

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012505	(X3) Date Survey Completed 07/26/2018
Name of Provider or Supplier Physicians Choice Dialysis-Montgomery	Street Address, City, State 1001 Forest Avenue, Montgomery, 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)
V0122	<p>IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL CFR(s): 494.30(a)(4)(ii)</p> <p>[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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, facility policy and staff interview, the facility failed to ensure staff followed the policy for disinfection of the dialysis station. This had the potential to affect all patients who dialyzed at the facility. Findings include: Title: Infection Control For Dialysis Facilities Policy: 1-05-01 Revision Date: April 2018 "Purpose: To minimize the spread of infections or bloodborne pathogens in the dialysis facility environment. Facility Hygiene ...44. Teammates will thoroughly wipe down all non-disposable items and equipment such as the blood pressure cuff, the inside and outside of the prime container...and the dialysis delivery systems, with an appropriate disinfectant after every treatment. **** 1. During observations of care on 7/24/18 at 10:10 AM, the surveyor observed Employee Identifier (EI) # 4, Certified Clinical Hemodialysis Technician (CCHT), clean the hemodialysis (HD) machine at station # 7. EI # 4 failed to remove and disinfect the prime waste container that contained clear solution. EI # 4 retrieved and placed dialysis supplies on top of the HD machine, opened the saline solution and placed solution lines into the dirty prime container. The surveyor interviewed EI # 4 at 10:15 AM regarding the HD disinfection and prime container. EI # 4 removed the dirty prime container from the HD machine, emptied, cleaned, dried and replaced the clean container on the contaminated HD machine. EI # 4 then discarded the dialysis supplies, but EI # 4 failed to disinfect the HD machine after removing the dirty prime container. An interview was conducted on 7/24/18 at 10:55 AM with EI # 2, Clinical Nurse Manager, who verified the aforementioned</p>

findings. EI # 2 instructed EI # 4 to discard the dialysis supplies, disinfect the HD machine and prepare the station with new dialysis supplies. 2. Observations of care on 7/25/18 at 9:35 AM at station 15, the isolation unit was conducted with EI # 3, Registered Nurse. EI # 3 disinfected the dialysis station but failed to clean the blood pressure cuff/tubing, wire basket, call light, green supply bag and top of the sharps container. In an interview on 7/25/18 at 10:00 AM, EI # 3 confirmed the above findings.