

<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>V0122</b>	<p><b>IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL</b> CFR(s): 494.30(a)(4)(ii)</p> <p>[The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>This STANDARD is not met as evidenced by: Based on observations, facility policy, and interviews, it was determined the facility failed to ensure staff followed the facility policy for cleaning and disinfection of the dialysis station between patients. This affected one of two blood spills observed during floor observations and eight of eight observations of dialysis station cleaning /disinfection and had the potential to affect all patients who dialyze at this facility. Findings include: Facility Policy: Infection Control for Dialysis Facilities Policy number: 1-05-01 Revision date: April 2023 Purpose: To minimize the spread of infections or blood borne pathogens in the dialysis facility environment. Disinfection ...12. Cleaning and/or disinfection of equipment and work surfaces will be performed as soon as possible following exposure to blood or potentially infectious materials (i.e. used or brought into the station)... a. Prior to routine disinfection, remove all visible blood... iii. Cleaning of visible blood should be performed when first observed. b. Use an appropriate disinfectant such as 1:100 (one to one hundred) bleach solution for routine disinfection of environmental surfaces. ...ii. Sufficient disinfectant should be applied so that surfaces are visibly wet. iii. Surfaces should be allowed to air dry in order to provide sufficient disinfectant contact time... 13. At the end of each treatment, the dialysis station will be cleaned and disinfected. ...ii. Priming containers are to be emptied prior to disinfection... 1. During a floor observation on 4/11/23 at 10:39 AM, two drops of blood were observed on the floor below the reclined foot rest of Patient Identifier (PI) # 7 at station 2. The blood drops remained on the floor throughout PI #</p>

7's treatment. At 3:21 PM, following station 2 being cleaned and clean supplies brought to the station in preparation for the next patient, the two drops of blood remained on the floor of station 2. The staff failed to clean blood spill immediately and clean visible blood prior to the routine disinfection of the station. An interview was conducted on 4/13/23 at 11:04 AM with Employee Identifier (EI) # 1, Facility Administrator, who confirmed the staff failed to clean the blood spill per the facility policy. 2. During an observation for cleaning and disinfection of dialysis station # 12 on 4/11/23 at 10:45 AM, EI # 5, Patient Care Technician (PCT), failed to clean the top of the left chair table and IV (intravenous) pole. An interview was conducted on 4/13/23 at 11:05 AM with EI # 1 who confirmed staff failed to follow facility policy for cleaning and disinfection of the dialysis station. 3. During a floor observation on 4/11/23 at 11:35 AM, EI # 9, PCT, was observed to place several bleach cloths at station 14, 15, 16 and 17, and the following observations were made while observing the cleaning and disinfection of the dialysis station: Station 17 was cleaned at 11:43 AM by EI # 9. During the observation, EI # 9 reclined the treatment chair and opened the arm rests of the treatment chair. EI # 9 cleaned the front of the reclined treatment chair and each arm rest individually then immediately placed the chair into an upright position and closed the arm rests without allowing the cleaned surfaces to air dry. Station 16 was cleaned at 12:17 PM by EI # 9, 47 minutes after the bleach cloths were placed at the station. During the observation, EI # 9 reclined the treatment chair and opened the arm rests of the treatment chair. EI # 9 cleaned the front of the reclined treatment chair and each arm rest individually then immediately placed the chair into an upright position and closed the arm rests without allowing the cleaned surfaces to air dry. EI # 9 then exited station 16 then resumed cleaning station 16 at 12:28 PM, 53 minutes after the bleach cloths were placed at the station. EI # 9 proceeded to clean the dialysis machine, blood pressure cuff, television control, dialysis tubing, wall box and counter. After the dialysis machine, blood pressure cuff, television control, wall box and counter were each individually cleaned the surface of each item was not visibly wet. Station 15 was cleaned at 12:35 PM by EI # 9, 60 minutes after the bleach cloths were placed at the station. EI # 9 cleaned the dialysis station including the following items: the treatment machine, treatment chair, wall box, station counter, blood pressure cuff and television control. After each item was cleaned in the dialysis station the surface of the item was not visibly wet. Station 14 was cleaned at 12:45 PM by EI # 9, 70 minutes after the bleach cloths were placed at the station. EI # 9 cleaned the dialysis station including the following items: the treatment machine, treatment chair, wall box, station counter, blood pressure cuff and television control. After each item was cleaned in the dialysis station the surface of the item was not visibly wet. An interview was conducted on 4/13/23 at 11:04 AM with EI # 1 who confirmed the PCT failed to follow the facility policy by not allowing the surfaces of the dialysis station to be visibly wet and to air dry. 4. An observation of cleaning and disinfection of station 3 was conducted on 4/11/23 at 12:50 PM. EI # 6, RN (Registered Nurse), removed the prime waste container from the side of the dialysis machine, cleaned the waste container and immediately replaced the container onto the side of the dialysis machine. EI # 6 failed to allow the prime waste container to dry before replacing the waste container onto the dialysis machine. An interview was conducted on 4/13/23 at 11:05 AM with EI # 1 who confirmed staff failed to follow the policy for cleaning and disinfection of the dialysis station. 5. During an observation for cleaning and disinfection of the dialysis station on 4/11/23 at 1:40 PM at station 6, EI # 5 failed to remove the prime waste container from dialysis machine, clean the outside surface of the container, clean the surface of the dialysis machine under the waste container and clean the countertop surrounding the station. An interview was conducted on 4/13/23 at 11:05 AM with EI # 1 who confirmed staff failed to follow the policy for cleaning and disinfection of the dialysis station. 6.

During an observation for cleaning and disinfection of dialysis station 5 on 4/12/23 at 9:25 AM, EI # 8, CCHT (Certified Clinical Hemodialysis Technician) failed to remove the prime waste container from the dialysis machine, clean the surface of the dialysis machine under the waste container, clean the right outside surface of the chair arm, clean the right tray table, and clean the underside of the left tray table. An interview was conducted on 4/13/23 at 11:05 AM with EI # 1 who confirmed staff failed to follow facility policy for cleaning and disinfection of the dialysis station.  
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