

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012502	(X3) Date Survey Completed 09/12/2023
Name of Provider or Supplier Tuscaloosa University Dialysis	Street Address, City, State 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.		

(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 review of medical records (MR), facility policies and interviews with the staff it was determined the facility failed to ensure: 1. Normal Saline (NS) used for prime and post treatment rinse was documented. 2. Patient Care Technician (PCT) notified the nurse when blood pressure (BP) readings were abnormal, UF (Ultrafiltration) was decreased or turned off, and when NS was administered. 3. Vital signs were documented at least every 30 minutes. 4. The physician was notified of the patient leaving greater than 1.0 kg (kilograms) over the Target Weight (TW). This deficient practice affected three of three in-center hemodialysis records reviewed and did affect Patient Identifier (PI) # 1, PI # 2, PI # 3, and had the potential to negatively affect all patients dialyzing at this facility. Findings include: Facility Policy: Treatment Initiation Utilizing Fresenius 2008 Series Dialysis Delivery Systems With All Single Use Dialyzer Types and Streamline or Combiset or Nipro Blood Lines Policy#: 1-03-08F Date Revised: October 2021 ...5. Calculate and set ultrafiltration per procedure. Remember to include the priming volume and rinse back. Facility Policy: CWOW (Clinic Without Walls) Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment Policy: 1-03-08 Date Revised: April 2021 Purpose: To obtain...document baseline and ongoing information about the patient before, during and after the dialysis treatment through data collection and nursing assessment...reviewing the patient's response to the treatment and status prior to discharge. Policy: 1. Patient data will be obtained and documented...Measurement of BP... 9. Intradialytic treatment monitoring...data collection may be performed by the</p>

PCT or licensed nurse... a. Vital signs and treatment monitoring: ... For non-nocturnal treatments is completed at least every thirty (30) minutes ... 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 notified the physician...as needed of changes in patient status. 13. All findings, interventions and patient response will be documented... Abnormal Findings Unless other abnormal parameters are established...the following are considered abnormal findings and should be reported to the license nurse and documented in the patient's medical record...the teammate who is observing or collecting information should report to the licensed nurse whenever there is concern for the patient's condition... Fluid Status: ...Post-treatment: If patient is above or below 1 kg (kilogram) from the target weight.

1. PI # 1 was admitted to the facility on 1/13/23 with a primary diagnosis of End Stage Renal Disease (ESRD). Review of the Treatment Detail Report (TDR) dated 8/18/23 revealed there was no documentation of the amount of NS used for the prime at the start of treatment and for the rinse back at the end of treatment. Review of the TDR's dated 8/21/23, 8/25/23 and 9/1/23 revealed there was no documentation of the amount of NS used for the prime at the start of treatment. An interview was conducted on 9/12/23 at 11:36 AM with Employee Identifier (EI) # 1, Facility Administrator, who confirmed the staff failed document the amount of NS given as prime or rinse back.

2. PI # 2 was admitted to the facility on 3/29/22 with a primary diagnosis of ESRD. Review of the TDR's dated 8/31/23, 9/2/23, and 9/5/23 revealed there was no documentation of the amount of NS used for the prime at the start of treatment. An interview was conducted on 9/12/23 at 11:45 AM with EI # 1, who confirmed the staff failed document the amount of NS given as prime at the start of treatment.

3. PI # 3 was admitted to the facility 6/17/11 with a primary diagnosis of ESRD. Review of the IDT (Interdisciplinary Team) Rounding Worksheet: Active Treatment Orders dated 8/22/23 revealed, "Target Weight: 115 kg (kilograms)." Review of the TDR dated 8/29/23 revealed documentation the treatment was started at 6:34 AM with a pretreatment weight of 121.9 kg and ended at 11:09 AM with a post treatment weight of 117.1 kg. There was no documentation the physician was notified of the patient post treatment weight of 2.1 kg over the ordered TW. Review of the TDR's dated 8/31/23 and 9/5/23 revealed there was no documentation of the amount of NS used for the prime at the start of treatment. Review of the TDR dated 9/2/23 revealed there was no documentation of the amount of NS used for the prime at the start of treatment and for the rinse back at the end of treatment. Review of the TDR dated 9/5/23 revealed documentation the treatment was started at 6:21 AM with a pretreatment weight of 121.1 kg and ended at 10:29 AM with a post treatment weight of 117.2 kg. There was no documentation the physician was notified of the patient post treatment weight of 2.2 kg over the ordered TW. Further review of the TDR dated 9/5/23 at 8:33 AM revealed, "BP low (95/64): UF goal decreased and at 9:03 AM UF turned off per pt (patient) request. BP improved (147/90). 200 cc (centimeters) NS. There was no documentation the staff notified the nurse of the low BP and UF decreased and turned off the per facility policy. There was no reason documented why the 200 cc NS was administered. Continued review of the 9/5/23 TDR revealed a BP and pulse documented at 9:03 AM. The next BP and pulse was documented at 10:26 AM, which was 83 minutes later. The staff failed to document vital signs every 30 minutes per facility policy. Review of the TDR dated 9/7/23 revealed documentation the treatment was started at 6:25 AM with a pretreatment weight of 121.4 kg and ended at 10:20 AM with a post treatment weight of 117.4 kg. There was no documentation the physician was notified of the patient post treatment weight of 2.4 kg over the ordered TW. Review of the TDR dated 9/9/23 revealed documentation the treatment was started at 6:24 AM with a pretreatment weight of 120.8 kg and ended at 10:53 AM with a post treatment weight of 117.0 kg. There was no documentation the physician

was notified of the patient post treatment weight of 2.0 kg over the ordered TW. An interview was conducted on 9/12/23 at 11:47 AM with EI # 1 who confirmed the staff failed to document the amount of NS given as prime or rinse back, document vital signs every 30 minutes, and notified the nurse when BP readings were abnormal, UF was decreased or turned off, and NS administered. EI # 1 also verified the staff failed to notify the physician of the patient leaving greater than 1.0 kg over the TW.