

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  012512	<b>(X3) Date Survey Completed</b>  11/17/2022
<b>Name of Provider or Supplier</b>  Fmc Dialysis Services Selma	<b>Street Address, City, State</b>  905 Medical Center Parkway, Selma, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

<b>(X4) ID Prefix Tag</b>	<b>Summary Statement of Deficiencies</b>  (Each deficiency should be preceded by full regulatory or LSC identifying information)
<b>E0000</b>	Based on the recertification survey conducted from 11/15/22 to 11/17/22 FMC Dialysis Services of Selma 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 11/15/22 to 11/17/22 at Fresenius Medical Care Dialysis Services Selma with standard level deficiencies cited.
<b>V0113</b>	<p><b>IC-WEAR GLOVES/HAND HYGIENE</b> 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 observations, review of the facility hand hygiene policy and staff interviews, it was determined the facility failed to ensure the staff followed the facility policy for hand hygiene in 6 of 16 observations conducted. This had the potential to negatively affect all patients who dialyze at the facility. Findings include: Facility Policy: Hand Hygiene Date: 11/4/19 Reference Number: 47664 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. Hands will be: Decontaminated using alcohol-based hand rub or by washing hands with antimicrobial soap and water. When: 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 parenteral medications. Immediately after removing gloves. After contact with inanimate objects near the patient. When moving from a contaminated body site to a clean body site of the same patient. Procedure for Decontaminating Hands With Alcohol Based Hand Rubs: Procedure: 1. If gloves are</p>

worn, remove and discard... 2. Apply alcohol-based hand rub to the palm of one hand using the amount recommended... 3. Rub hands together covering all surfaces of the hands and fingers, until hands are dry. Allowing alcohol to dry completely allows adequate contact time to kill germs... 1. An observation was conducted on 11/15/22 at 9:15 AM with Employee Identifier (EI) # 5, Registered Nurse (RN), to observe a single dose medication being drawn up from the vial and taken to station # 16. After drawing up the medication in a syringe, EI # 5 removed gloves and donned clean gloves, failed to sanitize hands prior to donning gloves and proceeded to station # 16. Once at the station EI # 5 documented on the machine. After completing documentation with the same gloves on, EI # 5 gave the medication to the patient, and documented on the machine. EI # 5 then removed gloves and washed hands. An interview was conducted on 11/17/22 at 10:50 AM with EI # 1, Clinic Manager, who confirmed the nurse failed to sanitize hands prior to donning clean gloves after drawing up the medication. EI # 1 also stated EI # 5 should have removed gloves after documentation on the machine and sanitized hands, donned clean gloves prior to giving the medication and EI # 5 failed to follow facility policy. 2. An observation was conducted on 11/15/22 at 10:20 AM with EI # 3, Certified Clinical Hemodialysis Technician (CCHT) to observe procedure for a water check. Once the water check was complete EI # 3 removed gloves and failed to sanitize or wash hands. An interview was conducted on 11/17/22 at 10:50 AM with EI # 1 who confirmed the CCHT failed to remove gloves and sanitize hands after completing the water check. 3. An observation was conducted on 11/15/22 at 11:30 AM to observe the discontinuation of a Central Venous Catheter (CVC) at station # 3 with EI # 5. After the blood lines were disconnected EI # 5 failed to remove gloves and sanitize hands and flushed line with Heparin, documented on the machine and with same gloves obtained 4 by 4 gauze and wrapped the CVC lines and taped with gauze. An interview was conducted on 11/17/22 at 10:55 AM with EI # 1 who confirmed the nurse failed to remove gloves and sanitize hands and don clean gloves after heparin flush and prior to documentation on the machine. EI # 5 also failed to sanitize hands and don clean gloves prior to obtaining four by four gauze, wrapping the CVC lines and taping in place. 4. An observation was conducted on 11/15/22 at 9:30 AM with EI # 3 to observe the cleaning of the dialysis station # 14. During the cleaning at station # 14, the dialysis machine at station # 15 began to alarm. EI # 3, removed gloves, donned clean gloves and did not sanitize hands prior to donning clean gloves, went to station # 15, reset the alarms and documented on the machine. EI # 3 removed gloves and did not sanitize hands and obtained clean supplies from the supply cart. EI # 3 then donned clean gloves did not sanitize hands and took clean supplies to station # 15. An interview was conducted on 11/17/22 at 10:57 AM with EI # 1 who confirmed the CCHT failed to follow the facility policy for glove change and sanitizing hands. 5. An observation was conducted on 11/15/22 at 9:45 AM with EI # 3 at station # 15 to observe the discontinuation of an AV (arterial venous) fistula or graft. During the observation EI # 3 removed the blood lines and with the same gloves on, documented on the machine. EI # 3 then removed gloves, donned clean gloves and failed to sanitize hands prior to donning clean gloves. An interview was conducted with EI # 1 on 11/17/22 at 11:00 AM who confirmed the CCHT failed to follow the facility policy and procedure for hand hygiene and glove change. 40119 6. An observation was conducted on 11/15/22 at 2:00 PM at station # 1 to observe the discontinuation of CVC. During the observation EI # 4, CCHT, obtained alcohol pads then entered station # 1 and handed the alcohol pads to the nurse without performing hand hygiene prior to obtaining clean supplies and entering station # 1. An interview was conducted with EI # 1 on 11/17/22 at 11:30 AM who confirmed the tech failed to follow the facility policy and procedure for hand hygiene.

**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 Myron L Operation Manual, and interviews with facility staff, it was determined the staff failed to follow the facility procedure for testing dialysate conductivity prior to treatment initiation. This affected 1 of 2 observations conducted and had the potential to negatively affect all patients who dialyze at the facility. Findings include: Title: Myron L Operation Manual Digital Dialysate Meter Date: February 16, 2018 ...C. Measuring pH (D-6, type of meter) ...2. Rinse pH (measure of how acidic/basic water is)/ORP (Oxidation Reduction Potential) sensor well and conductivity cell three times with sample to be measured. Shake out each sample to remove any residual liquid. 3. Refill pH/ORP sensor well and conductivity cell with sample. 4. Press pH... An observation was conducted on 11/16/22 at 9:30 AM to observe Employee Identifier (EI) # 5, Registered Nurse, perform conductivity testing with a Myron L D-6 meter in the preparation of a Hemodialysis machine at station 13. EI # 5 filled the sensor well and conductivity cell with dialysate solution one time, attempted to obtain reading, poured sample in the sink, refilled sensor well and conductivity cell and obtained conductivity reading. EI # 5 failed to fill sensor well and conductivity cell three times with sample when obtaining conductivity reading. An interview was conducted with EI # 1, Clinic Manager, on 11/17/22 at 11:30 AM who confirmed the staff failed to follow procedure for checking conductivity.

**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 review of policy and procedure, Digital Dialysate Meter Operation Manual, the Clinical Log Readings Report, observations and interviews with the staff it was determined the facility failed to: 1. Perform the PH (Potential Hydrogen) and conductivity testing daily on one of two Myron L D-6 meters present in the dialysis facility 2. Ensure all supplies for use on the dialysis floor were not expired. Findings include: Myron L D6 Meter Maintenance Procedure Published Date: 9/1/22 Reference Number: 64380 Procedure: 2. Enter date of meter verification 3. Enter time of daily verification 4. At the beginning of the day, check conductivity, TDS (total dissolved solutes) (442), and pH solutions for expiration dates... 5. Measure a sample of 14.00 mS (MilliSiemens) Conductivity solutions... Document value and continue with verification. 6. Measure a sample of 3000 TDS (442) solution... Compare results with acceptable range... and document value and continue with verification. 7. Measure a sample of 7.00 pH solution... compare results with acceptable range...document value

and continue with verification... 8. Measure a sample of 4.00 pH buffer solution... compare results with acceptable range...document and continue with verification... 9. Measure a sample of 10.00 pH buffer solution...compare results with acceptable range...document value and continue with verification... 10. At the end of the day the pH sensor well must be filled with pH sensor storage solution... 11. Enter initial of staff member performing verification. 12. Enter any comments. Documentation: Daily verifications will be documented on Myron L D6 Daily Verification Form. Calibrations will be documented on Myron L D6 Calibration Form... Digital Dialysate Meter Operation Manual Myron L Company February 18, 2016 Policy: B. Calibration Intervals: If using the Dialysate Meter to check Dialysate concentrations, you should check the calibration of the pH and Conductivity functions at the beginning and the end of each work day or more often if required by the clinics internal procedures. Then recalibrate if indicated... XI. Calibration Intervals A. Suggested Calibration Intervals: Checking Dialysate: Conductivity: Check against standard conductivity solutions. Frequency: At the beginning and end of each work day. Check cell cup cleanliness: At the beginning and end of each work day. pH: Check against standard buffer solution. Frequency: At the beginning and end of each work day. Check sensor well cleanliness: At the beginning and end of each work day... Facility Policy: Storage of Supplies Date: 4/5/21 Version: 2 Policy: Supplies must be rotated First in-First Out (FIFO) to ensure products maintain quality and do not expire. Appropriately dispose of items that have reached the expiration date. 1. Review of the FKC (Fresenius Kidney Care) Clinical Log Readings Report dated 9/20/22 to 11/15/22 revealed documentation for the Myron L D 6 meter # D605924. Further review revealed no documentation for the Myron L D6 Meter D609988 for the two months requested and the meter D609988 was currently being used on the dialysis floor and in the water room. An interview was conducted on 11/17/22 at 9:05 AM with Employee Identifier (EI) # 2, Bio Technician, who confirmed the machine numbers were entered wrong in the computer system and there is no documentation for the meter D609988 for the daily meter checks. 2. An observation was conducted on 11/15/22 at 9:05 AM on the dialysis floor. During the observation a pack of 67 red top blood tubes was found on the dialysis counter and had expired on 9/30/22. An interview was conducted on 11/17 /22 at 10:00 AM with EI # 1, Clinic Manager who confirmed the blood tubes were expired and had been removed from the dialysis floor.

**V0543**

POC-MANAGE VOLUME STATUS  
CFR(s): 494.90(a)(1)

The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status;

This STANDARD is not met as evidenced by:  
Based on review of medical records (MR), facility policies and procedures, and interviews with the staff it was determined the facility failed to ensure: 1. The physician was notified of the patient leaving greater than 2.0 kg (kilograms) over the EDW (Estimated Dry Weight). 2. Vital signs were taken every 30 minutes per facility policy. 3. The nurse and/or the physician was notified of patient's continued high blood pressure (BP) and/or Clonidine was given per the physician orders for systolic BP greater than 180 and/or diastolic BP greater than 100. This deficient practice affected 4 of 7 MR's reviewed and did affect Patient Identifier (PI) # 3 , PI # 5, PI # 2 and PI # 4 and had the potential to negatively affect all patients dialyzing at this facility. Findings include: Facility Policy: Determination of Blood Pressure Policy

Number: 45285 Date: 2/7/22 Purpose: The purpose of this procedure is to provide guidance for measuring the patient's blood pressure. Policy: Obtain blood pressure readings pre- and post-dialysis sitting and standing (if applicable) and every 30 minutes or more during hemodialysis treatments... The Medical Director in conjunction with the Clinical Manager will determine what the blood pressure upper and lower range parameters will be for the facility... FMC (Fresenius Medical Center) and Dallas County Standing Orders 2020 Updated 1. Initiate, Monitor, and Terminate treatment per FMC P&P (Policy and Procedure) by access type as adopted by facility: E. EDW if patient is greater than or less than 2 kg from EDW post treatment document assessment and notify MD (Medical Doctor). K. BP and Safety check at 30 minutes and PRN (as needed) per P&P 5. Treatment complications: Hypertension Systolic greater than 180 and Diastolic greater than 100: RN (Registered Nurse) assesses and sets UF (Ultra filtration) utilizing UF profile at RN discretion. If no response to UF of greater than 2 liters removed administer Clonidine 0.1 mg (milligrams) by mouth. If no response to Clonidine after 30 minutes notify MD for further orders. Facility Policy: Patient Assessment and Monitoring Policy Number: Version 3 Date: 9/29/18 Pre-Treatment: Direct patient care staff may collect pre-treatment weight. BP, pulse, respirations, temperature, general observations, access and complaints reported by the patient. ...any changes or abnormal findings in patient's condition or vascular access are observed...the patient care technician must report the changes in the patient condition to a registered nurse who will further assess the patient prior to initiation of the treatment. An abnormal finding confirmed by the RN will be reported to the attending physician for assessment and intervention... Post-Treatment: The staff member who collects the information and evaluates the patient post-treatment will document their findings on the hemodialysis treatment record... any changes or abnormal findings in the patient's condition, vital signs or vascular access are observed...must report the changes in the patient condition to a registered nurse who will further assess the patient prior to discharge... An abnormal finding confirmed by the RN will be reported to the attending physician... 1. The direct patient care staff may obtain the following data: Weight: Record pre-weight. Compare pre-weight to estimated dry weight. 2. Monitoring During Treatment: Obtain blood pressure and pulse rate every 30 minutes or more as needed... Document machine parameters and safety checks every 30 minutes or more as needed... 1. Blood Pressure: Report to nurse: Systolic blood pressure greater than 180 mm/hg (millimeters per hemoglobin) and/or Diastolic blood pressure greater than 100 mm /hg... 1. PI # 3 was admitted to the facility on 2/7/22 with admitting diagnoses of Hypertensive Kidney Disease with Stage 1 through 4 Chronic Kidney Disease and End Stage Renal Disease. Review of the Orders Summary Report dated 10/7/22 for Hemodialysis revealed the following orders to dialyze Monday, Wednesday and Friday for 4 hours and 0 minutes. EDW 67 kg. Review of the Treatment Flow Sheet (TFS) dated 11/2/22 revealed at 2:44 PM, PI # 3's blood pressure was 197/109 and at 3:08 PM which was the end of treatment the blood pressure was 197/104. Further review of the TFS dated 11/2/22 revealed no documentation the RN was notified of the increase in BP, no was Clonidine administered to decrease the BP per standing orders. Review of the TFS dated 11/7/22 revealed the patient's post weight was 70.4 kg which was 3.4 kg over the EDW of 67 kg. Further review of the TFS dated 11/7/22 revealed no documentation the RN was notified nor was there documentation the physician was notified of the patient leaving 3.4 kg over the EDW. Further review of the TFS dated 11/7/22 revealed the following Blood Pressures: 11:09 AM - 169/106 start of treatment 11:32 AM - 187/113 12:05 PM - 171/110 1:02 PM - 164/102 1:34 PM - 198/108 2:02 PM - 191/108 2:23 PM - 200/118 end of treatment Further review of the TFS dated 11/7/22 revealed no documentation the RN was notified of the high blood pressure, no documentation the RN administered Clonidine per standing orders

or no documentation the RN notified the physician of the increase of BP during treatment. Review of the TFS dated 11/9/22 revealed the patient's post weight was 69.4 kg which was 2.4 kg over the EDW. Further review of the TFS dated 11/9/22 revealed no documentation the RN was notified nor was there documentation the physician was notified of the patient leaving 2.4 kg over the EDW. Further review of the 11/9/22 TFS revealed the following blood pressures: 11:22 AM - 163/106 - Start of Treatment 11:32 AM - 169/117 12:08 PM - 168/110 12:35 PM - 185/122 1:02 PM - 190/122 1:34 PM - 171/102 1:59 PM - 194/ 113 - End of Treatment Further review of the TFS dated 11/9/22 revealed no documentation the RN was notified of the high blood pressure, no documentation the RN administered Clonidine per standing orders or no documentation the RN notified the physician of the increase of BP during treatment. Review of the TFS dated 11/11/22 revealed the patient's post weight was 69.6 kg which was 2.6 kg over the EDW. Further review of the TFS dated 11/11/22 revealed no documentation the RN was notified nor was there documentation the physician was notified of the patient leaving 2.6 kg over the EDW. Review of the TFS dated 11/11/22 revealed vital signs were taken at 12:02 PM and not again until 1:04 PM which was one hour and 2 minutes later. Further review of the 11/11/22 TFS revealed the following blood pressures: 11:25 AM - 180/124 - Start of Treatment 11:40 AM - 180/124 12:02 PM - 178/119 1:04 PM - 175/117 1:32 PM - 146/110 Further review of the TFS dated 11/11/22 revealed no documentation the RN was notified of the high blood pressure, no documentation the RN administered Clonidine per standing orders or no documentation the RN notified the physician of the increase of BP during treatment. Review of the TFS dated 11/14/22 revealed the patient's post weight was 71.7 kg which was 4.7 kg over the EDW. Further review of the TFS dated 11/14/22 revealed no documentation the RN was notified nor was there documentation the physician was notified of the patient leaving 4.7 kg over the EDW. Further review of the Treatment Flow Sheet dated 11/14/22 revealed vital signs were taken at 1:06 PM and not again until 2:05 PM which was 59 minutes later. Further review of the 11/14/22 TFS revealed the following blood pressures: 11:25 AM - 159/104 - Start of Treatment 11:34 AM - 169/118 12:07 PM - 167/108 12:40 PM - 159/105 1:06 PM - 156/102 2:05 PM - 162/113 - End of Treatment Further review of the TFS dated 11/14/22 revealed no documentation the RN was notified of continued high blood pressure, no documentation the RN administered Clonidine per standing orders or no documentation the RN notified the physician of the increase of BP throughout treatment. An interview was conducted on 11/17/22 at 10:50 AM with Employee Identifier (EI) # 1, Clinic Manager, who confirmed the staff failed to notify the RN of the continued high blood pressure, the RN failed to administer Clonidine per physician orders and notify the physician of the high blood pressure and the RN failed to notify the physician of patient leaving greater than 2 kg over the EDW per facility policies. 2. PI # 5 was admitted to the facility on 11/27/2020 with admitting diagnoses of Type I Diabetes Mellitus with Diabetic Kidney Disease and End Stage Renal Disease. Review of the Order Summary Report for Hemodialysis dated 8/29/22 revealed the patient dialyzed 3 times a week on Monday, Wednesday and Friday for 4 hours 0 minutes EDW was 88 kg. Review of the TFS dated 10/28/22 revealed the following blood pressures: 8:58 AM - 201/115 - Start of Treatment 9:33 AM - 206/103 10:09 AM - 190/98 10:42 AM - 182/97 11:06 AM - 193/101 11:11 AM - 196/107 Further review of the TFS dated 10/28/22 revealed no documentation the RN was notified of the high blood pressure, no documentation the RN administered Clonidine per standing orders nor was there documentation the RN notified the physician of the increase of BP throughout treatment. Further review of the TFS dated 10/28/22 revealed the patient's post weight was 93.3 which was 5.3 kg over the EDW. Further review of the TFS dated 10/28/22 revealed no documentation the RN was notified of the patient leaving 5.3 kg over EDW nor was there documentation the

physician was notified of the patient leaving 5.3 kg over the EDW. Review of the TFS dated 10/31/22 revealed the following blood pressures: 6:28 AM - 191/107 - Start of Treatment 6:34 AM - 191/107 7:02 AM - 200/111 7:32 AM - 213/100 8:02 AM - 195/103 10:08 AM - 192/102 Further review of the TFS dated 10/31/22 revealed no documentation the RN was notified of the high blood pressure, no documentation the RN administered Clonidine per standing orders nor was there documentation the RN notified the physician of the increase of BP throughout treatment. Further review of the TFS dated 10/31/22 revealed the patient's post weight was 94.8 which was 6.8 kg over the EDW. Further review of the TFS dated 10/31/22 revealed no documentation the RN was notified of the patient leaving 6.8 kg over EDW nor was there documentation the physician was notified of the patient leaving 6.8 kg over the EDW. Review of the TFS dated 11/4/22 revealed the following blood pressures: 6:33 AM - 195/106 - Start of Treatment 7:05 AM - 207/105 7:39 AM - 200/100 8:07 AM - 205/105 8:34 AM - 209/103 9:03 AM - 210/104 9:35 AM - 213/109 - End of Treatment Further review of the TFS dated 11/4/22 revealed no documentation the RN was notified of the high blood pressure, no documentation the RN administered Clonidine per standing orders nor was there documentation the RN notified the physician of the increase of BP throughout treatment. Further review of the TFS dated 11/4/22 revealed the patient's post weight was 92.2 which was 4.2 kg over the EDW. Further review of the TFS dated 11/4/22 revealed no documentation the RN was notified of the patient leaving 4.2 kg over EDW nor was there documentation the physician was notified of the patient leaving 4.2 kg over the EDW. Review of the TFS dated 11/8/22 revealed the patient's post weight was 91.5 which was 3.5 kg over the EDW. Further review of the TFS dated 11/8/22 revealed no documentation the RN was notified of the patient leaving 3.5 kg over EDW nor was there documentation the physician was notified of the patient leaving 3.5 kg over the EDW. Further review of the TFS dated 11/8/22 revealed vital signs were taken at 12:12 PM and not again until 1:03 PM which was 51 minutes later. Review of the TFS dated 11/11/22 revealed the following blood pressures: 6:49 AM - 188/105 - Start of Treatment 7:09 AM - 171/101 9:03 AM - 197/115 9:36 AM - 199/106 10:00 AM - 216/106 10:36 AM - 208/136 - End of Treatment. Further review of the TFS dated 11/11/22 revealed no documentation the RN was notified of high blood pressure, no documentation the RN administered Clonidine per standing orders nor was there documentation the RN notified the physician of the increase of BP throughout treatment. Further review of the TFS dated 11/11/22 revealed the patient's post weight was 91.2 which was 3.2 kg over the EDW. Further review of the TFS dated 11/11/22 revealed no documentation the RN was notified of the patient leaving 3.2 kg over EDW nor was there documentation the physician was notified of the patient leaving 3.2 kg over the EDW An interview was conducted on 11/17/22 at 10:55 AM with EI # 1 who confirmed the staff failed to notify the RN for the increased BP, failed to notify the MD of patient leaving over the EDW and of the continued elevated blood pressure and the RN failed to provide Clonidine per the standing orders. 40119 3. PI # 2 was admitted to the facility on 7/7/22 with diagnosis including End Stage Renal Disease (ESRD). Review of the Orders Summary Report dated 9/21/22 revealed a physician order for an EDW of 109 kg. Review of the TFS dated 10/19/22 revealed treatment was started at 9:31 AM with a pre treatment weight of 116 kg and a post treatment weight of 113 kg. There was no documentation the physician was notified of the patient post treatment weight of 4 kg above the ordered EDW. Further review of the 10/19/22 TFS revealed at 10:12 AM, 43 minutes into treatment, PI # 2's BP was 169/104. PI # 2's diastolic BP remained over 100 until 11:07 AM when it was documented at 100. Further review of the 10/19/22 TFS revealed the following diastolic BP's with no documentation the nurse was notified of a diastolic BP greater than 100 per facility policy: At 11:36 AM, PI # 2's diastolic BP was 106. At 12:06 PM, PI # 2's diastolic BP was 116. At 12:40 PM, PI #

2's diastolic BP was 109. At 1:06 PM, PI # 2's diastolic BP was 113. At 1:27 PM, PI # 2's diastolic BP was 106. An interview was conducted on 11/17/22 at 11:07 AM with EI # 1, who confirmed there was no documentation the nurse was notified of the greater than 100 diastolic BP and the physician was notified of the patient post treatment weight of 4 kg above the ordered EDW on 10/19/22. 4. PI # 4 was admitted to the facility on 4/16/14 with diagnosis including ESRD. Review of the Orders Summary Report dated 8/19/22 revealed a physician order for an EDW of 76 kg. Review of the TFS dated 11/9/22 revealed treatment was started at 5:28 AM with a pre treatment weight of 79.4 kg and a post treatment weight of 78.3 kg. There was no documentation the physician was notified of the patient post treatment weight of 2.3 kg above the ordered EDW. Review of the TFS dated 11/11/22 revealed treatment was started at 5:21 AM with a pre treatment weight of 80.3 kg and a post treatment weight of 78.9 kg. There was no documentation the physician was notified of the patient post treatment weight of 2.9 kg above the ordered EDW. Review of the TFS dated 11/14/22 revealed treatment was started at 5:25 AM with a pre treatment weight of 80.3 kg and a post treatment weight of 78.6 kg. There was no documentation the physician was notified of the patient post treatment weight of 2.6 kg above the ordered EDW. An interview was conducted on 11/17/22 at 10:37 AM with EI # 1, who confirmed there was no documentation the physician was notified of the patient post treatment weight of 2 kg above the ordered EDW per the facility policy on 11/9/22, 11/11/22 and 11/14/22.

**V0544**

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

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

This STANDARD is not met as evidenced by:

Based on review of medical records, facility policy and procedure, observations and interviews with the staff it was determined the facility failed to ensure the BFR (Blood Flow Rate) and the DFR (Dialysate Flow Rate) were documented and entered into the dialysis machine correctly per the physician orders and facility policy. This affected 4 of 7 MR's reviewed and did affect Patient Identifier (PI) # 3, PI # 5, PI # 2, and PI # 4 and had the potential to negatively affect all patients served by the 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 2/7/22 with admitting diagnoses of Hypertensive Kidney Disease with Stage 1 through 4 Chronic Kidney Disease and End Stage Renal Disease. Review of the Orders Summary Report dated 10/7/22 for Hemodialysis revealed the following orders to dialyze Monday, Wednesday and Friday for 4 hours and 0 minutes, BFR 400 and DFR Manual 500 mL/min (milliliters per minute). Review of the Treatment Flow Sheet (TFS) dated 11/2/22 at 12:38 PM revealed the DFR was set at 800 and remained at 800 until 1:35 PM when it was changed to 500 per the MD (Medical Doctor) orders. Further review of the TFS dated 11/2/22 at 12:38 PM revealed no documentation as to why the DFR was not set per the MD orders. Review of the TFS dated 11/7/22 at 11:32 AM revealed the DFR was set at 600 and remained

at 600 until 1:34 PM when it was changed to 500 per the MD orders. Further review of the TFS dated 11/7/22 at 11:32 AM revealed no documentation as to why the DFR was not set per the MD orders. Review of the TFS dated 11/14/22 at 11:25 AM revealed the BFR was set at 200 and not the 400 per MD orders and remained at 200 until the end of treatment at 1:06 PM. Further review of the TFS dated 11/14/22 at 11:25 AM revealed no documentation as to why the BFR was not set per the MD orders. An interview was conducted on 11/17/22 at 10:50 AM with Employee Identifier (EI) # 1, Clinic Manager, who confirmed the technician and the nurse failed to ensure the BFR and the DFR was sent per the MD orders.

2. PI # 5 was admitted to the facility on 11/27/2020 with admitting diagnoses of Type I Diabetes Mellitus with Diabetic Kidney Disease and End Stage Renal Disease. Review of the Order Summary Report for Hemodialysis dated 8/29/22 revealed the patient dialyzed 3 times a week on Monday, Wednesday and Friday for 4 hours 0 minutes, BFR 400 and the DFR was Autoflow 2.0 (800). Review of the TFS dated 11/8/22 at 11:04 AM revealed the BFR was set at 410 and the DFR was at 580 and not the 400 /800 per MD orders. Further review of the TFS dated 11/8/22 at 11:35 AM revealed the DFR was at 500 and remained at 500 until the end of treatment at 1:03 PM. Further review of the TFS dated 11/8/22 at 11:35 AM revealed no documentation as to why the BFR and DFR were not set per the MD orders. An interview was conducted on 11/17/22 at 10:55 AM with EI # 1 who confirmed the BFR and DFR was not set correctly per the MD orders.

40119 3. PI # 2 was admitted to the facility on 7/7/22 with diagnosis including End Stage Renal Disease (ESRD). Review of the Orders Summary Report dated 9/21/22 revealed a physician order for dialysis treatment BFR of 400 and DFR Autoflow was 2.0, which was 800. Review of the Treatment Sheet dated 10/14/22 revealed the treatment was started at 9:30 AM with a BFR of 400 and DFR of 800. At 10:00 AM through 12:08 PM there was no documentation of the BFR or DFR. Review of the Treatment Sheet dated 10/19/22 revealed the treatment was started at 9:31 AM with a BFR of 400 and DFR of 800. At 12:06 PM through 1:06 PM there was no documentation of the BFR or DFR. An interview was conducted on 11/17/22 at 11:07 AM with EI # 1, who confirmed the treatment BFR and DFR was not documented per the facility policy on 10/14/22 and 10/19/22.

4. PI # 4 was admitted to the facility on 4/16/14 with diagnosis including ESRD. Review of the Orders Summary Report dated 8/19/22 revealed a physician order for dialysis treatment DFR of 500. Review of the Treatment Sheet dated 11/2/22 revealed the treatment was started at 5:24 AM with a DFR of 600, the DFR of 600 continued until 5:44 AM then increased to 800 from 6:35 AM to 7:08 AM. At 8:08 AM through the end of treatment at 9:32 AM the DFR was 800. There was no documentation of the reason the DFR was not administered at 500 as ordered. Review of the Treatment Sheet dated 11/4/22 revealed the treatment was started at 5:24 AM with a BFR of 400 and DFR of 800, the DFR continued at 800 until 6:38 AM. There was no documentation of the BFR or DFR from 7:09 AM until 8:06 AM, 57 minutes, when the BFR was 400 and DFR 800. The DFR remained at 800 through the end of treatment at 9:27 AM the DFR was 800. There was no documentation of the reason the BFR and DFR were not documented for 57 minutes and DFR was not administered at 500 as ordered. Review of the Treatment Sheet dated 11/9/22 revealed the treatment was started at 5:28 AM with a DFR of 800, the DFR of 800 continued until 6:30 AM. At 8:05 AM, the DFR was 800 through the end of treatment at 9:30 AM. There was no documentation of the reason DFR was not administered at 500 as ordered. An interview was conducted on 11/17/22 at 10:37 AM with EI # 1, who confirmed the treatment BFR and DFR was not documented per the facility policy and/or physician's orders on 11/2/22, 11/4/22 and 11/9/22.