

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)
V0550	<p>POC-VASCULAR ACCESS-MONITOR/REFERRALS CFR(s): 494.90(a)(5)</p> <p>The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement.</p> <p>This STANDARD is not met as evidenced by: Based on observations, review of facility policy and interviews, it was determined the staff failed to ensure vascular assess (VA) sites were washed with soap and water upon entering the facility and prior to treatment. This affected 3 of 3 of HD (hemodialysis) AVF/AVG (arteriovenous fistula/graft) treatment initiations with unsampled patients, PI (Patient Identifier) # 12, PI # 9, PI # 15 and had the potential to negatively affect all patients who dialyzed via VA sites at the facility. Findings include: Facility Policy: Access Assessment and Cannulation Published: 08/22/2018 Version: 1 Policy Assessment of Vascular Access Follow the steps below to access the vascular access: Step 1. Prior to treatment, ask your patient to wash access area with liquid soap for one minute, rinsing well. Dry with clean paper towel. Wash access (per above) if patients unable to clean their access. 1. During observations of care on 7/12/21 at 11:00 AM CST the surveyor observed PI # 12 enter the treatment floor, obtain a pre treatment weight then proceed to station 4 without first washing the AVF site with soap and water. At 11:07 AM, EI (Employee Identifier) # 5, PCT (Patient Care Technician), failed to ensure the access site was washed with soap and water before cannulation attempts to the left upper arm AVF. 2. During observations of care on 7/12/21 at 11:35 AM CST the surveyor observed PI # 9 enter the treatment floor, obtain a pre treatment weight then proceeded to station 6 without first washing the AVF site with soap and water. At 11:45 AM, EI # 4, PCT failed to ensure the</p>

access site was washed with soap and water before cannulation attempts to the left upper arm AVF. 3. On 7/12/21 at 11:40 AM CST, PI #15 entered the treatment floor, obtained a pre treatment weight and proceeded to station 3 without first washing the AVF/AVG site. At 11:55 AM, EI # 5, PCT prepped the access site with alcohol then cannulated the site without first ensuring the access was washed with soap and water. In interviews on 7/14/21 at 11:20 AM CST, EI # 1, Director of Operations confirmed staff must ensure access sites were washed with soap and water before cannulation and confirmed staff failed to follow the facility policy. 34107