

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012508	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2006
NAME OF PROVIDER OR SUPPLIER BIRMINGHAM EAST DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1105 EAST PARK AVENUE BIRMINGHAM, AL 35235	
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V 144	<p>405.2136(d)(1) PERSONNEL P/P: STAFF QUALIFIED</p> <p>The governing body, through the chief executive officer of the ESRD facility, is responsible for maintaining and implementing written personnel policies and procedures that ensure that all members of the facility's staff are qualified to perform the duties and responsibilities assigned to them and meet such Federal, State, and local professional requirements as may apply.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on observation of staff, review of the policy and procedure manuals, and interview with the agency staff it was determined the facility failed to have a policy, orientation check list and competency checklist to ensure the nurses were qualified to administer Activase (used to restore Central Venous Catheter patency) and failed to ensure the facility's staff were qualified to add the correct Acid Concentrate Additives for the different baths prescribed for patients.</p> <p>Findings include:</p> <p>1. Review of medical record # 416766 revealed that the Registered Nurse (RN) administered Activase on 3/14/06 due to the inability to aspirate blood from the catheter access site.</p> <p>Review of the personnel record for the RN above revealed no documentation of a Competency Checklist for the administration of Activase.</p> <p>An interview with the Regional Director on 5/11/06 at 11:30 AM verified there was no documentation in the RN personnel record of a Competency Checklist for the administration of Activase.</p>	V 144		6/26/06
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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V 144	Continued From page 1 2. An observation was made of a patient start up on 5/10/06 at 11:15 AM with a dialysis bath of 2K-2.5 Ca++. Review of the patient's flow sheet revealed that the bath should have been 3K-2.5 Ca++. The RN then mixed the correct bath and provided 3K-2.5Ca++. An observation was made of a patient start up on 5/10/06 at 12:30 PM with a bath of 2K-2.5 Ca++. Review of the patient's flow sheet revealed that the bath should have been 3K-2.5 Ca++. The RN then mixed the correct bath and provided 3K-2.5Ca++. An interview with the Regional Director on 5/11/06 at 11:30 AM verified there was no policy, orientation check list or competency checklist to ensure the facility's staff were qualified to add the correct Acid Concentrate Additives for the different baths the facility was using.	V 144			
V 157	405.2136(f) PATIENT CARE POLICIES: WRITTEN The ESRD facility has written policies approved by the governing body concerning the provision of dialysis and other ESRD services to patients. This STANDARD is not met as evidenced by: Based on observation of staff, review of the policy and procedure manuals, and interview with the agency staff it was determined the facility failed to ensure that a policy was written for the correct Acid Concentrate Additives for the different baths the facility was using. Findings include:	V 157		6/26/06	

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V 157	Continued From page 2 An observation was made of a patient start up on 5/10/06 at 11:15 AM with a bath of 2K-2.5 Ca++. Review of the patient's flow sheet revealed that the bath should have been 3K-2.5 Ca++. The RN then mixed the correct bath and provided 3K-2.5Ca++. An observation was made of a patient start up on 5/10/06 at 12:30 PM with a bath of 2K-2.5 Ca++. Review of the patient's flow sheet revealed that the bath should have been 3K-2.5 Ca++. The RN then mixed the correct bath and provided 3K-2.5Ca++. An interview with the Clinical Director on 5/11/06 at 11:30 AM verified there was no written policy for additives to be used for the different baths the facility was using.	V 157			
V 227	405.2138(e) GRIEVANCE MECHANISM All patients are encouraged and assisted to understand and exercise their rights. Grievances and recommended changes in policies and services may be addressed to facility staff, administration, the network organization, and agencies or regulatory bodies with jurisdiction over the facility, through any representative of the patient's choice, without restraint or interference, and without fear of discrimination or reprisal. This STANDARD is not met as evidenced by: Based on observation of the patient common area and 16 of 16 records reviewed, the facility failed to inform the patients of their right to address grievances through the network organization or the State agency. Findings include:	V 227		6/26/06	

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V 227	Continued From page 3	V 227			
V 240	<p>During the initial tour of the facility on 5/9/06 at 10:30 AM, there was no grievance or patient rights notice posted with telephone numbers of the network organization or the State agency.</p> <p>Sixteen of sixteen patient records reviewed did not contain documentation of a grievance mechanism with the telephone numbers of the network organization or the State agency.</p> <p>405.2139(a) MEDICAL RECORD: ORDERS</p> <p>All medical records contain diagnostic and therapeutic orders.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on review of medical records, policies and procedures and interviews the facility failed to ensure orders were obtained for 1 of 1 patients observed receiving IDPN (Intradialytic Parenteral Nutrition) and 1 of 2 patients receiving Activace.</p> <p>Findings include:</p> <p>1. Medical Record # 9 was observed on 5/9/06 to receive IDPN during the hemodialysis treatment. The labeled contents on the bag Amino Acid 15% 500 ml (millileters) and Lipids 20% 100 ml. The total volume to infuse was 600 ml (millileters) and the fluids were infusing at 200 cc/hr for three hours for a total of 500 calories.</p> <p>The policy and procedure titled, "Intradialytic Parenteral Nutrition (IDPN) included, ".....The patient's attending nephrologist provides written orders that include: IDPN formulation to be administered, including any specific additives and time frame for additives. Time rate and volume of</p>	V 240		6/26/06	

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V 240	<p>Continued From page 4 infusion. Additional laboratory tests and frequency of ordered tests."</p> <p>A review of the medical record revealed no physician orders for this nutritional treatment.</p> <p>A review of the Registered Dietitian progress notes, dated 3/29/06, included, "Nutrition remains inadequate. Encouraged increased caloric intake with intake of dense foods.....IDPN aggressive nutritional intervention continues with each tx (treatment)." There was no further documentation of an assessment of the specific needs or evidence the patient's nutritional needs were being met.</p> <p>A review of the treatment flow sheets from 4/11/06 to 5/9/06 revealed no documentation the patient received the IDPN.</p> <p>An interview with the nurse manager on 5/10/06 at 2:30 PM confirmed no physician orders had been obtained for this treatment.</p> <p>2. Medical record # 7 began dialysis on 2/16/06. Review of the flowsheets revealed the patient was given Activase on 3/14/05 at 9:29 AM, due to the nurses inability to aspirate blood from the patient's Central Venous Catheter. There was no documentation as to the amount of Activase given and there was no documentation of a physician's order for the administration of Activase.</p> <p>An interview with the Regional Director on 5/11/06 at 11:45 AM verified there was no documentation of a physician's order for the administration of Activase.</p>	V 240			

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V 240	Continued From page 5 3. Medical record # 2 began dialysis on 3/18/05. Review of the patient's flowsheets revealed the nurse administered Clonidine 0.1 mg (milligram) on 8/11/05 at 1:18 PM due to systolic blood pressure of 182. Review of the physicians orders dated 3/18/05 revealed an order to administer Clonidine 0.1 mg for SBP (systolic blood pressure) >200. There was no documentation of an order to administer Clonidine for the SBP 182.	V 240			
V 258	405.2140(a)(2) PE: EQUIPMENT MAINTENANCE PROGRAM All electrical and other equipment used in the facility is maintained free of defects which could be a potential hazard to patients and personnel. There is established a planned program of preventive maintenance of equipment used in dialysis and related procedures in the facility. This STANDARD is not met as evidenced by: Based on observations, review of facility policies and interview with management staff, the facility failed to ensure that the conductivity was checked before each treatment for two of two patients. Findings include: The policy titled "Prescription Verification and Safety Checks" included, "Procedure: Trained teammates will verify the dialysis prescription and perform safety checks prior to each treatment initiation...Safety checks: ... Manual conductivity appropriate to sodium and bicarbonate level prescribed. pH between 6.0-8.0 by test strip. Rationale: Conductivity should not be less than 13.5 or greater than 15.0 to prevent cell	V 258		6/26/06	

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V 258	Continued From page 6 destruction." Observations during the survey on 5/10/06 at 11:00 AM revealed two patient dialysis treatments were initiated without the conductivity or pH manually checked using a meter or test strips. An interview with the Regional Director on 5/11/06 at 12:30 PM confirmed the machine conductivity is manually checked on the machines once a day and is not manually checked for conductivity or pH prior to each patient's treatment initiation as required in the facility policy.	V 258		
V 280	405.2140(d)(2) EMERGENCY PREP: PERIODIC DRILLS All personnel are trained, as part of their employment orientation, in all aspects of preparedness for any emergency or disaster. The emergency preparedness plan provides for orientation and regular training and periodic drills for all personnel in all procedures so that each person promptly and correctly carries out a specific role in case of an emergency. This STANDARD is not met as evidenced by: Based on review of fire drill reports, policies and procedures and interviews it was determined the facility failed to follow their policy for emergency preparedness. Findings include: The policy titled, "Fire/Disaster Drills" included, "Fire drills are to be conducted quarterly in order that all teammates are familiar with the appropriate steps which are to be followed during	V 280		6/26/06

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V 280	Continued From page 7 a fire." A review of the Fire Drill reports for 2005 revealed a fire drill was conducted on 1/24/05. There was no other fire drills conducted in 2005. Interview with the facility manager on 5/10/06 at 10:30 AM confirmed only one fire drill had been conducted in 2005.	V 280			
V 431	405.2162(a) REGISTERED NURSE The dialysis facility employs at least one full time qualified nurse responsible for nursing service. (See 405.2102.) This STANDARD is not met as evidenced by: Based on observation of care and interview with the facility staff, it was determined the agency failed to follow the prescribed treatment orders in 2 of 8 patient's that were interviewed and 5 of 5 records reviewed of patients with diabetes. Findings include: 1. Medical record # 11 began dialysis on 3/21/06 with the diagnoses including Diabetes Mellitus. An interview was conducted with the Clinical Director on 5/9/06 at 11:00 AM which verified that the bath 2K-2.5 Ca++ was the only bath that was piped in to the unit. During an interview with the patient on 5/9/06 at 3:00 PM the surveyor noted that there was no jug for acid. Review of the current physician's orders revealed the bath to be 1K-2.5 Ca++ due to the elevated K	V 431		6/26/06	

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V 431	<p>Continued From page 8 level of 6.7 on 4/13/06.</p> <p>Review of the standing orders dated 3/21/06 revealed instructions for the staff to perform foot checks weekly and blood glucose each treatment.</p> <p>Review of 13 flowsheets from 4/1/06 to 5/9/06 revealed only 4 blood glucose levels were documented and no foot checks had been completed.</p> <p>2. Medical record # 5 began dialysis on 2/26/02. During an interview with the patient on 5/10/06 at 10:30 AM the patient was being treated with a 210H dialyzer. Review of the flowsheet revealed the patient should have been on a 170H.</p> <p>An interview with the Clinical Director on 5/10/06 at 11:30 AM verified the patient had the wrong dialyzer.</p> <p>3. Medical record # 4 began dialysis on 1/24/06 with diagnoses including Diabetes Mellitus. Review of the standing orders dated 1/24/06 revealed instructions for the staff to perform foot checks weekly and blood glucose each treatment. Review of 12 flowsheets between 4/11/06 and 5/6/06 revealed no documentation of a foot check and 3 of 12 flowsheets contained no documentation of a blood glucose.</p> <p>4. Medical record # 3 began dialysis on 12/16/04 with diagnoses including Diabetes Mellitus. Review of the standing orders dated 12/16/04 revealed instructions for the staff to perform foot checks weekly and blood glucose each treatment. Review of 13 flowsheets between 10/01/05 and 11/21/05 revealed no documentation of a foot check and 3 of 12 flowsheets contained no</p>	V 431			

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V 431	Continued From page 9 documentation of a blood glucose. 5. Medical record # 6 began dialysis on 8/1/05. Review of the standing orders dated 8/1/05 revealed instructions for the staff to perform foot checks weekly and blood glucose each treatment. Review of the flowsheets between 4/01/06 and 4/29/06 revealed no documentation of a foot check and 3 of 12 flowsheets contained no documentation of a blood glucose. 6. MR # 9 was admitted for hemodialysis with diagnoses including Diabetes Mellitus and End Stage Renal Disease. A review of the medical record treatment flow records from 4/11/06 to 5/9/06 revealed 9 of 12 records did not include glucose results. There was no documentation of foot checks for this time period.	V 431			