

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 105460	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2020
NAME OF PROVIDER OF SUPPLIER NORTH FLORIDA REHABILITATION AND SPECIALTY CARE		STREET ADDRESS, CITY, STATE, ZIP 6700 NW 10TH PLACE GAINESVILLE, FL 32605	
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 observation, interview, and record review, the facility failed to prevent the possible spread of infection by not performing hand hygiene, handling clean laundry in a manner that prevents potential cross contamination, and failing to keep the clean linen area in a sanitary and organized manner. This has the possibility of affecting the total population of 100 residents. Findings include: A review of the facility policy from the Environmental Services Operations Manual, Healthcare Services Group, Inc., revised 6/2016 reads 2. Transmission Based Precautions - Hand Hygiene. Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: after handling soiled or used linen, after handling soiled equipment or utensils, after removing gloves or aprons. An observation of the clean side of the laundry room was conducted on 10/18/20 at 9:40 AM. Staff A, Housekeeper was present and folding clean linen. She was observed folding sheets, pulling the sheet across her body, folding, then pulling the sheet across her body again to refold the sheet again. She was observed to use her body to fold the sheet into a small square then put the linen on the cart to go to the nursing floor. She repeated this process several more times. Staff A was then observed pulling clean laundry from out of a dryer into a bin. This laundry was observed to be pulled toward her body, coming into contact with her housekeeping uniform. An interview was conducted with Staff A, Housekeeper on 10/18/20 at 9:50 AM. She stated she just came into laundry to help get linen out to the floor because no one was in laundry yet. When asked if she was supposed to wear one of the gowns hanging next to the dryer over her housekeeping uniform while she was handling linen, she stated she didn't usually work in the laundry, she was just trying to help. An observation on 10/18/20 at 9:52 AM of the clean side of the laundry room showed it was cluttered. The folding table had a cardboard box on it, with a pile of clothes on top of that. There was an additional area covered with personal clothing that was not folded. An observation on 10/19/20 at 9:18 AM of the clean side of the laundry room was conducted. Staff B, Housekeeper was observed wearing gloves and a yellow gown over his clothes. He was folding large pieces of linen. He was observed to hold the linen under his chin while folding the linen into smaller squares. The folding table continued to have a cardboard box on it, covered with clothing, clothing on the table between the wall and the box, leaving a small area on the table to use for folding. Staff B stated the clothing was clean personal laundry for residents. Staff B was then observed to remove his gloves, he threw the soiled gloves on the floor in the corner of the room where other debris was observed which included other soiled gloves and lint. An interview was conducted with the Account Manager on 10/20/20 at 7:05 AM. She confirmed it was the policy of this facility to wear the yellow gown over the staff's uniform when handling clean laundry. She confirmed that garbage should not be thrown on the floor. She stated there is a receptacle for garbage that should be used, and the lint is supposed to be cleaned up using the shop vac.</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.