

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  852608	<b>(X3) Date Survey Completed</b>  04/17/2024
<b>Name of Provider or Supplier</b>  Peachtree Dialysis Center, Llc	<b>Street Address, City, State</b>  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.		

<b>(X4) ID Prefix Tag</b>	<b>Summary Statement of Deficiencies</b>  (Each deficiency should be preceded by full regulatory or LSC identifying information)
<b>V0122</b>	<p><b>IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL</b> CFR(s): 494.30(a)(4)(ii)</p> <p>[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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and a review of facility policy and procedures, it was determined that the Infection Control Committee failed to ensure that one of one Registered Nurse, (RN AA) observed, while performing pre-dialysis assessment, utilized appropriate infection control techniques to prevent cross contamination. Failure to disinfect stethoscope between each patient use, had the potential for cross contamination. The facility census was four. Findings include: On 4/17/24 at 11:07 a. m., RN AA performed post-assessment on P#1 at Station (S1), using a stethoscope. After the procedure, RN AA slung the stethoscope on the back of her neck without disinfecting the stethoscope. - RN AA acknowledged this breach in infection control on 4/17/24 at approximately 11:12 a.m., and RN AA asked this surveyor, which part of the stethoscope should she disinfect.</p>