STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105271	A. BUILDING _____ B. WING _____	**06/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BOCA CIEGA CENTER	**1414 59TH ST S GULFPORT, FL 33707**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure adherence to and implement infection control and prevention practices as evidenced by: 1) dietary staff (A, B, C, D) not wearing or wearing a surgical mask incorrectly; 2) not maintaining a clean and sanitary environment in the laundry area, and 3) inaccurate screening of one staff member (Staff I) of one staff member reviewed for COVID-19. Findings included: 1) On 6/3/20 at 9:30 a.m. an interview was conducted with the Director of Nursing (DON). She stated she was currently acting as the Infection Preventionist for the facility. She stated the facility had recently tested all residents and staff members in the facility and the results revealed one staff member was identified as positive for COVID-19 (Staff I, Registered Nurse). She stated the employee was working at the facility and at a local hospital. She stated the facility received the results on 5/27/20. She stated they are still awaiting on some testing results. She stated all staff in the building are currently required to wear a surgical mask while in the facility and at all times. She stated there were currently three residents in the building with signs and symptoms of COVID-19 that are being monitored. She stated the residents were isolated in one area of the facility in rooms [ROOM NUMBERS]. On 6/3/20 at 10:10 a.m. a tour of the facility kitchen was conducted. Staff A, Cook, was observed with a surgical mask pulled down exposing her nose. An interview was conducted with Staff A. Staff A stated that sometimes she wears the mask and sometimes she does not. She stated if they are working inside of the kitchen, they do not have to wear the mask. Staff B, Dietary Aide, was observed in the kitchen area washing dishes. Staff B had no mask on her face at all. Staff C, Dietary Aide, was observed in the kitchen area working with trays. Staff C had a surgical mask pulled down exposing her nose. The surveyor located and conducted an interview with Staff D, Certified Dietary Manager. Staff D was observed with a surgical mask incorrectly placed on his face. Staff D had part of his nose and mouth exposed as the mask was pulled to the right of his face. Staff D stated the staff in the kitchen are supposed to have on a surgical mask, at all times, while they are in the facility including inside of the kitchen. A review of the facility provided document entitled, Appropriate PPE,with no date, indicated the standard PPE (personal protective equipment) for staff in a Well Unit with no positive cases of COVID-19 should be at a minimum the use of a mask. 2. On 6/3/20 at 11:00 a.m. a tour of the laundry area was conducted with Staff H, a laundry staff member at the facility. In the clean area of the laundry, an air conditioner was noted to be positioned over the linen folding table. The air conditioner was leaking water on to the linen folding table. A blanket was noted rolled up on the back edge of the table to catch the dripping water. Staff H stated the air conditioner had been leaking for a long time and the blanket was used to keep the water from forming on the clean linen folding table. In a corner of the floor, a stack of bedspreads was noted on the floor. Staff H stated the bedspreads were clean and placed on the floor for storage. Staff H stated they should not be on the floor and she picked them up off the floor. The floor in the clean linen area was noted to have debris, chipping paint and brown spots on it. Staff H was not able to state when the last time the floor was cleaned in the area. Also observed were linens stored on top of a metal cabinet in the area and dust and debris were observed on the linen. Staff H stated the linens were clean and the linens were the table linens for the dining room. She stated since the dining room was not in use, they placed them on top of the cabinet. (Photographic Evidence Obtained) On 6/3/20 at 11:20 a.m. an interview was conducted with the Housekeeping/Laundry Director. She stated she was not aware of the leaking air conditioner and she would make sure it was addressed immediately. She confirmed that clean linen should not be stored on the floor or above the metal cabinet in the clean linen area. She stated she did not know when the floor was cleaned last and indicated she would also have the floor addressed. A review of the policy entitled, Linen and Linen Distribution, dated April 2017 indicated the following: Procedure: Clean Linen Linen will be maintained in clean, closed areas, and separate from soiled linen or contaminated equipment. A review of the policy entitled, Laundry Storage of Linen, dated April 2017 indicated the following: Procedure: After linen has been folded, it should be stored on a covered delivery cart until needed at the nursing unit. On 6/3/20 at 1:30 p.m. an interview was conducted with the Administrator, the DON and the Regional DON. They indicated all employees in the building were to wear a surgical mask; at all times an anywhere in the building. They confirmed the storage of linen should be in a clean and sanitary manner; at all times. 3) A review of the document titled, Long Term Care Screening Tool, All Requesting Entry: Health Questions, for Staff I, Registered Nurse (RN), dated 05/22/20 and completed at 2:45 p.m. revealed that she had a symptom of repeated shaking with chills. The form indicated, If YES, STOP, put on mask consult with DON/NHA/Infection Prevention Nurse to evaluate for testing- Must self-isolate, monitor, record twice daily temp checks. Consult with your local DOH (Department of Health) and notify state agency of symptomatic staff. If no temperature below 100.0 and no symptoms present, go to Check #3. Also noted on the form, Check #4, was marked Yes for, Are you living with a positive COVID19 person or a person that is self-isolating for suspicion of COVID19. The form indicated, If YES to either question; must self-isolate then follow return to work directions of the center. If No: Go to Check #5. In addition, Check #6 was checked Yes for, Did you wear a surgical mask when working with a patient COVID19 + or PUI (person under investigation) who was wearing a face covering? The document was signed by Staff I, RN and Staff J, Staffing Coordinator. A review of the Nurse's Assignment report for 5/22/20 revealed that Staff I, RN worked 8.25 hours on 05/22/20 on the 100 hall, even though the screening indicated that she had a symptom of repeated shaking with chills, and that she was living with a positive COVID-19 person or a person that was self-isolating for suspicion of COVID-19. A review of the facility's line listing for staff revealed that Staff I, RN had a positive COVID-19 test on 05/27/20. On 06/03/20 at 9:30 a.m., the DON reported that Staff I was working at the facility as a PRN (as needed) nurse and at a local hospital. On 06/03/20 at 10:33 a.m., the Administrator reported that Staff I's last day worked in the facility was on 05/22/20. The Administrator reported that Staff I was self-quarantining. On 06/03/20 at 1:49 p.m., an interview was conducted with the Administrator, DON, and Regional Nurse. They reported that staff had completed competencies for screening staff and visitors. The DON reported that the screening dated 05/22/20 was completed by Staff J, Staffing Coordinator, and that she did not think the screening was accurate. The Administrator also reported that the screening was inaccurate. The Administrator reported that Staff I, RN was prompted to get tested on ,[DATE]. Staff I was unable to come into the facility for testing, so the test was conducted at her other job. The Administrator reported that Staff I reported the results to her. On 06/03/20 at 1:55 p.m., an interview with Staff J, Staffing Coordinator revealed that she might have checked the boxes marked yes by mistake. Staff J reported that she would not have checked yes for Staff I, RN related to symptoms, and that Staff I did not say she was around anyone that was positive for COVID-19. Staff J reported that if a person was experiencing symptoms, she would mark the question yes and contact the DON and Administrator. Staff J reported that she checked the questions wrong and would never let anyone in the facility with symptoms. The policy provided by the facility titled, COVID 19- Guidance, dated February 2020 revealed the following: Communication/Education Screeners to be educated on their role and how to complete the COVID 19 Screening and report findings. Monitoring Facility leadership will observe staff, residents and visitors for signs of illness.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105271	A. BUILDING _____ B. WING _____	**06/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BOCA CIEGA CENTER	**1414 59TH ST S GULFPORT, FL 33707**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)