STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135059	A. BUILDING _____ B. WING _____	**07/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FRANKLIN COUNTY TRANSITIONAL CARE	**44 NORTH 100 EAST PRESTON, ID 83263**

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** Based on observation, professional nursing standards of practice, staff interview, and policy review, it was determined the facility failed to ensure blood glucose results were performed and documented by the same staff member. This was true for 1 of 1 resident (Resident #1) reviewed for quality of care. This failure created the potential for harm if an incorrect test result was recorded by documenting a blood glucose the staff member did not perform or witness. Findings include: The Potter Perry Fundamentals of Nursing Eighth Edition Textbook, copyright 2013, under Professional Standards in Nursing Practice stated: *A factual record contains descriptive, objective information about what a nurse sees, hears, feels, and smells. *An objective description is the result of direct observation and measurement. The textbook also stated under the section for Legal Guidelines for Recording, nurses should only chart for themselves, are accountable for information they enter into a patient's chart, and nurses were never to chart for someone else. This professional standard of practice was not followed. On 7/7/20 at 11:35 AM, CNA #2 stated she was trained to perform blood glucose checks. CNA #2 stated she notified RN #1 of Resident #1's blood glucose test results. Resident #1's July 2020 MAR (Medication Administration Record), dated 7/7/20 at 11:00 AM, documented Resident #1's blood glucose result was 347 mg/dl (a measurement that indicates the amount of glucose in the blood) and 8 units of Humalog Insulin were administered. The entry in the MAR indicated [REDACTED]#1's MAR. On 7/8/20 at 10:15 AM, ICP #1 stated the facility did not have a policy regarding staff documenting another staff member's task.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, policy review, nationally recognized standards of practice, and staff interview, it was determined the facility failed to ensure infection control prevention practices were implemented and maintained to provide a safe and sanitary environment. This failure created the potential for negative outcomes by exposing residents to the risk of infection and cross-contamination including COVID-19. Findings include: 1. The facility's policy for Blood Sugar Monitoring, reviewed 3/27/20, directed staff after they performed the blood glucose procedure, they were to remove and dispose of their gloves, wash their hands, and wipe off the glucometer with an antiseptic wipe prior to leaving the room. This policy was not followed. On 7/7/20 at 11:30 AM, CNA #2 was in the doorway of Resident #1's isolation room wearing a gown, face mask, face shield, and gloves. Another CNA inside Resident #1's room, handed CNA #2 a plastic bin filled with a box of alcohol wipes, a box of lancets (small needles used to stick a finger to obtain blood), a box of sanicloths (disinfectant used to disinfect the glucometer), a bag of cotton balls, and a glucometer. CNA #2 placed the plastic bin on a barrier on the isolation cart outside of Resident #1's room. She then removed the glucometer from the bin, disinfected the glucometer, and placed it back in the plastic bin. CNA #2 did not remove and dispose of her gloves, wash her hands, and disinfect the glucometer before she exited the room. CNA #2 did not disinfect the plastic bin before replacing the disinfected glucometer. On 7/7/20 at 11:50 AM, the DNS stated CNA #2 should not have taken the plastic glucometer bin into the resident's room. The DNS stated CNA #2 should have only taken what she needed to check Resident #1's blood glucose. 2. The facility's policy for Eyewear Protection: Wearing and Removal/Cleaning, reviewed 3/27/20, documented when removing protective eyewear, HCP were to: * Remove gloves and wash hands. * Remove eyewear immediately, or as soon as possible, after the completion of a procedure. The front of the goggles is considered contaminated and do not touch. Remove the front of the goggles or face shield from the back by lifting headband or ear pieces. * If the eyewear is non-disposable, then it should be cleaned with soap and water, immediately after use and put away. (When cleaning use gloves if contaminated with blood or body substances.) * Wash hands. This policy was not followed. On 7/6/20 at 5:30 PM, CNA #3 exited Resident #1's room that had a sign on the door for droplet precautions. CNA #3 was not wearing gloves. CNA #3 removed her face shield with her bare hands and disinfected the face shield with a wipe. CNA #3 stated she did not perform hand hygiene prior to exiting Resident #1's room and should have put gloves on prior to disinfecting the face shield. CNA #3 said after disinfecting the face shield, she should have performed hand hygiene. On 7/6/20 at 5:35 PM, ICP #2 stated CNA #3 should have performed hand hygiene, put on a new pair of gloves, removed the face shield, disinfected it, and then removed the gloves and performed hand hygiene.

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.