STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015361	A. BUILDING _____ B. WING _____	**08/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAUDERDALE CHRISTIAN NURSING HOME	**2019 COUNTY ROAD 394 KILLEN, AL 35645**

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 observation, interviews, review of Resident Identifier (RI) #1's medical record, the facility's policy titled Prevention of transmission of Bloodborne Pathogens with fingerstick Glucometers and the Glucometer Competency Checklist, the facility failed to ensure Employee Identifier (EI) #2, a Licensed Practical Nurse (LPN) did not place a glucometer on top of the medication cart and RI #1's overbed (bedside) table without placing a barrier prior to obtaining RI #1's fingerstick blood sugar. The facility further failed ensure EI #2, an LPN, did not dispose of a used blood glucose test strip, alcohol wipe and Kleenex containing blood in RI #1's trash can. These deficient practices affected RI #1, one of three residents observed for medication pass administration. Findings include: The facility's policy titled Prevention of transmission of Bloodborne Pathogens with fingerstick Glucometers reviewed March 2020, documented: . 1. Wash hand (soap and water or alcohol-based rub). Place Barrier, then place meter on barrier . Glucometers . 4. Dispose of used test strip into sharps container . An undated facility document with a procedure title of Glucometer Competency Checklist, documented: . Place barrier, then place glucometer (equipment) on barrier . Dispose of lancet, alcohol wipe and test strip into sharps container . RI #1 was admitted to the facility on [DATE]. RI #1 has a medical history to include a [DIAGNOSES REDACTED]. During medication pass observation on 8/4/2020 at 7:59 AM, EI #2, an LPN cleaned the glucometer and placed it on top of the medication cart without a barrier. Once EI #2 entered RI #1's room, she placed the glucometer on RI #1's overbed (bedside) table without a barrier. EI #2 pricked RI #1's finger and obtained a blood glucose reading of 144. EI #2 used an alcohol wipe to wipe the blood along the resident's finger and a Kleenex to stop the bleeding. EI #2 was observed to roll the bloody alcohol wipe and Kleenex into her gloves, then she placed the gloves into the trash can in the resident's room. EI #2 returned to her medication cart to clean and disinfect the glucometer. When asked where she placed the used test strip, EI #2 stated in the sharps container. EI #2 was then asked to return to RI #1's room and retrieve the gloves she had placed in the resident's trash can to see the items that were rolled into the gloves. When EI #2 unrolled the gloves, she had removed from the trash can, she found the bloody alcohol wipe, bloody Kleenex, and the used test strip that contained blood. EI #2 stated, That (used test strip) should be in (the) sharps. I shouldn't have done that. In an interview on 8/4/2020 at 2:54 PM, EI #2, an LPN, was asked how should blood glucose test strips be discarded after obtaining a resident's fingerstick blood sugar (FSBS). EI #2 said they should be discarded in the sharps container only. EI #2 was asked where any items with blood products should be discarded. EI #2 stated in the sharps or red bag container. EI #2 was asked why any items containing blood products should not be placed in a resident's trash can in their room. EI #2 replied that anyone could rummage through the trash can and if they had any open areas to their skin they could contract any disease that could contain a bloodborne pathogen. EI #2 was asked where she placed RI #1's glucometer after cleaning it before obtaining RI #1's FSBS. EI #2 said on top of her cart. EI #2 was asked did she place a barrier down before placing the glucometer on the cart. EI #2 said no. EI #2 was asked where she placed the glucometer when she entered RI #1's room. EI #2 said on the resident's bedside table. EI #2 was asked did she clean the surface or place a barrier before placing the glucometer on the table. EI #2 stated that the bedside table was cleaned after picking up RI #1's breakfast meal. EI #2 was asked did she observe RI #1's bedside table from the time it was cleaned until she checked his/her FSBS. EI #2 said no, she was not able to visualize the bedside table to ensure it was not contaminated because it was not in her constant visual line of sight. EI #2 was asked was a bedside table considered a potentially contaminated surface. EI #2 stated yes. EI #2 was asked what she should do before placing a glucometer or any other equipment on a potentially contaminated surface. EI #2 replied it should have a barrier. EI #2 was asked what the concern was with the things discussed. EI #2 answered cross contamination and infection control. On 8/4/2020 at 3:52 PM, an interview was conducted with EI #1, Registered Nurse (RN)/Assistant Director of Nursing (ADON)/Infection Control Preventionist (ICP). EI #1 was asked where should used test strips be discarded after obtaining a resident's FSBS. EI #1 said they should be placed in the sharps container. EI #1 was asked where alcohol wipes or Kleenex containing blood products should be placed. EI #1 replied in the sharps container or red bags. EI #1 was asked should any medical equipment, including glucometer be placed on potentially contaminated surfaces after being cleaned. EI #1 stated no. EI #1 was asked where should clean equipment be placed prior to use. EI #1 said a barrier should be placed. EI #1 was asked what the concern was with items containing blood products being placed in a resident's trash can. EI #1 said there was a potential for any other infection or people touching those contaminated items since blood-borne pathogens could be on it. EI #1 was asked what the concern was with the situations discussed. EI #1 answered infection control and cross contamination.

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.