STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012500	A. BUILDING ______ B. WING ______	04/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FMC CAPITOL CITY	**255 SOUTH JACKSON STREET** **MONTGOMERY, AL 36104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 144	405.2136(d)(1) PERSONNEL P/P: STAFF QUALIFIED	V 144		4/17/06

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 all members of the facility's staff are qualified to perform the duties and responsibilities assigned to them and meet such Federal, State, and local professional requirements as may apply.

This STANDARD is not met as evidenced by:

Based on review of facility policies and review of personnel records revealed the facility failed to ensure that the policy on Corrective Action was followed concerning documentation and cannulation.

Findings include:

Facility Policy: Corrective Action

....Generally, the steps may be skipped based upon the severity of the infraction.

Step 1

Verbal Warning (Counseling): This is the first step in the corrective action process and involves discussion between the supervisor and the employee. The supervisor identifies the problem, the impact on co-workers and department operations, the measures necessary to rectify the situation and the consequences if no change occurs.

Step 2

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012500	A. BUILDING ______ B. WING ______	04/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FMC CAPITOL CITY	255 SOUTH JACKSON STREET MONTGOMERY, AL 36104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 144	Continued From page 1 Written warning: Written warning may be issued as a first step for a serious violation or as the second corrective action following one or two verbal warnings. Step 3 Final Written Warning: A Final Written Warning is the last chance for an employee to demonstrate acceptable performance or conduct. It is used when neither the Verbal Warning nor the Written Warning has corrected the unsatisfactory conduct or performance. Step 4 Suspension Disciplinary Suspension:...Suspension may also follow previous verbal and written warnings. Step 5 Termination: Termination is the final step in the corrective action process. Termination may also occur immediately as a result of a serious violation by the employee, including but not limited to misconduct, harassment, insubordination, or actions jeopardizing patient care. Review of PCT # 1's personnel record revealed the following Corrective Actions: 4/8/04 - Written - " Numerous patient complaints related to patient care and conduct. Investigation revealed that patients c/o PCT ....poor cannulation technique. "	V 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012500	A. BUILDING ______ B. WING ______	04/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FMC CAPITOL CITY	255 SOUTH JACKSON STREET MONTGOMERY, AL 36104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 144	Continued From page 2 7/8/05 - " Final Written - Infiltrated 3 patients within the last week. The physician has ordered that PCT #1 not be allowed to cannulate without being under direct supervision of the CN (Charge Nurse) and has been retrained & certified by the Education Department. " Review of the personnel record for PCT # 1 revealed no documentation of a certification after 7/8/05 for cannulation. The surveyor requested the certification from the Education Department and was presented a certification form dated November 25, 2002. 7/19/06 - Written - " A patient stated PCT had problems cannulating him, that the wrong dialyzer was put up & (the patient) had to tell the PCT to change it, When HD (Hemodialysis) was initiated, blood backed up into the NS bag...Patient stated the PCT had a very bad attitude & request PCT not take care of him in the future. " Review of the personnel record revealed a letter to the Administrator which stated PCT # 1 was observed by the Education Department on 8/24/05 with the following remarks: "cleans in an up and down motion instead of a circular motion very roughly, doesn't choose sites prior to cleaning, touches site after it has been cleaned, doesn't reclean site prior to cannulation, has more than a 45 degree angle for a graft, doesn't level off the needle prior to advancing needle " . Review of the personnel record revealed that the PCT # 1 did attend Cannulation Camp on 8/25/05. Review of the CQI minutes dated 1/12/06 revealed that a patient had a c/o with PCT # 1	V 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012500	A. BUILDING ______ B. WING ______	04/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FMC CAPITOL CITY	**255 SOUTH JACKSON STREET MONTGOMERY, AL 36104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 144	Continued From page 3 cannulation, stated the patient went to the VA & was instructed not to allow PCT # 1 to cannulate again. Review of the PCT # 1 personnel record revealed a Memo dated 1/25/06 that listed the following expectations and action plans: " Patient complaints will cease, primarily relating cannulation On 5/1/05 Education & CM will evaluation use of Policy & Procedure & Cannulation technique; if improvement is not noted, determination of future employability will be assessed. Will be reeducated by Education department by 1/31/06. On 2/6/06 Area Manager & Clinical Manager will audit cannulation technique and infection control". Review of the personnel record for PCT # 1 revealed no documentation of reeducation by the Education Department nor of an audit for 2/6/06. The education department presented a memo to the surveyor on 4/12/06 that stated "During the week of March 20 - 24, 2006, PCT # 1 cannulation technique was observed with the following findings: 1. The angle of cannulation is still to deep... " " 3. (PCT# 1) still needs to work on his cannulation angle for a graft. He sometimes places his thumb in the way, which causes the needle to go in at a greater angle." An observation of PCT # 1 on 4/11/06 at 11:00 AM include cannulation to two patients one with a fistula and one with a horseshoe graft. There was not a CN in the area when the cannulation was completed by PCT # 1.	V 144		
V 147	405.2136(d)(2) PERSONNEL P/P: HEALTH	V 147		4/19/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012500	A. BUILDING ____ B. WING ____	04/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FMC CAPITOL CITY	**255 SOUTH JACKSON STREET MONTGOMERY, AL 36104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 147	Continued From page 4 EXAMS 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 health supervision of personnel is provided, and they are referred for periodic health examinations and treatments as necessary or as required by Federal, State, and local laws. This STANDARD is not met as evidenced by: Based on review of personnel records, policies and procedures and interview the facility failed to ensure annual health examinations had been signed by a physician for fourteen of fourteen employees. The policy and procedure for "New Hire Medical Evaluation", dated 2/1/98, included, "Note: If there are state laws which mandate initial and/or annual physical exams for staff, the location must comply with these mandates." Findings include: 1. A review of fourteen personnel records revealed a physical health examination had not been signed completed by the physician. An interview with facility management on 4/12/06 at 3:00 PM confirmed physicals had been completed, however had not been signed by a physician.	V 147		
V 188	405.2137(a)(1) LONG-TERM PLAN TEAM MEMBERS There is a written long-term program representing	V 188		4/28/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012500	A. BUILDING ______ B. WING ______	04/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FMC CAPITOL CITY	255 SOUTH JACKSON STREET MONTGOMERY, AL 36104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 188	Continued From page 5 the selection of a suitable treatment modality (i.e., dialysis or transplantation) and dialysis setting (i.e., home, self-care) for each patient that is developed by a professional team which includes but is not limited to the physician director of the dialysis facility or center where the patient is currently being treated, a physician director of a center or facility which offers self-care dialysis training (if not available at the location where the patient is being treated), a transplant surgeon, a qualified nurse responsible for nursing services, a qualified dietitian and a qualified social worker. This STANDARD is not met as evidenced by: Based on record review and interview with staff, it was determined the facility failed to document each of the professional team members involvement in the long term care plan (LTCP) process for four of nine patients requiring a LTCP. Findings include: 1. Medical Record (MR) # 4's LTCP, dated 8/05, revealed no signature by the Social Worker (SW). 2. MR # 10's LTCP, dated 3/23/06, revealed no signature by the Skilled Nurse (SN) or Registered Dietitian (RD). 3. MR # 11's LTCP, dated 7/25/05, revealed no signature by the SN. An interview on 4/12/06 at 3:30 PM with administrative staff confirmed the LTCP did not always include the signatures of all the members.	V 188		
V 190	405.2137(a)(3) LONG TERM PLAN: PATIENT	V 190		4/24/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012500	A. BUILDING ______ B. WING ______	04/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FMC CAPITOL CITY	**255 SOUTH JACKSON STREET MONTGOMERY, AL 36104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 190	Continued From page 6 INVOLVED The written long-term program includes that the patient, parent, or legal guardian, as appropriate, is involved in the development of the patient's long-term program, and due consideration is given to his preferences. This STANDARD is not met as evidenced by: Based on record review and interview with staff, it was determined the facility failed to include the patient or legal guardian's involvement in the long term care plan (LTCP) process for three of nine patients requiring a LTCP. Findings include: 1. MR # 7's LTCP, dated 5/26/05, revealed no signature by the patient. 2. MR # 10's LTCP, dated 3/7/05 and 3/27/06, revealed no signature by the patient. 3. MR # 12's LTCP, dated 7/28/05, revealed no signature by the patient. An interview on 4/12/06 at 3:30 PM with administrative staff confirmed the LTCP did not always include the signatures of the patient or family member.	V 190		
V 194	405.2137(b)(2) PATIENT CARE PLAN: TEAM The patient care plan is developed by a professional team consisting of at least the physician responsible for the patient's ESRD care, a qualified nurse responsible for nursing services, a qualified social worker, and a qualified dietitian.	V 194		4/28/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012500	A. BUILDING ______ B. WING ______	04/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FMC CAPITOL CITY	**255 SOUTH JACKSON STREET MONTGOMERY, AL 36104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 194	Continued From page 7	V 194		

Continued From page 7

This STANDARD is not met as evidenced by:

Based on record review and interview with staff, it was determined the facility failed to document each of the professional team members involvement in the short term care plan (STCP) process for eight of nine patients requiring a STCP.

Findings include:

1. Medical Record (MR) #4's short term care plan (STCP), dated 3/30/06, revealed no signature by the skilled nurse (SN).

2. MR #5's STCP dated 12/22/05, 1/19/06, 2/23/06 and 3/30/06 revealed no signature by the SN.

3. MR #6's STCP dated 12/19/05 and 1/16/06 revealed no signature by the SN or Registered Dietitian (RD).

4. MR #7's STCP dated 12/19/05 and 1/23/06 revealed no signature by the RD.

5. MR # 8's STCP dated 4/11/06 revealed no signature by the Social Worker (SW) and 2/14/06 no signature by the patient.

6. MR #10's STCP dated 2/22/06 and 3/27/06 revealed no signature by the SN or patient.

7. MR # 11's STCP dated 7/25/05, 8/22/05, 9/19/05, 10/27/05, 11/27/05, 12/22/05, 1/19/06, 2/27/06 and 3/30/06 revealed no signatures by the SN.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012500	A. BUILDING B. WING	04/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FMC CAPITOL CITY	255 SOUTH JACKSON STREET MONTGOMERY, AL 36104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 194	Continued From page 8 8. MR # 12's STCP dated 9/22/05, 12/20/05, 1/19/06 and 2/23/06 revealed no signature by the patient. An interview on 4/12/06 at 3:30 PM with administrative staff confirmed the STCP did not always include the signatures of all the members.	V 194		
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: Based on observation and review of facility policies revealed the facility failed to ensure that the conductivity was checked before each treatment. Findings include: Facility Policy: Checking Final Conductivity of the Dialysate Purpose: To assure that the dialysate is at the proper conductivity to prevent hemolysis or crenation of the patient's blood. Conductivity must be checked before each treatment. Facility Policy: Setting Up the Individual Dialysis Machine. 4. Check conductivity with hand held meter...	V 258		4/19/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012500	A. BUILDING ______ B. WING ______	04/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FMC CAPITOL CITY	255 SOUTH JACKSON STREET MONTGOMERY, AL 36104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 258	Continued From page 9 During an observation of a PCT #1 setting up a treatment, the surveyor requested to see the PCT check the conductivity with a hand held meter. The hand held meter was not readily available for use. The surveyor then observed PCT #1 attempt to check the conductivity with the same hand held meter on another patient. The Chief Tech instructed the PCT #1 that the battery on the meter was very low and would give a false reading. An observation of PCT # 2 on 4/11/06 between 11:00 and 12:00 revealed 2 patients treatments were initiated without the conductivity checked using the hand held meter. Review of the flowsheets for the 2 patients revealed the conductivity was the same as the machine setting.	V 258		
V 266	405.2140(b)(1) PE: INFECTION CONTROL There are written policies and procedures in effect for preventing and controlling hepatitis and other infections. These policies include, but are not limited to, appropriate procedures for surveillance and reporting of infections, housekeeping, handling and disposal of waste and contaminants, and sterilization and disinfection, including the sterilization and maintenance of equipment. Where dialysis supplies are reused, there are written policies and procedures covering the rinsing, cleaning, disinfection, preparation, and storage of reused items which conform to requirements for reuse in 405.2150. This STANDARD is not met as evidenced by: Based on observations, interviews, and review of the facility policies, it was determined the facility	V 266		6/1/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012500	A. BUILDING ____ B. WING ____	04/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FMC CAPITOL CITY	255 SOUTH JACKSON STREET MONTGOMERY, AL 36104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 266	Continued From page 10 staff failed to follow their infection control policies for patient care and environmental cleaning. Findings include: Policy: Post Dialysis Access Care. "Patients can be trained to hold their own needle sites. The patient's ability to do so must be evaluated and the training documented in the medical record. The patient should wear a glove on the hand used to hold pressure to avoid introducing surface bacteria into the blood stream." During observations of dialysis treatments on 4/11/06 from 10:00 AM to 12:00 noon, the surveyors observed three patients holding their site with an ungloved hand. Two of the three patients were observed leaving the building without washing their hands. Policy: " Disinfection Standards For Equipment III. Surface Disinfection 3. Frequency of Disinfection a. the following surfaces should be disinfected at the completion of each patients treatment: Hemodialysis Machine (all external surfaces), Dialysis Chair...." During observations of dialysis treatments on 4/11/06 from 10:00 AM to 12:00 noon, the surveyor observed a patient whose temperature was 101 degrees completing treatment. Another patient arrived on a stretcher, ready for a treatment. The PCT instructed the patient to be placed in the same chair as the patient with the temperature of 101. The chair had not been cleaned.	V 266		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012500	A. BUILDING ______ B. WING ______	04/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FMC CAPITOL CITY	**255 SOUTH JACKSON STREET** **MONTGOMERY, AL 36104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 266	Continued From page 11 An interview with the Area Director on 4/12/06 at 2:30 PM verified that the patients were to hold their site with a gloved hand and that the dialysis chairs were to be cleaned between patients. These citations were written as a result of the recertification survey and complaint survey #'s AL00007325 and AL00007330.	V 266		