

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 852608	(X3) Date Survey Completed 04/17/2024
Name of Provider or Supplier Peachtree Dialysis Center, Llc	Street Address, City, State 3850 Holcomb Bridge Road Ste 435, Peachtree Corners, 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)
V0113	<p>IC-WEAR GLOVES/HAND HYGIENE CFR(s): 494.30(a)(1)</p> <p>Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.</p> <p>This STANDARD is not met as evidenced by: Based on observation and a review of facility Policy and Procedures (P& P), it was determined that the Infection Control Committee failed to ensure that one of one Registered Nurse (RN AA) observed, changed gloves and performed hand hygiene (by handwashing or using an alcohol-based hand sanitizer), after touching contaminated equipment or "dirty area or task". Failure to perform infection control techniques such as changing gloves and performing hand hygiene, increased the risk for cross contamination with the potential to expose patients and staff to blood-borne pathogens in the dialysis environment. This deficient practice had the potential to negatively affect the health and safety of Patient, (P#2) who was undergoing initiation of hemodialysis (HD) treatment using the arterial catheter limb of the Central Venous Catheter and the venous needle of the Arteriovenous (AV) Fistula on P#2's left upper arm. The facility's current census was four. Findings include: During observation in the Patient Treatment Room on 4/17/24 between 8:45 a.m. and 9:25 a.m., the following was revealed: - RN AA was observed going from adjusting the venous needle of the AV fistula (which was not flowing well) by re-positioning and re-taping the venous needle (dirty task), to touching/re-setting the HD machine (dirty task), which was constantly alarming, and opening the arterial catheter limb cap (clean) to attach the bloodline, RN AA did not change gloves and did not perform hand hygiene between glove changes. In addition, RN AA did not scrub the catheter hub prior to attaching the bloodline. - A review of the facility Policy Number: 06.100, titled,</p>

"Infection Control", Section: Infection Control Guidelines, with an effective date of 6/1/23, stated: 4. Examples of when fresh pair of gloves must be put on: ... when going from a "dirty" area or task to a "clean" area or task... - When moving from a contaminated body site to a clean body site of the same patient...