Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012509	(X3) Date Survey Completed 03/30/2023
Name of Provider or Supplier North Alabama Nephrology Center	**Street Address, City, State** 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.		

(X4) ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency should be preceded by full regulatory or LSC identifying information)
V0143	IC-ASEPTIC TECHNIQUES FOR IV MEDS CFR(s): 494.30(b)(2) [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 This STANDARD is not met as evidenced by: Based on observations, review of facility policy, and interview, it was determined the facility staff failed to ensure: 1. All multi-dose medication vials (MDV) were labeled legibly when opened. 2. All intravenous (IV) medications were secured and stored according to facility policy. This affected three of four observations for IV medication preparation and administration, and included PI (Patient Identifier) # 8, PI # 6, and PI # 14, and had the potential to negatively affect all patients served by this facility. Findings include: Facility Policy: Medication Preparation and Administration Published: 2/6/23 Reference Number: 47488 Version: 9 Purpose: To administer medications with the goals of staff and patient safety, optimal therapeutic response, and infection control. ...Labeling Vials: When preparing medications if the vial is not used immediately in its entirety, the nurse ... must place the date and time the vial was opened on the medication label along with their initials. ...Pre-drawing Medications Medications may be pre-drawn up to 4 hours... These pre-drawn medications shall be labeled and must be kept under the preparer's control or in a locked designated medication storage area ... until delivery to the appropriate patient for administration. ...Monitoring Expired Medications: ...Any open multi-dose vials must be discarded 28 days after opening or per manufacturer's expiration date. 1. During a tour of the treatment floor 3/28/23 at 8:30 AM, an open MDV of Tuberculin Purified Protein Derivative (PPD) with an expiration date of 10/25/23 was observed stored inside the Helmer refrigerator. There was a label on the MDV that was completely illegible, rendering it impossible for facility staff to be able to determine when the MDV was

	opened, or when the MDV needed to be discarded. In an interview on 3/28/23 at 8:45 AM, Employee Identifier (EI) # 2, Registered Nurse, (RN) Charge Nurse, who was present during the tour, confirmed the open MDV Tuberculin PPD date was not legible. 30952 2. During observations on the treatment floor on 3/29/23 at 8:10 AM, EI # 3, RN entered the patient treatment floor around the area of stations 11, station 15, and station 10 with prefilled/prepared IV medications in hand. EI # 3 placed two IV syringes on the supply cart across from the station, exited the supply cart, and entered station 11, leaving the IV medications unattended on the supply cart. EI # 3 returned to the supply cart, retrieved the two syringes, entered station 15, and placed the two syringes on the chairside table at station 15. Next, EI # 3 exited station 15 and entered station 10. After approximately two to three minutes, EI # 3 returned to station 15 and administered the two IV medications to PI # 8. EI # 3 failed to ensure IV medications were stored and secured per policy. In an interview conducted on 3/30/23 at 10:05 AM, EI # 1, Facility Administrator confirmed staff failed to follow the facility policy for IV medications. 3. An observation was conducted on 3/29/23 at 10:21 AM to observe EI # 4, RN, prepare and administer an IV medication for PI # 14 at station 17. After preparing the IV medication (Venofer), EI # 4 proceeded to station 17 and placed the IV medication (Venofer) on the chair side tabletop. EI # 4 then left the station and proceeded to the medication preparation area, leaving the IV medication (Venofer) unsecured/unattended. An interview was conducted on 3/30/23 at 10:01 AM, EI # 1 confirmed staff failed to store medications as directed per the facility policy. 4. During observations on the treatment floor at 11:08 AM, EI # 3, RN placed two syringes filled with IV medication and two prefilled saline syringes on the supply cart across from station 6. EI # 3 left the supply cart leaving the IV medications on the supply cart unsecured. The staff failed to ensure IV medications were stored and secured per policy. In an interview on 3/29/23 at 11:10 AM, EI # 2, witnessed to the unsecured syringes, confirmed staff should not leave medications unsecured. On 3/29/23 at 11:15 AM, the surveyor observed EI # 3 retrieved and administered the IV medications to PI # 6 during treatment discontinuation. In an interview conducted on 3/30/23 at 10:05 AM, EI # 1 confirmed staff failed to follow the facility policy for IV medications. 28327