STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106128	A. BUILDING _____ B. WING _____	05/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FAIR HAVENS CENTER	201 CURTISS PKWY MIAMI SPRINGS, FL 33166

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to prevent neglect by not providing the quality of care necessary to prevent further harm to the residents. The facility failed to immediately isolate eleven residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, & #11) who were roommates of other residents that tested positive for COVID-19/Coronavirus. Furthermore, they cohorted the eleven residents with fifteen other residents (Residents #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25 and #26) that tested negative and who were not previously exposed to the Coronavirus. The facility failed to place the eleven residents on droplet precaution and contact precautions. They did not follow the Center for Disease Control and Prevention (CDC) guidelines and their own policy for COVID-19 for isolating the eleven residents. The deficient practice affected 26 out of 109 sampled residents. Based on these concerns, it was determined that the provider's non-compliance caused, or was likely to cause, serious injury, harm, impairment or death to residents. On May 7, 2020 at 7:45 p.m. the facility's administration were notified of ongoing Widespread Immediate Jeopardy that started on 4/27/2020. Cross Reference: F835-Administration F880- Infection Control & Prevention F921- Safe/Functional/Sanitary/Comfortable Environment The findings included: Review of the facility's policy titled, Coronavirus prevention last revised on 03/18/20, documented that any residents suspected or exposed to COVID-19 infection will be removed from other residents and placed in separate rooms. They will further be in isolation and monitored for 14 days. It further showed that the facility will follow Standard, Contact, and Droplets precautions that are recommended for the management of residents suspected of an Coronavirus infection by the CDC. Review of the CDC guidelines under the title, Responding to Coronavirus in Nursing Homes revealed, roommates of residents with COVID-19 should be considered exposed and potentially infected and should not share a room with other residents. It further showed that they need to remain asymptomatic and test negative for COVID-19, 14 days after their last exposure. In an observation conducted on 05/06/20 at 9:30 AM, it was noted that 61 residents (#47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107), who were positive for COVID-19 were placed on a droplet/contact isolation unit on the 2nd floor of the facility. The remaining residents were placed on the 1st floor, in various rooms. Further observation showed that 13 residents (#34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, and #46) were placed on droplet/contact isolation for various reasons on the 1st floor. Record review of the facility's census dated 05/06/20 showed 190 in house residents. Further record review showed that the 11 exposed residents who had roommates that were positive for COVID-19 were placed in rooms with the 15 other residents who tested negative for COVID-19 and had not been previously exposed to COVID 19. According to the CDC guidelines titled, People Who Are at Higher Risk for Severe Illness, documents adults over the age of 65 and who have serious underlying medical conditions might be at a higher risk for serious severe illness from COVID-19. These medical conditions may include [MEDICAL CONDITION], heart conditions, obesity, diabetes and liver disease. Review of the clinical records for the 11 exposed residents who had roommates who tested positive for COVID-19 showed the following: Resident #1, [AGE] years old, was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #2, [AGE] years old, was admitted on [DATE] with [DIAGNOSES REDACTED]. The resident had a known exposure to a positive COVID-19 resident on 04/27/20. Resident #3, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. The resident had a known exposure to a positive COVID-19 resident on 04/27/20. Resident #4, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #5, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. The resident had a known exposure to a positive COVID-19 resident on 04/27/20. Resident #6, [AGE] years old, was admitted on [DATE] with [DIAGNOSES REDACTED]. The resident had a known exposure to a positive COVID-19 resident on 04/27/20. Resident #7, [AGE] years old, was admitted on [DATE] with [DIAGNOSES REDACTED]. The resident had a known exposure to a positive COVID-19 resident on 04/27/20. Resident #8, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. The resident had a known exposure to a positive COVID-19 resident on 04/27/20. Resident #9, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. The resident had a known exposure to a positive COVID-19 resident on 04/27/20. Resident #10, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. The resident had a known exposure to a positive COVID-19 resident on 04/27/20. Resident #11, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. The resident had a known exposure to a positive COVID-19 resident on 04/27/20. Record review of the (15) residents who were located in the same room with the (11) exposed residents revealed the following: Resident #12, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #13, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #14, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #15, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #16, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #17, [AGE] years old, who was admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #18, [AGE] years old, who was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #19, [AGE] years old, who was admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #20, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #21, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #22, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #23, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #24, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #25, [AGE] years old, who was admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #26, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. On 05/06/20 at 10:30 AM, the Director of Nursing, (DON) stated, currently they have 93

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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FAIR HAVENS CENTER	201 CURTISS PKWY MIAMI SPRINGS, FL 33166

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) residents that tested positive for the COVID-19. The DON reported, 32 of the residents that tested positive for COVID-19 were admitted to the hospital. The DON explained, the 11 roommates who were exposed to the positive COVID-19 residents remained in the facility and were not placed on isolation. The DON further reported, they had full in-house testing for COVID-19 which was provided by a private laboratory on 04/25/20 and on 04/27/20 they received the results for all the residents. However, two residents (Resident #46 and #120) did not receive their results until 04/29/20. According to the DON, they immediately isolated all positive residents for COVID-19 on the 2nd floor on 04/27/20. On 05/06/20 at 12:30 PM, the facility's Vice President of Operations, was asked why they did not place the 11 residents who were exposed to residents positive for COVID-19 on droplet/contact isolation and why they cohorted those 11 residents with the other 15 residents who tested negative and were not previously exposed. The Vice President of Operations reported, if they had to isolate the 11 residents who were exposed, they would run out of Personal Protective Equipment in one week. The Vice President of Operations further stated, they also had 32 staff members who tested positive for COVID-19, and if they had to isolate all residents who were exposed to them it would be the entire facility. In an interview conducted on 05/06/20 at 3:00 PM, the facility's Vice President of Clinical Services reported, the 11 residents who had positive COVID-19 roommates, were not placed on isolation because they did not show any symptoms of COVID-19. The Vice President of Clinical Services further stated, all residents in the facility are being monitored every shift for any signs and symptoms of COVID-19. During an observation conducted on 05/06/20 at 5:00 PM, the 11 residents who were exposed to positive COVID-19 residents were not on any type of contact isolation/droplet precautions and were not separated from the 15 residents who tested negative that were not previously exposed to COVID-19. Review of the facility's two weeks staffing documentation of the combined nurses and Certified Nurse Assistant (CNA) ratio, showed for nurses and CNAs was above 3.5. The nursing ratio was above 1.0 and the CNAs was above 2.5 indicating no issues with the facility's staffing or lack of staffing for the last two weeks in the facility. In an observation conducted on 05/07/20 at 10:00 AM, of the facility's multiple supply rooms, showed boxes of Personal Protective Equipment's. The boxes were a combination of gowns, masks, face shields, and gloves. In this observation, the Vice President of Operations reported, the facility has plenty of supplies, and they always made sure that they have two weeks of supplies on hand. No concerns or issues were reported during this observation and interview related to purchasing supplies or shortage of supplies.
F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility's administration failed to ensure that their policies and the Center for Disease Control and Prevention (CDC) guidelines related to infection control and COVID-19 were implemented. The facility's administration failure to place eleven roommates of sixty-one residents that tested positive for COVID-19 on isolation. The facility placed the eleven residents in resident rooms with fifteen residents that were not exposed to COVID-19. The placement of the eleven residents exposed the fifteen residents to COVID-19. This deficient practice affected twenty-six (residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25 and #26) out of the 109 sampled residents. It was determined that the provider's non-compliance caused, or was likely to cause, serious injury, harm, impairment or death to residents. The facility's administration was notified that Ongoing Immediate Jeopardy existed on May 7, 2020 at 7:45 p.m. Refer to: F600 -Free From Abuse and Neglect F880- Infection Control & Prevention F921- Safe/Functional/Sanitary/Comfortable Environment The findings included: Review of the facility's Plan of Action titled, COVID-19- Breakout Improvement Plan/ Plan of action, dated 04/27/2020 revealed, the objective & goals of this Plan of Action was to minimize the spread of the COVID-19 infection in the facility, implementing facility Infection Control measures to minimize risk. In the Action Steps, it was documented that suspected or exposed residents needed to be on isolation and the facility would follow the outbreak policy. Review of the facility's policy titled, Policies and Procedures: Coronavirus Prevention last reviewed on 03/18/2020 revealed, any residents suspected or exposed to COVID-19 infection would be removed from other residents and placed in a separate room. They would be in isolation and monitored for 14 days. The facility would follow Standard, Contact, Droplets and Airborne precautions that were recommended for the management of residents suspected with the Coronavirus infection by the CDC. Review of the CDC guidelines under the title, Responding to Coronavirus in Nursing Homes revealed, roommates of residents with COVID-19 should be considered exposed and potentially infected and should not share a room with other residents. It further showed that they need to remain asymptomatic and test negative for COVID-19, 14 days after their last exposure. Review of the Job Description for the Nursing Home Administrator revealed, the Administrator is responsible for the direct day-to-day functions of the facility in accordance with federal, state, and local standards, guidelines and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all the times. Review of the Job Description for the Director of Nursing revealed, the Director of Nursing responsibilities included planning, organizing, developing and directing the overall operation of the Nursing Service Department in accordance with current federal, state and local standards, guidelines and regulations that govern the facility, and as may be directed by the administrator and the Medical Director, to ensure that the highest degree of quality care is maintained at all times. Review of the Job Description for the Risk Manager revealed, the Risk Manager is responsible for planning, organizing, budgeting, coordinating, evaluating and developing policy for the facility's risk management systems in accordance with current federal, state, and local standards, guidelines, and regulations to protect residents, staff, and the facility from loss. Review of the Job Description for the Assistant Director of Nursing (ADON) Services revealed, the Assistant Director of Nursing Services is responsible for assisting the Director of Nursing Services in planning, organizing, developing, and directing the day-to-day functions of the Nursing Service Department in accordance with federal, state and local standards, guidelines, and regulations that govern facility, and as may be directed by the Administrator, the Medical Director, and/or the Director of Nursing Services, to ensure that the highest degree of quality care is maintained at all the times. Review of the Job Description for the Infection Preventionist revealed, the Infection Preventionist or designee is responsible for reporting to the State Department of Health Infectious Disease Division, within one working day of knowledge of a case, suspected case, carrier, or death from any of the diseases such as [DIAGNOSES REDACTED], Anthrax, etc. In addition, the Infection Preventionist or designee shall monitor the effectiveness of the facility's infection prevention and control work practices and protective equipment, that included, but were not limited to, the surveillance of the workplace to ensure that established infection prevention and control practices are observed, and protective clothing and equipment are provided and properly used; investigation of known or suspected transmission of healthcare-associated infections; improvement in training, work practices, or protective equipment to prevent recurrence of occupational exposures and/or healthcare-associated infections; effective implementation of hand-hygiene practices by all departments to prevent spread of infections. On 05/06/20 at 10:23 AM, in an attempt by the surveyor to get information related to concerns, the Nursing Home Administrator (NHA) was unable to respond or give answers to questions asked by the surveyor. The NHA reported that she cannot give the correct information because she was not sure and told the surveyor to ask the Vice President (VP) of Clinical Services or the Director of Nursing (DON). During an environmental tour of the COVID 19 Unit on 05/06/20 at 10:40 AM with Assistant Director of Nursing (ADON), the ADON was asked how the facility is managing the trash and laundry on the COVID Unit, which is located on the second floor of the facility. The ADON stated that they have a laundry shoot and a trash shoot at the end of the hallways. At 11:19 AM the ADON showed the surveyor the locked door with a sign on the door LINEN CHUTE. Also, on the door were paper signs in English and Spanish that read DO NOT THROW GARBAGE IN THIS BIN (photographic evidence obtained). The ADON opened the locked door and stated, Wait a minute this is the garbage chute. The ADON explained that one chute was being used for laundry and one chute was being used for trash. The ADON was asked about the conflicting signage on the door, the ADON stated that he could not speak to the signage. The ADON was asked how staff would know that this chute was not to be used for linen, the ADON stated that he was not sure how that information was given to the staff. On 05/06/20 at approximately 12:00 PM an unlabeled spray bottle was observed in the Personal Protective Equipment (PPE) doffing area of the COVID Unit. Doffing is the practice of employees removing work-related Personal Protective Equipment (PPE). The ADON stated that in order to conserve PPE staff was washing the protective face shields then spraying the face shield with the unlabeled spray bottle. The ADON was asked what was in the unlabeled spray bottle, the ADON stated that he did not know. The ADON was asked what the contact time for the unknown unlabeled product is, the ADON stated, I think it is ten minutes. The ADON was asked what staff did with the

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F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) face shield after disinfecting them, the ADON stated they take them home, so they don't lose them. The ADON was asked to clarify that facility staff working in the COVID Unit are instructed to take used PPE home, the ADON stated, yes, because we do not have a lot of them. The ADON was asked if it is the facilities expectation that all staff exiting the COVID Unit doff all PPE and cleanse their face shield and stand in the COVID Unit with no PPE on for the 10 minutes to disinfect the face shield, the ADON stated that the staff can put the masks in a plastic bag. It was observed at this time that there were no plastic bags in the COVID Unit doffing area. The ADON stated that there should be plastic bags in the soiled utility room. The soiled utility room is located approximately 30 feet away from the doffing area. On 05/07/20 at approximately 5:00 PM, the Risk Management COVID 19 Breakout Improvement Plan Dated 04/27/20 was reviewed with the Director of Nursing (DON) who is also the Risk Manager. The DON revealed, the area of focus was the multiple residents that tested positive when the mass testing was done. Review of the Action Steps revealed, suspected or exposed residents need to be on isolation. Staff are to wear appropriate Personal Protective Equipment (PPE) for Droplet precautions. The DON stated, we discussed how we were managing the relocation of the residents. We were focused on getting the positives onto the COVID Unit. We were thinking a negative can cohort with another negative, and we are surveilling everyone. The residents with exposure should have been isolated and on droplet precautions. We have placed everyone on precautions.

F 0880

Level of harm - Immediate jeopardy

Residents Affected - Many

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, record review, staff interviews, the facility failed to follow the Centers for Disease Control and Prevention (CDC) guidelines to practice Standard and transmission-based precautions to prevent the spread of a known infection, Coronavirus Disease 2019 (COVID 19). The facility failed to immediately isolate eleven residents whose roommates tested positive for COVID-19. The facility cohorted the eleven residents with fifteen residents that tested negative and did not have known direct exposure to COVID 19 positive residents. The facility failed to place the eleven residents on Droplet precautions (actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions). They did not follow the Center for Disease Control and Prevention (CDC) guidelines and their own policy for COVID-19 for isolating eleven residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, & #11). The facility exposed fifteen other residents by cohorting the 11 residents with known exposure to the 15 residents to include (Residents #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, & #26). The facility failed to maintain droplet precautions on the COVID Unit. The facility failed to maintain resident equipment in a sanitary manner on the COVID Unit, a mechanical lift. The facility failed to maintain side rail bumpers in a sanitary manner for 1 resident on the COVID Unit (Resident # 51). The facility's deficient practice affected 27 out of 109 sampled residents. It was determined the provider's non-compliance caused, or was likely to cause, serious injury, harm, impairment or death to residents. On May 7, 2020 at 7:45 p.m. the facility's administration was notified that ongoing Immediate Jeopardy existed.

Cross reference: F600- Free from Abuse and Neglect F835-Administration F921- Safe/Functional/Sanitary/Comfortable Environment The findings included: 1. In an observation conducted on 05/06/20 at 9:30 AM, it was noted that 61 residents (#47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107), who were positive for COVID-19 were placed on a droplet/contact isolation unit on the 2nd floor of the facility (COVID Unit). The remaining residents were placed on the 1st floor, in various rooms. On 05/06/20 at approximately 10:00 AM the Administrator and the Director of Nursing were asked to identify the roommates of the 61 COVID-19 positive residents at the time of the testing. The Administrator provided a list of 11 residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11). Review of the facility's census on 05/06/20 showed that the 11 exposed residents who had roommates that were positive for COVID-19 were placed in rooms with 15 other residents who tested negative for COVID-19 and did not have known direct exposure to COVID-19. The residents included, Residents #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25 and #26. Observation of these residents revealed, none of the identified resident were on droplet precautions. Review of the facility's policy titled, Coronavirus Prevention last revised on 03/18/20, documented that residents suspected or exposed to COVID-19 are to be in isolation and monitored for 14 days. The policy documents that staff are to wear appropriate personal protective equipment (PPE) such as masks, gowns, gloves, shoe covers, etc. It further showed that the facility will follow Standard, Contact, Droplets precautions that are recommended for the management of residents suspected with COVID 19 by the CDC. Review of the facility's COVID 19 Breakout Improvement Plan/Plan of action, dated 04/27/20 revealed, suspected or exposed residents need to be on isolation and staff are to wear appropriate PPEs for droplet precautions. The document revealed that the Assistant Director of Nursing and the Staff Developer are responsible for these action items as part of the COVID 19 Breakout Improvement Plan/Plan of action. Review of the CDC guidelines under the title, Responding to Coronavirus in Nursing Homes revealed, roommates of residents with COVID-19 should be considered exposed and potentially infected and should not share a room with other residents. It further showed that they need to remain asymptomatic and test negative for COVID-19, 14 days after their last exposure. Review of the clinical records for the 11 exposed residents who had roommates who tested positive for COVID-19 showed the following: Resident #1, [AGE] years old, was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #2, [AGE] years old, was admitted on [DATE] with [DIAGNOSES REDACTED]. The resident had a known exposure to a positive COVID-19 resident on 04/27/20. Resident #3, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. The resident had a known exposure to a positive COVID-19 resident on 04/27/20. Resident #4, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #5, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED].

The resident had a known exposure to a positive COVID-19 resident on 04/27/20. Resident #6, [AGE] years old, was admitted on [DATE] with [DIAGNOSES REDACTED]. The resident had a known exposure to a positive COVID-19 resident on 04/27/20. Resident #7, [AGE] years old, was admitted on [DATE] with [DIAGNOSES REDACTED]. The resident had a known exposure to a positive COVID-19 resident on 04/27/20. Resident #8, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. The resident had a known exposure to a positive COVID-19 resident on 04/27/20. Resident #9, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. The resident had a known exposure to a positive COVID-19 resident on 04/27/20. Resident #10, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. The resident had a known exposure to a positive COVID-19

resident on 04/27/20. Resident #11, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. The resident had a known exposure to a positive COVID-19 resident on 04/27/20. Record review of the (15) residents who were located in the same room with the (11) exposed residents revealed the following: Resident #12, [AGE] years old, admitted on [DATE] with [DIAGNOSES

REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #13, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20

by a roommate who had a previous roommate that tested positive for COVID-19. Resident #14, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested

positive for COVID-19. Resident #15, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #16, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #17, [AGE] years old, who was admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive

for COVID-19. Resident #18, [AGE] years old, who was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #19, [AGE]

years old, who was admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #20, [AGE] years old, admitted on [DATE] with [DIAGNOSES

REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #21, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20

by a roommate who had a previous roommate that tested positive for COVID-19. Resident #22, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested

positive for COVID-19. Resident #23, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #24, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. Resident #25, [AGE] years old, who was admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on 4/27/20 by a roommate who had a previous roommate that tested positive

for COVID-19. Resident #26, [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Was exposed to COVID-19 on

4/27/20 by a roommate who had a previous roommate that tested positive for COVID-19. In an interview conducted on

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	106128	A. BUILDING _____ B. WING _____	05/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FAIR HAVENS CENTER	201 CURTISS PKWY MIAMI SPRINGS, FL 33166

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) 05/06/20 at 10:30 AM, the Director of Nursing, (DON) stated that the 11 roommates who were exposed to positive COVID-19 residents remained in the facility and were not placed on isolation. The DON further reported that they had a full in-house testing for COVID-19 which was provided by a private laboratory on 04/25/20 and on 04/27/20 they received the results for all the residents. However, two residents (Resident #46 and #120) did not receive their results until 04/29/20. According to the DON, they immediately isolated all positive residents for COVID-19 on the 2nd floor on 04/27/20. In an interview on 05/07/20 at approximately 5:00 PM the DON, who is also the facility Risk Manager, stated that the area of focus was the multiple residents that tested positive when we did the mass testing. The DON stated, the Risk Management COVID 19 Breakout Improvement Plan Dated 04/27/20 was the tool the facility had developed to manage the COVID 19 virus outbreak. The DON was asked to address the COVID 19 Breakout Improvement Plan Action Steps for suspected or exposed residents needing to be on isolation and staff are to wear appropriated PPEs for Droplet precautions. The DON stated, we discussed how we were managing the relocation of the residents. We were focused on getting the positives onto the COVID Unit. We were thinking a negative could cohort with another negative, and we are surveilling everyone. The residents with exposure should have been isolated and on droplet precautions. We have placed everyone on precautions. In an interview conducted on 05/06/20 at 12:30 PM, with the facility's Vice President of Operations, he was asked why they did not place the 11 residents who were exposed to positive COVID-19 on droplet/contact isolation. Furthermore, why they cohorted those 11 residents with the other 15 residents who tested negative and were not previously exposed. The Vice President of Operations reported, if they had to isolate the 11 residents who were exposed, they would run out of Personal Protective Equipment in one week. He further stated that they also had 32 staff members who tested positive for COVID-19, and if they had to isolate all residents who were exposed to them it will be the entire facility. 2. On 05/06/20 at 10:50 AM, observation revealed, Staff T, an activities aide, on the COVID -19 unit doffing her gown in front of the surveyor. Observation revealed Staff T with bare hands, pinched the gown on the dirty side of her left sleeve, pulled the gown off and place it on the biohazard trash can. On 05/06/20 at 10:51 AM, Staff T was asked if she was supposed to touch the outside of the gown, Staff T stated that she removed her gloves and took the gown off. Staff T stated, that she is not supposed to touch the outside of the gown. On 05/06/20 at approximately 11:20 AM, an observational tour of the facility's first floor north unit revealed, Staff C, a Licensed Practical Nurse (LPN) in front of a medication cart. Observation revealed Resident #141 sitting in a wheelchair out in the hallway wearing a mask, they were observed to be approximately three (3) feet apart, not the recommended six (6) feet, as per CDC guidelines. Continued observation revealed, Resident #142 and Resident #143 were sitting in a wheelchair next to each other out in the hallway next to their room door and were approximately three (3) feet distanced from Resident #142 and approximately two (2) feet distanced from Staff C. Further, observations revealed no evidence of Staff C attempting to separate the residents or to provide education regarding social distancing. On 05/06/20 at 11:25 AM, an interview was conducted with Resident #142. Resident #142 stated that he is supposed to be six (6) feet apart from them and confirmed that he was not distanced. Resident # 143 was asleep and not interviewable. On 05/06/20, at 11:30 AM, an interview was conducted with Staff C. Staff C stated that she is supposed to keep her residents six (6) apart. At 11:35 AM on 5/6/20, observations revealed Staff C left the medication cart with medications in her hand and entered a random resident's room. Staff C did not move Resident #142 and Resident #143 six (6) apart from each other after the interview. Review of Resident #141 Minimum Data Set (MDS) quarterly assessment dated [DATE] documents resident's BIMS (brief interview for mental status) score was 14 of 15, indicative of little to no cognitive impairment. Review of Resident #142 Minimum Data Set (MDS) quarterly assessment dated [DATE] documents the resident's BIMS (brief interview for mental status) score was 14 of 15, indicative of little to no cognitive impairment. Review of Resident #143 Minimum Data Set (MDS) quarterly assessment dated [DATE] documents resident's BIMS (brief interview for mental status) score was 12 of 15, indicative of little to no cognitive impairment. On 05/06/20 at 11:50 AM, during the continued observational tour of the first-floor north unit revealed Resident #144 and Resident #145 sitting in wheelchairs outside their room in the hallway distanced approximately three (3) feet, and not six (6) feet as recommended by the CDC guidelines. Observation revealed Resident #145 was wearing her mask underneath her chin and talking to the people walking in front of her. Continued observation revealed, the unit secretary walked in front of Resident #144 and Resident #145 and did not acknowledge that the residents were not six feet apart and did not attempt to place Resident #145's mask on properly. On 05/06/20 at 11:52 AM, an attempt was made to interview Resident #144 and Resident #145 and revealed they were not able to follow the questions asked. On 05/06/20 at 12:01pm, an interview was conducted with Staff D, a Registered Nurse. Staff D was asked to observe and tell the surveyor what was wrong between Resident #144 and Resident #145. Staff D kept looking at both residents and was not able to state what was wrong. Staff D was asked about social distancing and stated that they are to keep residents six feet apart. Staff D was asked to demonstrate how she measured the six feet and proceeded to go to the front of both residents and counted from wheelchair leg rest to wheelchair leg rest. Staff D was asked to count how many feet were between the residents' side by side and she counted four (4) feet. Staff D confirmed that Resident #144 and Resident #145 were not six feet apart as per CDC guidelines and proceeded to distance Resident #144. Staff D moved away from Resident #145 and did not attempt to place or to ask her to place her mask properly. Staff D was asked about the resident wearing the mask on her chin. Staff D stated that she had educated the resident about keeping her mask in place, but that she takes it off. Staff D failed to offer or ask Resident #145 to place the mask on her face despite the concern brought to her attention by the surveyor that the resident was not wearing her mask properly. Review of Resident #144 Minimum Data Set (MDS) quarterly assessment date 02/12/20 documents the resident's BIMS (brief interview for mental status) score was 6 of 15, indicative of severe cognitive impairment. Review of Resident #145 Minimum Data Set (MDS) quarterly assessment date 02/11/20 documents the resident's BIMS (brief interview for mental status) score was 8 of 15, indicative of moderate cognitive impairment. On 05/06/20 at 5:50 PM, observation revealed Staff U, a receptionist at the facility's entry point blowing her nose, placing the tissue into the trash can without hand sanitation, went to the screening desk, retrieved a surgical mask from a box located at the desk, placed the mask on her face and then answered the phone. On 05/06/20 at 5:59 PM, an interview was conducted with Staff U and she confirmed that she blew her nose and did not do hand sanitation. Staff U stated, she should have wash her hand after blowing her nose and added that she will do now. Review of the CDC guidelines, [MEDICAL CONDITION] Disease 2019 (COVID-19) How to protect yourself or others, last reviewed on 04/24/20 documents, everyone should wash hands .after blowing your nose Review of the facility policy titled, [MEDICAL CONDITION] Prevention revised on 03/18/20 documents wash your hands often .especially after .blowing your nose . On 05/06/20 at 6:02 PM, an observational tour to the facility's Kellogg unit was conducted. Observation revealed Staff A, a Certified Nursing Assistant (CNA) and Staff B, a Certified Nursing Assistant in the lunchroom. On 05/06/20 at 6:05 PM, an interview was conducted with Staff A. Staff A stated that she usually worked the day shift but was asked to work the evening shift. On 05/06/20 at 6:08 PM, Staff A was asked about her assigned residents and she proceeded to their rooms one by one. Staff A entered a random resident in room [ROOM NUMBER], donned one glove without hand sanitation, re-arrange the resident's cover sheet, removed the glove without hand sanitation proceeded to room [ROOM NUMBER], donned one glove, pulled the window curtain to close it, then removed the glove and without hand sanitation, entered room [ROOM NUMBER], donned gloves, removed the resident food tray, removed her gloves and performed hand sanitation. During an interview, Staff A stated that she did hand sanitation. Review of the facility's policy titled, Hand washing/hand hygiene revised on 08/2015 documents use an alcohol-based hand rub .or alternatively, soap and water for the following situations .before donning gloves .after removing gloves . On 05/06/20 at 6:19 PM, during an interview, Staff A was asked about her face shield care and stated that she uses a face shield during work and before she goes home, she cleans the face shield with soap and water, then wiped it with alcohol pads, placed it in a plastic bag and leaves it in her car for her to use the next day. On 05/06/20 at 6:20 PM, an interview was conducted with Staff B, a Certified Nursing Assistant. Staff B stated that she uses a face shield during work and before she goes home, she cleans the face shield with soap and water, then wiped it with alcohol pads, placed in a plastic bag and leaves it in her car for her to use the next day. Review of the Center for Disease Control and Prevention (CDC) guidelines titled, Strategies for Optimizing the Supply of Eye Protection last reviewed on [DATE] documents under Options for Reprocessing Eye Protection While wearing gloves, carefully wipe the inside, followed by the outside of the face shield .using a clean cloth saturated with neutral detergent solution or cleaner wipe. Carefully wipe the outside of the face shield .using a wipe or clean cloth saturated with EPA-registered hospital disinfectant solution. Wipe the outside of face shield .with clean water or alcohol to remove residue. On 05/07/20, at 9:50 AM, observation revealed two (2) random residents smoking outside and a cigarette ash tray container between them. Observation revealed the residents were approximately three feet apart, not six feet apart as per CDC guidelines. Further

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F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 4) observation revealed the facility's Director of Nursing (DON) walked outside facing the two residents and did not attempt to separate them or educate them or the aide regarding social distancing. On 05/07/20 at 9:55 AM, an interview was conducted with Staff E, a Restorative Aide, and stated that she is watching the two residents smoking because they can't be alone. Staff E was asked how many feet apart the residents must be and she stated six feet. Staff E was asked if the two random residents were six feet apart and she stated, no, they are not and added that she keeps telling them, but they do not listen. Staff E was informed that the surveyor has been standing behind the residents inside the facility observing them and her and that she did not attempt to separate them until surveyor asked her. Staff E acknowledged the findings. On 05/07/20 at 4:35 PM, an interview was conducted with the DON and she stated that they educated the residents on keeping the social distancing and they don't listen. The DON was apprised that Staff E did not attempt to separate them during the observations and did it after an interview with the surveyor. On 05/07/20 at 1:35 PM, observation revealed five (5) staff members (Staff G, Staff H, Staff I, Staff J and Staff K, all Certified Nursing Assistants) sitting in a 10 x 10 lunchroom table located on the facility's first floor north unit lunchroom without keeping social distancing, they were observed almost elbow to elbow. The surveyor walked by the room three times, the staff looked at the surveyor and they continued to eat and stay in the small room. On 05/07/20 at 1:39 PM, Staff F, the unit supervisor was called to observe the five staff members in the lunchroom. Staff F stated that they are not six feet apart and that they know that only two staff members at a time are allowed in the room. Staff F added that Staff J was doing documentation and was not supposed to be there. On 05/07/20 at 1:40 PM, Staff G stated that she was finished and was ready to leave the room. Staff G stated that she is aware of the social distancing and confirmed that she was not six feet apart. On 05/07/20 at 1:42 PM, in an interview Staff H stated, we got the education, but I did it wrong today. Staff H confirmed that she was not six feet apart from Staff G during lunch. On 05/07/20 at 1:44 PM, Staff I stated that she is aware of the social distancing and confirmed that she was not six feet apart from Staff J. On 05/07/20 at 1:44 PM, in an interview Staff J stated, that she is aware of the social distancing and confirmed that she was in between Staff G and Staff I, less that one foot apart from Staff G and Staff I. Staff J confirmed that she was in the lunchroom documenting and it was not her time to be in the room. On 05/07/20 at 1:46 PM, surveyor asked for Staff K to conduct an interview and was informed that she left the unit. Staff K was not available for an interview. On 05/07/20 at 1:50 PM, an interview was conducted with Staff G, a Certified Nursing Assistant revealed, she had 11 residents in three rooms with room capacity of 3 to 4 residents per room that were on droplet precautions assigned to her. Observation revealed all the assigned rooms for droplet precautions had room doors wide open. Staff G was asked if those room doors were supposed to be open and she stated that she kept them open because she likes to see her residents. Staff G was not aware that the doors were supposed to be closed due to the droplet precautions.
F 0921 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a clean and sanitary environment that is free of hazards to ensure the health and safety of the 190 residents residing in the facility. The facility failed to follow the Centers for Disease Control and Prevention (CDC) guidelines for infection control, to practice Standard and transmission-based precautions to prevent the spread of a known infection, Coronavirus Disease 2019 (COVID 19). This systemic failure and the provider's non-compliance caused, or was likely to cause, serious injury, harm, impairment or death to residents. The facility's administration was notified that Immediate Jeopardy existed on May 7, 2020 at 7:45 p.m. Refer to: 483.12: F600 -Free From Abuse and Neglect 483.70: F835-Administration 483.80: F880- Infection Control & Prevention The findings included: Review of the facility's policy titled, [MEDICAL CONDITION] Prevention last revised on 03/18/20, documented that residents suspected or exposed to COVID-19 are to be in isolation and monitored for 14 days. The policy documents that staff are to wear appropriate personal protective equipment (PPE) such as masks, gowns, gloves, shoe covers, etc. It further showed that the facility will follow Standard, Contact, Droplets precautions that are recommended for management of residents suspected with COVID 19 by the CDC. Review of the facility's COVID 19 Breakout Improvement Plan/Plan of action, dated 04/27/20, revealed suspected or exposed residents need to be on isolation and staff are to wear appropriate PPEs for droplet precautions. During an environmental tour of the COVID 19 Unit on 05/06/20 at 10:40 AM with Assistant Director of Nursing (ADON), the ADON was asked how the facility is managing the trash and laundry on the COVID-19 Unit, which is located on the second floor of the facility. The ADON stated, they have a laundry chute and a trash chute at the end of the hallways. At 11:19 AM, the ADON presented the locked door in the East Wing with a sign on the door LINEN CHUTE. Also, on the door were paper signs in English and Spanish that read DO NOT THROW GARBAGE IN THIS BIN (photographic evidence obtained). The ADON opened the locked door and stated, Wait a minute this is the garbage chute. The ADON explained that one chute was being used for laundry and one chute was being used for trash. The ADON was asked about the conflicting signage on the door, the ADON stated that he could not speak to the signage. The ADON was asked how staff would know that this chute was not to be used for linen, the ADON stated that he was not sure how that information was given to the staff. At 11:23 AM on 05/06/20 the ADON presented the locked linen chute on the West Wing hall. The ADON was unable to unlock the door and called Staff W, a housekeeper to unlock the door. Staff W was wearing a white full body suit PPE. Staff W unzipped the full body suit and reached inside and took out a key chain with an approximate 24-inch nylon lanyard attached. Staff W opened the stainless-steel door to the chute, on the inside of the door was a copious amount of a raised dried brown organic substance (photographic evidence obtained). The stainless-steel door jamb of the linen chute was observed to have compacted dried brown organic substance (photographic evidence obtained). Staff W's PPE remained unzipped while opening the linen chute, Staff W then removed the key chain with the 24-inch nylon lanyard and placed it back inside the full body suit PPE. During the environmental tour of the COVID-19 Unit on 05/06/20 at 10:52 AM, Resident #51 was observed in bed with full side rails and full padded bumpers. The bumpers were torn open exposing the foam padding over approximately 50% of the length of the bumper. The exposed padding was observed to be pitted and stained (photographic evidence obtained). The ADON was asked how staff were cleaning and disinfecting the exposed pitted foam, the ADON stated, I don't know, those need to be replaced immediately. During the environmental tour of the COVID-19 Unit on 05/06/20 and observation was made at 10:59 AM of a mechanical lift in the shower room with brown dried material on both handles (photographic evidence obtained). On 05/06/20 at approximately 12:00 PM an unlabeled clear spray bottle was observed in the doffing area of the COVID-19 Unit. Doffing is the practice of employees removing work-related Personal Protective Equipment (PPE). The ADON stated, that in order to conserve PPE staff was washing the protective face shields then spraying the face shield with the liquid in the unlabeled spray bottle. The ADON was asked what was in the unlabeled spray bottle, the ADON stated that he did not know. The ADON was asked what the contact time for the unknown liquid product in the unlabeled spray bottle, the ADON stated, I think it is ten minutes. The ADON was asked what staff did with the face shield after disinfecting them, the ADON stated, they take them home, so they don't lose them. The ADON was asked to clarify that facility staff working in the COVID-19 Unit are instructed to take used PPE home, the ADON stated, yes the face shields because we do not have a lot of them. The ADON was asked if it is the facilities expectation that all staff exiting the COVID-19 Unit doff all PPE and cleanse their face shield and stand in the COVID-19 Unit with no PPE on for the 10 minutes to disinfect the face shield, the ADON stated that the staff can put the masks in a plastic bag. It was observed at this time that there were no plastic bags in the COVID-19 Unit doffing area. The ADON stated that there should be plastic bags in the soiled utility room. The soiled utility room is located approximately 30 feet away from the doffing area. The ADON was asked what education had been provided to the staff when the facility opened the COVID-19 Unit or when new protocols are introduced. The ADON stated that the Staff Developer, a Registered Nurse, had done a tremendous amount of training and in-servicing related to the COVID Unit. On 05/07/20 at approximately 1:20 PM Staff W was observed placing soiled laundry in the linen chute on the COVID-19 Unit without a face shield. On 05/07/20 at approximately 04:30 PM, the Infection Control Nurse/Staff Developer was asked what education had been provided to the staff that related to the opening of and/or the daily staffing rolls and responsibilities of the COVID-19 Unit, the Infection Control Nurse/Staff Developer stated, none.