STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105234	A. BUILDING _____ B. WING _____	**06/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REHABILITATION AND HEALTHCARE CENTER OF TAMPA	**4411 N HABANA AVE 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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility did not ensure that dignity was maintained for one resident (#1) out of 3 residents sampled within the facility related to the exposure of Resident #1's breast to other residents and staff at the nurses' station. Findings included: An observation on 6/11/20 10:41a.m., Resident #1 was seen lying in a Trendelenburg position (a position in which a person lies face upward with the pelvis higher than the head) in a specialty chair that reclines, tilts, and has leg rests that move up and down, that was pushed next to the wall directly adjacent to the nurse station. The outside wall of the nurse station was on the resident's right side. There were 4 residents comprised of 2 male residents and 2 female residents, sitting in wheelchairs against the opposite wall facing the nurse station, and Resident #1. Additional observations on 6/11/20 of Resident #1 included: 10:42 a.m.: Resident #1 was observed trying to get out of the chair by attempting to crawl over the arm rest on the left side of the chair. 10:45 a.m.: The resident's clothing had become disheveled from trying to crawl out of the chair and both of her pant legs were up to her knees, and her shirt had twisted and pulled up exposing her entire abdomen and left breast. 10:46 a.m.-10:50 a.m.: Staff A, B, and C, Certified Nursing Assistants (CNAs) walked past the resident while she was trying to get out of her chair and her breast was exposed. Staff E, Registered Nurse (RN) walked to the nurse station with her medication cart and had to walk behind the resident to get into the nurse station. There was a physician sitting behind the desk at the nurse station. Staff A, B, C, CNAs, Staff E, RN and the physician did not attempt to assist the resident. 10:51 a.m.: A therapy staff member stopped and talked to the resident attempting to redirect the resident. While therapy was talking to the resident, Staff A, CNA came to the resident and pulled her shirt down. A review of the Admission Record for Resident #1 revealed that she was admitted to the facility on [DATE] with the most recent readmitted being 2/17/2020 for [DIAGNOSES REDACTED]. A review of Resident #1's comprehensive care plan initiated on 11/29/19 included: *Focus: At risk for falls or fall related injury (revision date of 6/11/20). Interventions included: frequently check resident for safety checks and frequently reposition for safety related to sliding and scooting. *Focus: Behavior problem related to anxious type behavior including fidgeting in chair/rocking/sliding/yelling out/impulsive with poor safety awareness. Interventions included: caregivers to provided opportunity for positive interaction, attention. Stop and talk to her as passing by. Observe for behavior episodes and attempt to determine underlying cause. Consider locations, time of day, persons involved and situation. In a quarterly Minimum Data Set (MDS) assessment dated [DATE] the resident was assessed to have a BIMS (brief interview for mental status) of 3, indicating severe cognitive impairment. The resident was assessed to require the extensive assistance of staff for dressing. On 6/11/2020 at 11:00 a.m. during an interview with Staff A, CNA, Staff B, CNA, and Staff C, CNA, they all said that they didn't see that the resident's shirt had lifted-up when they walked by the resident. Staff A said that she noticed it when she saw therapy stop to talk to the resident, and that's why she pulled her shirt down. When it was brought to their attention that the resident had sat there for 5 minutes with her breast exposed, they did not have anything to say. During an interview conducted at 2:45 p.m. with the Director of Nursing, she said that staff walking by the resident should have seen that she was exposed and covered her up immediately. There was no reason why she should have been exposed to other residents for that long. Review of a policy given by the facility with the subject Resident Rights, dated effective January 2017, under Policy it was revealed that, The facility strives to assure that each resident has a dignified existence, ., and The facility will protect and promote the rights of each resident.
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 and record 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. The facility failed to ensure adherence to infection control practices as evidenced by: staff not performing required hand hygiene before donning or after doffing of gloves, staff not following posted droplet precautions related to Personal Protective Equipment (PPE), staff not following procedures for reuse of eye protection on one unit identified as a Person Under Investigation for COVID-19 of one unit in the facility, and staff not maintaining the tubing for an indwelling catheter off the floor for one resident (#5) of 13 residents with indwelling catheters. Findings included: An observation on 06/11/20 at 11: 15 a.m. revealed Resident #5 sitting in the doorway of his room in a gown with his overbed table in front of him. He was an elderly frail gentleman. Observed a clip board with money lying on it and a can of soda as well as other items lying on the overbed table. Resident #5 was touching the overbed table and the objects on it as well. The door had a droplet precaution sign and Personal Protective Equipment (PPE) was observed hanging in the room. Staff F, Certified Nursing Assistant (CNA) entered the room wearing two masks. After she put on her gown, gloves and face shield she picked up the clip board and soda. She then handed both to the resident in the B bed. The resident in B bed handed her the clipboard and a pen back. She leaned the clipboard on the wall on the floor. She then removed her gloves. She removed her face shield and hung it up on the hook inside the door. She removed her gown and the outer mask. She removed the face shield from the hook and picked up the clipboard from the floor. She placed the face shield under her arm and exited the room. She leaned the face shield and the clipboard against the wall, on the floor, outside the resident room. She had her pen in her hand, dispensed hand sanitizer into her hand and rubbed it on the pen and then placed the pen into her pocket. She then put on a new mask. She picked up the clipboard and face shield and went into the dirty utility room across the hall. She was observed cleaning the face shield with her bare hands. She then washed her hands and placed the face shield in a bag and placed the bag on a hook in the resident's room. An interview occurred on 06/11/20 at 2:40 p.m. with Staff F, CNA and the Director of Nursing (DON) present regarding droplet isolation and PPE donning and doffing. Staff F stated that she would verify with the nurse the type of isolation the resident was on. She was currently working on the step-down unit and both residents in room [ROOM NUMBER] had been admitted after hospitalization and were on droplet isolation. She stated that she was supposed to wash her hands, put on her mask, her gown, face shield and then her gloves. She was to provide resident care, then remove her gown and hang it up on the hook. She stated that she was able to use it again for those residents. She was to remove her gloves and throw them in the trash. She was then to remove her face shield and disinfect it with the spray and let it sit for 4 minutes, while wearing gloves. She stated that she was to bag the face shield and place it on the hook in the resident room. She was then to wash her hands. The DON nodded and said yes, she was supposed to clean the face shield with gloves on. The surveyor reviewed the observation of what occurred at 11:15 a.m. with Staff F, CNA in room [ROOM NUMBER]. The DON verified that there were breaks in infection control practices during Staff F's care regarding the clipboard, soda, exiting without hand hygiene, cleaning face shield bare handed, etc. The DON stated that with the COVID-19, the residents

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) were not able to come down to the reception area to get money for the soda machine and that the staff was having to go to the reception desk and request the money for the resident's and then have the resident sign for the money and change. On 06/11/20 at 1:50 p.m. observed Resident #5 self-propelling himself down the hallway in a wheelchair. He did have a mask in place. His urinary catheter tubing was noted to be dragging on the floor. The Assistant Director of Nursing (ADON) went to the resident and turned him around and pushed him back toward his room. She placed him in the doorway of his room. She was observed moving her hair to behind her left ear. She then went to the nursing station and started typing on her laptop computer. The DON was present and was asked about the urinary catheter tubing being on the floor. The DON applied gloves (without hand hygiene) and moved the catheter tubing back onto the wheelchair, but it was still on the floor. She then asked the ADON to look at it. The DON removed her gloves and performed hand hygiene using hand sanitizer. The ADON donned gloves (without hand hygiene) and moved the urinary catheter tubing off the floor and back onto the wheelchair. The ADON removed her gloves and performed hand hygiene. The DON stated that the urinary catheter tubing should not be on the floor. The ADON stated that Resident #5 was only on the step down unit because he was readmitted and had multiple falls in the past. She stated that they had to keep an eye on him so he would not fall. When asked about him self-propelling himself in a wheelchair down the hallway and being on droplet precautions, she stated that he was only on precautions because he had been readmitted . They needed to keep an eye on him due to falls. On interview the ADON stated that she had been educated on hand hygiene. They were to clean their hands before and after the donning of gloves. When asked about not cleaning after moving the resident, the ADON stated she should have sanitized after moving him and before she put on gloves to touch his urinary catheter tubing. Observation on 06/11/20 at 2:00 p.m. the call light went off in room [ROOM NUMBER]. A staff member was observed going in the room and donning the required PPE. She asked the Risk Manager, (RM) to get her face shield for her. She stated that the face shield needed to be cleaned. The RM brought a face shield to room [ROOM NUMBER], drying it with a paper towel and swinging it back and forth. On interview the RM stated that she had cleaned the face shield with a bleach wipe and was drying it with a paper towel. During an interview on 06/11/20 at 2:40 p.m. the DON stated that the ADON should have performed hand hygiene after moving the resident and before gloving for the urinary catheter tubing adjustment. She also verified that the RM should not be swinging the face shield around to dry it, it should be cleaned and let air dry. During an interview on 06/11/20 at 3:20 p.m. the Infection Control Preventionist / Staff Development person stated that the staff had been taught to perform hand hygiene before and after glove changes, resident care, and when going in and out of isolation rooms. Review of the CDC, Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, dated May 18, 2019 showed Healthcare Personnel should perform hand hygiene before and after all patient contact, contact with potential infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. Facilities should have policies and procedures describing a recommended sequence for safely donning and doffing PPE. Gloves: put on clean, non-sterile gloves upon entry into the patient room or care area. Remove and discard gloves when leaving the patient room or care are, and immediately perform hand hygiene. Record review of the facility's training document titled, Donning and Doffing PPE, presented to staff on 05/26/20, showed it was based on CDC and Occupational Safety and Health Administration (OSHA) guidelines. The sequence for donning PPE: gown, mask or respirator, goggles or face shield, gloves. Sequence for doffing PPE: gloves, goggles or face shield, gown, mask or respirator. After removing PPE, perform hand hygiene before leaving the resident's room. Record review of the facility's policy titled, Hand Hygiene, dated December 2017 showed personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. Personnel shall follow the handwashing / hand hygiene guidelines to help prevent the spread of infections to other personnel, residents, and visitors. Employees must wash their hands for twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: before and after direct resident contact; before and after entering isolation precaution settings; before and after handling invasive devices; before and after inserting indwelling catheters; upon and after coming in contact with a resident's intact skin; after handling soiled or used linens, dressings, bedpans, catheters, and urinals; and after removing gloves or aprons. The alternate method of hand hygiene is with an alcohol-based hand rub (ABHR). Hand hygiene is the final step after removing and disposing of personal protective equipment. The use of gloves does not replace handwashing/hand hygiene. Record review of the facility's policy titled, COVID-19 Guidance, dated February 2020, showed practice proper hand washing hygiene. All employees should clean their hands before and after interaction with residents and their environment with an alcohol-based hand sanitizer that contains at least 60-95% alcohol or wash their hands with soap and water for at least 20 seconds. Soap and water should be preferentially if hands are visibly dirty. Record review of the facility's policy titled, Isolation-Categories of Transmission-Based on Infection, not dated, showed to limit movement of resident from the room to essential purposes only. A review of the Guidelines for Prevention of Catheter-Associated Urinary Tract Infections (CAUTI) 2009, last updated: June 6, 2019, revealed: III. Proper Techniques for Urinary Catheter Maintenance. Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. https://www.cdc.gov/infectioncontrol/guidelines/cauti/. Record review of the facility's protocol, Strategies for Optimizing the Supply of Eye Protection, from the CDC showed carefully wipe or spray the inside, followed by the outside of the face shield or goggles using a clean cloth saturated with neutral detergent solution or cleaner wipe. Carefully wipe the outside of the face shield or goggles using a wipe or clean cloth saturated with EPA-registered hospital disinfectant solution. Dry (air dry or use clean absorbent towels). Remove gloves an perform hand hygiene.