

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  012509	<b>(X3) Date Survey Completed</b>  03/30/2023
<b>Name of Provider or Supplier</b>  North Alabama Nephrology Center	<b>Street Address, City, State</b>  1311 North Memorial Parkway #200, Huntsville, 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 a recertification survey conducted from 3/28/23 to 3/30/23, North Alabama Nephrology Center was found to be in substantial compliance with the Conditions of Participation for Emergency Preparedness.
<b>V0000</b>	"Core" A recertification survey was conducted on 3/28/23 to 3/30/23 at North Alabama Nephrology Center. Condition level and related standard level deficiencies were cited for 494.30 Infection Control.
<b>V0101</b>	<p><b>COMPLIANCE WITH FED/STATE/LOCAL LAWS</b> CFR(s): 494.20</p> <p>The facility and its staff must operate and furnish services in compliance with applicable Federal, State, and local laws and regulations pertaining to licensure and any other relevant health and safety requirements.</p> <p>This STANDARD is not met as evidenced by: Based on review of the Alabama Department of Public Health for Rules for End Stage Renal Disease Treatment and Transplant Centers Chapter 420-5-5, the facility Absence and Hospitalization, Discharged to the Hospital Report documentation, and staff interviews, it was determined the facility failed to follow State Licensure Rules for End Stage Renal Disease for reporting all unusual occurrences to the State Survey Agency (SSA) for unscheduled transports to a hospital. This had the potential to affect all patients served by the facility. Findings include: Rules of Alabama State Board of Health Alabama Department of Public Health Chapter 420-5-5 End Stage Renal Disease Treatment and Transplant Centers Amended December 18, 2007 page 7 420-5-5-.01 General (7) Unusual Occurrences Unusual occurrences which threaten the welfare, safety and health of patients, personnel or visitors shall be reported by the ESRD (End Stage Renal Disease) facility within 24 hours, either by telephone (and confirmed in writing), or by facsimile to the Alabama Department of Public Health,</p>

Division of Health Care Facilities, and other agencies/authorities as required. Examples of unusual occurrences include: misuse of medical devices or medications, defective devices, suspected cases of patient abuse or neglect, life threatening burns, fires or other catastrophic occurrences, medical conditions or deaths that occur as the result of unusual circumstances. Any acute event that results in a patient receiving emergency treatment must be reported. Emergency treatment includes unscheduled transportation to a hospital or receipt of cardiac life support from a hospital, ambulance service or rescue squad, or staff member. Also, to be reported are outbreaks of infectious disease or any condition in the facility, including the water treatment system, which would necessitate the temporary or long term closure of the dialysis facility (excluding inclement weather). Review of the facility Absence and Hospitalization, Discharged to the Hospital Report dated 3/28/22 to 3/28/23, revealed a total of 15 patients were discharged to the hospital. An interview was conducted on 3/30/23 at 8:10 AM with EI (Employee Identifier) # 1, Facility Administrator who verified the 15 patients documented on the Absence and Hospitalization, Discharged to the Hospital Report were transferred from the facility to the hospital per emergency /ambulance service. The surveyor requested the facility documentation for all unusual occurrences reported to the SSA over the past 12 months. No documentation was provided. During an interview conducted on 3/30/23 at 8:46 AM, EI # 1 confirmed there was no documentation the facility reported any unusual occurrences from January 2022 to March 28, 2023 to the SSA including unplanned transfers to the hospital from the facility.

**V0110**

CFC-INFECTION CONTROL  
CFR(s): 494.30

This CONDITION is not met as evidenced by:  
Based on observations, facility policies and procedures, and interviews, 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 119, V 122, V 130, and V 143.

**V0111**

IC-SANITARY ENVIRONMENT  
CFR(s): 494.30

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

This STANDARD is not met as evidenced by:  
Based on observation, review of facility policy and procedure, and staff interview, it was determined the staff failed to ensure hemostasis was achieved and each needle site was clean and dry prior to discharge when discontinuing an AVF/AVG (arteriovenous fistula/graft). This did affect Patient Identifier (PI) # 9, one of two patients observed for discontinuation of dialysis and post dialysis access care for AVF /AVG. Findings include: Facility Policy: Post Treatment Fistula Needle Removal Version: 2 Published: 07/06/2021 Procedure: 8. Once hemostasis is achieved: ... Remove the gauze... Place a Band-Aid, adhesive dressing or gauze dressing secured with clean tape Facility Policy: Patient Assessment and Monitoring Version: 3 Published: 09/29/2018 Post Treatment Follow the steps below for obtaining post-

treatment assessment data: 1. The direct patient care staff may obtain the following: Assessment and Data Collection Access... Evaluate access prior to discharge for: ... Bleeding... Swelling... Any changes during the treatment. 1. An observation was conducted on 3/29/23 at 10:05 AM to observe Employee Identifier (EI) # 6, Certified Clinical Hemodialysis Technician (CCHT), discontinue dialysis on PI # 9 at station 5 with an AVF/AVG. After holding pressure to the second needle site, PI # 9 removed his/her glove and proceeded to exit the treatment floor at 10:20 AM without having his /her AVF/AVG examined for hemostasis (the stopping of a flow of blood). EI # 6 failed to ensure hemostasis was achieved and that each needle site was clean and dry prior to discharge. An interview was conducted on 3/30/23 at 10:01 AM with EI # 1, Facility Administrator, who confirmed the staff failed to follow the facility policy for discontinuation of dialysis with an AV Fistula/AV Graft.

**V0113**

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

Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.

This STANDARD is not met as evidenced by:  
Based on observations, review of the facility policy and staff interviews, it was determined the facility failed to ensure: 1. Staff followed the facility policy for hand hygiene during observations conducted during: a. three of three accesses of AVF /AVG (arteriovenous fistula/graft) for initiation of dialysis including Patient Identifier (PI) #10, PI # 11, and PI # 8. b. two of two AVF/AVG discontinuation of dialysis including PI # 12, and PI # 9. 2. Staff followed the facility policy and maintained fingernails no greater in length than one quarter inch (1/4 in). 3. Patients performed hand hygiene after holding exit sites prior to exiting the clinic including PI # 9, and an unsampled patient observed during a blood loss after dialysis treatment discontinuation. This had the potential to negatively affect all patients who dialyze at the facility, staff, and visitors. Findings include: Facility Policy: Hand Hygiene Published: 11/4/19 Reference Number: 47664 Version: 6 Purpose: The purpose of this policy is to prevent transmission of pathogenic microorganisms to patients and staff through cross contamination. Responsibility All staff, patients...must follow the same requirements for hand hygiene. Policy: Hand hygiene includes either washing hands with soap and water or using a waterless alcohol-based antiseptic hand rub with 60-90% alcohol content... ...below identifies when hands should be washed specifically with soap and water or when alcohol-based hand rubs can be used: Before and after direct contact with patients Entering and leaving the treatment area ...Before performing any invasive procedure such as vascular access cannulation or administration of parental medications. Immediately after removing gloves. After contact with body fluids or excretion.... ...After contact with inanimate objects near the patient. When moving from a contaminated body site to a clean body site... Hand Hygiene: Patients Patients should perform hand hygiene if able, prior to and after each dialysis treatment. Caution Regarding Fingernails ...Natural fingernails length shall be kept to 1/4 inch or less... During observations of care on 3/29/23 from 7:05 AM until 11:30 AM, the following were observed: 1. At 7:45 AM at station 10 during dialysis treatment initiation with an AVF/AVG access for PI # 10, Employee Identifier (EI) # 7, PCT (Patient Care Technician), with gloves on, cleaned the stethoscope with an alcohol pad, evaluated the access sites using a stethoscope and palpation, applied antiseptic using two alcohol pads to the cannulation sites, and inserted the cannulation

needles. Next EI # 7 documented at the dialysis machine keyboard, initiated the treatment, removed his/her gloves, then sanitized his/her hands. EI # 7 failed to perform hand hygiene after access site evaluation and before access site antisepsis. EI # 7 failed to perform hand hygiene after access site cannulation and before documenting on the dialysis keyboard. In an interview conducted on 3/30/23 at 10:05 AM, EI # 1, Facility Administrator, confirmed staff failed to follow facility policy for hand hygiene during treatment initiation. 2. At 7:49 AM, the surveyor observed EI # 3, RN (Registered Nurse) tapping his/her nails on the surface of the common supply cart across from station 6 and station 7. The surveyor observed EI # 3's nails were greater than one fourth inch in length. In an interview on 3/29/23 at 7:50 AM, EI # 3 stated his/her nails were natural and were greater than 1/4 in length. 3. At 7:59 AM at station 15 during dialysis treatment initiation with an AVF/AVG access for PI # 8, EI # 5, Certified Clinical Hemodialysis Technician (CCHT), with gloves on, cleaned the stethoscope with an alcohol pad, evaluated the access sites using a stethoscope and palpation, applied antiseptic using two alcohol pads to the cannulation sites, and inserted the cannulation needles. EI # 5 failed to perform hand hygiene after access site evaluation and before access site antisepsis. In an interview conducted on 3/30/23 at 10:01 AM, EI # 1 confirmed staff failed to follow the facility hand hygiene policy. 4. At 8:45 AM, EI # 6, CCHT was observed at station 4 discontinuing dialysis for an AVF for PI # 12. EI # 6 reinfused the extracorporeal circuit and disconnected the bloodlines. EI # 6 failed to remove gloves and perform hand hygiene after disconnecting the bloodlines. In an interview conducted on 3/30/23 at 10:05 AM, EI # 1, confirmed staff failed to perform hand hygiene per facility policy. 5. At 9:52 AM, an unsampled patient was observed at station 20 after dialysis was discontinued via an AVF/AVG. The patient stood, and exited the station. While walking in the treatment area, the cannulation sites began to bleed. Site care was performed by EI # 8, CCHT, and a new dressing was applied. After holding pressure to both cannulation sites with a gloved hand, the unsampled patient removed his/her glove and exited the treatment floor at 10:32 AM without performing hand hygiene per facility policy. The staff failed to ensure the patient performed hand hygiene after glove removal and after holding access sites. In an interview conducted on 3/30/23 at 10:05 AM, EI # 1 confirmed staff failed to ensure the facility hand hygiene policy was followed. 6. At 10:05 AM EI # 6 was observed at station 4 discontinuing dialysis for an AVF/AVG for PI # 9. After holding pressure to both cannulation sites with a gloved hand, PI # 9 removed his/her glove and proceeded to exit the treatment floor at 10:20 AM without performing hand hygiene per facility policy. In an interview conducted on 3/30/23 at 10:01 AM, EI # 1 confirmed staff failed to ensure the facility hand hygiene policy was followed. 7. At 10:15 AM, while working at station 6, EI # 3, performed two unsuccessful attempts to access a new AVG for PI # 11. EI # 3 left the cannulation needle in place, and summoned EI # 5, to the station. EI # 5 donned gloves, cleaned the stethoscope with an alcohol prep pad, assessed the access site and needle placement, removed the tape, repositioned the cannulation needle with blood return. With the same gloves on, EI # 5 accessed the second access location using the stethoscope, cleaned the access site with an antiseptic, an alcohol prep pad, then cannulated the second access site with blood return. EI # 5 failed to perform hand hygiene after access site evaluation and before antiseptic application to the access site. In an interview conducted on 3/30/23 at 10:05 AM with EI # 1, Facility Administrator, the surveyors reviewed the infection control observation findings that included staff's failure to follow facility policy for hand hygiene during treatment initiation/discontinuation with an AVF/AVG, staff fingernail length noncompliance, and patient's failure to perform hand hygiene after holding access sites before exiting the treatment floor. EI # 3 confirmed staff failed to follow facility infection control policies. 28327 41624

## IC-SUPPLY CART DISTANT/NO SUPPLIES IN POCKETS

CFR(s): 494.30(a)(1)(i)

If a common supply cart is used to store clean supplies in the patient treatment area, this cart should remain in a designated area at a sufficient distance from patient stations to avoid contamination with blood. Such carts should not be moved between stations to distribute supplies. Do not carry medication vials, syringes, alcohol swabs or supplies in pockets.

This STANDARD is not met as evidenced by:

Based on observation, review of facility policy and procedure, and interview, it was determined the facility failed to ensure staff disinfected the dialysis station before patient supplies were set up per facility policy. This had the potential to negatively affect all patients who dialyzed at the facility. Findings include: Facility Policy: Cleaning and Disinfection of the Dialysis Station Reference Number: 47806 Published: 11/07/2022 Version: 13 Purpose The purpose of this policy is to provide guidelines to prevent the spread of infectious disease in accordance with appropriate regulations, and to maintain a clean, safe, and aesthetically pleasant environment for patients, staff, and visitors. Responsibility All dialysis facility staff Background The Centers for Medicare and Medicaid Services (CMS) has regulations that in order to prevent contamination, a dialysis station must be cleaned and disinfected between dialysis patients. The chair and dialysis equipment are used by multiple patients during a treatment, and it is critical that these be thoroughly cleaned and disinfected between uses. Definition Dialysis Station: Area including the dialysis machine, chair /bed and other reusable equipment or supplies utilized during dialysis treatment... Equipment in the dialysis station may include... the following: Dialysis machine /cycler and attachments such as IV (Intravenous) pole, B/P (Blood Pressure) cuff... Chair/bed General Cleaning The dialysis station could become contaminated with blood and other body fluids during treatment. Work Surface Cleaning and Disinfection without Visible Blood using Bleach Solutions. All work surfaces shall be cleaned and disinfected with 1:100 bleach solution after completion of procedures. Make the surface glistening wet and let air dry unless otherwise specified by the manufacturer. Vacating the Machine To prevent cross-contamination between patients...the previous patient...vacate the station before staff begin cleaning and disinfection of the station and set up for the next patient. For patients dialyzing in a treatment area where multiple patients dialyze...vacate the dialysis station before the dialysis machine can be externally disinfected, allowed to dry and set up for the next treatment. Procedure Follow the steps below to disinfect the dialysis station after each dialysis treatment: Step: ...3. Use a cloth wetted with 1:100 bleach solution... to clean and disinfect the dialysis station (chair/bed, tables, machine, television, IV pole, B/P cuff... chaise wall behind chair... 4. Clean all surfaces... 1. On 3/29/23 at 9:22 AM, the surveyor observed EI (Employee Identifier) # 6, CCHT (Certified Clinical Hemodialysis Technician) clean/disinfect the dialysis machine at station 4. After EI # 6 disinfected the dialysis machine, EI # 6 cleaned the left chairside table top, exited the station and returned with patient supplies, a dialyzer, saline solution bag and dialysis lines and proceeded to set up the saline solution, prime the dialysis lines and dialyzer. EI # 6 failed to complete the dialysis station disinfection before patient supplies were brought to the station and treatment set up for the next patient had begun. In an interview conducted on 3/30/23 at 10:05 AM, EI # 1, Facility Administrator confirmed staff failed to follow the facility policy and disinfect the dialysis station before setting up the dialysis machine for the patient.

[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 procedure, and interview, it was determined the facility failed to ensure staff cleaned and disinfected the dialysis station after patient treatments. This affected two of two observations of the cleaning and disinfection of the dialysis station. Findings include: Facility Policy: Cleaning and Disinfection of the Dialysis Station Reference Number: 47806 Published: 11/07/2022 Version: 13 Purpose The purpose of this policy is to provide guidelines to prevent the spread of infectious disease in accordance with appropriate regulations, and to maintain a clean, safe, and aesthetically pleasant environment for patients, staff, and visitors. Responsibility All dialysis facility staff Background The Centers for Medicare and Medicaid Services (CMS) has regulations that in order to prevent contamination, a dialysis station must be cleaned and disinfected between dialysis patients... Definition Dialysis Station: Area including the dialysis machine, chair/bed and other reusable equipment or supplies utilized during dialysis treatment... Equipment in the dialysis station may include... the following: Dialysis machine /cycler and attachments such as IV (Intravenous) pole, B/P (Blood Pressure) cuff... Chair/bed General Cleaning The dialysis station could become contaminated with blood and other body fluids during treatment. Work Surface Cleaning and Disinfection without Visible Blood using Bleach Solutions. All work surfaces shall be cleaned and disinfected with 1:100 bleach solution after completion of procedures. Make the surface glistening wet and let air dry unless otherwise specified by the manufacturer. Procedure Follow the steps below to disinfect the dialysis station after each dialysis treatment: Step: ...3. Use a cloth wetted with 1:100 bleach solution... to clean and disinfect the dialysis station (chair/bed, tables, machine, television, IV pole, B/P cuff... wall behind chair... 4. Clean all surfaces... 1. An observation was conducted on 3/29/23 at 9:22 AM to observe EI (Employee Identifier) # 6, Certified Clinical Hemodialysis Technician (CCHT), perform cleaning and disinfection of station 4. EI # 6 removed the television remote from the wire basket on the side of the dialysis machine, cleaned the remote then placed the clean remote back in the wire basket which had not been cleaned. EI # 6 failed to disinfect the wire basket and the surface inside the basket. EI # 6 failed to disinfect the sharps container on the dialysis machine. In an interview conducted on 3/30/23 at 10:05 AM with EI # 1, Facility Administrator, the surveyors reviewed observations for dialysis station cleaning and disinfection. EI # 1 confirmed staff failed to follow the facility policy for dialysis station cleaning/disinfection. 2. An observation was conducted on 3/29/23 at 9:35 AM to observe EI # 8, Certified Clinical Nephrology Technician (CCNT), perform cleaning and disinfection of dialysis station 17. EI # 8 first cleaned the dialysis chair with bleach cloths and failed to ensure all surfaces were visibly wet. EI # 8 failed to clean and disinfect underneath the chairside tabletops bilaterally. EI # 6 then proceeded to unplug the chair and failed to the clean and disinfect the cord and placed the chair cord in the chair. EI # 8 failed to re-clean the chair after placing the dirty chair cord in the chair. EI # 8 then began cleaning and disinfection of the dialysis machine and equipment. EI # 8 cleaned and disinfected the B/P cuff and placed the B /P cuff in the dirty chair without first re-cleaning the chair. Further observations

revealed EI # 8 failed to clean and disinfect the front surfaces of the dialysis machine (Heparin pump and Venous chamber), the side surfaces (IV pole, wire basket, television remote, sharps container, dialysate hoses, Hansen connectors), and the counter top behind the dialysis station. An interview was conducted on 3/30/23 at 10:01 AM, with EI # 1, who confirmed the staff failed to follow the facility policy for cleaning and disinfection of the dialysis station. 30952

**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: Facility Policy: Dialyzing Patients with Positive Hepatitis B Antigen (HBsAg+) Published 3/20/13 Policy Number: None Version: Seven Purpose: To prevent transmission of Hepatitis B Equipment and Supplies: Separated dedicated supplies and equipment...must be used to provide care to the HBsAG positive patient: All supplies used in the isolation room/area such as clamps, blood pressure cuffs, testing reagents, etc., should be labeled "isolation" and not routinely removed. 1. On 3/28/23 at 9:20 AM observations were conducted with EI (Employee Identifier) # 2, RN (Registered Nurse), facility Charge Nurse, in the isolation room during inspection of the equipment/supplies housed in the isolation unit. There was no isolation label on the following equipment/supplies: Patient treatment chair One HD (Hemodialysis) machine # (number) 22 One container for 1 to 100 bleach concentration One gallon size container of Pure Bright bleach One Rolling Sharps container One Rolling Bio-hazard box One Treatment stool In an interview conducted on 3/28/23 at 9:29 AM, EI # 2 confirmed all equipment and supplies in the isolation room were not labeled and designated for isolation only use.

**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 interview, it was determined the facility staff failed to ensure: 1. All multi-dose medication vials (MDV) were labeled legibly when opened. 2. All intravenous (IV) medications were secured and stored according to facility policy. This affected three of four observations for IV medication preparation and administration, and included PI (Patient Identifier) # 8, PI # 6, and PI # 14, and had the potential to negatively affect all patients served by this facility. Findings include: Facility Policy: Medication Preparation and Administration Published: 2/6/23 Reference Number: 47488 Version: 9 Purpose: To administer medications with the goals of staff and patient safety, optimal therapeutic response,

and infection control. ...Labeling Vials: When preparing medications if the vial is not used immediately in its entirety, the nurse ... must place the date and time the vial was opened on the medication label along with their initials. ...Pre-drawing Medications Medications may be pre-drawn up to 4 hours... These pre-drawn medications shall be labeled and must be kept under the preparer's control or in a locked designated medication storage area ... until delivery to the appropriate patient for administration. ...Monitoring Expired Medications: ...Any open multi-dose vials must be discarded 28 days after opening or per manufacturer's expiration date. 1. During a tour of the treatment floor 3/28/23 at 8:30 AM, an open MDV of Tuberculin Purified Protein Derivative (PPD) with an expiration date of 10/25/23 was observed stored inside the Helmer refrigerator. There was a label on the MDV that was completely illegible, rendering it impossible for facility staff to be able to determine when the MDV was opened, or when the MDV needed to be discarded. In an interview on 3/28/23 at 8:45 AM, Employee Identifier (EI) # 2, Registered Nurse, (RN) Charge Nurse, who was present during the tour, confirmed the open MDV Tuberculin PPD date was not legible. 30952 2. During observations on the treatment floor on 3/29/23 at 8:10 AM, EI # 3, RN entered the patient treatment floor around the area of stations 11, station 15, and station 10 with prefilled/prepared IV medications in hand. EI # 3 placed two IV syringes on the supply cart across from the station, exited the supply cart, and entered station 11, leaving the IV medications unattended on the supply cart. EI # 3 returned to the supply cart, retrieved the two syringes, entered station 15, and placed the two syringes on the chairside table at station 15. Next, EI # 3 exited station 15 and entered station 10. After approximately two to three minutes, EI # 3 returned to station 15 and administered the two IV medications to PI # 8. EI # 3 failed to ensure IV medications were stored and secured per policy. In an interview conducted on 3/30/23 at 10:05 AM, EI # 1, Facility Administrator confirmed staff failed to follow the facility policy for IV medications. 3. An observation was conducted on 3/29/23 at 10:21 AM to observe EI # 4, RN, prepare and administer an IV medication for PI # 14 at station 17. After preparing the IV medication (Venofer), EI # 4 proceeded to station 17 and placed the IV medication (Venofer) on the chair side tabletop. EI # 4 then left the station and proceeded to the medication preparation area, leaving the IV medication (Venofer) unsecured/unattended. An interview was conducted on 3/30/23 at 10:01 AM, EI # 1 confirmed staff failed to store medications as directed per the facility policy. 4. During observations on the treatment floor at 11:08 AM, EI # 3, RN placed two syringes filled with IV medication and two prefilled saline syringes on the supply cart across from station 6. EI # 3 left the supply cart leaving the IV medications on the supply cart unsecured. The staff failed to ensure IV medications were stored and secured per policy. In an interview on 3/29/23 at 11:10 AM, EI # 2, witnessed to the unsecured syringes, confirmed staff should not leave medications unsecured. On 3/29/23 at 11:15 AM, the surveyor observed EI # 3 retrieved and administered the IV medications to PI # 6 during treatment discontinuation. In an interview conducted on 3/30/23 at 10:05 AM, EI # 1 confirmed staff failed to follow the facility policy for IV medications. 28327

**V0228**

**MIXING SYSTEMS-LABELING**  
CFR(s): 494.40(a)

5.4.4.1 Mixing systems: labeling Labeling strategies should permit positive identification by anyone using the contents of mixing tanks, bulk storage/dispensing tanks, and small containers intended for use with a single hemodialysis machine. Mixing tanks: Prior to batch preparation, a label should be affixed to the mixing tank that includes the date of preparation and the chemical composition or formulation of the concentrate being prepared. This labeling should remain on the mixing tank until

the tank has been emptied. Bulk storage/dispensing tanks: These tanks should be permanently labeled to identify the chemical composition or formulation of their contents. Concentrate jugs: At a minimum, concentrate jugs should be labeled with sufficient information to differentiate the contents from other concentrate formulations used at the facility.

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 bicarbonate (bicarb) mixing systems were labeled for one of one observation as directed per the facility policy while patients were being dialyzed in the facility. This had the potential to negatively affect all patients being dialyzed by this facility. Findings include: Facility Policy: Concentrate Labeling Requirements Version 5 Published: 05/27/2021 Policy: Temporary Labeling When a mix tank contains a solution, a label identifying the solution must be conspicuously displayed on the tank and must remain until the mix tank is emptied. Mix tank labeling must include: Date and time of mixing. 1. During a tour of the water treatment room on 3/29/23 at 8:25 AM with Employee Identifier (EI) # 6, Certified Clinical Hemodialysis Technician (CCHT), an observation was conducted of the bicarb system mixing area which revealed the presence of one bicarb mix and distribution tank. The bicarb mix and distribution tank was filled with approximately 75 gallons of solution and two labels on the tank read, "Tank Empty, Date, Time, Initials". There was no label identifying the solution, date, time, and initials documented on the label of the mixing and distribution tank per the tank label and facility policy. The surveyor asked EI # 6, "Is this the bicarb solution the patients are currently dialyzing on?" EI # 6 replied, "Yes". The surveyor then asked EI # 6, "Is the tank labeled per the facility policy?" EI # 6, replied, "No". An interview was conducted on 3/29/23 at 8:40 AM with EI # 1, Facility Administrator, who verified the Bicarb mixing systems tank was not labeled as directed per the facility policy.

**V0403**

PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU  
CFR(s): 494.60(b)

The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations.

This STANDARD is not met as evidenced by:

Based on observations, review of facility policies, Occupational Safety & (and) Health Administration (OSHA) guidelines, and interviews, it was determined the facility failed to ensure: a. Oxygen cylinders stored in the facility were secured and protected. b. Supplies available for patient use were not expired. This did affect two of two observations conducted and had the potential to negatively affect all patients who dialyze at this facility. Findings include: Facility Policy: Emergency Administration of Oxygen Reference Number: 47557 Version: 3 Published: 11/01/2021 Oxygen Cylinders Oxygen (O2) cylinders must be secured in an area where they will not fall. OSHA: Compressed Gas Safety General Safety Guidelines 2. Cylinder Storage Gas cylinders must be secured at all times to prevent tipping. Use appropriate material, such as chain, plastic coated wire cable, commercial straps ... to secure cylinders. ... Cylinders must be stored where they are protected from the ground to prevent rusting... Facility Policy: Storage of Supplies Version: 2 Published: 04/05/2021

Background: Proper storage conditions are necessary to provide a safe environment and to ensure supplies are not expired... Policy ... Supplies must be rotated... to ensure products maintain quality and do not expire. Appropriately dispose of items that have reached the expiration date. 1. During the flash tour of the facility on 3/28/23 at 8:30 AM and during observations on 3/29/23 at 7:11 AM, the surveyor observed two upright, free-standing O2 cylinders in the medical records room, which was located inside the treatment floor. The O2 cylinders were not secured to prevent from tipping. Further observations during the flash tour of the treatment floor on 3/28/23 at 8:55 AM revealed the following supplies were expired: Supply Drawer Cabinet next to station 1: a. Male to Male Luer Adapters x (times) 51: expired 9/19/21 Supply Drawer Cabinets in the center aisle: a. Male to Male Luer Adapters x 37: expired 4/17/22 Supply Drawers Cabinet located next to the medication preparation area: a. two packages of Oxygen Nasal Cannula Flared Tip: expired 7/15/22 b. two Yankauer Suction Instruments: expired 7/25/22 An interview was conducted on 3/28/23 at 9:00 AM with Employee Identifier (EI) # 2, Registered Nurse(RN), Charge Nurse (CN) who verified the supplies were expired and available for patient use. 2. During inspection of the isolation room supplies and equipment on 3/28/23 at 9:20 AM, the following supplies were observed in the supply cart as expired: a. Six male to male adapters: expired 9/19/21 b. One male to male adapter: expired 4/17/22 c. One Diasafe Plus filter expired: 4/30/22 In an interview conducted on 3/28/23 at 9:29 AM, EI # 2, who was present during the inspection, confirmed the isolation supplies were expired. An interview was conducted on 3/29/23 at 8:20 AM with EI # 2 who verified the O2 cylinders were not secured per facility policy and OSHA guidelines. 30952 41624

**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 policy, and staff interviews, it was determined the facility failed to ensure the staff followed the physician orders for: 1. BFR (Blood Flow Rate) 2. DFR (Dialysate Flow Rate). This affected five of five MR's reviewed, including PI (Patient Identifier) # 3, PI # 1, PI # 4, PI # 2, PI # 5, and had the potential to negatively affect all patients who dialyze at this facility. Findings include: Facility Policy: Patient Assessment and Monitoring Date: 9/29/18 Version: 3 ...Monitoring During Treatment... document machine parameters and safety checks every 30 (minutes) or more often as needed but not to exceed 45 minutes. ...3. Machine Parameters and Extracorporeal Circuit Check machine settings and measurements... Check prescribed blood flow is being achieved... Check dialysate flow rate setting is correct, and the prescribed flow is being delivered. 1. PI # 3 was admitted to the facility on 5/3/19 with a diagnosis of End Stage Renal Disease (ESRD). Review of the Orders Summary Report (OSR) revealed hemodialysis (HD) orders dated 3/3/23 that included BFR 450 and DFR Manual 800 ml/min (milliliters per minute). Review of the Treatment Sheet (TS) dated 3/15/23 revealed treatment start was 5:56 AM with a BFR 450. At 9:27 AM the BFR was decreased to 400 until end of treatment at 10:01 AM. There was no reason documented why the BFR was decreased to 400. There was no physician order for BFR 400. Review of the TS dated 3/17/23 revealed treatment start was 5:48 AM and treatment end was 9:57 AM. The

BFR was 400 for the entire treatment. There was no reason documented why the physician's order for BFR 450 was not administered. There was no physician order for BFR 400. Review of the TS dated 3/20/23 revealed the treatment start was at 5:57 AM with a BFR 450. At 9:04 AM BFR was decreased to 400 until end of treatment at 9:57 AM. There was no reason documented why the BFR was decreased to 400. There was no physician order for BFR 400. Review of the TS dated 3/27/23 revealed the treatment start was at 6:53 AM with a BFR 450. At 9:23 AM BFR was decreased to 400 until end of treatment at 10:55 AM. There was no reason documented why the BFR was decreased to 400. There was no physician order for BFR 400. In an interview on 3/30/23 at 9:25 AM with Employee Identifier (EI) # 1, Facility Administrator (FA), EI # 1 confirmed on HD treatments dated 3/15/23, 3/17/23, 3/20/23, and 3/27/23 staff failed to document why the BFR was changed and failed to follow physician's orders for BFR. 30952 2. PI # 1 was admitted to the facility on 5/23/19 with diagnoses including ESRD. Review of the OSR revealed HD orders dated 3/3/23 which included BFR 450 and DFR Autoflow 1.5 (700). Review of the TS dated 3/24/23 revealed from 1:29 PM the BFR was 300 and DFR was 500 until treatment end at 2:54 PM. There was no reason documented why the BFR was 300 and not 450 as ordered. There was no physician order for the DFR 500. Review of the TS dated 3/27/23 revealed at 11:31 AM, treatment initiation until 1:21 PM, the BFR was 400 and DFR was 800. At 1:21 PM, the BFR was decreased to 350 and DFR remained at 800 until treatment termination at 3:19 PM. There was no reason documented why the BFR was 400 and 350 and not 450 as ordered. There was no physician's order for DFR 800. In an interview conducted on 3/30/23 at 8:50 AM, EI # 1 verified the staff failed to document the reason the BFR was not delivered as ordered and failed to administer the DFR per physician orders. 3. PI # 4 was admitted to the facility on 2/25/22 with diagnoses including ESRD. Review of the OSR revealed HD orders dated 1/20/23 which included BFR 400 and DFR Manual 500. Review of the TS dated 2/10/23 revealed from 12:29 PM, at treatment initiation, until 2:43 PM, the DFR was 600. At 2:43 PM, the DFR was increased to 800 until treatment termination at 3:00 PM. There was no physician's order for DFR 600 and DFR 800. In an interview conducted on 3/30/23 at 9:08 AM, EI # 1 confirmed staff failed to follow the physician's DFR orders during treatment delivery. 28327 4. PI # 2 was admitted to the facility on 6/23/22 with diagnoses including ESRD. Review of the OSR revealed HD orders dated 2/20/23 which included BFR 400 and DFR Manual 800. Review of the TS dated 3/10/23 revealed the BFR was decreased to 350 from 1:22 PM to 2:30 PM, then increased to 370 at 3:00 PM. There was no reason documented why the BFR was 350 and 370 and not 400 as ordered. There was no physician's order for the BFR 350 and BFR 370. Review of the TS dated 3/15/23 revealed the BFR was decreased to 300 from 3:32 PM to 4:00 PM. There was no reason documented why the BFR was 300 and not 400 as ordered. There was no physician order for the BFR 300. Review of the TS dated 3/20/23 revealed the BFR was 350 the entire treatment from 12:51 PM to 4:41 PM. There was no reason documented why the BFR was 350 and not 400 as ordered. There was no physician order for the BFR 350. Review of the TS dated 3/22/23 revealed the BFR was decreased to 200 from 1:23 PM until the end of treatment at 3:02 PM. There was no reason documented why the BFR was 200 and not 400 as ordered. There was no physician order for the BFR 200. An interview was conducted on 3/30/23 at 8:51 AM with EI # 1 who verified the staff failed to document the reason the BFR was not delivered as ordered and failed to administer the BFR per physician orders. 5. PI # 5 was admitted to the facility on 2/14/22 with diagnoses including ESRD. Review of the OSR revealed HD orders dated 2/20/23 which included BFR 400 and DFR Autoflow 1.5 (600). Review of the TS dated 3/15/23 revealed treatment started at 6:41 AM and from 6:46 AM to 7:29 AM BFR 400 and DFR 0. There was no reason documented why the DFR was 0 and not 600 as ordered.

There was no physician order for the DFR 0. Review of the TS dated 3/24/23 revealed the BFR was 450 the entire treatment from 7:02 AM to 10:25 AM. There was no reason documented why the BFR was 450 and not 400 as ordered. There was no physician order for the BFR 450. An interview was conducted on 3/30/23 at 8:49 AM with EI # 1 who verified the staff failed to follow the physician's DFR orders during treatment delivery and failed to document the reason the BFR was not delivered as ordered.

**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 the medical record (MR), the facility policy, and staff interviews, it was determined the IDT (Interdisciplinary Team) failed to ensure staff followed the facility policy for managing missed treatments due to non-adherence. This affected PI (Patient Identifier) # 4, in one of one record reviews with continued treatment non-adherence. Findings include: Facility Policy Title: Managing Missed Treatments due to Non-Adherence or Prolonged Hospitalization or Vacation Published: 07/05/2022 Reference Number: 45116 Version: 3 Purpose To provide guidance on managing missed treatments for patients who: Miss their scheduled treatment(s) without rescheduling... Non-Adherent to Treatment Schedule ...Patients who are non-adherent to their treatment schedule: May not be involuntarily discharged or removed from the regular schedule. Should be referred to the Social Worker (SW) for assessment of their psychosocial status and identification of root cause affecting adherence. ...2a. If the patient is located, offer to reschedule the missed treatment if a slot is available. 2b. If staff is unable to reach the patient or their emergency contact, notify the... nephrologist...inquire... if... the patient was admitted to the hospital. Staff may also... attempt to locate the patient and determine if they are safe...Check nearby hospitals... Contact the police to request...to go by the patient's home to check on the patient. 3. Document the missed treatment and all actions taken to locate the patient... 4. Refer the patient to the SW who can utilize the Root Cause Analysis (RCA) and Intervention Tool (IT) for Patients Not Meeting Quality Goals to assess reason for missed treatment and if there's a barrier that might contribute to more misses in the future. 5, SW reports assessment findings to Clinical Manager to determine a plan for preventing future missed treatments. Consult or notify attending nephrologist of any plan....identified. 6. Discuss the plan with the patient, update the plan of care if necessary...make any additional documentation in the MR. If the Patient...Continues to miss regularly scheduled treatments...1-2 dialysis treatments per week despite education, offers to reschedule and/or counseling efforts... 1. Refer the patient to SW for reassessment 2. Schedule an IDT meeting with the patient to discuss assessment findings and develop a plan to address barriers. Include...patient's goals/ideas for improving adherence. 3. Use the missed treatment focused intervention tools to determine barriers... 4. Re-educate the patient... Explore feasibility of other treatment modalities, including the option of no treatment... If the Patient...Has Missed 3 consecutive treatments...Does not contact the facility...efforts to locate...through

emergency contacts...have been unsuccessful... 1. Notify the attending nephrologist. 2. Send Missed 3 Treatments letter via certified mail... 3. Notify the network of the situation... If the Patient has not contacted the...facility and has missed 6 consecutive treatments...Efforts to locate or communicate...unsuccessful... 1. Notify the attending nephrologist. 2. Notify the Network... 3. Send Missed 6 Treatments letter via certified mail... 1. PI # 4 was admitted to the facility on 2/25/22 with diagnoses including End Stage Renal Disease. Review of PI # 4's current plan of care (POC), a 6 month CIA (comprehensive interdisciplinary) assessment, approved by the IDT on 10/19/22, revealed the patient's status was stable. The SW documented "patient is very stable and compliant with treatment adherence". The IDT scheduled the next POC meeting for 4/17/23. MR review revealed an Orders Summary Report which included hemodialysis orders for 4 hour dialysis treatments on Monday, Wednesday, and Friday. Review of the Treatment Sheet (TS) dated 2/3/23 (Friday) revealed PI # 4 dialyzed 2 hours 7 minutes. Review of the facility report titled, Clinical Record View Report (CRVR), revealed the following documentation: 2/6/23 No Show-Patient Refused to Attend Treatment 2/8/23 No Show-Patient Refused to Attend Treatment There were no reasons documented why PI # 4 refused treatments and no documented attempts to reschedule the 2 missed treatments. Review of the TS dated 2/10/23 (Friday) revealed PI # 4 dialyzed 2 hours 30 minutes. Further review of the CRVR documentation revealed the following: 2/13/23 No Show-Patient Refused to Attend Treatment 2/15/23 No Show-Patient Refused to Attend Treatment 2/17/23 No Show-Patient Refused to Attend Treatment There were no reasons documented why PI # 4 refused treatments and no documented attempts to reschedule 3 missed treatments. There was no documentation the Missed 3 consecutive treatments letter was sent and no documentation the Network was notified. Review of the TS dated 2/20/23 (Monday) revealed PI # 4 dialyzed 1 hour 31 minutes. Further review of the CRVR documentation revealed the following: 2/22/23 No Show-Patient Refused to Attend Treatment 2/24/23 No Show-Patient Refused to Attend Treatment 2/27/23 No Show-Patient Refused to Attend Treatment There were no reasons documented why PI # 4 refused treatments, and no documented attempts to reschedule 3 missed treatments. There was no documentation the Missed 3 consecutive treatments letter was sent and no documentation the Network was notified. Review of the TS dated 3/1/23 (Wednesday) revealed PI # 4 dialyzed 1 hour 48 minutes. Further review of the CRVR documentation revealed the following: 3/3/23 No Show-Patient Refused to Attend Treatment 3/6/23 No Show-Patient Refused to Attend Treatment 3/8/23 No Show-Patient Refused to Attend Treatment Review of the TS dated 3/10/23 (Friday) revealed PI # 4 dialyzed 1 hour 58 minutes. Further review of the CRVR documentation, the Absence and Hospitalization Record, and Nurse Note dated 3/24/23 revealed the following documentation: 3/13/23 No Show-Patient Refused to Attend Treatment, pt (patient) refused reschedule 3/15/23 No Show-Patient Refused to Attend Treatment, pt refused reschedule 3/17/23 No Show-Patient Refused to Attend Treatment, pt refused reschedule 3/20/23 No Show-Gastrointestinal Upset 3/22/23 No Show-Patient Refused to Attend Treatment, reported hospitalized 3/24/23 No Show-Patient Refused to Attend Treatment, clothes not ironed There was no documentation the Missed 6 consecutive treatments letter was sent and no documentation the Network was notified. Review of the TS dated 3/27/23 (Monday) revealed PI # 4 dialyzed 1 hour 57 minutes. There was no documentation the SW completed an RCA to identify treatment adherence barriers and no documentation an IDT meeting with the patient to discuss assessment findings was conducted. There was no documentation the IDT developed a plan to address barriers and included the patient's goals/ideas for improving adherence. There was no documentation the Network was notified. In an interview conducted on 3/30/23 at 9:08 AM, Employee Identifier # 1, Facility Administrator, confirmed the IDT failed to ensure facility staff

followed the facility treatment non-adherence policy.

**V0634**

**QAPI-INDICATOR-MEDICAL INJURIES/ERRORS**  
CFR(s): 494.110(a)(2)(vi)

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

This STANDARD is not met as evidenced by:

Based on observation, facility policy and procedure, facility Adverse Event (AE) Report dated 3/28/22 to 3/28/23, and staff interviews, it was determined the facility failed to ensure staff reported, documented, and investigated all AE's including a Near Miss per facility policy. This affected Patient Identifier (PI) # 11, one of three observations of access of AVF/AVG (arteriovenous fistula/graft) for initiation of dialysis and had the potential to negatively affect all patients who dialyzed at the facility. Findings include: Facility Policy: Patient Safety Event Reporting and Documentation Published: 02/06/2023 Reference Number: 61085 Version: 2 Purpose: The purpose of this policy is to provide guidelines for all clinical staff on identifying, reporting and documentation of patient related Near Misses, Safety Events (SE) and Serious Safety Events (SSE) in the In-Center...setting to: - Provide a standardized process for the identification and management of all patient related safety events - Promote a culture of safety ...Policy: When a Near Miss, SE or SSE occurs, staff are required to report, document, and review the event as noted in this policy. Staff are responsible for timely completion of these policy requirements. Procedure Reporting of any patient event...should occur in person or verbally and not be communicated via email or text message. Clinical Staff are required to report all SEs and SSEs to the patient's physician. State or local agencies should be notified in accordance with applicable state regulations... Near Miss...does not result in patient clinical harm, either through early detection or sheer luck. It is an unsafe situation that is indistinguishable from a safety event except for the outcome. Step 1. Clinical Staff to notify...Clinical Manager...Technical Services if applicable... Clinical Staff will perform documentation in the...medical record if appropriate, Patient Safety Data Entry Site Clinical Manager or facility designee will review during Quality Assessment and Performance Improvement. Documentation of all patient events shall be factual, complete, timely and concise...include patient assessment and represent an accurate recording of the events, times, interventions, and result of interventions... Careful consideration should occur when a late entry is necessary... 1. Review of the facility Adverse Events (AE) Report dated 3/28/22 to 3/28/23 revealed a total of seven SE's were documented, that included one fall, one clotted dialyzer, two needle dislodgements, one cardiac arrest, one blood loss and one access infiltration. 2. An observation of care was conducted on 3/29/23 at 10:10 AM at station 6 with EI (Employee Identifier) # 3, Registered Nurse, to initiate dialysis treatment for PI # 11, who had both a CVC (central venous catheter) and a new AVG. EI # 3 cleaned the AVG site with alcohol prep pads, picked up the Nipro Safety Needles from the chairside table, exited the station, then placed the Nipro Safety Needles into the trash can. In an interview on 3/29/23 at 10:12 AM, the surveyor asked EI # 3 what was wrong with the needles and why he/she discarded the unused needles? EI # 3 responded the needles were the wrong size. An interview was conducted on 3/30/23 at 7:30 AM with EI # 1, Facility Administrator. The surveyor requested facility SE/AE documentation for 3/29/23. EI # 1 provided SE/AE documentation dated 3/29/23 for

one blood loss event. There was no documentation staff completed an AE/SE for the Near Miss observed on 3/29/23 at 10:15 AM. EI # 1 confirmed staff failed to complete required documentation for an AE/SE for the Near Miss.

**V0681**

PQ-STAFF LIC AS REQ/QUAL/DEMO COMPETENCY  
CFR(s): 494.140

All dialysis facility staff must meet the applicable scope of practice board and licensure requirements in effect in the State in which they are employed. The dialysis facility's staff (employee or contractor) must meet the personnel qualifications and demonstrated competencies necessary to serve collectively the comprehensive needs of the patients. The dialysis facility's staff must have the ability to demonstrate and sustain the skills needed to perform the specific duties of their positions.

This STANDARD is not met as evidenced by:

Based on review of facility policies, facility personnel record, and interview, it was determined facility failed to ensure the Certified Clinical Hemodialysis Technician (CCHT) was competent to reinfuse the extracorporeal circuit for a patient who dialyzed via a Central Venous Catheter (CVC). This affected Patient Identifier (PI) # 6, one of two patients observed for discontinuation of dialysis with a CVC and had the potential to negatively affect all patients with a CVC served by this facility. Findings Include: Facility Policy Title: Knowledge, Skills and Competency Evaluation for Clinical Staff Published: 10/12/21 Version: 3 Purpose ...provides all clinical field employees with initial and ongoing development and evaluation of the knowledge and skills essential for a...well-trained workforce. Policy ...Employees are required to successfully complete all skills requirements, including an initial and annual skills validation... Employees without current documented competency...may be removed from performing independent direct patient care...until competency is demonstrated and documented... Facility Policy: Termination of Treatment Using a Central Venous Catheter and Optiflux Single Use Ebeam Dialyzer Published: 2/7/22 Reference Number: 45640 Version 7 Purpose: The purpose of this policy is to provide direction to reinfuse blood in the extracorporeal system to the patient at completion of the hemodialysis treatment using a Central Venous Catheter (CVC) and an Optiflux Single Use electron beam Dialyzer. Responsibility: ...Direct Patient Care Staff (based on job description, license, certification, Federal/State Regulation). Qualifications: Refer to Eligibility and Performance Requirements Policy for mandatory qualifications for a ...Patient Care Technician (PCT)....to provide hemodialysis catheter care and initiating and terminating treatments as permitted by State Regulation and or State Nursing Practice Acts and under the delegation of duties by the registered nurse... 1. On 3/29/23 at 11:00 AM, an observation of care was conducted at station 14 with EI (Employee Identifier) # 5, CCHT. EI # 5 paused the dialysis treatment, turned the blood flow to 200, squeezed (with his/her hands) the normal saline solution bag hanging from the IV (intravenous), then reinfused the extracorporeal circuit via a CVC. Review of EI # 5's personnel file documentation revealed the hire date was 7/25/22. EI # 5's personnel file included a Direct Patient Care Skills Validation Checklist dated 10/12/22 which revealed CVC Components for discontinuation of dialysis via a CVC was marked NA (not applicable). An interview was conducted on 3/30/23 at 10:02 AM with EI # 1, Facility Administrator, who verified staff should be competent to perform the task per facility policy. EI # 1 confirmed there was no documentation EI # 5 was competent to reinfuse the extracorporeal circuit with a CVC.