

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)
V0117	<p>IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS CFR(s): 494.30(a)(1)(i)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, a review of the Centers for Disease Control and Prevention (CDC) guidelines and recommendations, a review of facility Policies and Procedures (P&P), and staff interview, it was determined that the Infection Control Committee failed to ensure that one of one Registered Nurse (RN AA) observed during initiation of hemodialysis (HD) treatment using one of two Central Venous Catheter (CVC) limbs, specifically, the arterial catheter limb that carries blood from the body to the dialyzer and using the venous access needle (which carries the filtered blood back to the body), of the arteriovenous (AV) fistula on the left upper arm, utilized appropriate infection control techniques to prevent cross contamination. This breach in infection control techniques could negatively affect the health and safety of two of two patients (P), (P#2 and P#3) who had a CVC, at this facility. The current facility census was four. Findings include: During observation in the Patient Treatment Room on 4/17/24</p>

between 8:45 a.m. and 9:25 a.m., the following was revealed: - RN AA was observed during initiation of HD treatment on P#2 at S2 using the arterial limb of the CVC and the venous needle of the AV fistula access. RN AA returned the used bloody syringe, used alcohol pads and gauze wrappers (dirty) back to the blue liner next to the remaining clean and sterile supplies. According to the CDC, cross contaminating (going from dirty to clean equipment/tasks/area), could cause the spread of bacteria /infections. - A review of facility Policy Number: 06.100, Section: "Infection Control Guidelines" with an effective date of 6/1/2023, did not show any specific policy or procedure for separating used supplies and clean supplies during CVC care. - RN AA was notified of this observation on 4/17/24 at approximately 9:30 a.m., which RN AA acknowledged and she stated that she should separate the dirty supplies and the clean supplies.