

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012515	(X3) Date Survey Completed 04/20/2023
Name of Provider or Supplier Fresenius Medical Care Opelika	Street Address, City, State 2609 Village Professional Drive, Suite 2, Opelika, 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)
V0407	<p>PE-HD PTS IN VIEW DURING TREATMENTS CFR(s): 494.60(c)(4)</p> <p>Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement).</p> <p>This STANDARD is not met as evidenced by: Based on observations, facility policy, and interview, it was determined the staff failed to ensure all access sites were visible during dialysis treatments. This affected Patient Identifier (PI) # 20, one of one patient dialyzing in the isolation unit, and had the potential to negatively affect all patients who dialyzed by this facility. Findings include: Facility Policy: Patient Monitoring and Safety checks During Hemodialysis (HD) Treatment Policy Number: 23502 Version 4 Policy: Patient monitoring and safety check guidelines: Note: All patients must be under continual observation... Safety Check Access: Safety Checks include: Ensure each patient's face and access are uncovered... Ensure all patient connections are ALWAYS secure and uncovered due to serious risk of exsanguinations that could go undetected if the access was covered... 1. An observation of care in the isolation room for PI # 20 was conducted on 4/23/23 at 8:39 AM. The surveyor observed PI # 20's vascular assess site was covered with a blanket. During the observation Employee Identifier (EI) # 7, Certified Clinical Hemodialysis Technician (CCHT) entered the isolation room at 8:42 AM, then exited at 8:47 AM. The access site remained covered. EI # 7 entered the room again at 9:15 AM to perform vital signs, and PI # 20 was observed uncovering the access site himself/herself to have the blood pressure cuff applied. The access site was covered from 8:39 AM to 9:15 AM, a total of 36 minutes. EI # 7 failed to instruct the patient to uncover the access site when he/she entered at 8:42 AM. An interview was conducted on 4/20/23 at 10:50 AM with EI # 1, Director of Operations who confirmed access sites should always remain visible.</p>