

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  012506	<b>(X3) Date Survey Completed</b>  04/13/2023
<b>Name of Provider or Supplier</b>  Dothan Dialysis	<b>Street Address, City, State</b>  216 Graceland Drive, Dothan, 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>V0111</b>	<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 observations, facility procedure and interviews, it was determined the facility failed to ensure staff completed vascular access care according to facility procedure. This affected Patient Identifier (PI) # 1 and PI # 9 in two of four observations for access initiation with an AVF/AVG (Arteriovenous Fistula or Graft) and had the potential to negatively affect all patients who dialyze at the facility. Findings include: Facility Procedure: AV (Arteriovenous) Fistula or Cannulation with Nipro or Medisystems Safety Fistula Needles (SFN) and Administration of Heparin Loading Dose. Procedure Number: 1-04-01E Revised Date: October 2022 Procedure: 1. ...wash access site with appropriate antibacterial soap...If patient unable to wash access site, patient care teammate will clean access extremity with skin cleansing agent... 5. Perform inspection, auscultation, and palpation on entire length of access... 10....prep each planned needle site...alcohol prep pad... ..13. Do not palpate insertion site once area has been prepped. Rationale: Once the access site has been prepped, touching it will contaminate the site and possibly allow for the introduction of bacteria during cannulation. 1. During an observation of care on 4/12/23 at 10:35 AM at station 15, the surveyor observed EI (Employee Identifier) # 4, CCHT (Certified Clinical Hemodialysis Technician), perform access site antisepsis to PI # 1's AVF /AVG site, cannulate access site one, apply tape and a dressing. EI # 4 palpated /touched access site two with his/her finger then cannulated the access. EI # 4 palpated /touched access site two with his/her finger without repeating skin antisepsis before cannulation, thus leading to potential contamination. An interview was conducted on 4</p>

/13/23 at 11:05 AM with EI # 1, Facility Administrator, who verified staff failed to follow the facility procedure for cannulating an AVF/AVG. 40119 2. During an observation of care on 4/12/23 at 11:25 AM at station 11, the surveyor observed EI # 9, Patient Care Technician (PCT), prep PI # 9's AVF/AVG site. After EI # 9 applied antiseptic to the AVF/AVG site, EI # 8, CCHT, entered station 11 to perform the cannulation. EI # 8 palpated the AVF site then proceeded to cannulate the AVF without repeating antisepsis to the AVF sites, thus leading to potential contamination. An interview was conducted on 4/13/23 at 11:05 AM with EI # 1 who verified staff failed to follow the facility policy for accessing of an AVF/AVG.