STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325123	A. BUILDING _____ B. WING _____	05/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVAMERE REHABILITATION AT FIESTA PARK	8820 HORIZON BOULEVARD NE ALBUQUERQUE, NM 87113

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 observation, interview, record review, and review of the facility's policies, it was determined the facility failed to ensure an effective Infection Prevention and Control Program (IPCP) was implemented for one of five sampled residents (Resident (R) 1). Observations on 05/11/20 revealed two facility staff members failed to wear Personal Protective Equipment (PPE) when entering a resident's room who was on physician ordered contact isolation precautions. Additionally, observations on 05/11/20 during the lunch meal revealed facility staff utilized an ice scoop that was not properly stored to serve residents ice. These failures had the potential to effect other residents in the facility. Findings include: 1.Review of the facility's policy titled, Isolation- Categories of Transmission-Based Precautions, revised August 2011, revealed .Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others.In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. a. Examples of infections requiring Contact Precautions include, but are not limited to: (2) Diarrhea associated with [MEDICAL CONDITION] .c. Gloves and Handwashing (1).wear gloves (clean, non-sterile) when entering the room.d. Gown (1).wear a gown (clean, non-sterile) for all interactions that may involve contact with the resident or potentially contaminated items in the resident's environment. Remove the gown and provide hand hygiene before leaving the resident's environment. Review of R1's Admission Record, undated, located in the resident electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of R1's Order Summary Report, undated, located in the resident's EMR under the orders tab, revealed on 05/06/20, the resident was ordered contact isolation per facility protocol every shift for [MEDICAL CONDITION] [MEDICAL CONDITIONS] until 05/09/20. Review of R1's Order Summary Report, for active orders as of 05/11/20, revealed the resident was ordered Continued Contact Isolation Per Facility Protocol for re-evaluation of symptoms every shift for [MEDICAL CONDITIONS]. Continued review of the order summary report revealed the order date and the start date was 05/10/20, with no end date. Observation on 05/11/20 at 10:05 AM of R1's room (room [ROOM NUMBER]), revealed a PPE holder on the door with a sign that stated, Contact Precautions .See nurse. Continued observation revealed a nurse in the room administering medications to R1; however, the only PPE the nurse was wearing was a medical face mask. Interview on 05/11/20 at 10:10 AM with Licensed Practical Nurse (LPN) 1 revealed she had been employed by the facility since March 2020. LPN1 stated she was administering R1 her medications and was not required to wear any PPE other than the face mask because the resident was not currently on contact precautions because they had been discontinued either this past Friday or Saturday (05/09/20 or 05/10/20). Continued interview with the LPN revealed R1 had been on contact precautions because she had [MEDICAL CONDITION]. After the LPN reviewed the physician orders [REDACTED]. The LPN further stated there was an order, dated 05/10/20, to continue contact isolation precautions and she had overlooked this. Review of LPN1's training document titled, Relias Transcript, revealed on 03/19/20, the LPN completed the following courses: Infection Control-The Basics, Personal Protective Equipment, and Transmission-Based Precautions. Interview on 05/11/20 at 10:15 AM with the Director of Nursing (DON) revealed R1 was still under isolation contact precautions related to [MEDICAL CONDITION]. The DON stated LPN1 should have had PPE on when she went into the resident's room. Interview on 05/11/20 at 10:30 AM with Charge Nurse (CN) 3 revealed she was the charge nurse for the Rio Grande floor where R1 resided. Continued interview with the charge nurse revealed it was her expectation LPN1 would have had PPE that consisted of gown, gloves, and a mask at a minimum prior to entering R1's room to administer medications. CN3 stated PPE should have been wore to prevent the spread of [MEDICAL CONDITION] to other residents. Observation on 05/11/20 at 1:17 PM revealed Patient Services Rep (PSR) 4 entered R1's room and asked her what she would like to drink; however, PSR4 did not put any PPE on prior to entering the room. 2. Review of the facility's policy titled, Ice Machines and Ice Storage Chest, revised August 2012, revealed ice-making machines, ice storage chests/containers, and ice can all become contaminated by improper storage or handling of ice. Continued review of the policy revealed to help prevent contamination of ice machines, ice storage chest/containers or ice, staff shall keep the ice scoop/bin in a covered container when not in use. Continuous observations on 05/11/20 starting at 1:10 PM and [MEDICATION NAME] until 1:25 PM revealed PSR4 and Certified Nurse Aide (CNA) 5 delivered lunch meal trays to the Rio Grande floor. The observations also revealed both PSR4 and CNA5 used an ice scoop with their bare hands to obtain ice from a silver ice container with a lid. In between each resident, both PSR4 and CNA5 would scoop ice out of the container, empty the ice into residents' cups, and then place the ice scoop back into the ice container while delivering trays to the rooms. The ice scoop was used to distribute ice to the following resident rooms after improper storage of the ice scoop and possible contamination of the ice: 435, 434, 432, 431, 430, 407, 406, and 405. Each of the rooms were private rooms. Interview on 05/12/20 at 2:15 PM with the Dietary Director revealed normally there is a plastic container on top of the meal cart for the ice scoop to be stored in between serving ice to residents. Continued interview revealed on 05/11/20 she forgot to put the ice scoop storage container on top of the meal cart before it left the kitchen. The Dietary Director stated the ice scoop should not had been stored in the ice container with the ice because of possible cross contamination. Interview on 05/12/20 at 2:11 PM with CNA5 revealed she had never heard that the ice scoop could not be placed in with the ice. The CNA stated usually there was a scoop holder on the meal cart but there was not one on the cart yesterday (05/11/20). Interview on 05/12/20 at 12:07 PM with the Administrator revealed it was his expectation staff would have had the ice scoop holder on the meal cart and utilized it instead of storing the ice scoop directly on the ice. Continued interview with the Administrator revealed it was also his expectation when there is a resident who is ordered contact isolation precautions, the facility staff would use all required PPE. The Administrator stated his expectations for the ice scoop holder to be used and the PPE to be wore was for infection control reasons. Interview on 05/12/20 at 12:50 PM, with the Infection Preventionist (IP) revealed it was her expectation all staff would have followed the contact precautions for R1. The IP stated the facility's signage was very clear of what to wear and the caddy on the resident's door holds the PPE to use. Continued interview with the IP revealed it was her expectation and the facility's policy for there to be a separate container for the ice scoop to be stored to prevent cross contamination. Interview on 05/12/20 at 1:30 PM with PSR4 revealed he has worked at the facility for approximately 3 weeks. Continued interview revealed he did not know the ice scoop was not to be stored in with the ice after using it. The PSR4 stated he knew he should not go into a resident's room that had isolation notice on the door; however, he was delivering meals and did not pay attention.

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.