STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015147	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GLENWOOD CENTER	211 ANA DRIVE FLORENCE, AL 35630

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of Resident Identifier (RI) #2's medical record and the facility's policy titled Medication Administration: Inhaled (MDIs) (Metered Dose Inhalers), the facility failed to ensure Employee Identifier (EI) #2, a Registered Nurse (RN) administered RI #2's inhaler medication in accordance with the facility's policy and procedure. This deficient practice affected RI #2, one of four residents observed for medication administration. Findings include: The facility's policy titled, Medication Administration: Inhaled (MDIs), with a revised date of 11/1/2019, documented . 3. Administer medication . 3.4 Evaluate patient's heart rate, respiratory rate, and breath sounds . 3.8 Instruct patient to slowly exhale through pursed lips. 3.9 Place spacer in patient's mouth. If not using spaces, hold MDI 1 1/2 inches away from patient's open mouth. 3.10 Instruct patient to begin inhaling slowly, while actuating the MDI. 3.11 Instruct patient to continue inhaling slowly and deeply, hold breath for 5 to 10 seconds, then exhale. 3.12 Wait for one minute between puffs of the same medication and five minutes between puffs of different medications . 8. Evaluate patient's heart rate, respiratory rate and breath sounds after administration . During medication pass observation on 8/26/2020 beginning at 7:55 AM, EI #2, a RN handed RI #2 an [MEDICATION NAME] inhaler for administration without any instructions on what to do or assessment of the resident. One minute later, EI #2 handed RI #2 the [MEDICATION NAME] inhaler. EI #2 again did not provide any instructions to the resident on what to do. EI #2 did not assess RI #2's heart rate, respiratory rate or breath sounds after administration of the inhaler medications. In an interview on 8/26/2020 at 10:35 AM, EI #2, a RN was asked if she assessed RI #2 prior to and after administration of the inhaler medications. EI #2 said no. When asked should she have, EI #2 replied yes. When asked why she didn't, EI #2 said she was nervous. EI #2 was asked if she instructed RI #2 on how to use the inhaler medication when it was handed to the resident. EI # answered, she did not. When asked if she waited five minutes in between the administration of the [MEDICATION NAME] and [MEDICATION NAME] inhalers, EI #2 replied, she did not. EI #2 stated she should have waited but she was nervous. EI #2 stated the concern with no waiting five minutes between each inhaler was that the resident might not get the full benefit of the medication.
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, review of FUNDAMENTALS OF NURSING NINTH EDITION and the facility's policy titled IC203 Hand Hygiene, the facility failed to ensure Employee Identifier (EI) #1, a Licensed Practical Nurse (LPN) did not place Resident Identifier (RI) #1's [MEDICATION NAME] Insulin pen on top of the medication cart without a barrier. The facility further failed to ensure EI #2, a Registered Nurse (RN) changed her gloves after touching a potentially contaminated item before she administered medications to RI #2. These deficient practices affected RI #1 and RI #2, two of four residents observed for medication administration. Findings include: 1) Page 445 of Chapter 29 titled Infection Prevention and Control of FUNDAMENTALS OF NURSING NINTH EDITION documented . Modes of Transmission . The major route of transmission of pathogens identified in the health care setting is the unwashed hands of the health care worker. Equipment used within the environment often becomes a source for the transmission of pathogens . During medication pass observation on 8/25/2020 at 3:31 PM, EI #1, an LPN placed RI #1's [MEDICATION NAME] Insulin pen on top of some papers and book on top of the medication cart prior to administering the medication to the resident. In an interview on 8/26/2020 at 10:54 AM, EI #1, an LPN was asked should she place items to be used in a medication pass on potentially contaminated surfaces. EI #1 said no. When asked where she placed RI #1's Insulin pen prior to administration, EI #1 replied on top of the book on the cart. EI #1 was asked what the book and papers should be considered. EI #1 stated potentially contaminated because she did not know what might be on them. EI #1 was asked what the concern was with placing an insulin pen on a potentially contaminated surface prior to administration. EI #1 answered cross contamination and infection control. In an interview on 8/26/2020 at 11:11 AM, EI #3, the Infection Control Preventionist was asked should items used in medication pass be placed on potentially contaminated surfaces. EI #3 replied, no, they must have a barrier. When asked what the concern was with placing an Insulin pen on a potentially contaminated surface, EI #3 answered the transmission of bacteria and infection control. 2) The facility's policy titled IC203 Hand Hygiene with a revision date of 11/28/2017, documented POLICY Adherence to hand hygiene practices is maintained by all Center personnel . PURPOSE To improve hand hygiene practices and reduce the transmission of pathogenic microorganisms . PROCESS 1. Perform hand hygiene: . 1.5 After contact with the patient's environment . During medication pass observation on 8/26/2020 at 7:55 AM, EI #2, a RN wore gloves while she adjusted RI #2's bed with the bed remote. EI #2 then wore those same gloves when she administered two inhaler medications, a nasal spray and by mouth medications to RI #2. In an interview on 8/26/2020 at 10:35 AM, EI #2, a RN was asked did she change her gloves and sanitize her hands after she used RI #2's remote to adjust the resident's bed prior to medication administration. EI #2 replied, no. EI #2 was asked what the concern was with not changing gloves after touching a potentially contaminated item or surface. EI #2 answered, the spread of infection by spreading bacteria on whatever touched to the resident. In an interview on 8/26/2020 at 11:11 AM, EI #3, the Infection Control Preventionist was asked should a nurse adjust a bed with the remote control while wearing gloves and then administer medications wearing those same gloves, EI #3 answered no. EI #3 explained the nurse should have set the medications down on a barrier on the bedside table, adjust the bed, sanitize her hands, reapply gloves, administer the medications then wash her hands. When asked what the concern was with not changing gloves after touching a potentially contaminated item then administering medication wearing the same gloves, EI #3 answered the transmission of bacteria and infection control.

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.