

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER Cleburne County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 122 Brockford Road Heflin, AL 36264	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, interviews, resident record review, and review of a facility policy titled Hand Hygiene the facility failed to ensure Employee Identifier (EI) #3, Certified Nursing Assistant (CNA), did not create the potential for cross-contamination during meal delivery on 9/25/2023 when she was observed not washing or sanitizing her hands between residents.</p> <p>after touching a dirty bedside table, dirty window blinds, and a resident chair before touching the clean tray cart, donning gloves and setting up a resident tray.</p> <p>This had the potential to affect 21 residents who received meal trays on unit two.</p> <p>Findings include:</p> <p>A facility policy titled Hand Hygiene with an implemented date of 6/1/2022 documented the following:</p> <p>. All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors.</p> <p>2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table.</p> <p>6. Additional considerations:</p> <p>a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.</p> <p>Hand Hygiene Table .</p> <p>Between resident contacts .</p> <p>After handling contaminated objects .</p> <p>Before applying and after removing personal protective equipment (PPE), including gloves .</p> <p>On 9/25/2023 at 5:14 PM, EI #2 CNA was observed delivering meal trays to residents in their rooms. EI #2 delivered a tray with bare hands, for RI #5, placing the tray on RI #5's bedside table. EI #2 then pulled the window blinds down and left the room without washing or sanitizing her hands. EI #2 then delivered a meal tray for RI #1, placing the tray on the bedside table, moving the bedside</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>table in front of RI #1, and exiting the room without washing or sanitizing her hands. RI #4 was in the hallway in a chair. EI #2 pushed RI #4 in the chair, holding the handles of the chair, to a common area without washing or sanitizing her hands. EI #2 continued to pass out meal trays without washing or sanitizing her hands, touching the food cart down the hall, and delivering a meal tray for RI #3. EI #2 set the tray down and moved the bedside table in front of the resident. EI #2 continued out of the room without washing or sanitizing her hands, and delivered a tray for RI #2. EI #2 placed the tray on the bedside table, turned the resident around in the wheelchair by the handles of the wheelchair, and then pushed the bedside table up to the resident. EI #2 then, without washing or sanitizing her hands, donned gloves and began setting up the meal tray for RI #2, opening containers of food, drinks, silverware, and condiments. EI #2 then removed her gloves and went to the common area down the hall and pushed RI #4 in a chair from the common area to RI #4's room. EI #2 then delivered RI #4's meal tray, all without washing her hands.</p> <p>On 9/25/2023 at 5:30 PM EI #2 CNA was asked, when was she supposed to wash or sanitize her hands. EI #2 responded, before entering and after leaving every room. EI #2 stated, that the facility policy was to wash or sanitize hands before entering and after leaving every room. EI #2 stated, she did not sanitize or wash her hands before touching the clean trays after handling the dirty bedside tables, window shades, resident's chairs, donning or doffing gloves. EI #2 stated, the risk of not washing or sanitizing her hands after touching a dirty tray was the spread of germs, infections. EI #2 stated, she should have washed or sanitized her hands after leaving each room before picking up each clean tray.</p> <p>On 9/26/2023 at 11:00 AM EI #1 Infection Preventionist was asked, according to policy when should staff wash or sanitize their hands. EI #1 responded, before entering a room, when visibly dirty, when in contact with a resident, when leaving the room, and when delivering or picking up the trays. EI #1 stated, the risk for what EI #2 had done, was contamination of everything she touched. EI #1 stated, she should have washed or sanitized her hands before entering every room and leaving every room.</p>		