Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	852539	07/26/2023
Name of Provider or Supplier	**Street Address, City, State**	
Eatonton Kidney Center	103 N Washington Avenue, Eatonton, GA	

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)
V0117	IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS CFR(s): 494.30(a)(1)(i) Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled. When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station. Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients. This STANDARD is not met as evidenced by: Based on observation, a review of the Centers for Disease Control and Prevention (CDC) guidelines, and staff interview, it was determined that the Infection Control Committee failed to ensure that one of one Registered Nurse (RN AA) observed, utilized appropriate infection control techniques to prevent cross contamination. This breach in infection control techniques could negatively affect the health and safety of one of one patient (P#4), who was undergoing hemodialysis (HD) treatment with central venous catheter (CVC - dialysis access) at the time of this observation. Findings include: During observation in the patient treatment room on 7/26/23 between 9:30 a.m. and 10:00 a.m., the following was observed: - RN AA was observed during initiation of HD treatment on P#4 with a CVC at Station 1. She placed the used syringes, gauzes and alcohol wipes (contaminated) on the blue liner that stored clean/sterile supplies such as Heparin-lock syringes, clean gauze pads, and clean alcohol pads. According to the CDC, measures to prevent contamination of

	clean or sterile items include not storing potentially contaminated (used) supplies in areas where clean (unused) supplies are handled. During an interview with the Facility Administrator on 7/26/23 at approximately 10:30 a.m., she stated that the nurse should have separated the clean supplies from the dirty/contaminated supplies to prevent cross contamination.