

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012502	(X3) Date Survey Completed 01/08/2020
Name of Provider or Supplier Tuscaloosa University Dialysis	Street Address, City, State 220 15th Street, Tuscaloosa, AL	
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)
V0116	<p>IC-IF TO STATION=DISP/DEDICATE OR DISINFECT CFR(s): 494.30(a)(1)(i)</p> <p>Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient. -- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient. -- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients.</p> <p>This STANDARD is not met as evidenced by: Based on observations, review of facility policy and interviews, it was determined the facility failed to ensure the staff cleaned and disinfected equipment before returning it to a common clean area or being used on another patient. This did affect 1 of 2 observations conducted for Discontinuation of Dialysis and Post Dialysis Access Care for AV (Atrioventricular) Fistula or Graft, 1 of 2 observations conducted for Access of AV Fistula or Graft, and 1 of 2 observations for Center Venous Catheter (CVC) Exit Care and Initiation of Dialysis with CVC. This affected Patient Identifier (PI) # 12, PI # 11, PI # 16 and had the potential to negatively affect all patients served by the facility. Findings include: Policy: Infection Control for Dialysis Facilities Policy Number: 1-05-01 Date Revised: October 2019 Purpose: To minimize the spread of infections or bloodborne pathogens in the dialysis facility environment. ...Teammate /Patient Safety ...25. Non-disposable items are to be disinfected between patients. 26. Stethoscopes will be disinfected with 1:100 (one to one hundred) bleach solution. ... Dialysis Station Management ...65. Items taken into the dialysis station will be... cleaned and disinfected before taken to a common area or used on another patient... 66. Teammates will thoroughly wipe down all non-disposable items and equipment...</p>

with an appropriate disinfectant... 1. During observation of Discontinuation of Dialysis and Post Dialysis Access Care for AV Fistula or Graft on 1/6/2020 at 10:07 AM, the surveyor observed Employee Identifier (EI) # 4, Certified Clinical Hemodialysis Technician (CCHT), removed the first needle from PI # 12, proceeded to the clean counter top, retrieved the thermometer, returned to station # 16 and assessed PI # 12's temperature. EI # 4 then proceeded to the clean sink, wet a cleaning wipe with water and cleaned the thermometer and returned thermometer to clean counter top. EI # 4 failed to clean and disinfect the thermometer with an appropriate disinfectant as directed per the facility policy. An interview was conducted on 1/8/2020 at 11:00 AM with EI # 4, who stated he/she failed to clean the thermometer with a disinfectant after use. 2. During observation of Access of AV Fistula or Graft for Initiation of Dialysis on 1/6/2020 at 10:25 AM, the surveyor observed EI # 2, CCHT, obtain cannulation supplies and thermometer from the clean counter top and proceed to station # 14 to assess PI # 11's temperature. EI # 2 then returned the thermometer to the clean counter top without first cleaning the thermometer. At 10:35 AM EI # 3, Registered Nurse, assessed PI # 11 with a stethoscope and hung the stethoscope around his/her neck. EI # 3 failed to disinfect the stethoscope after use. An interview was conducted on 1/8/2020 at 12:05 PM with EI # 2 and EI # 1, Facility Administrator who verified the staff failed to follow the facility policy for cleaning equipment after use. 39098 3. During observation of Initiation of Dialysis with CVC on 1/6/2020 at 11:35 AM on PI # 16, the surveyor observed EI # 6, CCHT, assess the patient's temperature. EI # 6 then returned the thermometer to the clean counter without first cleaning the thermometer. An interview was conducted on 1/8/2020 at 10:38 AM with EI # 6, who confirmed she/he failed to clean the thermometer per policy.