STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105690	A. BUILDING _____ B. WING _____	**06/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLAND PINES REHABILITATION CENTER	**1111 S HIGHLAND AVE CLEARWATER, FL 33756**

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.** Based on observations, interviews, policy review, and review of the Centers for Disease and Prevention (CDC) guidelines the facility did not ensure infection control measures were implemented related to: 1) staff members (F, H, I, J & K) not wearing face masks correctly to protect residents from respiratory emissions in the resident area by one of three nurses' stations, one of one secured units, and one of one kitchens; and 2) not maintaining the laundry in a clean and sanitary manner for one of one rooms designated as a clean room. Findings included: 1. On 6/3/2020 at 4:03 p.m. by the 200/300 nurse station, Staff H, Certified Nursing Assistant (CNA) walked up to an interview in progress with another staff member. Staff H's surgical face mask was observed to be placed below her nose and her nostrils were exposed. Staff H was asked about the placement of her mask and she then lifted it back up to the bridge of her nose without comment. On 6/3/2020 at 4:30 p.m. during a tour in the Secured/Dementia unit (Zone 5), Staff F, CNA was observed to walk down the long hall and into the activity/dining room. He was observed wearing a surgical mask that was hooked on his right ear and hanging down on the right side of his face. His mouth and nose were both exposed. He then walked into the activity/dining room, which had 16 residents seated in there, with his mask placed so that his mouth and nose were exposed. He then walked by five residents to the door on the other side of the room, opened the door and went outside to the enclosed courtyard. Staff F proceeded to walk to the middle of the courtyard where one resident was smoking. Staff F was observed to smoke. When he came back inside, and again passed all the residents in the activity/dining room, he then positioned his mask over the bridge of his nose and hooked it on both ears. An interview with Staff F revealed he has been trained on how and when to wear PPE (personal protective equipment), to include a face mask, and that he confirmed that he did have it pulled to one side for a bit. On 6/3/2020 at 5:10 p.m. the kitchen door was open, and three kitchen staff were observed plating food for the dinner meal. One kitchen staff member, Staff I, was observed to push a metal food tray cart out from the kitchen and down the hall to the unit station. When Staff I was observed in the kitchen, she was observed with her surgical mask pulled down below her neck. When she pushed the cart out from the kitchen and walked down the hall approximately ten feet, she then pulled her mask up over her face and past the bridge of her nose. Further observation in the kitchen revealed Staff J plating food from the steam table. She was observed wearing a black face mask and it was pulled down below her chin. When she was interviewed, she pulled the mask up to her nose, with her nostrils exposed. She said she was provided with masks to wear and that she has been trained on how and when to wear the masks and that was to include during work hours and while inside the facility. She did not have an answer as to why she was not wearing her face mask correctly, while plating food in the kitchen. While passing the kitchen again at 5:27 p.m., Staff J was again observed at and near the steam table and walking through to the other side of the kitchen with her face mask pulled down completely below her chin and resting on her neckline. In addition, Staff K, Dietary Manager was observed standing in the kitchen near the food preparation station and the steam table. He was observed with his face mask pulled down below his nose. The face mask was a cloth mask, one that was not provided by the facility. At 5:35 p.m. Staff K was observed still in the kitchen and seated in a chair, near the food preparation station and with his face mask pulled all the way down below his chin, with his mouth and nose exposed. The Director of Nursing (DON) was present during this observation and she noted that all staff are to wear face masks at all times and wear them appropriately while covering both the mouth and nose entirely. She confirmed it was not acceptable that staff, who are in the kitchen and preparing and serving food to residents, wear their masks below their noses and mouth. 2. On 6/2/2020 at approximately 5:10 p.m. the designated clean area of the laundry room was entered with Staff L, Laundry Worker present. Upon immediate entrance to the room, three housekeeping carts were observed on the right side of the wall. The carts were positioned next to each other. On closer observation, the three carts had garbage containers that contained garbage. One of the three housekeeping carts was pushed up against a white linen cart that contained clothing that was hung up on hangers. The housekeeping cart was observed touching the clothing. Staff L confirmed that the clothing on the hangers were personal clothing of the residents, and that the clothing had been clean. An additional observation revealed that on the left side of the laundry room there were two large metal racks with multiple mechanical lift slings hanging off the racks. The slings were observed to be touching the floor. The observation revealed a white linen cart positioned on the right side of the room and pushed up against a wall. The wall behind the cart revealed missing pieces of the wall with wall debris. Scant pieces of wall debris were present on the bottom shelf of the linen cart. During this observation, two air conditioning units were observed next to each other on the same wall. The unit on the left presented to be new in appearance. The second unit (on the right) was smaller and older in appearance. The unit on the right side (the smaller/older unit) had a white towel protruding from the wall. The smaller unit contained a moderate amount of gray, in color, fuzzy debris attached to the grill that stood erect as cool air flowed through it. The Laundry Director was present and removed the grill/cover and revealed a moderate amount of layered gray fuzzy debris. On the bottom of the smaller unit large drops of water were observed. As the water drops released from the unit they landed on a wooden edge. The wooden edge was noted now wet with a layer of black bio-growth. (Photographic Evidence Obtained) In addition, slightly above and between the two air-conditioning units were two electrical outlets. Both outlets were covered with gray fuzzy debris along with the wall surface. Underneath the two air-conditioning units sat a large bin. The large bin contained clean laundry. A floor fan was running as it stood in place facing the driers and the large bin of clean unfolded laundry. The fan contained a moderate amount of gray fuzzy debris that clung on top of the fan. The Director of Laundry Services was present and confirmed the findings. At 5:55 p.m. an interview was conducted with the DON was informed of the laundry room findings and she was not aware of the housekeeping carts being stored in the clean laundry area. The facility provided a copy of their procedure titled, Infection Control Policy and Overview, that contained a revision date on 6/2016, and revealed: Preventing Spread of Infection Preventing the spread of infection is the core of our environmental services department, and, is also a major part of our food/nutrition services procedures. All employees must be made aware of how they can play a part in preventing the spread of infection, including: Prevent and control outbreaks and cross-contamination using transmission based precautions in addition to standard precautions (formerly referred to as Universal Precautions); Implement hand hygiene (hand washing) practices consistent with accepted standards of practice, to reduce the spread of infections and prevent cross-contamination; and properly store, handle, process, and transport (cover) linens/food to minimize possible contamination. A review of the CDC guidelines (https://www.cdc.gov/niosh/npptl/pdfs/UnderstandDifferenceInfographic-508.pdf)revealed: Surgical Mask Testing and Approval Cleared by the U.S. Food and Drug Intended Use and Purpose: Fluid resistant and provides the wearer protection against large droplets, splashes, or sprays of bodily or other hazardous fluids. Protects the patient from the wearer's respiratory emissions. Leakage occurs around the edge of the mask when user inhales. Filtration Does NOT provide the wearer with a reliable level of protection from inhaling smaller airborne particles and is not considered respiratory protection.

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