Department of Health & Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0391

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number	(X3) Date Survey Completed
	012515	08/06/2025
Name of Provider or Supplier	**Street Address, City, State**	
Fresenius Medical Care Opelika	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)
V0544	POC-ACHIEVE ADEQUATE CLEARANCE CFR(s): 494.90(a)(1) 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. This STANDARD is not met as evidenced by: Based on observations, review of patient Treatment Sheet (TS) documentation, and interview, it was determined the facility failed to ensure the dialysate flow rate (DFR) and blood flow rate (BFR) orders were followed. This affected one of five dialysate prescription verifications conducted, and included Patient Identifier (PI) # 1, and one of four TS reviews for early termination, and included PI # 2. Failure to delivery BFR and DFR according to physician orders was cited during the recertification survey conducted on 4/20/23. This failure to follow the dialysis prescription for DFR and BFR had the potential for problem meeting adequacy goals and could negatively affect the one hundred two incenter (IC) patients who dialyze at the facility. Findings include: 1. Dialysis prescription verifications conducted on 8/5/25 at 11:45 AM at station two with Employee Identifier (EI) # 3, Registered Nurse, revealed PI # 1's ordered DFR was 800 and the current DFR delivery was 500. EI # 3 confirmed staff had failed to follow the physician orders for DFR. 2. Observations of care were conducted on 8/5/25 from 4:05 PM to 4:50 PM and revealed four patients had remaining dialysis treatment time and the treatments were discontinued before completion, which included PI # 2. Review of PI # 2 's TS dated 8/5/25 revealed the ordered BFR was 400 and DFR was 2.0 (800). Further review of the 8/5/25 TS revealed the BFR was 350 and DFR 700 the entire three-hour twelve-minute

	treatment. An interview was conducted on 8/7/25 at 1:30 PM with EI # 1, Clinical Manager, who confirmed the staff failed to follow physician order for BFR/DFR delivery.