| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **105813** | A. BUILDING _____ B. WING _____ | **07/14/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **PARK RIDGE NURSING CENTER** | **730 COLLEGE STREET JACKSONVILLE, FL 32204** |

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<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program by not conducting appropriate visitor screenings to prevent the transmission of [DIAGNOSES REDACTED]-CoV-2 (COVID-19) during three of three opportunities observed. The has the potential to affect the staff and 69 residents of the facility. The findings include: 1. Upon entrance into the facility on [DATE] at 9:05 AM, Employee A, Administrative Assistant, failed to screen Surveyor #1 for symptoms consistent with COVID-19, history of travel to high-risk locations, and contact/exposure to individuals with symptoms. Only a temperature was taken. 2. On 7/14/20 at 9:07 AM, Employee A failed to screen Surveyor #2 for symptoms consistent with COVID-19, history of travel to high-risk locations, and contact/exposure to individuals with symptoms. Only a temperature was taken. 3. On 7/14/20 at 9:08 AM, Employee A failed to screen Surveyor #3 for symptoms consistent with COVID-19, history of travel to high-risk locations, and contact/exposure to individuals with symptoms. Only a temperature was taken. 4. An interview was conducted with Employee A on 7/14/20 at 12:25 PM. The employee confirmed that she was responsible for conducting the visitor screenings on 7/14/20. She was asked to explain the facility's screening processes. The employee explained that her process is to simply check the temperature of the visitor and document the temperature on a paper log kept at the screening station. Following the temperature screening, the visitor would be asked to perform hand hygiene and then would be permitted entry. The employee confirmed that she was not screening visitors for symptoms consistent with COVID-19, history of travel to high-risk locations, and contact/exposure to individuals with symptoms. 5. An interview was conducted with the Regional Director, a Registered Nurse, on 7/14/20 at 12:43 PM. She was asked about the facility's screening processes for visitors. The Regional Director confirmed that upon entry into the facility, visitors were to be screened for fever, respiratory symptoms, and recent travel. She explained that the findings from the screening were to then be documented on the screening form and the person conducting the screening then signs the form. 6. A copy of the facility's screening policy, titled Entrance Screening, was reviewed. The policy indicated that all non-staff individuals entering the building must sign in and complete the screening prior to entrance into any other area of the facility. The policy also indicated that screens will be completed and signed by the receptionist/first contact person in the facility. 7. A COVID-19 Screener Competency, signed by the facility and dated 3/2/20, was reviewed for Employee A. Requirement #1 on the form indicated the screener Understands the need to screen individuals visiting the facility for fever, respiratory symptoms, history of travel to high-risk places and/or contact/exposure to individuals with symptoms or history of travel to high-risk places. The form was checked Yes to indicate the employee was competent in the requirement at the time the competency was conducted. |

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.