STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105486	A. BUILDING _____ B. WING _____	**10/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GATEWAY CARE CENTER	**8600 US HWY 19 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 -** 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 facility policy, the facility failed to implement and maintain an infection prevention and control program to prevent the potential spread of infection as evidenced by: 1. not ensuring the fingernails of two direct-care staff (M and N) were kept in a manner that would prevent a transfer of microorganisms between staff and residents, 2. one staff member (A) not performing hand hygiene while serving meals and providing meal set up for residents, and 3. not ensuring personal protective equipment (PPE) was kept in a clean and sanitary manner on one hall (North) by keeping one resident (#69) of one resident observed from utilizing the PPE freely in the storage containers and placing contaminated PPE back into the storage containers. Findings included: 1. On 10/4/20 At 10:22 a.m., Staff M, CNA was observed in the Secured Unit's shower room with artificial fingernails, which extended approximately 1/2-3/4 inches above the tip of her finger. When asked about her fingernails, she confirmed they were not natural and then put her hands into her shirt pockets. On 10/6/20 at 10:58 a.m., Staff K, Licensed Practical Nurse/Nurse Supervisor (LPN), was observed, during the facility task of Medication Storage, with artificial nails that extended approximately 1/2-3/4 inches above the tip of her fingers. Staff K confirmed they were artificial. On 10/7/20 at 12:03 p.m., the Director of Nursing (DON) was interviewed related to the observed artificial nails on Staff M and K. She stated staff should not be wearing artificial nails, and the fingernails should not be more than 1/4 inches long. According to the Centers of Disease Control and Prevention (CDC), (https://www.cdc.gov/handhygiene/providers/index.html), Germs can live under artificial fingernails before and after using an alcohol-based hand sanitizer and handwashing. It is recommended that healthcare providers do not wear artificial fingernails or extensions when having direct contact with patients at high risk. Keep natural nail tips less than 1/4 inch long. A review of the facility policy titled, Standard Precautions, dated 2001 and revised October 2018, indicated that Standard Precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. The policy identified that artificial fingernails are discouraged among staff with direct resident contact. 2. On 10/4/2020 at 12:00 p.m., the North unit was observed during the in-room lunch meal service to include tray pass and meal set up. At 12:05 p.m. Staff A, CNA was observed to walk out from resident room [ROOM NUMBER] and walked up to the meal tray cart. She proceeded to remove a tray and walked to resident room [ROOM NUMBER] and went inside the room to drop off the tray and set up the meal, then proceeded to leave the room and walked back into resident room [ROOM NUMBER]. She left the room, picked up a tray from the meal tray cart and walked back into resident room [ROOM NUMBER] at 12:07 p.m. After dropping off the tray, she left the room at 12:08 p.m. and got another meal tray and went into resident room [ROOM NUMBER]. After she went into the room, she came back out with the tray and walked to the nurses station and spoke with a nurse. At 12:10 p.m., she then walked the tray back to the meal tray cart and put it on one of the racks. During the entire observation from 12:05 p.m. to 12:10 p.m. and after going in and out of three resident rooms, Staff A did not perform hand hygiene before or after meal delivery and set up. She was interviewed at 12:13 p.m. and said that she thought she sanitized her hands. 3. On 10/4/2020 at 10:55 a.m. on the North unit hall by the nurses' station and between resident rooms [ROOM NUMBERS], the main hallway was observed with a plastic storage container with PPE in it. Resident #69, who was observed walking up and down the hallways previously and was not wearing any type of face covering, went up to the plastic storage container and pulled open the middle drawer and pulled out a bunch of surgical masks with her left hand. She pulled one apart and then stuffed the rest of the face masks back in the drawer, and then closed the drawer. The resident did not perform hand hygiene prior to taking out a surgical mask. She then put it on her face and walked away. During this observation facility staff were observed in the area. On 10/5/2020 at 8:15 a.m., Resident #69 was observed to walk up and down the hallway and towards the door that led to the smoking/patio area. She went outside and came back in about three minutes later. She was observed wearing a surgical mask and then took it off and dropped it on the floor. She then picked it up and went to the PPE plastic storage container just outside of resident rooms 110/112. She opened the middle drawer and pulled out a bunch of surgical masks and took a new one. She then put the rest, along with the one she was previously wearing and dropped on the floor, back into the drawer with the other face masks. She had been observed during the day to reach in and grab a new surgical mask at least three more times, unsupervised and not redirected by staff in the area. On 10/7/2020 at 9:20 a.m., an interview with the North Unit Manager revealed that staff stock PPE in all the PPE plastic storage containers along the hallway and she ensured there was sufficient PPE in the containers as well. She confirmed that when staff take from the PPE plastic storage containers, that they maintain hand washing or hand sanitizing prior to getting any PPE. She was asked if residents were allowed to go in these containers and get PPE to include face masks on their own. She said, Absolutely not, the staff should be getting masks for the residents, not the residents themselves. The Unit Manager was then told of the previous observations of Resident #69 getting her own masks with her bare hands and also putting in used masks back in the drawer with new clean masks. She was surprised and indicated that they need to monitor Resident #69 better and maybe provide her with masks in her room.

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