STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025018	A. BUILDING _____ B. WING _____	**06/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PROVIDENCE TRANSITIONAL CARE CENTER	**910 COMPASSION CIRCLE ANCHORAGE, AK 99504**

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 observation, interview, policy and record review, the facility failed to ensure: 1) staff handled linens properly for 1 resident (#3) ; 2) a glucose monitor was cleaned between use for 3 residents (#s1, 2, and 6); 3) personal protective equipment (PPE) was worn by staff on the COVID-19 unit; 4) staff completed proper hand hygiene prior to donning PPE when entering 3 resident's rooms (#s4, 5, and 7) and when going from dirty to clean tasks for 1 resident (#4); 5) hand hygiene was offered to 1 resident (#7) before a meal; and 6) during screening hand hygiene and proper PPE was completed prior to staff entering the Long Term Care (LTC). These failed practices had the potential to prevent the spread of infection and/or COVID-19 (infectious virus that caused acute respiratory syndrome, multi-organ failure, and septic shock) for all residents that resided in the facility (based on a current census of 33). Findings: Observations of the facility, on 6/8-10/20, revealed a north and south wings were located at the end of a long hallway. During an entrance conference conducted at 6/8/20 at 12:50 pm, the Infection Control Nurse (ICN) and Quality Staff (QS) stated the south hall housed COVID-19 positive residents and non-positive residents, while the north hall residents had tested negative. Both staff stated a respirator mask (a fitted filtration mask worn over the mouth and nose) and a face shield was required by all staff that worked on both sides of the facility. Use of Soiled Items: Record review on 6/9-10/20 revealed Resident #3 had [DIAGNOSES REDACTED]. Review of the MDS (Minimum Data Set) assessment, 1/10/20, a quarterly assessment, revealed the Resident required total assistance with bed mobility and transfers. During an observation on 6/8-10/20, Licensed Nurse (LN) #4 responded to Resident #3's call light. The Resident told the LN he/she was cold and needed a warm blanket. When LN #4 held up a blanket, he/she inadvertently dropped it on the floor. The LN stated It fell on the floor, shook the blanket a couple times, and placed it on the Resident. Glucometer Observations on 6/9/20 at 8:00 am revealed, LN #2 checking residents' blood sugars with an Accuchek Inform II glucometer, used for checking finger stick glucose (sugar). Prior to obtaining Resident #1's blood sugar, LN #2 stated Resident #1 was on contact precautions, anyone that entered the room past the entryway of the door had to dress in PPE (personal protective equipment-a gloves and gown), in addition to the respirator and face shield. After dressing in PPE, the LN entered Resident #1's room. The LN set the glucometer on the Resident's bedside table and obtained the finger stick. LN #2 then carried the glucometer to the alcohol dispenser located by the doorway, balanced it on top, removed the PPE and sanitized his/her hands. LN#2 then carried the glucometer out of the room, and without cleaning the glucometer, set it on top of the medication cart. The LN picked up the now contaminated glucometer and carried it into Resident #2's room. After sanitizing hands and donning gloves, the LN sat on a chair next to the Resident's bed and placed the glucometer on the bed. After LN#2 obtained the Resident's blood sugar, the LN set the glucometer on top of the hand sanitizer dispenser, disposed of the supplies, removed the gloves and sanitized his/her hands. The LN then carried the glucometer meter out of the room, and without cleaning it, placed the glucometer on top of the medication cart. LN #2 pushed the cart down the hall, sanitized both hands, donned gloves, picked up the contaminated glucometer and carried it into Resident #6's room and set the glucometer on the Resident's bed. After checking the Resident's blood sugar, the LN placed the glucometer on top of the sanitizing dispenser, removed the gloves and sanitized his/her hands. The LN then carried the contaminated glucometer out of the room and placed it on top of the medication cart. During an interview on 6/9/20 at 8:30 am, when asked how often the glucometer was cleaned, LN #2 stated the nurses were to clean the glucometer after use and dock it at the nurses' station. When asked how staff cleaned the glucometer, the LN pointed to the white topped sanitizing wipes located on the medication cart. Closer examination of the wipes revealed they were the OXIVER Tb Wipes. Review of the facility's Cleaning Product Information, undated, revealed OXIVER .Not approved for blood sugar machines. Review of the facility protocol, Care of Glucose Monitoring Machine: Accuchek Inform II Meter, dated 12/11/17, revealed 16. Clean and disinfect the meter after each resident: a. Turn off the meter b. Use Super Sani Cloths (purple top wipes) (2 minute wet time) or Bleach wipes (red top wipes) (when [MEDICAL CONDITION] is a concern; 4 minute wet time) . PPE on COVID Unit: Observation on the COVID unit on 6/9/20 at 12:05 pm, Certified Nursing Assistant (CNA) #2 walked across hallway towards the nurse station. The CNA was not wearing a respirator mask and face shield. After making eye contact, CNA #2, turned around, disappeared around the corner and returned wearing a respirator mask and face shield. Hand Hygiene prior to Gloving on COVID Unit : Observation during the noon meal delivery on the COVID unit, on 6/9/20, revealed staff donned gowns and gloves that was located in cabinets outside of the room. The staff then removed the food from the delivery cart and delivered it to the residents. At 12:50 pm, LN # 1 donned a gown and gloves. The LN had not performed hand hygiene prior to donning the gloves. The LN picked up Resident #5's lunch and entered the room. At 12:54 pm, CNA #3 donned a gown and gloves from the cabinet located between Resident #4 and #7's rooms. The CNA did not perform hand hygiene prior to donning the gloves. CNA gathered the paper products off Resident # 7's tray, entered the room, and served the Resident lunch. At 1:00 pm, CNA #3 donned gown and gloves without performing hand hygiene prior to donning the gloves. The CNA picked up Resident #4's lunch off the cart and entered the Resident's room. Observation of the unit revealed the hand sanitizer dispensers were on the wall inside the residents' rooms, bottles on nurses' medication carts, and a dispenser on the wall at the beginning of the hallway. There were no hand sanitizer dispensers in located in some of the cabinets with the gowns and the gloves. During an interview on 6/10/20 at 3:17 pm, when asked how staff sanitized hands when they dressed in gowns and gloves in the hallway, LN #1 stated he/she used the sanitizer bottle that was on the medication cart. When asked about the CNAs, the LN stated they used the sanitizer from the closets (located between the residents' rooms). LN #1 stated the nursing staff stocked the rooms, as central supply no longer came to the units. During an interview on 6/17/20 at 11:15 am the ICN stated staff were to don and doff PPE in the 3-foot entrance just inside the residents' rooms. Hand Hygiene During Personal Care: Record review on 6/9-10/20 revealed Resident #7 had a [DIAGNOSES REDACTED]. The Resident required extensive physical assistance with actives of daily living. Observation during personal care on 6/9/20 at 1:00 pm revealed Resident #7 had been incontinent of stool. The Resident had feces on his/her right arm and hand, left bed rail, bedding, and shirt. After LN #1 came in to assist, the CNA used several washcloths and cleaned the feces off the Resident's skin, bedding, and side rail. Without performing hand hygiene and changing gloves, the CNA, replaced the residents disposable undergarment, changed the bottom sheet, draw sheet, and top sheet. While wearing the same gloves the CNA replaced the Resident's soiled shirt with a clean one. As LN #1 left the room, with the soiled linen and trash, the CNA use the bed controls and raised the head of the Resident's bed. CNA #3 removed both soiled gloves, applied hand sanitizer and vigorously rubbed both hands together, donned new gloves, and began feeding Resident #4 lunch. Review of the facility's policy, PSJH-CLON 1205 Hand Hygiene Policy, revised 9/2019, revealed Indications for Hand Hygiene, .Hand hygiene will be performed before and after the following activities .10. Before putting on gloves (Product Selection) ABHS (Alcohol Based hand Sanitizer) or soap and water .12. If moving between contaminated body sites to another body sites during care of the same patient (Product Selection) ABHS or soap and water . Resident Hand Hygiene: Record review on 6/9-10/20 revealed Resident #7 had [DIAGNOSES REDACTED]. During an observation on 6/9/20 at 1254 am, after donning PPE, CNA #1, gathered lunch items off the cart, entered Resident #7's room and cleared the bedside table. The CNA placed the lunch on the table,

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) gathered the trash and exited the room. CNA #1 did not ask the Resident if he/she wanted to wash his/her hands before eating. Review of the facility's policy, PSJH-CLON 1205 Hand Hygiene Policy, revised 9/2019, revealed Patient Hand Hygiene: Patients should be offered the opportunity to clean their hands before meals; after using the toilet, commode bedpan and at other times as appropriate. Screening: During a continuous observation at the staff screening entrance on 6/9/20 from 6:30 am - 8:25 am revealed, the Staff Screener (SS) conducting staff screening as incoming staffs entered the screening area. At 6:49 am, CNA # 1 entered the screening area. SS asked the CNA the screening questions and did a temperature check. The CNA proceeded past the screening area into the LTC hall without doing hand hygiene. At 6:57 am, CNA # 4 entered the screening area. The SS asked the CNA the screening questions and did a temperature check. The CNA proceeded past the screening area into the LTC hall without doing hand hygiene. At 8:03 am, a LTC Support Staff (LTCSS) entered the screening area. The SS proceeded with the screening process. After the screening process was completed the LTCSS walked unmasked into the LTC hall way toward the units. At this time the surveyor told the LTCSS the staff member was unmasked and the SS went into the hall of the LTC calling out to the LTCSS to return to the screening area as they were unmasked. Throughout the continuous observation, the SS did not instruct the incoming staffs to do hand hygiene. .