

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 105730	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2020
NAME OF PROVIDER OF SUPPLIER SPRING LAKE REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 1540 6TH ST NW WINTER HAVEN, FL 33881	
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	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, interviews, and record review, the facility failed to implement their infection prevention and control program to mitigate the spread of infection in the laundry room. The facility failed to ensure adherence to their infection control policy as evidenced by failure to ensure linens were handled appropriately, appropriate hand hygiene was completed after removing the PPE, clean resident care equipment was appropriately covered and stored, and one of two clean linen carts was stored in the clean area of the laundry room. Findings included: On 6/25/20 at 10:20 a.m., a tour was conducted in the laundry room with the housekeeping supervisor. There were five blue carts in the room, two small and three large. The three large blue carts were lined up against the wall and covered with blankets. Both washing machines were operating at the time. Both of the small blue carts were empty. One was located in front of a washer, and the other was lined up with the dirty carts against the wall. The supervisor reported the small carts were for removing clean linens from the washers. The smaller blue cart near the larger blue carts containing soiled linens was lined up against a wall with them. The supervisor agreed the clean linen cart should not be stored with the dirty linen carts. Photographic evidence was obtained. At 10:25 a.m. Staff A, laundry attendant, pushed a large gray linen cart that had just been delivered, to the back of the dirty wash room. She put on a gown and gloves (she was wearing a mask and glasses), and began sorting the soiled linens. One of the washers had finished running, so she went over still wearing the gown and gloves, opened the machine, and removed the clean linens from it. She placed them in the small blue cart that was located in front of it, still wearing the gloves and gown she had just used for sorting the soiled linens. Next Staff A, laundry attendant took the cart with the clean linens through a door to the clean side where the dryers were. She opened a dryer and placed the clean linens in it while still wearing the dirty gloves and gown. She pressed the setting on the dryer and started it. She left the small blue cart in the clean dryer room. She returned to the dirty wash room and went back to the soiled linens to sort them. At 10:30 a.m. in an interview with Staff A, laundry attendant, conducted through the housekeeping supervisor who interpreted, she confirmed she had put on the gown and gloves and sorted soiled laundry. She also confirmed she had removed clean laundry from the washer and transported it to the clean dryer room while still wearing the soiled gown and gloves. The housekeeping supervisor asked her to remove them. She disposed of the gown and gloves in a trash can near the sink. Then she walked over to where the gowns and gloves were located, removed a clean gown and began opening the packaging. The housekeeping supervisor confirmed Staff A, laundry attendant, had not performed hand hygiene or washed her hands after removing the contaminated gown and gloves. She instructed her to wash her hands in the sink. During the observation on 6/25/20, a large metal rack with shelves was noted against the wall opposite the soiled linen carts, near the washer. There was a basket on the top shelf with clean Hoyer slings in it. They were not covered. Next to them on the same shelf were some clean blankets sitting directly on the shelf. They were not covered. There were also two baskets on the second shelf containing clean mop heads and cleaning cloths. They were also not covered. Photographic evidence was obtained. At 10:35 a.m. in an interview with the housekeeping supervisor, she agreed the clean items should not be stored on the dirty side of the laundry room. She also reported that usually the clean carts for transporting clean linens from the washers to the dryers should be kept in the clean drying room. On 6/25/20 at 1:45 p.m. in an interview with the Infection Preventionist, she said the laundry attendant should have removed her gown and gloves and performed hand hygiene or washed her hands. The DON (Director of Nursing) who was also participating in the interview, said the clean laundry cart should be stored in a clean area in the clean dryer room. The NHA (Nursing Home Administrator) who was also present, said they already removed the bins with the clean Hoyer slings, mop heads, and cleaning cloths. He said No, that's not where they should be stored. Review of the policy, Department Guidelines-Laundry-Handling of Linen, dated 2013, reflected the following: Overview The facility strives to reduce the risk of infection to the resident and employees. Linens will be handled as little as possible and with minimal agitation to prevent gross microbial contamination of the air and person handling the linen. All soiled linen will be bagged and/or placed in containers at the location where it is used. Linen heavily contaminated with blood or bodily fluids will be bagged and transported in a manner that will prevent leakage. Sorting of linen is restricted to the laundry area. Linen will not be sorted or rinsed in the resident room. Standard precautions will be followed when handling soiled linens. Refer to the Standard Precautions procedures. Personal protective equipment (PPE) will be worn when handling linen contaminated with blood or other potentially infectious body fluids. Linen may be washed using a detergent and hot water washing, or utilizing low temperature washing when chemicals used are suitable for low-temperature washing and at the proper concentration. Procedure 1. Wash hands after handling soiled linen and prior to handling clean linen, even when gloves are worn. Transportation of Clean Linen 3. Cover stored linen to protect from contamination until the linen is distributed for resident use.</p>		

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.