

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)
V0119	<p>IC-SUPPLY CART DISTANT/NO SUPPLIES IN POCKETS CFR(s): 494.30(a)(1)(i)</p> <p>If a common supply cart is used to store clean supplies in the patient treatment area, this cart should remain in a designated area at a sufficient distance from patient stations to avoid contamination with blood. Such carts should not be moved between stations to distribute supplies. Do not carry medication vials, syringes, alcohol swabs or supplies in pockets.</p> <p>This STANDARD is not met as evidenced by: Based on observations, facility policies and interviews, it was determined the facility failed to ensure all supplies for patient use were stored in a clean area. This had the potential to negatively affect all patients served at the facility. Findings include: Facility Policy: Dialysis Precautions Published: 1/4/12 Version: 4 ...The purpose of this policy is to provide an overview of dialysis precautions Policy Dialysis Precautions will be followed by all employees... General Approach All patients...are infectious All blood, body fluids, tissues, needles, and sharps... are contaminated ...All supplies and equipment used for a patient's treatment...are contaminated Clean Versus Dirty Areas Clean area: An area designated for clean and unused equipment, supplies and medications Dirty area: An area where...a potential for contamination...or used supplies, equipment...are stored or handled. Clean areas should be clearly designated for the preparation and handling and storage of...unused supplies and equipment. Clean areas should be clearly separated from dirty areas where used supplies, equipment or blood samples are handled or stored... Facility Policy: Access Assessment and Cannulation Published: 8/22/18 Version: 1 ...Supplies ...Taping the Fistula Needle Step 1 ...Tape from multi-use roll: Tape must be prepared outside of the patient station to prevent risk of cross contamination...When you are ready to cannulate, go to the clean area and retrieve the stack of tape... Observations of care on 7/12/21 from 10:00 AM CST (Central Standard Time) to 3:30 PM CST the surveyors</p>

observed the following breaches for staff failing to ensure patient supplies were kept in a clean area. 1. At 10:55 AM CST lying beside the handwashing sink at station 2, the surveyor observed a 180 NR dialyzer, blood line tubing, and a bag of Normal Saline. Employee Identifier (EI) # 7, Certified Clinical Hemodialysis Technician (CCHT), confirmed patient supplies should not be next to the handwashing sink. 2. At 12:45 PM, CST, the surveyor observed 2 plastic clip boards lying on counter at the back of station 17 and 13, an area where there is a potential for contamination, which is a dirty area. The clip boards contained several lines of paper tape strips. The surveyor asked EI # 9, CCHT, "Can patient supplies stored on this counter?" She answered yes and confirmed the paper tape strips should be stored in clean area. In an interview conducted with EI # 1, Director of Operations (DOO) on 7/14/21 at 11:25 AM CST confirmed the staff failed to ensure all patient supplies were stored in clean area. 30952 3. At 12:50 PM CST, the surveyor observed a cart along the back wall adjacent to the nurse station with patient supplies on the bottom shelf including vacutainer holders and an unused access cannulation needle. There were 3 face shields, all with tape around the ears next to the patient supplies. 4. At 2:40 PM CST, the surveyor observed a cart on the treatment floor adjacent to the water room exit. The cart contained an open box of gloves and multiple individual gloves were out of the box lying on a barrier pad. There were 4 rolls of used tape, a stethoscope and a 2 face shields on the barrier. Also, on the cart was a document from the Centers for Disease Control, Care of a Patient with C-Difficile Clostridium Difficile (an infectious gastrointestinal bacteria), in a document saver. In an interview on 7/12/21 at 2:40 PM CST, EI # 5, PCT, was asked if this was a clean cart? EI # 4 reported it was a clean cart used for a patient with C Diff (Clostridium Difficile) who dialyzed on TTS (Tuesday, Thursday, and Saturday). EI # 5 confirmed staff re-usable equipment should not be on a clean cart. In an interview on 7/14/21 at 11:25 AM CST, EI # 1, DOO reported no longer was an an active C Diff case in the clinic and the cart should have been removed from the treatment floor. EI # 1 stated staff equipment and patient supplies should not stored together.