Department of Health & Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0391

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 852582	(X3) Date Survey Completed 04/26/2023
Name of Provider or Supplier West Clayton Dialysis	Street Address, City, State 100 Promenade Pkwy Suite C, Fayetteville, 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)
V0122	IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL CFR(s): 494.30(a)(4)(ii) [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. This STANDARD is not met as evidenced by: 1. Based on observation, staff interview, a review of Centers for Disease Control and Prevention (CDC) guidelines and recommendations, and a review of facility Policy, it was determined that the Infection Control Committee failed to ensure that one of one Licensed Practical Nurse (LPN AA) observed, utilized appropriate infection control techniques to prevent cross contamination. This deficient practice had the potential to negatively affect the health and safety of six of six patients (P#8, P#9, P#10, P#11, P#12, and P#13), who were currently undergoing hemodialysis treatment at the time of this observation. The facility census was 68. Findings include: - LPN AA was observed on 4/26/23 at 3:20 p.m., disinfecting the hemodialysis machine at Station 17 while Patient #12 was sitting at his dialysis chair, holding his dialysis access. - When this surveyor asked LPN AA on 4/26/23 at 3:30 p.m. if she was supposed to disinfect the machine while patient was still sitting in his chair, LPN AA stated, "No". According to the CDC guidelines and recommendations, a dialysis station, in order to prevent cross contamination, must be completely vacated by the previous patient before the ESRD (End Stage Renal Disease) staff may begin cleaning and disinfection of the station and set up for the next patient. A review of the facility Policy: 1-05-01 titled, "Infection Control for Dialysis Facilities" with latest revision date of April 2023, stated: Dialysis station must be completely vacated by the previous patient before teammates can begin to bring disinfection supplies to the station, clean or disinfect the station and set up for the next patient. 2. Based on observation, staff

	interviews, a review of the CDC guidelines and recommendations, and a review of facility Policy, it was determined that the Infection Control Committee failed to ensure that five of five Direct Patient Care (DPC) Staff: (Registered Nurse (RN) AA, Licensed Practical Nurse (LPN) AA, Patient Care Technicians (PCT) AA, BB and CC, who were working in the Treatment Room at the time of this observation, practiced infection control techniques to prevent cross contamination. This deficient practice had the potential to negatively affect the health and safety of 13 patients (P#1-P#13) who were undergoing hemodialysis treatment at the time of this observation. The facility census was 68. Findings include: - During observation in the Patient Treatment Room on 4/26/23 between 12:05 p.m. and 1:15 p.m., the following was revealed: - Two of three Hemodialysis machines sampled that had been vacated and disinfected at Station (S) 11, and S12, had dried, white sediments at the back of the machines. This observation was confirmed by PCT AA on 4/26/23 at 12:30 p.m., when this surveyor asked the assistance of PCT AA to move the machines to have a better look on the machines' front and back. PCT AA also stated that the back of the machines were not routinely cleaned between patient treatment. - The dialysis wall boxes (which are frames recessed into the wall at each hemodialysis station that contain connections for the dialysis machine to receive acid and base concentrates and treated water, and dispose of waste products), at S4, S9, and S12, had dried, white sediments. (The facility used a Bibag which is attached to a special connector incorporated into the front of the 2008T hemodialysis machine. The hemodialysis machine draws dialysis grade water into the Bibag to produce a saturated solution of Sodium Bicarbonate online or base concentrates). A review of the facility's Policy: 1-05-01, titled, "Infection Control for Dialysis Facilities", with latest revision date of April 2023, stated: 13. At the end of each treatment, the dialysis station will be cleaned and disinfected. a. Surfaces to disinfect include but are not necessarily limited to: all surfaces in contact with the patient or their belongings (e.g., dialysis chair, tray tables...) and frequently contacted by healthcare personnel (e.g., control panel; top, front and sides of dialysis machine...) i. The Wall box, Drain and Water supply lines are considered part of the dialysis delivery system... Teammates will monitor and address wall box residue/build up and patency issues... According to the CDC guidelines and recommendations, Dialysis Wall Boxes have several infection prevention and control issues unique to wall boxes. They can become easily contaminated with microorganisms, which can subsequently be transferred to dialysis patients, a vulnerable group at high risk of infection. Wall boxes contributed to a large number of infections in patients on dialysis... Thus, wall boxes need to be cleaned, disinfected, and properly maintained to decrease risk of patient infections.