Department of Health & Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0391

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number	(X3) Date Survey Completed
	012513	07/14/2021
Name of Provider or Supplier	**Street Address, City, State**	
Bma Langdale	8 Medical Park North, Valley, AL	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency should be preceded by full regulatory or LSC identifying information)
E0000	Based on a recertification survey conducted on 7/12/21 to 7/14/21 BMA Langdale was found to be in substantial compliance with the Condition of Participation for Emergency Preparedness.
V0000	Based on the recertification survey conducted 7/12/21 to 7/14/21 BMA Langdale was not in compliance with the Conditions for Coverage (CfC) at 494.30 Infection Control and 494.90 Patient Plan of Care and related standard level deficiencies. 'CORE'
V0101	COMPLIANCE WITH FED/STATE/LOCAL LAWS CFR(s): 494.20 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. This STANDARD is not met as evidenced by: Based on observation, facility policy and interview, it was determined the staff had failed to display the current CMS (Centers for Medicare and Medicaid Services) Performance Score Certificate (PSC) in a prominent area in the facility viewable to patients. This had the potential to negatively affect all patients treated at the facility. Findings include: Facility Policy: ESRD (End Stage Renal Disease) Quality Incentive Program (QIP): Reviewing the Facility Reports Published: Not Set Version 3 Background ...Dialysis facilities are required by law to post their PSC prominently in a patient area until a new certificate is issued the following year. Policy ...In December of each year, PSC are posted on the qualitynet.org website for the facilities to download and print. It is the Clinical Managers responsibility to print, and display the PSC in a place where it is viewable to patients...Facilities have 15 business days from the date the PSC is available to post the document...signed by the Medical Director...posted in English and Spanish...behind a glass enclosure that prevents

	certificates from being stolen, defaced, or covered by other material.... During the facility tour on 7/12/21 at 10:30 AM Central Standard Time (CST), the surveyor observed the facility 2019 CMS performance scores posted in the lobby. In an interview on 7/12/21 at 10:55 AM CST, Employee Identifier # 1, Director of Operations, confirmed the staff had failed to display the 2021 PSC in the facility as required.
V0110	CFC-INFECTION CONTROL CFR(s): 494.30 This CONDITION is not met as evidenced by: Based on observations, facility policies and procedures, CDC (Centers for Disease Control) Injection Safety Information for Providers 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 113, V 115, V 119, V 122, V 130, V 143, V 147, and V 250.
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 facility policies and interviews, it was determined the facility failed to ensure staff and patients followed the facility policy for hand hygiene. This affected unsampled PI's (Patient Identifier) # 12, # 26, # 9, # 11, sampled patient, PI # 8, unsampled PI # 14, and sampled patient, PI # 2. This had the potential to negatively affect all patients, visitors, and staff. Findings include: Facility Policy: Hand Hygiene Published: 11/4/19 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 room. Before performing any invasive procedure such as vascular access cannulation or administration of parental medications. Immediately after removing gloves. ...After contact with inanimate objects near the patient. Hand Hygiene: Patients Patients should perform hand hygiene if able, prior to and after each dialysis treatment. ... Gloves must be provided to patients when performing procedures which risk exposure to blood or body fluids, such as...holding access site post treatment... To help ensure the prevention of cross contamination to their family members or other patients, hand hygiene must be performed. Facility Policy: Medication Preparation and Administration Published: 4/5/21 Version: 6 Purpose: To administer medication with the goals of staff and patient safety, ...and infection control. ...Infection Control The following steps must be taken to ensure infection control. Perform hand hygiene prior to accessing supplies, handling vials and IV (intravenous) solutions and preparing or

administering medications. Aseptic technique will be used to prepare and administer IV medications. Observations of care on 7/12/21 from 10:00 AM CST (central standard time) to 3:30 PM revealed the following hand hygiene infection control breaches: 1. At 11:07 AM CST (Central Standard Time) at station 4 for AVF (arteriovenous fistula) access for dialysis treatment initiation, EI (Employee Identifier) # 5, PCT (Patient Care Technician) with gloved hands, palpated, auscultated using a stethoscope and applied a tourniquet to PI # 12's access site. EI # 5 performed AVF antisepsis using an alcohol prep, then cannulated the AVF. EI # 5 failed to perform hand hygiene and don clean gloves after access evaluation and before antiseptic application. 2. At 11:35 AM CST at station 6, PI # 26 was observed holding the access site with gloved hand. At 12:05 PM, PI # 26 exited the treatment floor still wearing the glove used to hold pressure to access site. PI # 26 failed to remove the glove and perform hand hygiene after holding an access site. 3. At 11:40 AM CST at station 6 for AVF access for dialysis treatment initiation, EI # 4, PCT, with gloved hands, palpated and auscultated site using a stethoscope then applied a tourniquet to the site. EI # 4 performed AVF antisepsis with an alcohol prep and attempted an unsuccessful cannulation on PI # 9. EI # 4 failed to perform hand hygiene and don clean gloves after access evaluation, palpation, auscultation, and prior to antiseptic application. 4. At 11:48 AM CST, EI # 5, PCT entered station 6 to assist with AVF cannulation. EI # 5 evaluated PI # 9's access with gloved hands, prepped the site with alcohol then cannulated the AVF. EI # 5 failed to perform hand hygiene and don clean gloves before applying the antiseptic and site cannulation. 5. At 12:05 PM CST at station 8, PI # 11 was observed holding the access site with gloved hand. At 12:39 PM, PI # 11 exited the treatment floor without performing hand hygiene. 6. At 12:30 PM CST, EI # 4, PCT exited the treatment floor wearing gloves, gown, and face shield with a bath jug in hand. EI # 4 failed to perform hand hygiene before exiting the treatment floor. 7. At 2:05 PM CST, EI # 5 was observed discontinuing care to PI # 8 at station 1. While EI # 5 was sitting on a rolling stool, EI # 5 rolled to the trash can in the middle of the treatment floor, placed trash in the can touching the side of the trash can. EI # 5 rolled back to the station and continued providing care. EI # 5 failed to remove gloves and perform hand hygiene after contact with the contaminated surface of the trash can. 8. At 2:15 PM CST, EI # 4, PCT exited the treatment floor wearing gloves, gown and face shield with a bath jug in hand. EI # 4 failed to perform hand hygiene before exiting the treatment floor and exited wearing dirty gloves. 9. At 3:00 PM CST, PI # 12 was observed holding pressure to the access site with a gloved hand at station 4. At 3:20 PM CST, assisted by EI # 5, PCT, the patient exited the treatment area via wheelchair without first performing hand hygiene. 34107 10. On 7 /13/21 at 9:55 CST AM, EI # 6, Registered Nurse, prepared Parsabiv IV (intravenous), then retrieved gloves from the clean glove box. On the way to station 8, EI # 6 donned the gloves prior to administration of Parsabiv IV medication. EI # 6 failed to perform hand hygiene before gloves were applied and IV medication administered to PI # 14. 11. On 7/13/21 at 11:35 CST AM, EI # 11, PCT, while wearing gloves, placed the adult BP (blood pressure) cuff on PI # 2 at station 17, then removed the cuff stating, "I need the baby cuff." EI # 11 removed the adult cuff, placed it on the chairside table and exited station 17 still wearing the dirty gloves. EI # 11 failed to remove the dirty gloves and perform hand hygiene. EI # 11 went to the cabinet on the left of the treatment floor and searched in several drawers for the "baby cuff". EI # 11 went to the nurse station, searched in drawers, then to the clean cart between station 6 and station 2 searching through cuffs on the cart bottom. EI # 11 then went to the plastic 3 drawer container in front of station 17 and found the pediatric cuff. EI # 11 failed to remove gloves and perform hand hygiene before exiting the station. EI # 11 potentially contaminated numerous "clean" areas on the treatment floor and nurse station while searching for patient equipment with dirty

	gloves on. During interview on 7/14/21 at 11:25 AM, CST, EI # 1, Director of Operations confirmed the staff failed to follow facility policies and procedures and the observations were breaches in infection control.
V0115	IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK CFR(s): 494.30(a)(1)(i) Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory. This STANDARD is not met as evidenced by: Based on observations, review of policies and interviews, it was determined the facility failed to ensure: 1. Visitors were provided with PPE (Personal Protective Equipment) while on the treatment floor. 2. Staff removed PPE before leaving the treatment area. This had the potential to negatively affect all patients dialyzed at this facility, visitors, and facility staff. Findings include: Facility Policy: Visitor Policy Published: 6/20/18 Version: 3 Policy: Visitors in the patient care area Visitors have a responsibility to abide by FKC (Fresenius Kidney Care) policies and procedures... PPE will be provided along with instructions for proper use... Policy: Visitors in the Isolation room/area... PPE will be provided, and visitors must abide by all requirements for PPE. Facility Policy: Personal Protective Equipment Published: 2/14/18 Version: 5 Purpose: ... to identify Personal Protective Equipment (PPE) and potential areas for use. Policy: All personal protective equipment shall be removed prior to leaving the treatment area... Observations of care on 7/12/21 from 10:00 AM CST (Central Standard Time) to 3:30 PM CST revealed the following PPE infection control breaches: 1. At 10:00 AM CST, a police officer was observed sitting in front of the isolation room with no PPE on. The isolation room door was open. 2. At 10:20 CST AM, 2 emergency medical services personnel were observed assisting an unsampled patient at station 7 onto a stretcher wearing no PPE (gown or gloves). 3. At 10:35 AM CST Employee Identifier (EI) # 5, Patient Care Technician (PCT), prepared the dialysis machine at station 4. EI # 5 left the dialysis station, exited the treatment floor into the lobby wearing gown, mask and face shield then returned to the treatment floor without removing PPE as directed per the facility policy. 30952 4. At 12:30 PM CST, EI # 4, PCT exited the treatment floor wearing gown, face shield, and gloved with a bath jug in hand. EI # 4 failed to remove PPE prior to leaving the treatment floor. 5. At 2:15 PM CST, EI # 4, PCT again exited the treatment floor wearing gown, and face shield, gloves with a bath jug in hand. EI # 4 failed to perform remove PPE before leaving the treatment floor. 6. At 2:45 PM CST after disinfection of station 2, EI # 5, PCT exited the treatment floor gloved with the bath jug in hand and wearing a face shield. EI # 5 failed to remove the face shield prior to exiting the treatment floor. In an interview on 7/14/21 at 11:25 AM CST EI # 1, Director of Operations confirmed staff failed to follow facility policy and procedure for PPE use.
V0119	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 observations, facility policies and interviews, it was determined the facility failed to ensure all supplies for patient use were stored in a clean area. This had the potential to negatively affect all patients served at the facility. Findings include: Facility Policy: Dialysis Precautions Published: 1/4/12 Version: 4 ...The purpose of this policy is to provide an overview of dialysis precautions Policy Dialysis Precautions will be followed by all employees... General Approach All patients...are infectious All blood, body fluids, tissues, needles, and sharps... are contaminated ...All supplies and equipment used for a patient's treatment...are contaminated Clean Versus Dirty Areas Clean area: An area designated for clean and unused equipment, supplies and medications Dirty area: An area where...a potential for contamination...or used supplies, equipment...are stored or handled. Clean areas should be clearly designated for the preparation and handling and storage of...unused supplies and equipment. Clean areas should be clearly separated from dirty areas where used supplies, equipment or blood samples are handled or stored... Facility Policy: Access Assessment and Cannulation Published: 8/22/18 Version: 1 ...Supplies ...Taping the Fistula Needle Step 1 ...Tape from multi-use roll: Tape must be prepared outside of the patient station to prevent risk of cross contamination...When you are ready to cannulate, go to the clean area and retrieve the stack of tape... Observations of care on 7/12/21 from 10:00 AM CST (Central Standard Time) to 3:30 PM CST the surveyors observed the following breaches for staff failing to ensure patient supplies were kept in a clean area. 1. At 10:55 AM CST lying beside the handwashing sink at station 2, the surveyor observed a 180 NR dialyzer, blood line tubing, and a bag of Normal Saline. Employee Identifier (EI) # 7, Certified Clinical Hemodialysis Technician (CCHT), confirmed patient supplies should not be next to the handwashing sink. 2. At 12:45 PM, CST, the surveyor observed 2 plastic clip boards lying on counter at the back of station 17 and 13, an area where there is a potential for contamination, which is a dirty area. The clip boards contained several lines of paper tape strips. The surveyor asked EI # 9, CCHT, "Can patient supplies stored on this counter?" She answered yes and confirmed the paper tape strips should be stored in clean area. In an interview conducted with EI # 1, Director of Operations (DOO) on 7/14/21 at 11:25 AM CST confirmed the staff failed to ensure all patient supplies were stored in clean area. 30952 3. At 12:50 PM CST, the surveyor observed a cart along the back wall adjacent to the nurse station with patient supplies on the bottom shelf including vacutainer holders and an unused access cannulation needle. There were 3 face shields, all with tape around the ears next to the patient supplies. 4. At 2:40 PM CST, the surveyor observed a cart on the treatment floor adjacent to the water room exit. The cart contained an open box of gloves and multiple individual gloves were out of the box lying on a barrier pad. There were 4 rolls of used tape, a stethoscope and a 2 face shields on the barrier. Also, on the cart was a document from the Centers for Disease Control, Care of a Patient with C-Difficile Clostridium Difficile (an infectious gastrointestinal bacteria), in a document saver. In an interview on 7/12/21 at 2:40 PM CST, EI # 5, PCT, was asked if this was a clean cart? EI # 4 reported it was a clean cart used for a patient with C Diff (Clostridium Difficile) who dialyzed on TTS (Tuesday, Thursday, and Saturday). EI # 5 confirmed staff re-usable equipment should not be on a clean cart. In an interview on 7/14/21 at 11:25 AM CST, EI # 1, DOO reported no longer was an an active C Diff case in the clinic and the cart should have been removed from the treatment floor. EI # 1 stated staff equipment and patient

	supplies should not stored together.
V0122	IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL CFR(s): 494.30(a)(4)(ii) [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. This STANDARD is not met as evidenced by: Based on observations, facility policy and procedure, and interviews, it was determined the facility failed to ensure staff: 1. Prepared and labeled bleach solutions daily. 2. Cleaned and disinfected the dialysis station after patient treatments per its own policy. This affected 4 of 4 dialysis station disinfection observations and had the potential to negatively affect all patients dialyzed by this facility. Findings include: Facility Procedure: Mixing Bleach Published: 8/25/2020 Version: 4 2. Pour measure amount of water needed into labeled opaque container... 4. Label opaque container with "Bleach Solution", strength of solution, date, and time prepared, and your initials. Facility Policy: Cleaning and Disinfection of the Dialysis Station Published: 11/02/2020 Version: 11 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 ...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... and attachment such as (IV) intravenous pole... General Cleaning The dialysis station could become contaminated with blood and other body fluids during treatment... After use, all equipment and supplies must be considered as potentially blood contaminated, and should be separated, handled with caution and either disinfected or discarded. Work Surface Cleaning and Disinfection without Visible Blood using Bleach Solutions. All work surfaces shall be cleaned and disinfected with 1:100 (1-part bleach, 100 parts water) bleach solution after completion of procedures. Make the surface glistening wet and let air dry unless otherwise specified by the manufacturer... During observations of the care from 10:00 AM CST (Central Standard Time) to 3:30 PM CST, the surveyors observed the following: 1. At 10:00 AM CST, 4 containers filled with liquid were observed 2 on each end of the treatment floor with white disposable cloths beside them. The surveyor asked Employee Identifier (EI) # 7 Certified Clinical Hemodialysis Technician (CCHT) what was in the containers. EI # 7 stated, "It's our bleach solution for cleaning." EI # 7 confirmed the containers were not labeled with type of bleach solution, date, time, or initials of the staff who prepared the solution. 2. At 10:15 AM CST at station 12 the surveyor observed Patient Identifier (PI) # 18 was dialyzing with the plumbed bath of 2.0 K (Potassium) 2.0 Ca (Calcium) 1.0 Mg (Magnesium) (2201). The surveyor noted a dialysate container labeled as 3.0 K, 2.5 Ca, 1 Mg (3231) sitting on the base of the dialysis machine. The surveyor asked EI # 7, "Is this for PI # 18?" EI # 7 stated, "No, I just didn't move it." EI # 7 failed to ensure all supplies were either disinfected or discarded. 3. At 12:25 PM CST at station 3, EI # 5, PCT (Patient Care Technician), disinfected the HD (hemodialysis) machine top, and HD right side but failed to disinfect the hand sanitizer container. In addition, EI # 5 failed to disinfect the Hansen connector. 30952 4. At 2:35 PM CST at station 2, EI # 5, PCT removed the bath jug from the base of the HD machine then placed the jug on the staff stool seat. EI # 5 disinfected the HD

	top, and HD right side but failed to disinfect the inside of wire BP (blood pressure) cuff basket and hand sanitizer container also inside the basket. In addition, EI # 5 failed to disinfect the Hansen connector. 5. EI # 5 completed disinfection of station 2 and at 2:45 PM CST, EI # 5 exited the treatment floor with the bath jug. EI # 5 failed to disinfect the staff stool after removing the bath jug from the stool. 6. At 2:55 PM CST at station 10 during the dialysis treatment of an unsampled patient, the surveyor observed 2 syringes that contained 1.5 ml- 2 ml dark substances in each lying on the chairside table. The surveyor asked EI # 7, CCHT what was in the 2 syringes on the patient chairside table. EI # 7 confirmed blood was in the syringes and disposed of the 2 syringes into the sharps container. EI # 7 failed to follow standard infection precautions and discard the syringes that contained visible blood from the chairside table. 7. At 3:00 PM CST at station 4 during an observation of care, the surveyor observed white crystals on the staff stool that were from the bath jug placed on the stool during station 2 disinfection and not disinfected by EI # 5. 8. On 7/13/21 at 10: 45 AM CST at station 17, EI # 11 PCT, disinfected the top of the HD machine and while disinfecting the IV pole, removed the blue clip from the IV pole and placed the clip in the bleach solution. EI # 11 failed to remove all reusable equipment before beginning disinfection. EI # 11 then returned to station 17 and completed disinfection of the HD machine, and failed to clean the back of the station or the arm of the TV. In an interview on 7/14/21 at 11:25 AM, EI # 1, Director of Operations confirmed the observations were breaches in the facility infection control policies and procedures.
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 observations, review of facility policy and interview, it was determined the facility failed to ensure: 1. All equipment used in the isolation room was designated and labeled for "isolation" only. 2. Infectious Waste in red bag was removed from the HBsAg (Hepatitis B surface Antigen) positive patient care room/area each day. This had the potential to negatively affect all Hepatitis B susceptible patients, visitors, and facility staff. Findings include: Policy: Dialyzing Patients with Positive Hepatitis B Antigen Published: 3/20/13 Version: 7 Purpose: To prevent the transmission of Hepatitis B. Policy: ...all patients with hepatitis B infection treated in the dialysis facility require additional infection control precautions... Isolation of Hepatitis B virus positive (HBsAg+) patients. All patients who are HBsAg positive must dialyze under isolation precautions. 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. (etcetera), should be labeled "isolation" and not routinely removed... All disposable items, including the patient's dialyzer, shall be considered infectious, and shall be red-bagged, labeled as Infectious Waste and removed from the HBsAg positive patient care room/area each day using Standard Precautions. 1. On 7/12/21 at 11:30 AM CST (Central Standard Time) the surveyor toured the isolation room with Employee Identifier (EI) # 10, Certified Clinical Hemodialysis Technician (CCHT). The following items were in the isolation room and not labeled "isolation": 1 pHoenix meter. 1 plastic container with white lid labeled 1:100 bleach solution. 4 gallons of vinegar. 2 gallons of bleach. 2. On 7/13/21 at 5:00 PM CST, the surveyors again

	toured the isolation room and observed the red-bagged hazardous waste trash was full and contained dialyzers and blood lines used from the 7/12/21 treatment day. During an interview conducted on 7/14/21 at 11:25 AM CST, EI # 1, Director of Operations, confirmed the equipment should have been labeled "isolation" and the red-bagged hazardous waste should have been emptied on 7/12/21.
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 observation, review of the CDC (Centers for Disease Control) Injection Safety Information for Providers, facility policy, and interview, it was determined Registered Nurse (RN), Employee Identifier (EI) # 3 failed to use a sterile syringe and needle when entering the medication vial. This affected unsampled Patient Identifier (PI) # 10, 1 of 2 observations of multidose vial medication preparation/administration and had the potential to negatively affect all patients who dialyzed at the facility. Findings include: CDC Injection Safety Information for Providers FAQ's (Frequently Asked Questions) Regarding Safe Practices for Medical Injections ....1. How should I draw up medications? Parental medications should be accessed in an aseptic manner... includes using a new sterile syringe and sterile needle to draw up medications... Medication Administration Questions ...The safest practice is to always enter a medication vial with a sterile needle and sterile syringe, even when obtaining additional doses of medication for the same patient. This adds an extra layer of safety in case...the medication vial is not discarded at the end of the procedure...and is inadvertently used on a subsequent patient... Facility Policy: Medication Preparation and Administration Published: 4/5/21 Version: 6 Purpose: To administer medication with the goals of staff and patient safety...and infection control. ...Infection Control The following steps must be taken to ensure infection control. Always use a sterile syringe and needle when entering a vial...If either vial is multi-use a different syringe must be used for entry into each vial... 1. During an observation of care on 7/13/21 at 12:30 PM CST (Central Standard Time) at the medication preparation counter, EI # 3 prepared Heparin from an opened multidose vial and withdrew 6 ml (milliliter) into a needle and syringe, which was insufficient for the ordered Heparin. EI # 3 then opened an unused multidose Heparin vial. Using the same syringe and needle, EI # 3 withdrew an additional 1 ml to 1.5 ml Heparin into the syringe. EI # 3 labeled the multidose Heparin vial and placed the vial in the locked medication cabinet. EI # 3 failed to use a sterile needle and syringe for parental medication preparation per CDC recommendations and facility policy. In an interview on 7/14/21 at 11:10 AM CST, EI # 1, Director of Operations, confirmed medication vials must be entered each time with a sterile needle and syringe.
V0147	IC-STAFF EDUCATION-CATHETERS/CATHETER CARE CFR(s): 494.30(a)(2) Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all

persons who manage intravascular catheters. II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].

This STANDARD is not met as evidenced by:
Based on observations, medical record (MR) review, facility procedure, and interviews, it was determined the facility failed to ensure staff: 1. Performed Central Venous Catheter (CVC) exit site care per policy in 2 of 4 care observations. This affected unsampled patient, Patient Identifier (PI) # 24 and PI # 2. 2. Documented CVC exit care and dressing change in 1 of 2 MR's reviewed with CVC's and included PI # 1. This had the potential to negatively affect all patients with CVC's dialyzed at this facility. Findings include: Facility Procedure: Changing the Catheter Dressing Published: 11/04/19 Version: 6 Supplies ...Underpad... Removal of Dressing and Inspection of Site Step 1. Place an underpad under catheter limbs to protect work area and clothing. ...Step 5. Inspect and remove old dressing... ...Cleaning the Site... Step 2... 2% Chlorhexidine and 70% alcohol: Using gentle back and forth friction, clean the exit site beginning in the center and continuing outward 2 inches in a concentric circle for 30 seconds and allow to dry a minimum of 30 seconds. Use both sides of the swab stick to clean an area the size of the dressing to be applied. If exudate or crusting is noted, an additional swab stick may be necessary to clean the exit site... Documentation Document the dressing change in the patient's medical record. Include any observations of the exit site, catheter integrity, notifications to the team ... of abnormal findings, instructions, or interventions made during the dressing change. 1. PI # 24 was admitted to the facility on 5/20/21 with the primary diagnosis of ESRD (End Stage Renal Disease). During an observation of CVC exit site care conducted on 7/13/21 at 10:40 AM CST (Central Standard Time), Employee Identifier (EI) # 3, Registered Nurse (RN) cleaned on the sides and top of the exit site with a Chlorprep swab stick and failed to clean under the CVC exit site. In an interview conducted on 7 /14/21 at 2:20 PM CST, EI # 1, Director of Operations (DOO), confirmed EI # 3 failed to follow facility procedure for CVC exit site care and dressing change. 2. PI # 2 was admitted to the facility on 5/29/21 with the primary diagnosis of Acute Kidney Injury. During an observation of CVC exit site care conducted on 7/13/21 at 11:50 AM CST at station 17, EI # 3, RN placed a blue underpad under the limbs of the CVC. EI # 3 cleaned on the sides and top of the exit site with a Chlorprep swab stick and failed to clean underneath the CVC exit site. EI # 3 opened the dressing package, PI # 2 reached up and his/her shirt and went up the sides of the cleaned area. EI # 3 pulled the shirt back down and placed the sterile dressing to the exit site. EI # 3 failed to secure shirt under the CVC site or re-clean the exit site before applying the sterile dressing. In an interview conducted on 7/14/21 at 11:25 AM CST, EI # 1 confirmed EI # 3 failed to follow facility procedure for CVC exit site care. 30952 3. PI # 1 was admitted to the facility 4/13/21 with diagnoses including Diabetic Glomerular Sclerosis and ESRD. Review of the Treatment Sheet dated 6/29/21 revealed the CVC access was used for dialysis treatment, but there was no documentation of the care provided to the CVC site. Review of the Treatment Sheet dated 7/6/21 revealed "CVC care provided" but failed to include documentation of the CVC care performed. In an interview on 7/14/21 at 1:09 PM CST, EI # 1, DOO confirmed staff failed to document the CVC care performed per the facility policy.

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 policy and procedure and interview it was determined the staff failed to rinse the pHoenix meter after each use per facility policy. This affected 4 of 4 observations and had the potential to negatively affect all patients who dialyze at this facility. Findings include: Facility Policy: Checking Conductivity and pH of Final Dialysate Published: 8/03/2020 Version: 7 Purpose: The purpose of this policy is to provide guidelines to verify final dialysate conductivity and pH prior to initiating hemodialysis treatments... Testing with pHoenix Meter Step 6 The pHoenix meter's internal cell must be rinsed between tests with RO (reverse osmosis) water. Attach the meter to the RO water bottle and rinse the cell two times. pHoenix Meter, pHoenix XL, and Tri-Station Care and Maintenance Published: 6/14/17 Version: 1 ...Maintenance Schedule Procedure Rinse Meter with RO after each use 1.On 7/12/21 at 11:05 AM CST (Central Standard Time) at the Tri-Station, Employee Identifier (EI) # 9, Certified Clinical Hemodialysis Technician (CCHT) tested dialysate solution from station 13 for pH and conductivity using the pHoenix meter. After results were obtained, EI # 9 expelled the solution into the dirty sink then placed the pHoenix meter on the rack. EI # 9 failed to rinse the pHoenix meter with RO water after use according to facility policy. 2. On 7/12/21 at 11:20 AM CST at the Tri-Station, EI # 4, PCT tested dialysate solution from station 6 for pH and conductivity using the pHoenix meter. After results were obtained, EI # 4 expelled the solution into the dirty sink then placed the pHoenix meter on the rack. EI # 4 failed to rinse the pHoenix meter with RO water after use according to facility policy. 3. On 7/12/21 at 11:35 AM CST at the Tri-Station, EI # 5, Patient Care Technician (PCT),) tested dialysate solution from station 4 for pH and conductivity using the pHoenix meter. After results were obtained, EI # 5 expelled the solution into the dirty sink then placed the pHoenix meter on the rack. EI # 5 failed to rinse the pHoenix meter with RO water after use according to facility policy. 30952 4. On 7/12/21 at 12:25 PM CST at the Tri-Station, EI # 7, Certified Clinical Hemodialysis Technician tested dialysate solution from station 11 for pH and conductivity using the pHoenix meter. After results were obtained, EI # 7 expelled the solution into the dirty sink then placed the pHoenix meter on the rack. EI # 7 failed to rinse the pHoenix meter with RO water after use. In interview on 7/14/21 at 11:25 AM CST, EI # 1, Director of Operations, confirmed staff had failed to follow the facility procedure and rinse the pHoenix meter with RO water after each use.
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 facility procedure, observations of care and staff interview, it was determined the facility failed to ensure staff had labeled open Tri-Station testing solution bottles. This had the ability to negatively affect all patients who dialyzed at the facility. Finding include: Procedure: Checking Conductivity and pH of Final Dialysate with the pHoenix Meter. Published date: 08/03/2020 Version: 7 Purpose This procedure provides instruction for measuring final dialysate conductivity and pH with a pHoenix meter. Supplies... Tri-Station with RO (Reverse Osmosis) water, 1% bleach, 14.0 mS (millisiemens, an electrical conversion unit) and 7.0 solutions. NEO-CARE Solution... Note: Tri-Station RO water and 1% bleach solutions are replaced daily. Label solutions with date, time, and initials... 1. A flash tour of the facility was conducted on 7/12/21 at 10:00 AM CST (Central Standard Time) and the surveyor observed Neo-Care, 14.0 mS, and 7.0 at the Tri-Station open and not labeled with the date opened. The 1% bleach bottle was not labeled with date, time, and initials. The RO water bottle was labeled with the date of 6/30/21. The surveyor asked EI (Employee Identifier) # 7, Certified Clinical Hemodialysis Technician, "Should solutions at the Tri-Station be labeled with date opened or replaced?" EI # 7 confirmed the solutions were not labeled when opened and RO water and bleach solution was not labeled when replaced daily. In an interview on 7/14/21 at 11:25 AM CST, EI # 1, Director of Operations confirmed staff had failed to label Tri-Station solutions when opened or replaced per policy.
V0540	CFC-PATIENT PLAN OF CARE CFR(s): 494.90 This CONDITION is not met as evidenced by: Based on observation, review of medical records (MR), facility policies and interviews, it was determined the facility failed to ensure staff provided care according to facility policies and procedures and physician orders and the patient's Plan of Care (POC) during care delivery. This had the potential to negatively affect all patients dialyzed at this facility. Refer to V 543, V 544, V 545, V 550, and V 551 for findings.
V0543	POC-MANAGE VOLUME STATUS CFR(s): 494.90(a)(1) The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; This STANDARD is not met as evidenced by: Based on review of the medical records (MR), facility agency policy and procedure, and interviews, it was determined the facility failed to ensure staff: 1. Documented the patient's BP (blood pressure) and pulse every 30 minutes or more often as needed but not to exceed 45 minutes. 2. Documented machine parameter and safety checks every 30 minutes or more often as needed but not to exceed 45 minutes. 3. Identified, documented, and reported changes in the patient condition to the RN (Registered Nurse) which included UF (Ultrafiltration Rate) rate off, NS (normal saline) administration and BP changes. 4. Post treatment re-assessments by the RN were completed and documented when pre-treatment patient conditions revealed abnormal

lung assessments and 2 plus edema (swelling) bil (bilateral) to the lower extremities (LE). 5. Documented the total fluid administered during treatments. This affected 7 of 8 medical records reviewed including Patient Identifier (PI) # 1, PI # 4, PI # 6, PI # 2, PI # 7, PI # 8 and PI # 3 and had the potential to negatively affect all patients served by the dialysis facility. Findings include: Policy: Patient Assessment and Monitoring Version: 3 Published Date: 09/29/18 Pre-Treatment Assessment and Data Collection Direct patient care staff may collect pre-treatment weight, BP...general observations... and complaints reported by the patient. If the PCT (Patient Care Technician) notes any changes, or abnormal in the patient...MUST report changes in the patient condition to a RN who will further assess the patient prior to initiation of the treatment. During treatment The RN will assess/re-assess any findings addressed pre or during treatment as needed. Post-Treatment Non-licensed staff may collect post-treatment weight, BP, pulse...general observations, access, and complaints reported by the patient. The staff member who evaluates the information and evaluates the patient post-treatment will document their findings on the...record. If any changes or abnormal findings...are observed or reported...the PCT...must report the changes in the patient condition to a RN who will further assess the patient prior to discharge after treatment. An abnormal finding confirmed by the RN will be reported to the attending physician if necessary...for assessment and intervention. The RN will assess/re-assess any findings addressed pre-treatment prior to discharge. Follow steps...obtaining pre-treatment assessment data: 2. During nursing rounds, the RN will review the data... and assess the following parameters as needed: ...Assess patient for symptoms...ask... if...had shortness of breath, chest pain... Lung sounds sounds...Auscultate...for... Decreased Breath sounds Rales (crackles) Rhonchi Wheezing Location Edema... location...Severity 3. Document findings and interventions in the medical record... Monitoring during Treatment Obtain blood pressure and pulse rate every 30 minutes or more as needed but not to exceed 45 minutes...Document machine parameter and safety checks every 30 minutes or more often as needed but not to exceed 45 minutes... Follow the steps below for monitoring patient and machine parameters during treatment: Step 1. Blood Pressure Record blood pressure. Recheck blood pressures after a drop that requires interventions such as administering normal saline (NS)... Report to the nurse: Systolic (BP top value obtained during contraction of the heart chambers) BP greater than 180 mm/Hg (millimeters/mercury); Diastolic (BP bottom value obtained during heart chamber relaxation) BP greater than 100 mm/Hg; BP less than or equal to 100 mm/Hg systolic. Ultrafiltration (UF) Rate (UFR) Monitor UF rate.... Reported by patient... Ask of any new complaints to report. General Observations/Mental Status Observe the patient's overall conditions during treatment. Report to the nurse any changes in the patient's overall condition... ...3. Machine Parameters and Extracorporeal Circuit Check machine settings and measurements. Check prescribed blood flow (blood flow rate-BFR) is being achieved or reason is documented in medical record if unable to meet prescribed blood flow. Check dialysate flow rate (DFR) setting is correct, and prescribed flow is being delivered. Check arterial pressure is less than 250 mmHg. Monitor high venous pressure for infiltration or clotting. Check the amount of fluid removed... Observe and ensure that: Normal saline line is double clamped. There is at least 300 ml of NS prior to termination... Post-Treatment Follow the steps below for obtaining post-treatment assessment data: 1. The direct patient care staff may obtain the following: ...State of well-being/Reported by the patient/General observation The RN will assess/re-assess post treatment as indicated. Lung sounds Edema... 2. Document findings in the patient's record. 1. PI # 1 was admitted to the facility 4/13/21 with diagnoses including Diabetic Glomerular Sclerosis and ESRD (End Stage Renal Disease). Review of the Treatment Sheet dated 6/29/21 revealed no BFR/DRF documented from 11:42 AM until 12:36 PM, which was 54 minutes. There was no BFR/DFR

documented from 2:04 PM until 3:03 PM, which was 59 minutes. Review of the Treatment Sheet dated 7/3/21 revealed no BP or pulse, no BFR/DFR, and no safety checks documented from 1:35 PM until 2:35 PM, which was 60 minutes. In an interview conducted on 7/14/21 at 1:09 PM CST (Central Standard Time), Employee Identifier (EI) # 1, Director of Operations, confirmed staff failed to perform and document patient assessment and monitoring per policy. 2. PI # 4 was admitted to the facility 5/15/2020 with diagnoses including ESRD. Review of the Treatment Sheet dated 6/29/21 at 2:10 PM revealed the following RN pre treatment documentation: breath sounds: rales/Crackling, Breath Sound location, all lobes; rhonchi, bil (bilateral) lungs; lower leg (edema)-severity 1 plus; 2 mm or less, disappears rapidly, edema lower leg...ankle; bil Lungs-sound location. Further review of the 6/29/21 Treatment Sheet post nursing evaluation at 6:54 PM failed to reveal documentation how/if the rales/rhonchi to bil lungs and bil lower leg/ankle edema were affected by the dialysis treatment. During an interview conducted on 7/14/21 at 1:28 PM CST, EI # 1 confirmed staff failed to follow the monitoring policy which included RN assessment and documentation post treatment assessment data when abnormal pre treatment findings were identified. 3. PI # 6 was admitted to the facility on 6/2/17 with diagnoses including Diabetes Mellitus with Diabetic Nephropathy and ESRD. Review of the Treatment Sheet dated 6/30/21 at 11:40 AM revealed the PCT documented the BP 85/50, pt(patient) denies complaints, UF off. At 12:09 PM, the PCT documented denied complaints, BP 114/54, UF off treatment ended. There was no reason documented why the UF was off and no documentation the PCT notified the RN the UFR was off for 29 minutes. Review of the Treatment Sheet dated 7/2/21 at 8:23 AM revealed the following RN pre-treatment data documentation: symptoms were shortness of breath, bilateral lungs decreased breath sounds, lower leg, and ankle edema-severity 2 plus; 2-4 mm (millimeter) indent bilateral (bil). Further review of the 7/2/21 Treatment Sheet post nursing evaluation at 11:58 AM failed to include post treatment documentation if/how the patient shortness of breath, bil lung sounds and bil leg edema were affected by the dialysis treatment. Review of the Treatment Sheet dated 7/5/21 at 9:37 AM revealed RN documentation the BP was 89/51, (pt) denies complaints, alert; chronic low BP, will monitor. Further review of the 7/5/21 Treatment Sheet revealed at 11:05 AM, the PCT documented BP 77/43, denies complaints, UF off, pt alert, 200 ml (ns) for low bp. There was no documentation the PCT notified the RN regarding the "low bp", when the UF was turned off and when 200 ml NS was administered. The low bp was not rechecked until 11:58 AM, at treatment end, which was 53 minutes. An interview was conducted on 7/14/21 at 12:56 PM CST and EI # 1 confirmed staff failed follow the patient assessment and monitoring policy. 34107 4. PI # 2 was admitted to the facility 5/29/21 with the primary diagnosis of Acute Kidney Injury. Review of the Treatment Sheet dated 7/1/21 revealed no BP or pulse, no BFR/DFR, and no safety checks documented from 2:10 PM until 3:12 PM, which was 62 minutes. In an interview conducted on 7/14/21 at 1:20 PM CST, EI # 1, confirmed the staff failed to perform and document patient assessment and monitoring per policy. 5. PI # 7 was admitted to the facility on 9/28/19 with the primary diagnosis of ESRD. Review of the 7/10/21 Treatment Sheet revealed documentation at 7:58 AM of "patient request to use restroom." There was no documentation of amount of NS to rinse back blood. Further review of 7/10/21 Treatment Sheet revealed at 8:19 AM, the documentation revealed, "Treatment resumed; resting comfortably, alert." There was no documentation of the amount of NS used to resume treatment. At 8:20 AM, the documentation revealed "300 ml NS rinse venous infiltration noted, unable to continue treatment due to pressures." In an interview conducted on 7/14/21 at 1:15 PM CST, EI # 1 confirmed the staff failed to document NS used to rinse back blood or prime re-start of treatment which resulted in an infiltration. 6. PI # 8 was admitted to the facility on 10/14/14 with the primary

	diagnosis of ESRD. Review of the Treatment Sheet dated 7/12/21 revealed no BP or pulse, no BFR/DFR, and no safety checks documented from 1:34 PM until 2:42 PM which was 68 minutes. On 7/12/21 at 12:55 PM CST the surveyor observed the BP of 214/67 and there was no NS solution in the bag hanging on the dialysis machine. 2:40 PM, EI # 5, PCT yelled across the treatment floor to the RN, "(Patient's Name) went out!" At 2:42 PM, the RN documented, patient was unresponsive for approximately 3 seconds. In an interview conducted on 7/14/21 at 1:06 PM CST, EI # 1 confirmed the staff failed to document patient assessment and monitoring per policy. 7. PI # 3 was admitted to the facility on 12/9/2020 with the primary diagnosis of ESRD. Review of the Treatment Sheet dated 6/30/21 revealed no BP or pulse, no BFR/DFR, and no safety checks documented from 11:06 AM until 12:12 AM which was 66 minutes. Review of the Treatment Sheet dated 7/5/21 revealed no BP or pulse, no BFR/DFR, and no safety checks documented from 8:06 AM until 9:37 AM which was 91 minutes. Further review of the 7/5/21 Treatment Sheet revealed BP reading at 10:05 AM, BP was 130/74. At 10:36 AM, the BP decreased to 104/65 and at 11:12 AM, the BP was 91/44. There was no documentation the RN was alerted to the low BP, 91/44. Review of the Treatment Sheet dated 7/7/21 revealed no BP or pulse, no BFR/DFR, and no safety checks documented from 11:00 AM until 11:46 AM, which was 46 minutes. Review of the Treatment Sheet dated 7/9/21 revealed no BFR/DFR documented from 8:11 AM to 9:33 AM, which was 82 minutes. Further review of the 7/9/21 Treatment Sheet revealed no BP or pulse, no BFR/DFR and no safety checks documented from 11:04AM until 12:12 PM, which was 66 minutes. Review of the Treatment Sheet dated 7/12/21 revealed no BP or pulse, no BFR/DFR, and no safety checks documented from 11:07 AM until treatment ended at 12:12 PM, which was 65 minutes. In an interview conducted on 7/14/21 at 1:05 PM CST EI # 1, confirmed the staff failed to perform/document the patient assessment and monitoring per policy as stated above for 5 of the 6 treatment records reviewed.
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 observation, review of medical records (MR), facility policy, and interviews with staff, it was determined the facility failed to ensure the staff: 1. Followed the physician order for the Blood Flow Rate (BFR) and Dialysate Flow Rate (DFR). 2. Followed physician orders for dialyzer size. This affected unsampled patient, Patient Identifier (PI) # 17, and 6 of 8 records reviewed and included PI # 2, PI # 7, PI # 8, PI # 1, PI # 5, PI # 4 and had the potential to negatively affect all patients dialyzing at this facility. Findings include: Policy: Patient Assessment and Monitoring Version: 3 Published Date: 09/29/2018 Monitoring during Treatment ...3. Machine Parameters and Extracorporeal Circuit Check machine settings and measurements. Check prescribed blood flow is being achieved or reason is documented in medical record if unable to meet prescribed blood flow. Check dialysate flow rate setting is correct, and prescribed flow is being delivered... 1. During observations of care on 7/12/21 at 3:25 PM, the surveyor observed an unsampled patient, PI # 17, at station 14 with a 180 NRe dialyzer. Review of PI # 17's 7/12/21 Hemodialysis orders revealed a 160 NRe Optiflux dialyzer was ordered. Employee Identifier (EI) # 10, Certified Clinical Hemodialysis Technican (CCHT), confirmed during the observation the wrong

dialyzer size and stated, "The nurse is going to get an order to change the dialyzer size." Review of the 7/12/21 Treatment Sheet revealed treatment assessments of: 12:36 PM with the blood pressure (BP) of 186/89. 1:05 PM with the BP of 128/69. 1:36 PM with the BP of 104/42. 2:08 PM with the BP of 112/49. 2:38 PM with the BP of 94/55. Normal Saline (NS) 200 milliliter (ml) given due to hypotension. 3:04 PM with the BP of 118/47. 3:15 PM with the BP of 102/54. NS 200 given due to cramping. 3:35 PM with the BP of 114/62. 4:08 PM with the BP of 101/49. 4:51 PM with the BP of 100/ 53. Further review of the 7/12/21 Treatment Sheet revealed no documentation the physician was contacted to increase the dialyzer size. In an interview conducted on 7/14/21 at 1:45 PM CST (Central Standard Time), EI # 1, Director of Operations, confirmed the staff failed to follow the physician order for dialyzer size. 2. PI # 2 was admitted to the facility 5/29/21 with the primary diagnosis of Acute Kidney Injury. Review of the current orders report dated 6/24/21 revealed a BFR of 400 and DFR Autoflow 1.5, which would be 600. Review of the Treatment Sheet dated 6/26/21 revealed the BFR was 400 and DFR 600 at 12:03 PM. From 12:30 PM to 1:33 PM revealed the BFR was decreased to 300 and DFR was decreased to 500. From 2:02 PM until 3:33 PM, the BFR was decreased to 275. There was no documentation why the BFR and DFR were not at the ordered rates or why the prescribed flow was not met. Review of the Treatment Sheet dated 7/1/21 revealed the BFR was 400 and DFR 600 at 12:26 PM to 12:36 PM. From 1:00 PM to 2:10 PM revealed the BFR was decreased to 250 and DFR was decreased to 500. There was no documentation why the BFR and DFR were not at the ordered rates or why the prescribed flow was not met. Review of the Treatment Sheet dated 7/8/21 revealed the BFR was 400 and DFR 600 at 11:57 AM to 1:06 PM. At 1:33 PM the BFR was decreased to 350. At 2:06 PM the BFR was decreased to 300 and DFR decreased to 500. There was no documentation why the BFR and DFR were not at the ordered rates or why the prescribed flow was not met. In an interview conducted on 7/14/21 at 1:20 PM, EI # 1, confirmed the BFR and DFR were not at the ordered rates and there was no documentation why the prescribed blood flow was not achieved for 3 of 6 treatment sheets reviewed. 3. PI # 7 was admitted to the facility on 9/28/19 with the primary diagnosis of End Stage Renal Disease (ESRD). Review of the current orders report dated 6/26/21 revealed a BFR of 400 and DFR Autoflow 1.5, which would be 600. Review of the Treatment Sheet dated 7/6/21 revealed the treatment started at 12:49 and there was no documentation of BFR or DFR until 1:09 PM. From 1:09 PM to 3:07 PM the BFR was 300 and DFR 500. There was no documentation why the BFR and DFR were not at the ordered rates or why the prescribed flow was not met. Review of the Treatment Sheet dated 7/8/21 revealed the DFR 500 at 6:38 AM to 8:04 AM. There was no documentation why the DFR was not at the ordered rate. In an interview conducted on 7/14/21 at 1:15 PM CST, EI # 1 confirmed the staff failed to document reasons why the BFR and DFR were not at the ordered rates. 4. PI # 8 was admitted to the facility on 10/14/14 with the primary diagnosis of ESRD. Review of the current orders report dated 6/25/21 revealed a BFR of 400 and DFR Autoflow 2.0, which would be 800. Review of the Treatment Sheet dated 7/7/21 revealed the treatment started at 10:38 AM with the BFR of 300 and DFR at 600. From 11:09 AM to 2:34 PM the BFR was 375 and the DFR 800. There was no documentation why the BFR and DFR were not at the ordered rates or why the prescribed flow was not met. In an interview conducted on 7/14/21 at 1:06 PM CST, EI # 1 confirmed the staff failed to document reasons why the BFR and DFR were not at the ordered rates. 30952 5. PI # 1 was admitted to the facility 4/13/21 with diagnoses including Diabetic Glomerular Sclerosis and ESRD. Review of the current orders report dated 6/15/21 revealed a BFR of 400 and DFR Autoflow 1.5, which would be 600. Review of the Treatment Sheet dated 6/29/21 revealed the BFR was 215 and DFR 800 at 11:42 AM. From 12:36 PM to 1:04 PM, the BFR was 210 and DFR 400. From 1:43 PM until 2:

	04 PM, the BFR was 250 and DFR was 500. There was no BFR/DFR documented at 2:30 PM. At 3:03 PM, the BFR was 250 and DFR 500 until 4:06 PM. There was no documentation why the BFR and DFR were not at the ordered rates or why the prescribed flow was not met. Review of the Treatment Sheet dated 7/1/21 revealed the BFR was 300 and DFR 500 from 1:18 PM until 2:40 PM. At 3:06 PM, the BFR was increased to 350 and DFR 600 until 5:05 PM. There was no documentation why the BFR was not 400 and DFR 600 as ordered. In an interview conducted on 7/14/21 at 1: 09 PM, CST EI # 1, Director of Operations, confirmed the BFR and DFR were not at the ordered rates and there was no documentation why the prescribed blood flow was not achieved. 6. PI # 5 was admitted to the facility 1/3/21 with diagnoses including Diabetes with Renal Manifestations and ESRD. Review of the current orders report dated 5/13/21 revealed a BFR of 450 and DFR Autoflow 2.0, which would be 800. Review of the Treatment Sheet dated 7/1/21 revealed the BFR was 400 from treatment start at 11:30 AM until 2:35 PM. At 3:03 PM, the BFR was 400. The BFR was 0 at 3:40 PM and at 4:07 PM the BFR was 250. There was no reason documented why the BFR was not 450 as ordered and no documentation why the prescribed blood flow was not achieved. Review of the Treatment Sheet dated 7/8/21 revealed the BFR was 400 at start at 11:26 AM and increased to 450 at 12:00 PM. At 1:04 PM, the BFR was decreased to 400 and remained 400 until 3:05 PM. There was no reason documented why the BFR was not 450 as ordered and no documentation why the prescribed blood flow was not achieved. In an interview conducted on 7/14/21 at 1:24 PM CST, EI # 1 confirmed the BFR were not administered per physician orders. 7. PI # 4 was admitted to the facility 5/15/2020 with diagnoses including ESRD. Review of the current orders report dated 6/5/21 revealed a BFR of 450 and DFR Autoflow 1.5, which would be 800. Review of the Treatment Sheet dated 6/26/21 revealed the BFR was 400 and DFR 600 from treatment start at 1:10 PM to treatment end at 5:10 PM. There was no documentation why the BFR and DFR were not at the ordered rates or why the prescribed flow was not met. During an interview conducted on 7/14/21 at 1: 28 PM CST, EI # 1 confirmed BFR and DFR was not administered as ordered.
V0545	POC-EFFECTIVE NUTRITIONAL STATUS CFR(s): 494.90(a)(2) The interdisciplinary team must provide the necessary care and counseling services to achieve and sustain an effective nutritional status. A patient's albumin level and body weight must be measured at least monthly. Additional evidence-based professionally-accepted clinical nutrition indicators may be monitored, as appropriate. This STANDARD is not met as evidenced by: Based on medical record (MR) review and interview with the staff, it was determined the facility failed to ensure staff followed the IDT (interdisciplinary team) orders for nutrition in 2 of 4 patients with ordered LiquaCel. This affected PI (Patient Identifier) # 6 and PI # 2 and had the potential to negatively affect all patients who dialyzed at the facility. Findings include: 1. PI # 6 was admitted to the facility on 6/2/17 with diagnoses including Diabetes Mellitus with Diabetic Nephropathy and ESRD (End Stage Renal Disease). Review of the Patient Plan of Care dated 3/12/21 included the following nutritional goals, Albumin >= (greater than equal to) 4.0 g/dL (gram /deciliter); Goal Due: 09/30/21. Open 03/22/21-Albumin 3.0 and trending down. Review of the Rounding Report printed on 7/12/21 revealed the following Albumin laboratory results: 4/28/21- 2.2 g/dL 5/26/21 - 2.3 g/dL 6/23/21 - 2.5 g/dL Review of the Current Orders Report revealed nutrition orders dated 5/31/21 for nutritional supplement, LiquaCel-1 oz (ounce) PO (by mouth) during dialysis 3 X (times) week.

	Review of the Treatment Sheets dated 7/7/21 and 7/12/21 for 2 of 6 treatment sheets reviewed revealed no documentation staff offered/administered LiquaCel. There was no documentation PI # 6 refused LiquaCel. An interview was conducted with EI (Employee Identifier) # 1, Director of Operations (DOO) on 7/14/21 at 12:56 PM CST (Central Standard Time) confirmed staff failed to document LiquaCel was administered as ordered. 34107 2. PI # 2 was admitted to the facility on 5/29/21 with diagnoses of Acute Kidney Injury. Review of the Patient Plan of Care dated 6/22/21 included the following nutritional goals, Albumin >=4.0 g/dL, Goal Due: 07/31/21. Open 6/8/21-Albumin 3.5. Review of the facility Lab Results Report printed on 7/12 /21 revealed the following Albumin laboratory results: 6/1/21- 3.5 g/dL 6/23/21 - 2.6 g /dL Review of the Current Orders Report revealed nutrition orders dated 6/8/21 for nutritional supplement, LiquaCel-1 oz (ounce) PO during dialysis 3 X week. Review of the Treatment Sheets dated 6/26/21, 7/1/21 and 7/8/21 for 3 of 6 treatment sheets reviewed revealed no documentation staff offered/administered LiquaCel and no documentation PI # 2 refused LiquaCel. In an interview conducted on 7/14/21 at 1:20 PM CST, EI # 1 confirmed staff failed to document LiquaCel was administered as ordered.
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 observations, review of facility policy and interviews, it was determined the staff failed to ensure vascular assess (VA) sites were washed with soap and water upon entering the facility and prior to treatment. This affected 3 of 3 of HD (hemodialysis) AVF/AVG (arteriovenous fistula/graft) treatment initiations with unsampled patients, PI (Patient Identifier) # 12, PI # 9, PI # 15 and had the potential to negatively affect all patients who dialyzed via VA sites at the facility. Findings include: Facility Policy: Access Assessment and Cannulation Published: 08/22/2018 Version: 1 Policy Assessment of Vascular Access Follow the steps below to access the vascular access: Step 1. Prior to treatment, ask your patient to wash access area with liquid soap for one minute, rinsing well. Dry with clean paper towel. Wash access (per above) if patients unable to clean their access. 1. During observations of care on 7/12/21 at 11:00 AM CST the surveyor observed PI # 12 enter the treatment floor, obtain a pre treatment weight then proceed to station 4 without first washing the AVF site with soap and water. At 11:07 AM, EI (Employee Identifier) # 5, PCT (Patient Care Technician), failed to ensure the access site was washed with soap and water before cannulation attempts to the left upper arm AVF. 2. During observations of care on 7/12/21 at 11:35 AM CST the surveyor observed PI # 9 enter the treatment floor, obtain a pre treatment weight then proceeded to station 6 without first washing the AVF site with soap and water. At 11:45 AM, EI # 4, PCT failed to ensure the access site was washed with soap and water before cannulation attempts to the left upper arm AVF. 3. On 7/12/21 at 11:40 AM CST, PI #15 entered the treatment floor, obtained a pre treatment weight and proceeded to station 3 without first washing the AVF/AVG site. At 11:55 AM, EI # 5, PCT prepped the access site with alcohol then cannulated the site without first ensuring the access was washed with soap and water.

	In interviews on 7/14/21 at 11:20 AM CST, EI # 1, Director of Operations confirmed staff must ensure access sites were washed with soap and water before cannulation and confirmed staff failed to follow the facility policy. 34107
V0551	POC-VA MONITOR/PREVENT FAILURE/STENOSIS CFR(s): 494.90(a)(5) The patient's vascular access must be monitored to prevent access failure, including monitoring of arteriovenous grafts and fistulae for symptoms of stenosis. This STANDARD is not met as evidenced by: Based on review of facility policy, medical records (MR) and staff interviews, it was determined the facility failed to ensure staff: 1. Documented access assessment findings in 1 of 1 record with a maturing access site AVF (arteriovenous fistula), identify an infiltration, and provide care to the maturing access site per policy. 2. Documented the presence/absence of a bruit and thrill (B/T) in 4 of 7 records reviewed with an AVF/AVG (arteriovenous graft). This did affect PI (Patient Identifier) # 1, PI # 4, PI # 3, PI # 8 and had the potential to negatively affect all patients who dialyzed at the facility. Findings include: Facility Procedure: Access Assessment and Cannulation Published: 08/22/2018 Version: 1 Purpose ...of this procedure is to provide guidance for placement of needles in an AV (arteriovenous) Fistula or AV Graft... Policy New Access Care and Cannulation Evaluation and preparation of the access will be performed routinely prior to cannulation at each dialysis session. ...assign clinical staff for the initial cannulations based on experience and expertise. Check fistula for adequate bruit and thrill to confirm patency Check for signs of infection. ...Perform skin disinfection as outlined in policy... Assessment of Vascular Access Follow the steps below to access the vascular access: 5. LOOK: Skin Discoloration/Redness/Bruising/lesion Hematomas Extremity or Other Swelling ... Greater than expected redness...Swelling 6...LISTEN: Bruit high pitch/whistle Bruit not present throughout access ...Document in eCC ("e-cube"-the facility electronic medical record documentation software) 7. FEEL: Pulse not soft/not easily compressible Thrill not strong at anastomosis Thrill not present throughout access Document in eCC. 8. Note and report any unusual findings to Team Leader or Charge Nurse, before proceeding with needle insertion... 9. Remove gloves, perform hand hygiene. Don new gloves. Skin disinfection Step 1 Disinfect Cannulation site...using... disinfectants...70 % Isopropyl alcohol pad... Facility Policy: Complications of Hemodialysis (HD)-Management and Prevention of Needle Infiltration Published: 08 /28/2020 Version: 5 ...The purpose of this policy is to provide guidelines for prevention, recognition, and appropriate treatment for needle infiltration. Policy Staff will be familiar with cannulation techniques used to prevent infiltration... Staff will monitor patients closely for signs and symptoms (s/s) of infiltration...Needle infiltration will be recognized, reported, and treated immediately when occurring while on HD, during needle insertion or needle removal. Background ...A quick response to a needle infiltration can help minimize damage to the access (2006 NKFK (National Kidney Foundation.../DOQI [Dialysis Outcomes Quality Initiative] Clinical practice Guidelines for Vascular Access) Possible Contributing Factors Access not cannulated properly... Patient movement causing needle to puncture vessel wall ... Immature access cannulated too early Inexperienced staff cannulating new...fistula /graft Prevention of Needle Infiltration ...Evaluate increased venous pressures or poor arterial flows Avoid premature cannulation of access Use expert cannulators to cannulate new...fistulas... Signs and Symptoms (s/s) of Needle Infiltration ...Staff may see: Swelling at the insertion site...above/or around the insertion site Hardness at the

insertion site ...Staff may discover: Increased venous pressure Loss of arterial blood flow... Treatment of Needle Infiltration The following steps should be followed to treat needle infiltration: Step 1. Establish that an infiltration has occurred. 2. Turn off blood pump... ...3. Notify the RN (Registered Nurse) 5. If the infiltration has occurred after the administration of heparin...apply ice to the site of the infiltration... 7. Instruct pt (patient) to apply ice to the infiltrate for the first 24 hours and then warm compresses for the following 24 hours 8. Instruct the pt to watch for...complications and contact the physician...Pain at site Reoccurrence of bleeding... Temperature elevation Additional swelling of area Absence of thrill 1. PI # 1 was admitted to the facility 4/13/21 with diagnoses including Diabetic Glomerular Sclerosis and ESRD (End Stage Renal Disease). MR review revealed an operative report dated 5/20/21 for a right arm brachiocephalic fistula procedure and surgical clinic note documentation dated 6/29/21, "ok to use AV Fistula". Review of the Treatment Sheets dated 6/29/21 and 7/1/21 revealed the pt was dialyzed via a central venous catheter. There was no documentation staff assessed the condition of the maturing AVF for the presence of a B/T or abnormal findings. Review of the Treatment Sheet dated 7/3/21 failed to include documentation staff assessed the condition of the maturing AVF for the presence of a B/T or abnormal findings pre-treatment. Further review of the 7/3/21 Treatment Sheet revealed documentation at 12:03 PM Heparin 5000 unit bolus was administered. At 12:20 PM, the RN documented, "pt bent right arm access-no infiltration however arterial needle exceeded pressures-using both arterial and venous lines". There was no AVF assess site documentation post treatment and no documentation of the presence/absence of a B/T. There were no documentation staff provided infiltration care. There was no patient education for infiltration care or possible complications documented. Review of the Treatment Sheet dated 7/6/21 revealed documentation staff assessed the right AVF with skin discoloration/redness /bruising/extremity swelling. Interventions documented were use alternative access, apply cold compress to site (1st 24 hr-[hour]). There was no documentation the maturing AVF was assessed on 7/6/21 for the presence of a B/T. The staff failed to provide accurate instructions for care of an infiltrate greater than 24 hours per policy. Review of the Treatment Sheet dated 7/8/21 revealed the AVF status, redness, bruising, lesion, hematomas, use alternative active access. There was no documentation staff assessed the maturing AV Fistula for the presence of B/T. In an interview on 7/14/21 at 1:09 PM CST (Central Standard Time), EI (Employee Identifier) # 1, Director of Operations (DOO), confirmed staff failed to follow the facility procedure for AVF assessment and documentation. 2. PI # 4 was admitted to the facility 5/15/2020 with diagnoses including ESRD. Review of the Current Orders Report revealed dialysis treatments were provided via an AVF. Review of the Treatment Sheet dated 7/8/21 revealed no documentation of an AVF assessment which included the presence/absence of a B/T. During an interview conducted on 7/14 /21 at 1:28 PM CST EI # 1 confirmed staff failed to document AVF assessment findings. 34107 3. PI # 3 was admitted to the facility 12/09/2020 with the primary diagnosis of ESRD. Review of the Current Orders Report revealed dialysis treatments were provided via an AVF. Review of the Treatment Sheets dated 6/30/21, 7/9/21 and 7/12/21 revealed no documentation of an AVF assessment which included the presence/absence of a B/T. In an interview conducted on 7/14/21 at 1:05 PM CST, EI # 1 confirmed 3 of the 6 treatments reviewed the staff failed to document the AVF assessment or B/T. 4. PI # 8 was admitted to the facility 10/4/14 with diagnosis including ESRD. Review of the Current Orders Report revealed dialysis treatments were provided via an AVF. Review of the Treatment Sheet dated 7/12/21 revealed no documentation of an AVF assessment which included the presence/absence of a B/T. In an interview conducted on 7/14/21 at 1:06 PM CST, EI # 1 confirmed the staff failed to document the AVF assessment or B/T.

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 review of facility policy, medical record (MR), and interviews, it was determined the staff failed to ensure the MR contained complete and accurate documentation of patient symptoms and therapeutic effectiveness for PRN (as needed) medication use. This affected Patient Identifier (PI) # 6, PI # 4, PI # 8 in 3 of 4 records reviewed in which staff administered PRN medications. Finding include: Facility Policy: Medication Preparation and Administration Published: 04/05/2021 Version: 6 Purpose: To administer medications with the goals of staff and patient safety, optimal therapeutic response, and infection control. ...Documentation Document all patient symptoms leading to PRN drug administration and patient's response to the PRN medication on treatment sheet or electronic medical record... 1. PI # 6 was admitted to the facility on 6/2/17 with diagnoses including Diabetes Mellitus with Diabetic Nephropathy and ESRD (End Stage Renal Disease). Review of the Treatment Sheet dated 7/12/21 revealed treatment initiation at 7:44 AM. At 7:50 AM, Ondansetron HCL (hydrochloride) 4.000/mg (milligram) was administered IVP (intravenous push) prn (as needed). There were no patient symptoms documented as why Ondansetron HCL was administered and no documentation of the patient response to the Ondansetron HCL. An interview was conducted with EI (Employee Identifier) # 1, Director of Operations on 7/14/21 at 12:56 PM CST (Central Standard Time) who confirmed staff failed document the reason for the IVP medication and the patient response. 2. PI # 4 was admitted to the facility 5/15/2020 with diagnoses including ESRD. Review of the Treatment Sheet dated 7/6/21 revealed at 2:47 PM Acetaminophen 650.000 mg oral (by mouth) prn was administered. There were no patient symptoms documented as why Acetaminophen was administered and no documentation of the patient response to Acetaminophen. During an interview conducted on 7/14/21 at 1:28 PM CST EI # 1 confirmed the staff failed to document all patient symptoms leading to PRN drug administration and the patient's response to the PRN medication on treatment sheet. 34107 3. PI # 8 was admitted to the facility 10 /4/14 with diagnoses including ESRD. Review of the Treatment Sheet dated 6/30/21 revealed at 9:50 AM, Acetaminophen 650.000 mg oral/prn was administered. There were no patient symptoms documented as why the Acetaminophen was administered. During an interview conducted on 7/14/21 at 1:06 PM CST, EI # 1 confirmed the staff failed to document the reason why the PRN medication was administered.