STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025010	A. BUILDING _____ B. WING _____	06/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KETCHIKAN MED CTR NEW HORIZONS TRANSITIONAL CARE	3100 TONGASS AVENUE KETCHIKAN, AK 99901

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 observation, record review, interview and policy review, the facility failed to ensure 1) residents were screened for signs and symptoms of COVID-19 twice daily with results documented in the resident's medical record; 2) staff screening was monitored for signs and symptoms of COVID-19 and hand hygiene for all staff entering the facility was completed; 3) hand hygiene for 2 residents out of 4 sampled residents was performed before a meal; 4) staff performed hand hygiene after caring for a resident and before moving to a clean surface. These failed practices had the potential to affect all residents, based on a census of 26, to properly prevent the spread of infection and/or COVID-19. Findings: Resident Cares: During an observation on 6/2/20 at 10:44 am, Certified Nursing Assistance (CNA) #1 was providing cares for Resident #1. Upon entering the room, the Resident had emesis on his/her bedsheets and floor. With gloved hands, CNA #1 had begun by wiping the emesis off the floor with paper towels. As CNA #1 discarded the soiled towels into the trash bin, he/she grabbed the trash bin to bring it closer to the work area. CNA #1 then opened the bottom drawer of the Resident's dresser with the now dirty gloves on, to remove cleaning wipes and continued to clean the floor. During the same observation, CNA #1 proceeded to change the bedsheets on Resident #1's bed. CNA #1 removed the soiled bedsheets and placed them on the floor of the Resident's room. Resident #1 continued to vomit and re-soiled his/her bedsheets. CNA # 1 had left the room to obtain more supplies and returned with CNA #2. During the same observation, CNA #1 and #2 provided cares for the Resident. After the cares, CNA #2 picked up the soiled linens from the floor and placed them in a plastic bag. CNA #2 then removed his/her gloves, and placed on clean gloves without first performing hand hygiene. During a joint infection control interview on 6/3/20 at 11:00 am, when asked if gloves should have been changed after cleaning the floor and prior to touching the Resident's drawers, the Director of Nursing (DON) stated that hand hygiene would have been expected after working on a dirty task and before touching the clean environment. During the same interview, when asked about the soiled linens being placed on the floor, the DON stated that the soiled linens should not have been placed on the floor, and that should not have happened. During the same interview, when asked about performing hand hygiene in between glove changes, the DON stated that it would have been standard practice to perform hand hygiene before and after placing on gloves. Review of the facility's policy Isolation Procedure, dated 12/27/19, revealed Indications for Hand Hygiene .After contact with .body fluids or excretions .Before and after glove removal. Resident hand hygiene prior to meals: During an observation on 6/2/20 at 12:01 pm, CNA #4 had served a lunch tray to Resident #2. CNA #4 had not offered or assisted the Resident with hand hygiene prior to the Resident dining. Further observation revealed CNA #4 served a lunch tray to Resident #3 without assisting or offering hand hygiene to the Resident prior to dining. When asked about the process for the Residents to perform hand hygiene prior to meals, the CNA stated he/she had to obtain the hand hygiene wipes for the Residents prior to the meal. CNA #4 further stated that he/she did not provide the wipes or hand hygiene for Residents #3 and #4 prior to lunch. During a joint infection control interview on 6/3/20 at 11:00 am, when asked about the process for the Residents to perform hand hygiene before meals, the DON stated that the Residents are encouraged to use hand wipes before meals. The DON further stated that the staff were to pass out the wipes before the meal was served. Resident Screening: Record review on 6/3/20 at 3:00 pm of the Resident's Vital Signs, dated 5/25/20-6/2/20, revealed Resident #'s 2, 3, 4, 5, 6, 7 and 8 had not had temperature and screening checks for signs and symptoms of COVID-19 documented twice per day. During an interview on 6/3/20 at 3:06 pm, the DON confirmed that the temperature and screening checks had not been performed twice per day. Staff Screening: During an observation on 6/2/20 at 6:40 pm, Staff Screener (SS) #1 (located at main campus entrance), when screening staff entering the campus, had not reviewed the screening log staff had filled out, or staff to do hand hygiene prior to entering the facility. During an observation on 6/2/20 at 6:50 pm, Licensed Nurse (LN) #1 and LN #2 entered the facility through the main campus entrance where they were screened by the SS #1 and filled out the screening log. The log was not reviewed by the SS #1. Next, LN #1 and #2 walked to the elevator to go to the (Long Term Care) LTC unit. Leaving the elevator they proceeded onto the LTC. LN #1 stopped in the hall where the log sheets were located. The screening station where the sheets were located was not staffed. LN #1 signed in on the screening log, answered the questions and wrote his/her temp from the main screening done previously and completed hand hygiene. LN #2 walked past the screening log and had not documented his/her screening information or hand hygiene. During an observation on 6/2/20 at 7:00 pm, CNA #7 entered the LTC. He/she stopped at the screening log documented his/her temperature, then walked away from the log without completing the screening log questions. Further observation revealed CNA #6 arrived on the LTC unit and signed in on screening log. CNA #2 and 5 were seated in LTC hall. No LTC staff member monitored sign in process or asked the staff to do hand hygiene. During an observation on 6/3/20 at 10:50 am, SS #1 (at the main campus entrance) screened staff entering the campus. SS #1 had not reviewed the screening logs to ensure it was filled out or instructed staff to do hand hygiene upon entry to the facility. At this time Surveyors proceeded to the facility elevator to the LTC unit. Upon arriving at the LTC screening location at 11:00 am, the LTC screener #1 took surveyors temperatures and asked both to sign screening log and answer questions. The LTC screener did not review screening answers or instruct surveyors to do hand hygiene before entering LTC. During an interview on 6/3/20 at 11:20 am, the DON stated screening of staff included temperature check, hand hygiene, monitoring of the logs by the screener. The DON further stated she reviewed the logs weekly. Record review of the facility Covid-19 policy, dated 3/12 /20 revealed . Policy: Efforts to Prevent COVID-19 .7. All staff and residents will perform hand hygiene . Resident and Staff Screening/Training 1. All residents and staff will be screened daily for signs and symptoms consistent with Covid-19, including fever > 100.4, sore throat, myalgia, fatigue, headache, cough, new onset diarrhea and oxygen saturation (residents only). Monitoring will be documented in the electronic medical record for each resident and on the LTC sign in log for staff . .

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