STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105786	A. BUILDING _____ B. WING _____	09/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONSULATE HEALTH CARE OF BAYONET POINT	8132 HUDSON AVENUE HUDSON, FL 34667

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 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure respiratory equipment was stored in a safe and sanitary manner for residents immunocompromised and at risk for respiratory infections, as evidenced by: 1) Failed to ensure oxygen tubing and nasal cannula were clean and stored properly for three residents (#1, #2, #3) out of 23 residents receiving oxygen related services, 2) Failed to ensure respiratory equipment for inhalation therapy was stored in a sanitary manner for two residents (#6, #7) out of seven residents with orders for respiratory inhalation therapy, and 3) Failed to ensure a [MEDICAL CONDITION] (Bi-level Positive Airway Pressure) respiratory face mask was stored in a sanitary manner when not in use for one resident (#5) out of one resident sampled. Findings included: 1. A review of the facility policy titled, Departmental (Respiratory Therapy)- Prevention of Infection, with a revised date of November 2011 revealed: Purpose - The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. General Guidelines: 1. distilled water used in respiratory therapy must be dated and initialed when open, and discarded after twenty-four (24) hours. Infection Control Consideration Related to Medication Nebulizers/Continuous Aerosol. 6. wipe the mouthpiece with damp paper towel or gauze sponge. 7. Store the circuit in a plastic bag, marked with the date and resident's name, between uses . An observation was conducted on 9/22/2020 at 9:30 a.m., Resident #1 was out on the 100 hall in her wheelchair and on the back of her wheelchair was an oxygen E-tank with oxygen tubing hanging off the back of the tank dragging on the floor. The nose piece (nasal cannula) had a brown crusty residue on it. (Photographic Evidence Obtained) An interview was conducted on 9/22/2020 at 9:35 a.m., Staff A, Nurse confirmed the oxygen tubing was on the floor. Staff A said, I did not see the tubing. It looks like her oxygen tank is empty too. A second observation was conducted on 9/22/2020 at 9:40 a.m., during a tour of Resident #1's room, the oxygen tubing and nasal cannula were out on top of the oxygen concentrator and not covered. The nose piece (nasal cannula) had a brown crusty residue on it. There was not a plastic storage bag observed at the resident's bedside.(Photographic Evidence Obtained) An interview was conducted on 9/22/2020 at 9:43 a.m., Staff A, Nurse said, Ok, I will put new oxygen tubing on there for her and get a new plastic bag for it to go into. A review of Resident #1's Admission Record revealed a pertinent [DIAGNOSES REDACTED]. A review of Resident #1's Medication Administration Record [REDACTED]. An observation was conducted on 9/22/2020 at 9:36 a.m. Resident #2 was in her bed and her oxygen tubing and nasal cannula were in a drawer that was open on her nightside stand. The oxygen tubing and nasal cannula were not covered and in the drawer with other personal care items. (Photographic Evidence Obtained) An interview was conducted on 9/22/2020 at 9:37 a.m., Staff B, Certified Nursing Assistant (CNA) said, Respiratory equipment is supposed to be stored in a bag when it is not in use. An interview was conducted on 9/22/2020 at 9:39 a.m., Staff A, Nurse said, Oh ok. No, it should not be in her drawer. I will take care of it. A review of the Resident #2's Admission Record revealed pertinent [DIAGNOSES REDACTED].#2's MAR for September 2020 revealed there was not a physician order for [REDACTED].#3, pointing to his oxygen tubing and nose piece on the floor next to his bed said, Can you get someone to help me get my oxygen on? A review of Resident #3's Admission Record revealed a pertinent [DIAGNOSES REDACTED].#3's MAR for September 2020 revealed there was not a physicians order for oxygen administration. A current physician order with a start date of 1/31/2020 showed to change tubing, mask and/or nasal cannula weekly . 2. An observation was conducted on 9/22/2020 at 9:58 a.m., Resident #6 was in her bed and on the nightstand next to her bed was a nebulizer machine with oxygen tubing and the nasal cannula sitting on top of the respiratory machine was uncovered (Photographic Evidence Obtained). An interview was conducted on 9/22/2020 at 9:59 a.m., Staff E, CNA said, Yes, I see the oxygen tubing. No, it should not be sitting out like that. There should be a bag that when the breathing treatment is done, the nurses put it in that bag. I do not see a bag. A review of Resident #6's Admission Record revealed a pertinent [DIAGNOSES REDACTED]. A review of Resident #6's MAR for September 2020 revealed there was not a physician order for [REDACTED]. An interview was conducted on 9/22/2020 at 10:06 a.m., Staff F, CNA confirmed Resident #7's nebulizer mask was out and uncovered and said, I see it. Yes, it is supposed to be in a bag when it is not in use. A review of Resident #7's Admission Record revealed pertinent [DIAGNOSES REDACTED]. A review of Resident #7's MAR for September 2020 revealed a physician order with a start date of 7/13/2020 for oxygen as needed at 2L/min <90% (less than). An additional physician order with a start date of 9/16/2020 showed [MEDICATION NAME]-[MEDICATION NAME] Solution 0.5-2.5 (3)MG/3ml (milligram/milliliter) 1 vial inhale orally three times a day related to [MEDICAL CONDITION]. An interview was conducted on 9/22/2020 at 11:45 a.m., Staff D, Registered Nurse (RN)/Staff Educator said, All respiratory equipment should be cleaned after use and stored in a plastic bag at the resident's bedside. If any tubing is in the floor, they are to throw it away and get new tubing. 3) An observation was conducted on 9/22/2020 at 9:56 a.m., Resident #5's [MEDICAL CONDITION] was sitting out on the dresser next to the resident's bed. An interview was conducted on 9/22/2020 at 9:56 a.m., Staff E, CNA said, The nurses, when they make their morning rounds and pass medications, are supposed to make sure all respiratory equipment at the bedside is in a plastic bag. The bag has the resident's name, room number and the date the tubing was changed. An interview was conducted on 9/22/2020 at 11:30 a.m., The Director of Nursing (DON) reviewed the photographic evidence and confirmed the findings. The DON said, All respiratory equipment after use is to be cleaned and put in a plastic bag at the bedside.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observations, interviews and record reviews the facility failed to follow standard precautions, the Centers for Disease Control and Prevention (CDC) guidelines and facility policy to maintain an infection prevention and control program to provide a safe, sanitary, and comfortable environment. The facility failed to ensure two staff members (I and C) performed hand hygiene when providing health care services and environmental services for three residents (#8, #9 and #4). Findings included: A review of the facility policy titled, Handwashing/Hand Hygiene, revised on August 2019 (2 pages) revealed: Policy: The facility considers hand hygiene the primary means to prevent the spread of infections. 5. Employees must wash their hands for twenty (20) seconds using antimicrobial soap or non-antimicrobial soap and water under the following conditions: After handling soiled equipment; After removing gloves or aprons. 6. The alternate method of hand hygiene is with an alcohol-based hand hygiene rub (ABHR) . 7. Hand hygiene is the final step after removing and disposing of personal protective equipment. 8. The use of gloves does not replace handwashing/hand hygiene. An observation was conducted on 9/22/2020 at 9:48 a.m., of Staff I, Nurse in Resident #8's room with a capped insulin syringe in her left hand and no gloves on. Staff I, Nurse confirmed the resident's call light (pressure pad) was draped across the IV (intravenous) pole and lifted the call light off the IV pole and placed it within the resident's reach. Staff I, Nurse then walked out of Resident #8's room with the capped insulin syringe without performing hand hygiene. Staff I walked across the hall and entered Resident #9's room. Staff I put the capped insulin syringe down on the top of a dresser and reached above the dresser and pulled out a pair of gloves. Staff I put on the gloves without performing hand hygiene, picked up the capped insulin syringe and walked over to Resident #9 and administered the insulin to the resident. An observation was conducted on 9/22/2020 at 9:50 a.m., Staff C, Housekeeping was in Resident #4's room cleaning up a large brown liquid puddle on the floor. Staff C, Housekeeping did not have on gloves while she was cleaning the floor. An interview was conducted on 9/22/2020 at 9:50 a.m., Staff C, Housekeeping said, Yes, I should have gloves on. Staff C then put on a pair of gloves without performing hand hygiene. Staff C said, I'm sorry I should have used hand sanitizer before I put the gloves on. An interview was conducted on 9/22/2020 at 10:00 a.m., at the nurses' station with Staff I, Nurse and Staff D, Registered Nurse (RN)/Staff Educator was present. Staff I, Nurse said, No, you are right I should have had on gloves when I entered (Resident #8's) room. I did not wash or use hand sanitizer when I walked out of the room and across the hall to (Resident #9's) room. No, I put on gloves in his room and did not wash or sanitize my hands. I should have had gloves on while I had the capped insulin syringe in my hand. Staff D, RN/Staff Educator said, Staff are to wash or use hand sanitizer before and after resident contact and before putting on gloves and after taking them off. An interview was conducted on 9/22/2020 at 11:00 a.m., Staff D, RN/Staff Educator said, Staff C, Housekeeping knows she should have had gloves on when she was

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) cleaning that mess on the floor. The account manager for environmental services in-serviced Staff C again on this.