

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012512	(X3) Date Survey Completed 11/17/2022
Name of Provider or Supplier Fmc Dialysis Services Selma	Street Address, City, State 905 Medical Center Parkway, Selma, 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 procedures, and interviews with the staff it was determined the facility failed to ensure: 1. The physician was notified of the patient leaving greater than 2.0 kg (kilograms) over the EDW (Estimated Dry Weight). 2. Vital signs were taken every 30 minutes per facility policy. 3. The nurse and/or the physician was notified of patient's continued high blood pressure (BP) and/or Clonidine was given per the physician orders for systolic BP greater than 180 and/or diastolic BP greater than 100. This deficient practice affected 4 of 7 MR's reviewed and did affect Patient Identifier (PI) # 3 , PI # 5, PI # 2 and PI # 4 and had the potential to negatively affect all patients dialyzing at this facility. Findings include: Facility Policy: Determination of Blood Pressure Policy Number: 45285 Date: 2/7/22 Purpose: The purpose of this procedure is to provide guidance for measuring the patient's blood pressure. Policy: Obtain blood pressure readings pre- and post-dialysis sitting and standing (if applicable) and every 30 minutes or more during hemodialysis treatments... The Medical Director in conjunction with the Clinical Manager will determine what the blood pressure upper and lower range parameters will be for the facility... FMC (Fresenius Medical Center) and Dallas County Standing Orders 2020 Updated 1. Initiate, Monitor, and Terminate treatment per FMC P&P (Policy and Procedure) by access type as adopted by facility: E. EDW if patient is greater than or less than 2 kg from EDW post treatment document assessment and notify MD (Medical Doctor). K. BP and Safety check at 30 minutes and PRN (as needed) per P&P 5. Treatment complications: Hypertension</p>

Systolic greater than 180 and Diastolic greater than 100: RN (Registered Nurse) assesses and sets UF (Ultra filtration) utilizing UF profile at RN discretion. If no response to UF of greater than 2 liters removed administer Clonidine 0.1 mg (milligrams) by mouth. If no response to Clonidine after 30 minutes notify MD for further orders. Facility Policy: Patient Assessment and Monitoring Policy Number: Version 3 Date: 9/29/18 Pre-Treatment: Direct patient care staff may collect pre-treatment weight, BP, pulse, respirations, temperature, general observations, access and complaints reported by the patient. ...any changes or abnormal findings in patient's condition or vascular access are observed...the patient care technician must report the changes in the patient condition to a registered nurse who will further assess the patient prior to initiation of the treatment. An abnormal finding confirmed by the RN will be reported to the attending physician for assessment and intervention... Post-Treatment: The staff member who collects the information and evaluates the patient post-treatment will document their findings on the hemodialysis treatment record... any changes or abnormal findings in the patient's condition, vital signs or vascular access are observed...must report the changes in the patient condition to a registered nurse who will further assess the patient prior to discharge... An abnormal finding confirmed by the RN will be reported to the attending physician... 1. The direct patient care staff may obtain the following data: Weight: Record pre-weight. Compare pre-weight to estimated dry weight. 2. Monitoring During Treatment: Obtain blood pressure and pulse rate every 30 minutes or more as needed... Document machine parameters and safety checks every 30 minutes or more as needed... 1. Blood Pressure: Report to nurse: Systolic blood pressure greater than 180 mm/hg (millimeters per hemoglobin) and/or Diastolic blood pressure greater than 100 mm/hg... 1. PI # 3 was admitted to the facility on 2/7/22 with admitting diagnoses of Hypertensive Kidney Disease with Stage 1 through 4 Chronic Kidney Disease and End Stage Renal Disease. Review of the Orders Summary Report dated 10/7/22 for Hemodialysis revealed the following orders to dialyze Monday, Wednesday and Friday for 4 hours and 0 minutes. EDW 67 kg. Review of the Treatment Flow Sheet (TFS) dated 11/2/22 revealed at 2:44 PM, PI # 3's blood pressure was 197/109 and at 3:08 PM which was the end of treatment the blood pressure was 197/104. Further review of the TFS dated 11/2/22 revealed no documentation the RN was notified of the increase in BP, no was Clonidine administered to decrease the BP per standing orders. Review of the TFS dated 11/7/22 revealed the patient's post weight was 70.4 kg which was 3.4 kg over the EDW of 67 kg. Further review of the TFS dated 11/7/22 revealed no documentation the RN was notified nor was there documentation the physician was notified of the patient leaving 3.4 kg over the EDW. Further review of the TFS dated 11/7/22 revealed the following Blood Pressures: 11:09 AM - 169/106 start of treatment 11:32 AM - 187/113 12:05 PM - 171/110 1:02 PM - 164/102 1:34 PM - 198/108 2:02 PM - 191/108 2:23 PM - 200/118 end of treatment Further review of the TFS dated 11/7/22 revealed no documentation the RN was notified of the high blood pressure, no documentation the RN administered Clonidine per standing orders or no documentation the RN notified the physician of the increase of BP during treatment. Review of the TFS dated 11/9/22 revealed the patient's post weight was 69.4 kg which was 2.4 kg over the EDW. Further review of the TFS dated 11/9/22 revealed no documentation the RN was notified nor was there documentation the physician was notified of the patient leaving 2.4 kg over the EDW. Further review of the 11/9/22 TFS revealed the following blood pressures: 11:22 AM - 163/106 - Start of Treatment 11:32 AM - 169/117 12:08 PM - 168/110 12:35 PM - 185/122 1:02 PM - 190/122 1:34 PM - 171/102 1:59 PM - 194/ 113 - End of Treatment Further review of the TFS dated 11/9/22 revealed no documentation the RN was notified of the high blood pressure, no documentation the RN administered Clonidine per standing orders or no documentation the RN notified the physician of the increase of BP during

treatment. Review of the TFS dated 11/11/22 revealed the patient's post weight was 69.6 kg which was 2.6 kg over the EDW. Further review of the TFS dated 11/11/22 revealed no documentation the RN was notified nor was there documentation the physician was notified of the patient leaving 2.6 kg over the EDW. Review of the TFS dated 11/11/22 revealed vital signs were taken at 12:02 PM and not again until 1:04 PM which was one hour and 2 minutes later. Further review of the 11/11/22 TFS revealed the following blood pressures: 11:25 AM - 180/124 - Start of Treatment 11:40 AM - 180/124 12:02 PM - 178/119 1:04 PM - 175/117 1:32 PM - 146/110 Further review of the TFS dated 11/11/22 revealed no documentation the RN was notified of the high blood pressure, no documentation the RN administered Clonidine per standing orders or no documentation the RN notified the physician of the increase of BP during treatment. Review of the TFS dated 11/14/22 revealed the patient's post weight was 71.7 kg which was 4.7 kg over the EDW. Further review of the TFS dated 11/14/22 revealed no documentation the RN was notified nor was there documentation the physician was notified of the patient leaving 4.7 kg over the EDW. Further review of the Treatment Flow Sheet dated 11/14/22 revealed vital signs were taken at 1:06 PM and not again until 2:05 PM which was 59 minutes later. Further review of the 11/14/22 TFS revealed the following blood pressures: 11:25 AM - 159/104 - Start of Treatment 11:34 AM - 169/118 12:07 PM - 167/108 12:40 PM - 159/105 1:06 PM - 156/102 2:05 PM - 162/113 - End of Treatment Further review of the TFS dated 11/14/22 revealed no documentation the RN was notified of continued high blood pressure, no documentation the RN administered Clonidine per standing orders or no documentation the RN notified the physician of the increase of BP throughout treatment. An interview was conducted on 11/17/22 at 10:50 AM with Employee Identifier (EI) # 1, Clinic Manager, who confirmed the staff failed to notify the RN of the continued high blood pressure, the RN failed to administer Clonidine per physician orders and notify the physician of the high blood pressure and the RN failed to notify the physician of patient leaving greater than 2 kg over the EDW per facility policies. 2. PI # 5 was admitted to the facility on 11/27/2020 with admitting diagnoses of Type I Diabetes Mellitus with Diabetic Kidney Disease and End Stage Renal Disease. Review of the Order Summary Report for Hemodialysis dated 8/29/22 revealed the patient dialyzed 3 times a week on Monday, Wednesday and Friday for 4 hours 0 minutes EDW was 88 kg. Review of the TFS dated 10/28/22 revealed the following blood pressures: 8:58 AM - 201/115 - Start of Treatment 9:33 AM - 206/103 10:09 AM - 190/98 10:42 AM - 182/97 11:06 AM - 193/101 11:11 AM - 196/107 Further review of the TFS dated 10/28/22 revealed no documentation the RN was notified of the high blood pressure, no documentation the RN administered Clonidine per standing orders nor was there documentation the RN notified the physician of the increase of BP throughout treatment. Further review of the TFS dated 10/28/22 revealed the patient's post weight was 93.3 which was 5.3 kg over the EDW. Further review of the TFS dated 10/28/22 revealed no documentation the RN was notified of the patient leaving 5.3 kg over EDW nor was there documentation the physician was notified of the patient leaving 5.3 kg over the EDW. Review of the TFS dated 10/31/22 revealed the following blood pressures: 6:28 AM - 191/107 - Start of Treatment 6:34 AM - 191/107 7:02 AM - 200/111 7:32 AM - 213/100 8:02 AM - 195/103 10:08 AM - 192/102 Further review of the TFS dated 10/31/22 revealed no documentation the RN was notified of the high blood pressure, no documentation the RN administered Clonidine per standing orders nor was there documentation the RN notified the physician of the increase of BP throughout treatment. Further review of the TFS dated 10/31/22 revealed the patient's post weight was 94.8 which was 6.8 kg over the EDW. Further review of the TFS dated 10/31/22 revealed no documentation the RN was notified of the patient leaving 6.8 kg over EDW nor was there documentation the physician was notified of the patient leaving 6.8 kg over the EDW.

Review of the TFS dated 11/4/22 revealed the following blood pressures: 6:33 AM - 195/106 - Start of Treatment 7:05 AM - 207/105 7:39 AM - 200/100 8:07 AM - 205 /105 8:34 AM - 209/103 9:03 AM - 210/104 9:35 AM - 213/109 - End of Treatment Further review of the TFS dated 11/4/22 revealed no documentation the RN was notified of the high blood pressure, no documentation the RN administered Clonidine per standing orders nor was there documentation the RN notified the physician of the increase of BP throughout treatment. Further review of the TFS dated 11/4/22 revealed the patient's post weight was 92.2 which was 4.2 kg over the EDW. Further review of the TFS dated 11/4/22 revealed no documentation the RN was notified of the patient leaving 4.2 kg over EDW nor was there documentation the physician was notified of the patient leaving 4.2 kg over the EDW. Review of the TFS dated 11/8/22 revealed the patient's post weight was 91.5 which was 3.5 kg over the EDW. Further review of the TFS dated 11/8/22 revealed no documentation the RN was notified of the patient leaving 3.5 kg over EDW nor was there documentation the physician was notified of the patient leaving 3.5 kg over the EDW. Further review of the TFS dated 11/8/22 revealed vital signs were taken at 12:12 PM and not again until 1:03 PM which was 51 minutes later. Review of the TFS dated 11/11/22 revealed the following blood pressures: 6:49 AM - 188/105 - Start of Treatment 7:09 AM - 171/101 9:03 AM - 197/115 9:36 AM - 199/106 10:00 AM - 216/106 10:36 AM - 208/136 - End of Treatment. Further review of the TFS dated 11/11/22 revealed no documentation the RN was notified of high blood pressure, no documentation the RN administered Clonidine per standing orders nor was there documentation the RN notified the physician of the increase of BP throughout treatment. Further review of the TFS dated 11/11/22 revealed the patient's post weight was 91.2 which was 3.2 kg over the EDW. Further review of the TFS dated 11/11/22 revealed no documentation the RN was notified of the patient leaving 3.2 kg over EDW nor was there documentation the physician was notified of the patient leaving 3.2 kg over the EDW An interview was conducted on 11/17/22 at 10:55 AM with EI # 1 who confirmed the staff failed to notify the RN for the increased BP, failed to notify the MD of patient leaving over the EDW and of the continued elevated blood pressure and the RN failed to provide Clonidine per the standing orders. 40119 3. PI # 2 was admitted to the facility on 7/7 /22 with diagnosis including End Stage Renal Disease (ESRD). Review of the Orders Summary Report dated 9/21/22 revealed a physician order for an EDW of 109 kg. Review of the TFS dated 10/19/22 revealed treatment was started at 9:31 AM with a pre treatment weight of 116 kg and a post treatment weight of 113 kg. There was no documentation the physician was notified of the patient post treatment weight of 4 kg above the ordered EDW. Further review of the 10/19/22 TFS revealed at 10:12 AM, 43 minutes into treatment, PI # 2's BP was 169/104. PI # 2's diastolic BP remained over 100 until 11:07 AM when it was documented at 100. Further review of the 10/19 /22 TFS revealed the following diastolic BP's with no documentation the nurse was notified of a diastolic BP greater than 100 per facility policy: At 11:36 AM, PI # 2's diastolic BP was 106. At 12:06 PM, PI # 2's diastolic BP was 116. At 12:40 PM, PI # 2's diastolic BP was 109. At 1:06 PM, PI # 2's diastolic BP was 113. At 1:27 PM, PI # 2's diastolic BP was 106. An interview was conducted on 11/17/22 at 11:07 AM with EI # 1, who confirmed there was no documentation the nurse was notified of the greater than 100 diastolic BP and the physician was notified of the patient post treatment weight of 4 kg above the ordered EDW on 10/19/22. 4. PI # 4 was admitted to the facility on 4/16/14 with diagnosis including ESRD. Review of the Orders Summary Report dated 8/19/22 revealed a physician order for an EDW of 76 kg. Review of the TFS dated 11/9/22 revealed treatment was started at 5:28 AM with a pre treatment weight of 79.4 kg and a post treatment weight of 78.3 kg. There was no documentation the physician was notified of the patient post treatment weight of 2.3 kg above the ordered EDW. Review of the TFS dated 11/11/22 revealed treatment

was started at 5:21 AM with a pre treatment weight of 80.3 kg and a post treatment weight of 78.9 kg. There was no documentation the physician was notified of the patient post treatment weight of 2.9 kg above the ordered EDW. Review of the TFS dated 11/14/22 revealed treatment was started at 5:25 AM with a pre treatment weight of 80.3 kg and a post treatment weight of 78.6 kg. There was no documentation the physician was notified of the patient post treatment weight of 2.6 kg above the ordered EDW. An interview was conducted on 11/17/22 at 10:37 AM with EI # 1, who confirmed there was no documentation the physician was notified of the patient post treatment weight of 2 kg above the ordered EDW per the facility policy on 11/9/22, 11/11/22 and 11/14/22.