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| <b>Statement of Deficiencies</b>   | <b>(X1) Provider/Supplier/CLIA Identification Number</b><br><br>012509                     | <b>(X3) Date Survey Completed</b><br><br>03/30/2023 |
| <b>Name of Provider or Supplier</b><br><br>North Alabama Nephrology Center   | <b>Street Address, City, State</b><br><br>1311 North Memorial Parkway #200, Huntsville, 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><br><br>(Each deficiency should be preceded by full regulatory or LSC identifying information)  |
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| <b>V0111</b>              | <p>IC-SANITARY ENVIRONMENT<br/>CFR(s): 494.30</p> <p>The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas.</p> <p>This STANDARD is not met as evidenced by:<br/>Based on observation, review of facility policy and procedure, and staff interview, it was determined the staff failed to ensure hemostasis was achieved and each needle site was clean and dry prior to discharge when discontinuing an AVF/AVG (arteriovenous fistula/graft). This did affect Patient Identifier (PI) # 9, one of two patients observed for discontinuation of dialysis and post dialysis access care for AVF/AVG. Findings include: Facility Policy: Post Treatment Fistula Needle Removal Version: 2 Published: 07/06/2021 Procedure: 8. Once hemostasis is achieved: ... Remove the gauze... Place a Band-Aid, adhesive dressing or gauze dressing secured with clean tape Facility Policy: Patient Assessment and Monitoring Version: 3 Published: 09/29/2018 Post Treatment Follow the steps below for obtaining post-treatment assessment data: 1. The direct patient care staff may obtain the following: Assessment and Data Collection Access... Evaluate access prior to discharge for: ... Bleeding... Swelling... Any changes during the treatment. 1. An observation was conducted on 3/29/23 at 10:05 AM to observe Employee Identifier (EI) # 6, Certified Clinical Hemodialysis Technician (CCHT), discontinue dialysis on PI # 9 at station 5 with an AVF/AVG. After holding pressure to the second needle site, PI # 9 removed his/her glove and proceeded to exit the treatment floor at 10:20 AM without having his/her AVF/AVG examined for hemostasis (the stopping of a flow of blood). EI # 6 failed to ensure hemostasis was achieved and that each needle site was clean and dry</p> |

prior to discharge. An interview was conducted on 3/30/23 at 10:01 AM with EI # 1, Facility Administrator, who confirmed the staff failed to follow the facility policy for discontinuation of dialysis with an AV Fistula/AV Graft.