

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

PRINTED: 11/30/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012588</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/26/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>SYLACAUGA DIALYSIS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1385 WEST FORT WILLIAMS STREET SYLACAUGA, AL 35150</b>	
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V 145	<p>405.2136(d)(2) PERSONNEL P/P: SAFE/SANITARY ENVIRONMENT</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 a safe and sanitary environment for patients and personnel exists.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on interview and observation of the facility medications in house, the facility failed to ensure that outdated medications were removed from availability for patient care.</p> <p>Findings Include:</p> <p>An observation of the Emergency Crash Cart was conducted on 10/26/06 at 8:30 AM. The following medications were found to be expired as follows: 5 vials of Epinephrine 1:1000 1mg (milligrams) /ml (milliliter) expired 1 August 06 5 vials of Diphenhydramine 50 mg/ml expired September 06 Nitrostat 0.4/ 1/150 gr (grains) expired February 06.</p>	V 145		
V 240	<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 record review and interview with staff, it was determined the facility failed to ensure orders were documented prior to providing treatments in 1 of 2 records reviewed of a transient patients.</p>	V 240		

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 240	Continued From page 1 Finding include:  1. MR # 3 was admitted as a visiting patient on 1/2/06 for four dialysis treatment. Review of the Hemodialysis Standing Orders from the sending facility revealed the following prescription: Blood Flow 450; Dialyzer 160 NRE; Dialysate Bicarb 40, Sodium 140, Calcium 2.5, and Potassium 3.0. Review of the medical record revealed no documentation of a prescription from the receiving physician.  Review of the Post Treatment Reports dated 1/2/06, 1/6/06, 1/9/06, and 1/13/06 revealed no documentation of the Prescription Information for the Dialyzer, Blood Flow, or Bath. There was no documentation of the bath given in the medical record. Review of the Patient Rounding Report revealed the patient was placed on 170H for 2 treatments and a PSN 170 for the other 2 treatments.  An interview with the Facility Administrator on 10/26/06 at 1:00 PM verified there was no documentation of a physician's order prior to treatment nor was there documentation of the bath the patient received.	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:	V 258			

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V 258	<p>Continued From page 2</p> <p>Based on observation, interview, record review and the manufacturer's recommendation, the facility failed to provide preventive maintenance to five of thirteen dialysis machines in use as recommended by the manufacturer and the facility failed to ensure that the conductivity was checked before each treatment for 5 of 5 patients.</p> <p>Findings include:</p> <p>The dialysis machines' preventive maintenance, "Centurysystem 3 Preventive Maintenance Procedure, The Centurysystem 3 Preventive Maintenance program must be completed every 3000 hours, or one year of machine operation. whichever comes first."</p> <p>Review of preventive maintenance records performed by the facility revealed machines # 2, 3, 6, 9, 14 and 15 had no preventive maintenance documented as performed.</p> <p>Interview with facility staff 10/26/06 at 10:00 AM confirmed the lack of documented maintenance on machines # 2, 3, 6, 9, 14 and 15.</p> <p>*****</p> <p>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 destruction."</p>	V 258			

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V 258	Continued From page 3 Observations during the survey on 10/25/06 at 9:30 to 11:00 AM revealed 5 patient dialysis treatments were initiated without the conductivity or pH manually checked using a meter or test strips.  An interview with the Facility Administrator and the RN on 10/25/06 at 11:30 PM verified conductivity is to be manually checked on the machines prior to each patient's treatment initiation as required in the facility policy.	V 258			
V 261	405.2140(a)(5) PE: WATER TREATMENT  The ESRD facility must employ the water quality requirements listed in 405.2140(a)(5)(ii) of this section developed by the Association for the Advancement of Medical Instrumentation (AAMI) and published in "Hemodialysis Systems," second edition, which is incorporated by reference.  Required water quality requirements are those listed in AAMI sections 3.2.1, Water Bacteriology; 3.2.2 Maximum Level of Chemical Contaminants; and in Appendix B: Guideline for Monitoring Purity of Water Used for Hemodialysis as B1 through B5.  Incorporation by reference of the AAMI's "Hemodialysis Systems," second edition, 1992, was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. If any changes in "Hemodialysis Systems," second edition, are also to be incorporated by reference, a notice to that effect will be published in the Federal Register.	V 261			

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V 261	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on review of Daily Water Quality Monitoring Log, tour, review of the facility policies and interview, it was determined the facility failed to ensure the hardness of the RO water was with in the guidelines as established by the facility and the hardness was check as indicated by the approved agency policy.</p> <p>Findings include:</p> <p>Agency Policy: Hardness Testing: Water</p> <p>Purpose: To ensure that the water softener is functioning properly and that the water hardness level remains &lt;1.0 grain per gallon (gpg).</p> <p>Policy:</p> <p>1. Hardness testing of water is done each treatment day:</p> <p>After the RO has been operating for no less than 15 minutes and prior to the first patient treatment</p> <p>At the end of the day after the last patient shift and reuse is complete.</p> <p>A tour of the facility stock room was conducted on 10/24/06 at 2:00 PM which revealed 4 bottles of 50 strips each, Low Range Water Hardness Reagent Strips with a expiration dates of 6/6/06. The water hardness had already been checked and documented as 0.3 while 5 patients were still being dialyzed.</p> <p>A tour of the Water Room on 10/24/06 at 2:15 PM revealed revealed a bottle with 7 Low Range Water Hardness Reagent Strips which expired on 6/6/06.</p>	V 261			

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V 261	Continued From page 5  An observation was made on 10/25/06 at 1:45 PM with the Patient Care Tech (PCT) checking the water hardness using the expired reagent strips. The PCT then rechecked the water hardness with a different type strip and the water hardness was measured at 1.5 gpg.  On 10/26/06 at 8:00 AM the surveyor observed the Daily Water Quality Monitoring Log and there was no documentation that the water hardness had been checked that morning. The surveyor then asked the PCT when the water hardness was checked and the surveyor was told, "after the system has been running for 2 hours". There was already 10 patients being dialyzed.	V 261			
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 interview and record review the facility failed to hold periodic drills to ensure staff preparedness for the safety of patients in case of a fire.	V 280			

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V 280	Continued From page 6  Findings include:  Agency Policy: Fire/Disaster Drills Policy Fire drills are conducted quarterly in order that all teammates are familiar with the appropriate steps which are to be followed during a fire.  Review of fire drill documentation revealed no fire drills had been held between 1/06/06 and 7/28/06. The surveyor requested for additional fire drills from the Facility Administrator between 1/06/06 and 7/28/06 and none was provided for review.	V 280			
V 284	405.2140(d)(5) EMERGENCY PREP: PATIENTS INFORMED  Patients are trained to handle medical and nonmedical emergencies. Patients must be fully informed regarding what to do, where to go, and whom to contact if a medical or nonmedical emergency occurs.  This STANDARD is not met as evidenced by:  Based on record review and interview with facility staff, it was determined that the facility failed to ensure that patients are trained for medical and nonmedical emergencies in 6 of 6 records reviewed that were current patients for the 3rd quarter of 2006.  Findings include:  Review of MR #s 5, 6, 7, 9, 10, and 11 Emergency Procedure Patient Instruction revealed no documentation of review with the patient for the 3rd quarter of 2006.	V 284			

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V 284	Continued From page 7 An interview with the Facility Administrator on 10/26/06 at 12:30 PM verified there was no documentation of the 3rd quarter review for emergencies.	V 284			
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 record review and interview with the staff, it was determined the agency failed to ensure the Registered Nurse (RN) followed the physician orders in 6 of 6 records with Diabetes Mellitus and 2 of 2 patients receiving Intradialytic Parenteral Therapy (IDPN).  Findings include:  1. Medical record # 5 was first seen in the agency on 4/21/03 with diagnosis that included Diabetes Mellitus. Review of the physician orders dated 2/24/06 revealed orders for IDPN every treatment to run at 163 ml per hour for a total volume of 650 ml.  Review of the physician orders dated 2/28/06 revealed instructions for the nurse to perform foot checks each week for diabetic patients and patients with peripheral vascular disease.  Review of the 13 Post treatment Reports between 9/25/06 and 10/23/06 revealed no documentation of the administration of the IDPN or that foot checks were performed.  An interview with the facility Administrator on	V 431			

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V 431	<p>Continued From page 8</p> <p>10/26/06 at 12:30 PM verified there was no documentation of the administration of the IDPN or that foot checks were performed.</p> <p>2. Medical record # 11 was first seen in the agency on 5/9/05 with diagnosis that included Diabetes Mellitus. Review of the physician orders dated 8/2/06 revealed orders for IDPN every treatment for a total volume of 250 ml.</p> <p>Review of the physician orders dated 2/28/06 revealed instructions for the nurse to perform foot checks each week for diabetic patients and patients with peripheral vascular disease.</p> <p>Review of the 13 Post treatment Reports between 9/25/06 and 10/23/06 revealed no documentation of the administration of the IDPN or that foot checks were performed.</p> <p>An interview with the facility Administrator on 10/26/06 at 12:30 PM verified there was no documentation of the administration of the IDPN nor the foot checks were performed.</p> <p>3. Medical record # 1 was first seen in the agency on 4/20/06 with diagnosis that included Diabetes Mellitus. Review of the physician orders dated 4/20/06 revealed instructions for the nurse to perform foot checks each week for diabetic patients and patients with peripheral vascular disease.</p> <p>Review of the 7 Post treatment Reports between 7/15/06 and 8/10/06 revealed no documentation foot checks were preformed.</p> <p>4. Medical record # 6 was first seen in the agency on 9/24/02 with diagnosis that included Diabetes</p>	V 431			

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V 431	<p>Continued From page 9</p> <p>Mellitus. Review of the physician orders dated 2/28/06 revealed instructions for the nurse to perform foot checks each week for diabetic patients and patients with peripheral vascular disease.</p> <p>Review of the 13 Post treatment Reports between 9/25/06 and 10/23/06 revealed no documentation foot checks were preformed for the weeks of 9/25/06, 10/2/06, and 10/9/06.</p> <p>5. Medical record # 7 was first seen in the agency on 11/1/04 with diagnosis that included Diabetes Mellitus. Review of the physician orders dated 2/28/06 revealed instructions for the nurse to perform foot checks each week for diabetic patients and patients with peripheral vascular disease.</p> <p>Review of the 13 Post treatment Reports between 9/25/06 and 10/23/06 revealed no documentation foot checks were preformed for the weeks of 9/25/06, 10/2/06, and 10/9/06.</p> <p>6. Medical record # 10 was first seen in the agency on 12/5/05 with diagnosis that included Diabetes Mellitus. Review of the physician orders dated 2/28/06 revealed instructions for the nurse to perform foot checks each week for diabetic patients and patients with peripheral vascular disease.</p> <p>Review of the 13 Post treatment Reports between 9/26/06 and 10/24/06 revealed no documentation of foot checks preformed for the weeks of 9/25/06, 10/2/06, and 10/9/06.</p>	V 431			