STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106093	A. BUILDING _____ B. WING _____	06/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KR AT HILLSBOROUGH LAKES	19091 N DALE MABRY HWY LUTZ, FL 33548

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 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to provide necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for two residents (#5, #6) with pressure ulcers related to not providing wound care in a clean and sanitary manner during two (#5, #6) of two resident wound care observations, and not cleaning equipment, such as scissors before and after use appropriately, not [MEDICATION NAME] hand hygiene when necessary and not providing the correct wound care. Findings Included: 1. At approximately 11:00 a.m. a wound care observation was conducted with Staff E, Licensed Practical Nurse. She removed a small souffle cup and placed medi-honey inside of it, one package of calcium alginate package 4 x 4 size, one 4 x 4 gauze package, one silicone adhesive boarder dressing, two normal saline vials, and one cotton tipped applicator. Staff E left the treatment cart at that time and walked to the other hallway where a treatment cart sat outside of bedroom door 179 (yellow zone). She used keys from her right-hand pocket and opened the cart top drawer. And removed a pair of scissors that sat on top of a paper towel. Staff E took the scissors and supplies to resident #6 bedroom. She entered the room without donning a gown. Resident #6 was alert and receptive to the treatment observation. As she appeared comfortable repositioning herself with ease. The old dressing was removed to upper buttocks that revealed an open area to right and left upper buttocks. The right area appeared the size of a dime with the left area the size of a penny. The old dressing contained light brown in color exudate that the staff E stated, it's the medi-honey. She returned to the bedside after hand hygiene and donning clean gloves. Staff E bent over the bed with the normal saline and cleansed the two open areas. As she performed this procedure her lanyard style name tag touched the pale green washable incontinent pad that was on the resident's bed. After both areas were cleansed, she removed her gloves while she walked to the bedroom door where a nurse stood. The nurse at the door spoke to the staff E who dropped her gloves in the garbage pail next to the door. As they spoke to each other staff E removed a clean pair of gloves from a mounted box on the wall that was just inside of the doorway. Staff E donned a clean pair of gloves without hand hygiene as she walked back to the resident's bedside. The nurse opened the package containing the applicator and applied the medi-honey to the right and then to the left open areas. While doing this her name tag again touched the resident's bed. Staff E picked up the scissors and cut the package calcium alginate in half and then in quarter pieces, applied calcium alginate to the right and to the left areas that were open then opened the secondary dressing that contained the silicon adhesive boarder. She removed a black marker from her right front pocket and wrote the date on the bordered dressing then put the pen back inside her pocket. After the treatment was performed the nurse exited the bedroom holding the scissors. Staff E took the scissors back to the treatment cart. She cleaned the scissors with one bleach wipe for six seconds. The container of Micro-Dot bleach wipes directions for use revealed: A contact time of 30 seconds is required to kill bacteria [MEDICAL CONDITION]. Reapply as necessary to ensure that the surface remains visibly wet for the entire contact time. The nurse placed the scissors back inside the treatment cart. Staff E was asked if any if the other nurses use the treatment cart, she stated all the nurses have the keys to the cart. Medical record review of resident #6's Admission Record Form indicated she was a new admission to the facility for short term rehabilitation. Review of a Skin assessment dated on 8/11/2020 indicated an open area to the left buttock/to the left gluteal crease with appearance of stage 2 pressure injury, partial thickness skin loss, No measurements were documented, House stock zinc. Review of a 8/17/2020 Wound Physicians initial wound evaluation and Management summary revealed Stage 3 pressure wound of the left buttock 3.1 x 2 x 0.2 centimeters (cm). Review of physician orders [REDACTED]. Further review of Physician orders [REDACTED]. At 1:48 p.m. the DON was updated on the treatment observation that had been conducted with staff E. She confirmed that if staff E had worn the gown when she performed the treatment to resident #6 her name badge wound not have come in contact with the incontinent product that the resident laid on top of. She additionally confirmed that a gown should have been worn in the bedroom as it was required upon entrance into the room. The DON confirmed that with multiple nurses having keys to the treatment cart it would have been unknown if the scissors had been cleaned appropriately. And that the scissors should have been cleaned prior to use. The DON then stated, they had training on cleaning the scissors. The DON said she would be looking into the additional open area that was identified by the surveyor during the treatment observation. During a 2:00 p.m. interview with Staff E, Licensed Practical Nurse she confirmed she had failed to wear a gown during the treatment provided to resident #6, the resident resided on the unit that required personal protective equipment as she may have been exposed to COVID-19. Staff E confirmed that she had not been unaware the open area to the right buttock was new. She additionally confirmed there had not been a treatment in place for resident #6's right buttock. Staff member E said she was unaware that her name tag came in contact with resident #6's incontinent product that was on the bed. Staff E confirmed that she had attended in-service on cleaning resident equipment supplies. She confirmed that she had not cleaned the scissors prior to using them, nor did she clean the scissors after use by following the recommended contact time of the bleach wipes 2. At 12:00 p.m. an wound care observation was conducted with Staff D; Registered Nurse who entered resident #5's bedroom and used a cleaning wipe to clean the top of the over the bed table, then dried it with a paper towel. Staff D then washed her hands in the bathroom and donned clean gloves. Staff D did not don a gown prior to entering the room the room that was designated for full PPE use. Resident #5 was sitting up in a geri-chair, her lower extremities were slightly elevated, both heels rested upon the chair's plastic surface. Resident #5 made eye contact when approached. Staff D removed a pair of scissors from her right front pocket of her scrub top and cleaned the scissors with one alcohol pad and set them on top of the table. She picked up a small garbage pail that was in the room and positioned it next to the bed. While wearing the same gloves she removed the antiskid sock from the resident's right foot which revealed kerlix gauze to her foot and partially up the ankle. Staff D used the scissors and cut off the kerlix dressing. The dressing was observed containing a moderate amount of tan to brown exudate. The entire heel was noted to be red in color. Staff D disposed of the dressing along with the gloves. Staff D performed hand hygiene, donned clean gloves and returned to the resident then used the scissors to cut open the small package that contained the skin prep. Staff D held up the resident's foot and revealed the open area located just medial to the heel. The open area was pink to red in color with the surrounding tissue from 9 to 3 o'clock white and macerated in appearance. As staff D held up the foot the back center of the heel revealed a second area that was opened. This area was just slightly above the heel and it was the size of a pencil eraser. The bed of the wound appeared with a yellow plug with the surrounding tissue white in color. Staff D stated I can't use a skin prep to this. She said that she would need to call the Physician to get a different order. The wound needs a different treatment. Staff D stated am going to clean it and wrap it for now and call the doctor. Staff D exited the bedroom still wearing gloves, stated I need a larger dressing. While wearing the same gloves she opened the treatment cart and removed normal saline and a dressing. She disposed of the gloves as she walked back to the bedside. When she bent over her face shield began to fall off. She removed it with her right hand and placed the shield on top of the dresser. With the normal saline in hand she identified she removed her gloves after reentering the bedroom. Staff D then removed a pair of gloves from her right pocket. The same pocket she had just removed her keys from to open and close

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 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) the treatment cart stating that's why I always carry and extra pair of gloves. Don't know when you will need them. She preceded to don the gloves without hand hygiene and cleaned the open areas on the resident's right heel. After she cleaned the areas, she removed an alcohol prep pad from her pocket and cleaned her eyeglasses then reapplied the face shield. She removed a marker from her right front pocket and dated the dressing. She placed a new dressing over the open areas then removed the gloves and performed hand hygiene. She left the room holding the scissors. She for a second time used an alcohol wipe to clean the scissors and put them back in her pocket. She was asked about the scissors. She stated, they're mine. She asked the surveyor should I do something different than putting them back in my pocket? Medical record review was conducted for resident #5 the Admission Record revealed that she had been at the facility for a few months and was geriatric in age. The [DIAGNOSES REDACTED]. Physician orders [REDACTED]. A Physician order [REDACTED]. No order was in place for the back area of the right heel that was observed. A current treatment was in place for the right medial heel, but the correct treatment was not provided during the observation. At 1:48 p.m. an interview was conducted with the DON related to the observation of treatment for [REDACTED]. She was informed that a new open area had been observed that was without a current treatment in place. She said that she would have a skin assessment performed for the resident. She was informed that the treatment had not been performed according to physician order, staff D had not read the correct treatment order for the right foot. The DON was asked about the plan of correction that indicated 100% compliance on cleaning resident equipment. She stated the scissors should not be cleaned with a alcohol pad. Everyone was educated on that. She confirmed that a gown should have been worn in the room, and that gloves should not be saved and used from a shirt pocket. At 2:54 p.m. an interview was conducted with Staff D, she was asked if she had been trained on the cleaning and disinfecting of her scissors. She said that she did not remember. Staff D stated I have been a nurse for [AGE] years and you always clean your scissors with an alcohol wipe At 3:05 p.m. the DON stated we have had all types of training. In person training for the plan of correction and immediate education. We had random training and observing treatments and on hand washing. The DON stated I've watched her before but she did not need scissors on that day. Our education was conducted in person and on calls. Record review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Equipment, dated 2019, showed resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment must be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection. Cleaning is the removal of visible soil from objects and surfaces and normally is accomplished manually or mechanically using water and detergents or enzymatic products. Disinfection is a process of eliminating microorganisms, except spores, from inanimate objects, usually by chemical means. Resident-care equipment is categorized based on the degree of risk for infection involved in the use of the equipment. Semi-critical items are exposed to non-intact skin. They require cleaning and high-level disinfection after each use. Non-critical items come in contact with intact skin, but not mucous membranes. These items require cleaning and low/intermittent level of disinfection .Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident. Multiple resident use equipment shall be cleaned and disinfected after each use.
F 0868 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Have the Quality Assessment and Assurance group have the required members and meet at least quarterly** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined that the facility failed to provide Quality Assessment and Assurance (QAA) that demonstrated monitoring and implementation of an effective Action Plan to correct previously cited deficient practices at F880, related to two (Staff D &E) out of two Licensed Nurses failing to clean and disinfect resident care equipment, scissors after use and not wearing required personal protective equipment, and failing to wear gown during resident wound care provided for two (#5 &6) out of two residents that are persons under investigation for possible exposure to COVID-19. Findings Included: On 6/15/2020 an unannounced Focused Infection Control Survey was conducted at the facility. Deficient practice was identified at that time related to infection control. A staff member was observed not performing hand hygiene before donning gloves and not cleaning equipment such as scissors and a pen during or after wound care. The facility was cited with F880, scope and severity of a D and received their letter and details on 6/29/2020. The facility's Plan of Correction showed a completion date of 7/15/2020 and included: 1. Immediate action(s) taken for the resident(s) found to have been affected include: The staff member (Staff B) was immediately in-serviced on proper hand hygiene procedures and procedures for cleaning and disinfecting resident care equipment. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All personnel will be in-serviced on the facility's policy for hand hygiene. All licensed nursing staff will be in-serviced on the facility's policy for cleaning and disinfection of resident-care equipment. In-service training includes random observation of personnel performing hand hygiene and cleaning and disinfecting resident care equipment procedures according to facility policy. Findings are reviewed with all personnel. Corrective action is provided as needed. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services (DNS), or designee, will complete random Validation Checklists of personnel and the timing and technique of hand hygiene procedure and cleaning and disinfection of resident-care equipment. To ensure personnel are performing the procedure in accordance with our facility's policy and procedure, random monitoring will occur each week for 4 weeks. Findings of this audit will be discussed with the Resident Council. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Review of the facility policy titled QAA/QI/QAPI and Risk Management Policy that did not contain a date revealed, Policy: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data driven QAPI (Quality Assurance Performance Improvement) program that focuses on indicators of the outcomes of care and quality of life. On 8/20/2020 a revisit survey was conducted with the following findings: On 8/20/2020 at 10:25 a.m. the Director of Nursing (DON) stated, her expectation when staff are going into residents' bedrooms, they need to wear N95/KN95, a gown and gloves. The DON confirmed that the entire facility except for the one resident in the positive (red zone) the rest of the facility is yellow. Yellow zone indicated residents who may have been exposed to COVID. 1. At approximately 11:00 a.m. a wound care observation was conducted with Staff E, Licensed Practical Nurse. She removed a small souffle cup and placed medi-honey inside of it, one package of calcium alginate package 4 x 4 size, one 4 x 4 gauze package, one silicone adhesive boarder dressing, two normal saline vials, and one cotton tipped applicator. Staff E left the treatment cart at that time and walked to the other hallway where a treatment cart sat outside of bedroom door 179 (yellow zone). She used keys from her right-hand pocket and opened the cart top drawer. And removed a pair of scissors that sat on top of a paper towel. Staff E took the scissors and supplies to resident #6 bedroom. She entered the room without donning a gown. Resident #6 was alert and receptive to the treatment observation, as she appeared comfortable repositioning herself with ease. The old dressing was removed to upper buttocks that revealed an open area to right and left upper buttocks. The right area appeared the size of a dime with the left area the size of a penny. The old dressing contained light brown in color exudate that the staff E stated, it's the medi-honey. She returned to the bedside after performing hand hygiene and donning clean gloves. Staff E bent over the bed with the normal saline and cleansed the two open areas. As she performed this procedure her lanyard style name tag touched the pale green washable incontinent pad that was on the resident's bed. After both areas were cleansed, she removed her gloves while she walked to the bedroom door where a nurse stood. The nurse at the door spoke to the staff E who dropped her gloves in the garbage pail next to the door. As they spoke to each other staff E removed a clean pair of gloves from a mounted box on the wall that was just inside of the doorway. Staff E donned a clean pair of gloves without hand hygiene as she walked back to the resident's bedside. The nurse opened the package containing the applicator and applied the medi-honey to the right and then to the left open areas. While doing this her name tag again touched the resident's bed. Staff E picked up the scissors and cut the package calcium alginate in half and then in quarter pieces, applied calcium alginate to the right and to the left areas that were open then opened the secondary dressing that contained the silicon adhesive boarder. She removed a black marker from her right front pocket and wrote the date on the bordered dressing then put the pen back inside her pocket. After the treatment was performed the nurse exited the bedroom holding the scissors. Staff E took the scissors back to the treatment cart. She cleaned the scissors with one bleach wipe for six seconds. The container of Micro-Dot bleach wipes directions for use revealed: A contact time of 30 seconds is required to kill bacteria [MEDICAL CONDITION]. Reapply as necessary to ensure that the surface remains visibly wet for the entire contact time. The nurse placed the scissors back

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F 0868 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) inside the treatment cart. Staff E was asked if any if the other nurses use the treatment cart, she stated all the nurses have the keys to the cart. At 1:48 p.m. the DON was updated on the treatment observation that had been conducted with staff E. She confirmed that if staff E had worn the gown when she performed the treatment to resident #6 her name badge wound not have come in contact with the incontinent product that the resident laid on top of. She additionally confirmed that a gown should have been worn in the bedroom as it was required upon entrance into the room. The DON confirmed that with multiple nurses having keys to the treatment cart it would have been unknown if the scissors had been cleaned appropriately and that the scissors should have been cleaned prior to use. The DON then stated, they had training on cleaning the scissors. The DON said she would be looking into the additional open area that was identified by the surveyor during the treatment observation. During a 2:00 p.m. interview with Staff E, Licensed Practical Nurse she confirmed she failed to wear a gown during the treatment provided to resident #6. The resident resided on the unit that required personal protective equipment in order to prevent possible exposure to COVID-19. Staff member E said she was unaware that her name tag came in contact with resident #6's incontinent product that was on the bed. Staff E confirmed that she had attended in-service on cleaning resident equipment supplies. She confirmed that she had not cleaned the scissors prior to using them, nor did she clean the scissors after use by following the recommended contact time of the bleach wipes 2. At 12:00 p.m. an wound care observation was conducted with Staff D; Registered Nurse who entered resident #5's bedroom and used a cleaning wipe to clean the top of the over the bed table, then dried it with a paper towel. Staff D then washed her hands in the bathroom and donned clean gloves. Staff D did not don a gown prior to entering the room the room that was designated for full PPE use (gloves, gown, mask, face shield). Resident #5 was sitting up in a geri-chair, her lower extremities were slightly elevated, both heels rested upon the chair's plastic surface. Resident #5 made eye contact when approached. Staff D removed a pair of scissors from her right front pocket of her scrub top and cleaned the scissors with one alcohol pad and set them on top of the table. She picked up a small garbage pail that was in the room and positioned it next to the bed. While wearing the same gloves she removed the antiskid sock from the resident's right foot which revealed kerlix gauze to her foot and partially up the ankle. Staff D used the scissors and cut off the kerlix dressing. The dressing was observed containing a moderate amount of tan to brown exudate. The entire heel was noted to be red in color. Staff D disposed of the dressing along with the gloves. Staff D performed hand hygiene, donned clean gloves and returned to the resident then used the same pair of scissors to cut open the small package that contained the skin prep. Staff D held up the resident's foot and revealed the open area located just medial to the heel. As staff D held up the foot the back center of the heel revealed a second area that was opened. Staff D stated am going to clean it and wrap it for now and call the doctor. Staff D exited the bedroom still wearing gloves, stated I need a larger dressing. While wearing the same gloves she opened the treatment cart and removed normal saline and a dressing. She disposed of the gloves as she walked back to the bedside. When she bent over her face shield began to fall off. She removed it with her right hand and placed the shield on top of the dresser. With the normal saline in hand she identified she removed her gloves after reentering the bedroom. Staff D then removed a pair of gloves from her right pocket. The same pocket she had just removed her keys from to open and close the treatment cart stating that's why I always carry and extra pair of gloves. Don't know when you will need them. She preceded to don the gloves without hand hygiene and cleaned the open areas on the resident's right heel. After she cleaned the areas, she removed an alcohol prep pad from her pocket and cleaned her eyeglasses then reapplied the face shield. She removed a marker from her right front pocket and dated the dressing. She placed a new dressing over the open areas then removed the gloves and performed hand hygiene. She left the room holding the scissors. She for a second time used an alcohol wipe to clean the scissors and put them back in her pocket. She was asked about the scissors. She stated, they're mine. She asked the surveyor should I do something different than putting them back in my pocket? The DON was asked about cleaning resident equipment. She stated the scissors should not be cleaned with a alcohol pad. Everyone was educated on that. She confirmed that a gown should have been worn in the room, and that gloves should not be saved and used from a shirt pocket. At 2:54 p.m. an interview was conducted with Staff D, she was asked if she had been trained on the cleaning and disinfecting of her scissors. She said that she did not remember. Staff D stated I have been a nurse for [AGE] years and you always clean your scissors with an alcohol wipe At 3:05 p.m. the DON stated we have had all types of training. In person training for the plan of correction and immediate education. We had random training and observing treatments and on hand washing. The DON stated I've watched her before but she did not need scissors on that day. Our education was conducted in person and on calls. Record review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Equipment, dated 2019, showed resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment must be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection. Cleaning is the removal of visible soil from objects and surfaces and normally is accomplished manually or mechanically using water and detergents or enzymatic products. Disinfection is a process of eliminating microorganisms, except spores, from inanimate objects, usually by chemical means. Resident-care equipment is categorized based on the degree of risk for infection involved in the use of the equipment. Semi-critical items are exposed to non-intact skin. They require cleaning and high-level disinfection after each use. Non-critical items come in contact with intact skin, but not mucous membranes. These items require cleaning and low/intermittent level of disinfection .Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident. Multiple resident use equipment shall be cleaned and disinfected after each use. Review of the CDC, Interim Infection Prevention and Control Recommendations for Patients, dated May 18, 2020 revealed Health Care Personnel should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE (personal protective equipment), including gloves .training and educate healthcare personnel .ensure that HCP (healthcare personnel) are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient. Review of Preparing for COVID-19 in Nursing Homes revealed: If COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community, follow the Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. This guidance should be implemented immediately once COVID-19 is suspected: Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown. Cloth face coverings are not considered PPE and should not be worn when PPE is indicated. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observations, interviews, review of the Centers for Disease Control and Prevention (CDC) guidelines, and review of the facility's policies and procedures, the facility failed to maintain an infection prevention and control program designed to provide a safe, and sanitary environment related to one staff member (Staff B) of one staff member not performing required hand hygiene before and after the donning of gloves, and not cleaning equipment, such as scissors and a pen after performing wound care. Findings included: An observation on 06/15/20 at 10:28 a.m. showed Staff B, Registered Nurse (RN) performing wound care on a resident in their room. Staff B placed the used scissors and pen on top of the wound cart at the door. He then removed his gloves and washed his hands. Staff B pushed the wound cart, with the used scissors and pen on top, to an area beside his medication cart. The area was a widened area in the hallway with room exits and two residents sitting in their wheelchairs. Staff B left the wound cart, with the scissors and pen still on top of the cart, and took the resident, he had performed wound care on, in her wheelchair down the hall. He was overheard stating he was taking her to therapy. Staff A, Licensed Practical Nurse, Infection Control Preventionist (LPN / ICP) stated that the scissors could harm a resident and they also needed to be disinfected. Staff B, RN returned and placed gloves on his fingertips only, and without hand hygiene. He was handed the dirty items by Staff A, LPN/ICP. Staff B then removed a bleach wipe from the bottom drawer of the medication cart. He asked Staff A for a cup to place the bleach wipe in. Staff B, RN then finished putting the gloves on his hands. Staff A, LPN / ICP placed a paper towel on the wound cart. Staff B wiped the scissors and pen with the bleach wipe and placed them on the paper towel. Staff A instructed Staff B to wipe down the wound cart also. He removed his gloves and replaced the gloves without hand hygiene. He wiped the wound cart down with a bleach wipe. Staff B went around the paper towel holding which was holding the cleaned scissors and pen. He stated that they needed to stay wet for 3-5 minutes. Staff B, RN, then picked up the paper towel that had the scissors and pen on it and placed it on a notebook lying on top of the medication cart. He removed his gloves and washed his hands in a resident's room. During the interview following the observation with Staff A, LPN / ICP and Staff B, RN they both agreed that Staff B,

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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	(continued... from page 3) RN did not perform hand hygiene before donning gloves and between changing of the gloves. They both agreed that leaving the scissors on top of the wound cart could pose a threat to the residents. They both also verified that Staff B had placed the paper towel that had been lying on the uncleaned wound cart, and that contained the cleaned scissors and pen, onto the top of the notebook on the medication cart. They agreed the paper towel could have been contaminated due to lying on top of the uncleaned wound cart. Review of the CDC, Interim Infection Prevention and Control Recommendations for Patients, dated May 18, 2020 revealed Health Care Personnel should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE (personal protective equipment), including gloves .training and educate healthcare personnel .ensure that HCP (healthcare personnel) are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient. Record review of the facility's policy titled, Hand Hygiene, dated 2019, showed all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Use hand hygiene when: before applying and after removing personal protective equipment (PPE), including gloves. Record review of the facility's policy titled, Personal Protective Equipment, dated 2019, showed to perform hand hygiene before donning gloves and after removal. Gloves are not a substitute for hand hygiene. Select gloves according to hand size. Extend the gloves to cover the wrist. Record review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Equipment, dated 2019, showed resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment must be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection. Cleaning is the removal of visible soil from objects and surfaces and normally is accomplished manually or mechanically using water and detergents or enzymatic products. Disinfection is a process of eliminating microorganisms, except spores, from inanimate objects, usually by chemical means. Resident-care equipment is categorized based on the degree of risk for infection involved in the use of the equipment. Semi-critical items are exposed to non-intact skin. They require cleaning and high-level disinfection after each use. Non-critical items come in contact with intact skin, but not mucous membranes. These items require cleaning and low/intermittent level of disinfection .Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident. Multiple resident use equipment shall be cleaned and disinfected after each use.