STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015124	A. BUILDING _____ B. WING _____	**07/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLAY COUNTY NURSING HOME	**83825 HIGHWAY 9 P O BOX 1270 ASHLAND, AL 36251**

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, staff interview record review, Centers for Disease Control and Preparedness (CDC) guidelines and review of the facility policy entitled, Personal Protective Equipment, the facility failed to ensure staff did not wear the same gown when caring for more than one (1) resident (extended use) with unknown COVID-19 status on one (1) of one (1) quarantine units. The facility also failed to have a policy on extended use of gowns that was consistent with CDC guidelines. This failure occurred during a COVID-19 Pandemic and had the potential to affect 22 of 71 residents due to cross contamination. The findings include: Review of the facility Resident Testing Log for COVID-19 revealed Resident #1, #2 and #3 tested positive for COVID-19 on 7/17/20. During an interview with the Director of Nursing (DON) on 7/22/20 at 11:15 a.m., she stated that the facility had a staff member who had been asymptomatic but who tested positive for COVID-19. After the staff member was identified as COVID-19 positive, the facility tested all residents and staff. The DON said three (3) residents on the Memory Care Unit (Unit 2) tested positive for COVID-19. Two (2) additional staff also tested positive. The DON stated that the residents who tested positive were now on a dedicated COVID-19 unit which was at the end of a hall on the Memory Care Unit. It was separated from the rest of the unit by a plastic barrier. Upon inquiry the DON confirmed that although all the other residents on Unit 2 tested negative initially and again on a second test, they were potentially exposed so the facility had put these residents on a 14 day quarantine for symptom monitoring. She added that the staff caring for these residents wore full PPE (gown, gloves, mask and face shield). On 7/22/20 at 1:20 p.m. the quarantine unit was observed with the Director of Nursing (DON). Upon entering the quarantine unit Nurse #1 was observed walking in the hall wearing a mask, face shield, disposable plastic gown and gloves. There were no isolation kits containing PPE, for donning prior to entering a resident's room, observed on the hall. During an interview with Nurse #1 on 7/22/20 at 1:30 p.m., she confirmed she wore the same gown, mask and face shield while caring for all residents on the quarantine unit. She stated that if she did go on a quick break outside she would go out the back exit door at the end of the hall and take of her gown, then spray it with sanitizer and hang it over the chain link fence that was near the door. Nurse #1 said she would put the gown back on before returning to the unit. Nurse #1 added that she would get a new gown the next day at the beginning of her shift. Upon inquiry Nurse #1 indicated that she was wearing gloves in the hall because the staff wore full PPE, including gloves, for the entire shift. She said that she sanitized her gloves as needed, like she would sanitize her hands as needed if she wasn't wearing gloves; in addition she said that she did change gloves between residents. During a telephone interview with the DON on 7/22/20 at 4:30 p.m., she confirmed that the facility practice and expectation for staff on the quarantine unit was to optimize the supply of gowns by wearing the same gown for the care of all residents for a full shift (extended use), unless it became soiled or damaged. The DON said that since the quarantine unit was a Memory Care unit the residents tended to congregate amongst themselves anyway and could potentially cross contaminate each other. She added that the facility had implemented full PPE on that unit as a protection for the staff to help them feel comfortable working on that unit. During a telephone interview with the DON on 7/23/20 at 8:00 a.m., she indicated that the facility used contingency capacity strategies for optimizing the supply of PPE due to limitations in availability. Upon inquiry the DON said the facility had 800 disposable gowns in stock and would be getting another shipment in the next few weeks. In addition she acknowledged they had cloth gowns that could be used as a contingency option. Review of the CDC guidance entitled Responding to Coronavirus (COVID-19) in Nursing Homes dated April 30, 2020 revealed, when a resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit. In addition HCP (health care providers) should use all recommended COVID-19 PPE for the care of all residents on affected units (or facility-wide if cases are widespread); this includes both symptomatic and asymptomatic residents. Maintain Transmission-Based Precautions for all residents on the unit at least until there are no additional clinical cases for 14 days after implementation of all recommended interventions. While the facility did follow the above CDC guidance and initiate a 14 day quarantine with transmission based precautions for the 22 affected residents on Unit 2, the facility did not have a policy that adequately addressed the extended use of PPE and did not follow the CDC guidance for extended as evidenced by the below facility policy and CDC guidance. Review of the facility policy entitled Personal Protective Equipment dated April 2020 revealed, extended use of gowns was included as a crisis capacity strategy for optimizing the supply of isolation gowns, however there was no further information to indicate under what circumstances extended use of the same gown with multiple residents was appropriate. Review of the CDC guidance entitled Strategies for Optimizing the Supply of Isolation Gowns dated March 17, 2020 revealed the following regarding extended use of isolation gowns: Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCP when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). This can be considered only if there are no additional co-infectious [DIAGNOSES REDACTED]. The facility was [MEDICATION NAME] extended use of gowns with residents who were potentially exposed to COVID-19 but whose COVID-19 status was not known as they were still under a 14 day quarantine and observation for symptoms of COVID-19, despite two negative COVID-19 tests (completed before day 14). This practice did not comply with CDC guidelines which indicate extended use can only be practiced when residents have the same infectious disease (i.e., COVID-19 positive residents).

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.