STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135048	A. BUILDING _____ B. WING _____	06/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLEARWATER HEALTH & REHABILITATION OF CASCADIA	1204 SHRIVER ROAD OROFINO, ID 83544

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 1 of 2 observations of incontinence care, record review, and staff interviews the facility failed to ensure staff performed hand hygiene when changing gloves visibly soiled with stool. This failure placed Resident R3 at risk of urinary tract infection, skin infection [MEDICAL CONDITION]. Findings include: Review of the medical record progress notes revealed R3 received antibiotics through a PICC (peripherally inserted central catheter) for antibiotic therapy. R3 experienced a change of condition on 4/29/20 with anxiety, confusion, dry mouth, shortness of breath, and required oxygen through the night. R3 transferred to the acute hospital for admission. The hospital diagnosed [MEDICAL CONDITION] and identified an abscess in the psoas muscle (hip/pelvis). According to the CDC at https://www.cdc.gov/sepsis/what-is-sepsis.[MEDICAL CONDITION] is the body's extreme response to an infection. It is a life-threatening medical emergency.[MEDICAL CONDITION] happens when an infection you already have -in your skin, lungs, urinary tract, or somewhere else-triggers a chain reaction throughout your body. Without timely treatment,[MEDICAL CONDITION] can rapidly lead to tissue damage, organ failure, and death. R3 readmitted to the facility on [DATE] for long term intravenous antibiotic therapy. The care plan indicated R3 had recurrent areas of open skin on the buttocks from incontinence and moisture. Openings in the skin increase the risk for skin infections. Personal care was observed for R3 on 6/11/20 at 1:42 PM. Nursing Assistant NAC1 and resident support staff RSS1 utilized the mechanical lift to transfer R3 from the wheelchair to the bed. NAC1 wore gloves, RSS had no gloves on. Once R3 was on the bed, NAC1 checked the incontinence brief for wetness. NAC1 advised R3 that she required a brief change NAC1 prepared supplies to cleanse the resident. RSS1 donned gloves. RSS said it was her job to assist the staff. RSS1 stood beside the bed to assist the resident in holding position on her side. NAC1 pulled the front of the incontinence brief down and used a moist wipe to cleanse the perineal area (in front between legs). R3 had a large amount of soft bowel movement. NAC1 cleansed R3 as she lay on her right side, then assisted R3 to roll to her left side. NAC1 cleansed the buttocks from both sides, then removed her gloves. NAC1 stated My left one was pooey referring to her gloves. Bowel movement was visible on both her gloves. NAC1 removed her gloves and immediately donned clean gloves without performing hand hygiene. NAC1 did not wash her hands and did not use ABHR (alcohol based hand rub) after removing the visibly soiled gloves. NAC1 proceeded to apply ski protectant cream to R3 then applied a clean dry brief and adjusted the bed linens. NAC1 removed gloves and washed her hands before leaving the resident room. On 6/11/20 at 2:30 PM the DNS (Director of Nursing) and licensed nurse LN1 were interviewed regarding infection control practices. The DNS said the facility followed CDC (Centers for Disease Control and Prevention) infection control guidelines. When informed of the observation of incontinence care for R3 and failure to perform hand hygiene with change of gloves grossly soiled with bowel movement. The DNS said it was a standard infection control practice, a facility expectation, and required by facility policy to perform hand hygiene with change of soiled gloves. DNS said employees were trained in the use of gloves and the need for hand hygiene after removing soiled gloves before donning clean gloves. DNS said failure to perform appropriate hand hygiene with change of gloves was unacceptable practice. When asked about the UTI (urinary tract infection) rate in the facility, the DNS said in April the facility identified an increase in UTI with urine cultures showing E-Coli (a specific bacteria found in stool). The DNS said the facility conducted peri-care (care of perineal area) audits and staff education. DNS said the rate went down in May 2020. LN1 provided documentation of an all-staff memo dated May 2020. The memo read in part; The following information requires your immediate review and acknowledgment. By signing below you are verifying that you understand the information given. The topic was UTI (urinary tract infection) Prevention and read; recently we have had an increase in UTI in the building. 5 of the 7 UTIs were E Coli (specific bacteria). This is indicative of fecal (bowel movement) contaminant (stool in the urine sample) and/or poor peri-care. The All Staff memo noted handwashing was the single most important procedure for preventing the spread of infection. The memo described how to use soap and water and ABHR and when to use each for hand hygiene. The memo directed: before you begin, wash your hands thoroughly and put on a pair of gloves. The memo did not discuss when to change gloves or need to perform hand hygiene with glove change. Eleven staff signed acknowledgment of the all staff memo, NAC1's name was not included. Glove use according to the CDC at: https://www.cdc.gov/handhygiene/providers/guideline.html Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. Gloves are not a substitute for hand hygiene. o If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. o Perform hand hygiene immediately after removing gloves. Change gloves and perform hand hygiene during patient care, if o gloves become damaged, o gloves become visibly soiled with blood or body fluids following a task, o moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs. Never wear the same pair of gloves in the care of more than one patient. Carefully remove gloves to prevent hand contamination.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE