Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	012306	02/27/2025
Name of Provider or Supplier	**Street Address, City, State**	
Childrens Hospital Of Alabama Esrd	1600 7th Avenue South, Birmingham, AL	

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

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
V0403	PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU CFR(s): 494.60(b) The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations. This STANDARD is not met as evidenced by: Based on observations, review of facility policy, and staff interview, it was determined the facility failed to ensure staff followed the policy for use of the Phoenix XL Meter when testing dialysate during two of two observations for preparation of the hemodialysis machine. This had the potential to negatively affect the 17 incenter patients dialyzing at this facility. Findings include: Facility Policy: Phoenix XL Meter Dialysate Testing: Policy Number: 18372 Date Published: Not listed Purpose: The purpose is to serve as a guide for dialysis nurses to use the Phoenix meter to check for accurate dialysate conductivity and potential of Hydrogen (pH) on the hemodialysis machine to ensure patient safety during treatment. ...Precautions: ...3. Keep fluid of syringe cell filled with fluid at all times ...Procedure: ...6. Once testing is complete; discard the used solution... ...8. Rinse the meter cell and syringe interior thoroughly with RO water (water that has been purified using Reverse Osmosis) after use. 9. Keep cell filled with RO water during use to preserve the integrity of the cell. 1. An observation was made on 2/25/25 at 11:40 AM with Employee Identifier (EI) # 7, Registered Nurse, using the Phoenix XL meter to test the conductivity and pH of the dialysate at station 5. After discarding the dialysate that was tested, EI # 7 failed to rinse the Phoenix meter with RO water and fill the cell with RO water to preserve the integrity of the cell. An interview was conducted on 2/27/25 at 12:18 PM with EI # 1, Director of Nursing, who confirmed staff failed to follow the policy for use of the Phoenix XL meter when testing the dialysate. 30952 2. An observation was made on 2

	/25/25 at 12:27 PM with EI # 1, at station 4, to test the conductivity and pH of the dialysate with the Phoenix XL meter. After testing the dialysate, EI # 1 placed the meter on the counter at station 4, and exited the station. EI # 1 failed to rinse the Phoenix meter with RO water and fill the cell with RO water to preserve the integrity of the cell. An interview was conducted on 2/27/25 at 12:18 PM with EI # 1, who confirmed staff failed to follow the policy for use of the Phoenix XL meter when testing the dialysate.