

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012506	(X3) Date Survey Completed 04/13/2023
Name of Provider or Supplier Dothan Dialysis	Street Address, City, State 216 Graceland Drive, Dothan, 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)
V0143	<p>IC-ASEPTIC TECHNIQUES FOR IV MEDS 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, facility policy, Centers for Disease Control and Prevention (CDC) frequently asked questions (FAQs) regarding safe practices for medical injections and interview it was determined the facility staff failed to ensure: 1. Intravenous (IV) nutrition therapy available for patient use was not expired. 2. Aseptic technique was utilized when accessing IV multi-dose vials (MDV). This affected two of five observations for IV medication storage, preparation and administration, including Patient Identifier (PI) # 6 and Unsampled Patient # 1, and had the potential to negatively affect all patients served by this facility. Findings include: Facility Policy: Medication Policy Policy Number: 1-06-01 Revision Date: October 2022 Policy: ...8. All teammates administering medications must utilize aseptic technique. ... 21. An aseptic environment and aseptic technique is used when preparing medications. Careful attention to proper handwashing is performed at this time. ...30. ...All medications are checked monthly for expiration dates. CDC FAQs regarding Safe Practices for Medical Injections: Review Date: 3/2/11 1. How should I draw up medications? ...the rubber septum should be disinfected with alcohol prior to piercing it. 1. An observation was conducted on 4/11/23 at 1:10 PM of parenteral (medications given by injection or infusion) medication preparation and administration by Employee Identifier (EI) # 6, Registered Nurse (RN), for PI # 6. EI # 6 was observed removing the plastic cap from a MDV of Venofer and immediately withdrawing the medication utilizing a syringe and needle. EI # 6 then removed the cap from a MDV of Epogen and immediately withdrew the Epogen dose utilizing a syringe and needle.</p>

EI # 6 failed to wipe the rubber septum with alcohol prior to piercing both MDVs and withdrawing the medications. An interview was conducted on 4/13/23 at 11:04 AM, EI # 1, Facility Administrator, who confirmed EI # 6 did not follow facility policy to utilize aseptic technique when accessing the MDVs. 2. A tour of the medication storage area was conducted on 4/11/23 at 3:00 PM. Inspection of the refrigerator storing parenteral medications revealed two 50 milliliter (ml) prepared bags of Proplete IDPN (Intradialytic Parenteral Nutrition) Protein Therapy 2:1 (Two to One) solution, designated for unsampled patient # 1. Review of the labels on the bag revealed the protein solutions were to be discarded after 4/7/23. The facility failed to discard the expired protein solutions after their expiration date. EI # 10, Senior Manager of Clinical Services, was present during the inspection and confirmed the protein solutions were available for patient use, unsampled patient # 1 was identified on the label as current dialysis patient, and the protein solution should have been discarded after 4/7/23.