STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105733	A. BUILDING _____ B. WING _____	**04/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALM GARDEN OF PINELLAS	**200 16TH AVE SE LARGO, FL 34641**

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 -** Few	**Provide and implement an infection prevention and control program.** Based on observation, interview, policy & procedure, standard precautions, and Centers for Disease and Control and prevention the facility failed to ensure 1. Hand hygiene was utilized after the disposal of garbage, 2. Personal protective equipment was not worn appropriately 3. The facility failed to ensure that best practices for nail length for one Unit Manager who had fingernails that were two inches longer beyond the nail bed, 4. And that resident's personal linen was distributed in a clean and sanitary manner. Findings Included: 1. On 4/26/2020 at 11:45 a.m. during the tour of the East hallway a housekeeper was noted exiting the Hair Salon carrying a large bag of garbage in her left hand. As she walked directly across the hallway, she was observed to transfer the bag into her right hand. The Housekeeper stopped just outside a door that was posted as the dirty utility room. With her right hand first digit she entered in a code on the keypad. Then, turned the knob on the door and entered the utility room. She tossed the bag inside of a large garbage can. The Housekeeper exited the utility room and walked back across the hallway to the Hair Salon, and used her right hand to open the door. The housekeeper was asked at that time if she was going to clean her hands after disposing the bag of garbage. She said yes as she walked back to the soiled utility room. 2. The lunch cart appeared on the East hallway as numerous staff members began to congregate in the area. Certified nursing assistant (CNA) A was noted, during this observation wearing an N95 mask. The mask's two straps were behind her neck. The CNA continued to touch the outside of the mask as she readjusted it over 5 times. The CNA indicated that it was her own mask that she wears at the facility. The other staff were wearing surgical masks. She was asked if anyone had given her education on wearing the N95 mask. She stated no. Interim Additional Guidance for Infection Prevention and Control for Patients with Suspected or Confirmed COVID-19 in Nursing Homes 'Extended use of respirators, facemasks, and eye protection, which refers to the practice of wearing the same respirator or facemask and eye protection for the care of more than one resident (e.g., for an entire shift) Extreme care must be taken to avoid touching the respirator, facemask or eye protection. If this must occur, HCP should perform hand hygiene immediately before and after contact to prevent contaminating themselves or others'. https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html. 3. During the distribution of the lunch trays on the east hallway a staff member walked over to the hydration cart and began filling cups with coffee. As she handed the staff members the filled cups of coffee her hands were observed with artificial acrylic nails. The nails were over two inches in length. The staff member indicated, at that time, that she was the Unit Manger and confirmed her nails were acrylic and two inches in length. She turned to the surveyor and asked, should I wear gloves? The facility provided a copy of from there Team Member Handbook Titled Team Member expectations that did not contain a date. Personal Appearance: NO acrylic nails are permitted for direct care givers and nails should not be over fingertip length as evidenced by the back of the hand. The effectiveness of hand hygiene can be reduced by the type and length of fingernails. Individuals wearing artificial nails have been shown to harbor more pathogenic organisms, especially gram-negative bacilli and yeasts, on the nails and in the subungual area than those with native nails. In 2002, CDC/HICPAC AORN Guideline for hand hygiene Fingernails Maintaining short fingernails decreases the risk of puncturing gloves, harboring pathogens under the nails, impeding proper hand hygiene, and possibly injuring patients. Studies have demonstrated that both artificial nails and nail extenders contribute to contamination of the hands and have led to outbreaks of infection. http://dx.doi.org/10.1016/j.aorn.2016.12.010 AORN, Inc, 2017.204 j. 4. At 12:15 p.m. the 100 hallway contained a linen cart that was not covered. The covering for the cart was noted lying on top of the cart. The opening of the linen cart revealed it was full of residents personal clothing. While observing the cart, the Nursing Home Administrator walked toward the linen cart pulled the covering off the top of it. The cart was now closed. Laundry Worker B (LWB) walked out of a bedroom shortly after and opened the linen cart back up. She removed personal clothing from the cart and walked directly into the resident's bedroom. Leaving the linen cart open and exposed. LW B was noted speaking with the resident that was lying in her bed. As she spoke her surgical mask was underneath her nose. LW B preceded to the closest in the bedroom where she placed the personal clothing inside it and removed bare hangers. Before she left the bedroom, she again stopped by the foot of the resident's bed. As she was speaking to the resident, the hangers that she was holding in her right hand dropped to the floor. LW B bent over and picked the hangers up off the floor and left the bedroom. She returned to the laundry cart and placed the hangers that were on the resident's floor, into the cart next to a resident's personal clothing. LW B removed additional clothing from the cart at that time and walked into a second bedroom. She opened the dresser drawer with her right hand and placed the clothing inside of the drawer. Then with her right hand she pushed the clothing in a downward motion to get the drawer to close. After LW B left the bedroom she was asked how long she had been doing her job. She stated for two weeks as the surgical mask remain positioned underneath her nose. Then she stated, I had great training. She was asked about leaving the cover off the cart in the hallway. She said it only needs to be covered when it is moved in the hall. She confirmed that she had placed the hangers inside of the linen cart after they were on the floor. She indicated that was not a concern. The NHA was in the hallway at the time and was asked about the proper procedure for distributing resident personal clothing. She confirmed that after picking something up off the floor it should not be placed back inside of a clean linen cart. The cart should be covered when sitting in the hall. The facility provided a copy of their policy tilted Laundry Practices Infection Control Assessment Checklist that did not contain a date. Transportation; is clean linen properly covered or sealed to prevent contamination during transport. Staff: is laundry staff trained in infection control efforts as they relate to their job tasks? Is staff using appropriate PPE? Is laundry staff using appropriate hand hygiene methods? Standard Precautions Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices Before moving from work on a soiled body site to a clean body site on the same patient After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal Healthcare facilities should: Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled. https://www.cdc.gov/handhygiene/providers/guideline.html.

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.