

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012507	(X3) Date Survey Completed 03/14/2019
Name of Provider or Supplier Fresenius Kidney Care Mobile	Street Address, City, State 2620 Old Shell Road, Mobile, 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 and procedure and interview, it was determined the facility failed to ensure all patients performed hand hygiene and washed the vascular access site and staff performed hand hygiene prior to IV (intravenous) medication administration and after cleaning the stethoscope. This affected PI (Patient Identifier) # 5, # 11, # 13 and # 12 had the potential to negatively affect all patients who dialyze at the facility. Findings include: Facility Policy: Hand Hygiene Document Number: FMS-CS-IC-II-155-090A Effective Date: 20-MAR-2013 ...The purpose of this policy is to prevent transmission of pathogenic microorganisms to patients and staff through cross contamination. ...Hand Hygiene Hands will be... decontaminated using alcohol based hand rub or by washing hands with antimicrobial soap and water... Before and after direct contact with patients Entering and leaving the treatment area Before performing any invasive procedure such as vascular access cannulation or administration of parental medications ...After contact with inanimate objects near the patient... Patients should perform hand hygiene if able, prior to and after each dialysis treatment. As needed, direct patient care staff will...explain risk of contamination with regard to their vascular assess and hands to all patients.... Facility Procedure: Access Assessment and Cannulation Document Number: FMS-CS-IC-I-115-014C Effective Date: 22-AUG-2018 ...Assessment of Vascular Access Step 1. Prior to treatment, ask your patient to wash access area with liquid soap and water for one minute. Dry with clean paper towel. Wash access...if patient's unable to clean their access... Policy: Cleaning and Disinfection of the Stethoscope Policy Number:</p>

FMC-CS-IC-II-155-123C Date Revised: 04-Jan-2012 Procedure: Step: 1. Clean hands with alcohol based hand sanitizer. 2. While the alcohol product still on hands, rub the diaphragm of stethoscopes with hands until the entire diaphragm surface covered with the alcohol product. 3. Complete hand hygiene.... An observation was conducted on 3/12/19 at 10:30 AM to observe care provided. During the observation, Employee Identifier (EI) # 7, Registered Nurse (RN), completed the post assessment of the patient at station 24. Once complete, EI # 7 obtained hand sanitizer and rubbed the diaphragm of the stethoscope. EI # 7 failed to obtain additional hand sanitizer and sanitize hands after equipment cleaning. An interview was conducted on 3/14/19 at 11:15 AM with EI # 1, Clinic Manager and EI # 2, Director of Operations, who confirmed the policy was not followed for hand hygiene. 30952 At 10:33 AM, Employee Identifier (EI) # 5, Registered Nurse, entered station 6, gloved, with a syringe in hand, then laid the syringe on the chairside table. EI # 5 assessed PI # 5 with the stethoscope, lifted PI # 5's pant legs and placed his/her gloved hands on the ankles and feet during patient assessment. With the same gloves, EI # 5 retrieved the syringe from the chairside table and administered IV medication. EI # 5 failed to remove gloves, perform hand hygiene and don clean gloves after direct patient contact and before IV medication administration. On 3/12/19 at 12:45 PM, PI # 11 entered the patient treatment area, then to the scales with EI # 6, Patient Care Technician. EI # 6 accompanied PI # 11 to station 3. PI # 11 failed to perform hand hygiene and wash the vascular access site upon entering the treatment area. After PI # 11 sat down at station 3, the surveyor observed PI # 11 with clear plastic wrap around the left arm access site. EI # 6 cleaned the access site with 70 % Isopropyl Alcohol prep pads. EI # 6 failed to encourage the patient to perform hand hygiene and the access site was not washed with soap and water prior to cannulation as directed per policy. At 12:55 PM, EI # 5 entered station 7 with a syringe in gloved hand laid the syringe on the chairside table. EI # 5 assessed PI # 13 with the stethoscope, then placed gloved hands on lower legs and feet. With the same gloves, EI # 5 administered IV medication. EI # 5 failed to remove gloves, perform hand hygiene and don clean gloves after patient contact and prior to IV medication administration. At 1:00 PM, PI # 12 entered the patient treatment area, weighed at the scales and sat down at station # 4. PI # 12 failed to perform hand hygiene and wash the vascular access site upon entering the treatment area. EI # 6 cleaned the access site with 70 % Isopropyl Alcohol prep pads and cannulated the access. Following treatment initiation, the surveyor interviewed PI # 12 who confirmed no hand hygiene and vascular access washing was performed upon entering the treatment area. At 1:05 PM, EI # 5 entered station 3 with a syringe in gloved hand and laid the syringe on the chairside table. EI # 5 assessed PI # 11 with a stethoscope, then assessed the lower legs and feet. Wearing the same gloves, EI # 5 administered the IV medication from the syringe. EI # 5 failed to remove gloves, perform hand hygiene and don clean gloves prior to administering IV medication as directed per the facility policy. In an interview on 3/14/19 at 10:45 AM, EI # 2, Director of Operations, confirmed staff failed to follow infection control procedures.