

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  012513	<b>(X3) Date Survey Completed</b>  07/14/2021
<b>Name of Provider or Supplier</b>  Bma Langdale	<b>Street Address, City, State</b>  8 Medical Park North, Valley, 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 the medical records (MR), facility agency policy and procedure, and interviews, it was determined the facility failed to ensure staff: 1. Documented the patient's BP (blood pressure) and pulse every 30 minutes or more often as needed but not to exceed 45 minutes. 2. Documented machine parameter and safety checks every 30 minutes or more often as needed but not to exceed 45 minutes. 3. Identified, documented, and reported changes in the patient condition to the RN (Registered Nurse) which included UF (Ultrafiltration Rate) rate off, NS (normal saline) administration and BP changes. 4. Post treatment re-assessments by the RN were completed and documented when pre-treatment patient conditions revealed abnormal lung assessments and 2 plus edema (swelling) bil (bilateral) to the lower extremities (LE). 5. Documented the total fluid administered during treatments. This affected 7 of 8 medical records reviewed including Patient Identifier (PI) # 1, PI # 4, PI # 6, PI # 2, PI # 7, PI # 8 and PI # 3 and had the potential to negatively affect all patients served by the dialysis facility. Findings include: Policy: Patient Assessment and Monitoring Version: 3 Published Date: 09/29/18 Pre-Treatment Assessment and Data Collection Direct patient care staff may collect pre-treatment weight, BP...general observations... and complaints reported by the patient. If the PCT (Patient Care Technician) notes any changes, or abnormal in the patient...MUST report changes in the patient condition to a RN who will further assess the patient prior to initiation of the treatment. During treatment The RN will assess/re-assess any findings addressed pre or during treatment as needed. Post-Treatment Non-licensed staff may collect post-</p>

treatment weight, BP, pulse...general observations, access, and complaints reported by the patient. The staff member who evaluates the information and evaluates the patient post-treatment will document their findings on the...record. If any changes or abnormal findings...are observed or reported...the PCT...must report the changes in the patient condition to a RN who will further assess the patient prior to discharge after treatment. An abnormal finding confirmed by the RN will be reported to the attending physician if necessary...for assessment and intervention. The RN will assess/re-assess any findings addressed pre-treatment prior to discharge. Follow steps...obtaining pre-treatment assessment data: 2. During nursing rounds, the RN will review the data... and assess the following parameters as needed: ...Assess patient for symptoms...ask... if...had shortness of breath, chest pain... Lung sounds sounds...Auscultate...for... Decreased Breath sounds Rales (crackles) Rhonchi Wheezing Location Edema... location...Severity 3. Document findings and interventions in the medical record... Monitoring during Treatment Obtain blood pressure and pulse rate every 30 minutes or more as needed but not to exceed 45 minutes...Document machine parameter and safety checks every 30 minutes or more often as needed but not to exceed 45 minutes... Follow the steps below for monitoring patient and machine parameters during treatment: Step 1. Blood Pressure Record blood pressure. Recheck blood pressures after a drop that requires interventions such as administering normal saline (NS)... Report to the nurse: Systolic (BP top value obtained during contraction of the heart chambers) BP greater than 180 mm/Hg (millimeters/mercury); Diastolic (BP bottom value obtained during heart chamber relaxation) BP greater than 100 mm/Hg; BP less than or equal to 100 mm/Hg systolic. Ultrafiltration (UF) Rate (UFR) Monitor UF rate.... Reported by patient... Ask of any new complaints to report. General Observations/Mental Status Observe the patient's overall conditions during treatment. Report to the nurse any changes in the patient's overall condition... ..3. Machine Parameters and Extracorporeal Circuit Check machine settings and measurements. Check prescribed blood flow (blood flow rate-BFR) is being achieved or reason is documented in medical record if unable to meet prescribed blood flow. Check dialysate flow rate (DFR) setting is correct, and prescribed flow is being delivered. Check arterial pressure is less than 250 mmHg. Monitor high venous pressure for infiltration or clotting. Check the amount of fluid removed... Observe and ensure that: Normal saline line is double clamped. There is at least 300 ml of NS prior to termination... Post-Treatment Follow the steps below for obtaining post-treatment assessment data: 1. The direct patient care staff may obtain the following: ...State of well-being/Reported by the patient/General observation The RN will assess/re-assess post treatment as indicated. Lung sounds Edema... 2. Document findings in the patient's record. 1. PI # 1 was admitted to the facility 4/13/21 with diagnoses including Diabetic Glomerular Sclerosis and ESRD (End Stage Renal Disease). Review of the Treatment Sheet dated 6/29/21 revealed no BFR/DRF documented from 11:42 AM until 12:36 PM, which was 54 minutes. There was no BFR/DFR documented from 2:04 PM until 3:03 PM, which was 59 minutes. Review of the Treatment Sheet dated 7/3/21 revealed no BP or pulse, no BFR/DFR, and no safety checks documented from 1:35 PM until 2:35 PM, which was 60 minutes. In an interview conducted on 7/14/21 at 1:09 PM CST (Central Standard Time), Employee Identifier (EI) # 1, Director of Operations, confirmed staff failed to perform and document patient assessment and monitoring per policy. 2. PI # 4 was admitted to the facility 5/15/2020 with diagnoses including ESRD. Review of the Treatment Sheet dated 6/29/21 at 2:10 PM revealed the following RN pre treatment documentation: breath sounds: rales/Crackling, Breath Sound location, all lobes; rhonchi, bil (bilateral) lungs; lower leg (edema)-severity 1 plus; 2 mm or less, disappears rapidly, edema lower leg...ankle; bil Lungs-sound location. Further review of the 6/29/21 Treatment Sheet post nursing evaluation at 6:54 PM failed to reveal documentation

how/if the rales/rhonchi to bil lungs and bil lower leg/ankle edema were affected by the dialysis treatment. During an interview conducted on 7/14/21 at 1:28 PM CST, EI # 1 confirmed staff failed to follow the monitoring policy which included RN assessment and documentation post treatment assessment data when abnormal pre treatment findings were identified. 3. PI # 6 was admitted to the facility on 6/2/17 with diagnoses including Diabetes Mellitus with Diabetic Nephropathy and ESRD. Review of the Treatment Sheet dated 6/30/21 at 11:40 AM revealed the PCT documented the BP 85/50, pt(patient) denies complaints, UF off. At 12:09 PM, the PCT documented denied complaints, BP 114/54, UF off treatment ended. There was no reason documented why the UF was off and no documentation the PCT notified the RN the UFR was off for 29 minutes. Review of the Treatment Sheet dated 7/2/21 at 8:23 AM revealed the following RN pre-treatment data documentation: symptoms were shortness of breath, bilateral lungs decreased breath sounds, lower leg, and ankle edema-severity 2 plus; 2-4 mm (millimeter) indent bilateral (bil). Further review of the 7/2/21 Treatment Sheet post nursing evaluation at 11:58 AM failed to include post treatment documentation if/how the patient shortness of breath, bil lung sounds and bil leg edema were affected by the dialysis treatment. Review of the Treatment Sheet dated 7/5/21 at 9:37 AM revealed RN documentation the BP was 89/51, (pt) denies complaints, alert; chronic low BP, will monitor. Further review of the 7/5/21 Treatment Sheet revealed at 11:05 AM, the PCT documented BP 77/43, denies complaints, UF off, pt alert, 200 ml (ns) for low bp. There was no documentation the PCT notified the RN regarding the "low bp", when the UF was turned off and when 200 ml NS was administered. The low bp was not rechecked until 11:58 AM, at treatment end, which was 53 minutes. An interview was conducted on 7/14/21 at 12:56 PM CST and EI # 1 confirmed staff failed follow the patient assessment and monitoring policy. 34107 4. PI # 2 was admitted to the facility 5/29/21 with the primary diagnosis of Acute Kidney Injury. Review of the Treatment Sheet dated 7/1/21 revealed no BP or pulse, no BFR/DFR, and no safety checks documented from 2:10 PM until 3:12 PM, which was 62 minutes. In an interview conducted on 7/14/21 at 1:20 PM CST, EI # 1, confirmed the staff failed to perform and document patient assessment and monitoring per policy. 5. PI # 7 was admitted to the facility on 9/28/19 with the primary diagnosis of ESRD. Review of the 7/10/21 Treatment Sheet revealed documentation at 7:58 AM of "patient request to use restroom." There was no documentation of amount of NS to rinse back blood. Further review of 7/10/21 Treatment Sheet revealed at 8:19 AM, the documentation revealed, "Treatment resumed; resting comfortably, alert." There was no documentation of the amount of NS used to resume treatment. At 8:20 AM, the documentation revealed "300 ml NS rinse venous infiltration noted, unable to continue treatment due to pressures." In an interview conducted on 7/14/21 at 1:15 PM CST, EI # 1 confirmed the staff failed to document NS used to rinse back blood or prime re-start of treatment which resulted in an infiltration. 6. PI # 8 was admitted to the facility on 10/14/14 with the primary diagnosis of ESRD. Review of the Treatment Sheet dated 7/12/21 revealed no BP or pulse, no BFR/DFR, and no safety checks documented from 1:34 PM until 2:42 PM which was 68 minutes. On 7/12/21 at 12:55 PM CST the surveyor observed the BP of 214/67 and there was no NS solution in the bag hanging on the dialysis machine. 2:40 PM, EI # 5, PCT yelled across the treatment floor to the RN, "(Patient's Name) went out!" At 2:42 PM, the RN documented, patient was unresponsive for approximately 3 seconds. In an interview conducted on 7/14/21 at 1:06 PM CST, EI # 1 confirmed the staff failed to document patient assessment and monitoring per policy. 7. PI # 3 was admitted to the facility on 12/9/2020 with the primary diagnosis of ESRD. Review of the Treatment Sheet dated 6/30/21 revealed no BP or pulse, no BFR/DFR, and no safety checks documented from 11:06 AM until 12:12 AM which was 66 minutes. Review of the Treatment Sheet dated 7/5/21 revealed no BP or pulse, no BFR/DFR,

and no safety checks documented from 8:06 AM until 9:37 AM which was 91 minutes. Further review of the 7/5/21 Treatment Sheet revealed BP reading at 10:05 AM, BP was 130/74. At 10:36 AM, the BP decreased to 104/65 and at 11:12 AM, the BP was 91/44. There was no documentation the RN was alerted to the low BP, 91/44. Review of the Treatment Sheet dated 7/7/21 revealed no BP or pulse, no BFR/DFR, and no safety checks documented from 11:00 AM until 11:46 AM, which was 46 minutes. Review of the Treatment Sheet dated 7/9/21 revealed no BFR/DFR documented from 8:11 AM to 9:33 AM, which was 82 minutes. Further review of the 7/9/21 Treatment Sheet revealed no BP or pulse, no BFR/DFR and no safety checks documented from 11:04AM until 12:12 PM, which was 66 minutes. Review of the Treatment Sheet dated 7/12/21 revealed no BP or pulse, no BFR/DFR, and no safety checks documented from 11:07 AM until treatment ended at 12:12 PM, which was 65 minutes. In an interview conducted on 7/14/21 at 1:05 PM CST EI # 1, confirmed the staff failed to perform/document the patient assessment and monitoring per policy as stated above for 5 of the 6 treatment records reviewed.