STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105257	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FORT PIERCE HEALTH CARE	**611 S 13TH ST FORT PIERCE, FL 34950**

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.** Based on observation, staff interview and administrative record review, the facility failed to implement the established policies and procedures for an ongoing infection prevention and control program (IPCP) to prevent and control the onset and spread of infection to the extent possible. This is evidenced by the facility's failure to implement in a timely manner appropriate storage of potentially infectious linen and waste for the confirmed COVID-19 positive unit; failure to implement and provide the necessary personal protective equipment and supplies for the Person Under Investigation (PUI) unit and ensure the 18 residents' rooms identified as requiring special droplet precautions had the necessary personal protection equipment and supplies, such as gowns, gloves, and cleaning disinfectant supplies, to adhere to the standard and transmission-based precautions to prevent spread of infections, while providing the necessary care and services to the residents in those rooms; and failed to ensure potentially infectious linen and waste was properly stored and transported consistently. The findings included: 1. Observation of the COVID-19 positive unit on 07/28/20 beginning at 1:16 PM revealed three (3) large yellow bins marked as linen were stored at the end of hall in the hallway in front of two resident's room. Further observation of the bins revealed two (2) of the 3 bins were overflowing with clear bagged trash containing the disposable food plates and other items. The third yellow bin contained overflowing contaminated linen, loosely stored in the bin. The bins had lids but secondary to the content in the bins, the lids were not fastened securely on the bins. An interview was conducted on 07/28/20 at approximately 2:15 PM with the Certified Nursing Assistant on the COVID unit, Staff B, who confirmed the overflowing bins and stated that housekeeping was to pick them up about 1:30 PM but had not come yet to pick it up. An interview was conducted on 07/28/20 at approximately 2:30 PM with the Registered Nurse, Staff A, who also confirmed the overflowing bins. On 07/29/20 at approximately 8:15 AM, the surveyor was driving up to the facility and observed two staff, later identified as the visiting Environmental Services Director and the housekeeper for the COVID-19 unit, pushing three overflowing bins down the street. The staff in the back, the housekeeper for the COVID unit, was pushing one bin and the staff was observed not to be wearing personal protective equipment when handling the overflowing bins. The staff was not wearing a mask. An interview was conducted on 07/29/20 at 9:35 AM with the Director of Nursing (DON). The surveyor reviewed the above observations with the DON. She stated that the staff are to remove the linen and trash from the COVID unit every 4 hours but was uncertain, if that was done or if this was often enough to ensure the unsecured linen and trash would be removed often enough to prevent overflowing. Additionally, because of where the unit is located in comparison to the laundry room, they have to push the bins down the street (13th) then down the side street to get to the laundry room. The staff should be wearing the appropriate PPE when transporting. Also reviewed with her the observation from 07/28/20 on the COVID unit when in the afternoon, the facility had overflowing linen and trash bins stored in the hallway. An interview was conducted on 07/30/20 at 7:55 AM with the visiting Environmental Services Director, who was one of the staff transporting the three bins observed on 07/29/20. She stated that 07/29/20 was her first time assisting at the facility and was alarmed at the current set-up for the linen not being contained in the yellow, meltaway bags, and overflowing trash stored on the COVID unit. She relayed the standard precautionary measures necessary to ensure safe storage and transport of potentially contaminated linen and trash. She further confirmed the overflowing bins of trash and linen she observed on 07/29/20 and stated they wore the proper PPE on the unit but removed them when she left the unit to transport the bins to the laundry room. 2. An observation was conducted on 07/28/20 beginning at approximately 6:45 AM on the West/Emerald wing which houses the PUI (Persons Under Investigation, who are exhibiting symptoms for COVID or have been exposed to someone who has tested positive for COVID-19) unit. Observation of the unit revealed there were 18 rooms marked as having residents which the staff were to observe Special Droplet Precautions. The sign special droplet precautions noted in addition to Standard Precautions, the staff are to Clean hands when entering and leaving room, wear face mask, wear eye protection (face shield or goggles), gown and glove at door; when doing aerosolizing procedures fit tested N-95 with eye protection or higher required; keep door closed; use patient dedicated or disposal equipment clean and disinfect shared equipment. The rooms did not have any set up for supplies to maintain the isolation precautions, nor were there PPE supplies readily available for the staff to use, as indicated above, to adhere to the designated precautions, nor were the residents' room door closed. Further observation revealed that there were 5 isolation gowns stored in an opened, cardboard box on the floor at the nurses' station. An interview was conducted on 07/28/20 at approximately 7:45 AM with the Certified Nursing Assistant on the West/Emerald wing, Staff C, who also cared for several residents whose rooms were noted as having Special Droplet Precautions. Staff C confirmed that the supplies were not available and stated, these precautions were new and she was not aware of where she was to obtain the necessary supplies. An interview was conducted on 07/28/20 at approximately 7:15 AM with the Nurse, Staff D, who confirmed, that the unit typically does not have adequate PPE supplies on the night shift. Per the nurse, she stated, they would run out of PPE supplies on the unit. An interview with another Night Nurse from another unit, Staff E, was conducted on 07/28/20 at approximately 5:45 AM, who confirmed being provided a packet of 10 gowns at the beginning of the shift and a package of surgical mask being provided at the entrance, to give staff one mask when the staff comes to work. She further stated they often have to go searching in other resident's rooms for gloves to use on nights. Staff E said, 'sometimes there are some (gloves) available in central supply but oftentimes on Thursday nights is when they would run out'. An interview was conducted on 07/28/20 at approximately 8:30 AM with the Assistant Director of Nursing, who reported that they started the PUI unit on this wing on Friday, 07/24/20 and isolation set ups should be in place. She acknowledged that the gowns were not available, but they would be using washable (reusable) gowns. She further confirmed that the reusable gowns were also not available at this time, but she would contact someone in laundry to get them to bring some gowns up.

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.