| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **105708** | A. BUILDING _____ B. WING _____ | **08/20/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **MANORCARE HEALTH SERVICES PALM HARBOR** | **2851 TAMPA RD PALM HARBOR, FL 34684** |

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 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, closed record review, and facility policy review, the facility failed to ensure supervision for one (Resident #2) of two residents related to falls with no or minor injury. The facility did not adhere to Resident #2's Care Planning for one to one observation for preventing and minimizing falls. Findings Include: Record review of Resident #2's Admission Record Report revealed an admission date of [DATE] with medical [DIAGNOSES REDACTED]. Review of Admission/Discharge To/From Report, page 4, revealed Resident #2 was discharged from the facility on 7/27/20. Record review of Resident #2's admission assessment Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Metal Status score of 5, which indicated that resident's mental status was severely impaired. Section E: Behavior revealed physical behaviors such as hitting, kicking, pushing, grabbing, and abusing others. The resident also displayed wandering behaviors, putting the resident at a significant risk of getting to a potentially dangerous place. Section G: Functional Status revealed Resident #2 required extensive assistance with two or more persons physically assisting for bed mobility, transfer, walking in the corridor, dressing, and toilet use. Record review of Care Plan, closed 7/27/20 due to Resident discharge from facility, revealed focuses including, At risk for falls due to noncompliance with use of assistive devices. Goals included minimizing risk for falls, initiated and created on 6/18/20. Decreasing number of falls, initiated and created on 6/27/20. Minimize risk for injury related to falls, initiated and created on 7/2/20. Interventions include one on one observation initiated 6/30/20 and created on 7/2/20. Record review of the Incident/Accident Log revealed Resident #2 had seven falls occur after being placed on one-to-one (1:1) observation, classified as a fall without injury (or minor injury), on, - 7/2/20 at 4:00 a.m. Incident location in the resident's room - 7/6/20 at 11:00 a.m. Incident location in the lounge - 7/7/20 at 1:15 a.m. Incident location in the resident's room - 7/7/20 at 4:08 p.m. Incident location in the resident's room - 7/21/20 at 2:45 a.m. Incident location in the resident's room - 7/24/20 at 10:30 a.m. Incident location in the resident's room - 7/26/20 at 10:05 p.m. Incident location in the resident's room. On 8/20/20 at 4:16 p.m., an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) occurred. The DON stated that on 7/1/20 at 8:04 p.m., Resident #2 attempted to exit to the courtyard; the courtyard is an enclosed area. Resident #2 stood up and was very strong, so staff was unable to restrain him. He went to the courtyard, fell , reported side pain, and 911 was called. Then on 7/2/20 about four in the morning, Resident #2 fell and hit his head. There was slight bleeding on his head and the resident complained of pain. He was sent to the emergency room but was not discharged . The resident returned later that morning. He had scans/x-rays, and nothing was found. He did have bruising and an abrasion. He was put on neuro checks. There was no treatment for [REDACTED]. The NHA continued, stating that the facility was aware the resident was a high fall risk and were trying to monitor and implement interventions. Both the DON and the NHA confirmed that the resident was on 1:1 observation during the 7/2/20 4:00 a.m. fall and the other falls, listed above, occurring in July. Both the DON and the NHA confirmed that 1:1 observation means a staff member always has eyes on the resident. The DON stated that due to the resident's behaviors of striking out and being aggressive, facility staff was instructed to monitor him at a distance. Record review of Progress Notes, dated 7/2/20 at 4:22 a.m., revealed, Pt (patient) fell around 4:00am and hit his head on the floor, there was slight bleeding and swelling, pt. complained of head pain. ESNF was called and suggested to send patient out to ER for evaluation, 911 was called and transfer to (Hospital Name) via stretcher, family was also informed . On 8/20/20 at 4:45 p.m., an interview with the DON occurred. She stated that the fall investigation report did not indicate if the fall was witnessed or unwitnessed. She called the Certified Nursing Assistant (CNA) on duty during the fall on 7/2/20 and the CNA stated that he could not re-call that night or what occurred during the situation. The DON stated that usually during the follow-up interviews after an incident, questions will be asked regarding what the resident was doing prior to the incident, and when the resident was last seen. However, the investigation report for the incident did not contain this information. There was no statement in the report that indicated 1:1 supervision was occurring. On 8/20/20 at 6:21 p.m. an interview with Staff A, Unit Manager/Registered Nurse (RN) occurred. She confirmed she was the unit manager for Resident #2 during his time at the facility. She stated the resident did not want people around him, so staff stayed outside the doorway. She confirmed that the resident was care planned for 1:1 supervision during the fall on 7/2/20. She confirmed that while the CNA's stated they did not remember the event; their statement indicated that they did not witness the resident fall. She confirmed that if someone is on 1:1 there should be someone watching the resident. Staff A, RN stated she would need to review the resident's notes to determine if the rest of the falls through July were found to be witnessed or unwitnessed. Record review of Progress Notes, dated 7/6/20 at 10:54 a.m. revealed, Resident was in lounge with (CNA) resident became insistent on leaving stoo(d) up from wheelchair and sat on floor did not hit head denied hurting self anywhere assisted onto couch per his request . Progress Notes, dated 7/7/20 at 4:19 a.m., revealed, Reported to this nurse. Res. (resident) on the floor sitting position behind bed (Resident Room #). No injuries noted . Denies any pain. L(i)fted up to w/c with three person. Neurochecks initiated. Up to nursing station to monitor. Redirected at times. Kept stated up w/ poor gait . Progress Notes, dated 7/7/20 at 7:00 a.m., revealed, CNA informed nurse that patient is on floor. Patient found sitting on butt beside bathroom. Assessed patient and VS (vital signs) w/in (within) normal parameters . Patient kept up at nurses' station for further monitoring. Progress Notes, dated 7/7/20 at 3:47 p.m., entered by the Medical Practitioner revealed, . In addition, since then, he has had multiple falls, with the most recent one earlier this morning where he was found sitting on the floor behind his bed. Of note, he had aggressive behaviors towards nursing staff and has been attempting to leave the facility and therefore his wandering bracelet has been applied Patient continues to report safety awareness, and has had multiple falls, nursing to continue to provide close supervision, and limit risk of injuries to falls. Record review of Progress Notes dated 7/21/20 revealed no notes related to the fall. Record review of Fall(s) dated 7/21/20 at 6:48 a.m. revealed the Care Plan was initiated/revisited. Progress Notes, dated 7/24/20 at 3:42 p.m., revealed, Resident on floor at 10:30 Resident removed his socks call bell not on sitting in urine on floor denies being hurt bed was in low position. Checked for bruising, bleeding, rom (range of motion) and assisted into wheelchair. Neuro checks initiated . Progress Notes, dated 7/26/20 at 10:56 p.m., revealed, Patient found on floor next to bed in room around 2040, 8:40 p.m., 7/26/20. Patient assessed immediately. No injuries, bleeding, or new skin issues. Patient stated, I was trying to get up and my socks slipped. Patient denied hitting head, pain, or discomfort . On 8/20/20 at 7:00 p.m. an interview with Staff A, the DON, and the NHA occurred. Staff A confirmed that the investigation reports/documentation related to the fall incidents in July did not indicate if the falls were witnessed or unwitnessed. She stated that the resident did not want staff in his room. It has been identified that issues are occurring and fall in-servicing has been started. All investigative reports indicate that the resident was sleeping prior. He would rest after the new medication was started. He was impulsive. He would always have to be re-directed. The DON continued stating there is no formal policy |

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 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>for 1:1 observation, a verbal notification is given to staff when a Resident is placed on 1:1 and a staff member is assigned to the resident. The nurse would notify the on-coming shift that a resident is on 1:1. The NHA and Staff A confirmed that there is no formal documentation that is used for 1:1 observation tracking. On 8/20/20 at 7:30 p.m. Staff A provided a blank 1:1 Observation form. She stated that CNAs' will fill out the document every 15 minutes, but the document is not kept in the Medical Record. The form would be discarded upon a resident's discharge. Policy review of Interdisciplinary Care Planning, updated 03/2018, revealed, The patient's care plan is a communication tool that guides members of the interdisciplinary healthcare team in how to meet each individual patient needs. It also identifies the types and methods of care that the patient should receive. The care plan should focus on preventing avoidable declines in function, managing patient risk factors, preserving and building on patient's strengths, patient goals and individualized preferences . planning for care to meet the patient's needs, and involving direct care staff . Care Plans must specify which care discipline is responsible for carrying out each intervention . Goals needs to have interventions that help the patient meet the goal. Interventions identify specific, individualized elements of care, provided by staff, which will help patients achieve their goals. Interventions are the instructions for delivering patient care and allow for continuity of care by staff. Just like goals, interventions are specific and measurable. Policy review of Design and Scope- Foundational Elements (Cont), n.d, revealed, Investigations are in-depth inquires and analyses of the facts surrounding an event or situation in an effort to clarify the time line of events and the role that individuals or other factors had on the outcome of the event or situation. Many of the same processes used in a root cause analysis are utilized when conducting an investigation. The purpose of an investigation is to obtain factual information surrounding the event or situation. Investigations focus on clarifying the who, what, why, when, where of an event . The steps in the investigation process include: 1. Plan - Choose the investigator - Determine the purpose of the investigation - Identify who will be interviewed - Identify what documents need to be reviewed 2. Gather Evidence - Review the documents - Conduct the interviews 3. Respond - Analyze the findings - Complete the documentation required - Formulate and implement recommendations . A near miss is defined as an unplanned event, occurrence or situation that has the potential for more serious consequences or outcomes. A near miss event provides an opportunity to review and correct a process before a more serious consequence or outcome occurs. Policy review of Phase 2: Plan, n.d., revealed, Comprehensive Care Plan . When the interdisciplinary team designs the comprehensive care plan to address the problem(s) associated with potential or actual falls, a measurable goal is developed, and a target date is established. Approaches are selected based on the patient's preferences, risk factors, co-morbid conditions and willingness to participate with the plan of care . The approaches for fall interventions are clear, specific and individualized for the patient's needs. Managing falls can be complex as many falls do not have a single cause but include a combination of risk factors and causes. Regardless of the interventions that are put in place, a key factor to success is the timely review of the interventions as the patient's condition and needs change. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, policy review, and review of the Center for Disease Control and Prevention (CDC) guidelines, the facility failed to implement and maintain an infection prevention and control program on one of one isolation units as evidenced by: not following guidelines for reuse of personal protective equipment (PPE) and failing to ensure decontamination between uses; not establishing consistency with facility policies and procedures for PPE reuse and PPE decontamination and not ensuring that facility staff were following facility procedure for PPE reuse and decontamination Findings Included: During the survey entrance conference on 08/20/20 at 9:46 a.m. the Director of Nursing (DON) confirmed there was one unit in the building that was considered an isolation unit. She reported that the unit contained residents who were newly admitted to the facility and placed on droplet isolation for 14 days as a precaution related to COVID -19. The DON reported that the unit also contained one resident, in a private room, who had been moved to the unit and was considered PUI (Person Under Investigation) for COVID-19 related to symptoms, was tested , and remained under droplet isolation precautions while waiting for test results. She confirmed that there were three residents on that unit that had Clostridioides difficile (C. diff) and were on transmission-based precautions. The DON reported that one facility employee had tested positive for COVID-19 on 08/18/20, during the facility's most recent staff testing cycle and as a result all residents who had possible exposure to that employee were tested and placed under droplet isolation precautions as PUI for COVID-19 while waiting for test results. The DON identified the location of those rooms on a separate unit of the building. At 12:44 p.m. observations were made on the unit identified by the DON as the isolation unit. Multiple observations were made of paper bags left in the hallway outside of resident rooms; some bags had N-95 respirator masks in them, and some were empty. The bags were left on top of PPE caddies outside resident room doors. The bags were labeled with staff name. At 12:45 p.m. Staff B, Licensed Practical Nurse (LPN) was interviewed. Staff B confirmed that the rooms on the unit were under droplet and transmission-based precautions. She confirmed that N-95 masks and face shields were required for entry into the rooms and confirmed that the PPE was re-used. Staff B stated that her process with her N-95 mask was to keep it on when providing care and remove it at the nurse's station on the unit between care. She said that after her shift she would take it home or store it in the unit manager's office. Regarding the process for decontaminating her face shield for re-use, Staff B reported that she used eyeglass lens cleaner, revealing her personal eyeglass lens cleaner product from her pocket, or alcohol stating, I don't know what to use. At 1:05 p.m. the Director of Rehabilitation (DOR) was observed entering the unit from the courtyard and donning PPE from a paper bag in preparation to enter a resident room. She confirmed that the paper bag contained her PPE for re-use including her N-95 mask. The DOR was accompanied by Staff C, Registered Nurse (RN) who reported she used her N-95 mask throughout her shift and kept in it a bag in her office. Staff C said she would discard her N-95 mask after true isolation which she defined as [DIAGNOSES REDACTED], droplet, or positive COVID. At 1:10 p.m. Staff D, Certified Nursing Assistant (CNA) was observed in the hallway preparing to enter a resident room. Staff D was not wearing a mask. There was a paper bag sitting on top of the PPE caddy outside of the door to the room which she identified as belonging to her and revealed that it contained her N95 mask which she said was re-used. She explained that she was preparing to don her PPE for entering the room to provide care. Staff B confirmed that the precautions in place for the room were droplet and that the resident also had [DIAGNOSES REDACTED]. Staff D was observed donning her N95 mask with bare hands and touching the outside of the mask during donning. Staff D could not identify a specific facility protocol for PPE storage and said that she would discard her N-95 mask after providing care because the resident had [DIAGNOSES REDACTED]. Photographic evidence was obtained. Review of facility document titled, Personal Protective Equipment Usage Guide dated 07/17/2020 revealed the following Conservation Guidance for N-95 respirator mask: If conservation is necessary, N-95 respirators can be worn until visibly soiled or moist. Masks are donned at the beginning of the shift and only removed during scheduled breaks out of the patient care areas. Masks are removed (without touching the front of the mask) and placed in a breathable paper bag at the beginning of break or end of the shift - labeled with the employee name and stored at the facility in a location that is convenient for the employee to obtain at the start of their next scheduled shift. The document revealed the following Conservation Guidance for face shields: If conservation is necessary, face shields may be cleaned when visibly soiled with approved cleaner or soapy water, rinsed and allowed to air dry. A review of staff education records revealed that education had been provided to the staff on following the guidelines in the facility Personal Protective Equipment Usage Guide. During an interview on 08/20/2020 at 5:14 p.m. with the nursing home administrator (NHA), the DON, and the Infection Control Preventionist (ICP), any additional facility policies related to PPE and transmission-based precautions were requested. The ICP provided two policies, both dated 05/2013: Personal Protective Equipment and Standard Precautions. Review of the policies revealed the following under heading Removal and Reuse of Goggles or Face Mask: .clean reusable products .use soap and water if device not contaminated .decontaminate in soiled utility area .clean with an approved disinfectant safe for use on [MEDICATION NAME] surface. The NHA, DON, and ICP confirmed that the facility was employing PPE re-use protocol for N-95 respirator masks and face shields. Regarding the inconsistencies observed with staff practices and understanding of the protocols, the NHA responded, in fairness to our staff they have been told multiple things to do. Regarding protocol with PPE for providing care for residents with [DIAGNOSES REDACTED] who were also under airborne and droplet transmission precautions, the ICP stated that a surgical mask should be applied over top of the N-95 respirator mask and following care the surgical mask should be discarded and the N-95 respirator mask retained for re-use. The NHA, DON, and ICP reviewed the facility document titled Personal Protective Equipment Usage Guide and all stated that yes that protocol was what staff had been educated to follow in the facility. The NHA stated that she agreed that the observations shared did not match the protocol and confirmed that the observations made of how N-95 respirator masks were being stored and donned/doffed was a problem. The ICP confirmed |

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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>that re-used face shields should be cleaned and decontaminated, identifying that approved facility options for cleaning and decontaminating face shields were peroxide spray, alcohol pads, or bleach wipes. She stated that the use of the peroxide spray had been recommended to facility staff but that there was no specific facility protocol for process and frequency stating, haven't addressed that. All parties stated they were not comfortable with the report from Staff B, LPN that she used eye glass lens cleaner for cleaning her face shield, and all confirmed that the product would not disinfect the item. The NHA confirmed that based on concerns presented, re-education of staff was needed. The NHA confirmed that a procedure for PPE re-use storage and a storage station was needed. Within their Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Facepiece Respirators in Healthcare Settings, the CDC has defined that Extended use refers to the practice of wearing the same N95 respirator for repeated close contact encounters with several patients, without removing the respirator between patient encounters and that Reuse refers to the practice of using the same N95 respirator for multiple encounters with patients but removing it ('doffing') after each encounter. With a reuse approach the respirator is stored in between encounters to be put on again ('donned') prior to the next encounter with a patient. According to the CDC, extended use is favored over reuse because it is expected to involve less touching of the respirator and therefore less risk of contact transmission. If a reuse approach is taken, the CDC states that measures should be taken to consider additional training and/or reminders (e.g., posters) for staff to reinforce the need to minimize unnecessary contact with the respirator surface, strict adherence to hand hygiene practices, and proper PPE donning and doffing technique, including physical inspection and performing a user seal check. Healthcare facilities should develop clearly written procedures to advise staff to take the following steps to reduce contact transmission: Discard N95 respirators following use during aerosol generating procedures. Discard N95 respirators contaminated with blood, respiratory or nasal secretions, or other bodily fluids from patients. Discard N95 respirators following close contact with any patient co-infected with an infectious disease requiring contact precautions. Hang used respirators in a designated storage area or keep them in a clean, breathable container such as a paper bag between uses. To minimize potential cross-contamination, store respirators so that they do not touch each other and the person using the respirator is clearly identified. Storage containers should be disposed of or cleaned regularly. Clean hands with soap and water or an alcohol-based hand sanitizer before and after touching or adjusting the respirator (if necessary for comfort or to maintain fit). Avoid touching the inside of the respirator. If inadvertent contact is made with the inside of the respirator, discard the respirator and perform hand hygiene as described above. Use a pair of clean (non-sterile) gloves when donning a used N95 respirator and performing a user seal check. Discard gloves after the N95 respirator is donned and any adjustments are made to ensure the respirator is sitting comfortably on your face with a good seal.<br>https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html The CDC guidelines for contingency capacity and crisis capacity strategies for reusable face shields state that health care providers must Ensure appropriate cleaning and disinfection between users if goggles or reusable face shields are used. Within these guidelines, a section titled Selected Options for Reprocessing Eye Protection revealed the following: When manufacturer instructions for cleaning and disinfection are unavailable, such as for single use disposable face shields, consider: 1. While wearing gloves, carefully wipe the inside, followed by the outside of the face shield or goggles using a clean cloth saturated with neutral detergent solution or cleaner wipe. 2. Carefully wipe the outside of the face shield or goggles using a wipe or clean cloth saturated with EPA-registered hospital disinfectant solution. 3. Wipe the outside of face shield or goggles with clean water or alcohol to remove residue. 4. Fully dry (air dry or use clean absorbent towels). 5. Remove gloves and perform hand hygiene. https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html |