STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025015	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WRANGELL MEDICAL CENTER LTC	**P.O. BOX 1081 WRANGELL, AK 99929**

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** - Many	**Provide and implement an infection prevention and control program.** . Based on observation, interview and record review, the facility failed to ensure proper infection control procedures during donning (putting on) and doffing (taking off) of personal protective equipment (PPE). Specifically, the facility failed to store the PPE without possible cross - contamination; to perform hand hygiene between mask changes; and to remain masked while speaking to other staff members. This failed practice had the potential to affect all residents, based on a census of 11, by potentially increasing the spread of COVID-19. Findings: Mask storage and hand hygiene: During an observation and interview on 9/16/20 at 10:15 am, in the hallway outside each Resident's room, brown paper bags were lined up against the wall containing a mask designated for use with each individual Resident. Certified Nursing Assistant (CNA) #5 was observed going into Resident #7's room and exchanging his/her mask. CNA #5 explained that he/she would have worn a surgical mask while in the hallway, and an N95 mask (used to protect the wearer from airborne particles and from liquid contaminating the face) in the Resident's rooms. Before entering the Resident's rooms, he/she would have retrieved his/her N95 mask from his/her brown paper bag, which was stored lined up outside each Resident's room. CNA #5 further explained that the surgical, or hallway mask, would then be placed in the same paper bag in which the N95 was stored. CNA #5 further stated that when leaving the Resident's room, he/she would have then placed the N95 mask back into the same bag where the surgical mask had been stored. Further observation revealed each staff had 1 brown paper bag for exchanging both their N95 and surgical masks. During an interview on 9/16/20 at 10:50 am, when asked about how he/she received education on donning and doffing, Licensed Nurse (LN) #1 stated the education was provided through e-mails. LN #1 further stated that he/she already knew how to put on PPE because he/she had been a nurse for a long time, but he/she probably made little mistakes. During an observation on 9/16/20 at 11:37 am, LN #1 was donning PPE to enter Resident #5's room. LN #1 removed his/her N95 mask from the paper bag and placed his/her surgical mask inside the same paper bag. LN #1 did not perform hand hygiene after removing the surgical mask and before placing on the N95 mask. During the same observation on 9/16/20 at 11:42 am, LN #1 was doffing PPE when exiting Resident #5's room. LN #1 removed his/her surgical mask from the paper bag, and placed his/her N95 mask in the same paper bag. LN #1 did not perform hand hygiene after removing the N95 mask and before placing on the surgical mask. During an observation on 9/16/20 at 11:53 am, CNA #5 was donning PPE to enter Resident #7's room. CNA #5 removed his/her N95 mask from the paper bag and placed his/her surgical mask inside the same paper bag. CNA #5 did not perform hand hygiene after removing the surgical mask and before placing on the N95 mask. During an interview on 9/16/20 at 11:55 am, CNA #4 stated that he/she had been trained on donning and doffing PPE with the Infection Control (IC) LN who had resigned. CNA #4 further stated that the current process of changing masks was not going on when he/she was trained. When asked if he/she had been observed by staff for proper donning and doffing techniques, CNA #4 stated that no one had ever watched him/her don/doff PPE. During an observation on 9/16/20 at 12:00 pm, CNA #5 was doffing PPE to exit Resident #7's room. CNA #5 removed his/her surgical mask from the paper bag and placed his/her N95 mask inside the same paper bag. CNA #5 did not perform hand hygiene after removing the N95 mask and before placing on the surgical mask. During an observation and interview on 9/16/20 at 2:58 pm, CNA #6 was observed leaving Resident #5's room and hanging his/her N95 mask on a hook on the other side of the hallway. When asked about the process of changing masks, CNA #6 replied that he/she did not want to place his/her mask into the same bag the other mask was in, because the bag would have been dirty. LN #1 responded we use the same bag for both masks because it's our germs. During the same interview, when asked if he/she had received education on donning and doffing, CNA #6 stated that when he/she was taught, staff were discarding the gowns and no one had shown him/her how to don and doff with the new process of recycling the supplies. During an interview on 9/16/20 at 3:15 pm with the Infection Control Preventionist (ICP) for the consortium, when asked if the same storage bag should have been used for both masks, it was stated that no, it was not appropriate to use the same bag for both masks. The ICP further stated that hand hygiene should have been performed every time staff had touched their masks. Review on 9/17/20 at 8:30 am of the facility's policy Isolation Precautions, Transmission Based, revised 1/7/19, revealed Respiratory Protection .Perform hand hygiene after removing the respiratory protection (mask) . Review on 9/17/20 at 10:00 am of Facemasks, updated 6/28/20, accessed at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html, revealed HCP (Health Care Provider) must take care not to touch their facemask. If they touch or adjust their facemask they must immediately perform hand hygiene . Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean sealable paper bag or breathable container. Afternoon mask observations: During an observation on 9/16/20 at 5:17 pm, LN #1 removed his/her surgical mask, while simultaneously removing his/her N95 mask from the paper bag in which it was stored. LN #1 placed his/her surgical mask in the same paper bag in which the N95 was stored. LN #1 did not perform hand hygiene after removing the surgical mask. While holding the N95 in his/her hand, LN #1 placed on his/her eye shield. Without a mask on, LN #1 knocked on Resident #10's door and asked the Resident if he/she was okay. LN #1 then walked down the hall toward Resident #3's room and the supply cart, LN #1 donned his/her N95 while walking down the hall. During the same observation, at 5:22 pm, LN #1 walked out of Resident # 10's room. LN #1 removed his/her N95 mask and retrieved his/her brown paper bag. LN #1, without performing hand hygiene, removed the surgical mask from the bag, then placed the N95 mask in the same bag. Unmasked, LN #1 was speaking to other staff members standing near him/her while performing this task. LN # 1 then placed on his/her surgical mask. During an observation on 9/16/20 at 5:23 pm, CNA #5 removed his/her N95 mask. Without performing hand hygiene, CNA #5 retrieved his/her surgical mask from his/her brown paper bag, then placed the N95 mask into the same brown paper bag. During this process, CNA #5, who was unmasked, was speaking to other staff members standing near him/her while unmasked. During the same observation, CNA #4 removed his/her N95 mask. Without performing hand hygiene, CNA #4 retrieved his/her surgical mask from his/her brown paper bag, then placed the N95 mask into the same bag. During an observation on 9/16/20 at 5:32 pm, CNA #6 was changing out his/her mask. Unmasked, CNA #6 was speaking to LN #1 who was standing next to him/her, while performing this task. Review on 9/17/20 at 9:30 am of Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated on 7/15/20, accessed at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html, revealed Implement Universal Source Control Measure (-) Source control refers to use of cloth face coverings or facemasks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. During an interview on 9/17/20 at 3:49 pm with the ICP for the consortium, it was stated that staff should not have been speaking to one another while changing their masks. Mask-less in Resident neighborhood: During an interview on 9/16/20 at 12:17 pm, LN #1 stated he/she just found out that he/she could not write on his/her mask and had discarded his/her mask in the trash receptacle. During a continuous observation on 9/16/20 from 12:18 pm to 12:20 pm, LN #1, who was unmasked during this time, stood in front of the administration office, near Resident #3's room, while awaiting a staff member to bring a new mask to him/her. During an

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 -** Many	(continued... from page 1) interview on 9/16/20 at 3:15 pm with the ICP for the consortium, when asked about staff being unmasked for 2 minutes while in the facility, it was stated that it was not appropriate to be without a mask for that length of time. During an observation on 9/16/20 at 5:30 pm, Activity Aide (AA) #10 left the Physical Therapy room unmasked. AA #10 walked 10-12 steps to Resident #5's room, then placed his/her mask on while standing outside the room. Review on 9/17/20 at 9:30 am of Infection Control for Nursing Homes, updated 6/25/20, accessed at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, revealed .HCP (health care personnel) should wear a facemask at all times while they are in the facility. Shields contaminated by gowns: During an interview on 9/16/20 at 9:57 am, CNA #7 stated the face shield would have been cleaned after leaving the Resident's room. During an observation on 9/16/20 at 12:35 pm, AA #11 doffed his/her PPE after exiting Resident #10's room. AA #11 wiped down his/her face shield with a disinfectant wipe. AA #11 then hung his/her gown on a hook outside of the room. AA #11 then placed his/her clean face shield on the same hook above the dirty gown, causing the inside of the face shield to rub against the outside of the contaminated gown. During an observation on 9/16/20 at 2:05 pm outside of Resident #7's room, CNA #5's face shield was hanging above his/her gown; the inside of the shield was rubbing against the gown. During the same observation outside of Resident 9's room, CNA #4's gown was placed hanging over his/her face shield; the inside of the face shield was rubbing against the gown. During an observation on 9/16/20 at 2:20 pm outside of Resident #1's room, CNA #6's shield was hanging above his/her gown; the inside of the shield was rubbing the outside of the gown. During an interview on 9/16/20 at 3:15 pm with the ICP for the consortium, when asked about the shields rubbing against the gowns, the ICP stated that the shields should have been turned around so that the inside of the shield would not be touching the outside of the gowns. Gowns over bags: An observation on 9/16/20 at 10:30 am of the donning/doffing area outside of Resident #3's room revealed LN #12's brown paper mask storage bag was stored behind CNA # 4's isolation gown, which was draped over and touching LN #12's mask bag. An observation on 9/16/20 at 10:35 am of the donning/doffing area outside of Resident #9's room revealed LN #1's mask storage bag was placed behind CNA #4's isolation gown. The gown was draped over and touching the storage mask bag. An observation on 9/16/20 at 2:05 pm of the donning/doffing area outside of Resident #10's room revealed CNA #4's brown paper mask storage bag was left open. AA #11 and CNA #4's gowns were draped over and rubbing against the opened mask storage bag. Further observation revealed CNA #5's mask storage bag was opened, and his/her gown was draped over and rubbing against the mask storage bag. An observation on 9/16/20 at 10:44 am revealed CNA #4 was donning PPE outside of Resident #11's room. While changing masks, CNA #4 touched LN #1's gown to retrieve his/her mask bag which was placed behind the LN's gown. CNA #4 did not perform hand hygiene after touching the LN's gown. An observation on 9/16/20 at 10:46 am revealed Housekeeper #1's mask storage bag was stored behind LN #1 and CNA #6's gowns, which were draped over and touching the Housekeeper's mask bag. Further observation revealed LN #12's mask storage bag was stored behind CNA #6's gown, which was draped over and touching the mask bag. Further observation revealed AA #11's mask bag was stored behind his/her gown, which was draped over and touching the mask bag. An observation on 9/16/20 at 2:09 pm of the donning/doffing area outside of Resident #3's room revealed LN #1's mask bag was opened, and his/her gown was draped over and touching the mask bag. An observation on 9/16/20 at 2:15 pm of the donning/doffing area outside of Resident #9's room revealed CNA #5's mask bag was left opened. LN #1's gown was draped over the CNA's storage bag and was rubbing against the bag. During an interview on 9/16/20 at 3:15 pm with the ICP for the consortium, when asked about the placing of the mask storage bags behind the gowns, it was stated that the isolation gowns should not have been draped over the mask storage bags, because the isolation gowns were considered contaminated, which would have then contaminated the bags. Review on 9/17/20 at 11:00 am of Infection Control for Nursing Homes, updated 6/25/20, accessed at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, revealed Reinforce adherence to standard IPC measures including hand hygiene and selection and correct use of personal protective equipment (PPE). Have HCP demonstrate competency with putting on and removing PPE and monitor adherence by observing their resident care activities. During a joint interview on 9/17/20 at 3:49 pm with the Director of Nursing, Infection Control LN and ICP for the consortium, when asked about staff training for donning and doffing, it was stated that staff had received on-line training last April and quick reference posters were placed at the donning/doffing stations. When asked to provide documentation of staff education with return demonstration of PPE use, the Course Completion History, dated 9/17/20, was provided which revealed online completion of Novel pathogens: donning & doffing PPE for aerosol-generating procedures. No education documentation of return demonstration was provided. An observation on 9/16/20 at 10:00 am at the donning / doffing stations revealed the quick reference posters created by the CDC on how to don and doff PPE did not show or depict a process for the gown and mask re-use and storage. During a joint interview on 9/17/20 at 3:49 pm with the Director of Nursing, Infection Control LN and ICP for the consortium, when asked about surveillance to assure staff were properly donning and doffing PPE, it was stated that Just in time training had taken place. When asked for surveillance documentation, it was stated that surveillance was done on 9/16/20. Review on 9/17/20 at 4:45 pm of the facility document PPE Personal Protective Equipment, dated 9/2020, revealed 6 staff members had been observed before and after utilizing equipment. All 6 staff members had the answer No under Donning per CDC Guidelines? which had revealed staff where donning incorrectly. Further review revealed all 6 staff member had the answer No under Doffing per CDC Guidelines? which revealed staff were doffing incorrectly. Further review revealed Just-in-Time Training was done with all 6 staff members. .