

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>395702</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>06/25/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>BEACON RIDGE, A CHOICE COMM</b>		STREET ADDRESS, CITY, STATE, ZIP <b>1515 WAYNE AVENUE INDIANA, PA 15701</b>	
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  <b>Level of harm - Minimal harm or potential for actual harm</b>  <b>Residents Affected - Few</b>	<p><b>Provide and implement an infection prevention and control program.</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on review of facility policies and documents, as well as observations and staff interviews, it was determined that the facility failed to follow infection control guidelines from the Pennsylvania Department of Health (PA DOH) to reduce the spread of infection and prevent cross-contamination during the COVID-19 pandemic. Findings include: The facility's policy regarding standard precautions (infection control procedures used for all residents at all times), dated August 1, 2019, revealed that standard precautions would be used during the care of all residents, regardless of their [DIAGNOSES REDACTED]. Standard precautions included that staff were to wash their hands after touching contaminated items, whether or not gloves were worn, use soap for routine hand washing, use an antimicrobial agent or a waterless antiseptic agent for specific circumstances (e.g. control of outbreaks or endemic infections), and wear gloves when touching contaminated items. The facility's policy regarding hand washing/hand hygiene, dated August 1, 2019, revealed that personnel were to follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. When hands were not visibly dirty, alcohol-based hand sanitizers were the preferred method for cleaning the hands in a healthcare setting, and soap and water were recommended for cleaning visibly dirty hands. Observations of the facility's screening process on June 25, 2020, at 8:00 a.m. revealed that Administrative Assistant 1 was behind a counter in the facility's main lobby area, with a table placed in front of the counter. On the counter there was a digital thermometer, a bottle of gel hand sanitizer, a cup with clean pens, and cup to place dirty pens. On the table there were two clip boards with screening forms and a box containing surgical masks. There was a contracted employee at the screening area. Administrative Assistant 1 had the contracted employee obtain the digital thermometer from the counter top and the contracted employee placed the digital thermometer on the table and obtained her temperature. The contracted employee placed the thermometer back onto the counter, completed the screening questions, and then placed the pen into the dirty pen cup. The contracted employee then obtained hand sanitizer and performed hand hygiene. Administrative Assistant 1 then obtained a disinfecting wipe and with her bare hands she cleaned the digital thermometer and pen. With the same disinfecting cloth, she then wiped her hands. She then called the first surveyor up to the screening area and had the surveyor obtain the digital thermometer from the counter and obtain her temperature. The surveyor placed the digital thermometer onto the counter, completed the screening questions, and then placed the pen into the dirty pen cup. The surveyor then obtained hand sanitizer and performed hand hygiene. Administrative Assistant 1 then obtained a disinfecting wipe and with her bare hands she cleaned the digital thermometer and pen. With the same disinfecting cloth, she then wiped her hands. She then called the second surveyor up to the screening area and had the surveyor obtain the digital thermometer from the counter and obtain his temperature. The surveyor placed the digital thermometer onto the counter, completed the screening questions, and then placed the pen into the dirty pen cup. The surveyor then obtained hand sanitizer and performed hand hygiene. Administrative Assistant 1 then obtained a disinfecting wipe and with her bare hands she cleaned the digital thermometer and pen. With the same disinfecting cloth, she then wiped her hands. During the screening process Administrative Assistant 1 did not review the questions answered by the people being screened. Interview with Administrative Assistant 1 on June 25, 2020, at 9:38 a.m. revealed that maybe she should have worn gloves while cleaning the digital thermometer and pen with the disinfecting wipes, and there were plenty of gloves behind the counter. She also had a supply of hand sanitizer available. The Pennsylvania Department of Health - Health Alert Network (PAHAN) 492 regarding Universal Mask Wearing, dated April 3, 2020, revealed that facilities were to implement universal masking of all persons entering the facility. Staff members who provide direct patient care were also to be masked with a commercially available surgical or isolation mask if available. The facility's policy regarding Infection Prevention and Control for Suspected or Confirmed Coronavirus, dated April 23, 2020, revealed that for the duration of the state of emergency in the state, all long-term care facility personnel/contracted staff were to wear a face mask while they were in the facility. Observations of the clean laundry area on June 25, 2020, at 9:30 a.m. and 11:04 a.m. revealed that Laundry Worker 2 was folding and hanging resident clothing without a facial mask on. Interview with Laundry Worker 2 at that time revealed that there were only two of them working in that area and that they do not use masks because they do not work close to each other. If they leave the area they make sure that they wear their masks. Interview with Infection Preventionist on June 25, 2020, at 2:20 p.m. confirmed that Administrative Assistant 1 should have worn gloves when cleaning the digital thermometer and pens, and that she should have used hand sanitizer instead of using the same disinfecting wipe that was used to clean the digital thermometer and pen. She also confirmed that Laundry Worker 2 should have been wearing a mask in the laundry area. 28 Pa. Code 211.12(d)(1) Nursing services.</p>		
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.