STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115563	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTBURY MEDICAL CARE AND REHAB	922 MCDONOUGH ROAD JACKSON, GA 30233

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 -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record review, the facility failed to ensure proper hand hygiene was performed prior to placing new oxygen nasal cannulas on the concentrators for two residents (R#1 and R#2) out of a sample of five. This failure had the potential to transmit infection from dirty surfaces to the clean nasal cannulas, which could cause or spread respiratory infection, including COVID-19. Findings include: 1. Per the 6/18/20 facility document, Current Resident COVID-19 Baseline Test Results, R#2 tested positive for COVID-19 on 4/14/20. R#2 had since been removed from transmission-based precautions for COVID-19 based on the facility's determination she had met the time and symptom criteria for removal from transmission-based precautions. R#2 had not been retested for COVID-19. On 6/18/20 at 11:28 a.m., Certified Nurse Aide (CNA) CC entered R#2's room to perform cleaning of the oxygen concentrator and change out the nasal cannula. R#2 was lying in bed with her oxygen on and the cannula in her nose. CNA CC donned gloves and used a bleach wipe to clean the outside of the concentrator. She then removed the filters from the concentrator and entered the bathroom to rinse them out. CNA CC then exited the bathroom, threw a paper towel in the trash can near the room entry, and removed the old cannula from R#2's nose while still wearing the same gloves. CNA CC then took the new nasal cannula out of the package, attached it to the concentrator, and placed the cannula in R#2's nose without first changing her gloves or washing her hands. On 6/18/20 at 11:36 a.m. in the hallway outside R#2's room, CNA CC stated she should have removed her gloves, washed or sanitized her hands, and donned a new pair of gloves prior to placing the new nasal cannula on the concentrator and into R#2's nose. 2. Per the 6/18/20 facility document, Current Resident COVID-19 Baseline Test Results, R#1 tested positive for COVID-19 on 4/21/20 and on 5/12/20. R#1 had since been cleared of COVID-19 based on the facility's determination he had met the time and symptom criteria; however, R#1 remained on contact and droplet precautions as he left the facility three times a week for [MEDICAL TREATMENT]. R#1 had not been retested for COVID-19. On 6/18/20 at 11:40 am, Licensed Practical Nurse (LPN) BB entered R#1's room to perform cleaning of the oxygen concentrator and change out the nasal cannula. R#1 was not in the room, as he was out for [MEDICAL TREATMENT]. LPN BB donned a gown, N95 respirator covered with a surgical mask, face shield, and gloves. She removed the filters from the concentrator and entered the bathroom to rinse them out. LPN BB then exited the bathroom, threw a paper towel in the trash can near the room entry, then wiped off the concentrator with a bleach wipe. LPN BB then took the new nasal cannula from the package and attached it to the oxygen concentrator while still wearing the same gloves. On 6/18/20 at 11:43 a.m. in the hallway outside R#1's room, LPN BB stated gloves should be removed, hands washed, or sanitized, and new gloves donned prior to touching the new nasal cannula. She stated she did wash and change gloves during the above observation. On 6/18/20 at 12:27 p.m. in the conference room, the Administrator and Assistant Director of Nursing (ADON), who served as the facility's Infection Preventionist, were alerted to the above observations. The ADON stated she was glad the two staff members were able to describe the correct procedure for hand hygiene and stated she would conduct audits of this practice to ensure compliance. On 6/18/20 at 2:00 p.m. in the ADON's office, the ADON and Director of Nursing (DON) were interviewed concurrently. The DON stated the facility had just changed their policy for nebulizer and oxygen equipment cleaning, and the new process was just implemented on 6/18/20. The DON stated, We did not yet do competency check-offs on the new process, but planned to begin them immediately, starting with CNA CC and LPN BB. The DON stated the policy, and her expectation, was to remove gloves, wash hands, and put on clean gloves after touching the dirty cannula and concentrator and before touching the clean nasal cannula. The DON stated she would immediately complete education with staff to ensure understanding of the new policy. The facility's 6/12/20 policy, Oxygen Concentrator (and) Nebulizer Cleaning (and) Storage, documented it was implemented on 6/18/20. The policy was to clean (and) store oxygen concentrators and nebulizer equipment in accordance with current CDC (Centers for Disease Control and Prevention) guidelines and manufacturer recommendations in order to prevent the occurrence or spread of infection. The guidelines included: Respiratory therapy equipment can become colonized with infectious organisms and serve as a source of respiratory infections . Staff shall perform hand hygiene and wear gloves whenever touching the nebulizer and oxygen equipment . Perform hand hygiene and apply clean gloves prior to cleaning equipment . Replace nebulizer mask set-up and oxygen tubing weekly. On 6/18/20 at 2:20 p.m. in the conference room, the DON provided two Oxygen Concentrators (and) Nebulizer Cleaning (and) Storage policies, signed by LPN BB and CNA CC, which documented The following employee has demonstrated and verbalized proper procedure. The DON stated these competency evaluations and education were done just then to address the above observed breaches in infection control practices.

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