STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015464	A. BUILDING _____ B. WING _____	**09/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ASPIRE PHYSICAL RECOVERY CENTER AT HOOVER, LLC	**575 SOUTHLAND DRIVE HOOVER, AL 35226**

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 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review and review of a facility policy titled, Wound Care Procedure for Major Wounds, the facility failed to ensure Employer Identifier (EI) #6, the Licensed Practical Nurse (LPN) Treatment Nurse, removed her gloves, sanitized her hands, and applied new gloves after cleaning Resident Identifier (RI) #1's sacrum pressure ulcer, and before patting the wound with clean, dry 4x4 gauzes and applying a clean bordered dressings to the sacrum when providing wound care for RI #1 on 9/22/2020. This deficient practice affected RI #1, one of one sampled resident observed for wound care. Findings include: The facility's policy titled Wound Care Procedure for Major Wounds, with an effective date of 12/1/2009, documented PURPOSE: To provide guidelines for clean technique in doing wound care . II. PROCEDURE . N. Clean the wound according to the order . P. Remove gloves and place in bag. Q. Put on new gloves. R. Apply clean dressing as ordered. . RI #1 was admitted to the facility on [DATE]. RI #1's September 2020 Physician order [REDACTED].#6, the LPN Treatment Nurse, was observed providing wound care to RI #1's Stage 2 pressure ulcer on the resident's left inner sacrum. EI #6, with gloved hands, cleaned the area with wound cleanser soaked 4x4 gauzes, and then with the same soiled/contaminated gloves, picked up dry, clean 4x4 gauzes and patted the area. EI #6 picked up the clean bordered dressing with the same soiled/contaminated gloves still on and placed the dressing over RI #1's sacrum area. In an interview on 9/22/2020 at 9:45 AM, EI #6, the LPN Treatment Nurse was asked what she should have done after cleaning RI #1's sacrum pressure ulcer, and before she patted the area with clean dry 4x4 gauzes, and before applying the clean bordered dressing. EI #6 said she should have removed her gloves and washed her hands. When asked what it would be considered when that was not done, EI #6 said cross contamination. On 9/22/2020 at 11:47 AM, an interview was conducted with EI #2, the Registered Nurse Unit Manager. EI #2 was asked what should be done when providing wound care, after the wound bed is cleaned, and before applying a clean dressing over the wound bed. EI #2 said gloves should be removed, and hands should be washed. When asked what type concern it would be considered when this was not done, EI #2 said cross contamination.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observations, interviews, and review of the facility's policy titled COVID-19 Cleaning IC (Infection Control) for Equipment, the facility failed to ensure: 1) Employee Identifier (EI) #3, a Certified Nursing Assistant (CNA), cleaned and disinfected the blood pressure (B/P) cuff, pulse oximeter and thermometer on a Dynamap machine between checking the vitals of Resident Identifier (RI) #2 and RI #3; and 2) four clear bags (one containing clean yellow cloth gowns, one with washcloths and towels, one with sheets and one with flat mop heads) were not left on the floor outside the COVID unit on 9/21/2020. These deficient practices affected RI #2 and RI #3, two of seven residents who were observed getting their vital signs checked; and one of four units at the facility. Findings include: 1) The facility's policy titled COVID-19 Cleaning IC for Equipment, with an effective date of 5/4/2020, documented Purpose: To establish a process to meet CDC (Centers for Disease Control and Prevention) and manufactures' requirements for Environmental Services cleaning infection control for Equipment. This will assist NHS (Northport Health Services) Facilities to follow CDC guidelines as it relates to Cleaning from an Infection Control approach . 2. Implement Infection Control Cleaning of Equipment . e. If a dedicated, disposable device is not available, disinfect all equipment before removing the device from the room and before using it with another patient . On 9/21/2020 at 3:18 PM, the surveyor observed a Dynamap machine on the 400 Hall with a container of Sani-Cloth Bleach Germicidal Disposable Wipes sitting on the Dynamap machine. At 3:20 PM, EI #3, a CNA, rolled the Dynamap machine to RI #3's room. EI #3 informed RI #3 it was time to check his/her vitals. EI #3 placed the B/P cuff on RI #3's left arm, placed the pulse oximeter on one of the fingers on RI #3's right hand, and placed a covering over the probe of the thermometer and placed it under RI #3's tongue. EI #3 turned on the Dynamap machine and once the vital signs registered, EI #3 removed the B/P cuff, pulse oximeter and thermometer and placed the equipment back on the Dynamap machine. At 3:25 PM, EI #3 rolled the Dynamap machine to RI #2's room. EI #3 informed RI #2 it was time to check his/her vitals. Without cleaning or sanitizing the B/P cuff, pulse oximeter or thermometer, EI #3 placed the B/P cuff on RI #2's right arm, placed the pulse oximeter on one of the fingers on RI #2's right hand, and after placing a covering over the probe of the thermometer, placed the thermometer under RI #2's tongue. On 9/21/2020 at 4:05 PM, an interview was conducted with EI #3, a CNA. When asked how she would clean and disinfect the B/P cuff, pulse oximeter and thermometer between resident use, EI #3 said she would use a sanitizing wipe. EI #3 said when a sanitizing wipe was not used between resident use that would be a potential for spreading germs and infection. EI #3 said she had been taught to clean and disinfect the B/P cuff, pulse oximeter and thermometer after use and to wait three to four minutes before using them again. When asked why the B/P cuff, pulse oximeter and thermometer was not disinfected between use for RI #3 and RI #2, EI #3 said at first, she did not think about what she was doing. In an interview on 9/22/2020 at 11:47 AM, EI #2, the Registered Nurse Unit Manager said the CNA should clean and disinfect the B/P cuff, pulse oximeter and thermometer between resident use by wiping them down and letting them dry according to the dry time on the label. EI #2 said there was a potential for spread of germs when the equipment was not cleaned and disinfected between resident use. During an interview on 9/22/2020 at 3:10 PM, the surveyor shared with EI #1, the Director of Nursing (DON) the observation of EI #3, a CNA, not cleaning and disinfecting the B/P cuff, pulse oximeter and thermometer between resident use. EI #1 said the equipment on the Dynamap machine should be disinfected between residents allowing for the manufacturer dry time of four minutes. When asked why the equipment should be disinfected between resident use, EI #1 said to prevent the spread of infection. (2) On 9/21/2020 at 5:55 PM, the surveyor along with EI #1, the DON, observed four clear plastic bags on the floor outside the COVID unit. One bag contained clean yellow cloth gowns, one clean towels and washcloths, one clean sheet and the other clean flat mop heads. In an interview on 9/22/2020 at 2:12 PM, the surveyor shared the observation of the clear plastic bags containing clean yellow cloth gowns, clean towels and washcloths, clean sheets and clean flat mop heads being left on the floor outside the COVID unit with EI #4, the Director of Housekeeping/Laundry. EI #4 said it was probably not communicated with the person delivering the bags of clean laundry where the bags should be placed. When asked should clean laundry ever be placed on the floor, EI #4 said no. EI #4 said clean laundry is placed on a table in the area. EI #4 said it would be considered cross contamination when laundry is placed on the floor. On 9/22/2020 at 2:17 PM, an interview was conducted with EI #5, the laundry attendant who placed the bags of clean laundry on the floor. When asked was the floor dirty or clean, EI #5 said dirty. EI #5 said laundry should not be placed on the floor but the reason she placed it on the floor was because she did not see a table to place it on. When asked what it was considered when clean laundry was placed on a dirty floor, EI #5 said, Contamination. During an interview on 9/22/2020 at 3:10 PM, EI #1, the DON was asked where the clean laundry observed on the floor outside the COVID unit on 9/21/2020 should have been placed. EI #1 said there was a table the laundry should have been placed on.

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.