STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105378	A. BUILDING _____ B. WING _____	**06/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST MARK VILLAGE	**2655 NEBRASKA AVE PALM HARBOR, FL 34684**

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 review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility did not maintain an effective infection prevention and control program as evidenced by: 1) one of one housekeeper that delivers laundry not transporting residents personal laundry in a safe and sanitary manner, 2) two of five direct care staff not washing hands after handling soiled linen appropriately, 3) one of housekeeping staff observed not maintaining proper infection control by placing a trash can on a resident's seated walker, 4) two or two laundry staff not maintaining proper infection control by storing personal items in the area of clean resident linen and using soiled metal carts to hold and transport linen. Findings included: 1. On 6/30/2020 at 11:00 a.m., a Laundry Staff Member I (LSMI) was observed pushing a large linen cart through the closed doors on to the north unit. As he passed the nursing station, the cart was observed to contain clean personal clothing on hangers for the residents. The cart was not covered as it was transported down the corridor. LSMI was asked why the linen cart was not covered. He stated, It's getting washed right now (referring to the cover). He confirmed that the facility only had one cover for this cart. On 6/30/20 at approximately 12:05 p.m., the Housekeeping Coordinator stated, The staff have been looking for the cover but have not been able to find it. She confirmed that the cart needed to be covered when out on the units. 2. On 6/30/20 at 11:15 a.m., Certified Nursing Assistant D (CNAD) was observed as she left a resident bedroom with two bags of soiled linen. She walked to the soiled room where she disposed of the two bags into a large container. CNAD then washed her hands in the sink for a total of nine seconds. She was informed at that time of the nine seconds of hand hygiene. She stated, Oh, I'm sorry and walked away. On 6/30/20 at approximately 1:30 p.m., the north unit bathroom was entered as Certified Nursing Assistant F (CNAF) was carrying a bag with a soiled brief inside of it. The brief was observed to contain a moderate amount of stool. CNAF placed the bag inside of a garbage container and then removed her gloves. She was observed as she washed her hands for a total of five seconds. After she completed the hand hygiene, she was asked if there was a recommended process time. She stated, I know it's supposed to be for 20 seconds and walked out of the bathroom. Hand Hygiene HCP (healthcare 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. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. HCP should perform hand hygiene by using ABHS (alcohol based hand sanitizer) with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS. Healthcare facilities should ensure that hand hygiene supplies are readily available to all personnel in every care location. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html 3. On 6/30/20 at 11:30 a.m., Housekeeping Staff Member B (HSMB) was observed in resident room [ROOM NUMBER] as she was lining the trash can with multiple clear trash liners. While completing this task, the housekeeper used the resident's seated rolling walker to rest the trash can. The Housekeeping Coordinator appeared at that time and was asked about the process of lining trash cans. She said that the trash cans should never touch the resident's belongings and should not be used to rest trash cans on. Interview with HSMB at the time of the observation confirmed that she used the resident's personal walker to rest the trash can on while she lined the trash cans. She reported that there was not enough room and that she should not have put the trash can on the walker. She reported that the outside of the trash can was clean because she cleans it sometimes. The Housekeeper said that the last time she cleaned it was on Sunday (2 days prior). 4. On 6/30/20 at 12:05 p.m., a tour of the clean laundry room was conducted with the Housekeeping Coordinator. Upon entrance to the clean linen room, a staff member's personal backpack was observed sitting on top of a metal rack. Just below the metal rack contained folded clean resident towels. A plastic beverage bottle that was half full with a pink liquid was observed inside of a portable linen cart that contained clean folded towels. A second beverage bottle with pink liquid was observed on the shelving unit touching clean resident's personal lap blankets. Above the clean folding area an air vent with a large amount of thick gray debris was observed. A fan was also observed and contained a large amount of thick gray colored debris. The Housekeeping Coordinator was asked about the placement of bottled drinks on the clean linen carts and she did not respond. Continued observation revealed a metal wheeled cart that was full of linen. The laundry aid confirmed that the linen inside of the cart was clean. On closer observation, the vast majority of the metal cart surface contained a reddish to orange colored brittle coating. The Housekeeping Coordinator confirmed the metal cart was no longer a cleanable surface as the metal coating was no longer intact. The soiled laundry room was observed and found to contain three more metal carts with wheels. All the carts contained the same reddish to orange colored brittle surface. The Housekeeping Coordinator confirmed that the carts were still in use.
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify residents and their representatives and families of any occurrence of a single confirmed infection of COVID-19 for 1 of 14 (Staff A) staff persons identified on the facility's staff COVID-19 Master -Positive list. Findings included: Review of the facility's listing of COVID-19 positive staff revealed that the facility had 1 staff person, Certified Nursing Assistant A (CNAA) with a first day of absence on 6/9/20, and has not yet returned to work. There was no documentation related to notification of residents, representatives or family members of the positive staff member. On 6/30/20 at 11:05 AM, Resident #1 was observed in the hallway with a staff person waiting to enter the shower room. The resident was wearing a surgical face mask. Resident #1 reported that as far as she knows there were no staff or patients who have COVID-19 and that she had not been informed of anything like that. Interview on 6/30/2020 at 2:30 PM with the Assistant Director of Nursing (ADON) revealed that Staff A worked as the staff screener for her entire shift on 6/8/20. Staff A reported to the facility that she hung out with family on the night of 6/8/20 and that the family member tested positive on 6/9/20. The ADON reported the facility was notified of the exposure on 6/9/20 and that Staff A was directed to get tested for COVID-19 and self quarantine at home for 14 days. The ADON reported that she believed that the staff person was tested on [DATE] and had positive results on 6/10/20 or 6/11/20. Continued interview with the ADON at this time revealed that this COVID-19 positive case was reported to the federal and local government agencies, but that she did not notify residents or their representatives and families of the positive case. The ADON reported that they did not think that it was necessary to report this positive case to residents and families as they believed that Staff A's exposure occurred after her last shift worked and on that last shift she screened staff and had no resident contact. When asked if the staff person had contact with anyone whom she may have screened, the ADON replied I guess she did. Review of the facility policy titled COVID-19 Reporting with an implementation date of April 2017 and a revised dated of May 2020 revealed the following: St. Mark Village staff will notify the proper agencies, staff, residents and resident family/resident representatives upon all confirmed cases of COVID-19, whether staff or resident, and 3 or more staff/residents with new-onset of respiratory symptoms that occur within 72 hours of each other. 1. St. Mark Village social workers or designee will notify residents and their representatives within 12 hours of the occurrence of a

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105378	A. BUILDING _____ B. WING _____	**06/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST MARK VILLAGE	**2655 NEBRASKA AVE PALM HARBOR, FL 34684**

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 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms that occur within 72 hours.