STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015169	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FLORENCE NURSING AND REHABILITATION CTR, LLC	2107 CLOYD BLVD FLORENCE, AL 35630

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 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and review of Resident Identifier (RI) #3's medical record, the facility failed to ensure Employee Identifier (EI) #5, the Licensed Practical Nurse (LPN) Treatment Nurse did not place wound supplies on the resident's mattress without a barrier; did not wipe drainage from below the wound bed back into the wound bed; and change gloves after cleaning RI #3's wound before applying a clean dressing. These deficient practices affected RI #3, one of one resident observed for wound care. Findings include: RI #3 was admitted to the facility on [DATE]. RI #3's physician order [REDACTED]. During wound care observation on 9/16/2020 at 10:19 AM, EI #5, the LPN Treatment Nurse placed 4x4s and a bordered dressing on RI #3's mattress without a barrier. EI #5 was observed to wipe bloody drainage from below RI #3's wound bed with a moistened 4x4 back into the wound bed. While still wearing the same gloves worn to clean RI #3's wound, EI #5 placed the aquacle and bordered dressing on RI #3's wound, without changing her gloves. In an interview on 9/16/2020 at 10:43 AM, EI #5, the LPN Treatment Nurse was asked when she should wash or sanitize her hands during wound care. EI #5 replied, when she removed the dirty dressing, she should remove her gloves wash her hands and put new gloves on. When asked how the resident's wound should be cleaned, EI #5 stated counter clock wise one time. When asked should she clean drainage from below the wound bed upward into the wound bed, EI #5 said no. When asked why not, EI #5 replied, because it would contaminate the wound and cause infection. EI #5 was asked did she clean bloody drainage from the below RI #3's wound into the wound bed. EI #5 answered yes. EI #5 was asked should she place wound supplies on the resident's mattress and she said no. When asked if she placed RI #3's wound supplies on the resident's mattress, EI #5 said yes. During an interview on 9/17/2020 at 8:45 PM, EI #3, the Infection Control Preventionist was asked when should a nurse change gloves and wash her hands during wound care. EI #3 replied, anytime going from a dirty to a clean area or getting anything else like supplies. When asked should a nurse wipe drainage from below the wound bed back into the wound bed when cleaning the wound, EI #3 answered no. EI #3 was asked should a nurse change gloves after cleaning a wound before applying a clean dressing. EI #3 replied, yes. When asked should a nurse place supplies for wound care on a mattress without a barrier, EI #3 answered no. When asked what the concern was with these things, EI #3 replied infection in the wound that could cause the wound to worsen.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation, interviews, and review of FUNDAMENTALS OF NURSING NINTH EDITION, the facility failed to ensure Employee Identifier (EI) #4, a Registered Nurse (RN): 1) did not pick up a pill with her bare hands and administer to Resident Identifier (RI) #2; 2) washed or sanitized her hands before she put gloves on to place a topical medication on RI #2's bilateral knees; 3) removed her gloves and sanitized her hands before she picked up RI #2's throw (blanket) and placed on the resident's knees; and 4) sanitized (cleaned) the pulse oximeter before and after use. These deficient practices affected RI #2, one of one resident observed for medication administration. Findings include: Page 445 of Chapter 29 titled Infection Prevention and Control of FUNDAMENTALS OF NURSING NINTH EDITION documented . Modes of Transmission . The major route of transmission of pathogens identified in the health care setting is the unwashed hands of the health care worker. Equipment used within the environment often becomes a source for the transmission of pathogens . Page 458 of Unit V Foundations for Nursing Practice of FUNDAMENTALS OF NURSING NINTH EDITION documented . Hand Hygiene. The most effective basic technique in preventing and controlling the transmission of infection is hand hygiene . The use of alcohol-based hand hygiene practices, protect health care workers hands, and reduce the transmission of pathogens to patients and personnel in health care settings . During medication pass observation on 9/16/2020 at 9:41 AM, EI #4, a RN opened and poured RI #2's by mouth medications into a cup. One of the pills dropped onto the medication cart and EI #4 picked up the pill with her bare hands and placed it back into the medication cup and administered it to RI #2. After EI #4 administered RI #2's inhaler and by mouth medications, EI #4 put gloves on, without washing or sanitizing her hands, and placed topical gel on RI #2's bilateral knees. While wearing the same gloves that had residue from the topical gel, EI #4 picked up RI #2's throw (blanket) and placed it over the resident's knees. Also noted, EI #4 removed from the medication cart to pulse oximeter to check RI #2's oxygen saturation. EI #4 did not clean the pulse oximeter before use. After RI #2's oxygen saturation was checked, EI #4 placed the pulse oximeter back into the medication cart without cleaning it. In an interview on 9/16/2020 at 3:11 PM, EI #4, a RN acknowledged she should wash or sanitize her hands when she removes gloves, before she put another pair of gloves on and in between residents. When asked what the concern was with handling PO (by mouth) medications with bare hands, EI #4 said contamination. EI #4 was asked if she picked up a pill from the top of medication cart and placed it in RI #2's cup of medications with her hands for administration. EI #4 replied, she did. When asked should she have, EI #4 said no. When asked why not, EI #4 replied obviously it's a contamination issue. EI #4 was asked what she should do with her gloves after administration of topical medications. EI #4 answered, remove the gloves and wash my hands. When asked if she removed her gloves and washed her hands after she applied topical gel on RI #2's bilateral knees before she picked up a throw and placed on the resident's knees, EI #4 replied, she did not. EI #4 was asked what the concern was with placing a resident's throw on their legs while wearing gloves used to administer topical medication. EI #4 stated, there might be some residue on the glove and it would get on the throw and the resident may put it somewhere it doesn't need to be and it's unsanitary. EI #4 acknowledged the pulse oximeter should be sanitized (cleaned) before and after use. When asked if she sanitized the pulse oximeter before and after use when she assessed RI #2's oxygen saturation, EI #4 said she did not. On 9/17/2020 at 8:45 PM, an interview was conducted with EI #3, the Infection Control Preventionist. EI #3 was asked should a nurse pick up a pill from the top of the medication cart with her hand hands and administer the pill to the resident. EI #3 said, absolutely not. When asked should a nurse wear gloves used for administration of topical gel to pick up a resident's throw and place it on their knees, EI #3 replied, no. EI #3 acknowledged the pulse oximeter should be cleaned before and after use.

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.