STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105202	A. BUILDING _____ B. WING _____	**05/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APOLLO HEALTH AND REHABILITATION CENTER	**1000 24TH ST N SAINT PETERSBURG, FL 33713**

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** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, policy review, and review of the Center for Disease Control and Prevention guidelines, the facility did not maintain an infection prevention and control program related to not properly maintaining and implementing best practices for COVID-19 as evidence by: 1. a screening device (pulse oximeter) used for staff and persons from outside services was not cleaned and disinfected following the recommended disinfectant contact time, 2. Staff not washing hands after leaving a resident care area, 3. Staff not following posted droplet precautions by not donning required personal protective equipment (PPE) for two residents (#6 and #7) of four [MEDICAL TREATMENT] residents on isolation for droplet precautions, 4. not providing dedicated resident equipment on droplet precautions and not cleaning a reusable blood pressure device by its recommended contact time and not properly storing a utilized N95 mask appropriately, 5. not donning required PPE to assist two residents (#4 and #5) on droplet precautions, 6. not maintaining tubing for an indwelling catheter and the drainage bag off the floor to potentiate cross contamination for one resident (#12) of 14 residents with indwelling catheters, and 7. not having appropriate PPE readily accessible in the isolation caddies for three of three resident rooms (room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]) indicated as droplet precautions. Findings included: 1. On 5/14/20 at 9:15 a.m. the survey team entered the facility as Staff A, Transportation Coordinator/Certified Nursing Assistant (CNA), donned in gloves and a face mask, stood at the entrance telling the surveyors to use the hand sanitizer. She picked up a [MEDICATION NAME] thermometer and finger pulse oximeter that lay on top of a white foam tray. The temperature was taken followed by the pulse oximeter. After the temperature and oximeter were used, she placed them directly on top of the receptionist desktop without cleaning the equipment. Staff A then completed the questioning process. She was asked at that time if she was the designated person that performed the screening. She said that she was the Transportation Coordinator and was only filling in until the receptionist arrived. At 9:18 a.m. Staff A was observed as she donned a pair of gloves. She removed one bleach wipe from a container and cleaned the oximeter and the thermometer for a total of three seconds. She then removed the gloves and used hand sanitizer. At 9:20 a.m. an outside vendor was allowed to enter the front entrance. He was observed wearing cloth utility gloves on both hands. While he waited at the receptionist desk, he donned a pair of purple gloves over the top of his utility gloves. Staff A picked up the thermometer and the oximeter, that had just been cleaned for 3 seconds, telling the vendor he needed to take his glove off. He removed the glove from this left hand as she placed the oximeter to his first digit. She placed both the thermometer and the oximeter directly on the bare surface of the desktop. A cell phone began to ring as it was observed lying on top of the desk positioned next to the used oximeter. Staff A picked up the phone as the vendor donned his gloves and left the reception area. The equipment and desktop were not cleaned. A nurse was standing outside of the front entrance with her uniform that indicated she was from a hospice agency. Staff A placed her phone back on top of the receptionist desk and walked over to the front door and used her ungloved right hand to open the door. Staff A performed the same process with the thermometer, oximeter and questionnaire with the hospice nurse. Staff A performed the same cleaning process of a total of 3 seconds with the thermometer, oximeter. Staff A donned a pair of gloves and removed one bleach wipe from the container. She used the one wipe to clean two thermometers and two oximeters, for a total of 12 seconds. The phone was never cleaned, nor the surface of the desk where the thermometers and oximeters were set. The container of the bleach wipes contained disinfection directions for use that revealed: 2. wipe surface with wipe until completely wet. 3. To disinfect, allow surface to remain wet for contact time: Bacteria-30 seconds, Viruses - 1 minute and [MEDICAL CONDITIONS] spores- 3 minutes. Cleaning Procedure: cleaning is to include vigorous wiping and/or scrubbing, until all visible soil is removed. Special attention is needed for high-touch surfaces. Do not reuse soiled clothes. Contact time: allow surfaces to remain wet for 1 minutes, let air dry, for all other organisms, see directions for contact times. (Photographic evidence obtained) The Regional Nurse was asked on 5/14/20 at approximately 2:00 p.m. for the manufacturer's contact time for the bleach wipes that the facility had been utilizing during the screening process. She indicated that the facility does not have anyone with [MEDICAL CONDITIONS] so the three-minute wet time did not need to be used. She was informed that the one-minute contact time had also not been observed for viruses during the screening process upon entry to the facility. The Regional Nurse did not respond. 2. At 10:10 a.m. on 5/14/20 Staff C, Certified Nursing Assistant (CNA) was observed as she left Resident room [ROOM NUMBER] by closing the door behind her. She stood in the hallway and removed gloves to both hands. A linen cart was just outside of the room as she reached inside of cart, without [MEDICATION NAME] hand hygiene, and removed a washcloth. Staff C then returned to resident room [ROOM NUMBER] and knocked on the door. She opened the door and reached inside of the doorway and handed the washcloth to the resident. Staff C, CNA walked across the hall and used a hand sanitizer to her hands. 3. On 5/14/2020 at 10:35 a.m. Resident #6's & #7's room door was closed. The door was observed with an isolation caddy holding personal protective equipment and a sign indicating droplet precautions. Just then the room door was opened and Staff D, CNA exited the room holding two clear colored bags. One of the bags was observed with a yellow gown and the second bag contained resident personal clothing. She was asked as she entered the hallway where her face shield was. She stated, I was wearing one. She was asked where her face shield was again. She did not respond as she walked down the hallway. Staff D walked the length of the North hall to a set of double doors at the end of the unit and continued to another set of double doors that lead to the outside of the facility. Staff D, CNA was asked if she had to leave the facility to dispose of the garbage and residents' personal clothing daily. She stated, Yes, they moved our dirty linen room for oxygen. She then added, I forgot to wear a face shield in (Resident #6's and #7's) room, as she confirmed the isolation personal protective equipment (PPE) posted for their room (droplet precautions) included to wear a face shield upon entry. A review of the Order Listing Reports dated 5/14/20 and 5/15/20 revealed Residents #6 and #7 were on droplet precautions as of 5/3/20. The DON revealed that both residents receive outside [MEDICAL TREATMENT] services and all residents that receive outside services are put on droplet precautions. The DON identified a total of four residents (#6, #7, #10 and #11) that received outside [MEDICAL TREATMENT] services. Additionally, the facility provided a list that contained all of the four residents' names that revealed they had come in contact with the receptionist that was currently out of work after being tested positive for COVID-19. 4. At 10:50 a.m. 5/14/20, Staff G, Licensed Practical Nurse (LPN) was observed standing in Resident #8's room, as the resident was noted sitting on the edge of his bed facing the nurse. On top of the over the bed side table an electronic blood pressure machine with an attached cuff lay on its bare surface. Staff G, LPN removed her personal PPE equipment of gown and gloves, and exited the room carrying the electronic blood pressure machine. She placed the machine next to two blood glucose monitors that were sitting on the medication cart in the hall. Staff G, LPN returned to her medication cart after washing her hands for 3 seconds and opened up the right second drawer, which revealed a brown paper bag. She removed her N95 mask and placed it inside of the bag. Just at that time the Regional Nurse approached and was overheard telling Staff G, LPN you can't store the mask inside of the drawer. Medical record review was conducted for Resident #8 and the Admission Record indicated he had been a long-term care resident at the facility with a history [MEDICAL CONDITIONS] and [MEDICAL CONDITION]. A review of his physician orders [REDACTED]. Resident #9 was the roommate for

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) Resident #8 and his Admission Record was reviewed and revealed a readmission date of [DATE] and [DIAGNOSES REDACTED]. In review of his physician orders [REDACTED]. obstructive [MEDICAL CONDITION] disease with (acute) exacerbation started on 4/25/20. The breathing treatment was given by a small volume nebulizer machine. The Director of Nursing and the Regional Nurse on 5/14/20 had indicated that all residents that receive breathing treatments are put on droplet precautions and confirmed that face shields need to be utilized upon entrance to the resident rooms. Review of the CDC and the World Health Organization hand hygiene guidelines revealed: Standard Precautions Handwashing with Soap and Water: O Wet hands first with water (avoid using hot water) O Apply soap to hands O Rub hands vigorously for at least 15 seconds, covering all surfaces of hands and fingers O Rinse hands with water and dry thoroughly with paper towel O Use paper towel to turn off water faucet 2. Indications for Hand Hygiene Always perform hand hygiene in the following situations: O Before touching a patient, even if gloves will be worn O Before exiting the patient's care area after touching the patient or the patient's immediate environment O After contact with blood, body fluids or excretions, or wound dressings O Prior to performing an aseptic task (e.g., accessing a port, preparing an injection) O If hands will be moving from a contaminated-body site to a clean-body site during patient care O After glove removal CDC Guideline for Hand Hygiene in Health-Care Settings (available at: http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf) WHO Guidelines on Hand Hygiene in Healthcare 2009 (available at: http://whqlibdoc.who.int/publications/2009/ 906_eng.pdf) At 11:00 a.m. 5/14/20 the Regional Nurse was asked about bringing equipment into residents' rooms that are on droplet precautions. She indicated that the residents should have their own equipment, and if it were to be used it needed to be cleaned and disinfected prior to reuse. The Regional Nurse was asked about the blood pressure machine that still remained on the medication cart that had not been cleaned after it was in an isolation room. Staff G, LPN confirmed she had not cleaned it yet. At that time, she removed a single bleach wipe from the medication cart. She first cleaned the bottom of the machine by swiping it one time. Then the top of the machine was cleaned by one swipe. She then followed the same technique by the outside of the cuff and the inside of the cuff with one swipe. The bleach wipe instructions indicated a contact time of one minute for viruses and a three-minute contact time for [MEDICAL CONDITION]. Neither of the two contact times were observed. At 11:40 a.m. 5/14/20 Staff G, LPN was observed as she opened up and exited the room of Resident #4 & #5, which was located directly across from the conference room where the survey team was located. She immediately hung up a face shield on the door and left the area. The face shield was not cleaned after it was brought out into the hallway on the North hall, as the face shield surface was observed dry. This observation was told to the Nursing Home Administrator as she walked into the conference room, 5. At 11:44 a.m. the call light went on for Resident #4 & #5, who resided in a room identified for droplet precautions by the Stop. See Nurse, sign on the resident room door. A staff member was in the hallway and directed Staff A, CNA to answer the call light. Staff A, CNA was observed donning a gown, gloves and surgical mask prior to entering the residents' room. The room door remained open as she was speaking with the resident and assisting with an article on the opposite side of his bed. She removed her PPE at the doorway and exited the room. She was asked at that time why neither a face shield nor a N95 mask had been worn when she entered the room. She stated, Didn't know that room was COVID. Staff A, CNA was asked if there were bleach wipes in the room. She stated, no, they are not kept in bedrooms or in the hallways. If something needs to be cleaned, you need to go to the desk to get the wipes. A medical record review was conducted for Resident #4 and the Admission Record indicated he had been at the facility for two months. His primary [DIAGNOSES REDACTED]. Nursing Progress notes were reviewed and revealed: 5/9/20 at 9:34 p.m. (21:34): T (temperature) 100.8, c/o (complaint of) painful cough, 02 (oxygen) sat (saturation) 95% on room air, no abnormal lung sounds are auscultated. Resident denied discomfort. provided prn (as needed) med (medication) with positive result (t 100), informed MD (medical doctor), ordered lab, chest X-ray. Continue to monitor. 5/10/20 at 3:08 p.m. (15:08): informed . ARNP (Advanced Registered Nurse Practitioner) of cbc, cmp, (standard blood tests) and chest xray results and members temp.97.6 temporal at this time, having loose stools x 3 today and complains of [MEDICAL CONDITION] at night received new orders: [MEDICATION NAME] 500 mg po x 5 days, flu and [MEDICAL CONDITION] screen swab. Hold colase x 3 days. 5/10/20 at 10:01 p.m. (22:01): BP 90/60m hr 125/min (vitals), informed MD, ordered EKG, consult with cardiologist. 5/11/20 at 1:53 a.m. vitals note Temperature Warning: value: 100.0 5/11/20 at 3:25 p.m. (15:25): spoke with dr. . regarding EKG orders. Received orders to start resident on NS at 75ml/hr (milliliters per hour) x 2 liters, sputum specimen, [MEDICATION NAME] 2 gm (grams) q8hrs (daily) x 7 days, continue with [MEDICATION NAME] 500 mg po BID (500 milligrams by mouth two times per day) x 7 days and stop [MEDICATION NAME]. 5/12/20 at 2:51 a.m. vitals note: temperature 100.2. Physician orders [REDACTED].#4 was started on droplet precautions on 5/11/20. A medical record review was conducted for Resident #5 and the Admission Record indicated he was admitted to the facility on [DATE] with a primary [DIAGNOSES REDACTED]. A review of the Order Listing Report dated 5/14/20 revealed that Resident #5 was placed on droplet isolation - presumptive every shift 5/11/20 with a revision on 5/12/20. On 5/15/20 around 10:03 a.m. an interview was conducted with the Director of Nursing (DON) and he confirmed that residents #4 and #5 were tested for COVID-19 and the results remained pending as of today (5/15). He was then asked about the delay in starting droplet precautions for Resident #4. His medical record indicated a change in condition on 5/9/20. The DON stated, It was on a weekend. I usually look at all the new orders. Even on the weekend. That was one weekend I didn't look at the orders until Monday 5/11/2020. He confirmed that it was missed. 6. At 11:40 a.m. on 5/15/20, Resident #12 was observed from her doorway entrance lying in bed. Her catheter tubing along with the drainage bag was lying on the floor (photographic evidence obtained). At 1:10 p.m. on 5/15/20, Resident #12 was observed sitting up in a chair in her bedroom she was positioned toward the television screen. Her lunch tray was sitting in front of her as she smiled at the surveyor standing outside of her room door. Resident #12 appeared comfortable and when she was asked how she was feeling today. She stated, Better, after they finally got me out of bed. I don't like being in bed all the time. Resident #12's catheter tubing and bag laid on the floor next to the chair. Staff H, LPN was in the hallway and she was asked if normal practice was to have indwelling catheter tubing lie on the floor next to the catheter bag. She stated, No, it should not be on the floor. Resident #12's Admission Record indicated that she had been readmitted to the facility on [DATE] with primary [DIAGNOSES REDACTED]. A review of the Catheter-Associated Urinary Tract Infections (CAUTI) revealed: III. Proper Techniques for Urinary Catheter Maintenance Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. https://www.cdc.gov/infectioncontrol/guidelines/cauti/index.html#anchor_ . 7. An observation on 5/14/20 was conducted at 9:55 a.m. on the East hall. Resident room [ROOM NUMBER] had an isolation kit on the door with a sign showing, Stop, see nurse before entering. There were gloves, gowns, and surgical masks in the kit. On the North hall, Resident room [ROOM NUMBER] had an isolation kit with gowns, surgical masks, gloves, and a sign on the door indicating, Stop. Please see nurse before entering, and Resident room [ROOM NUMBER] had a sign indicating, Stop. Please see nurse before entering. There were gowns, surgical masks, gloves, and wipes in the isolation kit on the door. There were no goggles or face shields in any of the kits. On 5/14/20 at 11:31 a.m. an interview was conducted with the Clinical Educator. She said [MEDICAL TREATMENT] patients are all on isolation because they go in and out of the building. They are cohorted on the North wing. There are five. She reported they were located in rooms [ROOM NUMBER]. At 12:05 p.m. on 5/14/20 an interview was conducted with the DON. He said all the [MEDICAL TREATMENT] residents are on droplet precautions presumptively. At 2:26 p.m. on 5/14/20 an interview was conducted with the DON. He said they check the isolation kits several times a day to ensure they are stocked and that whatever is listed on the signs should be in the caddy. An additional observation on 5/15/20 at 9:13 a.m. of the sign on the door for Resident room [ROOM NUMBER] indicated Stop see nurse before entering. The sign was green indicting droplet precautions. The PPE, indicted on the back of the sign, was a gown, gloves, mask, and face shield or goggles. An additional observation of the sign on Resident room [ROOM NUMBER] door indicating, Stop. Please see nurse before entering, revealed it was green, indicating droplet precautions. The PPE indicated on the back of the sign was a gown, gloves, mask, and face shield or goggles. An additional observation of the green sign on the door above the isolation caddy for Resident room [ROOM NUMBER] indicated the need for gloves, gowns, mask, goggles or a face shield. Review of Attachment A, Centers for Medicare and Medicaid Services (CMS) Long Term Care (LTC) Infection Control Worksheet LTC Facility Self-Assessment Tool, dated 3/24/20, revealed the following: (page 16) G.1. Supplies necessary for adherence to proper personal protective equipment use (e.g., gloves, gowns, masks) are readily accessible in resident care areas (i.e., nursing units, therapy rooms, and resident rooms). The box was checked 'yes'. A review of the Coronavirus Disease 2019 (Covid-19) Preparedness Checklist for Nursing Homes and other Long-term Care Settings, undated, reflected the following information: Supplies and Resources The facility provides supplies necessary to adhere to recommended IPC practices including: (bullet 5) Necessary PPE is available immediately outside of the resident room and in other areas where resident care is provided. The box was marked completed. (bullet 6) Facilities should have

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) supplies of facemasks, respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested HCP), gowns, gloves, and eye protection (i.e., face shield or goggles). The box was marked completed. A review of the facility's policy titled, Manual: Infection Control Standards and Guidelines: Transmission Based Precautions, with an issue date of 3/2018, revealed: Droplet - small droplets that contain infectious organisms that can be expelled for up to 3 feet by coughing or sneezing. A susceptible host can contract the infection by inhaling these organisms or through contact with mucous membranes (eyes, nose, and mouth). (Utilize Green Stop and See Nurse signage outside resident room or on door), and It is important to use the standard approaches, as defined by the CDC for transmission-based precautions: airborne, contact, and droplet precautions. The category of transmission-based precaution determines the type of PPE to be used. Communication (e.g., verbal reports, signage) regarding the particular type of precaution to be utilized is important. When transmission-based precautions are in place, PPE should be readily available. Proper hand washing remains a key preventive measure, regardless of the type of transmission-based precaution employed. The section titled, Guidelines for Contact Precautions, Gloves, revealed: 5. Wearing gloves is not a substitute for hand antisepsis. Gloves will be removed and discarded before leaving the resident's room, hand will immediately be washed with soap, and water or a waterless hand antiseptic will be used.