

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  012508	<b>(X3) Date Survey Completed</b>  12/12/2019
<b>Name of Provider or Supplier</b>  Birmingham East Dialysis	<b>Street Address, City, State</b>  1105 East Park Drive, Birmingham, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

<b>(X4) ID Prefix Tag</b>	<b>Summary Statement of Deficiencies</b>  (Each deficiency should be preceded by full regulatory or LSC identifying information)
<b>V0122</b>	<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 observations, review of facility policy and interviews with staff, it was determined the facility failed to ensure 1. Reusable equipment was cleaned and disinfected after use. 2. Bleach solution was mixed daily and labeled. 3. Contaminated supplies was disposed of in the biohazard container. This deficient practice affected Patient Identifier (PI) # 9, # 10 and had the potential to negatively affect all patients in this facility. Findings Include: Title: Infection Control For Dialysis Facilities Policy: 1-06-01 Revision Date: October 2019 Policy: The Centers for Disease Control (CDC) Recommendations for Preventing Transmission of Infections among Chronic Hemodialysis Patients (Dialysis Precautions) will be followed when caring for all patients. ... 25. Non-disposable items are to be disinfected between patients. Dialysis Station Management... 66. Teammates will thoroughly wipe down all non-disposable items and equipment such the blood pressure cuff, the inside and outside of the prime container,... 73. Sufficient disinfectant should be applied so that surfaces are visibly wet. 74. Surfaces should be allowed to air dry in order to provide sufficient disinfectant contact time... 1. During the flash tour of the facility conducted on 12/10/19 at 7:45 AM, the surveyor observed the bleach container at the back of the nurse's station labeled as prepared on 12/9/19 at 5:00 AM. In an interview conducted on 12/10/19 at 9:00 AM, Employee Identifier (EI) # 9, Facility Administrator (FA) # 2, confirmed 1 of 2 bleach containers were not labeled correctly. 2. During an observation of cleaning and disinfection of the dialysis station conducted on 12/10/19</p>

at 8:30 AM the surveyor observed EI # 4, Patient Care Technician (PCT), clean the dialysis chair. EI # 4 opened the sides of the dialysis chair, cleaned with bleach soaked cloths and immediately closed the sides of the chair. EI # 4 failed to allow the chair to dry before closing the sides of chair as directed per policy. In an interview conducted on 12/10/19 at 9:30 AM, EI # 9, FA # 2, confirmed the above findings. 3. During and observation of care conducted on 12/10/19 at 8:50 AM, the surveyor observed EI # 5, PCT, change the transducer for PI # 10 at station 2. After connecting the new transducer, EI # 5 placed the bloody contaminated transducer directly on the chair side table. An interview was conducted on 12/10/19 at 9:30 AM with EI # 7, Registered Nurse, who confirmed the PCT should have placed the contaminated transducer in the biohazard container and not placed it on the chair side table. 4. An observation of care was conducted on 12/10/19 at 9:00 AM to observe EI # 3, RN Charge Nurse, perform CVC (Central Venous Catheter) care for PI #9. EI # 3 failed to disinfect the stethoscope after use on an unsampled patient at station 11, prior to auscultating PI # 9. An interview was conducted on 12/12/19 at 10:00 AM with EI # 1, who confirmed the above mentioned findings. 5. An observation of care was conducted on 12/11/19 at 11:30 AM to observe EI # 4, PCT, prepare the dialysis station for the next patient. EI # 4 checked the dialysis machine conductivity with the pHoenix meter, informed the surveyor of the result, then proceeded to place the used pHoenix meter on the counter top at the nurses station without disinfecting the machine. An interview was conducted on 12/12/19 at 10:05 AM with EI # 1 who confirmed the staff should have disinfecting the used pHoenix meter. 34107