

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)
V0147	<p>IC-STAFF EDUCATION-CATHETERS/CATHETER CARE CFR(s): 494.30(a)(2)</p> <p>Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters. II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].</p> <p>This STANDARD is not met as evidenced by: Based on observations, medical record (MR) review, facility procedure, and interviews, it was determined the facility failed to ensure staff: 1. Performed Central Venous Catheter (CVC) exit site care per policy in 2 of 4 care observations. This affected unsampled patient, Patient Identifier (PI) # 24 and PI # 2. 2. Documented CVC exit care and dressing change in 1 of 2 MR's reviewed with CVC's and included PI # 1. This had the potential to negatively affect all patients with CVC's dialyzed at this facility. Findings include: Facility Procedure: Changing the Catheter Dressing Published: 11/04/19 Version: 6 Supplies ...Underpad... Removal of Dressing and Inspection of Site Step 1. Place an underpad under catheter limbs to protect work area and clothing. ...Step 5. Inspect and remove old dressing... ...Cleaning the Site... Step 2... 2% Chlorhexidine and 70% alcohol: Using gentle back and forth friction, clean the exit site beginning in the center and continuing outward 2 inches in a concentric</p>

circle for 30 seconds and allow to dry a minimum of 30 seconds. Use both sides of the swab stick to clean an area the size of the dressing to be applied. If exudate or crusting is noted, an additional swab stick may be necessary to clean the exit site...

Documentation Document the dressing change in the patient's medical record. Include any observations of the exit site, catheter integrity, notifications to the team ... of abnormal findings, instructions, or interventions made during the dressing change. 1.

PI # 24 was admitted to the facility on 5/20/21 with the primary diagnosis of ESRD (End Stage Renal Disease). During an observation of CVC exit site care conducted on 7/13/21 at 10:40 AM CST (Central Standard Time), Employee Identifier (EI) # 3, Registered Nurse (RN) cleaned on the sides and top of the exit site with a Chlorprep swab stick and failed to clean under the CVC exit site. In an interview conducted on 7/14/21 at 2:20 PM CST, EI # 1, Director of Operations (DOO), confirmed EI # 3 failed to follow facility procedure for CVC exit site care and dressing change. 2. PI #

2 was admitted to the facility on 5/29/21 with the primary diagnosis of Acute Kidney Injury. During an observation of CVC exit site care conducted on 7/13/21 at 11:50 AM CST at station 17, EI # 3, RN placed a blue underpad under the limbs of the CVC. EI # 3 cleaned on the sides and top of the exit site with a Chlorprep swab stick and failed to clean underneath the CVC exit site. EI # 3 opened the dressing package, PI # 2 reached up and his/her shirt and went up the sides of the cleaned area. EI # 3 pulled the shirt back down and placed the sterile dressing to the exit site. EI # 3 failed to secure shirt under the CVC site or re-clean the exit site before applying the sterile dressing. In an interview conducted on 7/14/21 at 11:25 AM CST, EI # 1 confirmed EI # 3 failed to follow facility procedure for CVC exit site care. 30952 3. PI # 1 was

admitted to the facility 4/13/21 with diagnoses including Diabetic Glomerular Sclerosis and ESRD. Review of the Treatment Sheet dated 6/29/21 revealed the CVC access was used for dialysis treatment, but there was no documentation of the care provided to the CVC site. Review of the Treatment Sheet dated 7/6/21 revealed "CVC care provided" but failed to include documentation of the CVC care performed. In an interview on 7/14/21 at 1:09 PM CST, EI # 1, DOO confirmed staff failed to document the CVC care performed per the facility policy.