STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105866	A. BUILDING _____ B. WING _____	**09/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLAZA WEST	**912 AMERICAN EAGLE BLVD SUN CITY CENTER, FL 33573**

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 observations, interviews and record reviews the facility failed to follow CDC (Centers for Disease Prevention and Control) guidelines to implement and maintain an infection prevention and control program to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of communicable diseases. The facility: 1) failed to ensure two staff members (Staff A and Staff B) performed hand hygiene after cleaning resident care areas on one floor (2nd floor) out of two floors, 2) failed to store respiratory equipment in a clean and sanitary manner for four residents (#1, #2, #4, and #5) out of 10 sampled residents, 3) failed to ensure an indwelling catheter was maintained in a sanitary manner for one resident (#2) out of four sampled residents, 4) failed to ensure soiled isolation bags with linen were disposed of properly on one floor (1st floor) out of two floors and, 5) failed to ensure tubing for a wound vac was positioned and maintained in a safe and sanitary manner for one resident (#3) out of one resident with a wound vac. Findings included: A review of the facility policy titled, Handwashing/Hand Hygiene, revised on August 2015 (2 pages) revealed: Policy: The facility considers hand hygiene the primary means to prevent the spread of infections. 5. Employees must wash their hands for twenty (20) seconds using antimicrobial soap or non-antimicrobial soap and water under the following conditions: After handling soiled equipment; After removing gloves or aprons. 6. The alternate method of hand hygiene is with an alcohol-based hand hygiene rub (ABHR) . 7. Hand hygiene is the final step after removing and disposing of personal protective equipment. 8. The use of gloves does not replace handwashing/hand hygiene. A review of the facility policy titled, Departmental (Respiratory Therapy)-Prevention of Infection, revealed under Purpose: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Infection Control Considerations Related to Oxygen Administration: 8. Keep the oxygen cannula end tubing used PRN (as needed) in a plastic bag when not in use . A review of the facility policy titled, Urinary Tract Infections (Catheter-Associated). Guidelines for Preventing. revised on September 2017, revealed under Policy: The purpose of this procedure is to provide guidelines for the prevention of catheter -associated urinary tract infections. Steps of the Procedure: 6. Maintain unobstructed urinary flow. a. Keep the catheter and tubing free of kinks. b. Secure catheter after insertion to prevent movement. c. Keep drainage bag below the level of the bladder at all times. Do not place the drainage bag on the floor. . A review of the facility policy titled, Cleaning and Disinfecting Non-Critical Resident-Care Items, with a revised date of June 2011 documented for the Purpose: The purpose of this procedure is to provide guidelines for disinfection of non-critical resident care items. General Guidelines: d. Reusable items are cleaned and disinfected or sterilized between resident (e.g., Stethoscopes, durable medical equipment. 1) An interview was conducted on 9/15/2020 at 9:50 a.m., during the entrance conference the Director of Nursing (DON) said, We do not have a designated COVID-19 or PUI (persons under investigation) Unit. The whole facility, all of the residents, are on droplet precautions. An observation was conducted on 9/15/2020 at 10:12 a.m., Staff A, Housekeeping was in the bathroom of resident room [ROOM NUMBER] cleaning the toilet with gloves on. Staff A came out of the bathroom to the housekeeping cart parked in the hall and put the cleaning bottle on the cart and then went back into the bathroom. Then Staff A, with the same gloves on, came out of the bathroom to the housekeeping cart and got the broom off the cart and walked back into resident room [ROOM NUMBER]. Staff A swept up the debris off the floor and then went back out to the cart to put the broom away. An interview was conducted on 9/15/2020 at 10:15 a.m., Staff A, Housekeeping confirmed she did not change her gloves after cleaning the bathroom toilet or perform hand hygiene before entering or exiting the resident room and retrieving additional cleaning equipment taken back into the room. An observation was conducted on 9/15/2020 at 10:31 a.m., Staff B, Physical Therapy Assistant (PTA), walked up to resident room [ROOM NUMBER] pushing a computer cart. Staff B left the cart in the hall and entered room [ROOM NUMBER] without performing hand hygiene. Staff B, PTA using a wooden ruler was observed measuring the distance between the wheels of the wheelchair, touching the arms of the wheelchair. Staff B, PTA walked out of resident room [ROOM NUMBER] without performing hand hygiene. An interview was conducted on 9/15/2020 at approximately 12:30 p.m., the Supervisor of Housekeeping said, I expect my staff to remove their gloves and put on hand sanitizer every time they take their gloves off. They should change their gloves too. 2) An observation was conducted on 9/15/2020 at 10:32 a.m., Resident #1 was in his room in bed and sitting out uncovered on his nightstand was a respiratory spirometer. (Photographic Evidence Obtained) An interview was conducted on 9/15/2020 at 10:33 a.m., Resident #1 said, They tell me to use it, (pointing to the spirometer) but I'm not. It has been there for a while. An observation was conducted on 9/15/2020 at 10:49 a.m., the oxygen tubing with nasal cannula for Resident #2 was on the floor. (Photographic Evidence Obtained). An interview was conducted at 10:49 a.m., Staff C, Certified Nursing Assistant (CNA) who confirmed the oxygen tubing was on the floor for Resident #2. An interview was conducted on 9/15/2020 at 10:52 a.m., Staff D, Licensed Practical Nurse (LPN) said, No, the oxygen tubing should not be on the floor. I'm going now and get new tubing and will replace the oxygen tubing that is on the floor. An interview was conducted on 9/15/2020 at 10:55 a.m., Staff E, CNA said, Oxygen tubing should not be on the floor if not being used, it needs to go in the zippy bag attached to the concentrator. An observation was conducted on 9/15/2020 at 10:59 Staff D, LPN was observed handling the new oxygen tubing for Resident #2, that was completely out of the package, trying to put a date on it handling the new oxygen tubing without gloves. The Unit Manager was standing there assisting Staff D, LPN. This writer pointed out that Staff D, LPN was handling the new oxygen tubing with his bare hands. The Unit Manager spoke up and told Staff D, LPN, You need to start all over. You should have gloves on. An observation was conducted on 9/15/2020 at 11:18 a.m., Resident #5 was in bed and her spirometer out uncovered on the bedside table. An interview was conducted on 9/15/2020 at 11:18 a.m., Resident #5 said, Yes, that is mine (pointing to the spirometer) sitting on her bedside table. I brought that with me from the hospital. An interview was conducted on 9/15/2020 at 11:39 a.m., Staff F, Unit Clerk said, Right now all respiratory equipment like that is supposed to be covered. All of the residents in here are on droplet precautions. An observation was conducted on 9/15/2020 at 11:15 a.m., Resident #4 was sitting up in his bed and his Continuous Positive Airway Pressure ([MEDICAL CONDITION]) mask was out uncovered on his nightstand. Next to the [MEDICAL CONDITION] mask was a gallon of distilled water with the resident's name on it and there was not a date to indicate when the distilled water was opened. (Photographic Evidence Obtained) An interview was conducted on 9/15/2020 at 11:15 a.m., Resident #4 said, Yes, I use my [MEDICAL CONDITION] at night. They never put my [MEDICAL CONDITION] in a bag. I am not sure if it has ever been cleaned or not. A review of the minimum date set ((MDS) dated [DATE] documented in Section C, Cognitive Patterns, Resident #4 had a brief interview for mental status score of 15 which indicated the resident was cognitively intact. A review of the Clinical Resident Profile reflected an admission date of [DATE]. A review of the physician orders for September 2020 revealed no order for the use of [REDACTED]. 3) An observation was conducted on 9/15/2020 at 10:49 a.m., Staff C, CNA was sitting at the bedside of Resident #2 and confirmed the resident was on 1 to 1 to monitor her. Resident #2's indwelling catheter bag and tubing was on the floor. Staff C, CNA got up out of her chair and walked around to the side of the bed next to the window and confirmed the indwelling catheter bag and tubing were on the floor. An interview was conducted on 9/15/2020 at 10:55 a.m., Staff E, CNA said, Nothing touches the floor. Even the

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) indwelling privacy bag should not touch the floor. An interview was conducted on 9/15/2020 at 10:59 a.m., the Unit Manager confirmed the indwelling catheter bag and tubing for Resident #2 was on the floor. Staff D, LPN stated they were going to fix it. A review of the Clinical Resident Profile for Resident #2 revealed an admission date of [DATE] with pertinent [DIAGNOSES REDACTED]. A review of the physician orders for September 2020 reflected an order to apply dignity bag every shift for Indwelling Catheter at all times and check for placement each shift. Oxygen at @ liters per NC (nasal cannula) as needed for shortness of breath. A review of the care plan for Resident #2 reflected a focus area that Resident #2 has a Indwelling Catheter related to [MEDICAL CONDITION] bladder initiated on 6/29/2020 and revised on 8/04/2020. Interventions listed for catheter care per policy; check tubing for kinks; Secure catheter to reduce friction; Position indwelling catheter bag and tubing below the level of the bladder. Resident #2 was care planned for a focus area: Resident #2 has a urinary tract infection dated 12/13/2019. 4) An observation was conducted on 9/15/2020 at 11:18 a.m., outside an occupied resident room (#112) there was a white bin with a yellow bag (isolation) of soiled linen sitting on top of the bin. A second observation of the isolation linen was conducted on 9/15/2020 at 11:27 a.m., the yellow bag was on the floor outside of resident room [ROOM NUMBER]. An interview was conducted on 9/15/2020 at 11:42 a.m., Staff F, Unit Clerk said, No, staff should not be putting dirty isolation bags on the floor or on top of anything. They are supposed to take down to the soiled utility room. An interview was conducted on 9/15/2020 at 12:20 p.m., the Director of Environmental Services said, The nursing staff are responsible for taking isolation linen in yellow bags down to the soiled utility room. They should not be left in the resident's rooms or on the floor. 5) An observation was conducted on 9/15/2020 at 11:28 a.m., Resident #3 was in her room sitting in her wheelchair beside the bed with a just a shirt and brief on. Observed a tubing coming from the left side of her abdomen, followed the tubing to the floor and underneath a wheel of the wheelchair. Hanging on the back of the wheelchair was a wound vac pump (Photographic Evidence Obtained). An observation was conducted of the wound vac tubing on the floor for Resident #3. Staff F, Unit Clerk walked into the room and observed the wound vac tubing on the floor underneath the wheel of the wheelchair. Staff F said, I am going to get the nurse. A review of the Clinical Resident Profile for Resident #3 revealed an admission date of [DATE] from an acute care hospital with pertinent [DIAGNOSES REDACTED]. A review of the Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form, with no signature date, documented under the Patient Health Status section for Skin Condition: Mid-abdominal Incision. A review of the hospital history and physical paperwork revealed that Resident #3 was admitted to an acute care hospital on [DATE] History of Present Illness: Presented in the emergency room for evaluation of constipation for the last 8 days. CT (computed tomography) of the abdomen and pelvis showed probable small bowel obstruction with pneumatosis. The patient was taken to the operating room and found to have ischemic bowels and required small bowel resection. A review of the physician orders for September 2020 revealed an order dated 9/04/2020 for, wound vac to abdominal wound cleanse with saline apply sponge and [MEDICATION NAME] cover @125mmgh (systolic blood pressure measures) continuous suction. The nurses note dated 9/14/2020 indicated the resident was currently on [MEDICATION NAME] for a urinary tract infection. A review of the care plan initiated on 9/03/2020 with a focus area identified as: Resident#3 has the potential/actual impairment to skin integrity. Wound vac to abdomen. Interventions/Tasks reflected, Assist with turning and reposition as needed. Reduce friction and shearing with us of lift/transfer sheets. An interview was conducted on 9/15/2020 at 1:10 p.m., the photographic evidence obtained was shared with the DON who confirmed all of the findings.