

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  012509	<b>(X3) Date Survey Completed</b>  03/30/2023
<b>Name of Provider or Supplier</b>  North Alabama Nephrology Center	<b>Street Address, City, State</b>  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>  (Each deficiency should be preceded by full regulatory or LSC identifying information)
<b>V0113</b>	<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 the facility policy and staff interviews, it was determined the facility failed to ensure: 1. Staff followed the facility policy for hand hygiene during observations conducted during: a. three of three accesses of AVF /AVG (arteriovenous fistula/graft) for initiation of dialysis including Patient Identifier (PI) #10, PI # 11, and PI # 8. b. two of two AVF/AVG discontinuation of dialysis including PI # 12, and PI # 9. 2. Staff followed the facility policy and maintained fingernails no greater in length than one quarter inch (1/4 in). 3. Patients performed hand hygiene after holding exit sites prior to exiting the clinic including PI # 9, and an unsampled patient observed during a blood loss after dialysis treatment discontinuation. This had the potential to negatively affect all patients who dialyze at the facility, staff, and visitors. Findings include: Facility Policy: Hand Hygiene Published: 11/4/19 Reference Number: 47664 Version: 6 Purpose: The purpose of this policy is to prevent transmission of pathogenic microorganisms to patients and staff through cross contamination. Responsibility All staff, patients...must follow the same requirements for hand hygiene. Policy: Hand hygiene includes either washing hands with soap and water or using a waterless alcohol-based antiseptic hand rub with 60-90% alcohol content... ..below identifies when hands should be washed specifically with soap and water or when alcohol-based hand rubs can be used: 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. Immediately after removing gloves. After</p>

contact with body fluids or excretion.... ...After contact with inanimate objects near the patient. When moving from a contaminated body site to a clean body site... Hand Hygiene: Patients Patients should perform hand hygiene if able, prior to and after each dialysis treatment. Caution Regarding Fingernails ...Natural fingernails length shall be kept to 1/4 inch or less... During observations of care on 3/29/23 from 7:05 AM until 11:30 AM, the following were observed: 1. At 7:45 AM at station 10 during dialysis treatment initiation with an AVF/AVG access for PI # 10, Employee Identifier (EI) # 7, PCT (Patient Care Technician), with gloves on, cleaned the stethoscope with an alcohol pad, evaluated the access sites using a stethoscope and palpation, applied antiseptic using two alcohol pads to the cannulation sites, and inserted the cannulation needles. Next EI # 7 documented at the dialysis machine keyboard, initiated the treatment, removed his/her gloves, then sanitized his/her hands. EI # 7 failed to perform hand hygiene after access site evaluation and before access site antiseptics. EI # 7 failed to perform hand hygiene after access site cannulation and before documenting on the dialysis keyboard. In an interview conducted on 3/30/23 at 10:05 AM, EI # 1, Facility Administrator, confirmed staff failed to follow facility policy for hand hygiene during treatment initiation. 2. At 7:49 AM, the surveyor observed EI # 3, RN (Registered Nurse) tapping his/her nails on the surface of the common supply cart across from station 6 and station 7. The surveyor observed EI # 3's nails were greater than one fourth inch in length. In an interview on 3/29/23 at 7:50 AM, EI # 3 stated his/her nails were natural and were greater than 1/4 in length. 3. At 7:59 AM at station 15 during dialysis treatment initiation with an AVF/AVG access for PI # 8, EI # 5, Certified Clinical Hemodialysis Technician (CCHT), with gloves on, cleaned the stethoscope with an alcohol pad, evaluated the access sites using a stethoscope and palpation, applied antiseptic using two alcohol pads to the cannulation sites, and inserted the cannulation needles. EI # 5 failed to perform hand hygiene after access site evaluation and before access site antiseptics. In an interview conducted on 3/30/23 at 10:01 AM, EI # 1 confirmed staff failed to follow the facility hand hygiene policy. 4. At 8:45 AM, EI # 6, CCHT was observed at station 4 discontinuing dialysis for an AVF for PI # 12. EI # 6 reinfused the extracorporeal circuit and disconnected the bloodlines. EI # 6 failed to remove gloves and perform hand hygiene after disconnecting the bloodlines. In an interview conducted on 3/30/23 at 10:05 AM, EI # 1, confirmed staff failed to perform hand hygiene per facility policy. 5. At 9:52 AM, an unsampled patient was observed at station 20 after dialysis was discontinued via an AVF/AVG. The patient stood, and exited the station. While walking in the treatment area, the cannulation sites began to bleed. Site care was performed by EI # 8, CCHT, and a new dressing was applied. After holding pressure to both cannulation sites with a gloved hand, the unsampled patient removed his/her glove and exited the treatment floor at 10:32 AM without performing hand hygiene per facility policy. The staff failed to ensure the patient performed hand hygiene after glove removal and after holding access sites. In an interview conducted on 3/30/23 at 10:05 AM, EI # 1 confirmed staff failed to ensure the facility hand hygiene policy was followed. 6. At 10:05 AM EI # 6 was observed at station 4 discontinuing dialysis for an AVF/AVG for PI # 9. After holding pressure to both cannulation sites with a gloved hand, PI # 9 removed his/her glove and proceeded to exit the treatment floor at 10:20 AM without performing hand hygiene per facility policy. In an interview conducted on 3/30/23 at 10:01 AM, EI # 1 confirmed staff failed to ensure the facility hand hygiene policy was followed. 7. At 10:15 AM, while working at station 6, EI # 3, performed two unsuccessful attempts to access a new AVG for PI # 11. EI # 3 left the cannulation needle in place, and summoned EI # 5, to the station. EI # 5 donned gloves, cleaned the stethoscope with an alcohol prep pad, assessed the access site and needle placement, removed the tape, repositioned the cannulation needle with blood return. With the same gloves on, EI # 5 accessed the second access location using the

stethoscope, cleaned the access site with an antiseptic, an alcohol prep pad, then cannulated the second access site with blood return. EI # 5 failed to perform hand hygiene after access site evaluation and before antiseptic application to the access site. In an interview conducted on 3/30/23 at 10:05 AM with EI # 1, Facility Administrator, the surveyors reviewed the infection control observation findings that included staff's failure to follow facility policy for hand hygiene during treatment initiation/discontinuation with an AVF/AVG, staff fingernail length noncompliance, and patient's failure to perform hand hygiene after holding access sites before exiting the treatment floor. EI # 3 confirmed staff failed to follow facility infection control policies. 28327 41624