STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106012	A. BUILDING _____ B. WING _____	06/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF PORT SAINT LUCIE	3720 SE JENNINGS RD PORT SAINT LUCIE, FL 34952

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** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review and interview, the facility failed to implement infection control measures to minimize the risk of transmission of the COVID-19 virus. The facility failed to advocate for dedicated staff for residents exposed to the COVID-19 virus, failed to appropriately quarantine 1 of 4 residents exposed to the COVID-19 virus (Resident #3), failed to limit staff movement within the COVID-19 unit and failed to wear face covering inside the facility. The findings included: Facility policy titled Coronavirus (COVID 19) ([DIAGNOSES REDACTED]-C0V-2) Revised: 3/17/2020, 3/18/20, 3/19/20, 3/24/20, 4/02/2020, 4/03/2020, 4/13/2020, 4/15/2020, 4/20/2020, 4/21 4/27/2020, 4/28/2020, 5/05/2020, 5/07/2020, 5/13/2020 and 5/22/2020 documents the following: Purpose To provide a framework to minimize the risk of potential exposure to the Coronavirus COVID-19 in the long-term care facility. Per CMS directive issued 4/2/2020, all facility associates should wear a facemask/face covering while they are in the facility for the duration of the state of emergency in their state. If the facility is not located in a state that has declared a state of emergency and COVID-19 is present in the facility or ongoing community transmission is present the facility, the associate will utilize face mask or other forms of facial coverings to reduce respiratory droplet spread to residents and other staff within the facility. Bed Management Strategies and Cohorting The facility should develop a plan for managing the following resident types, all of these residents will need to be placed in droplet and contact precautions with eye protection. N95 respirators should be used for care of these residents if available (a medical grade face of mask can be used if N95 respirators are not available, but and N95 respirators must be used for all aerosol generating procedures); New admissions and readmissions, Residents with COVID-19 exposures, and residents who develop symptoms. COVID-19 positive residents Cloth face coverings are not considered PPE (Personal Protective Equipment) and should not be worn by HCP (Healthcare Provider) when PPE is indicated. Cohorting decisions should be performed in consultation with local or state health department and current CDC (center of Disease Control) guidance. The facility should place residents in dedicated areas of the facility depending on COVID 19 status. Colors (Red, Yellow, Green) can be used on facility maps to help visualize testing results to facilitate moving of residents. COVID-19 Positive (Red) - These are residents who are confirmed COVID-19 positive and who, based on CDC criteria, still warrant transmission-based precautions. These residents should be placed in transmission-based precautions (droplet and contact) and cohort into a COVID-19 wing, floor, or building. If facilities have dedicated COVID-19 memory units, residents may continue to socialize so long as there are no COVID-19 negative residents or residents with unknown COVID-19 status in these units. Assign dedicated HCP to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. HCP working on the COVID-19 care unit should ideally have a restroom, break room, and work area that are separate from HCP working in other areas of the facility. To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the unit. Assign housekeeping associates to work only on the unit. Unknown COVID-19 status (Yellow): All residents in this category warrant transmission-based precautions (droplet plus contact with eye protection.) Waiting for test results - These are residents whose COVID-19 status is unknown. This can include; Residents who are admitted , or readmitted , to a facility where they are likely to have been exposed to COVID-19 (e.g., transferred from a facility with an outbreak). Residents who have been tested and are waiting on results, Residents in this category should, if possible, be isolated from residents with a known COVID-19 status (both positive and negative). Residents in this category who have been tested and are waiting on results, may stay in their facility location until test results are back. This can include remaining with a roommate who is known to be COVID- 19 positive if no other private rooms are available. If a private room is available the unknown should be transferred to a private room. After test results are back residents should be moved to the appropriate area of the facility. If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit. For a resident who tests negative for COVID-19, but has had a roommate who is positive, it is not recommended to place them with another roommate until 14 days after their exposure, assuming they have not developed symptoms or had a positive test. Ensure HCP practice source control measures and social distancing in the break room and other common areas (i.e., HCP wear a facemask and sit more than 6 feet apart while on break). During the observation tour of the facility, conducted on 06/11/20 starting at 8:45 AM, while accompanied by the Assistant Director of Nursing (ADON), who is the Infection Preventionist, and the representatives from the Department of Health (DOH) revealed the following concerns. Interview with Staff A, a Licensed Nurse, conducted on 06/11/20 at approximately 9 AM, revealed she currently cares for residents that have tested negative for the COVID 19 virus and residents that are in quarantine due to being exposed to [MEDICAL CONDITION]. Staff A is concerned that the residents moved last night, (06/10/20) from the Long -Term Care Unit were exposed to [MEDICAL CONDITION] and are now mixed in with other residents with no previous exposure. Staff A is not sure of how many residents because the movement of residents just happened. Interview with the ADON on 06/11/20 at approximately 9:10 AM to clarify the cohort/quarantine unit revealed last night (06/10/20), after conferring with the DOH, the facility moved multiple residents to create the COVID-19 Unit. Residents from the long-term care unit were moved to the cohort/quarantine unit and the long- term care unit was converted into the COVID-19 unit, as most of the positive cases originated in the long- term care section. The current Cohort/Quarantine section is for new admissions, which they are not taking any at this time, and for residents that went out (either for medical appointments or hospitalization s) and have returned to the facility; and residents that have been exposed to [MEDICAL CONDITION] by residents that have tested positive. The ADON verified the unit now also has residents that tested negative and is not sure how many negative residents with no previous exposure to the COVID-19 virus are in the unit and is not sure how many are sharing the same staff or rooms with residents in quarantine. Furthermore, The ADON was not sure how many residents that have tested negative and had no known exposure were placed in rooms with residents that are in quarantine. The administrator and DON coordinated the resident placement and the ADON doesn't have the complete count of residents that were relocated at this time. Further observation of the cohort/quarantine unit at approximately 9:35 AM, revealed Resident #3, who was identified as being exposed to [MEDICAL CONDITION] by a roommate who tested positive on 06/06/20 (Resident #5), had a roommate. Per the ADON, Resident #3's tests results are pending and confirmed the resident has a new roommate (Resident #6). The ADON was questioned regarding his placement and replied she thought the resident was placed in a single room for fourteen days. Review of the facility clinical records indicates Resident #6, (the current roommate for Resident #3), had tested negative as of 06/10/20 and no previous exposure to [MEDICAL CONDITION] have been identified. The ADON reiterated, many residents were moved over night, she is not sure how many, but knows all positive COVID-19 residents are now in the COVID-19 unit and cannot explain, the set up in the cohort/quarantine unit for bed placement. Observation conducted on 06/11/20 at 10:13 AM revealed two dietary staff members sitting in an office, not [MEDICATION NAME] social distancing. One of the staff did not have a mask or face covering, until the surveyor and DOH members looked thru the glass window. Subsequently, the ADON advised them to wear the N95 masks at all times. The ADON explained the staff has been mandated to wear the provided N95 masks at all times while in the facility. Observation conducted on 06/11/20 at approximately 10:22 AM

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 -** Some	(continued... from page 1) revealed a male staff member (Staff B) leaving the COVID-19 unit using the courtyard entrance. Interview with Staff B, a Licensed Nurse, revealed he went in the unit to pick up medications for one of his patients. The staff stated he washed his hand before entering and after leaving and was not aware of entrance restrictions to minimize traffic to the COVID-19 unit. Staff B knew there is a separate entrance to the unit from the outside of the building. On 06/11/20 at 10:30 AM, the Director of Nursing (DON) and ADON escorted the surveyor and Department of Health members to the COVID-19 unit. The ADON led the way by exiting the building thru the main door, at this time it was noted, Staff D, in the admission office, was not wearing a face mask or face covering. The ADON was advised and the staff member apologized and stated she knows masks are required while in the facility and proceeded to put on her mask. Random observation conducted on 06/11/20 at 10:47 AM, revealed Staff C, a housekeeper entering the COVID-19 unit from the courtyard. The staff was not wearing eye protection. Interview with the staff revealed she is the assigned housekeeper for the COVID-19 unit and left the unit using the courtyard entrance to have her lunch in the staff break room, and she was just returning to work. The staff was able to verbalize the required PPE but could not explain why she was not wearing eye protection. The ADON and DON who were present during the observation, stated the changes to the layout are new to the staff and they will reeducate the staff as needed. The COVID-19 unit has a separate entrance, and the maintenance person, is working on signs to minimize entrance to the unit from the main building and use of the required PPE. Interview with The DON on 06/11/20 at approximately 1:30 PM, revealed the facility delay in creating a dedicated unit for positive COVID-19 residents and implementing dedicated staff for this unit, was due to miscommunication with the Department of Health and waiting on their guidance for residents' placement.