STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105812	A. BUILDING _____ B. WING _____	09/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROYAL CARE OF AVON PARK	1213 W STRATFORD RD AVON PARK, FL 33825

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 observations, interviews, record reviews, review of facility policy, and review of the Center for Disease Control and Prevention (CDC) guidelines, the facility failed to implement and maintain an infection prevention and control program to prevent the potential spread of infection by three staff members (A, B and D) not [MEDICATION NAME] proper sanitizing and storage of reusable equipment and not ensuring COVID-19 symptom screening and documentation were completed properly before employees entered the facility for 2 staff members (E and D) observed and 17 (B, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T and U) of 92 staff members sampled for pre-shift screening. Findings included: An observation was conducted on 09/23/2020 at 10:08 AM, with the facility's Assistant Director of Nursing (ADON), of the employee screening area and entrance. Three storage bins with three drawers each were observed on top of a white table inside of a small hallway, which lead to the employee entrance. The ADON stated that employees do not enter through the front of the facility, they enter through a back door instead. Staff are supposed to screen each other and take each other's temperatures when entering the building. The ADON stated that staff are not to take their own temperatures and pointed to a sign on the door leading into the facility which stated the same. A drawer on one of the storage cabinets was opened and revealed an N95 mask stored by itself and not inside of a bag (Photographic Evidence Obtained). The ADON observed the N95 mask and stated, That's disgusting. The ADON also stated that all staff members were given paper bags and should be storing their N95 or KN95 masks in the paper bags. Several plastic bags were observed with face shields in them and some had paper bags inside of them. The ADON stated that staff were instructed to store their mask inside of a paper bag, then store that paper bag inside of a plastic bag containing their face shield. Several other drawers in the storage area were opened, which revealed several plastic bags containing employee face shields and N95 masks. A plastic bag inside of one of the drawers was observed to have 2 N95 masks and 1 KN95 mask inside of it (Photographic Evidence Obtained). The ADON stated that she was not sure why that employee had so many masks inside of the plastic bag and that the masks should be stored inside of a paper bag. An observation was made of a clear plastic spray bottle with a clear solution inside of it. The bottle was not observed to be labeled (Photographic Evidence Obtained). The ADON stated that the bottle contained a bleach water solution and that employees use it to sanitize their face shields before storing them in the storage area. The ADON also stated that there was not a specific amount of time that the bleach water had to be in contact with the face shields to sanitize them and that staff were instructed to just spray it on and wipe it off. The ADON stated that the bottle should have a label on it and also stated that the kill time for the bleach solution was like a minute. An observation of the screening logs for employees revealed several employee screening questionnaires not filled out or improperly filled out. A request was made for a copy of the screening logs. The ADON was not able to explain why some employees were not screening properly and stated that all employees have been educated on the screening requirements before entering the building. If no other staff member is there to assist with screening, then the employee must find someone to assist them with the screening process. The ADON stated that all department heads should be checking the screening books to ensure their employees were properly screened in before coming into work. An observation was made during a tour of the facility at 11:30 AM. Staff A, Certified Nursing Assistant (CNA) was observed entering an isolation room through a plastic barrier to answer a resident's call light. Staff A, CNA quickly exited the room after approximately one minute with a cordless phone. Staff A, CNA was observed putting the cordless phone onto a charger at the nurse's station. Staff A, CNA was not observed sanitizing the cordless phone before hanging it back on the charging station at the nurse's station. Staff A, CNA was interviewed following the observation. Staff A, CNA stated that he used a paper towel and hand sanitizer to wipe off the phone before putting the phone back onto the charging station. Staff A, CNA also stated that he would normally use the Brand A sanitizing wipes to sanitize equipment, but he was not able to find any. Staff A, CNA was observed searching in several places to find the sanitizing wipes but was not able to find them. Staff A, CNA stated that the facility had conducted education regarding hand hygiene, PPE (personal protective equipment) usage, sanitizing equipment, and employee screening. Staff A, CNA stated that all employees entered through the back entrance of the facility and that he fills out the screening tool and takes his own temperature when coming into work. Staff A, CNA also stated that he did not sanitize his face shield after coming out of the isolation room. An interview was conducted at 11:49 AM with Staff B, CNA. Staff B, CNA stated that when coming on shift, employees enter through the back entrance of the facility, take their own temperature, and fill out the screening questionnaire before coming into the building. Staff B, CNA then stated that temperatures are supposed to be taken by another employee and that she did not take her own temperature during the screening process. Staff B, CNA was observed to have a visibly soiled face shield with several finger marks and dried material. Staff B, CNA stated that she sanitized her face shield at the beginning of the shift with the bleach water solution at the storage and screening area. Staff B, CNA also stated that she sanitized her face shield after going into an isolation room by using a paper towel and hand sanitizer. Staff B, CNA addressed that her face shield appeared dirty and that she needed to clean it. An interview was conducted at 12:04 PM with the ADON. The ADON stated that staff clean their face shields before the start of the shift and at the end of the shift or if it becomes visibly soiled using the bleach water solution provided. The ADON was not able to state whether or not employees were sanitizing their face shields after going into an isolation room but addressed that staff should be. The ADON stated that staff are able to use the Brand A wipes and bleach wipes on the nurse's cart to sanitize their face shields or any shared items, including the cordless phone, after use. The ADON also stated that it would not be acceptable for a staff member to use a paper towel and hand sanitizer to sanitize equipment. An interview was conducted at 1:18 PM with Staff C, Physical Therapist (PT). Staff C, PT stated that all employees come into the building through the back door to the screening station where they fill out the screening questionnaire and record their temperature with the assistance of another staff member if there's someone to find. Staff C, PT also stated that there have been times that she has had to take her own temperature if there was not a staff member available to take it for her. Staff C, PT stated that it was her understanding that the ADON checked the screening books for compliance and was not aware that the department heads were tasked with that duty. An observation was made at 2:41 PM of the employee screening area. During the observation, Staff E, Patient Care Assistant (PCA) was observed taking her own temperature and recording it into the employee log book. Four other employees were present in the area when Staff E, PCA took her own temperature. Several other staff members were observed filling out the questionnaire and having their temperature taken by other staff members. Observation of the employee screening area continued at 2:52 PM. An observation was made of another staff member taking their own temperature and recording it in the log before entering the building. Another staff member was observed in the area at the time. Staff D, CNA was observed entering the building with a face shield and N95 mask already on. Staff D, CNA entered the building without answering the screening questionnaire or having his temperature taken. An observation was made of one staff member removing her face shield to sanitize it with the clear solution provided at the screening station. The staff member then looked into one of the drawers and stated that she could not find her bag. The staff member then put her face shield underneath all of the other items in the drawer without placing it in a bag (Photographic Evidence Obtained)

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) before exiting the building. An interview was conducted at 2:56 PM with Staff E, PCA. Staff E, PCA stated that when entering the building, staff are supposed to have another staff member take their temperature and fill out the screening questionnaire before going onto the floor for their shift. Staff D, PCA addressed that she took her own temperature when entering the building and stated, Usually nobody is here and I'm not going to walk on to the unit to go get someone. Staff E, PCA stated that most of the time there is not a staff member available to take her temperature, so she has to do it herself. A review of the Before Entry Health Questions filled out by facility staff revealed that 17 of 92 screening questionnaires were either not completed correctly, only included a temperature reading, or was not completed at all. Interviews were conducted with staff members that were in the building at the time of the review. The following is a breakdown of the Before Entry Health Questions forms completed by the 17 staff members reviewed (B, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T and U): Contact and Risk Assessment Questions and Travel Question not completed or not completed correctly: Staff B, F, H, I, J, K, L, M, O, R Some Contact and Risk Assessment Questions and Travel Question not completed or not completed correctly: Staff U, P, Q Some Contact and Risk Assessment Questions Not Completed: Staff G, S, T Did not indicate temperature: Staff N An interview was conducted at 4:16 PM with Staff F, Licensed Practical Nurse (LPN). Staff F, LPN stated that staff all come in the back entrance of the building and fill out the screening questionnaire before coming onto the floor. Staff F, LPN also stated that temperatures were supposed to be taken by another staff member, but if there was not a staff member available, she would take her own temperature and record it in the book. Staff F, LPN stated that she did not fully complete her screening questionnaires because she thought that if the answer to the question was no then the question could be skipped. A review of Staff F, LPN's Before Entry Health Questions sheet revealed that only a temperature was recorded on 9/9, 9/10, 9/11, 9/16, 9/17, 9/18, and 9/23/2020 and that the screening questions were not completed. An interview was conducted at 4:19 PM with Staff B, CNA. Staff B, CNA stated that her temperature was being monitored when she came on for her shift, but she was not writing it in the log because she had forgotten her pen. Staff B, CNA addressed that the last time she recorded an entry on the log was 09/12/2020 and stated that she did not complete the entries because she did not have a pen on the other days that she worked. A review of Staff B, CNA's Before Entry Health Questions sheet revealed only two entries made on 9/11 and 9/12/2020, which only included a temperature reading. No screening questions were completed in Staff B, CNA's log and no temperatures were recorded after 09/12/2020. An interview was conducted with Staff D, CNA. Staff D, CNA stated that he conducted his own screening and took his own temperature when coming into work. Staff D, CNA addressed that he was observed entering the building without performing screening and stated, I'm just having a bad day. Staff D, CNA also addressed that no entries were found on his Before Entry Health Questions sheet since 09/11/2020. Staff D, CNA stated that he had been doing screening before work but was not able to state why the entries were not documented in the log book. A review of the facility policy titled, COVID-19 Pandemic Infection Control Measures, revised in May 2020, revealed under the section Policy Interpretation and Implementation that if a pandemic is detected in the geographic region of the facility, measures will be taken to prevent or delay the introduction of [MEDICAL CONDITION] to the facility, including screening all employees for [MEDICAL CONDITION] before coming on duty and send any symptomatic employees home. Do not allow entrance to anyone that does not meet screening requirements. The policy also revealed that the facility would designate one entrance for all employees, vendors, and visitors for screening. A review of the CDC's website (https://www.cdc.gov/coronavirus/2019/hcp/long-term-care.html), dated 6/25/2020, revealed guidelines to help prepare long term care facilities for COVID-19. The guidance revealed, under the section titled Evaluate and Manage Healthcare Personnel (HCP) that facilities should screen all HCP at the beginning of their shift for fever and symptoms of COVID-19 and to actively take their temperature and document absence of symptoms consistent with COVID-19. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace. The guidance also revealed, under the section titled Environmental Cleaning and Disinfection that facilities should ensure Environmental Protection Agency (EPA)-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. The review of the CDC's website (https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidancextuse.html), dated 6/25/2020, also revealed guidelines for recommendations for extended use and limited reuse of N95 filtering facepiece respirators in healthcare settings. The guidance revealed, under the section titled Respirator Reuse Recommendations, to hang used respirators in a designated storage area or keep them in a clean, breathable container such as a paper bag between uses. To minimize potential cross-contamination, store respirators so that they do not touch each other and the person using the respirator is clearly identified. Storage containers should be disposed of or cleaned regularly.