

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012509	(X3) Date Survey Completed 03/30/2023
Name of Provider or Supplier North Alabama Nephrology Center	Street Address, City, State 1311 North Memorial Parkway #200, Huntsville, 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)
V0544	<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 review of medical records (MR), facility policy, and staff interviews, it was determined the facility failed to ensure the staff followed the physician orders for: 1. BFR (Blood Flow Rate) 2. DFR (Dialysate Flow Rate). This affected five of five MR's reviewed, including PI (Patient Identifier) # 3, PI # 1, PI # 4, PI # 2, PI # 5, and had the potential to negatively affect all patients who dialyze at this facility. Findings include: Facility Policy: Patient Assessment and Monitoring Date: 9/29/18 Version: 3 ...Monitoring During Treatment... document machine parameters and safety checks every 30 (minutes) or more often as needed but not to exceed 45 minutes. ...3. Machine Parameters and Extracorporeal Circuit Check machine settings and measurements... Check prescribed blood flow is being achieved... Check dialysate flow rate setting is correct, and the prescribed flow is being delivered. 1. PI # 3 was admitted to the facility on 5/3/19 with a diagnosis of End Stage Renal Disease (ESRD). Review of the Orders Summary Report (OSR) revealed hemodialysis (HD) orders dated 3/3/23 that included BFR 450 and DFR Manual 800 ml/min (milliliters per minute). Review of the Treatment Sheet (TS) dated 3/15/23 revealed treatment start was 5:56 AM with a BFR 450. At 9:27 AM the BFR was decreased to 400 until end of treatment at 10:01 AM. There was no reason documented why the BFR was decreased to 400. There was no physician order for BFR 400. Review of the TS dated 3/17/23 revealed treatment start was 5:48 AM and treatment end was 9:57 AM. The BFR was 400 for the entire treatment. There was no reason documented why the physician's order for BFR 450 was not administered. There was no physician order for</p>

BFR 400. Review of the TS dated 3/20/23 revealed the treatment start was at 5:57 AM with a BFR 450. At 9:04 AM BFR was decreased to 400 until end of treatment at 9:57 AM. There was no reason documented why the BFR was decreased to 400. There was no physician order for BFR 400. Review of the TS dated 3/27/23 revealed the treatment start was at 6:53 AM with a BFR 450. At 9:23 AM BFR was decreased to 400 until end of treatment at 10:55 AM. There was no reason documented why the BFR was decreased to 400. There was no physician order for BFR 400. In an interview on 3/30/23 at 9:25 AM with Employee Identifier (EI) # 1, Facility Administrator (FA), EI # 1 confirmed on HD treatments dated 3/15/23, 3/17/23, 3/20/23, and 3/27/23 staff failed to document why the BFR was changed and failed to follow physician's orders for BFR. 30952 2. PI # 1 was admitted to the facility on 5/23/19 with diagnoses including ESRD. Review of the OSR revealed HD orders dated 3/3/23 which included BFR 450 and DFR Autoflow 1.5 (700). Review of the TS dated 3/24/23 revealed from 1:29 PM the BFR was 300 and DFR was 500 until treatment end at 2:54 PM. There was no reason documented why the BFR was 300 and not 450 as ordered. There was no physician order for the DFR 500. Review of the TS dated 3/27/23 revealed at 11:31 AM, treatment initiation until 1:21 PM, the BFR was 400 and DFR was 800. At 1:21 PM, the BFR was decreased to 350 and DFR remained at 800 until treatment termination at 3:19 PM. There was no reason documented why the BFR was 400 and 350 and not 450 as ordered. There was no physician's order for DFR 800. In an interview conducted on 3/30/23 at 8:50 AM, EI # 1 verified the staff failed to document the reason the BFR was not delivered as ordered and failed to administer the DFR per physician orders. 3. PI # 4 was admitted to the facility on 2/25/22 with diagnoses including ESRD. Review of the OSR revealed HD orders dated 1/20/23 which included BFR 400 and DFR Manual 500. Review of the TS dated 2/10/23 revealed from 12:29 PM, at treatment initiation, until 2:43 PM, the DFR was 600. At 2:43 PM, the DFR was increased to 800 until treatment termination at 3:00 PM. There was no physician's order for DFR 600 and DFR 800. In an interview conducted on 3/30/23 at 9:08 AM, EI # 1 confirmed staff failed to follow the physician's DFR orders during treatment delivery. 28327 4. PI # 2 was admitted to the facility on 6/23/22 with diagnoses including ESRD. Review of the OSR revealed HD orders dated 2/20/23 which included BFR 400 and DFR Manual 800. Review of the TS dated 3/10/23 revealed the BFR was decreased to 350 from 1:22 PM to 2:30 PM, then increased to 370 at 3:00 PM. There was no reason documented why the BFR was 350 and 370 and not 400 as ordered. There was no physician's order for the BFR 350 and BFR 370. Review of the TS dated 3/15/23 revealed the BFR was decreased to 300 from 3:32 PM to 4:00 PM. There was no reason documented why the BFR was 300 and not 400 as ordered. There was no physician order for the BFR 300. Review of the TS dated 3/20/23 revealed the BFR was 350 the entire treatment from 12:51 PM to 4:41 PM. There was no reason documented why the BFR was 350 and not 400 as ordered. There was no physician order for the BFR 350. Review of the TS dated 3/22/23 revealed the BFR was decreased to 200 from 1:23 PM until the end of treatment at 3:02 PM. There was no reason documented why the BFR was 200 and not 400 as ordered. There was no physician order for the BFR 200. An interview was conducted on 3/30/23 at 8:51 AM with EI # 1 who verified the staff failed to document the reason the BFR was not delivered as ordered and failed to administer the BFR per physician orders. 5. PI # 5 was admitted to the facility on 2/14/22 with diagnoses including ESRD. Review of the OSR revealed HD orders dated 2/20/23 which included BFR 400 and DFR Autoflow 1.5 (600). Review of the TS dated 3/15/23 revealed treatment started at 6:41 AM and from 6:46 AM to 7:29 AM BFR 400 and DFR 0. There was no reason documented why the DFR was 0 and not 600 as ordered. There was no physician order for the DFR 0. Review of the TS dated 3/24/23 revealed the BFR was 450 the entire treatment from 7:02 AM to 10:25 AM. There was no

reason documented why the BFR was 450 and not 400 as ordered. There was no physician order for the BFR 450. An interview was conducted on 3/30/23 at 8:49 AM with EI # 1 who verified the staff failed to follow the physician's DFR orders during treatment delivery and failed to document the reason the BFR was not delivered as ordered.