STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105924	A. BUILDING _____ B. WING _____	**05/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLOUNTSTOWN HEALTH AND REHABILITATION CENTER	**16690 SW CHIPOLA RD BLOUNTSTOWN, FL 32424**

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 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 with representatives from the State of Florida public health authority (Florida Department of Health (DOH)), facility staff interviews and record reviews, the facility failed to consistently follow DOH, Centers for Disease Control and Prevention (CDC), State Survey Agency, (Agency for Health Care Administration (AHCA)), the Florida Division of Emergency Management (DEM) and the Centers for Medicare and Medicaid (CMS) infection control orders, directives, recommendations and guidelines related to the Coronavirus Disease 2019 (COVID-19) pandemic. The Administration failed to implement appropriate isolation precautions and cohorting recommendations for both COV1D-19 infected residents and Persons Under Investigation (PUIs) to control or prevent the potential spread of COVID-19. The Administration failed to consistently deny entry to staff members with sore throats, coughs, and/or other possible COVID-19 symptoms and failed to consistently screen employees prior to the start of their shifts. The Administration also failed to provide adequate training to staff regarding personal protective equipment (PPE). These failures affected all 81 residents residing in the facility on [DATE] plus 2 additional COVID-19 infected residents who had been hospitalized (#12 & 13). The facility failures resulted in 23 residents, some from every wing in the facility, becoming infected with COVID-19 as of [DATE] (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 15, 16, 20, 21, 31, 33, 34, 35, 36, & 38). The facility census on [DATE] was 81. Individuals who are [AGE] years and older, those with chronic underlying medical conditions, and those living in nursing homes are at high risk for developing serious complications from COVID-19 illness. Individuals who are infected could develop serious disease with difficulty breathing, and might require intensive care for the treatment of [REDACTED]. COVID-19 infection can lead to death. COVID-19 is a new disease, caused by a new coronavirus that has not previously been seen in humans. Currently, there is no vaccine and no approved treatment for [REDACTED]. The cumulative result of these administrative concerns led to a widespread finding of immediate jeopardy at a scope and severity of L. The Nursing Home Administrator was informed of the findings of immediate jeopardy on [DATE] at 3:15 PM. It was determined the provider's non-compliance caused, or was likely to cause, serious injury, harm, impairment or death to residents. The immediate jeopardy was determined to start on [DATE] and was ongoing. Cross reference F880. The findings include: On [DATE], The Office of the Governor issued Executive Order Number ,[DATE] directing the Florida Department of Health to issue a Public Health Emergency. The Executive Order documented, Coronavirus Disease 2019 (COVID-19) is a severe acute respiratory illness that can spread among humans through respiratory transmission and presents with symptoms similar to those of influenza. Section 2 directed the State Health Officer to take any action necessary to protect the public health. Section 3 directed the State Health Officer to follow the guidelines established by the CDC (Centers for Disease Control and Prevention) in establishing protocols to control the spread of COVID-19. Section 4 designated the Florida Department of Health as the lead state agency to coordinate emergency response activities among the various state agencies and local governments. Section 5 specified that all actions taken by the State Health Officer with respect to this emergency before the issuance of this Executive Order are ratified. Section 6 stated The Florida Department of Health will actively monitor, at a minimum, all persons meeting the definition of a Person Under Investigation (PUI) as defined by the CDC for COVID-19 for a period of at least 14 days. Active monitoring by the Florida Department of Health will include at least the following: A. Risk Assessment with 24 hours of learning an individual meets the criteria for a PUI and B. Twice daily temperature checks. Section 7 directed the Florida Department of Health, pursuant to its authority in section 381XXX , Florida Statutes, will ensure that all individuals meeting the CDC's definition of a PUI are isolated or quarantined for a period of 14 days or until the person tests negative for COVID-19. Section 8 directed Florida Department of Health to make its own determinations as to quarantine, isolation and other necessary public health interventions as permitted under Florida Law. Section 9 directs all agencies under the direction of the Governor to fully cooperate with the Florida Department of Health, and any representative thereof in furtherance of this Order. On [DATE], The Office of the Governor issued Executive Order Number ,[DATE] declaring a state of emergency for the entire State of Florida as a result of COVID-19. On [DATE], the Division of Emergency Management (DEM) Emergency Order No. ,[DATE] restricting entrance into residential health care facilities including nursing homes. The Order limited persons who were allowed to enter the facility and directed screening of all individuals seeking entry. The order documented, Individuals seeking entry to the facility under the above section 1 (includes staff) will not be allowed to enter if they meet any of the screening criteria listed below: a. Any person infected with COVID-19 who has not had 2 consecutive negative test results separated by 24 hours; b. Any person showing, presenting signs or symptoms of, or disclosing the presence of a respiratory infection, including cough, fever, shortness of breath or sore throat; c. Any person who has been in contact with any person(s) known to be infected with COVID-19, who has not yet tested negative for COVID-19 within the past 14 days; d. Any person who traveled through any airport within the past 14 days; or e. Any person who traveled on a cruise ship within the past 14 days. Part 5 of the Order stated, The following documentation must be kept for visitation within a facility: a. Individuals entering a facility subject to the screening criteria above may be screened using a standardized questionnaire or other form of documentation. b. The facility is required to maintain documentation of all non-resident individuals entering the facility. Documentation must include: 1. Name of the individual; 2. Date and time of entry; and 3. The documentation used by the facility to screen the individual showing the individual did not meet any of the enumerated screening criteria, including the screening employee's printed name and signature. The President declared a Nationwide emergency for COVID-19 on [DATE] and approved a major disaster declaration for Florida on [DATE]. On [DATE] the Agency for Health Care Administration (AHCA), the state survey agency, issued an Alert entitled, Residential and Long Term Care Facilities to Implement Universal Use of Facial Masks. The directive stated, Effective immediately staff of residential and long term care facilities are to implement universal use of facial masks while in the facility. All staff, essential healthcare visitors and anyone entering the facility are to don a face mask upon the start of their shift or visit and only change it once it becomes moist. It is important to keep hands away from the face mask and only touch the straps of the face mask. Gloves are to be worn when providing care to the resident. Continue to perform hand hygiene prior to donning gloves, after removing gloves, and anytime there is contact with the resident environment. Staff in a room with a patient with respiratory symptoms of unknown cause or a patient with known or suspected COVID-19 should adhere to Standard, Contact, and Droplet Precautions with eye protection. This includes wearing gown, gloves, N95 face mask (as fitted and available - if not available, at least a facial mask), and eye protection such as face shields or goggles. In addition to securing more gowns, gloves, and masks, facilities will need to immediately order the appropriate eye protection (I.e. face shields) since many do not have this on hand. In the event you are unable to acquire the necessary PPE, please notify your local emergency management agency. Facilities will need to educate their staff on the proper donning (putting on), doffing (taking off), and disposal of any PPE. Information about

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 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) the recommended duration of Transmission-Based Precautions is available in the Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of hospitalized Patients with COVID-19. 1. Administration's failure to implement appropriate isolation precautions and cohorting recommendations for both COV1D-19 infected residents and Persons Under Investigation (PUIs) to control or prevent the potential spread of COVID-19: On [DATE] at approximately 12:50 PM, during the entrance conference, the Nursing Home Administrator (NHA) and Director of Nursing (DON) identified the 400 hall as the isolation unit for COVID-19 infected residents. At about 1:50 PM the NHA and DON stated that the 500 Hall was designated as a monitoring area for hospital transfers and residents requiring observation. On [DATE] at approximately 11:20 AM the surveyor asked the DON to provide resident surveillance records and a comprehensive list containing all test data for all residents in the facility. The DON was unable to provide a comprehensive list of test information for all residents including which laboratory conducted the testing, what date the tests were obtained and what date the results were received, as many residents had been tested more than once and by different laboratories. However, she did provide a Line List (list of ill residents) for residents which had fields for resident name, age, sex, room number, date of onset, duration of illness, fever, cough, sore throat, runny nose, nasal congestion, chest congestion, shortness of breath, muscle aches, vomiting, diarrhea, pneumonia, x-ray results, hospitalization , death, COVID-19 and date of COVID-19 test, among others. The Line List did not contain all relevant information and in some cases contained inaccurate information. The list contained the names of 25 residents and two entries were whited out. The fields for age and duration of illness were not completed for any resident. Room numbers were not recorded for two residents (Resident #2 and #4). Date of onset was not recorded for seven residents (Residents #3, 8, 10, 13, 15, 33 and 34). Some of the asymptomatic roommates of positive residents were included on the list while others weren't. Resident #1's test result was documented as being obtained by the hospital when she hadn't been to the hospital. Similarly, the surveyor noticed that a resident who was known to be at the hospital (Resident #12), was not indicated to be at the hospital. The surveyor brought this to the DON's attention who stated that it was actually Resident #12, not Resident #1 who was at the hospital and said, I don't know what I did there. Further review of the Line List revealed Resident #7 was tested on [DATE] with a positive result on [DATE] but was recorded with a negative test result on the DON's undated census that was being used to track residents' COVID-19 status. The surveyor brought this to the DON's attention who stated that it was a mistake and Resident #7 is indeed positive. Resident #39's test date according to the Line List was listed as [DATE] while the DOH, who conducted that test, documented a [DATE] test date. Resident #35's test date was listed as [DATE] on the Line List whereas it was documented as [DATE] on the undated census the DON was using to record resident test results. Lastly, the Line List revealed Resident #43 on the 300 wing developed a fever and cough on [DATE] and was diagnosed with [REDACTED].#44 on the 300 wing developed a fever, cough and chest congestion on [DATE]. Both residents had roommates according to the census, however, neither roommate appeared on the Line List. And neither Resident #43 or #44's rooms were observed to have precautions in place during the facility tours. On [DATE] at approximately 12:40 PM a tour conducted of the isolation unit (400 Hall) with the DON which revealed that 4 of the rooms had COVID-19 infected (positive) residents (#2, 4, 5, 10), sharing a room with COVID-19 negative residents (#14, #30, #31 and #33) and one of the rooms had a PUI (#39) sharing a room with COVID-19 negative resident (#36). Also observed were three rooms that housed COVID-19 negative residents (#41, 37, 35, 42, 26 & 27) who had not been moved off the isolation unit despite being asymptomatic and receiving negative test results. When asked, the DON confirmed the negative test results and added that resident #26 and #27 were being moved off the hall so that their room can be used for a staff breakroom. The surveyor expressed concern to the DON again regarding the presentation of rooms on the isolation unit. The DON stated that designated staff working the hall know which residents are positive and which are negative and there aren't enough bins to setup separate isolation precaution stations outside each room so there are no signs or PPE stations setup outside each individual room. She also stated that she was trying to move the negative residents off the isolation. As the tour of the facility continued it was observed that 2 resident rooms, outside the dedicated isolation area, were noted to have COVID-19 Positive residents (511 & 602) and there were 5 rooms (504, 508, 511, 602, & 604) that housed residents who were PUIs. There was no signage indicating isolation or contact precautions, there was no PPE available for use and the doors leading into the rooms were found to be open. Review of the facility's policy, Novel [MEDICAL CONDITION] Prevention and Response Policy, with a [DATE] implementation date, revealed under Section 5(e)(i), Posting signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE. Further review of the policy under Section 5(e)(ii) revealed, Make PPE, including facemask, eye protection, gowns, and gloves, available immediately outside of the resident's room. According to the CDC's webpage titled, Responding to Coronavirus (COVID-19) in Nursing Home, last reviewed on [DATE] and located at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html, roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for COVID-19 14 days after their last exposure (e.g. date their roommate was removed). 2. Administration failure to consistently deny entry to staff members with sore throats, coughs, and/or other possible COVID-19 symptoms: On [DATE] at approximately 12:50 PM, the joint DOH and AHCA team conducted an interview with the DON and NHA. The surveyor asked for confirmation of the current number of known cases. They stated that there's one positive resident, Resident #11, and two positive staff, Staff O, Activities, and Staff T, an RN. The surveyor asked for an explanation of events leading up to the identification of the first positive case, Resident #11. The NHA stated that resident (#11) had coded (required resuscitation) several times before she was transferred to the hospital on [DATE]. The DON stated that three nurses responded to the code events: RN X, , LPN JJ, and LPN KK. The DON stated that RN X and LPN KK both performed Cardiopulmonary Resuscitation (CPR). The surveyor asked about the status of each of the three staff involved and the NHA stated that RN X was at home self-isolating, LPN KK, who was pregnant, decided not to return to work after being informed of her COVID-19 exposure, and LPN JJ was currently working. The surveyor asked if designated staff were overseeing the employee screening at the door. The NHA stated that the staff that was there at the time, Dietary Staff RR, covers the screening booth from 08:00 AM to 5:00 PM and approximately nine other staff who are department heads have screening responsibilities when she's not there. The surveyor asked if any staff had failed the screening process due to fever or report of other symptoms and the NHA replied, No. The surveyor asked how many residents currently had respiratory symptoms. The DON responded one, Resident #1, who had an 80% oxygen saturation on room air and a fever of 101 degrees Fahrenheit. The surveyor asked the DON how frequently residents are being screened for symptoms and she stated once per 12-hour shift. On [DATE] a review was conducted of the staff screening materials from [DATE] through [DATE]. The records reflected that 20 staff from all departments within the facility including direct care, nursing, and housekeeping, presented for their shifts reporting coughs, fever, shortness of breath, headache, loss of taste or muscle ache, often a combination of several symptoms, and were nonetheless directed to report for service within the facility (Staff A, H, I, L, J, K, M, U, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, & HH). One of these individuals, Staff U, a Licensed Practical Nurse (LPN), was sent home on [DATE] by representatives of Florida's Department of Health (DOH) after LPN U had served residents for approximately four (4) hours. Review of the facility's policy Coronavirus Surveillance implemented [DATE] revealed under Policy Explanation and Compliance Guidelines section 8 revealed The facility will refer to current CDC guidance for exposures that might warrant restricting asymptomatic staff from reporting to work. 3. Administration's failure to adhere to CDC guidance and AHCA and DOH staff recommendations to keep resident's doors closed: On [DATE] at approximately 12:40 PM, a joint DOH and AHCA visit was conducted at the facility with the following DOH staff: Calhoun & Liberty Counties Health Administrator (CHA), Epidemiologist and Long-Term Care Liaison. The team made observations of resident room doors throughout the building being left open. This included 6 of the 8 resident rooms on the 100 Hall; 5 of the 7 resident rooms on the 200 Hall; 9 of 11 resident rooms on the 300 Hall; and 7 of 8 rooms on the 600 Hall. On the 400 Hall, the Isolation unit, all resident room doors with exception of rooms [ROOM NUMBERS] were observed to be open. On [DATE] at 2:40 PM, a conference was conducted with the joint team and the facility DON and the facility Administrator. The team made recommendations which included keeping resident room doors closed throughout the facility to help contain the spread of COVID 19. On [DATE] at approximately 11:20 AM, the AHCA surveyor and facility DON conducted a tour of the facility which revealed that most doors on the 100 Hall were open, 6 out of 7 resident room doors on the 200 Hall were open, most resident room doors on the 300 Hall were open and 5 of the 10 rooms observed on the isolation unit (400 Hall) were documented as being open during the tour. The DON was reminded of guidance provided by DOH and the CDC to keep resident room doors closed. The next day, on [DATE] at approximately 11:00 AM, a tour of the facility revealed that the following resident rooms were observed with open doors: 103, 105, 109, 201, 202, 203, 205, 206, 207, 303, 305, 306, 307, 309, 310, and 311. A review of the Interim Infection Prevention and Control recommendations for patients with suspected for confirmed COVID-19

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F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) in Health Care Settings under Key Concepts retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html Isolate symptomatic patients as soon as possible. Set up separate, well-ventilated triage areas, place patients with suspected or confirmed COVID-19 in private rooms with the door closed. 4. Administration's failure to provide adequate training to staff regarding personal protective equipment (PPE): On [DATE] at approximately 1:50 PM, the surveyor observed Dietary Staff A in the kitchen rolling metal silverware in paper napkins. She had a surgical face mask around her neck and no gloves on. Dietary Staff A saw the surveyor and pulled her surgical face mask up over her nose and mouth. She then immediately resumed rolling silverware. Dietary Staff A did not perform hand hygiene before or after touching her surgical face mask. On [DATE] at approximately 1:50 PM, the surveyor immediately brought the identified concern to the NHA's attention. The NHA and the Certified Dietary Manager (CDM) re-educated Dietary Staff A on hand hygiene and facility policy regarding face masks. On [DATE], an observation was made of a housekeeping cart in use by Staff B, a Housekeeper, which did not visibly indicate it was designated for the isolation hall only. At approximately 2:15 PM, the surveyor asked Housekeeper B if there was a designated cart for the isolation hall. She replied, No. The surveyor asked if she used that same cart to clean other parts of the facility and she stated that she used it to clean the 600 Hall earlier that shift. The surveyor asked how often the mop solution is changed and Housekeeper B responded that the bucket is filled at the start of her shift and the mop heads stay in that same solution until the end of her shift when housekeeping launders them. At approximately 2:30 PM, the surveyor asked the Maintenance Director if there was a designated housekeeping cart for the isolation hall. He replied, As far as I know there isn't one. On [DATE], an observation was made in the isolation unit (400 hall) of the facility during which three bins were noted at the end of the hallway inside the double doors leading out to the East Wing Nurses' Station. The surveyor asked the DON, who was present, to explain the purpose for each bin. The DON stated that one was intended for trash, one for torn/soiled gowns to be discarded and one for gowns that are in good condition to be re-used. The surveyor questioned the practice of re-using disposable gowns that are not intended for repeat use. On [DATE] at approximately 12:55 PM, Staff V, a CNA, was observed exiting room [ROOM NUMBER]. The door to room [ROOM NUMBER] was open and had an airborne precaution sign posted on the door. CNA V did not remove the yellow gown or surgical face mask she was wearing before exiting room [ROOM NUMBER], which housed two COVID-19 infected residents. CNA V immediately walked across the hallway to enter room [ROOM NUMBER], which housed two COVID-19 negative residents, while wearing the same yellow gown and surgical face mask in place. room [ROOM NUMBER] also had an open door, and no droplet precaution sign was on the door. Before CNA V entered room [ROOM NUMBER] this surveyor stopped her. An interview with CNA V was immediately conducted. The surveyor asked why she was wearing the gown in the hallway after exiting a resident's room who was on airborne precautions. CNA V did not have an immediate answer. The surveyor advised of the CDC recommendation regarding not exiting an isolation room without first removing the PPE, especially when there are residents and staff in this area who have tested negative. The surveyor further communicated that staff should not enter the room of a resident, who has not yet tested positive, wearing soiled PPE. In response, CNA V stated, We did not know we were supposed to do all of that. At this time the surveyor then asked which staff members were caring for the residents who were positive, and which were caring for those who were negative. The surveyor expanded on the inquiry and asked if specific CNAs and nurses were caring for the positive residents and other staff members caring for those who were negative. CNA V replied, No, we care for all the residents back here. CNA V further stated, No one has told us. We did not know. The surveyor asked: Why are the doors on this hallway open? CNA V replied, We were not told to close them. The surveyor advised CNA V of the CDC and DOH recommendation that all doors on the hall should be closed. The staff later closed all the doors on the hallway. A review of the job description for the administrator that was electronically signed on [DATE] revealed the General Purpose of this position is To lead and direct the overall operations of the facility in accordance with customer needs, government regulations and company policies, with focus on maintaining excellent care for the residents . A review of the unsigned job description for the Director of Nursing (DON) revealed that the DON Performs specific functions outlined in the Job Description/Performance Appraisal, which includes, but is not limited to, assumes accountability for the development, organization and implementation of approved policies and procedures; Directs, evaluates and supervises all resident care to maintain compliance with state/federal regulations, as well as company standards, policies and procedures; Directs and implements nursing services, educational programs including, but not limited to, orientation, and in services for licensed and unlicensed nursing personnel.; Establish open lines of communication with consultants and consistently take follow-up action on recommendations; Observes infection control procedures related to the department: Identify safety hazards and initiates corrective action immediately.
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 observations, interviews with representatives from the State of Florida public health authority (Florida Department of Health/(DOH)), facility staff interviews and record reviews, the facility failed to consistently follow DOH, Centers for Disease Control and Prevention (CDC), State Survey Agency (Agency for Health Care Administration/(AHCA)), the Florida Division of Emergency Management (DEM) and the Centers for Medicare and Medicaid (CMS) infection control orders, directives, recommendations and guidelines related to the Coronavirus Disease 2019 (COVID-19) pandemic. The facility failed to implement appropriate isolation precautions and cohorting recommendations for both COV1D-19 infected residents and Persons Under Investigation (PUIs) to control or prevent the potential spread of COVID-19. Four COV1D-19 infected residents (#2, 4, 5 and 10) were sharing a room with COVID-19 negative roommates (#14, #30, #31 and #33), and Resident #39 a PUI was sharing a room with COVID-19 negative resident (#36). The facility failed to ensure that staff were consistently screened prior to facility entry. The facility failed to consistently deny entry to staff members with sore throats, coughs, and/or other possible COVID-19 symptoms. The facility failed to store housekeeping chemicals in properly labeled containers with clear instructions for use. This failure affected all 81 residents residing in the facility on [DATE] plus 2 additional COVID-19 infected resident who had been hospitalized (#12 & 13). The facility failures resulted in 23 residents, some from every wing in the facility, becoming infected with COVID-19 as of [DATE] (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 15, 16, 20, 21, 31, 33, 34, 35, 36, and 38). The facility census on [DATE] was 81. Individuals who are [AGE] years and older, those with chronic underlying medical conditions, and those living in nursing homes are at high risk for developing serious complications from COVID-19 illness. Individuals who are infected could develop serious disease with difficulty breathing and might require intensive care for the treatment of [REDACTED]. COVID-19 infection can lead to death. COVID-19 is a new disease, caused by a new coronavirus that has not previously been seen in humans. Currently, there is no vaccine and no approved treatment for [REDACTED]. The cumulative result of these infection control concerns led to a widespread finding of immediate jeopardy at a scope and severity of L. The Nursing Home Administrator and Director of Nursing were informed of the findings of immediate jeopardy on [DATE] at 3:15 PM (CST). The immediate jeopardy was determined to start on [DATE] when the facility failed to follow Centers for Disease Control and Prevention (CDC) guidelines related to the COVID-19 pandemic regarding the use of designated isolation housekeeping carts and designated staff for residents suspected or confirmed of having COVID-19. It was determined the provider's non-compliance caused, or was likely to cause, serious injury, harm, impairment or death to residents. Facility staff also failed to perform hand hygiene and wear PPE (face mask) when appropriate. The immediate jeopardy was ongoing. Cross reference F835. The findings include: On [DATE], The Office of the Governor issued Executive Order Number ,[DATE] directing the Florida Department of Health to issue a Public Health Emergency. The Executive Order documented, Coronavirus Disease 2019 (COVID-19) is a severe acute respiratory illness that can spread among humans through respiratory transmission and presents with symptoms similar to those of influenza. Section 2 directed the State Health Officer to take any action necessary to protect the public health. Section 3 directed the State Health Officer to follow the guidelines established by the CDC (Centers for Disease Control and Prevention) in establishing protocols to control the spread of COVID-19. Section 4 designated the Florida Department of Health as the lead state agency to coordinate emergency response activities among the various state agencies and local governments. Section 5 specified that all actions taken by the State Health Officer with respect to this emergency before the issuance of this Executive Order are ratified. Section 6 stated The Florida Department of Health will actively monitor, at a minimum, all persons meeting the definition of a Person Under Investigation (PUI) as defined by the CDC for COVID-19 for a period of at least 14 days. Active monitoring by the Florida Department of Health will include at least the following: A. Risk Assessment with 24 hours of learning an individual meets the criteria for a PUI and B. Twice daily temperature checks. Section 7 directed the Florida Department of Health, pursuant to its authority in section 381XXX , Florida Statutes, will ensure that all individuals meeting the CDC's definition of a PUI are isolated or quarantined for a period of 14 days or until the person tests negative for COVID-19. Section 8 directed Florida Department of Health to make its own determinations as to

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) quarantine, isolation and other necessary public health interventions as permitted under Florida Law. Section 9 directs all agencies under the direction of the Governor to fully cooperate with the Florida Department of Health, and any representative thereof in furtherance of this Order. On [DATE], The Office of the Governor issued Executive Order Number ,[DATE] declaring a state of emergency for the entire State of Florida as a result of COVID-19. On [DATE], the Division of Emergency Management (DEM) Emergency Order No. ,[DATE] restricting entrance into residential health care facilities including nursing homes was issued. The Order limited persons who were allowed to enter the facility and directed screening of all individuals seeking entry. The order documented, Individuals seeking entry to the facility under the above section 1 (includes staff) will not be allowed to enter if they meet any of the screening criteria listed below: a. Any person infected with COVID-19 who has not had 2 consecutive negative test results separated by 24 hours; b. Any person showing, presenting signs or symptoms of, or disclosing the presence of a respiratory infection, including cough, fever, shortness of breath or sore throat; c. Any person who has been in contact with any person(s) known to be infected with COVID-19, who has not yet tested negative for COVID-19 within the past 14 days; d. Any person who traveled through any airport within the past 14 days; or e. Any person who traveled on a cruise ship within the past 14 days. Part 5 of the Order stated, The following documentation must be kept for visitation within a facility: a. Individuals entering a facility subject to the screening criteria above may be screened using a standardized questionnaire or other form of documentation. b. The facility is required to maintain documentation of all non-resident individuals entering the facility. Documentation must include: 1. Name of the individual; 2. Date and time of entry; and 3. The documentation used by the facility to screen the individual showing the individual did not meet any of the enumerated screening criteria, including the screening employee's printed name and signature. The President declared a Nationwide emergency for COVID-19 on [DATE] and approved a major disaster declaration for Florida on [DATE]. On [DATE] the Agency for Health Care Administration (AHCA), the state survey agency, issued an Alert entitled, Residential and Long-Term Care Facilities to Implement Universal Use of Facial Masks. The directive stated, Effective immediately staff of residential and long-term care facilities are to implement universal use of facial masks while in the facility. All staff, essential healthcare visitors and anyone entering the facility are to don a face mask upon the start of their shift or visit and only change it once it becomes moist. It is important to keep hands away from the face mask and only touch the straps of the face mask. Gloves are to be worn when providing care to the resident. Continue to perform hand hygiene prior to donning gloves, after removing gloves, and anytime there is contact with the resident environment. Staff in a room with a patient with respiratory symptoms of unknown cause or a patient with known or suspected COVID-19 should adhere to Standard, Contact, and Droplet Precautions with eye protection. This includes wearing gown, gloves, N95 face mask (as fitted and available - if not available, at least a facial mask), and eye protection such as face shields or goggles. In addition to securing more gowns, gloves, and masks, facilities will need to immediately order the appropriate eye protection (I.e. face shields) since many do not have this on hand. In the event you are unable to acquire the necessary PPE, please notify your local emergency management agency. Facilities will need to educate their staff on the proper donning (putting on), doffing (taking off), and disposal of any PPE. Information about the recommended duration of Transmission-Based Precautions is available in the Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of hospitalized Patients with COVID-19. According to an interview with the DOH Nursing Director who oversees Calhoun and Liberty Counties, on [DATE] at 2:52 PM, she was notified by phone of the facility's first positive COVID-19 case (Resident #11) on [DATE] by the Bay County Health Department (BCHD). The DOH Nursing Director stated that the local hospital, which received Resident #11 and tested for COVID-19 on [DATE], contacted the BCHD on [DATE] to report the positive result it received on [DATE]. The DOH Nursing Director then immediately called the facility's Director of Nursing (DON) on [DATE] to notify her of the positive test result and obtain a list of anyone in the building who was known to be in close contact with Resident #11 recently. The DOH Nursing Director stated that she felt like the facility was going to need some help and didn't believe the facility had a real grasp of the severity of the situation, so she submitted a mission request for staffing to the local Emergency Operations Center (EOC) on [DATE]. The EOC was able to send two teams of infection control experts to assist. A Florida Division of Emergency Management (DEM) contracted Strike Team consisting of four Registered Nurses (RNs) and ten Certified Nursing Assistants (CNAs) who made daily visits from [DATE] to [DATE]. A United States Department of Veterans Affairs (VA) team consisting of one doctor, one Registered Nurse (RN), two Licensed Practical Nurses (LPNs) and one nursing assistant made daily visits to the facility from [DATE] to [DATE]. The Calhoun County Health Department contacted the Agency for Health Care Administration (AHCA) to request a joint on-site facility visit be conducted on [DATE] to complete an infection control assessment and epidemiological investigation. At the time of the joint visit, the facility had a total of three positive cases: one resident (Resident #11) and two staff (Staff O and T) who had direct contact with the resident. On [DATE] through [DATE] AHCA surveyors made a second onsite visit to the facility. In the time between the surveyors' first and second visits, the facility had five more staff (Staff N, P, Q, R and S) and 12 more residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10) test positive for COVID-19, two of which were in the hospital (Resident #12 and #13). During the time between the surveyors' 2nd and 4th visits, one staff (Staff U) and five more residents tested positive (Resident #15, #33, #35, #36 and #37). AHCA was informed by the DOH Nursing Director that five additional residents (Resident #16, #20, # 21, #34 and #38) and two staff (Staff V and W) tested positive for COVID-19 since the surveyors exited the facility on [DATE]. On [DATE] at approximately 12:40 PM, a joint AHCA visit was conducted at the facility with the following DOH staff: Calhoun & Liberty Counties Health Administrator (CHA), Epidemiologist and Long-Term Care Liaison. On [DATE] at approximately 12:50 PM, the joint team conducted an interview with the DON and Nursing Home Administrator (NHA). The surveyor asked for confirmation of the current number of known cases. They stated that there's one positive resident, Resident #11, and two positive staff, Staff O, Activities, and Staff T, a RN. The surveyor asked for an explanation of events leading up to the identification of the first positive case, Resident #11. The NHA stated that the resident (#11) had coded (required resuscitation) several times before she was transferred to the hospital on [DATE]. The DON stated that three nurses responded to the code events: Staff X, an RN, Staff JJ, an LPN, and Staff KK, an LPN. The DON stated that RN X and LPN KK both performed Cardiopulmonary Resuscitation (CPR). The surveyor asked about the status of each of the three staff involved and the NHA stated that RN X was at home self-isolating, LPN KK, who was pregnant, decided not to return to work after being informed of her COVID-19 exposure, and LPN JJ was currently working. The Nursing Home Administrator (NHA) and Director of Nursing (DON) identified the 400 hall as the isolation unit for COVID-19 infected residents and the 500 Hall was designated as a monitoring area for hospital transfers and residents requiring observation. The surveyor asked if designated staff were overseeing the employee screening at the door. The NHA stated that the staff that was there at the time, Staff RR, Dietary, covers the screening booth from 8:00 AM to 5:00 PM and approximately nine other staff who are department heads have screening responsibilities when she's not there. The surveyor asked if any staff had failed the screening process due to fever or report of other symptoms and the NHA replied, No. The surveyor asked how many residents currently had respiratory symptoms. The DON responded one, Resident #1, who had an 80% oxygen saturation on room air and a fever of 101 degrees Fahrenheit. The surveyor asked the DON how frequently residents are being screened for symptoms and she stated once per 12-hour shift. The following observations and interviews were obtained during the [DATE] joint visit: Six of the eight resident room doors on the 100 Hall were open and one resident was seated in a wheelchair in the hall with no facial covering. Five of the seven resident room doors on the 200 Hall were open. Nine of the eleven resident room doors on the 300 Hall were open and three residents were seated in wheelchairs in the hall with no facial coverings. On [DATE] at approximately 1:50 PM, the surveyor observed Staff A, Dietary, in the kitchen rolling metal silverware in paper napkins. She had a surgical face mask around her neck and no gloves on. Staff A observed the surveyor and pulled her surgical face mask up over her nose and mouth. She then immediately resumed rolling silverware. Staff A did not perform hand hygiene before or after touching her surgical face mask. On [DATE] at approximately 1:50 PM, the surveyor immediately brought the identified concern to the NHA's attention. The NHA and the Certified Dietary Manager (CDM) who was sitting in her office in the kitchen re-educated Staff A on hand hygiene and facility policy regarding face masks. The NHA and CDM also stated that Staff A was instructed to wash all of the rolled silverware and then re-roll it. According to the NHA, as of today all staff are required to wear N95 face masks while in the building, whereas prior to today they were required to wear surgical face masks at all times. Review of the facility's, Prevent COVID-19 Start of Shift Employee Screening Log, dated [DATE], revealed Staff A documented having a cough that week. 400 Hall Isolation Unit: All resident room doors except rooms [ROOM NUMBERS] were open. There was a housekeeping cart in use by Staff B, a Housekeeper, which did not visibly indicate it was designated for the isolation hall only. At approximately 2:15 PM, the surveyor asked Housekeeper B if there was a designated cart for the isolation hall. She replied, No. The surveyor asked if she used that same cart to clean other parts

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	105924	A. BUILDING _____ B. WING _____	**05/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLOUNTSTOWN HEALTH AND REHABILITATION CENTER	**16690 SW CHIPOLA RD BLOUNTSTOWN, FL 32424**

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 4) of the facility and she stated that she used it to clean the 600 Hall earlier that shift. The surveyor asked how often the mop solution is changed and Housekeeper B responded that the bucket is filled at the start of her shift and the mop heads stay in that same solution until the end of her shift when housekeeping launders them. At approximately 2:30 PM, the surveyor asked the Maintenance Director if there was a designated housekeeping cart for the isolation hall. He replied, As far as I know there isn't one. There was an open meal cart on the isolation hall that contained reusable trays and cups. There was a shared stethoscope hanging on the side of the medication cart in the hallway. There were three bins at the end of the hallway inside the double doors leading out to the East Wing Nurses' Station. At approximately 2:20 PM, the surveyor asked the DON who was present to explain the purpose for each bin. She stated that one was intended for trash, one for torn/soiled gowns to be discarded and one for gowns that are in good condition to be re-used. The surveyor questioned the practice of re-using disposable gowns that are not intended for repeat use. Observation of areas outside the isolation hall: On [DATE] at approximately 1:50 PM during the tour with the NHA and DON the team was informed that the 500 Hall designated as a monitoring area for hospital transfers and residents requiring observation. Four of 11 bedrooms on the 500 Hall were vacant and the hall contained all private rooms. Seven of eight resident room doors on the 600 Hall were open and three residents were seated in wheelchairs in the hall with no facial coverings. On [DATE] at 2:40 PM an end of day conference was conducted during which the joint team made recommendations including, but not limited to, keeping bedroom doors closed throughout the facility, assigning designated and seasoned nurses to provide all care needs to residents on isolation, not re-using disposable gowns, changing mop solution more frequently, and using all disposable items for meal service as well as disposable vital sign equipment on the isolation unit. While onsite, the Epidemiologist tested three residents, which included the roommate of the first confirmed case (Resident #14) and two symptomatic residents who shared a room on that same hall (Resident #1 and #12). On [DATE] the facility conducted COVID-19 testing that included all residents and the majority of staff. The results were returned from [DATE] to [DATE]. On [DATE] at approximately 11:20 AM the AHCA surveyor returned to the facility. At that time the surveyor asked the DON to provide resident surveillance records and a comprehensive list containing all test data for all residents in the facility. The DON was unable to provide a comprehensive list of test information for all residents including which laboratory conducted the testing, what date the tests were obtained and what date the results were received, as many residents had been tested more than once and by different laboratories. However, she did provide a Line List for Residents, a tool used to track all individuals being monitored for or meeting the case definition for the outbreak illness, which had fields for resident name, age, sex, room number, date of onset, duration of illness, fever, cough, sore throat, runny nose, nasal congestion, chest congestion, shortness of breath, muscle aches, vomiting, diarrhea, pneumonia, x-ray results, hospitalization , death, COVID-19 and date of COVID-19 test, among others. The line list did not contain all relevant information and in some cases contained inaccurate information. The list contained the names of 25 residents and two entries were whited out. The fields for age and duration of illness were not completed for any resident. Room numbers were not recorded for two residents (Resident #2 and #4). Date of onset was not recorded for seven residents (Resident #3, #8, #10, #13, #15, #33 and #34). Some of the asymptomatic roommates of positive residents were included on the list while others weren't. Resident #1's test result was documented as being obtained by the hospital when she hadn't been to the hospital. Similarly, the surveyor noticed that a resident who was known to be at the hospital (Resident #12), was not indicated to be at the hospital. The surveyor brought this to the DON's attention who stated that it was actually Resident #12, not Resident #1 who was at the hospital and said, I don't know what I did there. Further review of the line list revealed Resident #7 was tested on [DATE] with a positive result on [DATE] but was recorded with a negative test result on the DON's undated census that was being used to track residents' COVID-19 status. The surveyor brought this to the DON's attention who stated that it was a mistake and Resident #7 is indeed positive. Resident #39's test date according to the line list was listed as [DATE] which DOH, who conducted that test, documented a [DATE] test date. Resident #35's test date was listed as [DATE] on the line list whereas it was documented as [DATE] on the undated census the DON was also using to record resident test results. Lastly, the line list revealed Resident #43, on the 300 Hall, developed a fever and cough on [DATE] and was diagnosed with [REDACTED].#44, also on the 300 Hall, developed a fever, cough and chest congestion on [DATE]. Both residents had current roommates, however, neither of the roommates appeared on the line list. Neither of the resident's rooms were observed to have precautions in place during the facility tours on [DATE] and [DATE]. On [DATE] at approximately 11:35 AM, a tour of the facility was conducted with the DON. Most doors on the 100 Hall were open, including Resident #18's which had a sign stating, See Nurse Before Entering, on the door as well as biohazard bags, gowns and gloves posted outside the room. The surveyor asked the DON about the status of Resident #18. The DON stated that she was the former roommate of a COVID-19 positive resident, Resident #6, who was moved to the isolation hall (the 400 Hall). Resident #40 was seated in his wheelchair at the end of the 100 Hall looking out the exterior doors. Resident #40 wore no facial covering. The DON who was with the surveyor at that time provided no redirection to the resident. At this time the DON stated that the resident takes his face mask off and doesn't stay in his room. A few minutes later, a VA staff donning full PPE came along and pushed the resident in his wheelchair back to his room, which ended up being on the 300 Hall on the opposite side of the West Wing. Six out of seven resident room doors on the 200 Hall were open, including Resident #17's, which had a, See Nurse Before Entering, sign on the door as well as a hanging [MEDICATION NAME] containing trash bags, gowns and gloves. The surveyor asked the DON about the status of Resident #17. The DON stated that she was the former roommate of a COVID-19 positive resident, Resident #5, who was moved to the isolation hall (400 Hall). Most resident room doors on the 300 Hall were open, including Resident #16's, which had a, See Nurse Before Entering, sign on the door as well as a hanging [MEDICATION NAME] containing biohazard bags, gowns and gloves. The surveyor asked the DON about the status of Resident #16. The DON stated that she is the former roommate of Resident #20 who developed symptoms today including a low-grade fever, diarrhea and chills and was moved to the 500 Hall. She continued that Resident #16 was placed on contact precautions in the existing room. At this time the surveyor reiterated to the DON the importance of keeping resident room doors throughout the facility closed. The DON stated that, The FEMA doctor said it's okay. A resident was seated in a wheelchair in the 300 hallway with no facial covering. The DON stated that N95 face masks have been worn by staff at the recommendation of FEMA since [DATE] with the development of additional positive cases. At approximately 12:00 PM, four staff wearing N95 face masks and gowns (one also donned gloves) were observed to be gathered around the East Wing Nurses' Station (Personal Care Assistant (PCA) L, CNA M, Restorative CNA Z and CNA MM). The surveyor asked the four staff if any of them currently had symptoms or had experienced any in the last week. All four staff replied, No. Review of the facility's, Prevent COVID-19 Start of Shift Employee Screening Log, revealed that in fact three of the four staff had documented having symptoms in the last week. PCA L documented a sore throat and muscle pain on [DATE] and a sore throat on [DATE], CNA M documented new shortness of breath or difficulty breathing, a cough, and muscle pain on [DATE], and Restorative CNA Z documented a headache on [DATE]. On [DATE] at approximately 12:40 PM, the following was observed immediately outside the double doors leading into the 400 Hall (isolation unit): A, Staging Area, sign was posted on the wall over a cart, a red biohazardous waste bin with an unsecured lid had discarded PPE hanging out over the rim. Also posted on the double doors leading into the isolation unit were a sign that read, Anyone Entering This Hall Must Be Wearing: Mask (N95), Gown, Gloves, and, Stop. Do not enter. Only staff working this hall. Just on the other side of the double doors inside the isolation unit were two more red bins with a, Place soiled and/or compromised gowns here for disposal *may also be used to dispose of used gloves, etc. sign posted. The other bin was for soiled linen. The DON and surveyor toured the hall together and the DON provided the COVID-19 status of each of the rooms as follows: The door was open to the room which housed Resident #41 and Resident #37. The DON stated that both the residents tested negative for COVID-19. Review of an undated census that the DON had recorded test results on revealed both residents were tested by the facility on [DATE] which came back negative on [DATE]. The door was open to the room which housed Resident #6 and Resident #8. The DON stated that both residents tested positive. The door was open to the room which housed Resident #10 and Resident #14. The DON stated that Resident #10 tested positive for COVID-19 and Resident #14's test was pending. However, review of the DON's Line List for Residents dated [DATE] to [DATE] revealed Resident #14 was tested by the DOH on [DATE] and in an e-mail dated [DATE] at 4:08 PM, the DOH Nursing Director confirmed that Resident #14's negative test result was received on [DATE]. Review of the facility's census dated [DATE] revealed that Resident #10 was moved into this room on [DATE]. At this time the surveyor asked the DON why she would move a symptomatic resident (Resident #10) in with a resident who just tested negative (Resident #14). The DON stated that Resident #14 had developed symptoms since her negative test result was obtained, however review of the DON's Line List for Residents revealed Resident #14 had no symptoms documented. Further review of the line list revealed Resident #10 was tested on [DATE] by the DOH with a positive result. An e-mail on [DATE] at 3:16 PM from the DOH Nursing Director revealed that

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 5) Resident #10's test was sent to the lab on [DATE], but it leaked, so the DOH re-tested the resident on [DATE] which came back positive on [DATE]. The DON failed to maintain complete and accurate surveillance records and the facility placed Resident #14, who was on Hospice and already a high risk, at an even greater risk of exposure by cohorting a confirmed negative (Resident #14) and symptomatic resident (Resident #10) in a room together. The door was open to the room which housed Resident #39, who occupied the A bed, and Resident #36, who occupied the B bed. The DON stated that both residents tested negative. Review of the DON's Line List for Residents dated [DATE] to [DATE] revealed Resident #39 had a 99.7 degree Fahrenheit temperature, cough, and chest congestion with a symptom onset date of [DATE]. The line list had no documented symptoms for Resident #36. Further review of the line list revealed Resident #39 was tested by DOH on [DATE] with a negative result, but the date the result was received wasn't recorded. On [DATE] at 5:20 PM the DOH Nursing Director verified that DOH administered the test on [DATE] and received the negative result on [DATE]. Review of an undated census that the DON was recording test results on revealed Resident #36 was tested on [DATE] with a negative result, but the date the results were received was not documented. An e-mail on [DATE] at 7:49 PM from the DOH Nursing Director revealed that the test obtained by the DOH on [DATE] leaked, so they re-tested the resident on [DATE], which had a negative result on [DATE]. The DON failed to maintain complete and accurate surveillance records requiring the surveyor to obtain records from outside the facility and failed to separate a symptomatic (Resident #39) and an asymptomatic (Resident #36) resident, both of whom had negative results and were housed on the isolation unit. The next room housed Resident #2 and Resident #31. The DON stated that Resident #2 tested positive and Resident #31 tested negative. She stated that Resident #31 was being moved to a different room on the isolation unit today, [DATE]. Review of the DOH lab slips revealed both residents were tested on [DATE] with results obtained on [DATE]. The room across the hall housed Resident #35 and Resident #42. The DON stated that both residents tested negative. Review of the facility's test results revealed neither resident had been tested by the facility. Review of the DON's Line List for Residents dated [DATE] to [DATE] revealed Resident #35 was tested by DOH on [DATE] with a negative result, but the date the results were received was not documented. Review of an undated census that the DON was recording test results on revealed Resident #35 was tested by DOH on [DATE] with a negative result, but the date the results were received was not documented. In an e-mail on [DATE] at 5:20 PM, the DOH Nursing Director verified that Resident #35 was test by DOH on [DATE] with a negative result on [DATE]. Review of the undated census the DON was recording test results on revealed Resident #42 was tested on [DATE] with a negative result received on [DATE]. The accuracy of this information could not be verified as Resident #42's name did not appear on the batch test report provided by the facility for tests administered on [DATE]. The door was open to the room which housed Resident #9 and Resident #1. The DON stated that both residents tested positive. Resident #9 was receiving oxygen via a nasal cannula and neither resident was wearing a face mask. Review of the facility's test results revealed Resident #9 was tested by the facility on [DATE] with a positive result, but the date the results were received was not indicated. Review of the DON's Line List for Residents dated [DATE] to [DATE] indicated the results were received on [DATE]. Resident #1 was tested by DOH on [DATE] with a positive result received on [DATE]. The room across the hall which housed Resident #30 and Resident #5. The DON stated that Resident #30 tested negative and Resident #5 tested positive. The surveyor expressed concern to the DON regarding a negative and positive roommate sharing a room. The DON stated that she was, figuring out where to move her (Resident #30). Review of the DON's Line List of Residents revealed Resident #5 developed a 100.7 degree Fahrenheit fever on [DATE]. Further review revealed no symptoms were documented for Resident #30. Review of the facility's census dated [DATE] revealed Resident #5 moved into this room on [DATE]. Review of the facility's test results reveal Resident #5 was tested on [DATE] with a positive result received on [DATE]. Review of the DOH's lab slips revealed Resident #30 was tested on 5/