

<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>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 observation, review of medical records (MR), facility policy, and interviews with staff, it was determined the facility failed to ensure the staff: 1. Followed the physician order for the Blood Flow Rate (BFR) and Dialysate Flow Rate (DFR). 2. Followed physician orders for dialyzer size. This affected unsampled patient, Patient Identifier (PI) # 17, and 6 of 8 records reviewed and included PI # 2, PI # 7, PI # 8, PI # 1, PI # 5, PI # 4 and had the potential to negatively affect all patients dialyzing at this facility. Findings include: Policy: Patient Assessment and Monitoring Version: 3 Published Date: 09/29/2018 Monitoring during Treatment ...3. Machine Parameters and Extracorporeal Circuit Check machine settings and measurements. Check prescribed blood flow is being achieved or reason is documented in medical record if unable to meet prescribed blood flow. Check dialysate flow rate setting is correct, and prescribed flow is being delivered... 1. During observations of care on 7/12/21 at 3:25 PM, the surveyor observed an unsampled patient, PI # 17, at station 14 with a 180 NRe dialyzer. Review of PI # 17's 7/12/21 Hemodialysis orders revealed a 160 NRe Optiflux dialyzer was ordered. Employee Identifier (EI) # 10, Certified Clinical Hemodialysis Technican (CCHT), confirmed during the observation the wrong dialyzer size and stated, "The nurse is going to get an order to change the dialyzer size." Review of the 7/12/21 Treatment Sheet revealed treatment assessments of: 12:36 PM with the blood pressure (BP) of 186/89. 1:05 PM with the BP of 128/69. 1:36 PM with the BP of 104/42. 2:08 PM with the BP of 112/49. 2:38 PM with the BP of 94/55. Normal Saline (NS) 200 milliliter (ml) given due to hypotension. 3:04 PM with</p>

the BP of 118/47. 3:15 PM with the BP of 102/54. NS 200 given due to cramping. 3:35 PM with the BP of 114/62. 4:08 PM with the BP of 101/49. 4:51 PM with the BP of 100/ 53. Further review of the 7/12/21 Treatment Sheet revealed no documentation the physician was contacted to increase the dialyzer size. In an interview conducted on 7/14/21 at 1:45 PM CST (Central Standard Time), EI # 1, Director of Operations, confirmed the staff failed to follow the physician order for dialyzer size. 2. PI # 2 was admitted to the facility 5/29/21 with the primary diagnosis of Acute Kidney Injury. Review of the current orders report dated 6/24/21 revealed a BFR of 400 and DFR Autoflow 1.5, which would be 600. Review of the Treatment Sheet dated 6/26/21 revealed the BFR was 400 and DFR 600 at 12:03 PM. From 12:30 PM to 1:33 PM revealed the BFR was decreased to 300 and DFR was decreased to 500. From 2:02 PM until 3:33 PM, the BFR was decreased to 275. There was no documentation why the BFR and DFR were not at the ordered rates or why the prescribed flow was not met. Review of the Treatment Sheet dated 7/1/21 revealed the BFR was 400 and DFR 600 at 12:26 PM to 12:36 PM. From 1:00 PM to 2:10 PM revealed the BFR was decreased to 250 and DFR was decreased to 500. There was no documentation why the BFR and DFR were not at the ordered rates or why the prescribed flow was not met. Review of the Treatment Sheet dated 7/8/21 revealed the BFR was 400 and DFR 600 at 11:57 AM to 1:06 PM. At 1:33 PM the BFR was decreased to 350. At 2:06 PM the BFR was decreased to 300 and DFR decreased to 500. There was no documentation why the BFR and DFR were not at the ordered rates or why the prescribed flow was not met. In an interview conducted on 7/14/21 at 1:20 PM, EI # 1, confirmed the BFR and DFR were not at the ordered rates and there was no documentation why the prescribed blood flow was not achieved for 3 of 6 treatment sheets reviewed. 3. PI # 7 was admitted to the facility on 9/28/19 with the primary diagnosis of End Stage Renal Disease (ESRD). Review of the current orders report dated 6/26/21 revealed a BFR of 400 and DFR Autoflow 1.5, which would be 600. Review of the Treatment Sheet dated 7/6/21 revealed the treatment started at 12:49 and there was no documentation of BFR or DFR until 1:09 PM. From 1:09 PM to 3:07 PM the BFR was 300 and DFR 500. There was no documentation why the BFR and DFR were not at the ordered rates or why the prescribed flow was not met. Review of the Treatment Sheet dated 7/8/21 revealed the DFR 500 at 6:38 AM to 8:04 AM. There was no documentation why the DFR was not at the ordered rate. In an interview conducted on 7/14/21 at 1:15 PM CST, EI # 1 confirmed the staff failed to document reasons why the BFR and DFR were not at the ordered rates. 4. PI # 8 was admitted to the facility on 10/14/14 with the primary diagnosis of ESRD. Review of the current orders report dated 6/25/21 revealed a BFR of 400 and DFR Autoflow 2.0, which would be 800. Review of the Treatment Sheet dated 7/7/21 revealed the treatment started at 10:38 AM with the BFR of 300 and DFR at 600. From 11:09 AM to 2:34 PM the BFR was 375 and the DFR 800. There was no documentation why the BFR and DFR were not at the ordered rates or why the prescribed flow was not met. In an interview conducted on 7/14/21 at 1:06 PM CST, EI # 1 confirmed the staff failed to document reasons why the BFR and DFR were not at the ordered rates. 30952 5. PI # 1 was admitted to the facility 4/13/21 with diagnoses including Diabetic Glomerular Sclerosis and ESRD. Review of the current orders report dated 6/15/21 revealed a BFR of 400 and DFR Autoflow 1.5, which would be 600. Review of the Treatment Sheet dated 6/29/21 revealed the BFR was 215 and DFR 800 at 11:42 AM. From 12:36 PM to 1:04 PM, the BFR was 210 and DFR 400. From 1:43 PM until 2:04 PM, the BFR was 250 and DFR was 500. There was no BFR/DFR documented at 2:30 PM. At 3:03 PM, the BFR was 250 and DFR 500 until 4:06 PM. There was no documentation why the BFR and DFR were not at the ordered rates or why the prescribed flow was not met. Review of the Treatment Sheet dated 7/1/21 revealed the BFR was 300 and DFR 500 from 1:18 PM until 2:40 PM. At 3:06 PM, the BFR was

increased to 350 and DFR 600 until 5:05 PM. There was no documentation why the BFR was not 400 and DFR 600 as ordered. In an interview conducted on 7/14/21 at 1:09 PM, CST EI # 1, Director of Operations, confirmed the BFR and DFR were not at the ordered rates and there was no documentation why the prescribed blood flow was not achieved. 6. PI # 5 was admitted to the facility 1/3/21 with diagnoses including Diabetes with Renal Manifestations and ESRD. Review of the current orders report dated 5/13/21 revealed a BFR of 450 and DFR Autoflow 2.0, which would be 800. Review of the Treatment Sheet dated 7/1/21 revealed the BFR was 400 from treatment start at 11:30 AM until 2:35 PM. At 3:03 PM, the BFR was 400. The BFR was 0 at 3:40 PM and at 4:07 PM the BFR was 250. There was no reason documented why the BFR was not 450 as ordered and no documentation why the prescribed blood flow was not achieved. Review of the Treatment Sheet dated 7/8/21 revealed the BFR was 400 at start at 11:26 AM and increased to 450 at 12:00 PM. At 1:04 PM, the BFR was decreased to 400 and remained 400 until 3:05 PM. There was no reason documented why the BFR was not 450 as ordered and no documentation why the prescribed blood flow was not achieved. In an interview conducted on 7/14/21 at 1:24 PM CST, EI # 1 confirmed the BFR were not administered per physician orders. 7. PI # 4 was admitted to the facility 5/15/2020 with diagnoses including ESRD. Review of the current orders report dated 6/5/21 revealed a BFR of 450 and DFR Autoflow 1.5, which would be 800. Review of the Treatment Sheet dated 6/26/21 revealed the BFR was 400 and DFR 600 from treatment start at 1:10 PM to treatment end at 5:10 PM. There was no documentation why the BFR and DFR were not at the ordered rates or why the prescribed flow was not met. During an interview conducted on 7/14/21 at 1:28 PM CST, EI # 1 confirmed BFR and DFR was not administered as ordered.