

<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>V0544</b>	<p>POC-ACHIEVE ADEQUATE CLEARANCE CFR(s): 494.90(a)(1)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observations, review of facility policy and interviews with the staff it was determined the facility failed to ensure the staff: a) Followed the physician order for the Blood Flow Rates (BFR) and Dialysate Flow Rates (DFR). b) Completed an Against Medical Advice (AMA) Form for early termination of treatment as documented. This affected 6 of 9 incenter medical records reviewed and did affect Patient Identifier (PI) # 4, PI # 5, PI # 7, PI # 9, PI # 6, PI # 3 and had the potential to negatively affect all patients that dialyzed in this facility. Findings include: Facility Policy: Prescribed Treatment Time Not Met Policy #: 1-01-09 Revision Date: October 2019 Purpose: To provide requirements for teammates to follow when a patient's treatment is terminated early. Policy: "A. Completion of the Early Termination of Treatment Against Medical Advice Form. 3. The RN (Registered Nurse) will obtain the patient's signature on the Early Termination of Treatment Against Medical Advice form prior to the patient being rinsed back from their treatment. B. Prescribed Treatment Time Not Met 1. If shortened/early termination time exceeds 30 or more minutes, the RN will notify the patient's attending nephrologist to discuss the appropriate intervention ... 3. If a patient's treatment is shortened/early terminated, the RN will document the event in the patient's medical record. Documentation will include, as appropriate: The amount of time by which the treatment was shortened;... A description of all other interventions planned to address the shortened treatment, including recommendations to the patient; and A copy of the Early Termination of Treatment Against Medical Advice form signed by the patient, if shortened</p>

voluntarily by patient. 1. PI # 4 was admitted on 8/14/14 with a primary diagnosis of End Stage Renal Disease (ESRD). Review of the Hemo (Hemodialysis) Treatment Orders dated 6/16/19 revealed an order for the BFR to run at 450 and the DFR at 800. Review of the 12/23/19 and 12/26/19 Treatment Sheet's revealed the DFR was ran at 600 the entire treatment. There was no documentation why the DFR was not ran at physician's ordered rate of 800. Review of the Treatment Sheet dated 12/31/19 revealed the BFR was decreased to 400 at 6:32 AM and then decreased to 350 at 9:02 AM. There was no documentation why the BFR was decreased and not ran at the ordered rate of 450. Review of the Treatment Sheet dated 1/4/2020 revealed the DFR ran at 600 the entire treatment. There was no documentation why the DFR was not ran at physician's ordered rate of 800. Further review of the 1/4/2020 Treatment Sheet revealed the BFR was decreased to 350 at 8:02 AM and then decreased to 315 at 8:32 AM. There was no documentation why the BFR was decreased and not ran at the ordered rate of 450. Interviews were conducted on 1/8/2020 from 10:00 AM to 11:05 AM with Employee Identifier (EI) # 9, RN, EI # 4, Certified Clinical Hemodialysis Technician (CCHT), EI # 11, CCHT and EI # 8, CCHT, EI # 1, Facility Administrator, who confirmed there was no documentation why the BFR's and DFR's were not ran at the ordered rates on the aforementioned dates. 2. PI # 5 was admitted to the facility on 5/6/10 with a primary diagnosis of ESRD. Review of the Hemo Treatment Orders dated 11/18/19 revealed an order for the BFR to run at 450. Review of the Treatment Sheet dated 12/24/19 revealed the BFR was decreased to 400 at 9:32 AM. There was no documentation why the BFR was decreased and not ran at the ordered rate of 450. Review of the Treatment Sheet dated 12/27/19 revealed the BFR was decreased to 325 at 9:32 AM and then decreased to 250 at 2:01 PM. There was no documentation why the BFR was decreased and not ran at the ordered rate of 450. Review of the Treatment Sheet dated 1/1/2020 at 10:59 AM revealed the BFR was ran at 350 and then decreased to 300 at 12:00 PM, 250 at 1:00 PM, 200 at 1:22 PM and at 2:00 PM the BFR was increased to 300. There was no documentation why the BFR was not ran at the ordered rate of 450. Review of the Treatment Sheet dated 1/3/2020 revealed the BFR was decreased to 400 at 12:10 PM. There was no documentation why the BFR was decreased and not ran at the ordered rate of 450. Review of the Treatment Sheet dated 1/6/2020 revealed the BFR ran the entire treatment at 400. There was no documentation why the BFR not ran at the ordered rate of 450. Interviews were conducted on 1/8/2020 from 10:33 AM to 12:15 PM with EI # 6, CCHT, EI # 8, EI # 11, CCHT, EI # 5, RN, and EI # 1 who confirmed there was no documentation why the BFR's were not ran at the ordered rates on the aforementioned dates. 3. PI # 7 was admitted to the facility on 7/6/18 with a primary diagnosis of ESRD. Review of the Hemo Treatment Orders dated 6/16/19 revealed an order for the BFR to run at 350. Review of the Treatment Sheet dated 12/23/19 revealed the BFR was decreased to 325 at 6:33 AM and then decreased to 300 at 7:00 AM. There was no documentation why the BFR not ran at the ordered rate of 350. Review of the Treatment Sheet dated 12/26/19 and 12/31/19 revealed the BFR's ran the entire treatment at 400. There was no documentation why the BFR not ran at the ordered rate of 350. Interviews were conducted on 1/8/2020 at 10:28 AM with EI # 6 and EI # 4 who confirmed there was no documentation why the BFR's were not ran at the ordered rates on the aforementioned dates. 4. PI # 9 was admitted to the facility on 12/9/11 with a primary diagnosis of ESRD. Review of the Hemo Treatment Orders dated 6/16/19 revealed an order for the DFR to run at 800 and a treatment time of 195 minutes. Review of the Treatment Sheet dated 12/30/19 revealed the DFR the entire treatment at 600. There was no documentation why the DFR not ran at the ordered rate of 800. Review of the Treatment Sheet dated 1/6/2020 revealed a duration of 160 minutes, which was 35 minutes less than ordered. There was no documentation the physician was notified per policy. The surveyor requested the AMA form signed by

the patient. None was provided. Interviews were conducted on 1/8/2020 from 10:45 AM with EI # 4 and EI # 1. EI # 4 confirmed there was no documentation why the DFR was not ran at the ordered rate. EI # 1 confirmed there was no AMA form completed per policy. 39098 5. PI # 6 was admitted to the facility on 2/19/13 with a primary diagnosis of ESRD. Review of the Hemo Treatment Orders dated 7/24/19 revealed a treatment time of 240 minutes. Review of the Treatment Sheet dated 1/6/2020 revealed a duration of 187 minutes, which was 53 minutes less than ordered. There was no documentation the physician was notified per policy. The surveyor requested the AMA form signed by the patient. None was provided. An interview was conducted on 1/8/2020 at 10:36 AM with EI # 1, who confirmed an AMA form was not completed. 6. PI # 3 was admitted to the facility on 12/4/95 with a primary diagnosis of ESRD. Review of the Treatment Sheet dated 12/26/19 revealed an ordered treatment duration of 210 minutes. The duration documented for the treatment was 197, which was 13 minutes less than ordered. The surveyor requested the AMA form signed by the patient and none was provided. An interview was conducted on 1/8/20 at 10:11 AM with EI # 1, who confirmed there was no AMA form completed.