| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | **105587** | A. BUILDING _____ B. WING _____ | **06/08/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **COUNTRYSIDE REHAB AND HEALTHCARE CENTER** | **3825 COUNTRYSIDE BLVD N 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) |
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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations, interviews, and record review the facility failed to implement their infection prevention and control program on a quarantine unit to mitigate the spread of COVID-19. The facility failed to ensure adherence to their infection control policy as evidenced by Staff not wearing Personal Protective Equipment (Masks) appropriately over their entire face in one of two units, to include the North Front hall rooms 201 - 212 Quarantine/Step Down unit and Staff not [MEDICATION NAME] best handwashing/hand hygiene practices after handling soiled laundry, or after touching soiled surfaces with soiled hands. Findings included: On 6/08/20 at 9:10 a.m. the facility was toured. While in the main hallway between the main dining room and the entrance/exit to the courtyard, a housekeeper was observed at her cart and pushing it down the hall. The housekeeper, Staff D was interviewed related to her housekeeping cleaning process. While speaking, Staff D pulled her surgical mask down below her nose three times and continually touched the mask with her hands. She revealed that it was hard to breathe in the surgical mask and that was why she kept pulling it down. Employee D revealed she was educated on how to use PPE and that her entire face should be covered to include her mouth and nose. She then pushed her cart down the hallway but did not wash or sanitize her hands. Observation on 06/08/20 at 11:55 a.m. showed Staff D, aide removing her cart from the housekeeping room. She had her mask down under her chin and was talking to another staff member down the hall. On 6/08/20 at 9:25 a.m., and while in the facility's laundry room, Certified Nursing Assistant Staff A was observed to walk in the room, go to the clean linen cart and pick up a few pieces of linen. While in the laundry room and while getting clean linen, she was observed with her N95 face mask pulled down to her chin. Her mouth and nostrils were observed exposed. She was observed to walk with the linen out of the laundry room and down the hallway to enter the Quarantine unit, still with her mask pulled down to her chin. The laundry aide, Staff C confirmed that they should all be wearing their masks appropriately and always keep their mouth and nose covered. Staff C confirmed that all staff have had recent in-services on how to use their PPE and to include face masks. Staff A had walked out from the room prior to being interviewed. On 6/08/2020 at 9:20 a.m., Certified Nursing Assistant, Staff A was observed to walk out from the North unit, Front hall, which was noted as Quarantine hall, and with rooms 201 - 212. Staff A had to push a plastic curtain aside to come out from that hall. She was observed carrying two bags of soiled linen/clothing. Staff A was wearing gloves and an N95 face mask respirator. She left the Quarantine unit with soiled bags of linen and proceeded to walk down the Non-Quarantine hall North unit station, turned right and walked to the soiled utility closet. She opened the door and while holding the door open with her foot, she dropped off the soiled linen/clothing in a bin and then proceeded to let the door close in front of her. She then removed her gloves and walked back toward the unit station. She was stopped at the unit station by this surveyor and was asked why she did not wash or sanitize her hands after dropping off the soiled bags. She explained that she dropped the bags off in the soiled utility closet, left the closet, and walked down past the unit station to the restroom to wash her hands. Staff A confirmed at this point she had not washed or sanitized her hands after dropping off the soiled linen/clothing in the soiled utility closet. She confirmed that there was a sink in the soiled utility closet and the water worked fine, but sometimes she liked to go to the restroom to wash her hands. At 9:40 a.m. an interview with the Assistant Director of Nursing (ADON)/Infection Control Nurse revealed that staff were to use best handwashing/ hand hygiene practices when dropping off soiled laundry into the soiled utility room. She explained that the soiled utility room located on the 300 hall near the North unit station had a working sink and did not know why Staff A would not wash her hands in that room. The ADON further explained that Staff A should wash her hands in that soiled utility room and not walk to other areas of the facility, while touching surfaces with soiled hands. The ADON did confirm that resident rooms 201 - 212 was the Quarantine hallway and was closed off with a plastic curtain at rooms [ROOM NUMBERS], and with double fire doors closed at rooms [ROOM NUMBERS]. The ADON revealed that there were no soiled utility closets on that hallway so staff did have to leave the Quarantine hallway and take soiled linen/clothing around the corner to another hallway, which had a soiled utility closet. During an observation and interview on 06/08/20 at 9:16 a.m., Staff C of housekeeping and laundry showed the laundry room area to the surveyors. She opened the dirty laundry room and stated that this was where the dirty laundry was kept until sorted and placed in the washing machines in the next room. She opened the three bins of dirty laundry and touched the bagged laundry inside of each bin with her bare hands. She then moved into the washing machine area by opening the door. She did not perform hand hygiene after touching the dirty laundry bins and bagged laundry. During her interview of the laundry process, she pulled her mask down below her mouth twice. An archway opening was present between the washing machines and dryers, without any physical separation. Staff C then touched the clean slings for the mechanical lifts, which were hanging next to the dryers on hooks. She still had not sanitized her hands. She moved farther into the dryer room and touched the clean linens which were in a laundry bin with her unclean hands. Observation on 06/08/20 at 9:45 a.m., showed Staff E, environmental staff exiting the quarantine hallway through the plastic sheeting wall with a white plastic or cloth item in his left hand. He was not wearing gloves. He walked approximately 20 feet to the dirty laundry door, another employee was in the dirty utility holding the door open. He placed the item in the dirty laundry room and kept walking down the hallway. He passed hand sanitizer but did not stop and use it. During an interview on 06/08/20 at 12:00 p.m., the Assistant Director of Nursing (ADON) and Administrator both stated that the staff had been educated on the proper hand hygiene and the use of Personal Protective Equipment (PPE). They stated that they had placed a plastic sheeting wall between the washing and drying area. Interview with the ADON revealed that they did not have a specific policy and procedure related to soiled linen removal from the Quarantine unit. Review of the Centers for Disease Control and Prevention Key Strategies to Prepare for COVID-19 in Long-term Care Facilities (LTCF's) with a last review date 4/15/2020 revealed information in the following link: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html To prevent spread of COVID-19: Actions to take now: o Ensure all HCP wear a facemask or cloth face covering for source control while in the facility. Cloth face coverings are not considered personal protective equipment (PPE) because their capability to protect healthcare personnel (HCP) is unknown. Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required. If COVID-19 is identified in the facility, restrict all residents to their rooms and have HCP wear all recommended PPE for care of all residents (regardless of symptoms) on the affected unit (or facility-wide depending on the situation). This includes: an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown. HCP should be trained on PPE use including putting it on and taking it off. o This approach is recommended because of the high risk of unrecognized infection among residents. Recent experience suggests that a substantial proportion of residents could have COVID-19 without reporting symptoms or before symptoms develop. |

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