STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING _____ B. WING _____	**04/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EXCEL CARE CENTER	**2811 CAMPUS HILL DR TAMPA, FL 33612**

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 -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and record review, the facility failed to ensure adherence to infection control practices as evidenced by: staff failure to disinfect medical equipment between use by different residents; staff failure to sanitize the ice water cooler after contact with the floor; failure to promptly dispose of a wound care tray; and failure to cover the tube feeding equipment to prevent possible contamination for one (1) resident (Resident #1). The failures to clean the lid to the ice water cooler and to disinfect shared equipment had the potential to affect all residents residing in the Long Term Care Unit (LRU) at the time of the survey. The findings include: 1. On 4/1/20 at 2:49 p.m., Certified Nursing Assistant (CNA) #1 was observed taking out the hoyer lift from Resident #2's room. CNA #1 transferred Resident #2 to his motorized wheelchair with the help of the Director of Nursing (DON) and another CNA. CNA #1 returned the hoyer lift to the equipment room. When CNA #1 was asked if she needed to do anything, CNA #1 stated, I'm done. CNA #1 did not clean or disinfect the equipment. This was confirmed by the DON. 2. On 4/1/20 at 2:55 p.m., the DON was observed picking up the big ice water cooler lid that had fallen on the floor. The ice water cooler which was used to provide cold water to residents in the LRU unit was filled half-full with ice and water. The ice water cooler was by the hallway of the LRU unit. The DON placed the lid back on. The DON did not sanitize the lid after it had been on the floor. 3. On 4/1/20 at 3:03 p.m., a styrofoam dressing tray was observed on top of the treatment cart exposed, with no barrier or covering. This was confirmed by the DON. The DON stated, Optimally it should not be there. During an interview with the DON on 4/1/20 at 1:28 p.m., when asked if staff should be cleaning and disinfecting the hoyer lift or any other shared equipment after use on a resident, the DON stated, Yes. When asked about the ice water cooler lid, the DON stated, That can be replaced. The DON further stated that he ordered a new one. Review of undated facility policy titled Cleaning and Disinfection of Resident-Care Items and Equipment revealed, Resident-care equipment including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogens Standard .Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). Review of the facility's undated policy titled Standard Precaution revealed, .Resident-Care Equipment .Ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleaned and reprocessed and single use items are properly discarded. Review of a CDC article titled Preparing for COVID-19: Long-term Care Facilities, Nursing Homes with review date of 3/21/20 revealed under Environmental cleaning and disinfection, A new respiratory disease - coronavirus disease 2019 (COVID-19) - is spreading globally and there have been instances of COVID-19 community spread in the United States. The general strategies CDC recommends to prevent the spread of COVID-19 in LTCF are the same strategies these facilities use every day to detect and prevent the spread of other respiratory viruses like influenza .Make sure that EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term- care-facilities.html 4. On 4/1/20 at 2:40 p.m., Resident #1 was observed lying in bed. Resident #1's [DEVICE] (a feeding tube inserted into the stomach through the abdomen used to supply nutrition) feeding spike set was exposed, not covered. The feeding tube was filled with the [DEVICE] formula. This was confirmed by the Director of Nursing (DON). Resident #1 was receiving [MEDICATION NAME] 1.5 (a fiber -fortified therapeutic nutrition that provides complete, balanced nutrition for long or short-term tube feeding) at 55 cc/hr (cubic centimeter per hour) for 20 hours. R1's feeding was turned off at that time. During interview with the DON on 4/1/20 at 1:28 p.m., when asked about his expectation from staff with [DEVICE] care, the DON stated, If it's disconnected, it should be capped. If it's exposed, then we have to throw it away. The DON further stated, Definitely they (nurses) should check the [DEVICE] connection when they pass meds. Review of undated facility policy titled Enteral Feedings-Safety Precautions revealed under General Guidelines, Maintain strict aseptic technique at all times when working with enteral nutrition systems and formulas .Regularly inspect tubing for proper connections. In an article titled Tube Feeding and Diarrhea dated 8/14/17 revealed, Diarrhea is the most commonly reported gastrointestinal complication of tube feeding, reports the American Dietetic Association 1. There are many possible causes of diarrhea when you are on tube feeding, and a slew of potential solutions .Formula contamination caused by improper handling and storage of formula and equipment can also induce diarrhea, cautions the Oley Foundation. Likewise, gastrointestinal infections, or over-colonization of bacteria, can irritate the intestine and lead to watery stools. https://healthfully.com/1-tube-feeding-and-diarrhea.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.