STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105428	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRANDYWYNE HEALTH CARE CENTER	1801 N LAKE MARIAM DR WINTER HAVEN, FL 33884

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 observations, interviews, and record review, the facility did not maintain an infection control program related to isolation of gastrointestinal infectious disease for 7 (Resident #3, 4, 5, 6, 7, 8, and 9) of 7 residents sampled for isolation precautions of 108 total residents. Findings included: A review of the facility's Infection Control log revealed the following infection symptom trending and tracking information for residents on the 200 hallway: Surveillance started on 3/4/2020. Resident #3 - Vomiting and diarrhea. Onset 03/11/2020. Resident #4 - Diarrhea. Onset 03/11/2020. Resident #5 - Vomiting and diarrhea. Onset 03/12/2020. Resident #6 - Vomiting and diarrhea. 03/12/2020. Resident #7 - Diarrhea. Onset 03/12/2020 Resident #8 - Diarrhea. Onset 03/12/2020. Resident #9 - Diarrhea. Onset 03/12/2020. A tour of the 200 hallway of the facility was conducted on 03/12/20 at 12:25 PM. No isolation carts or door signage was observed in any resident rooms during the tour. An interview was conducted on 3/12/20 at 2:44 PM with the facility's Director of Nursing (DON). The DON stated that the facility was dealing with a gastrointestinal (GI) illness, which started on 03/04/2020. The DON stated that the GI illness was being treated as Norovirus based on the signs and symptoms. The GI illness started with 2 residents on the 1st floor, the facility's lockdown unit for Alzheimer's and Dementia, but the cases of GI illness increased. The residents on the 1st floor were isolated to the unit due to the increase in GI illness and visitation was limited to residents on the 1st floor. The facility also stopped admitting residents to the 1st floor of the facility during the outbreak. Residents were observed 72 hours after signs and symptoms were resolved. Staff that were effected with signs and symptoms were to report symptoms and be completely without symptoms for 48 hours before returning to work, per facility policy. The DON stated that they were unable to place residents on the 1st floor on isolation because of the population of Alzheimer's and Dementia residents on the floor and the inability for them to be instructed to stay isolated. The Health Department and the Medical Director were also notified of the potential outbreak on 03/04/2020. The DON stated that resident's on the 200 unit with signs and symptoms were put on isolation precautions. A tour was conducted on the 200 unit on 3/12/20 at 04:35 PM with the DON to verify that effected residents were on isolation precautions. The DON addressed that no residents on the 200 hall were on isolation precautions. The DON stated that residents with signs and symptoms of GI illness would be placed on contact isolation immediately. A review of the facility policy titled Norovirus Prevention and Control revealed under the section Policy Interpretation and Implementation that residents should be placed on Contact Precautions in a single occupancy room, if possible, when symptoms are consistent with Norovirus gastroenteritis. The policy also revealed that during outbreaks, residents with Norovirus gastroenteritis will be placed on Contact Precautions for a minimum of 48 hours after the resolution of symptoms. A review of the Department of Health recommendations and guidance for the control of Norovirus outbreaks, dated 05/19/2020, recommended that infection control measures, which may include contact isolation, should be instituted immediately with a single case of diarrhea of new onset without a non-infectious etiology. The guidance also recommended to exclude all non food service staff members for at least 48 hours after resolution of symptoms. An interview was conducted on 03/12/20 3:19 PM with Staff Member B, Maintenance, regarding the facility's GI illness outbreak. Staff B stated that around 04:00 AM on 03/09/2020, he had an episode of vomiting and an increased temperature around 100 degrees Fahrenheit. He sent a text message to the facility's Administrator and Staff Member E, Housekeeping Supervisor, and reported his symptoms. Staff B returned to work on 03/10/2020 and stated that he did not speak to the Administrator or Staff E before returning to work and that he returned to work because his GI symptoms had subsided. An observation was made in the 200 unit of the facility on 03/13/2020 at 10:22 AM. During the observation, Staff F, Housekeeping, was cleaning Resident #3's room. Signage on Resident #3's door indicated that he was placed on isolation precautions and to see the nurse before entering the room. Staff F was observed inside of Resident #3's room performing housekeeping duties, not wearing any personal protective equipment. Staff F was interviewed and stated that she did not see the signage posted on Resident #3's door before going into the room and that she did not know that Resident #3 was on isolation precautions. Staff F then donned a protective gown, gloves, and a face mask before re-entering the room. Staff F did not perform hand hygiene before donning personal protective equipment. A follow up observation was made on 03/13/2020 at 10:36 AM of Staff F. Staff F was observed removing her protective gown, gloves, and face mask after cleaning Resident #3's room. Staff F then disposed of the items and moved across the hallway to clean another resident room. Staff F did not perform hand hygiene after removing her personal protective equipment. Staff F stated that she did not perform hand hygiene in Resident #3's room because she just cleaned Resident #3's room and performing hand hygiene would contaminate the room. Staff F also stated she would perform hand hygiene upon entering the next resident room because the room is already dirty. An interview was conducted on 03/13/2020 at 10:46 AM with Staff C, Licensed Practical Nurse regarding Resident #3's isolation precautions. Staff C, LPN stated that she was not sure why Resident #3 was on isolation precautions and that she was not aware of any cases of Norovirus on the 200 unit. Staff C, LPN also stated that she does not usually work on the 200 unit and was not familiar with all of the residents. An interview was conducted on 03/13/20 at 11:03 AM with the DON. The DON stated that isolation precautions were presumptively based on the Norovirus outbreak and that it was communicated to the staff on the 200 unit. The DON also stated that the housekeeping staff was also aware of the Norovirus outbreak and that she would expect housekeeping staff to wear personal protective equipment before cleaning the room of a resident on precautions. Floor nurses should be aware of why residents are on isolation and what precautions to take. Housekeeping staff should speak with the nurse on the unit so they would know what personal protective equipment (PPE) to don just like the sign says. The DON stated that she would expect staff to perform hand hygiene after removing PPE and before entering another resident's room. An interview was conducted on 03/13/20 at 11:14 AM with Staff E, housekeeping supervisor. Staff E stated that they received updates regarding the facility's GI illness outbreak in the morning meeting and that findings are also communicated to housekeeping staff. Housekeeping staff were notified of which residents were on isolation and that they should be communicating with the nurse to see what PPE they need to use. Staff E stated that she would expect housekeeping staff to perform hand hygiene after removing PPE and before leaving a resident's room. An interview was conducted on 03/13/20 at 12:10 PM with the facility's Administrator (NHA). The NHA stated that she experienced symptoms of GI illness on the night of 03/05/2020, but still came in to work on 03/06/2020. The NHA also stated that she isolated herself in her office on 03/06/2020 and away from residents. Addressed that the Health Department recommended that employees should not return to work for 48 hours after symptoms subsided, but stated that she was feeling better on 03/06/2020. The NHA stated that she may have allowed staff members that showed signs of GI illness to return to work sooner than 48 hours, but could not recall any specific instances. An interview was conducted on 03/13/2020 at 01:03 PM with the facility's Medical Director (MD). The MD stated that he was notified of the possible Norovirus outbreak about a week ago and that he had ordered stool samples for the effected residents to confirm the [DIAGNOSES REDACTED]. The MD stated that staff, including housekeeping staff, should be using contact isolation precautions for any residents that display symptoms of Norovirus. The MD also stated that staff should not return to the building unless they have been free of signs and symptoms for at least

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 -** Few	(continued... from page 1) 48 hours. An interview was conducted on 03/13/20 1:49 PM with Staff A, Registered Nurse (RN). Staff A, RN stated that she felt nauseous while at work on 03/02/2020, but did not have any other symptoms at the time. Staff A, RN stated that on 03/03/2020 she had increased symptoms of GI illness, but came to work on 03/04/2020. She mentioned to the previous DON on 03/05/2020 that she had experienced symptoms of GI illness on 03/03/2020, but was feeling better. Staff A, RN stated that the DON allowed her to remain at work. An interview was conducted on 03/13/20 at 01:54 PM with Staff G, Floor Tech. Staff G stated that he experienced symptoms of GI illness on 03/07/2020, but felt better on 03/08/2020. Staff G stated that his symptoms returned on 03/09/2020 upon driving to the facility, so he went home. Returned to work on 03/10/2020. Staff G stated that Staff E, housekeeping supervisor told him that he may return to work but that the DON told him to not return for 48 hours. Staff G stated that he remained at work on 03/10/2020 and did not discuss it with the DON.