

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012508	(X3) Date Survey Completed 12/12/2019
Name of Provider or Supplier Birmingham East Dialysis	Street Address, City, State 1105 East Park Drive, Birmingham, 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 the recertification survey conducted on 12/10/19 to 12/12/19, the facility was found to be in substantial compliance with the Conditions of Participation for Emergency Preparedness.
V0000	CORE Based on the recertification survey conducted 12/10/19 to 12/12/19 standard level deficiencies were cited.
V0113	<p>IC-WEAR GLOVES/HAND HYGIENE CFR(s): 494.30(a)(1)</p> <p>Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.</p> <p>This STANDARD is not met as evidenced by: Based on review of facility policy, observations and interviews with the staff it was determined the facility failed to ensure staff followed the facility policy for: 1. Performing hand hygiene including sanitizing hands and changing gloves. This deficient practice had the potential to negatively affect all patients, visitors and staff. Findings include: Policy: Infection Control For Dialysis Facilities Policy Number: 1-05-01 Revised Date: April 2019 Purpose: To minimize the spread of infections or bloodborne pathogens in the dialysis facility environment. Policy: The centers for Disease Control (CDC) recommendations for Preventing Transmission of Infections among Chronic Hemodialysis Patients (Dialysis Precautions) will be followed when caring for all patients... 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... 2. If</p>

hands are not visibly contaminated, use of alcohol-based hand rub may be substituted for handwashing... Teammate/Patient Safety 11. Teammates will wear disposable gloves when caring for 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... 13. Gloves should be changed when: ...When going from a "dirty" area or task to a "clean" area or task. ...After touching one patient or their dialysis delivery system and before arriving to care for another patient or touch another patient's dialysis delivery system. ChairSideSnappy Terminal and Cart 71. The ChairSideSnappy cart, monitor and keyboard are considered clean areas. 72. Gloves are to be removed and hands washed or alcohol based hand rubs used before and after touching the keyboard. 1. During an observations of care conducted on 12/10/19 at 7:45 AM to 10:15 AM, the surveyor observed the following: At 8:02 AM, Employee Identifier (EI) # 5, Patient Care Technician (PCT), entered the treatment floor and went to station 1, applied gloves and reset the dialysis machine alarm. EI # 5 removed gloves and obtained face shield, reapplied gloves and addressed the alarms on the dialysis machine at station 3. EI # 5 failed to perform hand hygiene when entering the treatment floor, after removing gloves, and between touching different patient dialysis machines. At 8:30 AM after cleaning the dialysis station 7, EI # 4, PCT, removed gloves, obtained a clean dialysis set up for the next patient. EI # 4 failed to perform hand hygiene after removing gloves and before obtaining clean supplies. In an interview conducted on 12/10/19 at 10:00 AM, EI # 9, Facility Administrator # 2, confirmed the staff failed to follow facility policy for hand hygiene.

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, review of facility policy and interviews with staff, it was determined the facility failed to ensure 1. Reusable equipment was cleaned and disinfected after use. 2. Bleach solution was mixed daily and labeled. 3. Contaminated supplies was disposed of in the biohazard container. This deficient practice affected Patient Identifier (PI) # 9, # 10 and had the potential to negatively affect all patients in this facility. Findings Include: Title: Infection Control For Dialysis Facilities Policy: 1-06-01 Revision Date: October 2019 Policy: The Centers for Disease Control (CDC) Recommendations for Preventing Transmission of Infections among Chronic Hemodialysis Patients (Dialysis Precautions) will be followed when caring for all patients. ... 25. Non-disposable items are to be disinfected between patients. Dialysis Station Management... 66. Teammates will thoroughly wipe down all non-disposable items and equipment such the blood pressure cuff, the inside and outside of the prime container,... 73. Sufficient disinfectant should be applied so that surfaces are visibly wet. 74. Surfaces should be allowed to air dry in order to provide sufficient disinfectant contact time... 1. During the flash tour of the facility conducted on 12/10/19 at 7:45 AM, the surveyor observed the bleach container at the back of the nurse's station labeled as prepared on 12/9/19 at 5:00 AM. In an interview conducted on 12/10/19 at 9:00 AM, Employee Identifier (EI) # 9, Facility Administrator (FA) # 2, confirmed 1 of 2 bleach containers were not labeled correctly. 2. During an

observation of cleaning and disinfection of the dialysis station conducted on 12/10/19 at 8:30 AM the surveyor observed EI # 4, Patient Care Technician (PCT), clean the dialysis chair. EI # 4 opened the sides of the dialysis chair, cleaned with bleach soaked cloths and immediately closed the sides of the chair. EI # 4 failed to allow the chair to dry before closing the sides of chair as directed per policy. In an interview conducted on 12/10/19 at 9:30 AM, EI # 9, FA # 2, confirmed the above findings. 3. During and observation of care conducted on 12/10/19 at 8:50 AM, the surveyor observed EI # 5, PCT, change the transducer for PI # 10 at station 2. After connecting the new transducer, EI # 5 placed the bloody contaminated transducer directly on the chair side table. An interview was conducted on 12/10/19 at 9:30 AM with EI # 7, Registered Nurse, who confirmed the PCT should have placed the contaminated transducer in the biohazard container and not placed it on the chair side table. 4. An observation of care was conducted on 12/10/19 at 9:00 AM to observe EI # 3, RN Charge Nurse, perform CVC (Central Venous Catheter) care for PI #9. EI # 3 failed to disinfect the stethoscope after use on an unsampled patient at station 11, prior to auscultating PI # 9. An interview was conducted on 12/12/19 at 10:00 AM with EI # 1, who confirmed the above mentioned findings. 5. An observation of care was conducted on 12/11/19 at 11:30 AM to observe EI # 4, PCT, prepare the dialysis station for the next patient. EI # 4 checked the dialysis machine conductivity with the pHoenix meter, informed the surveyor of the result, then proceeded to place the used pHoenix meter on the counter top at the nurses station without disinfecting the machine. An interview was conducted on 12/12/19 at 10:05 AM with EI # 1 who confirmed the staff should have disinfecting the used pHoenix meter. 34107

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, review of facility policy, and interviews, it was determined the facility failed to ensure all expired medications were discarded by the facility staff. This had the potential to affect all patients dialyzed at the facility. Findings include:
Facility Policy: Medication Policy Policy #: 1-06-01 Revision Date: April 2019
Purpose: To provide guidance for medication management in the facility and to provide guidance for the safe and aseptic preparation of all medications. Policy: ... 28. Medications containing a preservative must be discarded 28 days after opening or accessed (e.g., needle punctured), unless the manufacturer specifies a different (shorter or longer) date or as directed by the manufacturer as in the case of vaccines or state specific pharmacy regulations. Each vial is labeled with the initials of the person opening the vial and the expiration date... 1. During an observation of care conducted on 12/10/19 at 10:00 AM, the surveyor observed a multi-dose vial of Zofran 40 milliliter (ml) labeled with the open date of 10/1/19. The surveyor asked Employee Identifier (EI) # 3, Registered Nurse (RN), "How long can this vial of Zofran be used?" EI # 3, replied, "90 days." On 12/11/19 at 8:15 AM the surveyor asked EI # 10, RN, to open the medication drawer and the surveyor observed the same vial of Zofran 40 ml labeled with the open date of 10/1/19. The surveyor asked EI # 10, "How long can this vial of Zofran be used?" EI # 10 stated, "60 days." In an interview conducted

on 12/11/19 at 9:00 AM, EI # 2, Manager Clinical Services, confirmed the staff lacked the knowledge of the facility policy for expired medications and failed to dispose of multi-dose vials with preservatives after 28 days.

V0199

RO-MEETS AAMI/MONITORED, RECORDED ON LOG
CFR(s): 494.40(a)

5.2.7 Reverse osmosis: meets AAMI/monitored/recorded on log Refer to RD62:2001, 4.3.7 Reverse osmosis: When used to prepare water for hemodialysis applications, either alone or as the last stage in a purification cascade, reverse osmosis systems shall be shown to be capable, at installation, of meeting the requirements of Table 1, when tested with the typical feed water of the user, in accordance with the methods of [AAMI] 5.2.2. 5.2.7 Reverse osmosis Users should carefully follow the manufacturer's instructions for feed water treatment and monitoring to ensure that the RO is operated within its design parameters. 6.2.7 Reverse osmosis All results of measurements of RO performance should be recorded daily in an operating log that permits trending and historical review.

This STANDARD is not met as evidenced by:

Based on review of facility Daily Water Treatment Log, DaVita Daily Water Treatment Log Explanation and staff interviews, it was determined the staff failed to check and document the product water quality values daily. Findings include: DaVita Daily Water Treatment Log Explanation Copyrighted 2017 ...RO (Reverse Osmosis) Product Water Quality... Enter the Product Water Quality values displayed on the RO Monitor. If the observed Quality value is outside the acceptable limits or if the RO monitor is not operational, immediately contact the Biomedical Team for direction and assistance. Review of the November 2019 Daily Water Treatment Log(s) revealed no documentation of the RO Product Water Quality from 11/18/19 to 11/24/19. An interview was conducted on 12/12/19 at 10:01 AM with Employee Identifier # 1, Facility Administrator, who confirmed the above findings.

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, review of facility procedures and interviews, it was determined the staff failed to: 1. Follow facility procedure for monitoring dialysate conductivity prior to treatment initiation. 2. Follow facility procedure for disinfection of the Phoenix XL meter. This affected 2 of 2 observations conducted to observe staff perform the conductivity using the Phoenix meter including Patient Identifier (PI) # 11 and had the potential to negatively affect all patients dialyzing in this facility. Findings include: Facility Procedure: Measuring Conductivity, Temperature and/or pH using the Phoenix Conductivity Meter Procedure Number: 2-08-01G Revision Date: April 2019 Materials required: ... Dialysis quality water Notes: Dialysis quality water should be obtained fresh same day of use prior to use with this procedure... Procedure... 3. Pull the syringe plunger and draw solution through the cell... observe

the reading on the meter display... 5. Expel sample solution into sink or waste container. 6. Rinse the cell and syringe interior by drawing dialysis quality water through the cell filling the syringe. Expel and discard water". Facility Procedure: Phoenix XL Meter Disinfection, Calibration Verification and Storage Procedures Procedure Number: 2-08-04 A Revision Date: October 2018 Procedure: ...3. Draw a 1% bleach solution through the measurement module and into the syringe.... 4. Allow 1% bleach solution to remain in instrument for 10 minutes... 5. Expel the bleach solution. Thoroughly rinse the 1% bleach solution from the syringe and measurement module by rapidly flushing with dialysis quality water at least three times. Document disinfection step on the pPhoenix XL meter log... 6. Test for residual bleach. After the bleach disinfection, equipment should not be used until results from residual bleach test have reached a level of less than 0.5 ppm (parts per million). Document the residual bleach test on the pPhoenix XL log. 1. During the flash tour of the facility conducted on 12/10/19 at 8:15 AM, the surveyor observed the Reverse Osmosis (RO) water on the Tri-Station was labeled 12/9/19. The staff failed to ensure the dialysis quality water was obtained fresh same day of use prior to use... In an interview conducted on 12/10/19 at 9:30 AM, Employee Identifier (EI) # 9, Facility Administrator (FA) # 2, confirmed the above findings. 2. An observation was conducted on 12/10/19 at 10:35 AM to observe EI # 5, Patient Care Technician (PCT), prepare the dialysis machine for PI # 11 at station 9. EI # 5 failed to rinse the phoenix meter with dialysis quality water before obtaining a dialysate sample. EI # 5 checked the conductivity with the phoenix meter, cleaned the meter, replaced the meter to the clean area. EI # 5 failed to rinse the cell and syringe with dialysis quality water after use. In an interview conducted on 12/12/19 at 11:30 AM, EI # 1, Facility Administrator, who confirmed the above findings. 22965 3. An observation was conducted on 12/10/19 at 11:30 AM to observe EI # 5, PCT, prepare the dialysis machine at station # 12. EI # 5 failed to rinse the pPhoenix meter with dialysis quality water before obtaining a dialysate sample for testing EI # 5 failed to rinse the cell and syringe with dialysis quality water after checking the conductivity and ph of Station 12 dialysis machine. An interview was conducted on 12/12/19 at 9:50 AM with EI # 1 who confirmed the staff failed to follow policy and procedures on the use of pPhoenix meters.

V0516

PA-FREQUENCY-INITIAL-30 DAYS/13 TX
CFR(s): 494.80(b)(1)

An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 hemodialysis sessions beginning with the first dialysis session.

This STANDARD is not met as evidenced by:
Based on the review of the facility policy, medical records (MR), and interviews with the staff, it was determined the facility failed to ensure the patients Initial Plan of Care was completed within 30 calendar days or 13 treatments of admission for 1 of 2 records of newly admitted patients to the facility. This affected Patient Identifier (PI) # 1, and had the potential to affect all patients dialyzed at this facility. Findings include: Facility Policy: Interdisciplinary Teams (IDT) Patient Assessment and Plan of Care (POC) Policy Number: 1-14-01 Revision Date: October 2019 Purpose: To provide guidance for the development of patient assessment and plan of care for IDT teammates. Policy: ... 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 needs... 10. An initial Plan of

Care, based on the findings from the comprehensive assessment, will be completed on all patients new to dialysis within 30 calendar days (or 13 outpatient dialysis sessions for hemodialysis) beginning with the first outpatient dialysis treatment or per state guidelines... Modality Change: Within 30 days of change in modality (or 13 treatments)... 1. PI # 1 was admitted to the facility on 9/23/19 with the diagnosis of End Stage Renal Disease (ESRD). Review of the medical record (MR) revealed the Comprehensive Assessments were completed on 12/6/19 by the Registered Nurse, Dietitian, and Social Worker. The new patient POC was scheduled for 12/16/19. In an interview conducted on 12/12/19 at 9:36 AM, Employee Identifier (EI) # 1, Facility Administrator, confirmed the facility failed to complete the new patient POC within 30 days or 13 treatments per policy.

V0544

POC-ACHIEVE ADEQUATE CLEARANCE
CFR(s): 494.90(a)(1)

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

This STANDARD is not met as evidenced by:
Based on observations, review of medical records, facility policy, and interviews, it was determined the facility failed to ensure: 1. Patient treatments were administered according to the physician orders for blood flow rate (BFR). 2. Heparin was administered as ordered. 3. Two teammates verified the dialysis prescription and machine settings before the initiation of treatment. This affected Patient Identifier (PI) # 1, PI # 3, PI # 4, 3 of 5 records reviewed and had the potential to negatively affect all patients that dialyze at this facility. Findings include: Title: Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment Policy Number: 1-03-08 Revision Date: April 2017 Purpose: To obtain and document baseline and ongoing information about the patient before, during and after the dialysis treatment 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. a. Data collection includes but is not necessarily limited to: 3. Patient...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... Prescription components include but are not necessarily limited to:... f. Blood flow rate... i. Correct dialysate composition ... and settings, including... 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, arterial and venous pressures... d. Hourly heparin infusion ordered by the physician... should be documented every 60 minutes... 10. If the dialysis prescription is not being met (including dialysis flow rate or change to / inability to obtain prescribed blood flow rate) the reason will be documented and the licensed nurse informed... 1. PI # 1 was admitted to the facility on 9/23/19 with the diagnosis of ESRD. Review of the 11/26/19 Post Treatment sheet revealed documentation the total Heparin administered was 0.5 Units. The amount should have been 1600 Units, and no physician's order was obtained to change the hourly Heparin dosage. Review of the 11/29/19 Post Treatment sheet revealed the BFR was decreased from 400 to 350 at 12:30 PM to 1:42 PM, and there was no documentation why the BFR was decreased. Review of the 12/2/19 Post Treatment sheet revealed the BFR was decreased from 400 to 300 at 10:02 AM to 11:02 AM. There was no

documentation why the BFR was decreased. Review of the 12/6/19 Post Treatment sheet revealed the BFR was decreased from 400 to 350 at 8:32 AM to 9:32 AM. There was no documentation why the BFR was decreased. In an interview conducted on 12/12/19, EI # 1, confirmed the staff failed to follow physician orders for Heparin and BFR. 2. PI # 3 was admitted to dialysis on 4/12/15 with a primary diagnosis of End stage Renal Disease. Review of the Treatment Orders dated 11/18/19 revealed the following hemodialysis order: Dialysate Flow Rate (DFR) 800. Review of the Hemodialysis Post Treatment sheet dated 12/6/19 revealed the DFR was decreased from 800 to 180 at 6:00 AM to 7:05 AM. There was no documentation why the DFR was decreased. In an interview with EI # 1 conducted on 12/12/19 at 10:00 AM, EI confirmed the above mentioned findings. 3. PI # 4 was admitted to the facility on 4/11/18 with diagnoses of End Stage Renal Disease. Review of the 11/26/19 Post Treatment sheet revealed the dialysis treatment was initiated at 5:47 AM by the PCT and the RN verified the machine prescription at 7:36 AM, which was 109 minutes after treatment initiation. Review of the 12/6/19 Post Treatment sheet revealed the dialysis treatment was initiated at 5:42 AM by the PCT and the RN verified the machine prescription at 8:13 AM, which was 151 minutes after treatment initiation. Review of the 12/9/19 Post Treatment sheet revealed the dialysis treatment was initiated at 5:53 AM by the PCT and the RN verified the machine prescription at 7:35 AM, which was 102 minutes after treatment initiation. In an interview conducted on 12/12/19 at 10:16 AM, EI # 1 confirmed the above findings.

V0550

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

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

This STANDARD is not met as evidenced by:

Based on review of medical record (MR), policy and procedure, staff and patient interviews, it was determined the facility failed to ensure the staff followed their own policy and procedure for care of an AVF/AVG (Arteriovenous Fistula/Graft). This affected 1 of 1 records reviewed with a new AVF/AVG including PI #1. This had the potential to negatively affect all patients with a new AVF/AVG (arteriovenous fistula /graft). Findings Include: Policy Title: Arteriovenous Fistula (AVF) and Arteriovenous Graft (AVG) Vascular Access Care Policy #: 1-04-01 Revision Date: April 2018 "Purpose: To reduce the risk of infection in the patient, to reduce trauma to the fistula or graft while minimizing blood loss and to maximize the lifetime of each access. Policy: 1. Inspection of the AVF or AVG access includes the following: ... Presence/absence of thrill and/or bruit ... Physical location of the access ... Condition of incision(s) especially in newly placed access or revised access ... 1. PI # 1 was admitted to the facility on 9/23/19 with the diagnosis of End Stage Renal Disease. Review of the 11/15/19 Hospital Operation Note revealed documentation a left arm fistula was placed in the cephalic vein and radial artery. Further documentation revealed a 3 centimeter incision and an excellent thrill noted. Review of the 11/26/19, 11/29/19, 12/2/19, 12/4/19, 12/6/19, and 12/9/19 Post Treatment sheets revealed no documentation the staff assessed the newly placed left AVF for

bruit and thrill or signs /symptoms of infection. In an interview conducted on 12/12/19 at 9:36 AM, Employee Identifier (EI) # 1, Facility Administrator, confirmed the staff failed to document the assessment of the newly placed AVF.

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 observations, review of facility policies, review of Early Termination of Treatment Against Medical Advice forms, and interview it was determined the facility failed to ensure: 1. The facility policy for Early Termination of Treatment Against Medical Advice was followed. This affected 6 of 6 records reviewed including Patient Identifier (PI) # 14, #8, # 9, # 4, # 13 and # 12. 2. Treatment notes included documentation of Oxygen administered during treatments. This affected 3 of 3 patients receiving oxygen therapy including PI # 3, # 13 and # 16. These deficient practices had the potential to negatively affect all patients receiving dialysis at this facility. Findings include: Facility Policy: Early Termination of Treatment Against Medical Advice Policy #: 1-01-09 Revision Date: October 2019 Purpose: To provide requirements for teammates to follow when a patient's treatment is terminated early or extended. Policy: A. Completion of the Early Termination of Treatment Against Medical Advice Form. 1. The RN will verify that a patient signs the Early Treatment Against Medical Advice (ETAMA) form any time the patient requests to terminate their treatment earlier than the prescribed run time... 3. If a patient's treatment is terminated early, the RN (Registered Nurse) will obtain the patient's signature on the ETAMA form prior to the patient being rinsed back from their treatment. If unable to obtain the patient's signature prior to rinse-back from their treatment, the RN will obtain the patient's signature on the form prior to the patient's departure from the facility... B. Prescribed Treatment Time Not Met... 3. If a patient's treatment is shortened/ early terminated... - The amount of time by which the treatment was shortened; - A description of why the treatment was shortened... Facility Policy: Medication Policy Policy #: 1-06-01 Revision Date: April 2019 Purpose: To provide guidance for medication management in the facility... Policy: ...9. Medications are administered as prescribed and then documented in the patient's medical record... 1. During the flash tour of the facility conducted on 12/10/19 at 7:45 AM, the surveyor observed a stack of incomplete Early Termination of Treatment forms on the nurse's desk. The forms had a purple sticky note with, "Need to be signed (Employee Identifier [EI] # 7, RN)" Review of the ETAMA form printed on 11/15/19 for PI # 14 revealed no documentation for the: Prescribed treatment time, Shortened treatment by ___ minutes, and the Reason (specify): were all blank. Further review of the form revealed no signature by the patient, witness, or nurse and the date was blank. The RN failed to complete the ETAMA form per policy. Review of the ETAMA form printed on 11/21/19 for PI # 8 revealed no documentation for the: Prescribed treatment time, and the Reason (specify): was blank. Further review of the form revealed no signature by the patient, or nurse and the date was blank. The RN failed to complete the ETAMA form per policy. Review of the ETAMA form printed on 11/21/19 for PI # 9 revealed no patient and nurse signature, and the date was blank. The RN failed to complete the ETAMA form per policy. Review of the ETAMA form printed on 11/22

/19 for PI # 8 revealed the following were blank: Prescribed treatment time; Reason treatment was shortened; Patient Signature and Licensed Nurse Signature. The RN failed to complete the ETAMA form per policy. Review of the ETAMA form printed on 12/6/19 for PI # 4 revealed no documentation for the prescribed treatment time, shortened treatment time, reason for shortened treatment and no signature and date by the Licensed Nurse. The RN failed to complete the ETAMA form per policy. Review of the ETAMA form printed on 12/6/19 for PI # 13 revealed no signature and date by the Licensed Nurse. The RN failed to complete the ETAMA form per policy. Review of the ETAMA form printed on 12/7/19 for PI # 12 revealed no signature for the Licensed Nurse and the date was blank. The RN failed to complete the ETAMA form per policy. In an interview conducted on 12/11/19 at 11:11 AM, EI # 2, Manager Clinical Services, confirmed the RN failed to complete ETAMA forms per policy. 40119 2. During an observation of the dialysis floor conducted on 12/11/19 at 8:00 AM the following patients were observed by the surveyor to have oxygen administration during the treatment: PI # 3, with oxygen concentrator set on 2 Liters. PI # 13, with oxygen concentrator set between 1.5 and 2 Liters PI # 16, with oxygen concentrator set at 2 Liters. Review of the Post Treatment Notes for PI # 3, PI # 13, and PI # 16 dated 12/11/19 revealed no documentation of the oxygen administration during the treatment. An interview was conducted on 12/12/19 at 9:56 AM with EI # 1, who confirmed the above findings.