STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015136	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FALKVILLE HEALTH CARE CENTER	10 WEST 3RD STREET PO BOX 409 FALKVILLE, AL 35622

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** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of Resident Identifier (RI) #1 and RI #2's medical record and the facility's policies titled Eye Drops - Instillation Of, Inhaler - Administration of Dry Powered and Handwashing - Hand Hygiene, the facility failed to ensure Employee Identifier (EI) #2, a Licensed Practical Nurse (LPN) did not: 1) place an inhaler and eye drop container on the overbed table of RI #1, without a barrier and return the medication containers to the medication cart without cleaning them; 2) apply gloves without washing her hands to administer an inhaler medication after administering RI #1's PO (by mouth) medications; and 3) wear the same gloves worn while administering RI #1's inhaler to administer RI #1's eye drops. The facility further failed to ensure EI #3, an LPN did not: 1) open RI #2's bathroom door while still wearing gloves worn when obtaining RI #2's finger stick blood sugar (FSBS); place an Insulin pen ([MEDICATION NAME]) on a shelf in the bathroom without a barrier prior to and after administering Insulin to RI #2; and 3) place the Insulin pen in her scrub pocket before returning it to the medication cart. These deficient practices affected RI #1 and RI #2, two of three residents observed for medication administration. Findings include: The facility's policy titled, Eye Drops - Instillation Of, revised 2/1/2015, documented . Procedure . 2. Wash and dry your hands thoroughly. 3. Put on gloves . 14. Clean equipment and return it to its designated storage area . The facility's policy titled, Inhaler - Administration of Dry Powered, with an effective date of 2/1/2017, documented Policy Medications are administered as prescribed, in accordance with good nursing principles and practices procedure Procedure 1. Wash hands before and after administration of medication . The facility's policy titled, Handwashing - Hand Hygiene, revised 3/6/2020, documented Policy Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Purpose . 2. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. . 6. Additional considerations: . b. The use of gloves does not replace hand washing. Wash hands after removing gloves . 1) RI #1 was admitted to the facility on [DATE]. RI #1 has a medical history to include a [DIAGNOSES REDACTED]. RI #1's Physician order [REDACTED]. During medication pass observation on 8/11/2020 at 8:18 AM, EI #2, an LPN, placed RI #1's inhaler and eye drop containers on RI #1's overbed table without a barrier; applied gloves without washing her hands to administer RI #1's inhaler after administering RI #1's PO medications; administered RI #1's eye drops without washing her hands or changing gloves; and placed the eye drop container and inhaler back in the medication cart without cleaning them. In an interview on 8/11/2020 at 11:18 AM, EI #1, the Infection Control Nurse was asked when should a nurse change gloves and wash her hands when giving PO medications, an inhaler and eye drops to the same resident. EI #1 said she should change her gloves and wash her hands after administering the PO medications, prior to administering the inhaler and then before she administered the eye drops. EI #1 was asked should the inhaler and eye drop containers be placed on the overbed table without a barrier and then returned to the medication cart. EI #1 stated no, there should be a barrier put down. EI #1 was asked what should happen if containers were placed on the overbed table without a barrier. EI #1 said they should be cleaned. EI #1 was asked what the concern was with those things. EI #1 answered cross contamination and infection control. In an interview on 8/11/2020 at 12:43 PM, EI #2, an LPN was asked when she should change gloves and wash her hands during medication pass. EI #2 said any time you have contact with a resident and in between giving different routes of medications, like between administering PO medications and before the inhaler and then after an inhaler and before eye drops are administered. EI #2 was asked did she change her gloves and wash her hands between giving RI #1's PO medication, inhaler and eye drops. EI #2 replied no. EI #2 was asked should she have, and she said yes. EI #2 was asked why she did not change her gloves and wash her hands. EI #2 stated she was nervous. EI #2 was asked where did she place RI #1's inhaler and eye drops after entering RI #1's room. EI #2 said she took them off the barrier and placed them on the bedside table. EI #2 was asked what the concern was with placing them on a potentially contaminated surface. EI #2 replied cross contamination when placing them back in the cart. EI #2 was asked what the concern was with placing potentially contaminated items in the medication cart. EI #2 stated cross contamination from that patient and whatever was on the cart to another patient. EI #2 was asked what the concern was with cross contamination. EI #2 answered putting another resident at risk for infection. 2) RI #2 was readmitted to the facility on [DATE]. RI #2 has a medical history to include a [DIAGNOSES REDACTED]. RI #2's Physician order [REDACTED]. During medication pass observation on 8/11/2020 at 10:40 AM, EI #3, an LPN obtained RI #2's FSBS. While still wearing the same gloves, EI #3 opened RI #2's bathroom door. At 11:03 AM, EI #3 returned to RI #2's room to administer [MEDICATION NAME]. EI #3 placed the [MEDICATION NAME] on a shelf in the bathroom without a barrier while washing her hands prior to and after administration of the Insulin. EI #3 was observed to place the [MEDICATION NAME] in her scrub pocket before returning the [MEDICATION NAME] to the medication cart. In an interview on 8/11/2020 at 11:18 AM, EI #1, the Infection Control Nurse was asked should a nurse wear gloves worn during obtaining a FSBS to open the bathroom door. EI #1 replied no. EI #1 was asked why not. EI #1 replied cross contamination. EI #1 was asked should a nurse place an Insulin pen ([MEDICATION NAME]) on a shelf in the bathroom without a barrier prior to and after administration of the Insulin or place the Insulin pen in her scrub pocket. EI #1 said never. EI #1 was asked what the concern was with those things. EI #1 answered cross contamination and infection control. On 8/11/2020 at 1:03 PM, an interview was conducted with EI #3, an LPN. EI #3 was asked when she should remove her gloves when obtaining a FSBS. EI #3 stated after she obtained the blood sugar. EI #3 was asked did she remove her gloves after obtaining RI #1's FSBS. EI #3 replied no. EI #3 was asked what the concern was with not removing her gloves before opening the bathroom door. EI #3 replied because she touched the doorknob with the gloves and she was contaminated and somebody else could touch it and be contaminated. EI #3 was asked what it was considered when she touched the doorknob wearing the gloves she wore obtaining the FSBS. EI #3 said cross contamination. EI #3 was asked where she placed the Insulin pen when she went in the bathroom to wash her hands prior to administering it. EI #3 stated on the bathroom shelf above the sink. EI #3 was asked did she place a barrier. EI #3 replied no. EI #3 was asked why she did not place a barrier. EI #3 stated she was nervous. EI #3 was asked where she placed the Insulin pen after she administered it to RI #2 while she was washing her hands. EI #3 said on the bathroom shelf and then into my pocket. EI #3 was asked should resident items be placed in or on a potentially contaminated surface. EI #3 replied no. EI #3 was asked what the concern was with the issues discussed. EI #3 answered cross contamination and infection control.

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.