STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025020	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DENALI CENTER	1510 19TH AVENUE FAIRBANKS, AK 99701

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 interview, observation, record review, document review and policy review, the facility failed to ensure infection control procedures were properly monitored and implemented. Specifically, the facility failed to: 1) ensure employees were adequately trained to perform the self-monitoring checks at the start of shift; 2) monitor the employee self-screening process and monitor for abnormalities of data and symptoms; and 3) ensure all nutrition services staff were following proper hand hygiene procedures. These failed practices had the potential to effect all residents, based on a census of 72, to be at risk for exposure to COVID19. Findings: Employee Self Screening During an interview on 6/22/2019 at 9:45 am the Director of Nursing (DON) stated that all staff self-screened at 8 hour shift start times 7:00 am, 3:00 pm, and 11:00 pm. Staff screening included taking temperature and reporting respiratory or other symptoms on a sign in sheet prior to the shift start. If symptoms or concerns were present, staff were to self-report to the supervisor on shift. She reported that many of the staff and residents who had tested positive were asymptomatic. The DON further stated that if a staff member had symptoms they were to be assessed by Occupational Health. During an interview on 6/23/20 at 2:00 pm, the DON stated there were two tables set up in the common area for staff self-screening. One was by the employee door between Willow and Tamarack units and one by the main entrance side of the building outside the Aspen unit. She further stated there were two entrances because of staff parking was located in two different lots. During an interview on 6/23/20 at 6:40 pm, Licensed Nurse (LN) #6 stated that staff were supposed to call out sick if they were experiencing any symptoms. LN #6 further stated that he/she happened to be at the self-screening desk the night before when a Certified Nurse Assistant (CNA) came in to the facility and was observed by LN #6 to have symptoms of illness. LN #6 stated that CNA stated to the LN #6 that he/she could work. LN #6 sent the CNA to Occupational Health for assessment. During an observation and interview on 6/23/20 at 6:45 pm, LN #5 reported to the screening table, put on gloves, took his/her temperature and signed the screening form, then performed hand hygiene. LN #5 stated that the process for employee screening prior to his/her shift was to go to one of the screening tables, write down his/her temperature and write down any symptoms of COVID that he/she had experienced. During a continuous observation on 6/23/20 from 6:40 pm through 7:20 pm, 5 staff starting the 7:00 pm shift were observed at the main door screening table in the common area. Each staff performed the screening process differently and then went to their assigned units. During an observation and interview on 6/23/20 at 6:45 pm, LN #4 stated the infrared thermometer was brand new. LN #4 had begun by wiping an alcohol pad over the lens of the thermometer. LN #4 then pressed the infrared thermometer onto his/her forehead, over his/her head bandana. LN #4 then moved the thermometer from side to side, while keeping the thermometer pressed against his/her forehead, over the bandana. LN #4 did not perform hand hygiene after self-screening. During the same observation, a hand written note was seen on the screening table, which read: New thermometer *Turn on w/ (with) power button, *hold 1 inch from your forhead and press start. *when sanitizing please DO NOT wipe over the lens or eye of the thermometer. During an observation on 6/23/20/at 6:52 pm, CNA #5 set his/her personal items on the screening table then signed in prior to hand sanitizing and donning gloves. An observation of on 6/23/20 at 7:10 pm of the employee sign in sheet revealed that CNA #6 recorded a temperature of 86.8 degrees at 6:52 pm. During an interview on 6/23/20 at 7:15 pm, LN #6, who was charge for the shift, stated there was no clear process for reviewing the staff self-check log sheet because the process was always changing. During the same interview, LN #6 was observed to notice the low temperature logged on the sign in sheet. CNA #6 was wheeling a resident from the Aspen unit out into the common area. He/she had already been on the unit working with residents for 23 minutes before his/her temperature was retaken. During an interview on 6/25/20 at 9:58 am, the DON stated that the self-check tables were set up in the common area so the charge nurse could have oversight of the employees as they were arriving. The DON stated that the sheets were supposed to be checked within the first hour of shift start by the charge nurse. The DON further stated that the sign in sheet were checked by LN Manager #3 during day shift and by the charge nurses evening, night shift and weekends. During an interview on 6/25/20 at 11:28 am, CNA #1 stated that the facility did not provide him/her with training on the infrared thermometer, he/she stated a co-worker had showed him/her how to use the thermometer. CNA #1 further stated that touching the lens with an alcohol pad would have damaged the lens which would have made the temperature inaccurate. During an interview on 6/25/20 at 11:25 am, LN #1 stated he/she had not had formal training on the infrared thermometer. LN #1 further stated that the correct technique to use the thermometer was to hold it 3 inches from the forehead to obtain the temperature. Review on 6/24/20 at 9:00 am, of the manufacturer's instructions for the THD2FE Non-Contact, Digital Forehead Thermometer, accessed at https://www.thermoworks.com/pdf/wand_operating_instructions.pdf, revealed Hold the instrument within 1.5 inches from the center of the forehead and press and hold 'Start' until you hear one beep (unless muted) to indicate the reading is complete .For Best Results: Keep the forehead area clean. Keep away from sweat, cosmetics, and scars while taking measurements. Review of an untitled facility document, provided by the facility when asked for the screening policy, last updated 6/17/20 revealed. .Individual Staff member responsibility: Monitor temperature twice daily, once before starting shift and once before leaving. Attest there are no new or worsening symptoms. If temperature exceeds the recommended threshold or new symptoms are present, communicate with supervisor, leave work, and call Occ Health immediately. Occ Health phone number is . During an interview on 6/25/20 at 1:45 pm, the DON stated there were no additional policies or procedures for employee self-screening as the process had changed numerous times since March. The expectation was that staff would self-monitor, self-report, and follow direction. Oversight of Employee Self Screening Review on 6/25/20 at 9:30 am, of the employee self-screening documents for the nursing department, dated 6/1-25/20 revealed missed temperature checks for 2 employees on 6/16/20. Further review revealed a temperature reading of: 94.9 degrees on 6/11; Illegible temp on 6/12; 87.0 degrees on 6/16; 94.3 degrees and 94.7 degrees on 6/19; 93.4 degrees on 6/21; 72.3 degrees and 94.6 degrees on 6/22; 93.7 degrees on 6/23. During an interview on 6/25/20 at 9:45 am, when asked about the screening process, LN Manager #3 stated he/she could not say that people hadn't slipped through the cracks and missed the self-screening. During an interview on 6/25/20 at 10:00 am, the DON stated that each department reviews their own employees self-screen log forms. For the nursing department, the Charge LN was responsible for reviewing the self-screening forms within the first hour of the employees starting their shift. The DON further stated that the self-screening was on the honor system, and the employee was to alert the Charge LN if they had symptoms of COVID or a temperature. During an interview on 6/25/20 at 12:16 pm, LN Manager #2 stated that he/she would have checked the employee self-screening sheet each day. When shown the missing temperatures on the self-screening sheet, LN Manager #2 replied that he/she could not explain the missed screening and that screening sheet was not reviewed. When asked if the Charge LN had signed the documents to ensure they were reviewed, the LN Manager #2 stated the person that reviewed the documents had not signed them. During a joint interview on 6/25/20 at 1:01 pm with the Infection Preventionist (IP) and the DON, when asked about the Charge LN review of the forms, stated that there had not been a place on the form for the Charge LN to sign once the review was completed. Further, it was stated that these completed forms go into the mailbox of the Clinical Nurse Manager LN #3, for further review and the empty spaces for the temperature checks had been oversighted the following day but only on weekdays. When asked if this information should have

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) been reviewed sooner, it was stated that yes, the screening form should have been reviewed by the Charge RN. When asked about the temperature reading of 72.3, the DON stated that should have been reviewed by the Charge RN. The DON stated that any recorded temperature below 96 degrees would be considered an invalid temperature. When asked if there was a risk associated with not following up on invalid temperatures, the DON stated there could be but nursing management had focused on temperatures higher than 99 degrees and not with low temperatures. When asked who was responsible for the oversight of ancillary staff such as nutrition and environmental services, the DON stated that oversight was completed by their department managers. The DON stated there was no P&P specific to the employee screening process as it had been changing over the course of the last few months. During an interview on 6/25/20 at 1:20 pm, the Director of Nutrition Services stated the Nutrition Department had used the honor system and Nutrition Services employees had self-screened prior to their shift. When asked about the oversight of the self-screening process, the Director of Nutrition Services stated that he/she gave the screening sheets to his/her manager at the end of each week. He/she did not look at all the temperature daily to ensure they were within normal limits and it had been a difficult task to check every employee because of varying shifts of the nutrition services staff. Review of a facility document entitled Situational Update dated 6/19/20 revealed Due to community spread of COVID-19 in Fairbanks and the sharp increase in the number of people who have tested positive for it, FMH began limiting visitor access on June 16. There was no directives identified in regards to employee screening and oversight. Review of an untitled facility document, provided by the facility when asked for the screening policy, last updated 6/17/20 revealed. .Leadership responsibility: Identify a location for your staff to do this. Identify a tool that works for your department tracking. Monitor the log for completeness (daily). Hold staff accountable for timely monitoring. Save this documentation in a place that is accessible to your department's leadership team for when this document will need to be retrieved. This should be a location where more than one person can access it. Nutrition Staff Hand Hygiene Observation on 6/22/20 at 11:15 am revealed Residents dining in the Fireweed Dining Hall. Nutrition Service Aide (NSA) #1 assisted Resident #1 with hand hygiene prior to lunch. NSA #1, with ungloved hands, assisted Resident #1 by rubbing the Resident's hands with a moistened towelette wipe. Without first performing hand hygiene, NSA #1 then removed a food container from the table, opened the refrigerator using the pinky side of his/her hand, then put the container in the refrigerator. NSA #1 then performed hand hygiene. Observation on 6/22/20 at 11:34 am and 11:37 am revealed NSA #1 had removed gloves from his/her front pocket of scrub shirt to perform food handling tasks. An observation on 6/22/20 at 11:40 am revealed NSA #1 assisted Resident #2 with hand hygiene. NSA #1 removed gloves from his/her front pocket and placed the gloves on before assisting the Resident cleanse his/her hands. With the same gloves on, NSA #1 took a pen out of his/her front pocket and took the Resident's food order, then placed the pen back into the same pocket used to carry the now dirty gloves. During an interview on 6/23/20 at 8:45 am, the DON stated that all staff including environmental services, nutrition services, and laundry staff had been trained on increased hand hygiene practices to prevent COVID spread. An observation on 6/23/20 at 11:40 am revealed NSA #1 pulled gloves out of his/ her pocket, did not perform hand hygiene prior to donning new gloves. Additional gloves were observed to be hanging out the top of his/her scrub top pocket. A box of new gloves was observed on top of the hot table shield. An observation on 6/23/20 at 11:48 am revealed NSA #1 had wheeled a resident to their room, washed his/her hands when returning to the dining room, then pulled a set of gloves out of his/her scrub pocket and donned them. During a joint interview on 6/25/20 at 1:01 pm with the Infection Preventionist (IP) and the DON, when asked if it was standard practice for staff to keep gloves in their pockets, The IP stated no, that staff should have removed the gloves from the glove box each time. When asked about staff hand hygiene after assisting the Resident and before handling a food container, the IP stated that staff hand hygiene should have been performed in-between tasks. Review of the facility's policy Hand Hygiene, dated 3/21/20, revealed Hands must be washed or sanitized before and after contact with any patient/resident, (or) items in the patient/resident environment . .