

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012501	(X3) Date Survey Completed 06/30/2021
Name of Provider or Supplier Gadsden Dialysis	Street Address, City, State 409 South First Street, Gadsden, 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)
V0111	<p>IC-SANITARY ENVIRONMENT CFR(s): 494.30</p> <p>The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas.</p> <p>This STANDARD is not met as evidenced by: Based on observation, review of facility policy and procedure and interviews, it was determined the facility failed to ensure the staff: followed the facility policy for the initiation of a dialysis treatment with an arteriovenous fistula (AVF). This affected 1 of 2 observations conducted and did affect Patient Identifier (PI) # 2 and had the potential to negatively affect all patients served by the facility. Findings include: Title: AV (Arteriovenous) Fistula or Graft Cannulation With Nipro or Medisystems Safety Fistula Needles (SFN) and Administration of Heparin Loading Dose. Policy Number: 1-04-01E Revised Date: April 2019 Procedure: 8. Locate and palpate the needle cannulation sites prior to skin preparation... 10. While maintain aseptic technique, prep each planned needle site by applying a 70% alcohol prep pad to each site using a circular rubbing motion, center out... 13. Do not palpate insertion site once area has been prepped... 1. During observations of care on 6/28/21 at 9:11 AM the surveyor observed Employee Identifier (EI) # 7, Certified Clinical Hemodialysis Technician, prepping the sites with an antiseptic for cannulation of PI # 2 at station 19. After the sites were prepped EI # 7 then palpated/touched both sites with his/her fingers without repeating skin antiseptics before cannulation, thus leading to potential contamination. An interview was conducted on 6/28/21 at 11:50 AM with EI # 1, Facility Administrator, who verified staff failed to follow the facility policy for accessing of an AV Fistula.</p>