STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105995	A. BUILDING _____ B. WING _____	**06/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HARBORCHASE OF NAPLES	**7801 AIRPORT PULLING ROAD N NAPLES, FL 34109**

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, and record review the facility failed to safeguard residents' well-being by failing to follow current infection control standards related to COVID-19 recommendations set forth by Centers for Disease Control and Prevention (CDC). Refer to https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html. The findings included: 1. The CDC guidance for donning respirators and facemasks, dated 5/11/20, directs staff to place straps at the crown of the head and base of the neck for masks that contain 2 straps. CDC guidance, updated 5/19/20, indicated HCP (Health Care Personnel) should wear facemasks at all times while they are in the facility. The guidance further directs Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room . On 6/2/20 at 9:05 a.m., observed Licensed Practical Nurse (LPN) Staff A wearing a facemask with a broken lower strap. On 6/2/20 at 9:06 a.m., Staff A acknowledged the mask should be replaced. On 6/2/20 at 9:10 a.m. observed Certified Nursing Assistant (CNA) Staff B in the West hall wearing an N95 respirator with one strap unsecured and dangling below CNA Staff B's chin. On 6/2/20 at 9:12 a.m., CNA Staff B acknowledged the strap should have been secured. On 6/2/20 at 9:15 a.m., observed the Director of Maintenance wearing an N95 respirator at the main nurses' station with one strap unsecured and dangling below his chin. On 6/2/20 at 9:30 a.m., observed Housekeeping Staff C in the middle hall wearing an N95 respirator with one strap unsecured and dangling below her chin. On 6/2/20 at 9:31 a.m., Housekeeping Staff C said she should have both straps secured. On 6/2/20 at 10:56 a.m., in an interview the Director of Nursing (DON) said newly admitted residents were kept isolated for 14 days after admission as a precaution to prevent the spread of COVID-19. A review of the resident record for Resident #2 revealed the resident was admitted to the facility on [DATE]. On 6/2/20 at 11:15 a.m., observed Resident #2 at the main nurses' station. Resident #2 was not wearing a facemask. A review of the resident record for Resident #3 revealed, the resident was admitted to the facility on [DATE]. On 6/2/20 at 2:45 p.m., observed Resident #3 wheeling himself in his wheelchair in the middle hall. Resident #3 was not wearing a facemask. On 6/2/20 at 3:03 p.m., Resident #3 was observed wheeling himself in the West hall. Resident #3 was not wearing a facemask. 2. On 6/2/20 at 9:05 a.m., observed Resident #4 in wheelchair, being pushed through lobby by Physical Therapy (PTA) Staff X. Resident #4 was not wearing a face mask. On 6/2/20 at 9:35 a.m., observed Resident #5 in wheelchair in Activity Room. Resident #5 was not wearing a face mask. On 6/2/20 at 9:37 a.m., observed Resident #6 using walker through lobby. Resident #6 was not wearing a face mask. On 6/2/20 at 9:48 a.m., observed Resident #4 sitting in lobby. Resident #4 was not wearing a face mask. On 6/2/20 at 9:50 a.m., in an interview the DON said residents were placed in isolation for the first 14 days after admission. After 14 days, residents were permitted to leave their rooms without wearing face masks. On 6/2/20 at 9:57 a.m., observed Resident #9 in the Therapy Room. Resident #9 was not wearing a face mask. PTA Staff Y who was working with Resident #9 said residents didn't wear masks when they left their rooms. On 6/2/20 at 10:08 a.m., observed Resident #3 in room [ROOM NUMBER]A with male staff. Resident #3 was not wearing a face mask. On 6/2/20 at 10:09 a.m., observed Resident #10 in room [ROOM NUMBER]A with female staff sitting at bedside for interview. Resident #10 was not wearing a face mask. On 6/2/20 at 10:10 a.m., observed wall mounted stainless steel water fountain in the hallway across from the Electric Room. The fountain was in working order and dispensed water when the button was pushed. There was nothing prohibiting the use of the water fountain due to COVID-19. On 6/2/20 at 1:33 p.m., observed Resident #12 and Resident #13 sitting together in wheelchairs in the lobby across from the nurses' station. They were positioned side by side, angled toward one another, and less than 6 feet apart. They were not wearing face masks. During interviews, PTA Staff X and LPN Staff Z confirmed the two residents were too close together and should be sitting at least 6-feet apart for proper social distancing.

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.