STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106005	A. BUILDING _____ B. WING _____	**04/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES	**16200 JOG ROAD DELRAY BEACH, FL 33446**

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 observations and interviews, the facility failed to have personal protection equipment (PPE) available in the dirty laundry area and in the isolation carts on the COVID-19 positive unit, for 2 of 2 units (100 and 200 units). The facility's census totaled 72. The facility has a total of 4 positive COVID-19 residents and 1 positive COVID-19 staff member. The findings included: On 04/23/20 at 3:30 PM a tour of the facility was conducted with the Palm Beach Department of Health Representatives and the Administrator and Director of Nurses (DON) due to positive COVID-19 cases in the facility. During the tour of the 100 unit where the positive residents are there were empty isolation carts outside of the rooms. There were small red signs indicating to see the nurse on the doorway and carts in the hallway, but the carts only contained stethoscopes, and thermometers. The nurse working the COVID-19 unit was asked where the supplies were to enter the COVID-19 room(s) and she replied that she goes to the other nurse who is working on the unit next to her who has the keys to open the area where the gowns are. Her face shield is in a bag by the nurse's desk. When asked what would happen if there was an emergency with a resident on isolation the DON did not have an answer to how nursing would get in the room quickly donned with PPE. The administrator stated that gowns are disappearing so she didn't want them kept in the isolation carts where the supply can't be monitored closely. The tour continued to the laundry room. Upon entering the dirty area, there were no gowns, no utility gloves and no mask with goggles. There were 5 buckets in the sink and some hangers. The administrator stated she did not know why the buckets were in the sink or if they were dirty. She replied that the director of housekeeping was not in the building. An interview was conducted with the laundry aide on 04/23/20 at 4:15 PM who was observed folding laundry with a yellow gown on before she exited the clean room. The laundry aide stated that she needed more gowns for the dirty area and more gloves. She was holding a box of gloves. She stated that she used a gown when she was in the dirty area . After exiting the laundry area, the kitchen was observed. Kitchen staff were wearing their masks below their nose. One of the kitchen staff was on his cell phone while working with gloves on and a mask under his nose. The Administrator corrected him and told him to wash his hands and throw the bread away that he was getting out of the bag. The tour continued to the 200 unit where the COVID-19 positive cases were first identified. There were no hand sanitizers mounted on the walls in the hallway . The administrator stated that they were unable to obtain the mounted sanitizers. The nurses had hand sanitizers on their carts. Those rooms are being used as isolation rooms for new admissions as they are on a 14-day quarantine when they come into the facility. This surveyor asked for their line list. The DON stated that she sent a line list to the Department of Health (DOH). I asked her for a copy. She revealed that she did not start a line list from the beginning of the outbreak, but she wrote everything down on paper. She returned 20 minutes later with a line list that was not complete. This surveyor reviewed the line list with the DON and administrator and filled in when the residents were tested and when they tested positive or negative for COVID-19. A review of the policy for laundry services issued 5/2013 reveals techniques minimizing potential healthcare associated and occupational risks associated with soiled linen handling linen include: wear personal protective equipment to include impermeable apron or gown, utility gloves and mask with goggles during manual rinsing and sorting. The Center for Disease Control (CDC) guidelines for PPE from Preparing for COVID-19 in Long Term Care (LTC) include: Make necessary PPE available in areas where resident care is provided, consider designating staff responsible for stewarding those supplies and monitoring and providing just-in-time feedback promoting appropriate use by staff. Facilities should have supplies of facemasks, respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit tested HCP), gowns, gloves, and eye protection (i.e., face shield or goggles).

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE