

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  01P001	<b>(X3) Date Survey Completed</b>  03/03/2022
<b>Name of Provider or Supplier</b>  Legacy Of Hope	<b>Street Address, City, State</b>  516 20th Street South, Birmingham, 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>E0000</b>	An unannounced Emergency Preparedness Organ Procurement Organization (OPO) Recertification Survey was conducted on-site at Legacy of Hope OPO on February 28 - March 3, 2022. Legacy of Hope was in substantial compliance with Medicare Regulations for Organ Procurement Organizations at CFR 486.360 - Condition for Coverage: Emergency Preparedness.
<b>Z0000</b>	An unannounced Organ Procurement Organization (OPO) Recertification Survey was conducted on-site at Legacy of Hope OPO on February 28 - March 3, 2022. Legacy of Hope was not in substantial compliance with Medicare Regulations at 42 CFR Part 486 - Conditions for Coverage: Organ Procurement Organizations. The OPO was out of compliance at the following Standard Level: Z175, Potential Donor Evaluation.
<b>Z0175</b>	<p>POTENTIAL DONOR EVALUATION CFR(s): 486.344(b)(5)</p> <p>[The OPO must do the following:] Obtain the potential donor's vital signs and perform all pertinent tests.</p> <p>This STANDARD is not met as evidenced by: Based on review of the Donor Record, policy review and staff interviews, the Organ Procurement Organization (OPO) failed to follow their policy to record donor vital signs hourly in the donor record or have evidence OPO staff continued to monitor the donor's vital signs in the three (3) hours prior to entering the operating room (OR) for organ recovery, for one (1) of ten (10) Donor Records reviewed (Donor Record #5). The findings include: Review of the Donor Record for Donor # 5 revealed this case was a Donation after Cardiac Death (DCD). A review of the DonorNet Electronic Medical Record (EMR) flowsheet with the date-time of vital signs revealed the OPO did not document hourly vital signs for three (3) hours. There were no vital signs documented, and the OPO was unable to provide evidence of</p>

documentation of vital signs hourly, from 10/8/21 at 11:00 am to the time the donor entered the operating room (OR) on 10/8/21 at 2:21 p.m. Review of Intraoperative Management sheet confirmed the Enter OR Date Time of 10/8/21 at 2:21 p.m. During an interview on 3/2/22 at 1:30 p.m. with Manager Donation Support #1, she stated "Vital signs are taken by the hospital staff hourly. The vital signs should then be documented on the flowsheet inside the electronic donor record." During an interview on 3/3/22 at 10:10 a.m. with Procurement Transplant Coordinator II # 1, he stated "The staff nurse (hospital staff) takes the vital signs. The Procurement Transplant Coordinator should document the information in iTransplant and upload to DonorNet for the recipient hospital to review for donor suitability." Review of the OPO Policy entitled "Donor Management" Document No: MGT 08.11; Revision: R4; Effective Date: 12/2/20 revealed, "The donor management process is characterized by thorough attention to the donor hemodynamics and good documentation. This is accomplished by monitoring and documenting donor vital signs and intake/output ..." Review the undated OPO document entitled "Legacy of Hope Donor Management Power Plan" revealed, "LoH (Legacy of Hope) Donor Evaluation: Vital Signs -Every one (1) hour (hr.) interval, STAT (with no delay)."