

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015440	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2022
NAME OF PROVIDER OR SUPPLIER Huntsville Health & Rehabilitation, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4010 Chris Drive Huntsville, AL 35802	

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)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, resident record review and review of a facility policy titled Perineal Care the facility failed to ensure Employee Identifier (EI) #2 Certified Nursing Assistant (CNA) provided incontinent care for Resident Identifier (RI) #76, a resident with a history of Urinary Tract Infections (UTI), in a manner to prevent UTI. During the survey on 1/11/22 EI #2 was observed wiping bowel movement from RI #76's buttocks, wiping RI #76's perineum from back to front, all while wearing he same pair of soiled gloves for the entire process of incontinent care.</p> <p>This affected one of five residents sampled for bowel and bladder incontinence.</p> <p>Findings include:</p> <p>The facility policy titled Perineal Care with an effective date of 10/1/2010, documented: . l. c) Remove and fecal matter or urine wiping . from front to back .</p> <p>RI #76 was readmitted to the facility on [DATE] with diagnoses to include: Personal History of Urinary Tract Infections (UTI).</p> <p>On 1/11/22 at 4:15 PM Employee Identifier (EI) #2 CNA was observed performing perineal care for RI #76 using wipes to remove bowel movement from RI #76's buttocks while wiping from the back toward the front. Without changing gloves or performing hand hygiene, EI #2 took new wipes to clean the front of RI #76's perineum. EI #2 also placed a new brief under RI #76 while wearing the same soiled gloves and without performing hand hygiene. EI #2 was not observed to remove soiled gloves or perform hand hygiene during the process of perineal care provided for RI #76.</p> <p>On 1/12/2022 at 8:23 AM EI #2 CNA, was asked to tell how she provided the incontinent care for RI #76. EI #2 said she started from the back. EI #2 was asked if she should have removed her gloves. EI #2 replied, yes. EI #2 was asked if she placed a new brief without changing her gloves. EI #2 replied, yes. EI #2 was asked if she was taught to change gloves. EI #2 replied, yes. EI #2 was asked, why did she not change her gloves. EI #2 replied, she was in a hurry.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/14/22 at 1:04 PM, EI #3, Director of Nursing (DON) was questioned about the perineal care RI #2 provided for RI #76. EI #2 was asked what EI #2 did that could cause a negative outcome to RI #76. EI #3 replied, not doing perineal care properly could cause an infection like a UTI. EI #3 was asked what EI #2 do that could cause a UTI. EI #3 replied, going from the dirty side to the clean side. EI #3 was asked what did EI #2 mean by starting from the back. EI #3 replied, she did not know, but perineal care starts from the front and goes toward the back. EI #3 was asked why perineal care should be performed from front to back. EI #3 replied, to not spread bowel movement from the rectum to the front of the perineal area, it could cause a bladder infection. EI #3 was asked what was the potential harm to the resident if perineal care was done from back to front. EI #3 replied, the resident could get a UTI.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>Based on observations, interviews, review of a facility policy titled Sanitation Principles and review of the facility Resident Census and Condition report, the facility failed to ensure one of two dumpster doors were closed and that there was no overflowing trash containers around the dumpster area and that gloves and paper were not laying on the ground outside the dumpster.</p> <p>This was observed on 1/10/2022 during the initial tour of the facility and had the potential to affect all 103 residents residing in the facility.</p> <p>Findings include:</p> <p>A facility policy titled Sanitation Principles with an effective date of 8/10/18 documented . PURPOSE: To prevent the spread of bacteria that may cause food borne illness.</p> <p>PROCESS: . d. (f.) Refuse containers and dumpsters outside the nursing facility should have tight fitting lids, and should be kept covered when not actually being loaded. The areas around the dumpster should be kept free of debris.</p> <p>On 1/10/22 at 4:57 PM during initial tour of the facility, the dumpster area was observed. One of two dumpsters was open. There were also two garbage with overflow of trash. There were two open bags of trash on the ground in white trash bags and a wheelchair arm on the ground. There were used gloves on the ground around one of the dumpsters.</p> <p>On 1/11/22 at 8:09 AM, an observation was made of the dumpster area. The door to dumpster #2 was closed, however, the overflowing trash cans and the white plastic bags were still on the ground. There was a third larger dumpster with overflowing trash noted.</p> <p>On 1/13/22 at 2:54 PM Employee Identifier (EI) #1, Certified Dietary Manager was asked what was going on Monday 1/10/22 when the surveyor came in. EI #1 answered, she was plating and unable to tour with the surveyor. EI #1 was asked how many dumpsters were there. EI #1 answered, there was a cardboard dumpster and a trash dumpster. EI #1 was asked if she was aware of the two trash bins. EI #1 answered, yes. EI #1 was asked, if she was aware there were two white trash bags on the ground, open and overflowing with trash. EI #1 replied, no. EI #1 was asked if she was aware they were overflowing with trash and used gloves were on the ground around the dumpster. EI #1 answered, no. EI #1 was asked, what was the policy concerning the dumpster and the area around it. EI #1 answered, it should be free of debris and the dumpster should be closed to contain the garbage and not get water in them. EI #1 continued by saying there were coyotes and raccoons around. EI #1 was asked, what was the harm in having the dumpster door open. EI #1 answered, it was an infection control problem, it should always be closed, her staff knew that, but nursing and housekeeping used it also. EI #1 was asked, who was responsible for monitoring that area. EI #1 answered, they all did including environmental services, housekeeping, and maintenance.</p>		