

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 852608	(X3) Date Survey Completed 04/17/2024
Name of Provider or Supplier Peachtree Dialysis Center, Llc	Street Address, City, State 3850 Holcomb Bridge Road Ste 435, Peachtree Corners, GA	
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)
E0000	An Initial Certification Survey was conducted at Peachtree Dialysis Center, LLC on April 17, 2024 through April 17, 2024. The survey revealed that the facility was in compliance with 42 CFR Part 494.62, Conditions for Coverage for Emergency Preparedness Plan for End Stage Renal Disease facilities. No deficiencies were cited.
V0000	An Initial Certification Survey was conducted at Peachtree Dialysis Center, LLC on April 17, 2024 through April 17, 2024. The survey revealed that the facility was in substantial compliance with 42 CFR Part 494 Conditions for Coverage for End Stage Renal Disease Facilities. However, the following standard level deficiencies were cited which resulted from the facility's noncompliance related to the survey:
V0113	<p>IC-WEAR GLOVES/HAND HYGIENE CFR(s): 494.30(a)(1)</p> <p>Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.</p> <p>This STANDARD is not met as evidenced by: Based on observation and a review of facility Policy and Procedures (P& P), it was determined that the Infection Control Committee failed to ensure that one of one Registered Nurse (RN AA) observed, changed gloves and performed hand hygiene (by handwashing or using an alcohol-based hand sanitizer), after touching contaminated equipment or "dirty area or task". Failure to perform infection control techniques such as changing gloves and performing hand hygiene, increased the risk for cross contamination with the potential to expose patients and staff to blood-borne pathogens in the dialysis environment. This deficient practice had the potential to negatively affect the health and safety of Patient, (P#2) who was undergoing initiation</p>

of hemodialysis (HD) treatment using the arterial catheter limb of the Central Venous Catheter and the venous needle of the Arteriovenous (AV) Fistula on P#2's left upper arm. The facility's current census was four. Findings include: During observation in the Patient Treatment Room on 4/17/24 between 8:45 a.m. and 9:25 a.m., the following was revealed: - RN AA was observed going from adjusting the venous needle of the AV fistula (which was not flowing well) by re-positioning and re-taping the venous needle (dirty task), to touching/re-setting the HD machine (dirty task), which was constantly alarming, and opening the arterial catheter limb cap (clean) to attach the bloodline, RN AA did not change gloves and did not perform hand hygiene between glove changes. In addition, RN AA did not scrub the catheter hub prior to attaching the bloodline. - A review of the facility Policy Number: 06.100, titled, "Infection Control", Section: Infection Control Guidelines, with an effective date of 6/1/23, stated: 4. Examples of when fresh pair of gloves must be put on: ... when going from a "dirty" area or task to a "clean" area or task... - When moving from a contaminated body site to a clean body site of the same patient...

V0117

IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS
CFR(s): 494.30(a)(1)(i)

Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled. When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station. Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients.

This STANDARD is not met as evidenced by:
Based on observation, a review of the Centers for Disease Control and Prevention (CDC) guidelines and recommendations, a review of facility Policies and Procedures (P&P), and staff interview, it was determined that the Infection Control Committee failed to ensure that one of one Registered Nurse (RN AA) observed during initiation of hemodialysis (HD) treatment using one of two Central Venous Catheter (CVC) limbs, specifically, the arterial catheter limb that carries blood from the body to the dialyzer and using the venous access needle (which carries the filtered blood back to the body), of the arteriovenous (AV) fistula on the left upper arm, utilized appropriate infection control techniques to prevent cross contamination. This breach in infection control techniques could negatively affect the health and safety of two of two patients (P), (P#2 and P#3) who had a CVC, at this facility. The current facility census was four. Findings include: During observation in the Patient Treatment Room on 4/17/24 between 8:45 a.m. and 9:25 a.m., the following was revealed: - RN AA was observed during initiation of HD treatment on P#2 at S2 using the arterial limb of the CVC and the venous needle of the AV fistula access. RN AA returned the used bloody syringe, used alcohol pads and gauze wrappers (dirty) back to the blue liner next to the remaining clean and sterile supplies. According to the CDC, cross contaminating (going from dirty to clean equipment/tasks/area), could cause the spread of bacteria /infections. - A review of facility Policy Number: 06.100, Section: "Infection Control Guidelines" with an effective date of 6/1/2023, did not show any specific policy or

procedure for separating used supplies and clean supplies during CVC care. - RN AA was notified of this observation on 4/17/24 at approximately 9:30 a.m., which RN AA acknowledged and she stated that she should separate the dirty supplies and the clean supplies.

V0122

IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL
CFR(s): 494.30(a)(4)(ii)

[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.

This STANDARD is not met as evidenced by:

Based on observation, staff interview, and a review of facility policy and procedures, it was determined that the Infection Control Committee failed to ensure that one of one Registered Nurse, (RN AA) observed, while performing pre-dialysis assessment, utilized appropriate infection control techniques to prevent cross contamination. Failure to disinfect stethoscope between each patient use, had the potential for cross contamination. The facility census was four. Findings include: On 4/17/24 at 11:07 a. m., RN AA performed post-assessment on P#1 at Station (S1), using a stethoscope. After the procedure, RN AA slung the stethoscope on the back of her neck without disinfecting the stethoscope. - RN AA acknowledged this breach in infection control on 4/17/24 at approximately 11:12 a.m., and RN AA asked this surveyor, which part of the stethoscope should she disinfect.

V0715

MD RESP-ENSURE ALL ADHERE TO P&P
CFR(s): 494.150(c)(2)(i)

The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers;

This STANDARD is not met as evidenced by:

Based on observation, staff interview, and a review of the facility's Policies and Procedures (P & P), it was determined that the Medical Director failed to ensure that one of one Registered Nurse (RN AA) observed, adhered to the facility's P & P relative to Patient (P), (P#3's) post assessment (after her hemodialysis treatment). This failure had the potential to negatively affect the health and safety of P#3. The facility's current census was four. Findings include: - On 4/17/24 at 11:40 a.m., RN AA did not perform post assessment on P#3 before she, (P#3), left the facility, after her hemodialysis treatment. - RN AA acknowledged this observation on 4/17/24 at approximately 11:45 a.m. and stated that she forgot. - A review of the facility's Policy Number: 02.117, titled, "Clinical Policy and Procedures", Section: Post Dialysis Treatment Assessment Policy and Procedure with an effective date of 6/1/23, stated: D. Fluid Status: 1. Lung Sounds a. Listen to the posterior lung sounds bilaterally with special attention to posterior basal lung sounds...