| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **015202** | A. BUILDING _____ B. WING _____ | **09/02/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **MCGUFFEY HEALTH & REHABILITATION CENTER** | **2301 RAINBOW DRIVE GADSDEN, AL 35999** |

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<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide and implement an infection prevention and control program.**<br><br>Based on observation, interviews, and review of FUNDAMENTALS OF NURSING NINTH EDITION, the facility failed to ensure Employee Identifier (EI) #2, a Licensed Practical Nurse (LPN) did not place Resident Identifier (RI) #1's eye drop medication container in her pocket prior to administration. Once inside of RI #1's room, EI #1 placed the eye drop medication container on the resident's over-bed table without a barrier and she failed to wash and/or sanitize her hands before she put gloves on to administer RI #1's eye drop medication. This deficient practice RI #1, one of two residents observed for medication pass. Findings include: 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 9/1/2020 at 3:59 PM, EI #2, an LPN placed RI #1's eye drop medication container in her scrub pocket prior to entering the resident's room. Once inside RI #1's room, EI #2 removed the eye drop medication container from her pocket and placed in on the resident's over-bed table without a barrier. EI #2 was also noted to put gloves on, without washing or sanitizing her hands prior to the administration of RI #1's eye drops. In an interview on 9/1/2020 at 7:07 PM, EI #2, an LPN was asked when she should wash or sanitize her hands during medication pass. EI #2 said before handling medications, before entering the room, before putting on and after taking off gloves and any time they become contaminated. EI #2 was asked where did she put RI #1's eye drop bottle prior to administration. EI #2 replied in her pocket. EI #2 was asked was her pocket clean. EI #2 stated no. EI #2 was asked where she put the container and cap when she entered RI #1's room. EI #2 said she put them on the bedside (over-bed) table with no barrier. EI #2 was asked should she have placed them there. EI #2 replied no, she should have placed a barrier between the container and the table. EI #2 was asked did she sanitize or wash her hands prior to putting on gloves to administer RI #1's eye drops. EI #2 said no. EI #2 was asked should she have sanitized her hands. EI #2 stated yes, because whatever she touched before she put her gloves on would have contaminated her hands before she put them on. During an interview on 9/1/2020 at 7:57 PM, EI #1, the Director of Nursing/Acting Infection Control Preventionist was asked when a nurse should wash her hands during medication pass. EI #1 said before they touch anything on the cart, before they put on and take off gloves, when visibly soiled, before and after administration, and after coming out of the room. EI #1 was asked where the eye drop container should be placed prior to administration. EI #1 replied on the barrier. EI #1 was asked should a nurse place an eye drop container in her pocket. EI #1 stated no. EI #1 was asked why not. EI #1 replied it was an infection control issue, because she does not know where the pocket had been. EI #1 was asked should a nurse place an eye drop container on an overbed table without a barrier. EI #1 said absolutely not, it should not have been placed there without a barrier to begin with because of infection control. EI #1 was asked should a nurse apply clean gloves without washing or sanitizing her hands. EI #1 replied no. EI #1 was asked what the concern was with the issues discussed. EI #1 answered infection control because of 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.