STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105422	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARE CENTER AT PINELLAS PARK, THE	8701 49TH ST N PINELLAS PARK, FL 33782

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, record review, policy review, and review of the Center for Disease Control and Prevention guidelines, the facility failed to maintain an infection prevention and control program on 2 of 2 units to prevent potential infections and cross contamination related to: 1) two staff members (A and B) not cleaning over bed tables and resident care equipment in accordance with manufacturer's guidelines and standards of practice, 2) four staff members (A, B, E, and F) not donning Personal Protective Equipment (PPE) in a manner that prevents the spread of infection, not wearing the PPE indicated for transmission-based precautions, and not performing hand hygiene and cleaning of face shields per practice standards and facility policy, 3) two staff members (D and F) wearing long artificial nails which could pose a risk to resident safety and harbor pathogens, and 4) not maintaining one (309) of four indwelling urinary catheter drainage bags in a clean and sanitary manner. Findings Included: 1. On 8/11/2020 at 10:20 a.m., a tour was conducted on the second floor of the facility. On the door of room [ROOM NUMBER], a sign was posted indicating transmission-based precautions. The sign instructed staff to wear PPE to include a face shield or goggles, a facemask (N95 or higher respirator), one pair of clean non-sterile gloves, and an isolation gown prior to entering the room. A small white cart was positioned outside of the doorway entrance that contained PPE. Staff Member A, housekeeper, stood in front of room [ROOM NUMBER] with a housekeeping cart. The door was open to the room and two residents were observed in the room in their respective beds. Staff A was observed as she donned a pair of clean gloves. She pushed up the back of her hair wearing the clean gloves and placed her hair inside of a hair cover. Next, she placed a set of shoes covers on both of her feet. She then opened the second drawer of the small white cart and removed a gown. After she donned the gown, she removed her surgical mask while still wearing the same gloves and donned a N95 mask. Staff A then placed the surgical mask on top of the N95 mask. She removed a bottle of Virex II (disinfectant spray/cleaner) off the housekeeping cart and entered the bedroom. Staff A did not don goggles or a face shield. After the housekeeper entered the room, Staff B, Certified Nursing Assistant (C.N.A.), was observed pushing a vital sign monitoring machine toward room [ROOM NUMBER]. She stopped outside of the room door and donned a pair of clean gloves. She opened the second drawer of the of the small white cart and found that the drawer was empty. Staff B walked across the hallway to room [ROOM NUMBER] to another white cart sat and removed a gown and shoe covers. She donned the gown and shoe covers while still wearing the same gloves. Staff B did not don goggles or a face shield. Staff B walked back to room [ROOM NUMBER] and pushed the vital sign monitoring machine in front of her into the resident occupied room. Staff B walked over to the bed by the window and was observed placing a piece of paper on top of the resident's bedside table. At that time, Staff A sprayed Virex on top of the bedside table of the resident in the door bed. After Staff A sprayed the table surface, she immediately wiped it off with a cloth rag. Staff B was observed walking with the vital sign machine to the resident by the door while Staff A walked over to the bed by the window. Staff A performed the same cleaning of the bedside table for the resident in the window bed. She sprayed the Virex on the table surface and immediately wiped it off. Continued observation revealed Staff B approached the resident by the door carrying the same piece of paper that was previously on the bedside table of the resident in the window bed. She placed the paper on top of the over bed table of the resident in the door bed. She then changed her gloves without performing hand hygiene prior to donning a new pair of gloves. Staff B walked over to the door and was heard asking for bleach wipes. The nurse at the desk responded by bringing a container of bleach wipes to the bedroom. Staff B brought the container of bleach wipes inside the resident room and placed them on top of the over bed table of the resident by the door. She removed one bleach wipe and wiped the outside of the vital sign monitoring machine. Staff B was not observed to clean the blood pressure cuff after using it on the resident in the window bed and then placing it on the resident by the door bed. Staff B removed a pen from her pocket and wrote on the piece of paper. Staff B then placed the paper inside of her right pocket of her scrub top along with the pen. Staff B placed the container of bleach wipes on top of the small white cart that was sitting outside of room [ROOM NUMBER]. Staff B then pushed the vital sign monitoring machine out into the hallway. She removed her gloves, gown and shoe covers and was not observed to perform hand hygiene prior to leaving the area. The vital sign machine was left in the hallway across from room [ROOM NUMBER]. Staff B returned after a short period time and picked up the container of bleach wipes. She removed one wipe from the container and cleaned the outside surface of the vital sign monitor. She then wiped approximately two inches of the pole that the monitor sat on. Using the same wipe, she cleaned the inside and outside of the pulse oximeter. She picked up the blood pressure cuff that laid inside of a small basket, that was attached to the monitoring system, and with the same wipe in hand swiped the cuff on both sides. She then folded the cuff in half and placed it back inside of the basket. She removed the piece of paper from her pocket that was previously on the over bed tables of both residents in room [ROOM NUMBER] and placed it on top of the blood pressure cuff. Interview with Staff B at the time of this observation revealed she used the paper to, write down the residents' vital signs on it. Observation of the paper revealed a total of nineteen different room #'s of residents and their vital sign readings. On 8/11/20 at 10:40 a.m., Staff B, C.N.A., was asked about the contact time of the bleach wipes. She stated that she didn't know and proceeded to ask the surveyor, 2 minutes? She indicated that she thought it was 2 minutes because she had watched a nurse clean with it. Staff B confirmed that she had used one wipe to clean the vital sign machine and the vital sign equipment. Staff B then picked up the piece of paper that contained the nineteen residents vital signs and placed it on top of the nursing desk along with the container of bleach wipes. She was heard telling the nurse at that time, I put the vital signs on your desk. Staff B confirmed that she did not wear eye protection when she entered room [ROOM NUMBER] nor did she wear clean gloves. On 8/11/20 at 10:50 a.m., Staff A, housekeeper, was observed leaving room [ROOM NUMBER]. She was asked if she knew the contact time of Virex II. She stated, no. She reported that she had received training on donning PPE prior to entering a resident's room. She was asked if she could verbalize the donning process. She stated, wash my hands, put on gloves, gown, shoe covers. She then stated, I don't remember the order. She was informed after she had placed clean gloves on, she had touched her hair, her mask and the PPE cart. Staff A stated, I shouldn't put on the gloves first? She confirmed that she forgot to wear eye protection. A review of the manufacturer's information for VIREX (Trademark) 11/256 One-Step Disinfectant Cleaner and Deodorant Using approved AOAC test methods (under Good Laboratory Practices, (GLP'sll, in the presence of 400 ppm hard water, 5% serum load and 10 minutes contact time, VIREX~ II/ 256 kills the following on hard non-porous inanimate surfaces: Viruses (Virucidal Activity) - (kills on hard non-porous inanimate surfaces:) Adenovirus Type 2, (VR-2). https://diversey.com/en/product-catalogue/virex-ii-256-one-step-disinfectant-cleaner-and-deodorant- . On 8/11/20 at 11:05 a.m., an interview was conducted with the Unit Manager (UM) relating to the isolation signage posted on the door of room [ROOM NUMBER]. She stated that yesterday, the residents had a fever and were both tested for COVID-19. She said that staff had been trained on the application of donning PPE. She was informed of the process that was observed by Staff A & B and stated that their gloves should have been changed prior to entering the room due to the contact with their hair, mask, and the PPE cart. The UM was asked about the process of handling the bleach containers and vital sign paper being taken in and out of an isolation room. She indicated that the container should not have been taken inside of

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) the resident room. The UM was informed that the paper and bleach container were both sitting on the nursing desk. She indicated that should not have happened and confirmed that there was a possibility of cross contamination. The UM was asked about the contact time for the bleach wipes and was also informed that Staff B used one wipe to clean all vital sign equipment. She indicated that more than one wipe should have been utilized. She stated, it's a 3 to 5-minute contact time for regular. I thought it was 5 minutes for [MEDICAL CONDITION]. Observation and review of the bleach wipe container revealed, Contact time: allow surface to remain visibly wet for 30 seconds to kill bacteria [MEDICAL CONDITION]. On 8/11/20 at 11:15 a.m., Staff A, housekeeper, was observed in room [ROOM NUMBER]. On the door of the room a sign was posted to wear full PPE. Staff A was observed not wearing a face shield or eye goggles. She stated, my glasses keep falling off when I wear them. The Infection Control Preventionist (ICP) provided a list titled COVID Watch Unit that identified, other isolation- COVID tests pending. This list contained the names of the residents in room [ROOM NUMBER]. 2. On 8/11/20 at 11:35 a.m., the third floor of the facility was toured. Staff D, Licensed Practical Nurse (LPN), confirmed that she was a floor nurse. Staff D's fingernails were observed to extend approximately one inch past the tips of the fingers. She confirmed that the nails were artificial and needed to be cut. 3. On 8/11/20 at 11:40 a.m., the meal cart was transported to the 300 COVID watch unit. Staff E, C.N.A. was observed donning PPE. Gloves were donned last and without hand hygiene practiced. Staff E entered room [ROOM NUMBER] and gave the resident her lunch meal. She bent downward and when doing so, the face shield fell off as she caught it and replaced it on her head. This happened two times while she was with the resident. Staff E entered the bathroom and performed hand hygiene and was overheard asking staff in the hallway for a paper towel. A staff member brought her a few paper towels that she blotted in her hands. During that time, one of the paper towels dropped to the floor. While holding the now wet paper towel, she bent over the paper towel by using it as a barrier to pick up the one on the floor. She then left the bedroom carrying a bag of soiled linen. At 11:47 a.m., Staff E walked over to the soiled utility room and disposed of a bag of linen. She left the soiled room without [MEDICATION NAME] hand hygiene. Next, she walked to room [ROOM NUMBER] and donned a clean gown, gloves and the same face shield that was resting in-between the hand railing and the wall. She entered room [ROOM NUMBER] with the resident's lunch meal. While the staff member was in the bedroom, the foot of the bed was observed with an indwelling urinary catheter drainage bag lying on the surface of the floor. Staff E left the bedroom without identifying the catheter drainage bag on the floor. A review of the medical record for the resident in this room revealed this was a newly admitted resident who was geriatric in age and had a [DIAGNOSES REDACTED]. On 8/11/20 at 2:45 p.m., Staff E confirmed that the face shield she was wearing had fallen off over 2 times when assisting a resident during her lunch meal. The ICP was present during this interview. Staff E reported that she had used a paper towel to pick up the paper towel up off the floor. The ICP said if the paper towel was wet it could have the potential for cross contamination. On 8/11/20 at 3:00 p.m., a tour was conducted with the ICP on the 300-isolation unit. During the tour, face shields were observed lying on top of PPE carts outside of room [ROOM NUMBER] and 308. The ICP said that they need to be kept in the cabinet and not on top of the PPE carts. 4. On 8/11/20 at 12:10 p.m., Staff F, C.N.A., was observed donning PPE outside of room [ROOM NUMBER]. She was observed with long fingernails that extended approximately one inch past the top of the fingertip. She was asked about her fingernails at the time of observation and confirmed that they were artificial. Her nails were formed to a point. She stated, the point of the nail was not hard but soft. Staff F then donned a pair of clean gloves and entered the resident's room. She was observed assisting the resident with repositioning and retrieving his TV remote. After she left the room, she was asked about the PPE that needed to be worn. She looked at the sign that was posted on the door to room [ROOM NUMBER] and confirmed she was not wearing a N95 mask and only had on a surgical mask. She stated, I don't have one and I have not been fitted for one. Staff F confirmed that she had been caring for the resident in that room all day and had been in the room at least three times that day. On 8/11/20 at 12:20 p.m., the UM was asked what the facility's process was to ensure staff wore the appropriate mask when entering a resident room. She stated, the normal process is that staff tell us when they need one. On 8/11/20 at 12:45 p.m., an interview was conducted with the ICP and the Director of Nursing (DON) related to staff not wearing face shields, face shields falling off while in resident rooms, and staff donning PPE and entering resident rooms with dirty gloves. The ICP said the staff members who have a lot of hair (braids) have other face shields that could be used. The ICP indicated that they were having the staff clean the face shields in between resident rooms on the isolation unit. She was informed that this cleaning was not observed during the lunch meal service on the isolation unit. Both the DON and the ICP confirmed that hand hygiene needed to be performed prior to entering a resident room and then gloves were donned. The DON and ICP were shown photographic evidence of the indwelling urinary catheter drainage bag lying on the floor in room [ROOM NUMBER]. They both indicated that the bag should not rest on the floor. The ICP indicated that there was dedicated equipment for residents on isolation and that the vital sign monitoring machine should not be taken into rooms that were on isolation. They were informed of the process observed of cleaning the vital sign monitoring machine/equipment and that the 30 second wet time was not maintained or known by facility staff. Additionally, the DON and ICP were informed that Staff A, housekeeper, did not know the contact time for Virex. The ICP and the DON did not respond when provided with this information. A review of the facility's policy titled Handwashing/ Hand Hygiene that was dated March 2020 revealed the following policy statement: This facility considers hand hygiene the primary means to prevent the spread of infection. Use an alcohol-based hand rub containing at least 60% alcohol: or, alternatively, soap and water for the following situations .n. Before and after entering isolation precautions 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 hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections . 11. Wearing artificial fingernails is strongly discouraged among staff members with direct resident-care responsibilities and is prohibited among those caring for severely ill or immunocompromised residents . Applying and Removing Gloves 1. Perform hand hygiene before applying non-sterile gloves. A review of the policy dated March 2020 titled, Admission, Readmission for COVID-19 revealed Policy Statement: It is the policy of this center that all the new and readmitted residents will be monitored closely to minimize the potential spread of infections related to COVID-19. This guidance is based on the currently limited information available about COVID-19 related to disease severity, transmission efficiency, and shedding duration. Purpose: To minimize the potential risk of transmitting COVID-19 to other residents and staff. 2. Universal precautions and isolation guidelines provided by CDC will be followed. 12. Facility will disinfect/clean high touch surfaces (knobs, hand rails, tables etc.) on regular basis throughout the day, at a minimum twice a day with increase amount warranted based on facility activity. A review of an article: Guideline Implementation: Hand Hygiene 1.1 www.aornjournal.org/content/cme; February 2017, Vol. 105, No. 2. Maintaining short fingernails decreases the risk of puncturing gloves, harboring pathogens under the nails, impeding proper hand hygiene, and possibly injuring patients. Studies have demonstrated that both artificial nails and nail extenders contribute to contamination of the hands and have led to outbreaks of infection. Nursing home or long-term care facility patients Effectiveness of hand hygiene can be reduced by the type and length of fingernails; artificial nails or nail extenders should not be worn by healthcare workers who have direct contact with residents. https://www.infectiousdiseaseadvisor.com/home/decision-support. A review of additional information provided by the facility with no date revealed, Facility uses all recommended PPE for the care of all residents on affected units .All staff wear surgical masks. On the PUI (persons under investigation) and new admission unit, all staff wear an N95 mask and full PPE: gown, gloves, eye protection, shoe covers. A review of the facility's LTC Facility Self- Assessment Tool dated 8/11/2020 revealed the following information on page 7 pf 18: Hand Hygiene is performed before entering resident care environment. The box was checked yes. On page 10 the box was checked yes, urine collection bag is kept below the level of the bladder and off the floor at all times. On page 10 of 18, The facility has cleaning/disinfecting policies which include routine and terminal cleaning and disinfection of resident rooms, and high touch surfaces in common areas. The facility additionally provided a copy of their polity titled Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing dated on September 2017. Purpose: The purpose of this procedure is to provide guidelines for the prevention of catheter associated urinary tract infections (CAUTIs). Steps in the procedure included: 6 c. Keep drainage bag below the level of the bladder at all times. Do not place the drainage bag on the floor.