STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105574	A. BUILDING _____ B. WING _____	**05/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALM GARDEN OF LARGO	**10500 STARKEY RD LARGO, FL 33777**

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 observations, interviews and record reviews, the facility failed to maintain an ongoing system to ensure their infection prevention and control program was followed to prevent the development and transmission of disease and infection on 3 of 3 wings (Rehab., A and C Wings) related to for hand hygiene after resident contact, removal of gloves and contact with isolation barrier; as well as promote proper cleaning and storage of a used blood pressure cuff and iPad found at the nurses station. Findings included: A review of the facility policy titled Handwashing/Hand Hygiene, 2001 MED-PASS, INC., with a revised date of August 2015, revealed the Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 7. Use of alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; l. After contact with objects (e.g., medical equipment)in the immediate vicinity of the resident; m. After removing gloves; n. Before and after entering isolation precaution settings; 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections . 1. An observation was conducted on 5/12/2020 at 10:00 a.m. Staff A, Environmental Services (ES), was observed outside of room [ROOM NUMBER] standing beside her housekeeping cart. A large Styrofoam cup of a liquid was on the top of the cart. Staff A opened a zippered area on the housekeeping cart and pulled out 2 medication bottles. Staff A opened each of the medication bottles and removed a tablet from each bottle medications, put them in her mouth one at a time, and picked up the large Styrofoam cup filled with a liquid and drank from the cup to swallow her pills. Staff A then proceeded into a resident's rooms without sanitizing her hands or donning gloves. 2. Staff B was observed on 5/12/2020 at 10:21 a.m., to walk out of room [ROOM NUMBER] with two (2) bags of soiled linen with un-gloved hands. Staff B, CNA, walked into the soiled utility room. A sink was observed in the soiled utility room from the door. While never letting the soiled utility room door completely close, Staff B put the bags of soiled linen in a gray can with a lid, then walked out of the soiled utility room on the C Wing and headed down the hall. After getting almost half-way down the hall and before entering a resident's room, an interview was conducted with Staff B, CNA, who said, Why would I walk down the hall with gloves on? Yes, I should have washed my hands or used hand sanitizer when I walked out of the soiled utility room. Yes, there is a sink in there. 3. An observation was conducted on 5/12/2020 at 10:25 a.m., Staff C, CNA came out of room [ROOM NUMBER] and began pushing a gray rolling cart with a top on it down the hall. Yes, I forgot to wash my hands. Staff C, CNA, then started to walk back into room [ROOM NUMBER] but stopped, Staff C, then used the hand sanitizer on the wall across from the room. An interview was conducted on 5/12/2020 at 10:26 a.m., with Staff D, Registered Nurse (RN), who was at her medication cart and witnessed the incident with Staff C. Absolutely, staff are expected to perform hand hygiene before and after exiting a resident's room. 4. An observation of Staff E, ES, on 5/12/2020 at 10:34 a.m., showed her cleaning the handrails on the A Wing (100 hall). Staff E dropped the cleaning cloth she was cleaning with on the floor. With gloves on both hands, Staff E reached down and picked up the cleaning cloth off the floor. Staff E then walked toward the nurse's station to the soiled utility room. Staff E opened the door, held it open with her leg, (a sink was observed with soap and towels in the soiled utility room), then took off one glove and put the dirty cleaning cloth into a gray bin and tossed the one (1) blue glove into a garbage can. Staff E then walked out of the soiled utility room and back down the hall. An interview was conducted with Staff E, ES on 5/12/2020 at 10:36 a.m., Yes, I should have washed my hands before coming out of the soiled utility room. I did take off only one (1) glove. 5. An observation on 5/12/20 at 10:38 a.m. at the nurse's station on the 300 (Rehab) Wing found an iPad, with a label that said Therapy, lying on the counter, and a blood pressure (BP) cuff in a wicker basket that contained shredded paper on top of the nurse's station. An interview was conducted with Staff F, who said, No, that iPad should not be there. When they are not using the iPad, they are supposed to clean it and put it on the charger. Staff G also said, The BP cuff should not be there. 6. An observation was conducted on 5/12/29 at 10:46 a.m. of the Director of Nurses (DON) standing in front of a plastic isolation barrier with her head inside of the plastic barrier. The barrier was unzipped. The DON zipped up the barrier and was noted not to have on any gloves. The DON walked away from the barrier and started walking down the hall towards the nursing station. An interview was conducted on 5/12/2020 at 10:49 a.m., said, Well, I did not go into the isolation area. I only talked with the nurse through the opening. I did not think, since I did not come in contact with anything, I had to perform hand hygiene. I see what you are saying about touching the isolation barrier.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE