STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105398	A. BUILDING _____ B. WING _____	**06/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TIERRA PINES CENTER	**7380 ULMERTON RD LARGO, FL 33771**

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 0583 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and policy review the facility failed to ensure personal medical information was maintained in a safe and secure manner as evidenced by one medication cart's (north) trash bin of five medication carts' trash bins contained pharmacy labels that revealed personal medical information for two residents (#1 & #2). Findings included: On 6/26/2020 at 10:26 a.m. during the initial tour of the first-floor unit the medication cart (north) trash bin was observed with a pharmacy label was attached to two plastic bags. On closer observation it revealed Resident #1's personal and medical information. The Unit Manager was in proximity at the time of the observation and was asked if she would remove the two plastic bags. After the two bags were removed an additional box was noted that contained a pharmacy label. Each of the two plastic bags contained a [MEDICATION NAME] flex touch pen. Both bags contained a pharmacy label for Resident #1. The labels contained Resident #1's name, room number, the name of the medication, directions for use, the resident's diagnosis, and the prescribing physician's name. In addition, the box that was found in the trash bin contained a pharmacy label. The label identified it was for Resident #2. The label contained eye drops for [MEDICATION NAME] 0.5% and the directions for use, the resident's room number, the resident's diagnosis, and the prescribing physician's name. A review of the Admission Record for Resident #1 revealed an admission date of [DATE] with [DIAGNOSES REDACTED].#2 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. She said that the labels are to be removed and placed in the shredder box. The facility provided a copy of their policy titled, Safeguards, Storage, and Disposal of Health Information Records, dated June15, 2017. The policy showed: POLICY: Protected Health Information will be maintained in a safe, secure but accessible location for authorized use in order to protect from unintentional disclosures. Purpose: to limit access of protected health information (PHI) to authorized team members. 15. Proper Disposal of PHI 15.1 PHI must only be disposed of in an approved manner listed below. PHI must never be thrown into the trash or dumpster or any other place or container accessible by the public or other unauthorized persons. 15.2.3 Maintaining labeled prescription bottles and other PHI in opaque bags in a secure area and using a disposal vendor as a business associate to pick up and shred or otherwise destroy the PHI.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, policy review, and review of the Centers for Disease Control and Prevention (CDC) guidelines the facility failed to maintain an infection and control program to provide a safe and sanitary environment to help prevent the development of and transmission of diseases and infection to include COVID-19 as evidenced by: 1. Staff (A & B) not performing hand hygiene, 2. Staff (D) not handling clean linen properly, and 3. Staff (D) wearing artificial fingernails. Staff (A, B & D) were observed in two halls (100 and 200 hall) of two halls of which the 200 hall included six resident rooms (225, 227, 229, 231, 230 and 232) with 9 residents under observation for COVID-19. Findings included: On 6/26/20 at 9:50 a.m. Staff A, Licensed Practical Nurse (LPN) was observed on the 200-hallway (observational area for residents under quarantine) walking towards the nursing station. Just prior to the station in the hallway a cart was present that contained personal protective equipment (PPE). Staff A removed a bag that contained a blue gown. When she did this a plastic bag fell to the floor. She bent over towards the bag and picked it up. Then she walked directly to the medication cart at the end of the hallway. After she reached the medication cart, she placed the plastic bag in the trash container that was located on the cart. Staff A, LPN proceeded to prepare medications that she indicated were for a resident in room [ROOM NUMBER]. The medications were observed crushed and then mixed with pudding. Staff A, LPN then donned PPE along with gloves and entered the room with the medications in her hand. Hand hygiene was not performed during this observation. At 10:02 a.m. Staff B, Registered Nurse (RN) was observed in the 200-hallway standing in front of a medication cart just left of room [ROOM NUMBER]. Staff B touched her face shield and patted her hair down on the top of her head with her right hand. Staff B continued to remove medications from the cart and then crushed them. After the medications were crushed, she placed them inside of a souffle cup and added a sauce with a spoon. Staff B, RN removed a gown from the medication cart. The gown was removed from the plastic bag. She located the neck area and then she tied the ties together. Staff B placed the gown over her head with her right hand. With her left hand in the same motion she removed the face shield. After the gown was in place, she redonned the face shield by touching her hair a second time during the process. Staff B donned clean gloves picked up the medication off the medication cart and entered room [ROOM NUMBER]. No hand hygiene was performed. After a short period of time, Staff B was approached, and she confirmed she had not performed hand hygiene prior to donning clean gloves. At 10:40 a.m. the first-floor unit Staff D, Certified Nursing Assistant (CNA) was observed in the 100 hallway donning a gown. She was noted holding towels and a washcloth in her right hand. She then placed the towels and washcloth in her left hand as she appeared to be struggling with the gown. After 30 seconds had passed Staff D placed the clean towels and wash cloth underneath her left axilla (arm pit) and was able to complete the donning of the gown. Staff D, CNA was asked about the process of donning the gown just as the Director of Nursing (DON) approached. Staff D, CNA placed her hands underneath the towels and her fingernails were then noted to be artificial nails extending over a half an inch in length past the tips of her fingers. The DON confirmed that resident towels should not be placed under the armpit while donning a gown. Staff D, CNA was then asked about her fingernails and she confirmed that they were artificial and over a half an inch in length. The DON confirmed that her nails were too long. At 12:25 p.m. an interview was conducted with the Nursing Home Administrator who stated, More training needed to be on gown donning and folding clean linen. A review of the Centers for Disease Prevention and Control (CDC) document titled, Hand Hygiene Recommendations Guidance for Healthcare Providers about Hand Hygiene and COVID-19, updated May 17, 2020 showed: Syndicate. This information complements the Infection Control Guidance and includes additional information about hand hygiene. Background: Hand hygiene is an important part of the U.S. response to the international emergence of COVID-19. [MEDICATION NAME] hand hygiene, which includes the use of alcohol-based hand rub (ABHR) or handwashing, is a simple yet effective way to prevent the spread of pathogens and infections in healthcare settings. CDC recommendations reflect this important role. The exact contribution of hand hygiene to the reduction of direct and indirect spread of coronaviruses between people is currently unknown. However, hand washing mechanically removes pathogens, and laboratory data demonstrate that ABHR formulations in the range of alcohol concentrations recommended by CDC, inactivate [DIAGNOSES REDACTED]-CoV-2. (1,2) ABHR effectively reduces the number of pathogens that may be present on the hands of healthcare providers after brief interactions with patients or the care environment. Methods: CDC recommends using ABHR with greater than 60% [MEDICATION NAME] or 70% [MEDICATION NAME] in healthcare settings. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and are effective in the absence of a sink. (3) Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/hand-hygiene.html) A review of the facility policy titled, Hand Hygiene, dated on January 9,2019, showed Purpose: To reduce the transmission of pathogenic microorganisms by utilizing frequent and

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) correct hand washing/hygiene techniques. This includes hand washing with soap and water when hands are visibly soiled and the use of alcohol-based hand rubs for routine decontamination in clinical situations. Process: proper and washing techniques will be carried out with soap and water under, but not limited to, the following circumstances: 1.2 Before and after direct customer contact. 2. Handwashing technique that should be followed includes: 2.3 apply soap, work up a lather, wash the front and back of your hands as well as between your fingers and nail area, rub the tips of your fingers against your palms, allow 20 seconds or hum the Happy Birthday song from beginning to end for a brisk friction rub. 2.6 Team members should also keep nail tips less than inches long. 6. It is acceptable for employee caregivers to use the hand washing facilities in the customers room after providing care to the customer. It is preferable for team members to wash their hands as close to the source of contamination as is practical. A review of the CDC guideline titled, Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Isolation Precautions and Recommendations for Infectious Diseases and Conditions in Healthcare Settings, - updated July 2019. The effectiveness of hand hygiene can be reduced by the type and length of fingernails559, 718, 719. 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 nails720, 721. In 2002, CDC/HICPAC recommended (Category IA) that artificial fingernails and extenders not be worn by healthcare personnel who have contact with high-risk patients due to the association with outbreaks of gram-negative bacillus and [MEDICAL CONDITION] as confirmed by molecular typing of isolates30, 31, 559, 722-725.The need to restrict the wearing of artificial fingernails by all healthcare personnel who provide direct patient care or by healthcare personnel who have contact with other high risk groups. (https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf)