

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  012500	<b>(X3) Date Survey Completed</b>  09/16/2021
<b>Name of Provider or Supplier</b>  Fmc Capitol City	<b>Street Address, City, State</b>  255 South Jackson Street, Montgomery, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

<b>(X4) ID Prefix Tag</b>	<b>Summary Statement of Deficiencies</b>  (Each deficiency should be preceded by full regulatory or LSC identifying information)
<b>V0143</b>	<p><b>IC-ASEPTIC TECHNIQUES FOR IV MEDS</b> CFR(s): 494.30(b)(2)</p> <p>[The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and</p> <p>This STANDARD is not met as evidenced by: Based on observations, review of policy, and interviews, it was determined the facility failed to ensure staff: 1. Properly prepared medication for administration. 2. Stored medications as directed per the facility policy. This did affect Patient Identifier (PI) # 15, PI # 14 (which was 1 of 3 Intravenous {IV} medication observations) and 2 unsampled patient and had the potential to negatively affect all patients served by this facility. Findings include: Facility Policy: Medication Preparation and Administration Published: 04/05/2021 Version: 6 "Purpose: To administer medications with the goals of staff and patient safety, optimal therapeutic response, and infection control. Pre-drawing Medications Medications may be pre-drawn up to 4 hours... These pre-drawn medications shall be labeled and must be kept under the preparer's control or in a locked designated medication storage area ... until delivery to the appropriate patient for administration. Infection Control ...Aseptic technique will be used to prepare and administer IV medications. ...Cleanse the diaphragm of a vial with alcohol prior to accessing the vial. 1. During observations on the treatment floor on 9/14/21 at 9:25 AM at station 15, the surveyor observed 2 syringes labeled "Heparin" lying on the chairside tabletop of PI # 15. At 9:35 AM, the Registered Nurse (RN) entered the dialysis station. The staff failed to keep the Heparin under the preparer's control or in a locked designated medication storage area until delivery to the patient station for administration as per the facility policy. An interview was conducted on 9/16/21 at 8:45 AM with Employee Identifier (EI) # 1, Clinic Manager, who confirmed staff failed to properly prepare and store medications as directed per the facility policy. 2. During</p>

observations on the treatment floor on 9/14/21 at 9:30 AM the surveyor observed 2 syringes labeled "Heparin" lying on the chairside tabletop of an unsampled patient at station 22. The medications were left unattended and the staff failed to ensure medications were kept under their control as directed per the facility policy. 3. During observations on the treatment floor on 9/14/21 at 10:07 AM the surveyor observed 2 syringes labeled "Heparin" lying on the chairside tabletop of an unsampled patient at station 8. The medications were left unattended and the staff failed to ensure medications were kept under their control as directed per the facility policy. 4. An observation was conducted on 9/14/21 at 12:09 PM to observe EI # 9, RN, prepare and administer an IV medication (Venofer) to PI # 14 at station 8. EI # 9 opened 1 vial of Venofer and proceeded to withdraw the medication into the syringe without first cleaning the diaphragm (stopper) as directed per the facility policy. An interview was conducted on 9/16/21 at 8:40 AM with EI # 1 who verified the staff failed to properly prepare and store medications as directed per the facility policy. 30952