STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025031	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTH PENINSULA HOSPITAL LTC	**4300 BARTLETT STREET HOMER, AK 99603**

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 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 record review, observation, and policy review, the facility failed to ensure staff performed handwashing between gloves changes when performing personal care for 2 residents (#s 2 and 5) out of 6 sampled residents. This failed practice had the potential to spread infectious diseases such as COVID-19 (an infection caused by [DIAGNOSES REDACTED]-CoV-2 virus that may result to acute respiratory syndrome, multi-organ system failure and septic shock) Findings: Resident #2: Record review on 8/11/20 revealed Resident #2 had [DIAGNOSES REDACTED]. Review of the most recent Minimum Data Set (MDS) quarterly assessment, dated 7/30/20, revealed the Resident required extensive assistance with personal hygiene and total assistance with transfers. The Resident was always continent of bowel and frequently incontinent of urine. Observation during personal care on 8/11/20 at 9:10 am, Certified Nursing Assistant (CNA) #2 sanitized both hands with hand sanitizer, donned gloves and entered Resident #2's room. The Resident stated he/she was ready to get out of bed and needed to use the commode. CNA #1 entered the room, sanitized both hands and donned gloves. After assisting the Resident with turning to his/her side, CNA #2 removed the Resident's wet disposable incontinence brief from under the buttocks and used disposable wipes to clean Resident #2's peri area. CNA #2 then removed both soiled gloves, and without performing hand hygiene, donned a new pair of gloves. Both CNAs then positioned a transfer sling under the Resident and used the ceiling lift to transfer him/her to the commode. After the Resident had a bowel movement in the commode, CNA #2 cleaned Resident #2's buttocks with a disposable wipe. CNA #2 then removed both soiled gloves, and without performing hand hygiene, donned a new pair of gloves and both CNAs transferred the Resident to his/her lounge chair. During the transfer, CNA #2 touched multiple items in the room with the same gloved hands. Resident #5: Record review on 8/11/20 revealed Resident #5 had a history of [REDACTED]. Review of a MDS quarterly assessment, dated 7/24/20, revealed Resident #5 needed total assistance with toileting and extensive assistance with hygiene. The Resident was always incontinent of urine and frequently incontinent of stool. Observation during personal care on 8/11/20 at 11:30 am, CNA # 1 and Licensed Nurse (LN) #1 assisted Resident #5 with personal cares. After entering the room, sanitizing hands, and donning gloves CAN #1 removed the urine soaked incontinence pad wrapped around the penis, and used disposable wipes to clean the Resident's groin. After he/she placed the soiled items in the trash, CNA #1 removed both gloves, and without performing hand hygiene, retrieved a pair from a box by the door, and changed into the new pair of gloves, while stating No Gloves in my pocket of course. CNA #1 then placed a clean incontinence pad around Resident #5's penis, and pulled a pad up between the Resident's legs. While wearing the same gloves, the CNA and LN #1 pulled the Resident up in bed and CNA #1 placed a wedge pillow under the Resident's right side, used a disinfecting wipe to clean the Resident's call light and side rails, and adjust both feet. Both staff then exited the room. Review of the Meeting Minutes, on 8/10/20, for the all staff meeting, conducted 6/17/20, revealed Change gloves and perform hand hygiene when performing care moving from a Dirty Area (peri care) to Clean Area (face/oral care) if moving from a contaminated body site to a clean body site during patient care .No gloves inside pockets! Considered dirty. According to CDC guidelines on hand hygiene in health care settings, accessed on 8/21/20 at https://www.cdc.gov/handhygiene/providers/guideline.html, stated Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient; Before performing an aseptic task .; Before moving from work on a soiled body site to a clean body site on the same patient; After touching a patient or the patient's immediate environment; After contact with blood, body fluids, or contaminated surfaces; (and) Immediately after glove removal .

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