

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  012512	<b>(X3) Date Survey Completed</b>  11/17/2022
<b>Name of Provider or Supplier</b>  Fmc Dialysis Services Selma	<b>Street Address, City, State</b>  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.		

<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>V0544</b>	<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, facility policy and procedure, observations and interviews with the staff it was determined the facility failed to ensure the BFR (Blood Flow Rate) and the DFR (Dialysate Flow Rate) were documented and entered into the dialysis machine correctly per the physician orders and facility policy. This 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 served by the 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 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, BFR 400 and DFR Manual 500 mL/min (milliliters per minute). Review of the Treatment Flow Sheet (TFS) dated 11/2/22 at 12:38 PM revealed the DFR was set at 800 and remained at 800 until 1:35 PM when it was changed to 500 per the MD (Medical Doctor) orders. Further review of the TFS dated 11/2/22 at 12:38 PM revealed no documentation as to why the DFR was not set per the MD orders. Review</p>

of the TFS dated 11/7/22 at 11:32 AM revealed the DFR was set at 600 and remained at 600 until 1:34 PM when it was changed to 500 per the MD orders. Further review of the TFS dated 11/7/22 at 11:32 AM revealed no documentation as to why the DFR was not set per the MD orders. Review of the TFS dated 11/14/22 at 11:25 AM revealed the BFR was set at 200 and not the 400 per MD orders and remained at 200 until the end of treatment at 1:06 PM. Further review of the TFS dated 11/14/22 at 11:25 AM revealed no documentation as to why the BFR was not set per the MD orders. An interview was conducted on 11/17/22 at 10:50 AM with Employee Identifier (EI) # 1, Clinic Manager, who confirmed the technician and the nurse failed to ensure the BFR and the DFR was set per the MD orders. 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, BFR 400 and the DFR was Autoflow 2.0 (800). Review of the TFS dated 11/8/22 at 11:04 AM revealed the BFR was set at 410 and the DFR was at 580 and not the 400 /800 per MD orders. Further review of the TFS dated 11/8/22 at 11:35 AM revealed the DFR was at 500 and remained at 500 until the end of treatment at 1:03 PM. Further review of the TFS dated 11/8/22 at 11:35 AM revealed no documentation as to why the BFR and DFR were not set per the MD orders. An interview was conducted on 11/17/22 at 10:55 AM with EI # 1 who confirmed the BFR and DFR was not set correctly per the MD 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 dialysis treatment BFR of 400 and DFR Autoflow was 2.0, which was 800. Review of the Treatment Sheet dated 10/14/22 revealed the treatment was started at 9:30 AM with a BFR of 400 and DFR of 800. At 10:00 AM through 12:08 PM there was no documentation of the BFR or DFR. Review of the Treatment Sheet dated 10/19/22 revealed the treatment was started at 9:31 AM with a BFR of 400 and DFR of 800. At 12:06 PM through 1:06 PM there was no documentation of the BFR or DFR. An interview was conducted on 11/17/22 at 11:07 AM with EI # 1, who confirmed the treatment BFR and DFR was not documented per the facility policy on 10/14/22 and 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 dialysis treatment DFR of 500. Review of the Treatment Sheet dated 11/2/22 revealed the treatment was started at 5:24 AM with a DFR of 600, the DFR of 600 continued until 5:44 AM then increased to 800 from 6:35 AM to 7:08 AM. At 8:08 AM through the end of treatment at 9:32 AM the DFR was 800. There was no documentation of the reason the DFR was not administered at 500 as ordered. Review of the Treatment Sheet dated 11/4/22 revealed the treatment was started at 5:24 AM with a BFR of 400 and DFR of 800, the DFR continued at 800 until 6:38 AM. There was no documentation of the BFR or DFR from 7:09 AM until 8:06 AM, 57 minutes, when the BFR was 400 and DFR 800. The DFR remained at 800 through the end of treatment at 9:27 AM the DFR was 800. There was no documentation of the reason the BFR and DFR were not documented for 57 minutes and DFR was not administered at 500 as ordered. Review of the Treatment Sheet dated 11/9/22 revealed the treatment was started at 5:28 AM with a DFR of 800, the DFR of 800 continued until 6:30 AM. At 8:05 AM, the DFR was 800 through the end of treatment at 9:30 AM. There was no documentation of the reason DFR was not administered at 500 as ordered. An interview was conducted on 11/17/22 at 10:37 AM with EI # 1, who confirmed the treatment BFR and DFR was not documented per the facility policy and/or physician's orders on 11/2/22, 11/4/22 and 11/9/22.