI # 17, susceptible patient. EI # 3 also cared for and susceptible, PI # 16. On 7/16/18 first shift, EI # 3 cared for PI # 19 HBsAg positive and PI # 14 and # 18, both susceptible. On 7/16/18 second shift, EI # 2 provided care to HBsAg positive PI # 20, and HBV susceptible, PI # 17. On 7/18/18 first shift, EI # 3 provided care to HBsAg positive patient, PI # 19 and PI # 18, who was susceptible. In an interview on 7/26/18 at 12:00 PM, EI # 1, Facility Administrator reported all facilities were short staffed. EI # 2, CNM and EI # 1 both confirmed they knew 1 RN was scheduled to provide care for both HBsAg positive and surface antibody negative (susceptible) patients simultaneously.

**V0250**

**DIALYS PROPOR-T-MONITOR PH/CONDUCTIVITY**  
CFR(s): 494.40(a)

5.6 Dialysate proportioning: monitor pH/conductivity It is necessary for the operator to follow the manufacturer's instructions regarding dialysate conductivity and to

measure approximate pH with an independent method before starting the treatment of the next patient.

This STANDARD is not met as evidenced by:

Based on observations, review of facility policies / procedures and interviews, it was determined the facility failed to ensure: 1. Staff followed the facility procedure for monitoring dialysate conductivity prior to treatment initiation 2. Staff rinsed the Myron L meter with dialysis quality water post testing. 3. The hemodialysis machine conductivity was within acceptable range +/- 0.4 mS (millisiemens) of the manual conductivity testing. This affected 2 of 6 in-center hemodialysis records reviewed, including Patient Identifier (PI) # 6 and PI # 7 and had the potential to negatively affect all patients who dialyze at this facility. Findings include: Facility Procedure: Title: Testing Dialysate Conductivity with Dual Range Myron L Meter (D-2) Procedure: 2-08-01E ... Procedure: ... 3. Obtain proportioned dialysate sample per manufacture's recommendations. 4. Rinse meter by filling cell cup with sample above top electrode and dropping plunger into sample to be tested 3 or 4 times and discard. Perform this step at least three (3) times. Rationale: 4. Verifies that any prior sample solution has been rinsed free from the cell. Procedure: 5. Fill cell cup with sample so upper electrode is immersed. Insert plunger. Press Read/Check battery button and read conductivity on appropriate scale. Rationale: 5. If electrode is not immersed, results may be affected. Procedure: 6. Repeat step % 3 twice and record the last reading... 9. When test is complete, rinse cell cup and plunger with dialysis quality water... Facility Policy Title: Testing pH and Conductivity if Proportioned Dialysate and verification of Temperature of Proportioned Dialysate Policy: 1-03-02 Purpose: To provide guidance for testing and documenting pH, conductivity and temperature of proportioned dialysate. Policy: ... 4. The acceptable range for machine displayed and final dialysate conductivity is 12-15.5 mS. (See step 5 below.) If the physician orders dialysate sodium of 136 or less in specific circumstances, then the acceptable range for final dialysate conductivity is 12.8 - 15.5 mS. If the machine displayed and final dialysate conductivity is not within this range, do not initiate treatment and investigate the reason the values are outside the acceptable range. 5. The final dialysate conductivity should be checked with approved independent meter. Independent meter reading should be +/- 0.4 mS of the machine displayed conductivity based on your facility's machine type: Fresenius Machine - TCD... (Note: This facility utilizes Fresenius 2008K machines) On 7/24/18 at 11:24 AM, the surveyor observed Employee Identifier (EI) # 4, Certified Clinical Hemodialysis Technician (CCHT) perform testing of dialysate. EI # 4 filled, rinsed and emptied the cup on the plunger three (3) times with dialysate sample. EI # 4 poured the next sample of the dialysate into the cell cup of the Myron L meter, then tested the sample. On 7/24/18 at 12:01 PM, the surveyor observed EI # 5, CCHT perform testing of dialysate. EI # 5 filled, rinsed and emptied the cup on the plunger one (1) time with dialysate sample. EI # 5 poured the next sample of the dialysate into the cell cup of the Myron L meter, then tested the sample. Both EI # 4 and EI # 5 failed to rinse the cell cup of the Myron L with dialysate 3 or 4 times prior to testing the sample and failed to rinse the Myron L with dialysate quality water after testing was completed. 1. PI # 6 was admitted to this facility on 7/7/14 with End Stage Renal Disease (ESRD) and was receiving in-center hemodialysis three times a week. Review of the Post Treatment Flowsheet dated 6/11 /18 revealed the manual conductivity was 14.1 and the machine conductivity was 13.6, which was 0.5 mS greater than the machine conductivity. An interview was conducted on 7/26/18 at 11:35 AM with EI # 1, Facility Administrator, who verified the above findings. 2. PI # 7 was admitted to this facility on 12/21/16 with ESRD and was receiving in-center hemodialysis three times a week. Review of the Post

Treatment Flowsheet dated 7/12/18 revealed the manual conductivity was 14.4 and the machine conductivity was 13.6, which was 0.8 mS greater than the machine conductivity. Review of the Post Treatment Flowsheet dated 7/17/18 revealed the manual conductivity was 14.1 and the machine conductivity was 13.6, which was 0.5 mS greater than the machine conductivity. An interview was conducted on 7/26/18 at 11:53 AM with EI # 1, who verified the above findings.

**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 facility policy, medical records and interviews, it was determined the facility staff failed to notify the licensed nurse and / or physician of patients with abnormal blood pressures. This affected Patient Identifier (PI) # 6 and PI # 7, 2 of 6 in-center hemodialysis patients and had the potential to negatively affect all patients that dialyze at this facility. Findings include: Facility Policy Title: Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment Policy: 1-03-08 Purpose: To obtain and document baseline and ongoing information about the patient before, during and after the dialysis treatment through data collection and nursing assessment. This information will be used in planning and documenting the patient's dialysis treatment, monitoring during treatment and for reviewing the patient's response to the treatment and status prior to discharge... Policy: ... Intradialytic Data Collection/Assessment ... 9. Intradialytic treatment monitoring and data collection which may be performed by the PCT (Patient Care Technician) or licensed nurse includes: a. Vital signs and treatment monitoring i. For non-nocturnal treatment 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 (refer to "Abnormal Findings" section in this policy). The licensed nurse will use his/her clinical judgement based on individual patient needs to determine if any clinical interventions are necessary. 12. The licensed nurse notifies the physician (or AHP {Allied Health Professional} if applicable) as needed of changes in patient status... Abnormal Findings: ... Members of the patient care team should report ANY changes in patient conditions or concerns of patient well-being immediately to the licensed nurse at any time... Blood Pressure - Intradialytic: Difference of 20 mm/Hg (milli-meter/ Mercury) increase or decrease from patient's last intradialytic treatment BP (blood pressure) reading... 1. PI # 6 was admitted to the facility on 7/7/14 with End Stage Renal Disease (ESRD) and was receiving in-center hemodialysis treatments three times a week. Review of the Post Treatment Flowsheet dated 6/13/18 revealed the patient's BP was 123/68 at 12:00 PM and 96/61 at 12:31 PM and was 110/60 at 12:32 PM, when it was retaken, 68/41 at 1:01 PM and 72/42 at 1:02 PM, when retaken and 200 cc (cubic centimeters) of fluid were administered and the nurse was notified at that time. The patient's low BPs were not reported to the licensed nurse immediately according to the facility policy. Review of the Post Treatment Flowsheet dated 6/18/18 revealed the patient's BP was 140/56 at 1:30 PM, 111/46 at 2:01 PM, 108/36 at 2:31 PM and 107/53 at 2:49 PM. There was no documentation the nurse was notified of the drop in the patient's BP. Review of the Post Treatment Flowsheet dated 6/20/18 revealed the patient's BP was 104/48 at 10:30 AM, 85/56 at 10:30 AM, 101/48 at 10:32 AM, 57/18 at 11:02 AM and 85/34 at 11:10

AM. There was no documentation the nurse was notified of the patient's low BPs. Review of the Post Treatment Flowsheet dated 6/25/18 revealed the Registered Nurse (RN) documented the patient's BP was 93/37 at 11:18 and 91/32 at 11:21 AM. There was no documentation the nurse notified the physician or AHP of the patient's low BPs. Further review of the Post Treatment Flowsheet dated 6/25/18 revealed the PCT documented the patient's BPs as follows: 79/29 at 11:37 AM, 63/23 at 11:39 AM, 84/37 at 11:42 AM, 92/40 at 12:01 PM, 76/24 at 12:43 PM, 83/36 at 12:46 PM, 84/34 at 1:01 PM and 89/46 at 1:04 PM. There was no documentation the PCT notified the nurse of the patient's low BPs. An interview was conducted on 7/26/18 at 11:35 AM with Employee Identifier (EI) # 1, Facility Administrator, who verified the above findings. 2. PI # 7 was admitted to this facility on 12/21/16 with ESRD and was receiving in-center hemodialysis three times a week. Review of the Physician Orders dated 12/14/16 revealed orders for interventions for Hypertension: If Systolic BP is greater than 180 after 1 hours on dialysis, give clonidine 0.1 mg (milli-gram). May repeat 2 times. If remains greater than 180, notify MD (Medical Doctor). Review of the Post Treatment Flowsheet dated 7/10/18 revealed the patient's BP was 167/87 at 12:30 PM, 193/82 at 1:00 PM, 189/90 at 2:00 PM and 185/86 at 2:30 PM. There was no documentation the nurse was notified of the patient's increased BP. Review of the Post Treatment Flowsheet dated 7/12/18 revealed the patient's BP was 194/63 at 1:02 PM, 189/95 at 2:02 PM and 200/85 at 2:32 PM. The patient's post treatment BP was 185/81 at 2:47 PM. There was no documentation of interventions for hypertension, nor was there documentation the nurse notified the physician of the patient's elevated BPs. Review of the Post Treatment Flowsheet dated 7/14/18 revealed the patient's pretreatment BP was 202/92 at 10:40 AM. Further review of the Post Treatment Flowsheet dated 7/14/18 revealed the patient's BP was as follows: 191/82 at 10:44 AM, 186/93 at 12:01 PM, 185/96 at 12:52 PM, 196/95 at 1:01 PM and 187/113 at 2:08 PM. There was no documentation the nurse was notified of the patient's increased BP. An interview was conducted on 7/26/18 at 11:53 AM with EI # 1, who verified the above findings.

**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 the observation, review of medical records, facility policies and interviews, it was determined the facility failed to ensure staff: 1) Followed physician orders for BFR (blood flow rate). 2) Completed AMA (Against Medical Advice) forms for all dialysis treatments ending prior to physician ordered time. This affected 1 of 6 in-center hemodialysis patient records reviewed, including Patient Identifier (PI) # 6 and had the potential to negatively affect all patients who receive in-center hemodialysis treatments at this facility. Findings include: Facility Policy Title: Refusal of Care / Treatment Against Medical Advice Policy: 1-01-10 Purpose: To provide requirements for teammates to follow when a patient refuses care or treatment against medical advice. Policy: ... B. Completion of the Refusal of Care / Treatment Against Medical Advice Form 1. The RN (Registered Nurse) will verify that a patient signs the 1-01-01A Refusal of Care / Against Medical Advice form 0417 form if a patient: Refuses their entire dialysis treatment... ... 3. The RN will obtain the patient's signature on the Refusal of Care / Treatment Against Medical Advice form prior to the patient being

rinsed back from their treatment. If unable to obtain the patient's signature prior to rinse-back, the RN will obtain the patient's signature on the form prior to the patient's departure from the facility. 4. The RN must countersign all Refusal of Care / Treatment Against Medical Advice forms. A witness signature is required only if the patient refuses to sign the form. 5. If the patient refuses to sign the Refusal of Care / Treatment Against Medical Advice form, the RN will document the patient's refusal with the words " patient refused" in the patient signature box along with the date. Under such circumstances, the RN will sign the form and will also obtain a witness' signature on the form... Facility Policy Title: Shortened / Early Termination of Treatment or Extended Treatment Policy: 1-01-09 Purpose: To provide requirements for teammates to follow when a patient's treatment is terminated early or extended... ...

B. Shortened / Early Termination of Treatment 1. If shortened / early termination of treatment time exceeds 30 or more minutes, the RN will notify the patient's attending nephrologist to discuss appropriate intervention (if any), including what additional medical orders may be necessary to address the patient's specific needs. NOTE: Shortened / Early Termination of the dialysis treatment included all reasons the prescribed dialysis time is not met by 30 or more minutes. This includes but is not limited to: the late initiation of treatment with termination at scheduled time, early termination at the end of treatment and interruptions of dialysis during the treatment i. e. machine or access problems or use of the bathroom by the patient... 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 description of the follow-up medical orders provided by the patient's attending nephrologist (if any); 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... 4. Additionally, if the patients dialysis is terminated 30 or more minutes prior to the ordered treatment length, the reason and corresponding sub-reason must be documented in ChairSide Snappy or in Snappy while reconciling or late reconciling the treatment times... 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... Medical Record Review: 1. PI # 6 was admitted to the facility on 7/7 /14 with End Stage Renal Disease (ESRD) and was receiving in-center hemodialysis treatments three times a week. Review of the Hemo Treatment Orders dated 5/15/18 revealed the patient's treatment time was 225 minutes. Review of the Post Treatment Flowsheet dated 6/22/18 revealed the patient's treatment was 140 minutes, which was 85 minutes shortened. Further review of the Post Treatment Flowsheet dated 6/22/18 revealed, "... Patient rides with (ambulance name) and was 2 hours late for treatment..." There was no documentation of an Early Termination Against Medical Advice form, nor was there documentation the patient's attending nephrologist was notified of the shortened treatment. Review of the Post Treatment Flowsheet dated 6 /25/18 revealed the patient's treatment was 194 minutes, which was 31 minutes shortened. Further review of the Post Treatment Flowsheet dated 6/25/18 revealed, "... Patient arrived late for treatment..." There was no documentation of an Early Termination Against Medical Advice form, nor was there documentation the patient's attending nephrologist was notified of the shortened treatment. An interview was conducted on 7/26/18 at 11:35 AM with Employee Identified (EI) # 1, Facility Administrator, who verified the above.

V0559

POC-OUTCOME NOT ACHIEVED-ADJUST POC

CFR(s): 494.90(b)(3)

If the expected outcome is not achieved, the interdisciplinary team must adjust the patient's plan of care to achieve the specified goals. When a patient is unable to achieve the desired outcomes, the team must- (i) Adjust the plan of care to reflect the patient's current condition; (ii) Document in the record the reasons why the patient was unable to achieve the goals; and (iii) Implement plan of care changes to address the issues identified in paragraph (b)(3)(ii) of this section.

This STANDARD is not met as evidenced by:

Based on review of facility policy, facility ESRD (end stage renal disease) Core Data Worksheet documentation, medical record and interview, it was determined the staff failed to develop an unstable Plan of Care that included interventions and goals to meet the needs of Patient Identifier (PI) # 4 determined to be unstable -psychosocial needs. This affected 1 of 1 in-center unstable in-center hemodialysis records reviewed and had the potential to affect all unstable patients treated at the facility. Findings include: Policy: 1-14-01 Title: Interdisciplinary teams (IDT) Patient Assessment and Plan of Care Revision Date: April 2017 ...Plan of Care: 8. The facility's interdisciplinary team will develop and implement a written, individualized, comprehensive plan of care that specifies the services necessary to address the patient's needed....and changes in the patient's condition, and will include measurable and expected outcomes and estimated timetables to achieve these outcomes..." Review of the facility ESRD Core Survey Data Worksheet on 7/24/18 revealed the facility designated PI # 4 unstable on 6/21/18 and on 7/5/18, primary reason documented, Psychosocial. Medical record review revealed the IDT Patient POC Meeting Report dated 7/2/18. The category title, Psychosocial, revealed all goals were met which included stable support system, stable living situation, stable mood and open communication between patient and clinical team. There was no documentation in the 7/2/18 IDT POC regarding PI # 4's unstable behavior, no interventions documented on the unstable POC to address any unstable psychosocial issues, no follow up time frames, no recent trigger date or source, no comments from the MSW or other IDT members and no planned interventions identified to meet the patients' needs. In an interview conducted on 7/26/18 at 11:18 AM, EI # 1, Facility Administrator submitted Registered Nurse documentation dated 6/21/18 regarding aggressive behavior by PI # 4 toward staff, Medical Social Worker (MSW) documentation dated 6/22/18 that revealed RISK (management) was notified regarding the incident and patient will be notified via written letter regarding clinic rules. On 6/25/18, documentation by the MSW concerning the IDT meeting with the patient, provided a copy of Patient Rights and Responsibility, Network 8 information and written warning. MSW will continue to assess and provide referrals, case management and emotional support. There was no documentation in the 7/2/18 POC of the IDT's plan to address the aggressive behavior which deemed the patient unstable for psychosocial reasons. There was no monitoring and interventions, counseling services or referrals to assist PI # 4 in achieving and sustaining an appropriate psychosocial status. During an interview on 7/26/18 at 3:30 PM, the aforementioned findings were confirmed by EI # 1.

**V0599**

**H-RECORDKEEPING SYSTEM**

CFR(s): 494.100(c)(2)

(2) The dialysis facility must maintain a recordkeeping system that ensures continuity of care and patient privacy. This includes items and services furnished by durable medical equipment (DME) suppliers referred to in 414.330(a)(2) of this chapter.

This STANDARD is not met as evidenced by:  
 Based on review of facility policy, medical records and interview, it was determined the facility failed to ensure the home treatment records were complete and accurate with intraperitoneal antibiotic administration for 1 of 1 home peritoneal dialysis patient with physician ordered intraperitoneal antibiotics. This affected Patient Identifier (PI) # 2 and had the potential to negatively affect all patients who perform home peritoneal dialysis in coordination with this facility. Findings include: Facility Policy: Title: Provision of Composite Antibiotics to Peritoneal Dialysis Patients for Catheter Infections and Peritonitis Policy: 5-07-18 Purpose: To assist peritoneal dialysis patients (PD patient) with the procurement and administration of Composite Antibiotics for catheter infections and/or peritonitis... Procedure: D. Entering Orders for Composite Antibiotics in the Electronic Clinical Information System: ... 3. The Facility Administrator (FA) or designee must reconcile home dialysis flowsheets against the PD Encounters and/or Daily Audit Report to verify that Composite Antibiotic administrations are properly documented as either "Nurse Administered / Administered in Facility" or as "Self-Administered / Given at Home". 1. PI # 2 was admitted to the facility 1/25/18 with End Stage Renal Disease and the patient was performing home PD seven (7) days a week. Review of the Physician orders contained Vancomycin 1000 mg (milli-grams) intraperitoneal for 6/16/18, 6/21/18 and 6/26/18. Review of the Daily Home Records dated 6/6/18 to 6/30/18 revealed no documentation the patient administered intraperitoneal Vancomycin. An interview was conducted on 7/26/18 at 11:06 AM with Employee Identifier # 7, Home Program Manager, who verified the above.

**V0628**

**QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS**  
 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) documentation, Pre Survey DFR (Dialysis Facility Report) Extract, policy and staff interview, it was determined the Quality Improvement Committee failed to accurately analyze and trend patient's mortality and causes. This affected Patient Identifier (PI) # 9 and had the potential to negatively affect all patients who dialyzed at the facility. Findings include: Policy:1-14-06 Title: Continuous Quality Improvement Program 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 verifying the execution of the Quality Improvement program... 7. The facility will measure, analyze, and track quality indicators...not limited to, the following...Infection Control...Vascular Access... Mortality-review of deaths... 8. Continuous monitoring of the above indicators will be reflected in the meeting minutes. Any area identified as under performing will be

reviewed to identify root causes...will have an action plan identified...track this change in performance ...to verify improvements are sustained... \*\*\*\* 1. Review of the Fiscal Year 2018 Pre-Survey DFR Extract printed 7/23/18 prior to the survey revealed this facility had a 15.4 % (percent) Death due to Infection rate and the U.S. (United States) average rate was 11.1 % which was 4.3 % above the average. Review of the 5 DaVita Mortality Review Forms provided to the surveyor 7/24/18 at 11:00 AM revealed the following documentation: 1. A death on 1/16/18, primary cause of death cardiac arrest. 2. A death on 2/20/18, primary cause of death cardiac arrest. 3. A death on 4/21/18 (PI # 4), primary cause of death cardiac arrest. 4. A death on 5/9/19, primary cause of death, # 62 (no reason documented). 5. A death on 5/29/19, primary cause of death cardiac arrest. All the death forms contained "NA" not applicable for the serial number and station number for the hemodialysis machine during the last treatment. On 7/26/18 at 10:00 AM in an interview, Employee Identifier (EI) # 2, Clinical Nurse Manager (CNM) confirmed on 4/12/18 PI # 4 was admitted to the hospital with a CVC (central venous catheter infection) as documented on the 4/12/18 inpatient history and physical. On 7/26/18 at 1:20 PM during the quality review, EI # 2 and EI # 1, Facility Administrator, was asked how the cause of death was determined, what was the analysis of the 5 deaths, and if any contributing factors were identified ? EI # 2 reported the Administrative Assistant and CNM obtains information from the family, hospital and physician and completes the DaVita Mortality Review which is discussed with the quality committee at the monthly FHR meeting. EI # 2 reported no contributing factors related the dialysis care were identified during the death review. The surveyor asked to see death certification (s) documentation and review the hospital discharge documentation. Review of the hospital death summary documentation for 2 of the 5 deaths on 7/26/18 at 1:25 PM with EI # 1 and EI # 2 revealed PI # 9 died of sepsis due to CVC infection, not cardiac arrest. Septic shock was the primary cause of death for the 5/9/18 death and not cardiac arrest as the mortality reviews indicated. The facility staff failed to thoroughly and accurately evaluate and analyze individual deaths to recognize trends in causes and contributory factors of deaths relative to infections which included PI # 9's CVC infection. An interview was conducted on 7/26/18 at 3:30 PM with EI # 1 who verified the aforementioned findings.

**V0715**

MD RESP-ENSURE ALL ADHERE TO P&P  
CFR(s): 494.150(c)(2)(i)

The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers;

This STANDARD is not met as evidenced by:  
Based on record review, facility policy and interview, it was determined the Medical Director failed to ensure the Registered Nurse (RN) followed the facility policy, completed and documented a nurse assessment evaluation prior to the first dialysis treatment in 1 of 1 new patient records reviewed. This affected Patient Identifier (PI) # 8 and had the potential to affect all patients served by this facility. Findings include: Policy: 1-03-07 Title: New Patient Pre-Treatment Evaluation Revision Date: October 2017 Purpose: To provide guidance for all new patients to be evaluate by a...RN prior to the initiation of their first treatment at the facility. Policy: 1. A...(RN) as required by federal regulation will perform an initial pre-treatment evaluation of all new patients prior to initiation of their first treatment at the facility... 2. The minimal

nursing evaluation prior to initiating treatment for a new patient... 4. This pre-treatment evaluation will be documented on the...New Patient Pre-treatment Initial Nurse Assessment... \*\*\*\* 1. PI # 8 was admitted to the facility on 4/24/18 with End Stage Renal Disease. Record review revealed post treatment documentation that treatment was initiated at 10:51 AM on 4/24/18. Review of the New Patient Pre-Treatment Initial Nurse Assessment documentation revealed the RN completed the nurse assessment at 1:44 PM, which was after the first dialysis treatment was initiated. An interview conducted on 7/26/18 at 10:50 AM with Employee Identifier # 1, Facility Administrator confirmed the RN failed to follow complete the new patient evaluation prior to treatment initiation.

**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 facility policy, medical record and staff interview, it was determined the facility staff failed to complete accurate medical record documentation regarding the condition and care of the patient. This affected Patient Identifier (PI) # 9, 1 of 6 in-center records reviewed and had the potential to negatively affect all patients dialyzed at the facility. Findings include: Policy: 3-02-17 Title: Progress Note Policy Revision Date: October 2017 Purpose: To verify progress notes are documented by the Physician, Nurse, Dietician and Social Worker...Documentation needs to include treatment given or planned, patient encounters and the condition of the patient. Policy: 1. Progress notes are completed to verify documentation of patient's problems/needs, intervention, response to intervention... 2. Progress notes are used to communicate information among the various disciplines...expand upon information or problems... 3. Progress notes will capture communication related to patient's care that occur outside the medical record (...telephone, Secure messaging...) 7. Progress notes should demonstrate implementation of the plan of care, complete and pertinent information about condition of a (the) patient, and clearly portray the patient, the care, and outcomes... Physician: The attending Nephrologist is required to record progress notes...that provides other interdisciplinary team members with an up-to-date picture of the status of the patient at all times... 1. PI # 9 was admitted to the facility on 12/19/16 with diagnoses including End Stage Renal Disease. Review of the 4/7/18 Post Treatment documentation revealed the CVC (central venous catheter) had dried blood on the dressing, and on the 4/10/18 Post Treatment sheet, the RN documented "redish yellow drainage from the CVC exit site." There was no documentation the Registered Nurse (RN) reported to the physician signs of infection at the CVC site. Review of the 4/12/18 Post Treatment documentation revealed a missed treatment. Further record review revealed a hospital history and physical dated 4/12/18 for an in-patient admit, chief complaint was "pus coming from the catheter site, sent out by the dialysis nurses to...ER (emergency room)...Impression: Sepsis with pus pouring from vascular catheter..." Review of the 4/10/18 and 4/12/18 physician note revealed the following: "This patient was seen and examined while on dialysis. Professional oversight of the patient's dialysis care, access care and dialysis related c-morbidities were addressed... with patient and/or staff. Patient is doing well, no significant new issues noted." There was no documentation the RN communicated with the physician regarding the CVC

infection and no documentation the RN communicated with the inpatient facility. The physician documentation failed to contain pertinent information about condition about the patients' CVC infection, clearly portray the patient, the care, and outcome of the patient on 4/10/18 and 4/12/18. In an interview on 7/26/18 at 10:00 AM, Employee Identifier # 2, Clinical Nurse Manager confirmed the RN failed to complete all patient assessment and physician communication documentation and the physician's documentation failed to accurately portray the current condition of the patient.