

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012505	(X3) Date Survey Completed 07/26/2018
Name of Provider or Supplier Physicians Choice Dialysis-Montgomery	Street Address, City, State 1001 Forest Avenue, 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)
V0726	<p>MR-COMPLETE, ACCURATE, ACCESSIBLE CFR(s): 494.170</p> <p>The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility.</p> <p>This STANDARD is not met as evidenced by: Based on facility policy, medical record and staff interview, it was determined the facility staff failed to complete accurate medical record documentation regarding the condition and care of the patient. This affected Patient Identifier (PI) # 9, 1 of 6 in-center records reviewed and had the potential to negatively affect all patients dialyzed at the facility. Findings include: Policy: 3-02-17 Title: Progress Note Policy Revision Date: October 2017 Purpose: To verify progress notes are documented by the Physician, Nurse, Dietician and Social Worker...Documentation needs to include treatment given or planned, patient encounters and the condition of the patient. Policy: 1. Progress notes are completed to verify documentation of patient's problems/needs, intervention, response to intervention... 2. Progress notes are used to communicate information among the various disciplines...expand upon information or problems... 3. Progress notes will capture communication related to patient's care that occur outside the medical record (...telephone, Secure messaging...) 7. Progress notes should demonstrate implementation of the plan of care, complete and pertinent information about condition of a (the) patient, and clearly portray the patient, the care, and outcomes... Physician: The attending Nephrologist is required to record progress notes...that provides other interdisciplinary team members with an up-to-date picture of the status of the patient at all times... 1. PI # 9 was admitted to the facility on 12/19 /16 with diagnoses including End Stage Renal Disease. Review of the 4/7/18 Post Treatment documentation revealed the CVC (central venous catheter) had dried blood</p>

on the dressing, and on the 4/10/18 Post Treatment sheet, the RN documented "redish yellow drainage from the CVC exit site." There was no documentation the Registered Nurse (RN) reported to the physician signs of infection at the CVC site. Review of the 4/12/18 Post Treatment documentation revealed a missed treatment. Further record review revealed a hospital history and physical dated 4/12/18 for an in-patient admit, chief complaint was "pus coming from the catheter site, sent out by the dialysis nurses to....ER (emergency room)...Impression: Sepsis with pus pouring from vascular catheter..." Review of the 4/10/18 and 4/12/18 physician note revealed the following: "This patient was seen and examined while on dialysis. Professional oversight of the patient's dialysis care, access care and dialysis related c-morbidities were addressed... with patient and/or staff. Patient is doing well, no significant new issues noted." There was no documentation the RN communicated with the physician regarding the CVC infection and no documentation the RN communicated with the inpatient facility. The physician documentation failed to contain pertinent information about condition about the patients' CVC infection, clearly portray the patient, the care, and outcome of the patient on 4/10/18 and 4/12/18. In an interview on 7/26/18 at 10:00 AM, Employee Identifier # 2, Clinical Nurse Manager confirmed the RN failed to complete all patient assessment and physician communication documentation and the physician's documentation failed to accurately portray the current condition of the patient.