

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012505	(X3) Date Survey Completed 07/21/2022
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)
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 observations, review of facility policy, CDC (Centers for Disease Control) Hand Hygiene in Healthcare Settings Guidance and interviews, it was determined the facility failed to ensure: 1. Staff followed the policy for gloving and hand hygiene. 2. Patients performed hand hygiene after removing gloves and prior to exiting the treatment area including a patient treating in the isolation station. This affected one of three observations conducted for central venous catheter (CVC) care/treatment initiation, one of two discontinuation of treatment with CVC, one of three observations AV (Atrioventricular) fistula (AVF) or graft treatment initiation, and one of three discontinuation of dialysis treatments. This did affect Patient Identifier (PI) # 18, PI # 21, PI # 20, PI # 19 and had the potential to negatively affect all patients dialyzing at this facility. Findings include: Facility Policy: Infection Control for Dialysis Facilities Policy number: 1-05-01 Date revised: October 2021 Purpose: To minimize the spread of infection or blood borne pathogens in the dialysis facility environment. Teammate Hygiene 1. Hand hygiene is to be performed upon entering the patient treatment area, prior to gloving, after removal of gloves... after patient and dialysis delivery system contact, between patients even if the contact is casual, ...and on exiting the patient treatment area... Teammate/ Patient Safety 11. Teammates will wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station and will remove gloves and wash hands or perform hand hygiene between each patient and/or station. 13. Gloves should be changed when: When soiled with blood, dialysate, or other body fluids. When going from a "dirty"</p>

area or task to a "clean" area or task... 14. Gloves should be provided to patients... if these individuals assist with procedures such as self-cannulation or holding access sites. 15. All personnel protective equipment (PPE) is to be removed as soon as possible if... contaminated... CDC Hand Hygiene in Healthcare Settings ...Healthcare Providers Clean Hands Count for Healthcare Providers ...When using alcohol-based hand sanitizer: Put product on hands and rub hands together Cover all surfaces until hands feel dry This should take around 20 seconds... Last Updated 1/8/21 During observations of care conducted 7/19/22 to 7/21/22 the following breaches in infection control hand hygiene and glove use were observed: 1. On 7/20/22 at 9:00 AM at station 13, Employee Identifier (EI) # 5 CCHT was observed with PI # 18 initiating dialysis via an AVF. EI # 5 with ungloved hands, documented at the computer adjacent to the dialysis station, retrieved the thermometer, monitored PI #18's temperature, and replaced the thermometer to a drawer beneath the computer screen /keyboard. Without first performing hand hygiene, EI # 5 gloved and disinfected PI # 18's access site with alcohol and betadine. 2. On 7/20/22 at 9:01 AM, EI # 9, CCHT, was observed discontinuing dialysis and post dialysis access care for AV Fistula or Graft for PI # 21. After the needles were removed, PI # 21 held pressure on the access sites with a gloved hand. After hemostasis was achieved, PI # 21 removed the glove, transferred to a wheelchair, was weighed on the scales in the wheelchair, and was rolled off the treatment floor by EI # 9. EI # 9 failed to ensure PI # 21 performed hand hygiene after removing his/her glove, and prior to leaving the treatment floor. 30952 3. On 7/20/22 at 9:35 AM at the isolation station, the surveyor observed PI # 20, with a gloved hand, hold the access site and obtained homeostasis (clotting). EI # 6, RN (Registered Nurse) applied a bandage to the access site and exited the isolation station. At 9:56 AM, PI # 20 removed/discarded his/her right hand glove and exited the isolation station to the in-center scales. PI # 20 touched the in-center scales. PI # 20 held the access site and failed to perform hand hygiene after glove removal. EI # 6 failed to ensure PI # 20 performed hand hygiene before exiting the isolation station. In an interview on 7/20/22 at 10:00 AM following the observation, EI # 6 confirmed PI # 20 did not perform hand hygiene after holding the access site following glove removal and before exiting the isolation unit. 4. On 7/20/22 at 10:20 AM at station 3 during CVC site care for PI # 19, EI # 7, RN placed 2 heparin syringes and CVC supplies on top of the dialysis machine, exited station 3 to the aisle, retrieved a chair, returned to the station 3. EI # 7 then donned gloves without first performing hand hygiene. During CVC exit care, EI # 7 removed the old CVC caps and removed gloves, sanitized hands, and waved his/her hands in air to dry. EI # 7 then donned gloves, scrubbed the catheter hubs with alcohol, removed gloves, sanitized hands for 3 seconds and with hands glistening wet, donned new gloves. EI # 7 failed to perform hand hygiene before donning gloves, sanitize hands for approximately 20 seconds and allow hand sanitizer to dry before donning gloves. EI # 7 placed the hourly heparin syringe onto the dialysis machine, labeled the CVC dressing, and removed gloves but failed to perform hand hygiene immediately after glove removal. After checking PI # 19's temperature, EI # 7 exited the station, returned to the station, donned gloves without first performing hand hygiene, placed a blue barrier under the CVC and secured the dialysis lines. EI # 7 failed to perform hand hygiene before donning clean gloves and after glove removal. 5. On 7/20/22 at 2:35 PM, EI # 7, RN, was observed discontinuing dialysis with CVC on PI # 19. EI # 7 placed the supplies on top of the dialysis machine, performed hand hygiene and donned gloves. With gloved hands, EI # 7 pulled a rolling chair up to the station. With the same gloves, EI # 7 retrieved saline flush syringes from the top of the machine, disconnected the blood lines, and attached syringes and flushed both lines. EI # 7 retrieved alcohol swabs and caps from the top of the machine and cleaned the hubs and placed the caps on the CVC lines. EI # 7 then retrieved the ziplock bag with the barrier still folded inside and placed in the

garbage. EI # 7 failed to place supplies on a clean barrier and failed to change gloves and perform hand hygiene after contaminating the gloves. In interviews conducted on 7/21/22 from 12:10 PM to 1:05 PM, EI # 1, Facility Administrator, confirmed the staff failed to follow facility hand hygiene policy and procedure and ensure patients performed hand hygiene after glove removal and upon exiting the facility.