

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  012506	<b>(X3) Date Survey Completed</b>  04/13/2023
<b>Name of Provider or Supplier</b>  Dothan Dialysis	<b>Street Address, City, State</b>  216 Graceland Drive, Dothan, 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 medical records (MR), facility policy, and staff interviews, it was determined the facility failed to ensure staff: 1. Notified the nurse with abnormal changes in the patient's condition, including changes in the blood pressure (BP) and heart rate (HR-pulse rate). 2. Notified the nurse when the UFR (ultrafiltration rate, which is the ratio of fluid removed to dialysis treatment time) was turned off or at the minimum. This affected PI (Patient Identifier) # 1, PI # 2, in two of five records reviewed and had the potential to negatively affect all patients who dialyze at the facility. Findings include: Facility Policy: Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment Policy Number: 1-03-08 Revision Date: 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... 2. The Nursing assessment will be performed and documented by a licensed nurse... Pre-Treatment Data Collection/Assessment 4. Any abnormal findings...outside of any patient specific physician ordered parameter discovered during pre-treatment data collection will be documented and immediately reported to the licensed nurse...If an abnormal finding is reported to the licensed nurse pre-treatment, the nurse will assess the patient prior to the initiation of dialysis... Intradialytic Data Collection/Assessment 9. Intradialytic treatment monitoring...data collection may be performed by the PCT (Patient Care Technician) or licensed nurse... ...b. At a minimum, obtain</p>

and document the following: ... 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... Post Treatment Data Collection/Assessment 15. The PCT or licensed nurse will obtain and document basic data on each patient post dialysis and compare to pre dialysis findings. 16. If abnormal finding(s) or concern is identified post treatment, this needs to be reported to the licensed nurse...will assess the patient prior to discharge. 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... Blood Pressure: Intradialytic: Difference of 20 mm/Hg increase or decrease from...last intradialytic treatment BP reading... Heart or Pulse Rate Pre/Intra/Post: Less than 60 beats per minute or greater than 100 beats per minute... 1. PI # 1 was admitted to the facility on 2/25/23 with a diagnosis of End Stage Renal Disease (ESRD). Review of the Treatment Details Report (TDR) dated 3/29/23 revealed at 9:19 AM the BP was 136/83. Further review of the 3/29/23 TDR revealed the PCT documented the following and there was no documentation the nurse was notified: At 9:39 AM BP 77/54 (a decrease in BP greater than 20 mm/Hg)... stable, rechecking BP At 9:44 AM (next entry documented) BP 119/80 no complaints At 10:19 AM BP 134/80 no complications. The UFR was 50, which is the minimum UFR. At 10:24 AM (next entry documented), no BP was documented, "Pull (ultrafiltration-UF) turned off" At 10:39 AM BP 159/118, rechecking BP (an increase in BP greater than 20 mm/Hg) At 10:53 AM (the next BP check), BP 121/72 bp better cramping mildly monitoring At 11:19 AM BP 116/52 no complaints. The UFR was 50 (minimum UFR-fluid pull/removal) At 11:59 AM BP 119/72, no complaints. The UFR was 50 At 12:19 PM, BP 109/76, no complaints. The UFR was 50 At 12:22 PM, treatment termination BP 186/100. The UFR was 50 The PCT failed to document the nurse was notified for BP increase and decrease of greater than 20 mm/Hg, and complaints of cramping. There was no documentation why the UFR was turned off at 10:24 AM, and no documentation the nurse was notified the UFR was 50 from 11:19 AM to 12:22 PM. Review of the TDR dated 4/5/23 revealed at 12:28 PM the BP was 130/80. At 12:48 PM BP was 85/62. There was no documentation the PCT notified the nurse of the decrease in BP greater than 20 mm/Hg. Further review of the 4/5/23 TDR revealed at 1:18 PM the nurse documented cramping, 200 ml (milliliter) NS (normal saline) given, UF turned to a minimum (50). Continued review of the 4/5/23 TDR revealed the PCT documented the following: At 1:30 PM, BP 125/63... improved. The UFR was 50 At 1:49 PM, BP 97/66...low, rechecking bp. The UFR was 50 At 1:58 PM, BP 156/98, awake, alert, no complaints. The UFR was 50 At 2:13 PM, BP 115/79 no complications. The UFR was 50 At 2:29 PM, BP 145/76 no complaints. The UFR was 50 At 2:41 PM, (no BP documented), awake, no complaints, bp improve. The UFR was 50 At 2:48 PM, BP 129/86 no complaints. The UFR was 50 At 2:54 PM, treatment terminated BP 131/77. The UFR was 50 There was no documentation the staff re-evaluated the need to re-establish the UFR with improved BP, and no patient complaints from 1:30 PM until treatment end at 2:54 PM. Review of the TDR dated 4/7/23 revealed at 2:13 PM the PCT documented patient cramping, RN (Registered Nurse) notified, UFR turned off. At 2:49 PM, the PCT documented no complaints. The UFR was 50. From 2:50 PM till 3:10 PM, the PCT documented tolerating treatment and the UFR was 50. At 3:15 PM treatment terminated and the UFR was 50. Further review of the 4/7/23 TDR revealed at 3:53 PM the nurse documented "appears to be tolerating treatment, late entry monitoring asymptomatic bp change". The 4/7/23 TDR documentation revealed the UFR

remained 50, which was at a minimum for 62 minutes of the 4 hour treatment despite documentation of no complaints, patient tolerating treatment. There was no documentation the staff re-evaluated the need to re-establish the UFR Review of the TDR dated 4/10/23 revealed the PCT documented the following: At 9:43 AM BP 125 /97, HR 67 no complaints At 10:03 AM BP 232/174 (increase greater than 20 mm /Hg), HR 55 (less than 60), elevated BP rechecking. There was no documentation the PCT notified the nurse of the abnormal HR and BP. At 10:23 AM BP 141/68, HR 114 (greater than 100 beats per minute), better bp At 10:43 AM BP 117/86, HR 103, lower bp monitoring, RN notified At 11:03 AM BP 122/78, HR 117, Patient monitored...no complaints At 12:17 PM BP 123/79, HR 126 no complaints At 1:23 PM, BP 108/67, HR 120 HR elevated, rechecking BP There was no documentation staff notified the nurse when the HR was 55, and when the HR was 114 to 126. An interview was conducted on 4/13/23 at 11:12 AM with EI (Employee Identifier) # 1, Facility Administrator, who confirmed staff failed to follow facility policy, notify the nurse /physician with complaints of cramping, abnormal BP, HR, and UFR adjustments. 40119 2. PI # 2 was admitted to the facility on 1/30/23 with a diagnosis of ESRD. Review of the TDR dated 3/8/23 revealed the PCT documented the following HR readings without documentation the nurse was notified: At 11:43 AM a HR of 105. At 12:03 PM a HR of 108. At 12:35 PM a HR of 109. At 12:44 PM a HR of 113. At 1:05 PM a HR of 114. At 1:17 PM a HR of 103. Review of the TDR dated 3/20/23 revealed the PCT documented the following pulse readings without documentation the nurse was notified: At 12:51 PM a HR of 112. At 1:12 PM a HR of 108. At 1:31 PM a HR of 109. At 1:52 PM a HR of 102. At 2:11 PM a HR of 108. At 2:31 PM a HR of 105. In an interview conducted on 4/13/23 at 12:02 PM, EI # 10, Senior Manager of Clinical Services, confirmed there was no documentation the nurse was notified of the patient pulse above 100 on 3/8/23 and 3/20/23.