STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105459	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONSULATE HEALTH CARE OF NEW PORT RICHEY	8417 OLD COUNTY RD 54 NEW PORT RICHEY, FL 34653

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review the facility failed to implement and maintain an infection prevention and control program as evidenced by: 1.staff did not perform (Staff A, Staff H, Staff D) hand hygiene on 2 halls (Friar Lane and Essex Lane) of 4 halls, 2. staff failed to don appropriate personal protective equipment (PPE) before entering an isolation room of one Resident (#6) out of three residents observed on isolation precautions, and 3. indwelling catheters were not maintained in a sanitary manner to prevent infection for two residents (#9, #11) out of the two residents sampled for indwelling catheters. Findings included: A review of the facility policy titled, COVID-19- Pandemic Plan, effective 3/02/2020 and revised on 5/14/2020, showed, 2. Staff will be retrained in Hand Hygiene and proper use of PPE (personal protective equipment) including competencies. Documented under the Policy Interpretation and Implementation section showed, Early prevention of influenza outbreak consists of the following measures .Training clinical staff in the modes of transmission of the [MEDICAL CONDITION] . The facility policies for hand hygiene and infection control and prevention were requested multiple times throughout the survey and were not provided upon exit of survey team. 1. An observation was conducted on 6/23/2020 at 9:07 a.m., Staff A, Activities Aide was observed at the front of Bed A in resident room [ROOM NUMBER] on Friar Lane, and holding onto the foot of the bed talking with the resident. Staff A, Activities walked out of room [ROOM NUMBER] to the nurses' station without performing hand hygiene. An interview was conducted on 6/23/2020 at 9:07 a.m. with Staff A, Activities Aide and she confirmed she had performed hand hygiene after leaving the resident's room after contact with furniture in the resident's immediate surroundings. An observation was conducted on 6/23/2020 at 9:09 a.m., Staff H, Licensed Practical Nurse (LPN) was observed administering an inhaled respiratory medication in resident room [ROOM NUMBER] on Friar Lane. Staff H, LPN walked out of room [ROOM NUMBER] with the inhaled respiratory medication and a cup in her hand, to her medication cart. Staff H, LPN reached into her uniform pocket and pulled her keys out and unlocked the medication cart, opened a drawer and then placed the respiratory medication back in the drawer of the medication cart. Staff H, LPN then closed and locked the medication cart and put the keys back in her uniform pocket. Staff H, LPN then reached for the pitcher of water on the top of the medication cart and poured water into the cup. Staff H, LPN then picked up the cup of water and walked back into room [ROOM NUMBER] without performing hand hygiene. An interview was conducted on 6/23/2020 at 9:10 a.m., Staff H, LPN confirmed she had not performed hand hygiene after patient contact. She said, I am going right back in (Resident Name) room. I just needed to get her some water. An observation was conducted on 6/23/2020 at 9:38 a.m., Staff D, Certified Nursing Assistant (CNA) came out of Resident #13's room on Essex Lane pushing the resident in her wheelchair. Staff D, CNA did not perform hand hygiene after exiting the resident room. She said, I am getting her ready for [MEDICAL TREATMENT], I have to get her up, dressed and weighed. This writer pointed out to the staff member she had not washed or sanitized her hands and she said, Oh yes. Staff D was then observed to walk to a wall hand sanitizer unit and sanitized her hands. 2. An observation was conducted on 6/23/2020 at 12:15 p.m., hanging on the outside of the door to the room for Resident #6 was a container of personal protective equipment (PPE) and signage posted that showed Contact Precautions. Staff E, CNA, entered Resident #6's room without donning PPE. An interview was conducted on 6/23/2020 at 12:18 p.m., Staff E, CNA said, I should have put on PPE, but I forgot. A review of the Admission record for Resident #6 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. An interview was conducted on 6/23/2020 at 12:20 p.m., Staff F, LPN said, The expectation for entering a room for a resident on contact precautions; should don a gown and gloves. An interview was conducted on 6/23/2020 at 12:21 p.m., Staff G, Registered Nurse (RN) said, My expectation of staff entering a contact precautions room is to don a gown and put on gloves before entering room. 3. A review of the facility policy titled, Catheter Care, Urinary, with an effective date of 11/30/2014 and a revision date of 9/05/2017, showed, Procedure: Identify resident. Provide privacy and explain procedure .Return equipment to proper place . An observation was conducted on 6/23/2020 at 9:17 a.m., Resident #9 was in bed and the indwelling catheter bag and tubing were on the floor. (Photographic Evidence Obtained) An interview was conducted on 9/23/2020 at 9:18 a.m., Staff F, LPN confirmed the indwelling catheter bag and tubing on the floor. She said, I will fix it. Review of the Admission Record for Resident #9 revealed a [DIAGNOSES REDACTED]. An observation was conducted on 6/23/2020 at 9:28 a.m., Resident #11 was in bed with an indwelling catheter bag and tubing on the floor next to the bed. Review of the Admission Record for Resident #11 a [DIAGNOSES REDACTED]. An interview was conducted on 6/23/2020 at 10:12 a.m., the Assistant Director of Nursing (ADON) said, My expectations are that staff wash their hands before and after leaving a resident room. A indwelling catheter and tubing should not be on the floor. It needs to be secured to the bed.

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.