

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  042573	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/02/2006
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NAME OF PROVIDER OR SUPPLIER  NRI - MARION <del>NATIONAL RENAL INSTITUTES</del>	STREET ADDRESS, CITY, STATE, ZIP CODE 2921 HIGHWAY 77, SUITE 8, BELLA VISTA COMMONS MARION, AR 72364
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
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V 110	<p>405.2136 GOVERNING BODY AND MANAGEMENT</p> <p>The ESRD facility is under the control of an identifiable governing body, or designated person(s) so functioning, with full legal authority and responsibility for the governance and operation of the facility.</p> <p>This CONDITION is not met as evidenced by:</p> <p>1. Based on review of Governing Body Meeting Minutes, review of policies and procedures and staff interview on 06/01/06, it was determined the new owners failed to identify who made up the Governing Body to oversee the operation of the facility, to appoint a Chief Executive Officer (CEO), to appoint an alternate CEO, to grant physician staff privileges, to appoint a Medical Director and to approve policies and procedures. The findings were:</p> <p>A. During interview of the Head Nurse on 06/01/06 at 1304, she stated the facility had a change of ownership recently and verbally identified an individual as her contact person.</p> <p>B. Review of Governing Body Meeting Minutes from 11/21/03 to 08/22/05 revealed the minutes were from the previous owners. There were no Governing Body Minutes to review from the new owners to identify who made up the new Governing Body to oversee the operation of the facility, to appoint a Chief Executive Officer (CEO), to appoint an alternate CEO, to grant physician staff privileges, to appoint a Medical Director and to approve policies and procedures.</p> <p>C. Review of the policy and procedure manual revealed the manual was from the previous owners.</p>	V 110	<p>1) The Governing Body will meet to appoint the members and the following members were appointed</p> <ol style="list-style-type: none"> <li>1. Medical Director</li> <li>2. Regional Vice-President</li> <li>3. Bio-med tech</li> <li>4. Clinical manager</li> <li>5. Dietician</li> <li>6. Social-work</li> <li>7. Alternate CEO</li> </ol> <p>Ownership for the new company was established all policies and procedures were adopted of former company until further notice. It was also discussed that by former companies policy governing body would meet at least twice a year. The medical director was appointed for privileges.</p>	6/4/06 ongoing
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  J. Director RN	TITLE	(X6) DATE 6/16/06
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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 256	<p>Continued From page 2</p> <p>environment for the storage of patient care items according to manufacturer's recommendations for temperature parameters. The findings follow:</p> <p>A. Upon entry into the water room at 1425 Surveyor #1 and #2 noted extreme environmental heat and standing water on the floor. Approximately 50 bags of Granuflo (dry acid powder) was stored in that area. The manufacturer's recommendation label on the boxes stated the product should be stored in a dry place and that excessive heat should be avoided. A thermometer was requested in order to take a true reading of the temperature and humidity. At 1445 the thermometer registered 90 degrees Fahrenheit with a humidity reading of 75%. The registered thermometer readings were verified with the Biomedical Technician at 1445.</p> <p>B. Upon entry into the supply room at 1450 Surveyor #1 and #2 noted the extreme heat. It was noted that 11 boxes of peritoneal dialysis fluid, 5 boxes of Naturalyte, 20 boxes of Optiflux and approximately 12 blood culture bottles were stored in that area. Manufacturer's storage recommendation labels for each of the items had a temperature range of 59 degrees Fahrenheit to 77 degrees Fahrenheit. A thermometer was requested in order to take a true reading of the temperature. At 1510 the thermometer registered 86 degrees Fahrenheit. The registered thermometer readings were verified with the Biomedical Technician at 1510.</p> <p>C. During interview of the Biomedical Technician on 06/01/06 at 1425, he stated the problem had been on-going during the summer months since the facility opened in 2003.</p>	V 256	<p>On a service call and it was determined that the air was working but the controls needed to be reset.</p> <p>2) On 6/5/06 G/S Automation, IN made a service call and reset all temperature control.</p> <p>3) Blood culture bottles were discarded</p> <p>4) A thermometer was placed in supply room and water room to continue an accurate monitoring of temperature.</p>	<p>6/4/06 Ongoing</p> <p>6/5/06</p> <p>6/4/06 Ongoing</p>
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