STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105640	A. BUILDING _____ B. WING _____	**10/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTH LAKE CARE CENTER	**750 BAYBERRY DRIVE LAKE PARK, FL 33403**

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 observation, interview, review of infection control surveillance records and Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to promptly test and initiate Transmission Based Precautions (TBP) for 2 of 2 symptomatic residents while awaiting COVID-19 testing results (Residents #29 and #2); and failed to change gloves and perform hand hygiene after personal care for 1 of 1 sampled residents observed during care (Resident #35). The findings included: 1. The Director of Nursing (DON) was asked to provide their Infection Control Surveillance line list for the month of September 2020. a) Review of the facility's Outbreak Surveillance Line List, dated Friday 09/11/20, documented Resident #29 had new onset cough and congestion. The next line list, dated Monday 09/14/20, documented for Resident #29, results indeterminate; resident to be retested with rapid COVID-19 test. The next line list, dated 09/15/20, documented for Resident #29, COVID-19 test results: Negative. A progress note, dated 09/15/20 by the DON, documented the same information as the line list. This note lacked any evidence of the initiation of Transmission Based Precautions (TBP) for Resident #29 with the onset of signs and symptoms consistent with the COVID-19 virus on 09/11/20 until the completed test was obtained on 09/15/20. Review of the orders lacked any documented droplet precautions for Resident #29. Resident #29 had a roommate during that time. During an interview on 10/01/20 at 11:11 AM, the DON stated if a resident was placed on droplet precautions there would be an order. There was no documented evidence the resident was placed on any precautions when the resident was exhibiting signs and symptoms on 09/11/20. b) A progress note dated 09/30/20 documented Resident #2 had audible congestion. On 09/30/20, Resident #2 had stated to the surveyor that he had a new cough; and when asked, the DON stated Resident #2 had a little cough. The DON provided the results of the rapid COVID-19 test for Resident #2 which was completed on 10/01/20 at 2:39 PM. This result was negative. As per observations by the surveyor and confirmation by the DON, the facility did not place Resident #2 on any type of precautions with the development of symptoms on 09/30/20 until the completion of the test on 10/01/20. Resident #2 had a roommate during that time. There was no documented evidence the resident was placed on any precautions. Surveyor observation lacked evidence that there was TBP implemented. The documentation lacked evidence that a rapid test was conducted until 24 hours after the signs and symptoms were exhibited (10/01/20). Current CDC guidelines documented, Preparing for COVID-19 in Nursing Homes, Updated June 25, 2020. Evaluate and Manage Residents with Symptoms of COVID-19. Ask residents to report if they feel feverish or have symptoms consistent with COVID-19. . If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions as described below. . People with COVID-19 have had a wide range of symptoms reported - ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to [MEDICAL CONDITION]. People with these symptoms may have COVID-19: Fever or chills; Cough; Shortness of breath or difficulty breathing; Fatigue; Muscle or body aches; Headache; New loss of taste or smell; Sore throat; Congestion or runny nose Nausea or vomiting; Diarrhea. If COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community, follow the Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. This guidance should be implemented immediately once COVID-19 is suspected: Residents with suspected COVID-19 should be prioritized for testing. Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom. . Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown. 2. During a confidential interview on 09/28/20 at 12:56 PM, a resident stated concerns that Staff F, a Certified Nursing Assistant (CNA), would provide personal care while wearing gloves, then continue to do other things in the room without changing those used gloves. The resident also voiced Staff F would take care of the roommate wearing the same gloves and would not change the gloves before caring for him/her. A random observation of Staff F was made on 09/30/20 at approximately 4:45 PM. The CNA had just given a shower to Resident #35, and they had returned to the resident's room. The CNA transferred the resident to the bed, then washed her hands and donned new gloves. The CNA then applied barrier cream to the resident's private areas (both front and back), applied the adult brief, then left her now contaminated gloves on, to cover the resident with the sheet, obtained a wedge to position her, move some of the resident's personal items, and continued work around the resident's room. During an interview on 09/30/20 at 5:03 PM, Staff F agreed with the observation and stated she needed to remove her gloves and perform hand hygiene after potential contamination. 3. Wound care was observed for Resident #19 on 09/30/20 at 1:00 PM with Staff X, a licensed practical nurse (LPN) and the unit manager (UM). Staff X was observed grabbing gloves out of box, located on the wall, in close contact of a privacy curtain. The gloves were observed touching the privacy curtain each time Staff X changed gloves during the wound care. Staff X was observed using her gloved finger to place Santyl ointment (debridement ointment) from a medicine cup on Resident #19's pressure ulcer on his right ankle. Post wound care, an interview was conducted with Staff X and the UM. They acknowledged the gloves used by Staff X were contaminated when removed from the box on the wall. They further acknowledged the medication (Santyl) applied to Resident #19's ankle with Staff X's gloved finger was contaminated. Staff X stated she knew when she did it but did not know what to do. Record review revealed Resident #19 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A comprehensive assessment dated [DATE] documented Resident #19 was moderately cognitive impaired and had 4 unstageable pressure ulcers acquired at the facility.
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility's Outbreak Surveillance Line Lists, interview, and current Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to follow infection control and prevention standards during COVID-19 testing for 1 of 2 staff observed (Staff H); and failed to implement prompt COVID-19 testing of all residents after the identification of a positive dietary staff (Staff G), in order to quickly identify any new cases of the [MEDICAL CONDITION] infection [DIAGNOSES REDACTED]-CoV-2. The findings included: 1. On 09/29/20 at 11:30 AM, the surveyor walked into an observation in the front lobby area and noted the Receptionist preparing to complete a COVID-19 self-test for Staff H, a Certified Nursing Assistant (CNA), utilizing the Curative remove the Brand name Laboratory test kit. The Receptionist, who had donned only a surgical mask for Personal Protective Equipment (PPE), was at her desk providing instructions to Staff H, who was standing directly in front of the Receptionist at the same desk, within 6 feet of each other. Upon surveyor arrival, At that time the Director of Nursing (DON) intervened and had instructed both the receptionist and CNA to don a pair of gloves. The Receptionist asked the CNA to go outside to cough. The CNA went outside, coughed into her mask while putting her right hand instinctively in front of the mask. The CNA then opened the front door with her right hand and came back into the building to the Receptionist's desk. Any hand hygiene? The testing kit had been placed on the Receptionist's desk, with no protective barrier in place. The CNA swabbed her mouth as per the Receptionist's instruction, standing at the desk. The CNA placed the swab with the sample in the tube. The Receptionist took the sample and placed it in the plastic bag to return to Curative. A second staff testing observation was done on 09/29/20 at 11:38 AM with the DON observing and

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105640	A. BUILDING _____ B. WING _____	**10/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTH LAKE CARE CENTER	**750 BAYBERRY DRIVE LAKE PARK, FL 33403**

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 0886 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) instructing the Division 2 Unit Manager with the Curative COVID-19 test. This process was done in the vestibule area between Division 2 and Division 3. During an interview on 09/29/20 at 3:38 PM, the Division 2 Unit Manager was asked where the staff COVID-19 testing was usually completed. The Unit Manager stated, I don't know why we did it back there (pointing to the vestibule between Division 2 and 3). I think for privacy; I think she did that so you all (referring to the surveyors) would have some privacy. We usually do it (the COVID-19 testing) in the room up front by the administrator's office but there was someone in there today. The Unit Manager was asked to provide the COVID-19 testing procedure used by the facility. During an interview on 10/01/20 at 11:07 AM, the Regional Clinical Manager stated they follow CDC guidelines for the COVID-19 testing process. Review of the current CDC guidelines at Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for COVID-19, Updated July 8, 2020 documented, Collecting and Handling Specimens Safely: For providers collecting specimens or within 6 feet of patients suspected to be infected with [DIAGNOSES REDACTED]-CoV-2, maintain proper infection control and use recommended personal protective equipment (PPE), which includes an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown, when collecting specimens. For providers who are handling specimens but are not directly involved in collection (e.g. self-collection) and not working within 6 feet of the patient, follow Standard Precautions. . PPE use can be minimized through patient self-collection while the healthcare provider maintains at least 6 feet of separation. 2. Review of the facility's Outbreak Surveillance Line list for 09/25/20 documented Staff G, a dietary staff member, was added to the list (indicating she had a COVID-19 positive test result) with no signs or symptoms. Review of the Curative Labs final Results Report documented the COVID-19 test was collected on 09/22/20 at 1:50 PM, received by the laboratory on 09/24/20 at 10:15 AM, with the positive result released to the facility on [DATE] at 5:22 PM. During an interview on 09/30/20 at 1:12 PM, the Director of Nursing (DON) volunteered that all residents were last tested in May or June of 2020. During an interview on 10/01/20 (six days after the identification of the dietary staff members positive COVID-19 status) at approximately 11:40 AM, the DON confirmed the recent positive COVID-19 test result of the dietary staff. When asked what their next testing step was related to the positive staff member, the DON stated, We have seven days to test all the residents. The DON confirmed they had not completed COVID-19 testing of all residents since the 09/25/20 notification of the positive HCP (healthcare professional). The DON was made aware of the current CDC guidance to promptly test all residents in response to an outbreak, which CDC considers a new [DIAGNOSES REDACTED]-CoV-2 infection in any healthcare professional or resident, followed by repeat testing every 3 to 7 days, until no new cases for a period of at least 14 days. Review of the current CDC guidance documented, Testing Guidelines for Nursing Homes: Interim [DIAGNOSES REDACTED]-CoV-2 Testing Guidelines for Nursing Home Residents and Healthcare Personnel, Updated July 21, 2020. Non-diagnostic testing of asymptomatic residents without known or suspected exposure to an individual infected with [DIAGNOSES REDACTED]-CoV-2 (apart from the initial testing referenced above) After initially performing [MEDICAL CONDITION] testing of all residents in response to an outbreak, CDC recommends repeat testing to ensure there are no new infections among residents and HCP and that transmission has been terminated as described below. Repeat testing should be coordinated with the local, territorial, or state health department. Continue repeat [MEDICAL CONDITION] testing of all previously negative residents, generally every 3 days to 7 days, until the testing identifies no new cases of [DIAGNOSES REDACTED]-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result. This follow-up [MEDICAL CONDITION] testing can assist in the clinical management of infected residents and in the implementation of infection control interventions to prevent [DIAGNOSES REDACTED]-CoV-2 transmission. Additional CDC guidance documented, Testing asymptomatic residents with known or suspected exposure to an individual infected with [DIAGNOSES REDACTED]-CoV-2, including close and expanded contacts (e.g., there is an outbreak in the facility). Perform expanded [MEDICAL CONDITION] testing of all residents in the nursing home if there is an outbreak in the facility (i.e., a new [DIAGNOSES REDACTED]-CoV-2 infection in any HCP or any nursing home-onset [DIAGNOSES REDACTED]-CoV-2 infection in a resident). A single new case of [DIAGNOSES REDACTED]-CoV-2 infection in any HCP or a nursing home-onset [DIAGNOSES REDACTED]-CoV-2 infection in a resident should be considered an outbreak. When one case is detected in a nursing home, there are often other residents and HCP who are infected with [DIAGNOSES REDACTED]-CoV-2 who can continue to spread the infection, even if they are asymptomatic. Performing [MEDICAL CONDITION] testing of all residents as soon as there is a new confirmed case in the facility will identify infected residents quickly, in order to assist in their clinical management and allow rapid implementation of IPC interventions (e.g., isolation, cohorting, use of personal protective equipment) to prevent [DIAGNOSES REDACTED]-CoV-2 transmission.