

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012500	(X3) Date Survey Completed 09/16/2021
Name of Provider or Supplier Fmc Capitol City	Street Address, City, State 255 South Jackson Street, Montgomery, 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)
V0543	<p>POC-MANAGE VOLUME STATUS CFR(s): 494.90(a)(1)</p> <p>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;</p> <p>This STANDARD is not met as evidenced by: Based on observations, review of the medical records (MR), facility policies, and interviews, it was determined the facility staff failed to ensure: 1. Patient faces, and access sites were visible and uncovered. 2. Changes in the patient condition which included BP (blood pressure) were reported to the nurse. 3. The Uncontrolled Hypertension algorithm was followed, BP's were re-checked, Clonidine was administered, and BP medication(s) reviewed for compliance/needs. 4. Blood pressure and pulse rate every 30 minutes were monitored or more as needed but not to exceed 45 minutes. 5. The physician was notified when physician's orders for the patient's Estimated Dry Weight (EDW) at the end of each treatment was not achieved. 6. The amount of normal saline used for prime was performed and documented. This affected 3 unsampled patients observed during observations of care, and 6 of 10 records reviewed including PI (Patient Identifier) # 5, PI # 7, PI # 3, PI # 1, PI # 4, and PI # 10. This had the potential to negatively affect all patients who dialyzed at the facility. Findings include: Facility Policy: Patient Assessment and Monitoring Published Date: 09/29/18 Version: 3 Pre-Treatment: Direct patient care staff may collect pre-treatment weight, BP (blood pressure), pulse, respirations, temperature, general observation, access, and complaints reported by the patient. ...An abnormal finding confirmed by the RN (Registered Nurse) will be reported to the attending physician for assessment and intervention. 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... complaints reported</p>

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 (Patient Care Technician)... 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: Step 1 The direct care staff may obtain the following data: weight... record pre-weight. Compare pre-weight to EDW. Step 2 During nursing rounds, the RN will review the data...and assess the following parameters as needed: ...Assess patient for symptoms... Step 3 Document findings and interventions in the medical record. Contact the physician as needed for additional orders based on assessment findings and clinical judgement.

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. BP...Recheck BP after a drop that requires intervention such as administering normal saline... Report to the nurse: Systolic BPs > (greater than) 180 mm/Hg (millimeter/mercury) Diastolic BP > 100 mm/Hg BP less than or equal to 100 mm/hg systolic... ..Ultrafiltration (UF) Rate: Monitor UF rate. Note: UF rates greater than 13 ml/kg/hr (milliliters/kilogram/hour) should be avoided if possible by providing adequate prescribed dialysis duration, and scheduling of additional treatments... ..General Observations/Mental StatusAll patients must be under visual observation by clinical staff during treatment...Ensure each patient's face is visible and uncovered... Access Observe connections are secure and visible...Ensure access remains uncovered throughout the treatment...Observe and ensure....needles are intact... 4. Document any findings and interventions in the medical record.

Facility In-Center HD (Hemodialysis) Standing Orders Uncontrolled Hypertension (elevated BP) algorithm: Notify MD (Medical Doctor)...for BP greater than equal to 180 systolic or diastolic greater than equal to 110 one hour or more into...treatment...Verify...not allergic to...clonidine then... 1...repeat BP...2. If BP remains at or above 180 systolic or 110 diastolic then, 3. Determine current BP meds (medications) patient is taking... 4...if any BP medications...need...refilled 5. Administer clonidine 0.2 mg (milligram) PO (by mouth)...8. Notify MD...if 60 minutes post clonidine BP....above 180/110 for additional recommendations.

1. During observations of care on 9/14/21, the surveyor observed the following: At 9:25 AM at station 5, the unsampled patient access was covered with a blanket. At 9:26 AM at station 16, the unsampled patient face and access were covered with a blanket. At 9:40 AM at station 1, the unsampled patient access was covered with a blanket. At 9:55 AM at station 5, the unsampled patient access remained covered. At 10:10 AM at station 16, the unsampled patient access remained covered. At 10:36 AM, at station 16, the unsampled patient access remained covered.

2. PI # 5 was admitted to the facility on 7/3/19 with diagnoses including Diabetes Mellitus with Diabetic Nephropathy and ESRD (End Stage Renal Disease). MR review revealed physician In-Center HD Standing Orders dated 12/16/2020 which included the above Uncontrolled Hypertension algorithm. Review of the Treatment Sheet dated 9/1/21 revealed the RN documented a pre treatment BP 210/89 at 6:03 AM and at treatment start 6:21 AM, the BP was 180/91, (patient) denies complaints. Further review of the 9/1/21 Treatment Sheet revealed the following PCT (Patient Care Technician) documentation: At 6:34 AM, BP 203/103, denies complaints At 7:00 AM, BP 206/114, denies complaints At 7:30 AM, BP 221/112, denies complaints At 8:03 AM, BP 197/114 There was no documentation the PCT notified the RN the BP's were above 180 systolic and above diastolic 110 one hour

into treatment. There was no documentation Clonidine was administered and current BP med compliance/needs were evaluated/verified. Review of the Treatment Sheet dated 9/8/21 revealed the RN documented a pre treatment BP 203/109 at 5:59 AM and at treatment start 6:11 AM the BP was 180/102, denies complaints. Further review of the 9/8/21 Treatment Sheet revealed the following PCT documentation: At 6:32 AM, BP 203/103, denies complaints At 7:02 AM BP 203/104, denies complaints At 7:31 AM BP 200/99, denies complaints At 8:03 AM BP 197/114, denies complaints At 10:00 AM BP 205/109. denies complaints At 10:32 AM BP 197/104 In addition, the RN documented the following: At 10:42 AM BP 221/118, denies complaints, treatment discontinued without problem At 10:45 AM post dialysis BP 230/110 There was no documentation the MD was notified of the elevated post treatment BP and no treatment for hypertension was provided. Review of the Treatment Sheet dated 9/10/21 revealed the RN documented the pre treatment BP 222/106 and at 6:24 AM at treatment start, the BP was 222/106, denies complaints. Further review of the 9/10/21 Treatment Sheet revealed the following PCT documentation: At 6:38 AM BP 222/115, denies complaints advised nurse of BP. At 7:02 AM (the next BP check), BP 214/113, denies complaints. At 7:33 AM BP 194/92, denies complaints. At 8:06 AM BP 185/99, denies complaints. There was no documentation the RN monitored the patients' the elevated BP after treatment start and addressed current BP meds compliance/refill needs per physician standing orders. Staff failed to follow physician's orders when the BP remained above 180 systolic and 110 diastolic during and post treatment. There was no documentation staff evaluated the BP med compliance or refill needs. There was no documentation staff administered Clonidine as ordered and no documentation the MD was notified for a post treatment BP 230/110. An interview was conducted with EI (Employee Identifier) # 1, Clinic Manager on 9/16/21 at 9:19 AM who confirmed staff failed to identify and treat the elevated BP per facility policy and physician orders. 3. PI # 7 was admitted to the facility 9/7/17 with diagnoses including ESRD. Review of the Treatment Sheet dated 9/4/21 revealed at 9:06 AM the PCT documented "Patient Alert; access/head covered". There was no documentation the PCT instructed PI # 7 to keep his/her head and access uncovered and 26 minutes passed until at 9:32 AM the PCT documented the access was visible. Review of the Treatment Sheet dated 9/7/21 revealed the following PCT documentation: At 9:06 AM "Patient Alert; access/head covered". At 9:33 AM "Patient Alert; access/head covered". At 10:04 AM "Patient Alert; access/head covered mask on...(treatment) Ended." There was no documentation staff were able to view the patient's head and access for a 58- minute period from 9:06 AM until 10:04 AM. Review of the Treatment Sheet dated 9/14/21 revealed the RN documented at 9:02 AM, "Patient Alert; head/access covered". There was no documentation PI # 7 was instructed to uncover his/her head and access. The documentation revealed 36 minutes passed until staff documented the access was visible at 9:38 AM. In an interview conducted on 9/16/21 at 8:59 AM, EI # 1 confirmed staff failed to ensure patient's face and accesses were visible throughout the treatment and there was no documentation patient safety education was completed. 4. PI # 3 was admitted to the facility 6/3/21 with diagnoses including ESRD. Review of the Treatment Sheet dated 9/9/21 revealed the pre treatment BP was 163/96 at 10:03 AM and treatment initiation was 10:15 AM. Further review of the 9/9/21 Treatment Sheet revealed the following PCT documentation: At 10:33 BP 174/102 At 11:31 AM which was 57 minutes later, BP 182/103 At 12:32 PM which was 61 minutes later, BP 197/114 At 1:04 PM, BP 172/91, denies complaints At 1:42 PM BP 224/223 There was no documentation the PCT notified the RN of the elevated BP's. The PCT failed to monitor and document pulse and BP at least every 45 minutes per policy. In addition on 9/9/21 at 1:43 PM, which was greater than 3 hours into treatment with BP's greater than 180/100, the RN documented Clonidine was administered. The staff failed to follow physicians' orders

for the Uncontrolled Hypertension algorithm, administer Clonidine 1 hour into the treatment for uncontrolled hypertension and determine PI # 3's current BP meds compliance and possible refill needs. Review of the Treatment Sheet dated 9/14/21 revealed the pre treatment BP was 167/98 at 10: 32 AM and treatment initiation was 11:05 AM. Further review of the 9/14/21 Treatment Sheet revealed the following PCT documentation: At 11:34 AM BP 162/102 At 12:06 PM BP 166/104 At 1:30 PM BP 159/105 At 2:05 PM BP 164/108 At 2:38 PM BP 173/106 At 3:05 PM BP 170/116 There was no documentation the PCT notified the RN of the elevated BP's during the dialysis treatment. Lastly, at 3:24 PM the RN documented BP 184/110, treatment discontinued. There was no documentation Clonidine was administered and no documentation staff evaluated/verified PI # 3's current BP med compliance and refill needs. In an interview conducted on 9/16/21 at 9:42 AM, EI # 1 confirmed staff failed to follow the patient monitoring and assessment policy and facility Uncontrolled Hypertension algorithm. 5. PI # 1 was admitted to the facility 7/24/21 with diagnoses including ESRD. Review of the Treatment Sheet dated 8/19/21 revealed the pre treatment BP was 165/98 at 10:56 AM and treatment initiation was 11:10 AM. Further review of the 8/19/21 Treatment Sheet revealed the following PCT documentation: At 11:32 AM BP 180/100, denies complaints At 12:01 PM BP 160/104, denies complaints At 1:02 PM BP 169/100, denies complaints At 1:33 PM BP 176/109, denies complaints At 2:02 PM BP 204/113 At 2:03 PM BP 185/94, denies complaints. At 2:34 PM, BP was 174/112, denies complaints At 2:35 PM, BP 159/109, denies complaints There was no documentation the PCT notified the RN of the elevated BP's. In addition, the RN documented the post treatment BP 193/105. There was no documentation Clonidine was administered and no documentation staff evaluated /verified PI # 1's current BP med compliance and refill needs. An interview was conducted on 9/16/21 at 9:02 AM with EI # 1, Clinic Manager, who confirmed staff failed to follow the patient monitoring and assessment policy and facility Uncontrolled Hypertension algorithm. 28327 6. PI # 4 was admitted to the facility on 9 /18/15 with diagnoses including ESRD. Review of the physician's orders dated 6/14 /21 revealed a target weight of 50.5 kg. Review of Treatment Sheet dated 9/1/21 revealed the post-treatment weight was 52.8 kg, which was 2.3 kg over the target weight. There was no documentation the physician was notified of the post-treatment weight. Review of the Treatment Sheet's dated 9/6/21 and 9/13/21 revealed no documentation a prime was administered prior to the start of treatment. Further review of Treatment Sheet dated 9/13/21 revealed the post-treatment weight was 52.2 kg, which was 1.9 kg over the target weight. There was no documentation the physician was notified of the post-treatment weight. An interview was conducted on 9/16/21 at 9:30 AM with EI # 1 who confirmed staff failed to notify the physician for weights over EDW and there was no documentation of a prime administered on 9/6/21 and 9 /13/21. 7. PI # 10 was admitted to the facility on 8/26/19 with diagnoses including ESRD. Review of the Orders Summary Report dated 10/30/2020 revealed, "Clonidine HCL (Hydrochloride) 0.2 mg oral during dialysis prn (as needed) - may repeat x (times) 1 hypertensive. Further review of the 9/6/21 Treatment Sheet revealed the following PCT documentation: At 1:33 PM the BP was 155/101. At 1:34 PM the BP was 155/101. At 2:03 PM the BP was 159/107. At 2:33 PM the BP was 173/101. At 2: 44 PM BP sit was 192/115 and BP stand was 172/120. At 2:45 PM the BP was 183 /113 and treatment discontinued. There was no documentation the PCT notified the RN of the elevated BP's during the dialysis treatment. There was no documentation Clonidine was administered as ordered. In an interview conducted on 9/16/21 at 9:14 AM, EI # 1 confirmed staff failed to follow the patient monitoring and assessment policy and administer Clonidine as ordered.