STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106033	A. BUILDING _____ B. WING _____	**05/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST PETERSBURG NURSING & REHABILITATION	**521 69TH AVE N SAINT PETERSBURG, FL 33702**

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 review, 1. The facility did not ensure that reusable, multi-resident use vital sign equipment were properly sanitized and stored on 2 of 2 units. 2. Facility did not ensure that employee education about personal protection equipment reuse, documented as given to employees, was the same as the infection control preventionists expressed expectations. 3. Facility did not ensure that the line listing for residents who tested positive for COVID19 was complete. and 4. Facility not ensuring the readily availability of bleach wipes to disinfect soiled face masks for eight of eight resident rooms under PUI (213, 210, 207, 117, 113, 112, 111, and 106). Findings included: 1. During the tour of the facility on 5/14/2020 at 10:15 am on the second-floor unit, walking by the nurses station, it was noted that there was an over the bed table sitting outside of a resident's room. On top of the table was a manual blood pressure cuff, an electronic upper arm blood pressure cuff, 2 finger pulse oximetry meters, a digital thermometer with probe covers, and a container of ammonium chloride wipes. Taped to the end of the table was a clear plastic bag with gloves and wipes inside of it, open to air. The room, 213, had an isolation box hanging on the door, with a sign that said to see the nurse before entry. When asked, the Assistant Director of Nursing (ADON) said that this room had a resident whose roommate was sent to the hospital with signs and symptoms (s/s) of COVID-19, so the resident was on isolation for closer observation until their test results came back. When asked if the equipment on the table was for the isolation room, she said that she didn't know. When she was asked if the equipment was clean, she said that she didn't know that either. When she was asked if the equipment should be there, she said No, it shouldn't. She called the unit manager over and asked her to remove the equipment and the table and make sure that the equipment was properly sanitized. At 10:45 am while touring the first-floor unit, walking passed the first-floor nurses station, there was an over the bed table sitting in the hallway in front of resident room [ROOM NUMBER]. This table had a moisture barrier on it, with a container of ammonium chloride wipes, a reusable thermometer, a multiple resident reusable blood pressure cuff, and a reusable finger pulse oximetry. When asked, the ADON said that it should not be out there, and she could not guarantee that the items were clean or if they had been sanitized. She said that she would make sure the equipment was cleaned and sanitized before being put away. In an interview with the Nursing Home Administrator on 5/14/2020 at 9 am, We are treating the whole building as PUI's (persons under investigation). Review of a COVID-19 Infection Control checklist supplied by the facility with items either checked or labeled n/a (not applicable) revealed that a checked item was Dedicated medical equipment for COVID-19+ and PUI unit/shared equipment cleaned and disinfected before reuse documentation including lifts, scales and pulse oximetry devices. 2. Review of the employee in-service sheets titled COVID-19 Personal Protective Equipment: Donning and COVID-19 Personal Protective Equipment: Doffing revealed they did not contain instructions for doffing eye shields. There was no employee education about how to clean or sanitize face shields/eye protection, only that it should be dedicated to one employee and reprocessed if visibly soiled or removed prior to putting it back on. On 5/14/2020 during a tour of the facility that started at 9:58 a.m. the Assistant Director of Nursing (ADON/ICP) said that she is the facility's infection control preventionist. She said that it is her expectation that after patient care is given to a resident that is considered a PUI (person under investigation), that face shields are wiped down with bleach wipes. At 10:30 a.m., in an interview with the Veterans Administration (VA) Team, it was said that face shields only need to be sanitized after contact with PUI's. At 1:00 p.m. in an interview with the Director of Nursing (DON), she said that when staff are wearing face shields and going into PUI rooms, they should be cleaning/sanitizing the face shield with bleach wipes prior to leaving the room. During the entrance conference at 9:00 a.m. with the Nursing Home Administrator (NHA), he said that all residents in the facility were PUI's. The ADON/ICP, DON, NHA and VA team all reported that the staff members were reusing facemasks as part of PPE (personal protection equipment) conservation. In a facility form titled COVID-19 Infection Control checklist, the 13th bullet square sub-titled Eye Protection reads Reusable eye protection must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to reuse. Disposable eye protection should be discarded after use unless following protocols for extended use or reuse. In a printout given by the facility titled Contingency Capacity Strategies from the CDC (only page 2 of 3 was given) under the sub-title Implement extended use of eye protection it read Extended use of eye protection is the practice of wearing the same eye protection for repeated close contact encounters with several different patients, without removing eye protection between patient encounters. Extended use of eye protection can be applied to disposable and reusable devices. 3. A line listing of COVID-19 positive residents was requested from the Director of Nursing (DON). On 5/14/2020 at 12:00 p.m. she brought in a list of residents who tested positive for [MEDICAL CONDITION]. The only COVID-19 information on the form was the resident name, what hospital they were sent to, the date of transfer and that they were positive. She was asked if she could please include symptoms and date of symptom onset to the list. At 12:43 pm, the DON brought in the line listing for COVID+ residents. There were no dates for symptom onset. She was asked if she could put the dates of symptom onset on the form. She said that as of Monday, if anyone had symptoms, they were tested and then sent to the hospital. She was asked to please put that information on the line listing. At 1:00 p.m. The DON brought in a printed line listing with all the previous information with the addition of dates for onset of symptoms. She said that if anyone was tested and resulted positive, they were sent to the hospital even if they didn't have symptoms. She said that the date of transfer was the date the resident tested positive for [MEDICAL CONDITION]. The facility had an employee line listing form that included columns for name, test results, symptoms, symptom onset date, maximum temperature, if they were hospitalized /where hospitalized , if they were in contact with a COVID case, if they had any procedures performed, any underlying health conditions, and if they smoke. The employee line listing form for COVID-19 had more information readily available to the reader than the line listing of residents who were COVID-19 positive. On 5/14/2020 at approximately 12:45 p.m. the Nursing Home Administrator said that the facility had resources they were using when it comes to putting together information about COVID-19 positive residents, but they are being used by different people. He said that he saw the importance of having all the resident information regarding COVID-19 in one place, rather than having small pieces of information kept in various places, by different people. Review of a CDC publication, updated 3/12/2019, Long-Term Care Respiratory Surveillance Line List revealed: The Respiratory Surveillance Line List provides a template for data collection and active monitoring of both residents and staff during a suspected respiratory illness cluster or outbreak at a nursing home or other LTC facility. Using this tool will provide facilities with a line listing of all individuals monitored for or meeting the case definition for the outbreak illness. Each row represents an individual resident or staff member who may have been affected by the outbreak illness (i.e., case). The information in the columns of the worksheet capture data on the case demographics, location in the facility, clinical signs/symptoms, diagnostic testing results and outcomes. While this template was developed to help with data collection for common respiratory illness outbreaks the data fields can be modified to reflect the needs of the individual facility during other outbreaks. Information gathered on the worksheet should be used to build a case definition, determine the duration of outbreak illness, support monitoring for and rapid identification of new cases, and assist with implementation of infection

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** - Some	(continued... from page 1) control measures by identifying units where cases are occurring. https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf 4. On 5/14/2020 at 9:58 a.m. a tour was conducted with another State surveyor and the Infection Control Nurse/Assistant Director of Nursing (ADON). Tour was started on the second floor of the two story building. After gowning with Personal Protective Equipment (PPE) to include: a disposable gown, gloves, hair and feet covers, face mask and face shield. All staff on the second floor were observed wearing the same PPE. The hall was observed with hand sanitizer stations on the wall and trash cans as well to doff PPE. It was further noted that all resident room doors were fully closed shut. The ADON then explained that there are rooms that have four residents and shared by a bathroom with siding room with additional four residents. So some rooms have as much as eight residents sharing the same bathroom per floor plan layout. They are looking for ways to contain or eliminate risks of spread of infection and that is why the Veteran's Administration (VA) team is here. During this part of the tour rooms 214 - 217 were observed. The ADON indicated that this portion of the hall to include seven rooms were empty. She indicated that the VA was assisting in coming up with a plan to use this hall as perhaps a Step down, Suspected, or Confirmed COVID hall. After walking back down the hall and past the nurse station more resident rooms, rooms 201 - 213 were observed. There were several doors that were observed with PPE supply trays hanging on them. The ADON indicated that they were treating residents in those rooms (213, 210, 207) as residents PUI (Patient Under Investigation). She confirmed the following PPE available on the hanging PPE tray: Gloves, disposable gowns, plastic bags. The Hanging PPE tray nor area near the door contained face shields, masks, sanitizers or bleach wipes to sanitize and or disinfect the PPE. The ADON indicated that when staff come to these rooms with PPE trays, they are to put on additional PPE to include another gown over the one they are already wearing, and ensure they are wearing face shield over their masks. The ADON further explained that when staff are done with care in these rooms, they are to first remove one of the gowns, gloves and dispose of them while in the room and then they are to wipe their face shields with bleach wipes and let it air dry before going into any other room. The ADON confirmed that there were no bleach wipes readily available in resident rooms, at the resident room door way or in the PPE bag tray hanging on the doors. She indicated that there should be bleach wipes available for staff to have immediately leaving those rooms (213, 210, and 207), but did not know why there was none close by. She revealed that they have more than sufficient supply of wipes but, didn't know why they were not readily available for staff. The tour of the building was continued and around 10:30 a.m. the first floor unit was approached. There were two closed double fire doors upon entering this unit. Prior to entering the unit, staff must don the following: disposable gown, gloves, hair and shoe covers, mask, and face shield. It was indicated from the VA team, that prior to going into the unit, one must put on a second disposable gown, on top of the one already wearing. They indicated that as of now, all residents on the floor are considered PUI and that they will be asking to take this extra precaution. Upon entrance to the first floor unit the entrance wall was observed with hand sanitizer station and with a table with various new and bagged gowns. There was a trash can near the area as well. During this time all staff to include nursing, housekeeping, aides were all wearing double gowns, face mask, N95 mask, face shield, gloves, hair and feet covers. They were going from rooms and assisting with ADL (activities of daily living) care. The short hall with rooms 114 - 120 were observed with all doors closed shut. This hall only had one room with PPE tray hanging on the door, which was room [ROOM NUMBER]. The ADON explained that there are residents in rooms on this hall and that room [ROOM NUMBER] is on isolation under PUI. This door tray was observed with the following PPE: Gowns, Gloves, plastic trash bags. The ADON again confirmed that there were no bleach wipes available for staff to use when leaving the room with their face shields. Further tour revealed rooms 113 - 101. The following resident rooms were observed with PPE supply trays hanging on the doors: 113, 112, 111, and 106. The ADON indicated that residents in rooms [ROOM NUMBER] are also all PUIs, and 106 is a resident with infection non-related COVID-19. It was confirmed that all the hanging PPE trays on the doors had the following PPE: Gowns, gloves, bags. There was no evidence of bleach wipes in the tray, in the rooms, or at the doorway for staff to use when they leave the room. She again stated that when staff leave rooms 113, 112, 111, and 106, they should be disinfecting/sanitizing the face shields. Interview with two aides on the floor and one nurse all confirmed there are no bleach wipes in or around resident rooms 113, 112, 111, and 106, in order to wipe down their face shields when leaving the room. They confirmed that they should be using the wipes on the face shields while wet for two minutes and then let air dry for one minute, prior to using the shield again, and prior to going into other resident rooms. At approximately 1:00 p.m. the Director of Nursing was interviewed and she indicated that there were bleach wipes available in the building and she did not know why there were not any readily available where PPE is located on resident room doors 213, 210, 207, 117, 113, 112, 111, and 106. She indicated that when staff are wearing face shields and going into PUI rooms, the staff who are wearing face shields should be sanitizing/disinfecting the face shield with bleach wipes prior to leaving the room. She did confirm that none of the residents in the mentioned rooms were on droplet precautions. Observations in the Nursing Home Administrator's office revealed large boxes with at least ten round plastic containers with bleach wipes in them. The facility had sufficient bleach wipes supply for the building. However, the wipes were not out on the floor and at the PUI rooms to be made available for staff to use. The administrator revealed that he receives PPE deliveries more than once a week and has sufficient PPE supplies to include Bleach wipes. He too did not know why there were no Bleach wipes readily available in and around the above mentioned resident rooms. Review of the Coronavirus Disease 2019 (COVID-19) Strategies for Optimizing the Supply of Eye Protection procedure as found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html revealed the following: 1. Facilities understand their eye protections inventory and supply chain. 2. Facilities understand their eye protection utilization rate. 3. Facilities have already implemented other engineering and administrative control measures including: - Excluding HCP (Health Care Provider) not essential for patient care from entering their care area. - Reducing face-to-face HCP encounters with patients. 4. Facilities have provided HCP with required education and training, including having them demonstrate competency with donning and doffing, with any PPE ensemble that is used to perform job responsibilities, such as provision of patient care. Use eye protection according to product labeling and local, state, and federal requirements. Contingency Capacity Strategies include: - Consider preferential use of powdered air purifying respirators (PAPRs) or full [MEDICATION NAME] respirators which have built in eye protection. - Ensure appropriate cleaning and disinfection between users if goggles or reusable face shields are used. Extended use of eye protection is the practice of wearing the same eye protection for repeated close contact encounters with several different patients, without removing eye protection between patient encounters, extended use of eye protection can be applied to disposable and reusable devices. - Eye protection should be removed and reprocessed if it becomes visibly soiled or difficult to see through. If a disposable face shield is reprocessed, it should be dedicated to one HCP and reprocessed whenever it is visibly soiled or removed (e.g., when leaving the isolation area) prior to putting it back on. See protocol for removing and reprocessing eye protection below. - Eye protection should be discarded if damaged (e.g., face shield can no longer fasten securely to the provider, if visibility is obscured and reprocessing does not restore visibility). - HCP should leave patient care area if they need to remove their eye protection. See protocol for removing and reprocessing eye protection below. Selected Options for Reprocessing Eye Protection Adhere to recommended manufacturer instructions for cleaning and disinfection. When manufacturer instructions for cleaning and disinfection are unavailable, such as for single use face shields, consider: 1. While wearing gloves, carefully wipe the inside, followed by the outside of the face shield or goggles using a clean cloth saturated with neutral detergent solution or cleaner wipes. 2. Carefully wipe the outside of the face shield or goggles using a wipe or clean cloth saturated with EPA-registered hospital disinfectant solution. 3. Wipe the outside of face shield or goggles with clean water or alcohol to remove residue. 4. Fully dry (air dry or use clean absorbent towels). 5. Remove gloves and perform hand hygiene.