STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015202	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MCGUFFEY HEALTH & REHABILITATION CENTER	2301 RAINBOW DRIVE GADSDEN, AL 35999

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, review of the 2017 U.S. (United States) Public Health Service Food Code, and review of a facility policy titled Hand Hygiene, the facility failed to ensure: 1) a Certified Nursing Assistant (CNA) washed hands when filling water pitchers with ice for Resident Identifier (RI) #s 35 and 100; and 2) CNAs did not touch food and utensils with bare hands when assisting RI #125 and RI #74 with meal set-up and/or feeding. These findings affected four of 157 total residents residing in the facility. Findings include: 1) A review of a facility policy titled, Hand Hygiene, with a revision date of 2/29/2020, revealed . 1) All personnel shall follow our established hand hygiene procedures to prevent the spread of infection and disease to other personnel, patients, and visitors. 2) Employees must perform hand hygiene procedures, either using an alcohol based hand rub or handwashing under the following conditions . After handling items potentially contaminated with . secretions . After removing gloves . RI #100 was readmitted to the facility on [DATE]. RI #35 was readmitted to the facility on [DATE]. On 03/10/2020 at 11:02 a.m., the surveyor observed Employee Identifier (EI) #1, a CNA, on Hall 500. EI #1 put gloves on both of her hands prior to entering RI #35's room, picked up RI #35's water pitcher from the bedside table, walked outside of RI #35's room with the water pitcher in her left gloved hand. EI #1 opened the lid of the ice chest with her right gloved hand, and picked up the ice scoop to fill RI #35's water pitcher with ice. EI #1 did not remove her gloves and wash or use hand sanitizer prior to entering or leaving RI # 35's room with the water pitcher. EI #1 reentered RI #35's room and placed the water pitcher on RI #35's bedside table. EI #1 did not remove her gloves or wash her hands prior to leaving the RI # 35's room. EI #1 then entered RI #100's room with the same gloves on from RI #35's room. RI #1 did not remove her gloves or wash her hands prior to entering RI #100's room. EI #1 picked up RI #100's water pitcher, walked out of RI #100's room with the water pitcher in her left gloved hand, opened the ice chest lid with her right gloved hand. EI #1 reentered RI #100's room with the same gloves on. EI #1 placed the water pitcher on the bedside table of RI #100 with her left gloved hand. On 3/10/2020 at 2:57 p.m., the surveyor conducted an interview with EI #1, a CNA. EI # 1 was asked what she should have done prior to leaving RI # 35's and RI #100's rooms with the water pitchers to fill them with ice, and prior to re-entering their rooms with the water pitchers. EI #1 stated she should have removed her gloves and washed her hands prior to leaving their rooms with the water pitchers and again before re-entering their rooms. EI #1 was asked what would be the concern if a CNA did not remove her gloves and wash or sanitize her hands when entering resident rooms and filling their water pitchers with ice. EI #1 stated it could cause contamination, illness, sickness, or infection to a resident or herself. On 3/10/2020 at 2:57 p.m., the surveyor conducted an interview with EI #2, Infection Control Preventionist/Director of Nursing/Registered Nurse. EI #2 was asked what should a CNA do prior to leaving a resident's room with the water pitcher to fill it with ice and prior to re-entering the resident's room with the water pitcher. EI #2 replied that she should have removed her gloves and washed her hands or used hand sanitizer. EI #2 was asked what would be the concern if a CNA did not remove her gloves and wash or use hand sanitizer on her hands. EI #2 stated the CNA could transport any kind of organism from one area to another or one resident to another resident. 2) The FDA 2017 Food Code included the following: . 3-301.11 Preventing Contamination from Hands . bare hand contact with ready-to-eat foods can contribute to the transmission of foodborne illness . critical factors in reducing food borne illness . no bare hand contact. . highly susceptible populations include persons who are immunocompromised . the elderly . may not use alternatives to the no bare hands contact with ready-to-eat food . RI #125 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of RI #125's Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed RI #125 had severe cognitive impairment and required extensive assistance of one person for eating. On 03/10/2020 at 11:56 a.m., the surveyor observed EI #5, CNA, pick up a piece of garlic bread with her bare hand and feed it to RI #125 during a meal observation in the dining room. An interview was conducted with EI #5 on 03/11/2020 at 02:30 p.m EI #5 was asked if she touched RI #125's garlic bread with her bare hands while feeding him/her lunch on 03/10/2020. EI #5 stated yes. EI #5 was asked if she continued to feed the resident the garlic bread after touching it with her bare hands. EI #5 stated yes. EI #5 was asked if she should have touched the garlic bread with her bare hands. EI #5 stated no. EI #5 was asked what the potential harm was in touching bread with her bare hands. EI #5 stated cross contamination. An interview was conducted with EI #2, Infection Control Preventionist/Director of Nursing/Registered Nurse, on 03/11/2020 at 6:25 p.m EI #2 was asked when should staff touch a resident's garlic bread with bare hands. EI #2 stated never. EI #2 was asked why should you not touch a resident's garlic bread with your bare hands. EI #2 stated you would not want to contaminate the resident's food with anything on your hands. EI #2 was asked should staff ever touch a resident's food with their bare hands. EI #2 stated no. EI #2 was asked what the potential harm is in touching bread with your bare hands. EI #2 stated cross contamination. RI #74 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of RI #74's Significant Change in Status Minimum Data Set (MDS) assessment dated [DATE], revealed RI #74 had severe cognitive impairment and required extensive assistance of one person for eating. On 03/11/2020 at 05:09 p.m., the surveyor observed EI #6 , A CNA, setting up a meal tray for RI #74. EI #6 was observed to take the paper wrapping off the straw and place it into RI #74's sweet tea touching the top of the straw with her bare hand. After RI #74 drank the tea, EI #6 was observed to place the same straw in RI #74's milk. An interview was conducted with EI #6 on 03/11/2020 at 05:58 p.m EI #6 was asked if she used her bare hands to put the straw in RI #74's sweet tea. EI #6 stated yes. EI #6 was asked if she should have used her bare hands. EI #6 stated no. EI #6 was asked why she should not have used her bare hands. EI #6 stated germs. EI #6 was asked what the potential harm is in touching the top of the straw that goes into the resident's mouth with your bare hands. EI #6 stated cross contamination.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of a facility policy titled Hand Hygiene, the facility failed to ensure a Licensed Nurse did not use gloves that were placed on top of the vanity sink in Resident Identifier (RI) #39's room to administer RI #39's oral medication inhaler. Further, the Licensed nurse did not wash or sanitize her hands prior to putting on another pair of gloves. This affected one of four residents and one of three Licensed Nurses observed during medication administration pass. Findings include: A review of a facility policy titled, Hand Hygiene, with a revision date of 2/29/2020, revealed . 1) All personnel shall follow our established hand hygiene procedures to prevent the spread of infection and disease to other personnel, patients, and visitors. 2) Employees must perform hand hygiene procedures, either using an alcohol based hand rub or handwashing under the following conditions . After handling items potentially contaminated with . secretions . After removing gloves . RI #39 was readmitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. On 3/12/2020 beginning at 8:14 a.m., the surveyor observed EI #3, a Licensed Practical Nurse (LPN),

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) during medication administration pass for RI #39. EI #3 applied gloves to her hands that had been placed on top of the vanity sink in RI #39's room prior to administering RI #39's oral medication inhaler. EI #3 did not wash or sanitize her hands after she removed her gloves and prior to putting on another pair of gloves, then administered RI #39's eye drops. On 3/12/2020 at 11:48 a.m., an interview was conducted with EI #3, a LPN. EI #3 was asked where did you get the gloves that you put on after you washed and dried your hands at RI #39's sink, and prior to administering RI #39's oral medication inhaler. EI #3 stated she picked the gloves up from the top of the vanity sink in RI #39's room. EI #3 further stated she should have put on a clean pair of gloves. EI #3 was asked why she put on the gloves from the top of the vanity sink in RI #39's. EI #3 stated she was nervous. When asked what the concern in this was, #3 stated it could cause cross contamination and could cause an infection to a resident or herself. EI #3 was asked what she should have done after giving RI #39's oral medication inhaler, prior to putting on another pair of gloves to administer RI #39's eye drop medication. EI #3 stated she should have washed or sanitized her hands because it could cause an infection to the staff, visitors, residents and herself. On 3/12/2020 at 12:16 p.m., an interview was conducted with EI #4, Director of Clinical Services. EI #4 was asked what would be the concern if a Licensed Nurse did not wash or sanitize her hands after she gave RI #39's oral medication inhaler, prior to putting on a new pair of gloves. EI #4 stated it was a potential for contamination. EI #4 was asked what would be the concern if a Licensed Nurse put on gloves from the top of the vanity sink in RI #39's room, prior to administering RI #39's oral medication inhaler. EI #4 stated it was a potential for contamination. EI #4 was asked what the facility's Hand Washing Policy stated should be done after touching the environment in a resident's room and after removing gloves. EI #4 stated you should perform hand hygiene.