

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012513	(X3) Date Survey Completed 07/14/2021
Name of Provider or Supplier Bma Langdale	Street Address, City, State 8 Medical Park North, Valley, 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 policies and interviews, it was determined the facility failed to ensure staff and patients followed the facility policy for hand hygiene. This affected unsampled PI's (Patient Identifier) # 12, # 26, # 9, # 11, sampled patient, PI # 8, unsampled PI # 14, and sampled patient, PI # 2. This had the potential to negatively affect all patients, visitors, and staff. Findings include: Facility Policy: Hand Hygiene Published: 11/4/19 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 room. Before performing any invasive procedure such as vascular access cannulation or administration of parental medications. Immediately after removing gloves. ...After contact with inanimate objects near the patient. Hand Hygiene: Patients Patients should perform hand hygiene if able, prior to and after each dialysis treatment. ... Gloves must be provided to patients when performing procedures which risk exposure to blood or body fluids, such as...holding access site post treatment... To help ensure the prevention of cross contamination to their family members or other patients, hand hygiene must be performed. Facility Policy: Medication Preparation and</p>

Administration Published: 4/5/21 Version: 6 Purpose: To administer medication with the goals of staff and patient safety, ...and infection control. ...Infection Control The following steps must be taken to ensure infection control. Perform hand hygiene prior to accessing supplies, handling vials and IV (intravenous) solutions and preparing or administering medications. Aseptic technique will be used to prepare and administer IV medications. Observations of care on 7/12/21 from 10:00 AM CST (central standard time) to 3:30 PM revealed the following hand hygiene infection control breaches: 1. At 11:07 AM CST (Central Standard Time) at station 4 for AVF (arteriovenous fistula) access for dialysis treatment initiation, EI (Employee Identifier) # 5, PCT (Patient Care Technician) with gloved hands, palpated, auscultated using a stethoscope and applied a tourniquet to PI # 12's access site. EI # 5 performed AVF antisepsis using an alcohol prep, then cannulated the AVF. EI # 5 failed to perform hand hygiene and don clean gloves after access evaluation and before antiseptic application. 2. At 11:35 AM CST at station 6, PI # 26 was observed holding the access site with gloved hand. At 12:05 PM, PI # 26 exited the treatment floor still wearing the glove used to hold pressure to access site. PI # 26 failed to remove the glove and perform hand hygiene after holding an access site. 3. At 11:40 AM CST at station 6 for AVF access for dialysis treatment initiation, EI # 4, PCT, with gloved hands, palpated and auscultated site using a stethoscope then applied a tourniquet to the site. EI # 4 performed AVF antisepsis with an alcohol prep and attempted an unsuccessful cannulation on PI # 9. EI # 4 failed to perform hand hygiene and don clean gloves after access evaluation, palpation, auscultation, and prior to antiseptic application. 4. At 11:48 AM CST, EI # 5, PCT entered station 6 to assist with AVF cannulation. EI # 5 evaluated PI # 9's access with gloved hands, prepped the site with alcohol then cannulated the AVF. EI # 5 failed to perform hand hygiene and don clean gloves before applying the antiseptic and site cannulation. 5. At 12:05 PM CST at station 8, PI # 11 was observed holding the access site with gloved hand. At 12:39 PM, PI # 11 exited the treatment floor without performing hand hygiene. 6. At 12:30 PM CST, EI # 4, PCT exited the treatment floor wearing gloves, gown, and face shield with a bath jug in hand. EI # 4 failed to perform hand hygiene before exiting the treatment floor. 7. At 2:05 PM CST, EI # 5 was observed discontinuing care to PI # 8 at station 1. While EI # 5 was sitting on a rolling stool, EI # 5 rolled to the trash can in the middle of the treatment floor, placed trash in the can touching the side of the trash can. EI # 5 rolled back to the station and continued providing care. EI # 5 failed to remove gloves and perform hand hygiene after contact with the contaminated surface of the trash can. 8. At 2:15 PM CST, EI # 4, PCT exited the treatment floor wearing gloves, gown and face shield with a bath jug in hand. EI # 4 failed to perform hand hygiene before exiting the treatment floor and exited wearing dirty gloves. 9. At 3:00 PM CST, PI # 12 was observed holding pressure to the access site with a gloved hand at station 4. At 3:20 PM CST, assisted by EI # 5, PCT, the patient exited the treatment area via wheelchair without first performing hand hygiene. 34107 10. On 7/13/21 at 9:55 CST AM, EI # 6, Registered Nurse, prepared Parsabiv IV (intravenous), then retrieved gloves from the clean glove box. On the way to station 8, EI # 6 donned the gloves prior to administration of Parsabiv IV medication. EI # 6 failed to perform hand hygiene before gloves were applied and IV medication administered to PI # 14. 11. On 7/13/21 at 11:35 CST AM, EI # 11, PCT, while wearing gloves, placed the adult BP (blood pressure) cuff on PI # 2 at station 17, then removed the cuff stating, "I need the baby cuff." EI # 11 removed the adult cuff, placed it on the chairside table and exited station 17 still wearing the dirty gloves. EI # 11 failed to remove the dirty gloves and perform hand hygiene. EI # 11 went to the cabinet on the left of the treatment floor and searched in several drawers for the "baby cuff". EI # 11 went to the nurse station, searched in drawers, then to the clean cart between station 6 and station 2 searching through cuffs on the cart bottom. EI # 11

then went to the plastic 3 drawer container in front of station 17 and found the pediatric cuff. EI # 11 failed to remove gloves and perform hand hygiene before exiting the station. EI # 11 potentially contaminated numerous "clean" areas on the treatment floor and nurse station while searching for patient equipment with dirty gloves on. During interview on 7/14/21 at 11:25 AM, CST, EI # 1, Director of Operations confirmed the staff failed to follow facility policies and procedures and the observations were breaches in infection control.