STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106137	A. BUILDING _____ B. WING _____	**06/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE PRESERVE	**14750 HOPE CENTER LOOP FORT MYERS, FL 33912**

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.** Based on observation and interview, the facility failed to implement an infection prevention and control plan based on Centers for Disease Control and Prevention Guidelines. Refer to: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html The findings included: On 6/15/20 at 12:35 p.m., during the kitchen tour with the Nursing Home Administrator (NHA), observed the Certified Dietary Manager (CDM) and 2 staff. Cook Staff A was standing near the sink washing a large object. Staff A's face mask was positioned below his nose and chin. The NHA and CDM confirmed Staff A should wear his face mask when in the facility. On 6/15/20 at 12:37 p.m., during the Therapy Room tour with the NHA, observed the Rehabilitation Director and 3 staff. Physical Therapy Assistant (PTA) Staff B was standing at the counter in a small kitchen area within the rehab unit. She was not wearing a mask. When Staff B saw the surveyor she took a mask from the box and put it on her face. Staff B said she was finished her shift and ready to leave the facility. She said she had her face mask off to drink some water. The NHA confirmed Staff B should wear a mask when she is in the facility. On 6/15/20 at 12:55 p.m., during a tour of the 2nd floor with the Director of Nursing (DON), observed Licensed Practical Nurse (LPN) Staff C sitting behind the nursing station typing on the computer. Staff C had her mask pulled down below her nose and mouth and her goggles were positioned up on her head. The DON confirmed Staff C should wear her mask and eye protection when working in the facility.

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.