STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025034	A. BUILDING _____ B. WING _____	**07/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PROVIDENCE VALDEZ MEDICAL CENTER	**911 MEALS AVENUE VALDEZ, AK 99686**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview, observation and policy review, the facility failed to ensure 1) staff testing for COVID-19 was performed in a well ventilated space with minimal equipment in the room and 2) masks re-used by staff were stored in a way to prevent the spread of infection. These failed practices had the potential to facilitate the spread of COVID-19 and affect all residents, based on a census of 8. Findings: Staff Testing Location: During an interview on 7/20/20 at 6:10 pm, Licensed Nurse (LN) #1 stated he/she was trained to perform COVID-19 nasopharyngeal (upper part of the throat behind the nose) swab tests on long term care staff members. LN #1 further stated the COVID-19 tests were performed in the nurse's station room. An observation on 7/20/20 at 6:15 pm revealed the nurse's station room contained the Residents' charts, staff computers, staff telephone, the Residents' medication cart for the preparation and storage of medications, and the Resident's glucometer (machine to test blood sugars). Review on 7/21/20 at 12:00 pm of Performing Facility-wide [DIAGNOSES REDACTED]-CoV-2 Testing in Nursing Homes, updated 5/19/20, accessed at https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-facility-wide-testing.html, revealed: Location of specimen collection for HCP * Ideally, specimen collection should be performed one individual at a time in a room with the door closed and no other individuals present. If individual rooms are not available, other options include: o Large spaces (e.g., gymnasiums) where sufficient space can be maintained between swabbing stations (e.g., greater than 6 feet apart). o An outdoor location, weather permitting, where other individuals will not come near the specimen collection activity. * Considerations for multiple HCP being swabbed in succession in a single room: o Consider the use of portable HEPA filters to increase air exchanges and to expedite removing infectious particles. o Minimize the amount of time the HCP will spend in the room. HCP awaiting swabbing should not wait in the room where swabbing is being done. Those swabbed should have a face mask or cloth cover in place for source control throughout the process, only removing it during swabbing. * Minimize the equipment kept in the specimen collection area. Consider having each person bring their own prefilled specimen bag containing a swab and labeled sterile [MEDICAL CONDITION] transport media container into the testing area from the check-in area. During an interview on 7/21/20 at 1:54 pm, when asked about the ventilation in the nurse's station room, LN #1 stated the air flowed through small slates in the window which did not provide good airflow through the room. During a phone interview on 7/21/20 at 4:56 pm, when asked about her COVID test, the Director of Nursing (DON) stated that when she was tested , the nurse's station room door had been left open. When asked about other staff members entering the room after the test was performed, the DON stated that the room had not been closed off, and staff could have entered within 10 minutes after the test was performed. Mask re-use storage: An observation on 7/20/20 at 6:41 pm of the staff screening area, revealed an area dedicated to mask re-use. Large open faced cups measuring 800cc were placed near the window with each employees name written on the cup. There were no dates observed on any of the cups. Further observation revealed 3 of the cups contained 2 masks per cup, in which the masks were touching one another inside the cup. Further, the masks of Certified Nursing Assistant (CNA) #4 and CNA #5 were sticking out of the cup and touching each another. Review on 7/21/20 at 10:30 am of the Strategies for Optimizing the Supply of Facemasks, updated 6/28/20, accessed at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html#conventional-capacity revealed Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean sealable paper bag or breathable container. During an interview on 7/21/20 at 1:35 pm, CNA #2 stated that the masks worn by staff were re-used. CNA #3 further stated that the masks could have been kept and re-used for 3 days, as long as the masks had not been soiled or damaged. When asked about the process for mask storage, CNA #3 replied the masks were kept in a cup with the staff members name written on the cup. When asked about the process for cleaning the cups, CNA #2 stated he/she would have cleaned the cup every once in a while. During an interview on 7/21/20 at 1:54 pm, when asked about the process for mask re-use, LN #1 stated that masks could have been re-used for 3 days, unless soiled. When asked about the storage process in-between uses, LN #1 stated that staff enter the building wearing their own cloth face covering, and would have dropped the cloth face covering into the cup and would have removed the surgical mask stored in the cup. When asked about the process for cleaning the cups, LN #1 stated that he/she would have wiped down his/her cup at the end of his/her 3 day work stretch. During an interview on 7/22/20 at 9:35 am, when informed of the mask storage process, the Infection Prevention (IP) Nurse stated that the current practice was not acceptable. The IP Nurse further stated that she was not aware that the staff were still conserving their masks; therefore, she had not given the staff the tools they needed to conserve the masks properly. Review on 7/22/20 at 11:30 am of the facility's policy PPE Extended Use in Long term Care, dated 4/2020, revealed The face mask, when not in use, can be stored in a paper bag. These bags are store in the lodge's designated area and marked with the HCP (Health Care Providers) name. .

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