

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012506	(X3) Date Survey Completed 04/13/2023
Name of Provider or Supplier Dothan Dialysis	Street Address, City, State 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.		

(X4) ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency should be preceded by full regulatory or LSC identifying information)
V0147	<p>IC-STAFF EDUCATION-CATHETERS/CATHETER CARE CFR(s): 494.30(a)(2)</p> <p>Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters. II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].</p> <p>This STANDARD is not met as evidenced by: Based on review of observations, facility procedure, and interview, it was determined the facility failed to ensure staff performed Central Venous Catheter (CVC) care per facility policy. This affected two of three observations for CVC exit site care, including Patient Identifier (PI) # 7 and PI # 6, one of three observations of initiation of dialysis with a CVC, including PI # 8, and had the potential to negatively affect all patients with CVC's who dialyze at the facility. Findings include: Facility Policy: Central Venous Catheter (CVC) Care with Clearguard HD (Hemodialysis) Antimicrobial End Caps Procedure Policy Number: 1-04-02 B Revised Date: April 2023 ... Perform a 15 second hub scrub of the CVC during the process of connecting or disconnecting from the blood lines... ... Device Disinfectant and Skin Antiseptic...2 % Chlorhexidine Gluconate/70 % Isopropyl Alcohol...Effective Contact Time...30 seconds back and forth motion... Procedure ...8. Holding catheter with the non-</p>

dominant hand and using aseptic technique, clean exit site with 2 % Chlorhexidine Gluconate/70 % Isopropyl Alcohol swab for a minimum of 30 seconds, apply to the CVC exit site in a "back and forth" pattern, using gentle friction... 37. Document findings and procedure in patient's electronic health record. 1. An observation was conducted on 4/11/23 at 10:26 AM at station 2 with Employee Identifier (EI) # 6, Registered Nurse (RN), to observe CVC exit site care provided to PI # 7. During the observation, EI # 6 cleansed the CVC exit site with a 2 % Chlorhexidine Gluconate/70 % Isopropyl Alcohol swabstick for 10 seconds. EI # 6 failed to cleanse the CVC exit site for 30 seconds per the facility procedure. An interview was conducted on 4/13/23 at 11:04 AM with EI # 1, Facility Administrator, who confirmed EI # 6 failed to cleanse the CVC exit site for 30 seconds per the facility procedure. 41624 2. An observation was conducted on 4/11/23 at 11:30 AM at station # 7 with EI # 7, RN, to observe initiation of dialysis with a CVC provided to PI # 8. During the observation, EI # 7 cleansed the CVC hubs with a 2 % Chlorhexidine Gluconate/70 % Isopropyl Alcohol swabstick for 9 seconds before connecting the blood lines. EI # 7 failed to cleanse the CVC connection hubs for 15 seconds per the facility procedure. An interview was conducted on 4/13/23 at 11:04 AM with EI # 1 who confirmed EI # 7 failed to cleanse the CVC hubs for 15 seconds per the facility procedure. 30952 3. An observation of CVC exit site care and dialysis treatment initiation for PI # 6 was conducted on 4/11/23 at 12:02 PM at station 8 with EI # 2, RN. Review of PI # 6's Treatment Details Report (TDR) dated 4/11/23 failed to reveal documentation of the specific care provided to PI # 6's CVC exit site during the observation. An interview was conducted on 4/13/23 at 11:20 AM with EI # 1 who confirmed the TDR documentation should include the specific CVC exit site care performed and staff failed to document the CVC exit site care provided during the observation.