

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012506	(X3) Date Survey Completed 04/13/2023
Name of Provider or Supplier Dothan Dialysis	Street Address, City, State 216 Graceland Drive, Dothan, 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)
E0000	Based on a recertification survey conducted from 4/11/23 to 4/13/23, Dothan Dialysis was found to be in substantial compliance with requirements for Emergency Preparedness.
V0000	'CORE' A recertification survey was conducted on 4/11/23 to 4/13/23, Dothan Dialysis was not in compliance with the Conditions for Coverage (CfC) at 490.30 Infection Control and related standards.
V0110	CFC-INFECTION CONTROL CFR(s): 494.30 This CONDITION is not met as evidenced by: Based on review of facility policies and procedures, Centers for Disease Control (CDC) Hand Hygiene in Healthcare Settings for use of hand sanitizer, CDC frequently asked questions (FAQs), observations and interviews with the staff it was determined the facility failed to ensure the staff followed infection control requirements per regulations and facility policies and procedures. Refer to: V 111, V 113, V 115, V 116, V 122, V 143 and V 147.
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 observations, facility procedure and interviews, it was determined the

facility failed to ensure staff completed vascular access care according to facility procedure. This affected Patient Identifier (PI) # 1 and PI # 9 in two of four observations for access initiation with an AVF/AVG (Arteriovenous Fistula or Graft) and had the potential to negatively affect all patients who dialyze at the facility. Findings include: Facility Procedure: AV (Arteriovenous) Fistula or Cannulation with Nipro or Medisystems Safety Fistula Needles (SFN) and Administration of Heparin Loading Dose. Procedure Number: 1-04-01E Revised Date: October 2022 Procedure: 1. ...wash access site with appropriate antibacterial soap...If patient unable to wash access site, patient care teammate will clean access extremity with skin cleansing agent... 5. Perform inspection, auscultation, and palpation on entire length of access... 10....prep each planned needle site...alcohol prep pad... ...13. Do not palpate insertion site once area has been prepped. Rationale: Once the access site has been prepped, touching it will contaminate the site and possibly allow for the introduction of bacteria during cannulation. 1. During an observation of care on 4/12/23 at 10:35 AM at station 15, the surveyor observed EI (Employee Identifier) # 4, CCHT (Certified Clinical Hemodialysis Technician), perform access site antisepsis to PI # 1's AVF /AVG site, cannulate access site one, apply tape and a dressing. EI # 4 palpated /touched access site two with his/her finger then cannulated the access. EI # 4 palpated /touched access site two with his/her finger without repeating skin antisepsis before cannulation, thus leading to potential contamination. An interview was conducted on 4 /13/23 at 11:05 AM with EI # 1, Facility Administrator, who verified staff failed to follow the facility procedure for cannulating an AVF/AVG. 40119 2. During an observation of care on 4/12/23 at 11:25 AM at station 11, the surveyor observed EI # 9, Patient Care Technician (PCT), prep PI # 9's AVF/AVG site. After EI # 9 applied antiseptic to the AVF/AVG site, EI # 8, CCHT, entered station 11 to perform the cannulation. EI # 8 palpated the AVF site then proceeded to cannulate the AVF without repeating antisepsis to the AVF sites, thus leading to potential contamination. An interview was conducted on 4/13/23 at 11:05 AM with EI # 1 who verified staff failed to follow the facility policy for accessing of an AVF/AVG.

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 review of facility policies and procedure, Centers for Disease Control (CDC) Hand Hygiene in Healthcare Settings for use of hand sanitizer, observations and interviews with the staff it was determined the facility failed to ensure the staff and patients performed hand hygiene per facility policy, including use of the hand sanitizer/rub. This affected three of five discontinuation of dialysis with an AVF/AVG (arteriovenous fistula/graft), including Patient Identifier (PI) # 15, 10, PI # 12, two of seven cleaning and disinfection of the dialysis station observations, one of three CVC (central venous catheter) exit site care and dialysis initiation, including PI # 6, one of five parenteral medication preparation and administration observations, including PI # 6, one of four preparation of the hemodialysis (HD) machine/extracorporeal circuit observation, including PI # 9 and three of four access of dialysis with an AVF/AVG, including PI # 11, PI # 1, and PI # 9. This had the potential to negatively affect all patients being served by the facility. Findings include: Facility Policy: Infection Control for Dialysis Facilities Policy Number: 1-05-01 Revision Date: April 2023

Purpose: To minimize the spread of infections or bloodborne pathogens in the dialysis facility environment. Policy: The CDC recommendations... will be followed... Hand Hygiene: 1. All teammates...will perform hand hygiene ...b. prior to gloving and immediately after removal of gloves. ...4. It is a requirement for all DaVita teammates whose primary location is working in a facility to have only natural nails and fingernail length should not extend more than 1/4 inch... 7. Disposable gloves will be worn when caring for the patient or touching the patient's equipment at the dialysis station... a. Gloves should be changed when: ...ii. When going from a "dirty" area or task to a "clean" area or task. Facility Procedure: Use of Alcohol-Based Hand Rubs Policy Number: 1-05-01 A Revision date: April 2023 Procedure ...3. Rub hands together covering all surfaces of hands and fingers until hand rub has evaporated and hands are dry. CDC Hand Hygiene in Healthcare Settings Reviewed Date: 1/8/21 ... Techniques for using alcohol-based hand sanitizer: When using alcohol-based hand sanitizer: Put product on hands and rub hands together. Cover all surfaces until hands feel dry. This should take around 20 seconds. ...Fingernail Care... Germs can live under artificial fingernails both before and after using an alcohol-based hand sanitizer and handwashing. It is recommended that healthcare providers do not wear artificial fingernails or extensions when having direct contact with patients at high risk... Facility Policy: Medication Policy Policy Number: 1-06-01 Revision Date: October 2022 Policy: ...21. An aseptic environment and aseptic technique is used when preparing medications. Careful attention to proper handwashing is performed at this time. 1. An observation was conducted on 4/11/23 at 10:02 AM at station 12 with Employee Identifier (EI) # 5, Patient Care Technician (PCT), to observe the discontinuation of dialysis and post dialysis AVF/AVG access care for PI # 15. After performing hand hygiene, EI # 5 donned gloves and used his/her left gloved hand to adjust the position of the rolling sharps container, used for multiple stations on the treatment floor, bringing it closer to him/her. EI # 5 then proceeded to remove the arterial needle from the AVF/AVG access. EI # 5 failed to remove gloves and perform hand hygiene while going from the dirty sharps container to the clean task of removing the arterial needle. An interview was conducted on 4/13/23 at 11:04 AM with EI # 1, Facility Administrator, who confirmed EI # 5 failed to remove gloves and perform hand hygiene when going from a dirty to a clean task per policy. 2. An observation was conducted on 4/11/23 at 10:45 AM with EI # 5, to observe cleaning and disinfection of dialysis station 12. EI # 5 removed the contaminated bloodlines, emptied the used prime receptacle, and proceeded to obtain the bleach cloths and clean the dialysis machine without removing gloves and performing hand hygiene prior to obtaining the bleach cloths and cleaning the machine. EI # 5 failed to follow facility policy to perform hand hygiene and change gloves when moving from a dirty to a clean task. An interview was conducted on 4/13/23 at 11:04 AM with EI # 1 who confirmed EI # 5 failed to follow facility policy for hand hygiene 3. During an observation of care on 4/11/23 at 12:02 PM at station 8 for CVC exit care and dialysis initiation, EI # 2, RN, (Registered Nurse) removed and discarded PI # 6's old CVC exit site dressings. Next, EI # 2 performed CVC exit site antisepsis with the Chloraprep swab stick. EI # 2 failed to remove his/her gloves, perform hand hygiene, and don clean gloves after removing the old CVC dressings. After EI # 2 disinfected the CVC hubs, EI # 2 attached the clean barrier to PI # 6's shirt using paper tape, removed his/her gloves, sanitized hands for five seconds, donned clean gloves, and collected lab via the CVC. EI # 2 failed to ensure his/her hands were thoroughly sanitized and dry, which takes around 20 seconds. An interview was conducted on 4/13/23 at 11:AM with EI # 1 who confirmed staff failed to follow the CDC recommendation for use of hand sanitizer and facility policy for hand hygiene during CVC exit site care. 4. An observation was conducted on 4/11/23 at 12:05 PM at station 18 with EI # 9, PCT, to observe the discontinuation of dialysis and post

dialysis AVF/AVG access care for PI # 10. EI # 9 performed hand hygiene prior to the initiation of the procedure, EI # 9 was observed to have artificial nails to bilateral hands which extended 1/2 to 1 inch from the end of the finger. EI # 9 failed to clean under the artificial nails while performing hand hygiene. After performing hand hygiene, EI # 9 proceeded to don gloves and use gloved hand to adjust the position of the rolling sharps container, used for multiple stations on the treatment floor, in the station. EI # 9 proceeded to remove the needles from the AVF/AVG access. EI # 9 failed to remove gloves and perform hand hygiene after contact with contaminated sharps container prior to removing needles from AVF/AVG. An interview was conducted on 4/13/23 at 11:04 AM with EI # 1 who confirmed EI # 9 failed to remove gloves and perform hand hygiene when going from a dirty to a clean task per policy and to adhere to the facility policy for nails. 5. An observation was conducted on 4/11/23 at 12:17 PM with EI # 9, to observe a cleaning and disinfection dialysis station 16. EI # 9 removed the trash bag from the trash can then proceeded to obtain the bleach cloths and clean the treatment chair without removing gloves and performing hand hygiene before cleaning the treatment chair. An interview was conducted on 4/13/23 at 11:04 AM with EI # 1, who confirmed EI # 9 failed to remove gloves and perform hand hygiene when going from a dirty to a clean task per policy. 6. An observation of care was conducted on 4/11/23 at 12:55 PM at station 19 for discontinuation of dialysis with an AVF/AVG for PI # 12. EI # 5 sanitized his/her hands for 5 seconds, donned clean gloves, then removed PI # 12's first cannulation needle. EI # 5 failed to thoroughly sanitize hands, allow hands to dry, which takes about 20 seconds before donning clean gloves. At 1:22 PM, EI # 6, RN, removed PI # 12's second cannulation needle, removed his/her gloves, sanitized his/her hands for four seconds, opened the supply drawer and retrieved tape. EI # 6 failed to thoroughly sanitize hands, allow hands to dry, which takes about 20 seconds before donning clean gloves. An interview was conducted on 4/13/23 at 11:05 AM with EI # 1 who confirmed staff failed to follow CDC recommendations for use of hand sanitizer. 7. An observation was conducted on 4/11/23 at 1:10 PM at the medication preparation area to observe preparation and administration of parenteral medications by EI # 6 for PI # 6. EI # 6 did not perform hand hygiene prior to performing this task. An interview was conducted on 4/13/21 at 11:04 AM with EI # 1 who confirmed EI # 6 did not follow facility policy, and should have performed hand hygiene prior to preparing the medications. 8. An observation was conducted on 4/12/23 at 9:55 AM with EI # 9, to observe the preparation of the HD machine/extracorporeal circuit for PI # 9. EI # 9 performed hand hygiene and donned gloves then used gloved hand to obtain and place trash can at station 11. EI # 9 then proceeded to prepare the HD machine /extracorporeal circuit without removing gloves and performing hand hygiene. An interview was conducted on 4/13/23 at 11:04 AM with EI # 1, who confirmed EI # 9 failed to remove gloves and perform hand hygiene when going from a dirty to a clean task per policy. 9. During an observation of care on 4/12/23 at 10:35 AM at station 24 for dialysis initiation with an AVF/AVG, the surveyor observed EI # 3 CCHT (Certified Clinical Hemodialysis Technician) evaluate PI # 11's access site, remove his /her gloves, sanitize hands for seven seconds, then donned clean gloves. EI # 3 failed to ensure his/her hands were thoroughly sanitized and dry, which takes around 20 seconds. After access site antisepsis, EI # 3 opened the needle packages, removed gloves, sanitized hands for four seconds, then charted at the dialysis keyboard. EI # 3 failed to ensure his/her hands were thoroughly sanitized and dry, which takes around 20 seconds, before clean gloves were donned. An interview was conducted on 4/13/23 at 11:05 AM with EI # 1 who confirmed staff failed to follow the CDC recommendations for hand sanitizer/hand rub. 10. During an observation of care on 4/12/23 at 11:00 AM at station 15 for dialysis initiation with an AVF/AVG, EI # 4, CCHT, sanitized hands for seven seconds, donned the right glove, and documented at

the dialysis station keyboard. EI # 4 failed to thoroughly sanitize hands, allow hands to dry, which takes about 20 seconds before donning clean gloves. Next, EI # 4 cleaned PI # 1's access site with P.A.W.S. (Personal Antimicrobial Wipes Safetec) antibacterial wipe (in place of soap and water), then applied alcohol and ExSept antiseptic cleaner to the access site. EI # 4 failed to remove gloves and perform hand hygiene after the access site was cleaned with P.A.W.S. and prior to the ExSept antiseptic application. An interview was conducted on 4/13/23 at 11:05 AM with EI # 1 who confirmed staff failed to follow CDC recommendations for use of hand sanitizer and failed to perform hand hygiene before access site antiseptics. 11. An observation was conducted on 4/12/23 at 11:25 AM at station 11 with EI # 9, to observe the access of PI # 9's AVF/AVG for the initiation of Dialysis. During the observation, EI # 9 applied hand sanitizer to bilateral hands three times and rubbed hands together for 3 seconds, without allowing the sanitizer to fully dry. EI # 9 completed hand hygiene then obtained a stool with bare hand and rolled the stool into station 11. EI # 9 proceeded to don gloves and clean the AVF/AVG site without performing hand hygiene after using bare hand to obtain stool and prior to the donning of gloves. An interview was conducted on 4/13/23 at 11:04 AM with EI # 1, who confirmed EI # 9 failed to allow hand sanitizer to fully dry and perform hand hygiene prior to donning of gloves per the facility policy and procedure. 30952 41624

V0115

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

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

This STANDARD is not met as evidenced by:
 Based on observations, review of facility procedure, and interview, it was determined the staff failed to properly wear face masks during one of three observations for Central Venous Catheter (CVC) Exit Site Care. This did affect Patient Identifier (PI) # 8 and had the potential to negatively affect all patients who dialyze at the facility. Findings include: Facility Procedure: Central Venous Catheter with Clearguard HD (Hemodialysis) Antimicrobial End Caps Procedure Procedure Number: 1-04-02B Revision Date: April 2023 Notes: Use Dialysis Precautions and aseptic techniques throughout procedure. Procedure: 1. ...Teammate and patient will wear masks covering the nose and mouth during this procedure ... These measures are vital to preventing the exposure of the catheter and exit site to nasal droplets and infectious bacteria ... 1. An observation was conducted on 4/11/23 at 11:25 AM at station 7 to observe Employee Identifier (EI) # 7, Registered Nurse (RN) perform CVC exit site care on PI # 8. EI # 7's face mask was worn below the level of the nose during the CVC site care and initiation of dialysis. EI # 7 failed to wear the face mask covering the nose and mouth per facility procedure. An interview was conducted on 4/13/23 at 11:04 AM with EI # 1, Facility Administrator, who confirmed the RN failed to properly wear face masks during CVC exit site care per facility procedure.

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 an observation, facility policy, and interviews, it was determined the facility failed to ensure: 1. Non-disposable items were disinfected after each patient use, prior to the removal from the treatment area/station. 2. Unused supplies taken into the station were not returned to a common clean area. This affected one of five discontinuation of dialysis with an AVF/AVG (arteriovenous fistula/graft), including Patient Identifier (PI) # 10 and one of four preparation of the hemodialysis (HD) machine/extracorporeal circuit observation, including PI # 9 and had the potential to negatively affect all patients served by the facility. Findings include: Facility Policy: Infection Control for Dialysis Facilities Policy number: 1-05-01 Revision date: April 2023 Purpose: To minimize the spread of infections or bloodborne pathogens in the dialysis facility environment. Supplies ...10. Unused supplies...taken into the station... should not be returned to a common clean area... Disinfection ...14. Non-disposable items are to be disinfected after each patient use, prior to removal from treatment area /station... 1. An observation was conducted on 4/11/23 at 12:05 PM at station 18 with Employee Identifier (EI) # 9, Patient Care Technician (PCT), to observe the discontinuation of dialysis and post dialysis AVF/AVG access care for PI # 10. Prior to the initiation of the procedure, EI # 9 obtained a clipboard from the nurses station and placed a form on the clipboard. EI # 9 proceeded to enter station 18 and hand the clipboard to PI # 10. PI # 10 held the clipboard to sign the paper on the clipboard then handed the clipboard back to EI # 9. EI # 9 then exited the station and laid the clipboard on the counter of the nurses station. EI # 9 failed to disinfect the clipboard after the patient use prior to the removal of the clipboard from the treatment station. An interview was conducted on 4/13/23 at 11:04 AM with EI # 1, Facility Administrator, who confirmed EI # 9 failed to disinfect the clipboard after the patient use prior to the removal of the clipboard from the treatment station per the facility policy. 2. An observation was conducted on 4/12/23 at 9:55 AM with EI # 9, to observe the preparation of the HD machine/extracorporeal circuit for PI # 9. During the observation, EI # 9 obtained an unused Solcart B (bicarbonate) Cartridge from station 11's counter and placed the cartridge with the common clean supplies. An interview was conducted on 4/13/23 at 11:04 AM with EI # 1 who confirmed EI # 9 failed to not return unused supplies taken into a dialysis station to a common clean area.

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 observations, facility policy, and interviews, it was determined the facility failed to ensure staff followed the facility policy for cleaning and disinfection of the dialysis station between patients. This affected one of two blood spills observed during floor observations and eight of eight observations of dialysis station cleaning /disinfection and had the potential to affect all patients who dialyze at this facility. Findings include: Facility Policy: Infection Control for Dialysis Facilities Policy number: 1-05-01 Revision date: April 2023 Purpose: To minimize the spread of infections or blood borne pathogens in the dialysis facility environment. Disinfection ...12. Cleaning and/or disinfection of equipment and work surfaces will be performed as soon as possible following exposure to blood or potentially infectious materials (i.e. used or brought into the station)... a. Prior to routine disinfection, remove all visible blood... iii. Cleaning of visible blood should be performed when first observed. b. Use an appropriate disinfectant such as 1:100 (one to one hundred) bleach solution for routine disinfection of environmental surfaces. ...ii. Sufficient disinfectant should be applied so that surfaces are visibly wet. iii. Surfaces should be allowed to air dry in order to provide sufficient disinfectant contact time... 13. At the end of each treatment, the dialysis station will be cleaned and disinfected. ...ii. Priming containers are to be emptied prior to disinfection... 1. During a floor observation on 4/11/23 at 10:39 AM, two drops of blood were observed on the floor below the reclined foot rest of Patient Identifier (PI) # 7 at station 2. The blood drops remained on the floor throughout PI # 7's treatment. At 3:21 PM, following station 2 being cleaned and clean supplies brought to the station in preparation for the next patient, the two drops of blood remained on the floor of station 2. The staff failed to clean blood spill immediately and clean visible blood prior to the routine disinfection of the station. An interview was conducted on 4/13/23 at 11:04 AM with Employee Identifier (EI) # 1, Facility Administrator, who confirmed the staff failed to clean the blood spill per the facility policy. 2. During an observation for cleaning and disinfection of dialysis station # 12 on 4/11/23 at 10:45 AM , EI # 5, Patient Care Technician (PCT), failed to clean the top of the left chair table and IV (intravenous) pole. An interview was conducted on 4 /13/23 at 11:05 AM with EI # 1 who confirmed staff failed to follow facility policy for cleaning and disinfection of the dialysis station. 3. During a floor observation on 4/11 /23 at 11:35 AM, EI # 9, PCT, was observed to place several bleach cloths at station 14, 15, 16 and 17, and the following observations were made while observing the cleaning and disinfection of the dialysis station: Station 17 was cleaned at 11:43 AM by EI # 9. During the observation, EI # 9 reclined the treatment chair and opened the arm rests of the treatment chair. EI # 9 cleaned the front of the reclined treatment chair and each arm rest individually then immediately placed the chair into an upright position and closed the arm rests without allowing the cleaned surfaces to air dry. Station 16 was cleaned at 12:17 PM by EI # 9, 47 minutes after the bleach cloths were placed at the station. During the observation, EI # 9 reclined the treatment chair and opened the arm rests of the treatment chair. EI # 9 cleaned the front of the reclined treatment chair and each arm rest individually then immediately placed the chair into an upright position and closed the arm rests without allowing the cleaned surfaces to air dry. EI # 9 then exited station 16 then resumed cleaning station 16 at 12:28 PM, 53 minutes after the bleach cloths were placed at the station. EI # 9 proceeded to clean the dialysis machine, blood pressure cuff, television control, dialysis tubing, wall box and counter. After the dialysis machine, blood pressure cuff, television control, wall box and counter were each individually cleaned the surface of each item was not visibly wet. Station 15 was cleaned at 12:35 PM by EI # 9, 60 minutes after the bleach cloths were placed at the station. EI # 9 cleaned the dialysis station including the following items: the treatment machine, treatment chair, wall box, station counter, blood pressure cuff and television control. After each item was cleaned in the dialysis station the surface of the item was not visibly wet. Station 14 was cleaned at 12:45

PM by EI # 9, 70 minutes after the bleach cloths were placed at the station. EI # 9 cleaned the dialysis station including the following items: the treatment machine, treatment chair, wall box, station counter, blood pressure cuff and television control. After each item was cleaned in the dialysis station the surface of the item was not visibly wet. An interview was conducted on 4/13/23 at 11:04 AM with EI # 1 who confirmed the PCT failed to follow the facility policy by not allowing the surfaces of the dialysis station to be visibly wet and to air dry. 4. An observation of cleaning and disinfection of station 3 was conducted on 4/11/23 at 12:50 PM. EI # 6, RN (Registered Nurse), removed the prime waste container from the side of the dialysis machine, cleaned the waste container and immediately replaced the container onto the side of the dialysis machine. EI # 6 failed to allow the prime waste container to dry before replacing the waste container onto the dialysis machine. An interview was conducted on 4/13/23 at 11:05 AM with EI # 1 who confirmed staff failed to follow the policy for cleaning and disinfection of the dialysis station. 5. During an observation for cleaning and disinfection of the dialysis station on 4/11/23 at 1:40 PM at station 6, EI # 5 failed to remove the prime waste container from dialysis machine, clean the outside surface of the container, clean the surface of the dialysis machine under the waste container and clean the countertop surrounding the station. An interview was conducted on 4/13/23 at 11:05 AM with EI # 1 who confirmed staff failed to follow the policy for cleaning and disinfection of the dialysis station. 6. During an observation for cleaning and disinfection of dialysis station 5 on 4/12/23 at 9:25 AM, EI # 8, CCHT (Certified Clinical Hemodialysis Technician) failed to remove the prime waste container from the dialysis machine, clean the surface of the dialysis machine under the waste container, clean the right outside surface of the chair arm, clean the right tray table, and clean the underside of the left tray table. An interview was conducted on 4/13/23 at 11:05 AM with EI # 1 who confirmed staff failed to follow facility policy for cleaning and disinfection of the dialysis station.

30952 41624

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 observations, facility policy, Centers for Disease Control and Prevention (CDC) frequently asked questions (FAQs) regarding safe practices for medical injections and interview it was determined the facility staff failed to ensure: 1. Intravenous (IV) nutrition therapy available for patient use was not expired. 2. Aseptic technique was utilized when accessing IV multi-dose vials (MDV). This affected two of five observations for IV medication storage, preparation and administration, including Patient Identifier (PI) # 6 and Unsampled Patient # 1, and had the potential to negatively affect all patients served by this facility. Findings include: Facility Policy: Medication Policy Policy Number: 1-06-01 Revision Date: October 2022 Policy: ...8. All teammates administering medications must utilize aseptic technique. ... 21. An aseptic environment and aseptic technique is used when preparing medications. Careful attention to proper handwashing is performed at this time. ...30. ...All medications are checked monthly for expiration dates. CDC FAQs regarding Safe Practices for Medical Injections: Review Date: 3/2/11 1. How should I draw up medications? ...the rubber septum should be disinfected with alcohol prior to piercing

it. 1. An observation was conducted on 4/11/23 at 1:10 PM of parenteral (medications given by injection or infusion) medication preparation and administration by Employee Identifier (EI) # 6, Registered Nurse (RN), for PI # 6. EI # 6 was observed removing the plastic cap from a MDV of Venofer and immediately withdrawing the medication utilizing a syringe and needle. EI # 6 then removed the cap from a MDV of Epogen and immediately withdrew the Epogen dose utilizing a syringe and needle. EI # 6 failed to wipe the rubber septum with alcohol prior to piercing both MDVs and withdrawing the medications. An interview was conducted on 4/13/23 at 11:04 AM, EI # 1, Facility Administrator, who confirmed EI # 6 did not follow facility policy to utilize aseptic technique when accessing the MDVs. 2. A tour of the medication storage area was conducted on 4/11/23 at 3:00 PM. Inspection of the refrigerator storing parenteral medications revealed two 50 milliliter (ml) prepared bags of Proplete IDPN (Intradialytic Parenteral Nutrition) Protein Therapy 2:1 (Two to One) solution, designated for unsampled patient # 1. Review of the labels on the bag revealed the protein solutions were to be discarded after 4/7/23. The facility failed to discard the expired protein solutions after their expiration date. EI # 10, Senior Manager of Clinical Services, was present during the inspection and confirmed the protein solutions were available for patient use, unsampled patient # 1 was identified on the label as current dialysis patient, and the protein solution should have been discarded after 4/7/23.

V0147

IC-STAFF EDUCATION-CATHETERS/CATHETER CARE
CFR(s): 494.30(a)(2)

Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters. II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].

This STANDARD is not met as evidenced by:
Based on review of observations, facility procedure, and interview, it was determined the facility failed to ensure staff performed Central Venous Catheter (CVC) care per facility policy. This affected two of three observations for CVC exit site care, including Patient Identifier (PI) # 7 and PI # 6, one of three observations of initiation of dialysis with a CVC, including PI # 8, and had the potential to negatively affect all patients with CVC's who dialyze at the facility. Findings include: Facility Policy: Central Venous Catheter (CVC) Care with Clearguard HD (Hemodialysis) Antimicrobial End Caps Procedure Policy Number: 1-04-02 B Revised Date: April 2023 ... Perform a 15 second hub scrub of the CVC during the process of connecting or disconnecting from the blood lines... ... Device Disinfectant and Skin Antiseptic...2 % Chlorhexidine Gluconate/70 % Isopropyl Alcohol...Effective Contact Time...30 seconds back and forth motion... Procedure ...8. Holding catheter with the non-dominant hand and using aseptic technique, clean exit site with 2 % Chlorhexidine Gluconate/70 % Isopropyl Alcohol swab for a minimum of 30 seconds, apply to the

CVC exit site in a "back and forth" pattern, using gentle friction... 37. Document findings and procedure in patient's electronic health record. 1. An observation was conducted on 4/11/23 at 10:26 AM at station 2 with Employee Identifier (EI) # 6, Registered Nurse (RN), to observe CVC exit site care provided to PI # 7. During the observation, EI # 6 cleansed the CVC exit site with a 2 % Chlorhexidine Gluconate/70 % Isopropyl Alcohol swabstick for 10 seconds. EI # 6 failed to cleanse the CVC exit site for 30 seconds per the facility procedure. An interview was conducted on 4/13/23 at 11:04 AM with EI # 1, Facility Administrator, who confirmed EI # 6 failed to cleanse the CVC exit site for 30 seconds per the facility procedure. 41624 2. An observation was conducted on 4/11/23 at 11:30 AM at station # 7 with EI # 7, RN, to observe initiation of dialysis with a CVC provided to PI # 8. During the observation, EI # 7 cleansed the CVC hubs with a 2 % Chlorhexidine Gluconate/70 % Isopropyl Alcohol swabstick for 9 seconds before connecting the blood lines. EI # 7 failed to cleanse the CVC connection hubs for 15 seconds per the facility procedure. An interview was conducted on 4/13/23 at 11:04 AM with EI # 1 who confirmed EI # 7 failed to cleanse the CVC hubs for 15 seconds per the facility procedure. 30952 3. An observation of CVC exit site care and dialysis treatment initiation for PI # 6 was conducted on 4/11/23 at 12:02 PM at station 8 with EI # 2, RN. Review of PI # 6's Treatment Details Report (TDR) dated 4/11/23 failed to reveal documentation of the specific care provided to PI # 6's CVC exit site during the observation. An interview was conducted on 4/13/23 at 11:20 AM with EI # 1 who confirmed the TDR documentation should include the specific CVC exit site care performed and staff failed to document the CVC exit site care provided during the observation.

V0250

DIALYS PROPORT-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, facility procedure, and interviews, it was determined the facility failed to ensure staff followed the facility procedure for pH (potential of hydrogen) testing of the dialysate. This did affect PI (Patient Identifier) # 14 and PI # 1, two of four observations for testing of the pH for dialysis machine preparation and had the potential to negatively affect all patients who dialyzed at this facility. Findings include: Facility Procedure: Testing pH For Dialysate using RPC E-Z CHEK K100-0117 6.8-8.5 Test Strips Procedure Number: 2-08-01K Revision Date: October 2020 ... 2. Obtain dialysate sample...then allow fluid to flow over the pad for one (1) second 3. Remove the strip from the fluid...shake off excess dialysate. After 10 (ten) seconds, compare the strip to the color chart on the bottle. 4. Match the strip as closely... 6. If results are outside the limit of 6.9-7.6, repeat test on another dialysate sample... 1. An observation was conducted on 4/12/23 at 10:10 AM with Employee Identifier (EI) # 8, CCHT (Certified Clinical Hemodialysis Technician), to observe pH testing at station 5 prior to treatment initiation for PI # 14. EI # 8 obtained the dialysate sample, allowed fluid to flow over the test pad, shook excess fluid off the strip, compared the test strip to the test strip color chart, then immediately read pH results as 7.0. EI # 8 failed to allow 10 seconds to pass before comparing the test strip to the color chart. An interview was conducted on 4/13/23 at 11:05 AM with EI # 1, Facility Administrator, who confirmed staff failed to follow the procedure for pH testing. 2. An observation

was conducted on 4/12/23 at 11:05 AM with EI # 4, CCHT, to observe pH testing at station 15 prior to treatment initiation for PI # 1. EI # 4 obtained the dialysate sample, allowed fluid to flow over the test pad, shook excess fluid off the strip, compared the test strip to the test strip color chart, then immediately read pH results 7.6. EI # 4 failed to allow 10 seconds to pass then compare the test strip to the color chart. An interview was conducted on 4/13/23 at 11:05 AM with EI # 1 who confirmed staff failed to follow the procedure for pH testing. 41624

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 policy, and staff interviews, it was determined the facility failed to ensure staff: 1. Notified the nurse with abnormal changes in the patient's condition, including changes in the blood pressure (BP) and heart rate (HR-pulse rate). 2. Notified the nurse when the UFR (ultrafiltration rate, which is the ratio of fluid removed to dialysis treatment time) was turned off or at the minimum. This affected PI (Patient Identifier) # 1, PI # 2, in two of five records reviewed and had the potential to negatively affect all patients who dialyze at the facility. Findings include: Facility Policy: Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment Policy Number: 1-03-08 Revision Date: 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... 2. The Nursing assessment will be performed and documented by a licensed nurse... Pre-Treatment Data Collection/Assessment 4. Any abnormal findings...outside of any patient specific physician ordered parameter discovered during pre-treatment data collection will be documented and immediately reported to the licensed nurse...If an abnormal finding is reported to the licensed nurse pre-treatment, the nurse will assess the patient prior to the initiation of dialysis... Intradialytic Data Collection/Assessment 9. Intradialytic treatment monitoring...data collection may be performed by the PCT (Patient Care Technician) or licensed nurse... ..b. At a minimum, obtain and document the following: ... 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... Post Treatment Data Collection/Assessment 15. The PCT or licensed nurse will obtain and document basic data on each patient post dialysis and compare to pre dialysis findings. 16. If abnormal finding(s) or concern is identified post treatment, this needs to be reported to the licensed nurse...will assess the patient prior to discharge. 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... Blood Pressure: Intradialytic: Difference of 20 mm/Hg increase or decrease from...last intradialytic treatment BP reading... Heart or Pulse Rate Pre/Intra/Post: Less than 60 beats per minute or greater than 100 beats per

minute... 1. PI # 1 was admitted to the facility on 2/25/23 with a diagnosis of End Stage Renal Disease (ESRD). Review of the Treatment Details Report (TDR) dated 3/29/23 revealed at 9:19 AM the BP was 136/83. Further review of the 3/29/23 TDR revealed the PCT documented the following and there was no documentation the nurse was notified: At 9:39 AM BP 77/54 (a decrease in BP greater than 20 mm/Hg)... stable, rechecking BP At 9:44 AM (next entry documented) BP 119/80 no complaints At 10:19 AM BP 134/80 no complications. The UFR was 50, which is the minimum UFR. At 10:24 AM (next entry documented), no BP was documented, "Pull (ultrafiltration-UF) turned off" At 10:39 AM BP 159/118, rechecking BP (an increase in BP greater than 20 mm/Hg) At 10:53 AM (the next BP check), BP 121/72 bp better cramping mildly monitoring At 11:19 AM BP 116/52 no complaints. The UFR was 50 (minimum UFR-fluid pull/removal) At 11:59 AM BP 119/72, no complaints. The UFR was 50 At 12:19 PM, BP 109/76, no complaints. The UFR was 50 At 12:22 PM, treatment termination BP 186/100. The UFR was 50 The PCT failed to document the nurse was notified for BP increase and decrease of greater than 20 mm/Hg, and complaints of cramping. There was no documentation why the UFR was turned off at 10:24 AM, and no documentation the nurse was notified the UFR was 50 from 11:19 AM to 12:22 PM. Review of the TDR dated 4/5/23 revealed at 12:28 PM the BP was 130/80. At 12:48 PM BP was 85/62. There was no documentation the PCT notified the nurse of the decrease in BP greater than 20 mm/Hg. Further review of the 4/5/23 TDR revealed at 1:18 PM the nurse documented cramping, 200 ml (milliliter) NS (normal saline) given, UF turned to a minimum (50). Continued review of the 4/5/23 TDR revealed the PCT documented the following: At 1:30 PM, BP 125/63... improved. The UFR was 50 At 1:49 PM, BP 97/66...low, rechecking bp. The UFR was 50 At 1:58 PM, BP 156/98, awake, alert, no complaints. The UFR was 50 At 2:13 PM, BP 115/79 no complications. The UFR was 50 At 2:29 PM, BP 145/76 no complaints. The UFR was 50 At 2:41 PM, (no BP documented), awake, no complaints, bp improve. The UFR was 50 At 2:48 PM, BP 129/86 no complaints. The UFR was 50 At 2:54 PM, treatment terminated BP 131/77. The UFR was 50 There was no documentation the staff re-evaluated the need to re-establish the UFR with improved BP, and no patient complaints from 1:30 PM until treatment end at 2:54 PM. Review of the TDR dated 4/7/23 revealed at 2:13 PM the PCT documented patient cramping, RN (Registered Nurse) notified, UFR turned off. At 2:49 PM, the PCT documented no complaints. The UFR was 50. From 2:50 PM till 3:10 PM, the PCT documented tolerating treatment and the UFR was 50. At 3:15 PM treatment terminated and the UFR was 50. Further review of the 4/7/23 TDR revealed at 3:53 PM the nurse documented "appears to be tolerating treatment, late entry monitoring asymptomatic bp change". The 4/7/23 TDR documentation revealed the UFR remained 50, which was at a minimum for 62 minutes of the 4 hour treatment despite documentation of no complaints, patient tolerating treatment. There was no documentation the staff re-evaluated the need to re-establish the UFR Review of the TDR dated 4/10/23 revealed the PCT documented the following: At 9:43 AM BP 125/97, HR 67 no complaints At 10:03 AM BP 232/174 (increase greater than 20 mm /Hg), HR 55 (less than 60), elevated BP rechecking. There was no documentation the PCT notified the nurse of the abnormal HR and BP. At 10:23 AM BP 141/68, HR 114 (greater than 100 beats per minute), better bp At 10:43 AM BP 117/86, HR 103, lower bp monitoring, RN notified At 11:03 AM BP 122/78, HR 117, Patient monitored...no complaints At 12:17 PM BP 123/79, HR 126 no complaints At 1:23 PM, BP 108/67, HR 120 HR elevated, rechecking BP There was no documentation staff notified the nurse when the HR was 55, and when the HR was 114 to 126. An interview was conducted on 4/13/23 at 11:12 AM with EI (Employee Identifier) # 1, Facility Administrator, who confirmed staff failed to follow facility policy, notify the nurse /physician with complaints of cramping, abnormal BP, HR, and UFR adjustments.

40119 2. PI # 2 was admitted to the facility on 1/30/23 with a diagnosis of ESRD. Review of the TDR dated 3/8/23 revealed the PCT documented the following HR readings without documentation the nurse was notified: At 11:43 AM a HR of 105. At 12:03 PM a HR of 108. At 12:35 PM a HR of 109. At 12:44 PM a HR of 113. At 1:05 PM a HR of 114. At 1:17 PM a HR of 103. Review of the TDR dated 3/20/23 revealed the PCT documented the following pulse readings without documentation the nurse was notified: At 12:51 PM a HR of 112. At 1:12 PM a HR of 108. At 1:31 PM a HR of 109. At 1:52 PM a HR of 102. At 2:11 PM a HR of 108. At 2:31 PM a HR of 105. In an interview conducted on 4/13/23 at 12:02 PM, EI # 10, Senior Manager of Clinical Services, confirmed there was no documentation the nurse was notified of the patient pulse above 100 on 3/8/23 and 3/20/23.

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 (MR), facility policies, and staff interviews, it was determined the facility failed to ensure the staff: 1. Followed the physician's orders for BFR (Blood Flow Rate) and DFR (Dialysate Flow Rate). 2. Developed and implemented an individualized Plan of Care (POC) to address in center Hemodialysis (HD) Kt/V (adequacy) of less than 1.2. This affected four of five MR's reviewed, including PI (Patient Identifier) # 4, PI # 1, PI # 2, PI # 5, and had the potential to negatively affect all patients who dialyze at this facility. Findings include: Facility Policy Title: Pre-Intra-Post Treatment Data Collection, Monitoring, and Nursing Assessment Policy Number: 1-03-08 Revision Date: April 2021 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... Policy: 1. Patient data will be obtained and documented by the patient care technician (PCT), or a licensed nurse... 3. Patient identity, prescription and machine settings are verified by teammate prior to initiation of treatment with the exception of blood flow rate which is verified and documented when the ordered rate is obtained after onset of treatment. The prescription components are confirmed by a licensed nurse within one (1) hour of treatment initiation ... Intradialytic Data Collection/ Assessment ...9. Intradialytic treatment monitoring and data collection which may be performed by the PCT, or licensed nurse includes: ...b. At a minimum, obtain and document the following: ...iii. Blood and dialysate flows... Facility Policy: Interdisciplinary Team (IDT) Patient Assessment and POC Policy Number: 1-14-01 Revision Date: April 2023 Purpose: To provide guidance for the development of patient assessment and POC for IDT teammates. Policy: Assessment: ...2. The IDT is responsible for providing each patient with an individualized and comprehensive assessment documenting his/her needs. The comprehensive assessment will be used to develop the patient's treatment plan and expectations for care. ...6. The adequacy of the patient's dialysis prescription will be assessed on an ongoing basis as follows: For HD patients, at least monthly calculations of delivered Kt/V or an equivalent measure... 7. A comprehensive re-assessment of each patient and a revision in the POC will be conducted: ...At least monthly for unstable patients... POC: 8. The facility's IDT will develop and implement a written, individualized comprehensive POC that specifies the services necessary to address the patient's needs...and will include measurable and expected

outcomes and estimated timetables to achieve these outcomes... 9. The POC will address...the following: ...An in-center HD Kt/V of a least 1.2... 1. PI # 4 was admitted to the facility on 1/11/21 with a diagnosis of End Stage Renal Disease (ESRD). Review of the IDT Rounding Worksheet (RW) revealed HD Treatment Orders dated 4/5/23 which included BFR 450 and DFR 600. Review of the Treatment Details Report (TDR) dated 4/8/23 revealed from 8:56 AM until treatment end at 10:22 AM, the BFR was 350. There was no reason documented why the BFR was not 450 and no physician's order for BFR 350. Review of the TDR dated 4/11/23 revealed from treatment start at 6:15 AM until treatment end at 10:15 AM the BFR was 400. There was no reason documented why the BFR was not 450 and no physician's order for BFR 400. An interview was conducted on 4/13/23 at 11:40 AM with Employee Identifier (EI) # 1, Facility Administrator (FA), who confirmed on HD treatments dated 4/8/23 and 4/11/23 the staff failed to follow the physician's order for BFR. 2. PI # 1 was admitted to the facility on 2/25/21 with a diagnosis of ESRD. Review of the IDT RW revealed HD Treatment Orders dated 3/15/23 which included BFR 300. Review of the TDR dated 4/3/23 revealed from treatment start at 10:50 AM until treatment end at 2:52 PM, the BFR was 350. There was no reason documented why the BFR was not 300 and no physician's order for BFR 350. An interview was conducted on 4/13/23 at 11:34 AM with EI # 1 who confirmed staff failed to follow the physician's order for BFR. 40119 3. PI # 2 was admitted to the facility on 1/30/23 with a diagnosis of ESRD. Review of the IDT RW revealed HD Treatment Orders dated 3/10/23 which included BFR 450. Review of the TDR dated 3/10/23 revealed from treatment start at 12:12 PM until treatment end at 3:07 PM, the BFR was 400. There was no reason documented why the BFR was not 450 and no physician's order for BFR 400. Review of the RN (Registered Nurse) Comprehensive Assessment Report dated 3/10/23 revealed documentation of a Kt/V on 3/6/23 of 0.76 and "... meets adequacy goal." Review of the Physician Comprehensive Encounter dated 3/13/23 revealed documentation PI # 2's adequacy had not been met for the month and a Kt/V on 3/10/23 of 0.93 Review of the IDT meeting and POC dated 3/13/23 revealed no documentation the IDT developed and implemented interventions and goals to address in center HD Kt/V of less than 1.2. Review of the TDR dated 3/13/23 revealed from treatment start at 12:15 PM until treatment end at 2:54 PM, the BFR was 400. There was no reason documented why the BFR was not 450 and no physician's order for BFR 400. Review of the TDR dated 3/20/23 revealed from treatment start at 12:34 PM until treatment end at 2:31 PM, the BFR was 400. There was no reason documented why the BFR was not 450 and no physician's order for BFR 400. Review of the RN Comprehensive Assessment Report dated 4/7/23 revealed documentation of a Kt/V on 3/6/23 of .76, on 3/10/23 of 0.93 and on 3/13/23 of 0.91. Further review revealed documentation of "meets adequacy goal." Review of the IDT meeting and POC dated 4/10/23 revealed no documentation the IDT developed and implemented interventions and goals to address in center HD Kt/V of less than 1.2. An interview was conducted on 4/13/23 at 12:02 PM with EI # 10, Senior Manager of Clinical Services, who confirmed there was no documentation of the reason the treatment BFR was not documented per the physician orders on 3/10/23, 3/13/23 and 3/20/23. EI # 10 also confirmed there was no documentation the IDT developed and implemented interventions and goals to address in center HD Kt/V of less than 1.2 in the patient's POC. 41624 4. PI # 5 was admitted to the facility on 11/23/22 with a diagnosis of ESRD. Review of HD Treatment Orders dated 3/28/23 included BFR 400 and DFR 800. Review of the TDR dated 3/28/23 revealed treatment began at 7:06 AM with BFR of 400 and DFR of 850. DFR was 790 from 7:26 AM to 8:46 AM, DFR was 840 from 9:06 AM to 9:46 AM, DFR was 780 at 10:06 AM, DFR was 790 at 10:26 AM, and DFR was 840 at end of treatment 10:38 AM. There was no documentation why the BFR was not at the ordered rate of 400. Review of the TDR dated 3/30/23 revealed

from treatment start at 7:20 AM until treatment end at 10:54 AM the BFR was 200. The DFR was 590 at start of treatment 7:20 AM, 610 from 7:40 AM to 8:20 AM, DFR was 600 at 8:40 AM, DFR was 610 at 9:00 AM, DFR was 600 at 9:20 AM, DFR was 600 at 10:00 AM, DFR was 610 from 10:20 AM until end of treatment at 10:54 AM. There was no documentation why the BFR was not at the ordered rate of 400, and no documentation why the DFR was not at the ordered rate of 800. Review of the TDR dated 4/1/23 revealed DFR at start of treatment 7:24 AM was 590, DFR was 610 at 7:44 AM, DFR was 600 from 8:04 AM to 8:25 AM, DFR was 610 at 8:45 AM, DFR was 600 from 9:25 AM to end of treatment at 10:58 AM. There was no documentation why the DFR was not at the ordered rate of 800. Review of the TDR dated 4/4/23 revealed BFR was 210 from start of treatment at 7:28 AM to end of treatment at 11:02 AM. The DFR at start of treatment 7:28 AM was 580, DFR was 610 from 7:48 AM to end of treatment at 11:02 AM. There was no documentation why the BFR was not at the ordered rate of 400, and no documentation why the DFR was not at the ordered rate of 800. Review of HD Treatment Orders dated 4/6/23 included BFR 250 and DFR 800. Review of the TDR dated 4/6/23 revealed BFR was 230 from start of treatment at 7:19 AM to end of treatment at 10:18 AM. There was no documentation why the BFR was not at the ordered rate of 250. Review of the TDR dated 4/8/23 revealed BFR was 200 from beginning of treatment at 8:01 AM to end of treatment at 10:54 AM. There was no documentation why the BFR was not at the ordered rate of 250. An interview was conducted on 4/13/23 at 11:47 AM with EI # 1 who confirmed the staff failed to follow the physician's orders for the BFR and/or DFR on 3/28/23, 3/30/23, 4/1/23, 4/4/23, 4/6/23, and 4/8/23,

V0550

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

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

This STANDARD is not met as evidenced by:
Based on the review of the facility policy, medical records, observations and interview, it was determined the facility failed to ensure the staff followed their own procedure for utilization of the vascular access clamps. This affected 1 of 3 patients observed using a vascular access clamp, which was Patient Identifier (PI) # 10 and had the potential to affect all patient served by this facility. Findings include: Facility Procedure: Utilizing Vascular Access Clamps Procedure #: 1-04-08A Revision Date: April 2023 Procedure: 5. After placement of clamp, check for thrill and bruit above and below clamp. If thrill cannot be palpated or bruit heard, release clamp slightly and recheck until thrill can be palpated or bruit heard. Rationale: 5. If thrill is not palpate or bruit heard, blood flow in the access is diminished and clotting may occur. Procedure: ...8. Clamp may remain in place for 5-10 minutes before checking to see if bleeding has stopped. 9. Bruit and thrill must be re-checked a minimum of every 10 minutes while using access clamps... 1. An observation was conducted on 4/11/23 at 12:05 PM at station 18 with Employee Identifier (EI) # 9, Patient Care Technician (PCT), to observe the discontinuation of dialysis and post dialysis AVF/AVG access care for PI # 10. During an observation, EI # 9 applied a vascular access clamp to the venous access site while the patient held the arterial access site at 12:08 PM. EI # 9 failed to check for thrill and bruit above and below clamp after the placement of the

clamp. EI # 9 did not return to the patient chair side until 12:22 PM, which was 14 minutes later. EI # 2 did not check to see if bleeding had stopped and the bruit and thrill were present after 10 minutes per policy. An interview was conducted on 4/13/23 at 11:04 AM with EI # 1, Facility Administrator, who confirmed EI # 9 did not follow the policy for vascular access clamps.