STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105680	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NSPIRE HEALTHCARE LAUDERHILL	2599 NW 55TH AVE LAUDERHILL, FL 33313

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0732 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Post nurse staffing information every day.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure nurse staffing information was posted at 1 of 2 nursing units, the North Wing, as evidenced by the daily staffing was not posted for review. The findings included: On 04/28/20 at approximately 2:30 PM, the North Wing, which comprises rooms [ROOM NUMBERS], the white staffing assignment board across from the nursing station was observed to have a census posted of 40. One nurse name was listed and no Certified Nursing Assistant (CNA) names were listed. An interview was conducted with Licensed Practical Nurse (LPN) Staff 'G' at this time and an inquiry made what the North Wing census was today. Staff 'G' stated she was not sure; however, would find out. Staff 'G' verified the nurses name listed on the board was her. She retrieved the daily resident census and started counting out the number of residents listed. She stated she would be right back. She then proceeded to the 300s hall and was verifying what was listed on the daily census to what resident was in the rooms. She returned a couple of minutes later and stated there are 18 residents on the 300s hall and there are 2 CNAs assigned to the 18 residents. An inquiry was made to Staff 'G' what time her shift started today and she stated she arrived at 9:00 AM. Staff 'G' could not explain why she did not know how many residents were residing on the North Wing. A further inquiry was made to Staff 'G' of how many residents were on the 400s hall. Taking the resident daily census, she entered the 400s hall and stated she will be right back. A couple of minutes later, she returned and stated there are 17 residents on the 400s hall and there are 2 CNAs assigned to the 17 residents. Staff 'G' confirmed there are 35 residents on the North Wing and not 40 as listed on the white staffing assignment board. Staff 'G' could not explain why the white staffing assignment board had not been updated to reflect the names of the staff that are working on this day shift and what resident assignments they are responsible for.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and review of Centers for Disease Control and Prevention (CDC) and Florida Department of Health (FL DOH) Novel Coronavirus-19 (COVID-19) infection prevention guidance, the facility failed to ensure they followed recommended infection control practices in attempt to ensure the health and safety of all their residents, when confirmed cases of the COVID-19 virus were identified in the facility, putting all residents in the facility at risk for the potential to contract or transmit the COVID-19 virus by not isolating residents to their rooms per CDC (Center for Disease Control) and FL DOH (Florida Department of Health) guidance. The facility census on 04/24/20 was 97. This deficient practice currently affected 18 of the 97 residents: On the 300 unit, Resident #10's, #1's, and #8's roommate, and Resident #2; On the 400 unit, Resident #7's, #4's, #3's and #9's roommate; On the 100 unit, 2 randomly observed residents in the hallway, and Resident #7's roommate; and the 200 unit, 7 residents observed in wheelchairs in the hallway. The findings included: Review of the Assessment of Long-Term Care Facility Guidance available from the Florida Department of Health on 04/01/20 documents in part, 'The DOH has provided the following clarification regarding Long Term Care facilities: In Counties where there is community spread - In facilities located where there is known COVID-19 community spread the county health departments may direct additional isolation measures. At this time Broward County is requiring residents be isolated in their rooms with the door closed. If residents come out of their rooms for any reason, they should be wearing a mask if available. All activities and dining in common areas are suspended. This is in addition to all other infection control procedures that have been communicated through AHCA (Agency for Health Care Administration - State licensing and regulatory agency), FL DOH, CDC and CMS.' Review of an email communiqu from AHCA forwarded to all long term care facility providers in the state of Florida dated April 6, 2020 and titled 'April 6 Update: Consolidation of Conference Calls for Nursing Homes and Health/Regulatory Partners', notifies long term care facility providers (informational) conference calls with an email link to the CDC infection control guidance site. Review of the CDC guidance for Nursing Home providers documents under Things Facilities Should Do Now 'Cancel communal dining and all group activities, such as internal and external activities. Remind residents to practice social distancing and perform frequent hand hygiene. Have residents wear a cloth face covering or facemask whenever they leave their room, including for procedures outside of the facility. Healthcare Personnel (HCP) Monitoring and Restrictions: Because of the higher risk of unrecognized infection among residents, universal use of all recommended PPE (personal protective equipment) for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP is identified in the facility. Resident Monitoring and Restrictions: Encourage residents to remain in their room. If there are cases in the facility, restrict residents (to the extent possible) to their rooms except for medically necessary purposes. If they leave their room, they should wear a cloth face covering or facemask, perform hand hygiene, limit their movement in the facility, and perform social distancing (stay at least 6 feet away from others). On 04/24/20 at 11:00 AM, an interview was conducted with the Administrator who confirmed they had several residents who have tested positive for the COVID-19 virus. Referring to a tracking form, it was noted 6 residents tested positive on the 300s unit and 1 resident tested positive on the 400s unit. The Administrator further stated the Director of Nursing (DON) has been out of the facility since 04/16/20 due to (reason), however is available by phone. An inquiry was made to the Administrator since the DON was not on site, who was in charge of nursing services, to which he stated he was not sure who was overseeing nursing services during the DON's absence. On 04/24/20 at 11:15 AM, a tour of the facility was commenced starting on the 300s unit, where 6 of the 7 positive residents resided. One of the 7 residents, Resident #10, remained a resident in the facility. The census on the 300s unit was 22. Residents were observed freely moving up and down the hallway in wheelchairs and ambulatory. There was no direction observed by staff to redirect the residents into their rooms. Resident #10 in room [ROOM NUMBER] was observed in her room. Resident #10 tested positive for [MEDICAL CONDITION] on 04/23/20. There was no isolation notification sign on the door and there was no PPE (personal protective equipment) cart outside of the room for staff to use when entering a room with a confirmed positive result. room [ROOM NUMBER], where Resident #2 resided and tested positive on 04/22/20, was observed to be empty. An inquiry was made to activity aide Staff 'A' where the roommate of Resident #2 was to which she pointed to a resident seated in a wheelchair in the hallway. Staff 'A' stated the resident tries to get up by herself so she placed her in the hall to keep an eye on her. An inquiry was made to Staff 'A' if she was aware the resident's roommate tested positive for [MEDICAL CONDITION] to which she stated she was aware Resident #2 was positive and was transferred out of the facility. room [ROOM NUMBER], where Resident #1 tested positive on 04/21/20 and was transferred to the hospital, was observed with Resident #1's roommate in the room in bed. There was a sign on the door that read 'Stop Put on PPE'. There was no PPE cart outside of room [ROOM NUMBER], but across the hall in front of room [ROOM NUMBER]. room [ROOM NUMBER], where Resident #8 tested positive on 04/22/20 and transferred to the hospital, was observed with Resident #8's roommate in the room. There was no isolation precaution sign on the door and no PPE cart available outside of the room. A housekeeper, Staff 'B' was observed exiting the room with a mop and without wearing a gown. An inquiry was made if she was aware Resident #8 has tested positive for [MEDICAL CONDITION] and the roommate should be under strict isolation at this time as a precaution, to which she looked surprised and stated she was not aware of this. Staff 'B' stated she does not

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) usually work this unit and is filling in today and nobody told her there were residents who tested positive for [MEDICAL CONDITION] on this unit. At 11:40 AM, the Administrator arrived to the 300s unit. He was advised that since they have confirmed cases of [MEDICAL CONDITION] in the building every attempt should be made to isolate the residents in their rooms. The Administrator stated they 'fumigated' the entire building yesterday so everything is clean. The Administrator was apprised the environment may be clean, however every precaution should be made with resident to resident contact as residents are [MEDICAL CONDITION] carriers, and the roommates of the confirmed positive cases may have contracted [MEDICAL CONDITION]. The Administrator had no comment. At no point during the tour on the 300s unit were any staff members observed to be attempting to redirect the residents back to their rooms. At 11:45 AM, a tour of the 400s unit was commenced where one resident was confirmed positive for the COVID-19 virus and 2 additional resident test results were pending. The census on the 400s unit was 19. room [ROOM NUMBER], where Resident #4 tested positive on 04/22/20 and transferred to another facility, was observed with Resident #4's roommate in the room sitting up in a wheelchair. There was a sign on the door that read 'Stop Put on PPE'. There was no PPE cart available outside of the room for staff to use upon entering the room. room [ROOM NUMBER] was where Resident #3 had resided and was transferred to another facility on 04/22/20. Resident #3's test results were pending. Resident #3's roommate was observed in the room in bed. There was a sign on the door that read 'Stop Put on PPE'. The PPE cart outside of the room only had gloves available. room [ROOM NUMBER] is where Resident #9 resided and tested positive on 04/23/20 and was transferred to the hospital. Resident #9's roommate was observed in the room in bed. There was no isolation sign on the door and no PPE cart available outside of the room. At 11:55 AM, observation was made of a Physical Therapist Staff 'C' exiting room [ROOM NUMBER] with a rolling therapy machine. An inquiry was made what kind of PPE she uses with direct contact with residents, considering there has been a positive resident on this unit and 2 more pending results to which she stated she wears a mask and gloves. She stated she only wears a gown for the residents who are positive. An inquiry was made which residents have tested positive and who their roommates might be, to which she stated that would be a nursing question. At 11:57 AM, an interview was conducted with a Certified Nursing Assistant (CNA) Staff 'D' who was standing outside of room [ROOM NUMBER]. An inquiry was made what the sign on the door 'Stop Put on PPE' meant to which she stated she was not sure, further stating they did not give me any information on that. The CNA stated she knows the resident's roommate went to the hospital and has not returned yet. At no point during the tour on the 400s unit were any staff members observed to be attempting to redirect the residents back to their rooms. At 11:58 AM, a tour of the 100s unit commenced. Two (2) random residents were observed wheeling themselves down the hallway, one touching the others wheelchair back. Residents were observed wandering ambulatory down the halls. Two (2) nursing staff were observed at the nursing station and making no efforts to redirect the residents back to their rooms. Resident #7 who resided in room [ROOM NUMBER] was transferred out to the hospital on [DATE] and was tested for [MEDICAL CONDITION]. Her results were pending. Resident #7s roommate was not observed in the room. An inquiry was made to Registered Nurse (RN) Staff 'F' where Resident #7s roommate was to which she stated her roommate was transferred to room [ROOM NUMBER] because Resident #7 was transferred to the hospital with flu symptoms and they are cleaning the room. Staff 'F' acknowledged that Resident #7's roommate was at risk for contracting [MEDICAL CONDITION] and precautions should be taken when entering the room. Resident #7s roommate was observed in room [ROOM NUMBER], residing by herself. There was no isolation precaution sign on the door and no PPE cart available outside of the room. At 12:00 PM, the 200s unit was observed. Seven (7) random residents were observed in wheelchairs sitting in a row down the hall, without a 6- foot spacial distance between them. An interview was conducted with CNA Staff 'E' and an inquiry made why these residents were sitting in the hall and not in their rooms. Staff 'E' stated she thinks it is because housekeeping was cleaning the rooms. An inquiry was made if there are any restrictions for resident movement throughout the facility since they have confirmed positive cases of [MEDICAL CONDITION] in the facility to which she stated she was not aware of any new rules. At no point during the tour on the 400s unit were any staff members observed to be attempting to place or redirect residents back to their rooms. At 12:15 PM, a further interview was conducted with RN Staff 'F' and an inquiry made if the DON is not on site, who is in charge of nursing services at this time. Staff 'F' stated she really was not sure, further stating maybe it is the unit managers. At 12:30 PM, an interview was conducted with the corporate Vice President (VP) of Clinical Services. The VP of Clinical Services observed the facility residents wandering the halls on their respective units. She was apprised the residents are required to be in their rooms as there are confirmed positive COVID-19 cases in the building and PPE was not available for those residents and resident rooms affected or potentially affected. She stated it is difficult to keep the dementia residents in their rooms and they cannot put out PPE as the residents will touch it and carry it off. The corporate VP of Clinical Services was re-apprised, the residents should not be in the halls therefore would not be able to touch the PPE and the PPE would then be readily available to staff. She stated possibly they may have to bring more staff on board to assist. An inquiry was made who was in charge of nursing services while the DON is not on site to which she stated she has been in contact with the facility remotely via telephone since 04/16/20. She stated she appointed 2 Unit Manager RNs to cover the facility during the DONs absence. The corporate VP of Clinical Services was apprised of the observations and interviews conducted on all the units. She stated when she learned of the first positive case on 04/21/20, she sent an email correspondence to the facility Administrator, DON, 2 Unit Manager RNs now in charge and additional key facility staff. She stated there was a 20 point list of actions to be taken immediately in an attempt to mitigate the situation. She stated the staff should have been implementing the 20 steps she outlined. A request was made to review the email. Review of the email dated 04/22/20 at 3:09 PM that the corporate VP of Clinical Services sent to the facility Administrator and the 2 Unit Managers in charge who were onsite in the facility was a 20 point list of actions stating 'Please put in place the following immediately: Place on isolation now the following residents: room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER]. Provide N95 masks, gowns, goggles to the CNA and Nurse providing care for room [ROOM NUMBER], 410, 405 and 411.' During the tour of the 300s unit, room [ROOM NUMBER] was not denoted as an isolation room. The resident was not isolated to her room, but was observed seated in the hallway in her wheelchair in contact with other residents and staff. During the tour of the 400s unit, rooms 405, 410 and 411 were observed to have a sign on the door stating Stop Put on PPE. All 3 rooms did not have PPE available for use outside of their rooms. The directives set forth by the corporate VP of Clinical Services, via the email sent out on 04/22/20, were not followed or enforced by the Administrator or the 2 RNs assigned in charge during the DON's absence. On 04/28/20 at 12:15 PM, an additional onsite infection control visit to the facility was conducted. The facility Administrator was met with briefly as he was exiting the building, and an inquiry was made how is everything going, to which he stated 'Everything is good.' Upon entering the facility, a medical response team from the Florida Department of Health consisting of 6 members was observed communicating with the corporate VP of Clinical Services. Once done, an interview was conducted with the corporate VP of Clinical Services who confirmed they now have 11 residents with confirmed positive COVID-19; and 13 additional residents had been tested with their results pending. Further, on 04/24/20, there was 1 staff member positive with [MEDICAL CONDITION]; and as of 04/28/20, there are 11 confirmed positive staff members with COVID-19 and an additional 7 staff had been tested with their results pending. The corporate VP of Clinical Services stated all confirmed positive staff worked on the 300s unit. On 04/28/20 at 2:20 PM, a tour of the 300s unit was conducted. Two (2) random female residents were observed seated in the hall, one in a wheelchair and one seated in a chair, who intermittently was observed to get up walk around a few steps then sit back down. One of the female residents was noted to be the roommate of the resident in room [ROOM NUMBER] who tested positive for [MEDICAL CONDITION] (Resident #2). This female resident was observed to have her mask around her chin, or taking it off altogether. The second female resident was observed to have her mask on and then would pull it down, then pull it back up. Staff were not observed to encourage the residents to keep their masks over their mouths and nose. An attempt was made to converse with the residents, however they were not interviewable. room [ROOM NUMBER] was observed to not have an isolation precaution sign on the door and no PPE available outside of the room. An interview was conducted with activity aide Staff 'A' and an inquiry was made why there was no isolation precaution sign on room [ROOM NUMBER], as the one resident in that room was sent out to the hospital with a confirmed positive test and the roommate remained seated in the hallway and she may have been exposed to [MEDICAL CONDITION] by her roommate. Activity aide Staff 'A' stated 'We do not have anyone under isolation on this unit right now.' On 04/28/20 at 2:25 PM, CNA Staff 'D' was observed wheeling a resident in a wheelchair through the double doors into the 300s unit. The resident was observed to have his mask below his nose. CNA Staff 'D' was asked where this resident was coming from to which she stated she took him to the front window so he could wave to his family. CNA Staff 'D' was informed the resident needs to keep his mask over his mouth and nose. She immediately pulled the mask up over the resident's nose and carried on. She was not observed to perform hand hygiene after coming in direct contact with the resident's mask. On 04/28/20 at approximately 2:35 PM, a tour of the

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) 200s unit was conducted accompanied by a representative from the facility's sister facility. Many residents were observed seated in the hallway in wheelchairs and not wearing masks. One resident was observed placed in the hallway in a geri chair recliner without a mask on. A nurse passing by stated they park him in the hallway because he attempts to get up and is a fall risk. room [ROOM NUMBER] was observed to have an isolation precaution sign on the door. There was no PPE cart available for staff use and no red biohazard container to dispose of used PPE. A PPE cart was observed a couple rooms down, however did not house any gloves, gowns or masks. room [ROOM NUMBER] was observed to be empty, and had not been cleaned from being used as an isolation room from a resident sent out to the hospital on [DATE] who tested positive for COVID-19. An interview was attempted to be conducted with a housekeeper a couple of rooms down, however there was a language barrier and she was not understanding the questions. A request was made to speak with her manager. On 04/28/20 at approximately 2:40 PM, an interview was conducted with the Director of Housekeeping who stated he had in-services with the housekeepers this morning on cleaning isolation rooms and use of PPE. He stated he will address the cleaning of room [ROOM NUMBER]. On 04/28/20 at approximately 2:45 PM, a tour of the 100s unit was conducted. Six (6) residents were seated in wheelchairs in the hallway, some wearing a mask, some not. A PPE cart was observed in the hallway however there were no gloves, gowns or masks available for staff use. An interview was conducted with the Director of Housekeeping at this time and he stated he will ensure the PPE carts are filled with supplies and he will ensure to provide red biohazard containers to dispose of the used PPE. On 04/28/20 at approximately 4:30 PM, the additional findings of the observations conducted on the 100s, 200s, 300s and 400s units were relayed to the corporate VP of Clinical Services. The corporate VP of Clinical Services acknowledged the findings and stated they will work on correcting the issues and continue to educate the staff on isolation practices for transmission based precautions. The Administrator was not available for interview or to apprise of the additional findings throughout the survey.