

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012515	(X3) Date Survey Completed 04/20/2023
Name of Provider or Supplier Fresenius Medical Care Opelika	Street Address, City, State 2609 Village Professional Drive, Suite 2, Opelika, 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	<p>IC-ASEPTIC TECHNIQUES FOR IV MEDS CFR(s): 494.30(b)(2)</p> <p>[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</p> <p>This STANDARD is not met as evidenced by: Based on observations, review of facility policy, and interviews, it was determined the facility staff failed to ensure: 1. All intravenous (IV) medications were secured and stored according to facility policy. 2. A new needle and syringe was used during entry into a multi-dose vial (MDV). This affected one of four observations for IV medication preparation and administration and included PI # 19, and two random observations of unsampled patients and had the potential to negatively affect all patients served by this facility. Findings include: Facility Policy: Medication Preparation and Administration Published: 4/5/21 Version: 6 Purpose: To administer medications with the goals of staff and patient safety, optimal therapeutic response, and infection control. ...Infection Control Perform hand hygiene prior to accessing supplies, handling vials and IV solutions and preparing or administering medications Aseptic technique will be used to prepare and administer IV medications. ...Always use a sterile syringe and needle when entering a vial...If...vial is multi-use, a different syringe must be used for entry... Securement The following steps must be taken for the securement: All medications will be kept in a locked cabinet except when in use. 1. During a tour of the treatment floor on 4/18/23 at 8:30 AM, the surveyor observed seven unopened IV medication vials, one open bottle of Heparin and three oral medication bottles sitting on the counter in the medication preparation (prep) area. There was no Registered Nurse (RN) at the medication counter. In an interview conducted on 4/18/23 at 11:50 AM, the Employee Identifier (EI) # 4, RN was present</p>

at the medication prep counter and the surveyor asked EI # 4 if the IV medications were allowed to be left on the counter, not in the medication cabinet? EI # 4 responded he/she did not know the answer. 2. During observations on the treatment floor on 4/18/23 at 10:29 AM, EI # 4, RN entered the patient treatment floor around the area of stations 5 and 10 with prefilled/prepared IV medications in hand. EI # 4 placed an IV syringe on the chairside table of station 10, then exited the station leaving the IV medication unattended. EI # 4 entered station 5 and placed an IV syringe on the chairside table of station 5, exited the station, leaving the IV medication unattended. EI # 4 returned to station 10 at 10:30 AM and administered the IV medication to an unsampled patient. EI # 4 returned to station 5 at 10:35 AM and administered the IV medication to an unsampled patient. EI # 4 failed to ensure IV medications were stored and secured per policy, leaving the IV medication at station 10 unattended for six minutes, and leaving the IV medication at station 5 unattended for approximately ten minutes. An interview was conducted on 4/20/23 at 10:50 AM with EI # 1, Director of Operations who confirmed the IV medications were not secured per policy. 3. An observation was conducted on 4/18/23 at 1:05 PM of parenteral (medications given by injection or infusion) medication preparation and administration by EI # 3, RN, for PI # 19. EI # 3 was observed entering a MDV of Hectoral with a syringe and needle, withdrawing approximately one milliliter (ml) of the medication, then re-entering the MDV with the same needle and syringe to withdraw an additional 0.5 ml. EI # 3 failed to follow facility policy and utilize a different syringe for each entry into the MDV. An interview was conducted on 4/20/23 at 10:40 AM with EI # 1 who confirmed per facility policy the RN should have utilized a different syringe before entering the MDV a second time. 41624