STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105417	A. BUILDING _____ B. WING _____	04/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HABANA HEALTH CARE CENTER	2916 HABANA WAY TAMPA, FL 33614

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 -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure adherence to infection control practices as evidenced by: staff failure to perform hand hygiene and utilize gloves properly; staff failure to use face mask properly; failure to observe proper handling of clean linens; and failure to properly dispose of wound supplies. These practices had the potential to affect all residents residing in the facility. The findings include: 1. A. On [DATE] at 2:53pm, Nursing Assistant2 (NA2) was observed walking out of room [ROOM NUMBER] while wearing gloves. This was verified by the Assistant Director of Nursing (ADON). When NA2 was asked if she should be walking the hallway with gloves she had worn while inside a resident ' s room, NA2 stated, No. B. On [DATE] at 3:00pm, NA3 was observed coming out of room [ROOM NUMBER] holding a used glove on her left hand. NA3 was observed discarding the used glove in room [ROOM NUMBER] ' s trash bin. NA3 did not perform hand hygiene. When asked why she was holding the used glove, NA3 admitted she did not wash her hands prior to leaving room [ROOM NUMBER]. NA3 added, OK. I have something on my finger. NA3 stated she did not see any hand sanitizer. This was confirmed by the ADON. NA3 was informed that the wall hand sanitizer was behind her, just outside of room [ROOM NUMBER]. C. On [DATE] at 3:32pm, NA1 was observed sitting in room [ROOM NUMBER] while holding her cellular phone. NA1 got up and placed her phone in her pocket. NA1 walked out of the room. NA1 did not perform hand hygiene. This was confirmed by the ADON. When asked if staff are allowed to use their personal phone and not perform hand hygiene, the ADON stated, No. During a phone interview with the Director of Nursing (DON) on [DATE] at 10:06am, when asked about her expectation from staff when using gloves, the DON stated, When they finished their task and before they leave the room, they have to undone their gloves and wash their hands properly and not to walk out of the room with gloves on their hands. When asked if staff are allowed to use their mobile phones inside resident ' s room and if staff should perform hand hygiene after touching their mobile phone, the DON stated, Staff are not supposed to be using mobile phones in the area. They should not be picking up calls in the area. Review of facility policy on Hand Hygiene with revision date of [DATE] revealed, The CDC defines hand hygiene as cleaning your hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e. alcohol based sanitizer including foam or gel) .purpose: to reduce the spread of germs in the health care setting .hand hygiene should be performed: .after contact with inanimate objects (including medical equipment) in the immediate patient vicinity. Review of facility ' s policy on Use of Personal Cellular Telephones and Electronic Devices revealed, .All employees are prohibited from using cellular telephones, pagers or any other electronic device while on duty throughout the care center. In a CDC article titled Guidelines for Hand Hygiene in Health-Care Settings dated [DATE] Vol. 51 No.RR-16 under Alcohols revealed, Alcohols have excellent in vitro germicidal activity against gram-positive and gram-negative vegetative bacteria, including multidrug-resistant pathogens (e.g.,[MEDICAL CONDITION] and VRE), [DIAGNOSES REDACTED], and various fungi (120122,124129) .Alcohols effectively reduce bacterial counts on the hands (14,121,125,134). Typically, log reductions of the release of test bacteria from artificially contaminated hands average 3.5 log10 after a 30-second application and 4.05.0 log10 after a 1-minute application (1). In 1994, the FDA TFM classified [MEDICATION NAME] 60%95% as a Category I agent (i.e., generally safe and effective for use in antiseptic handwash or HCW hand-wash products) (19). Although TFM placed [MEDICATION NAME] 70%91.3% in category IIIE (i.e., insufficient data to classify as effective), 60% [MEDICATION NAME] has subsequently been adopted in Europe as the reference standard against which alcohol-based hand-rub products are compared (79). Alcohols are rapidly germicidal when applied to the skin, but they have no appreciable persistent (i.e., residual) activity. However, regrowth of bacteria on the skin occurs slowly after use of alcohol-based hand antiseptics, presumably because of the sublethal effect alcohols have on some of the skin bacteria (135,136). https://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf According to a CDC article titled Emerging Infectious Diseases Volume 11, Number 7 [DATE] revealed, .cell phones may have a notable role in the nosocomial transmission of MDR (multi-drug resistant) microbes to patients. Cell phones are particularly problematic compared to stationary devices and may facilitate intra- and inter-ward (and perhaps inter-hospital) transmission. Additionally, the potential for nosocomial transmission of MDR pathogens by other electronic devices, such as handheld computers or personal digital assistants, with bedside applications, should be recognized. Since restriction or even prohibition of such devices may prove impractical, strategies for preventing nosocomial transmission in this context are needed, especially given the risk of continuing contamination through repeated handcell phone contact. Such strategies should target behavioral controls of personnel (enforcing infection control precautions), environmental disinfection, and ultimately, optimal disinfection methods that will prevent contamination without damaging these sensitive electronic devices. https://wwwnc.cdc.gov/eid/article/[DATE]-0221_article. According to an article titled If your Smartphone is covered with Germs, so is your doctor ' s dated [DATE] revealed, Health care workers ' mobile devices could make patients sick .In the course of a day ' s work, a nurse or doctor ' s phone can be splashed, splattered, or smeared with wound drainage, blood, or god-knows-what other bodily dreck. Handling the device can transfer bacteria to the ears, nostrils, and hands. And bacteria parked on a Galaxy S9 screen or a My Little Pony iPhone case can live for months. If the germs are lucky, they ' ll get to cross-contaminate something the provider later touchesa nice fresh incision, a cozy catheter, or a warm ventilator tube, say. The result may be a health careassociated infection. Three percent of hospital patients per year in the United States will develop a health careassociated infection, and about 72,000 patients will die of one. Mobile devices are a known source of the agents that cause these infections. https://slate.com/technology/,[DATE]/health-care-workers-germs-smartphones-infections.html 2. A. On [DATE] at 2:26pm, Laundry Worker1 (L1) was observed folding clean linen close to her body and the linen was touching her clothing. B. On [DATE] at 3:10pm, a clean linen cart was parked by the third floor hallway. An open box of gloves and a used glove was observed on top of the clean linen cart. This was confirmed by the ADON. When asked if the glove was clean or used, the ADON stated, Looks like used. Yes it is. C. On [DATE] at 3:25pm, NA4 was observed walking the hallway wearing a face mask. NA4 ' s mask when placed under her chin. The mask was not covering her nose and mouth. This was confirmed by the Assistant Director of Nursing. NA4 was observed carrying a plastic bag with clean linens. NA4 went to room [ROOM NUMBER] and placed the bag on top of the first bed by foot part while a resident was lying in bed. She took off a clean gown and some linens and placed it towards the left side of the foot part of the resident ' s bed. NA4 left the room. NA4 did not perform hand hygiene and was still carrying the plastic bag of clean linen. When asked, NA4 stated These are clean linens. When further asked about the mask, NA4 stated, I took it off earlier when I was talking to one (unnamed) resident. During a phone interview with the Director of Nursing on [DATE] at 10:06am, when asked about her expectation from staff when handling clean linens, the DON stated, When they are handling clean linen, it should be away from them. If they need to give clean linen, it should be bagged individually for each resident. And not just use one bag. When asked about her expectation from staff when wearing a face mask, the DON further stated, In the unit, staff should wear the mask on properly. Review of facility ' s policy titled Laundry Services dated [DATE] revealed, Facility laundry Services shall collect, process and distribute linens and clothing in an efficient and sanitary manner .1. Infection control guidelines shall be observed.

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 -** Many	(continued... from page 1) Review of facility policy titled Personal Protective Equipment Using Face Masks with review date of [DATE] revealed, Purpose: to guide the use of masks .Objectives: to prevent transmission of infectious agents through the air; to protect the wearer from inhaling droplets; to prevent transmission of some infections that are spread by direct contact with mucous membranes .Do not hang the face mask around the neck .Place the mask over the nose and mouth . In a CDC article titled Guidelines for Hand Hygiene in Health-Care Settings dated [DATE] Vol. 51 No.RR-16 under Models of Hand Transmission revealed, .The transmission of organisms from artificially contaminated donor fabrics to clean recipient fabrics via hand contact also has been studied . Results indicated that the number of organisms transmitted was greater if the donor fabric or the hands were wet upon contact (63). Overall, only 0.06% of the organisms obtained from the contaminated donor fabric were transferred to recipient fabric via hand contact. Staphylococcus [MEDICATION NAME], Pseudomonas aeruginosa, and Serratia spp. were also transferred in greater numbers than was Escherichia coli from contaminated fabric to clean fabric after hand contact. https://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf C. On [DATE] at 3:30pm, an open foil package of Xeroform dressing (a sterile wound dressing made up of [MEDICATION NAME] blend of fine mesh gauze that does not stick to the wound so dressing changes are less painful. The dressing promotes a moist healing environment) was observed on top of the treatment cart on the second floor. There was no barrier or covering on top of the treatment cart. A section of the foil package was cut off exposing a portion of the dressing to air. This was confirmed by the ADON. When asked if this should be left exposed on top of the treatment cart, the ADON stated, No. During a phone interview with the Director of Nursing on [DATE] at 10:06am, when asked about her expectation from staff on the use of Xeroform once opened, the DON stated, Discard it. It should be in the garbage. When further asked if staff should use a barrier on top of cart before placing dressing supplies, the DON stated, They should gather all their supplies and put a barrier on a clean surface for their treatment supplies. Review of facility policy titled Storage and Expiration of Medications, Biologicals, Syringes and Needles with revision date [DATE] revealed, #5. Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. In an undated article titled Infected Wounds revealed, Most cases of infected wounds are caused by bacteria, originating either from the skin, other parts of the body or the outside environment. The skin contains bacteria (normal flora) which are normally harmless if the skin is intact. However, the protective barrier formed by the skin is disrupted when there is a wound, and these normal flora are able to colonize the injured area. This results in further tissue damage and may prolong wound healing by promoting more inflammation, which prolongs the process of wound healing. The most common bacteria causing wound infection is Staphylococcus aureus and other groups of staphylococci. Contamination from other parts of the body may also cause wound infection. Poor wound dressing techniques and unhygienic conditions may increase the risk for wound infection. https://www.woundcarecenters.org/article/wound-types/infected-wounds