

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  012502	<b>(X3) Date Survey Completed</b>  01/08/2020
<b>Name of Provider or Supplier</b>  Tuscaloosa University Dialysis	<b>Street Address, City, State</b>  220 15th Street, Tuscaloosa, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

<b>(X4) ID Prefix Tag</b>	<b>Summary Statement of Deficiencies</b>  (Each deficiency should be preceded by full regulatory or LSC identifying information)
<b>V0543</b>	<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 review of the medical records (MR), agency policy and procedure and interviews, it was determined the facility failed to: a) Ensure the staff performed and documented the amount of normal saline (NS) used for prime and/or rinse back. b) Achieve physician's orders for the patient's target weight at end of each treatment. c) Ensure staff administered antihypertensives and notified the physician of patient's hypertension or hypotension. This affected 8 of 9 incenter medical records reviewed including Patient Identifier (PI) # 2, PI # 6, PI # 3, PI # 1, PI # 5, PI # 7, PI # 8, PI # 9, and had the potential to negatively affect all patients served by the dialysis facility. Findings include: Policy: Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment Policy Number: 1-03-08 Revision Date: April 2017 Purpose: To obtain and document baseline and ongoing information about the patient before, during and after the dialysis treatment... Policy: ...Pre-Treatment Data Collection/ Assessment 4. Any abnormal findings or findings outside of any patient specific physician ordered parameters discovered during pre-treatment data collection will be documented and immediately reported to the licensed nurse. 5. The assessment is a nursing responsibility... 6. The licensed nurse will use his/her clinical judgement... The physician... will be notified of any concerns that may preclude the initiation of dialysis. ...Intradialytic Data Collection/ Assessment ...11. Abnormal findings or findings outside of any patient specific physician ordered parameters will be reported to the licensed nurse immediately... 12. The licensed nurse notifies the physician... as needed of changes in the patient status. 13. All findings, interventions and patient</p>

response will be documented in the patient's medical record. ...Post Treatment Data Collection/ Assessment 15. The PCT (Patient Care Technician) or licensed nurse will obtain and document basic data on each patient post dialysis and compare to pre dialysis findings. 16. If an abnormal finding or concern is identified post treatment, this needs to be reported to the licensed nurse... 17. Licensed nurse will use his/her clinical judgement... to determine if any clinical interventions or notification of physician... is necessary prior to discharge of the patient from the facility. Abnormal Findings: ...Fluid Status: Post-treatment: If patient is above or below 1 kg (kilogram) from the target weight. Blood pressure- Pre dialysis: Systolic greater than 180 mm (millimeters)/ Hg (mercury) or less than 90 mm/ Hg. Diastolic greater than or equal to 100 mm/Hg. Blood pressure- Intradialytic: Difference of 20 mm/Hg increase or decrease from patient's last... BP (Blood Pressure) reading. Blood Pressure Post Treatment: If the patient can stand: Standing systolic BP greater than 140 mm/Hg or less than 90 mm/Hg. Standing diastolic BP greater than 90 mm/Hg or less than 50 mm/ Hg. Sitting BP for patient's that cannot stand: Sitting systolic BP greater than 140 mm/Hg or less than 90 mm/Hg. Sitting diastolic BP greater than 90 mm/Hg or less than 50 mm/ Hg. 1. PI # 2 was admitted to the facility on 8/2/19 with a primary diagnosis of Acute Kidney Injury. Review of the Treatment Sheet dated 12/27/19 revealed no documentation prime and rinse back fluids were given. Review of the Treatment Sheet dated 12/30/19 revealed no prime fluids were given. Review of the Treatment Sheet dated 1/1/2020 revealed no prime fluids were documented. Review of the Treatment Sheet dated 1/6/2020 revealed no documentation rinse back fluids were given. Interviews were conducted on 1/8/2020 at 11:46 AM with Employee Identifier (EI) # 10, RN (Registered Nurse), and at 12:16 PM with EI # 1, Facility Administrator (FA), who confirmed the fluids were not documented. 2. PI # 6 was admitted to the facility on 2/19/13 with a primary diagnosis of ESRD (End Stage Renal Disease). Review of the physician's orders dated 7/24/19 revealed a target weight of 125.0 kg, and a prn (as needed) order for Clonidine 0.10 mg (milligrams) PO (by mouth), give 1 tab (tablet) for systolic BP > (greater than)/ = (equal to) 180. May repeat 1 x (time). Review of Treatment Sheet dated 12/27/19 revealed a pre-treatment BP 199/114 sitting, and 210/108 standing. Review of the intradialytics revealed the following BP's: 9:02 AM: 196/103 9:32 AM: 190/110 10:02 AM: 192 /101 10:47 AM: 188/112 The post- treatment weight was 128.4 kg, which was 3.4 kg over the target weight. There was no documentation the patient received Clonidine, or that the physician was notified of the patient's hypertension and post-treatment weight. Review of the Treatment Sheet dated 12/30/19 revealed no documentation of rinse back fluids. Review of the Treatment Sheet dated 1/6/2020 revealed no documentation prime fluids were given. An interview was conducted on 1/8/2020 at 10:34 AM with EI # 6, CCHT (Certified Clinical Hemodialysis Technician), who confirmed she/he failed to document the prime and rinse back fluids, and in an interview at 11:52 AM with EI # 10, she/he confirmed there was no Clonidine given as ordered and no physician notification of the post-treatment weight. 3. PI # 3 was admitted to the facility on 12/4/95 with a primary diagnosis of ESRD. Review of the PRN Orders dated 3/19/07 revealed an order for Normal Saline Solution 0.9% NACL (Sodium Chloride) 100 ml Intravenous, Give 100 ml NS IV PRN for hypotension. Review of the Treatment Sheet dated 12/21/19 revealed a pre-treatment BP 99/57 sitting, and 105/66 standing. Treatment was initiated at 11:37 AM. The following BP's were documented: 12:32 AM: 90/48 1:02 PM: 63/32 1:32 PM: 79/50 2:02 PM: 89/55 There was no documentation the CCHT notified the RN of the patient's hypotension, and no documentation NS was administered as ordered for hypotension. Review of the Treatment Sheet dated 12/26/19 revealed treatment was initiated at 12:05 PM. The intradialytic BP's were documented as follows: ...12:32 PM: 89/51 1:02 PM: 69/55 1: 03 PM: 77/45 1:05 PM: 73/48 1:32 PM: 84/49... There was no documentation the

CCHT notified the RN of the patient's hypotension, and no documentation NS was administered. Review of the Treatment Sheet dated 12/28/19 revealed no documentation of rinse back fluids. Review of the Treatment Sheet dated 12/31/19 revealed treatment was initiated at 11:29 AM, with a BP of 104/63. There were no prime fluids documented. At 12:34 the BP was 74/57. There was no documentation the CCHT notified the RN or administered NS. At 2:21 PM the treatment was terminated, which was 38 minutes early. Review of the AMA form dated 12/31/19 revealed the CCHT documented the treatment was shortened by 45 minutes, not 38 as documented on the treatment sheet. The reason listed by the CCHT was, "...pt (patient) request pt cramping." Review of Treatment Sheet dated 1/2/2020 revealed the following intradialytic BPs: 1:02 PM: 114/65 1:33 PM: 71/50 2:03 PM: 100/69 2:32 PM 88/59 There was no documentation the CCHT notified the RN of the patient's drop in BP, or NS administered. Interviews were conducted on 1/8/2020 from 10:09 AM to 12:14 PM with EI # 11, CCHT, EI # 1, and EI # 8, CCHT, who confirmed fluids were not documented, or NS given as ordered for hypotension. 28327 4. PI # 1 was admitted to the facility on 10/17/19 with a primary diagnosis of ESRD. Review of the Treatment Sheet dated 12/26/19 revealed no documentation a rinse back was given at the end of treatment. Review of treatment sheet dated 12/28/19 revealed no documentation the prime fluids were given. Interview's were conducted on 1/8/2020 at 10:40 AM with EI # 6, CCHT, and 11:40 AM with EI # 10, RN who confirmed the fluids were not documented on the aforementioned dates. 5. PI # 5 was admitted to the facility on 5/6/10 with a primary diagnosis of ESRD. Review of the Treatment Sheet dated 12/24/19 revealed no documentation a rinse back was given at the end of treatment. Review of the Treatment Sheet dated 12/27/19 revealed no documentation the prime fluids or rinse back was given. Review of treatment sheet dated 12/30/19 revealed no documentation the prime fluids were given. Review of the Treatment Sheet dated 1/1/2020 revealed no documentation a rinse back was given at the end of treatment. Interviews were conducted on 1/8/2020 at 10:33 AM with EI # 6 and EI # 1 who confirmed the fluids were not documented. 6. PI # 7 was admitted to the facility on 7/6/18 with a primary diagnosis of ESRD. Review of the Treatment Sheet dated 12/23/19 revealed no documentation a rinse back was given at the end of treatment. Review of the Treatment Sheet dated 12/31/19 revealed no documentation the prime fluids or rinse back was given. An interview was conducted on 1/8/2020 at 10:28 AM with EI # 6 who confirmed the fluids were not documented. 7. PI # 8 was admitted to the facility on 4/16/19 with a primary diagnosis of ESRD. Review of the physician's orders dated 4/11/19 revealed a prn order for Clonidine 0.10 mg PO, give 1 tab for systolic BP > / = 180. May repeat 1 x. Further review of the physician's orders dated 8/14/19 revealed a target weight of 90.0 kg. Review of the Treatment Sheet dated 11/30/19 revealed no documentation the prime fluids was given. Review of Treatment Sheet dated 12/3/19 revealed a pre-treatment weight of 99.5 kg and a post treatment weight of "NA". Further review of the Treatment Sheet revealed, "Actual Target Removal: 5.00 kg", which was 4.5 kg over the target weight. There was no documentation the physician was notified of the patient's post-treatment weight. Review of the Treatment Sheet dated 12/5/19 a pre-treatment BP 220/105 sitting. Review of the intradialytics revealed the following BP's: 11:46 AM: 225/110 12:02 PM: 215/105 12:32 PM: 212/92 1:02 PM: 202/97 1:32 PM: 199/108 2:32 PM: 214/86 3:15 PM: 219/85 3:34 PM: 206/87 3:48 PM: 217/93 Post Treatment: 206/93 There was no documentation the licensed nurse was notified of PI # 8's elevated BP pre-treatment, during treatment or post treatment as directed per the facility policy. There was no documentation the patient received Clonidine, or that the physician was notified of the patient's hypertension. Review of the Treatment Sheet dated 12/12/19 revealed no documentation a rinse back was given at the end of treatment. Interviews were conducted on 1/8/2020 from 10:12 AM to 11:35 AM with EI # 11, EI # 5, RN

and EI # 6. EI # 11 stated, "I should have notified the nurse of the patient's target weight". EI # 11 also stated, "I notified the nurse of the patient's BP, but I failed to document it". EI # 5 confirmed he/she failed to administer Clonidine as ordered and notify the physician of the patient's elevated BP. EI # 6 confirmed the fluids were not documented. 8. PI # 9 was admitted to the facility on 12/9/11 with a primary diagnosis of ESRD. Review of the Treatment Sheet dated 12/24/19 revealed no documentation the prime fluids was given. An interview was conducted on 1/8/2020 with EI # 9 who confirmed the fluids were not documented.