STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105269	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GROVES CENTER	**512 S 11TH ST LAKE WALES, FL 33853**

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 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility did not ensure a safe, homelike environment related to ceiling and roofing repairs to prevent water leakage on 3 of 4 units in the facility. Findings included: An observation was made on 09/01/2020 at 08:55 AM near the front entrance of the facility. A yellow caution sign was observed with a white towel underneath the sign. Water was observed dripping from the ceiling above the caution at a slow rate. An observation was made at 10:50 AM in the facility conference room. A small amount of water dripped suddenly from the ceiling and formed a puddle onto the floor. A small drip of water appeared to remain on the drop ceiling frame above the water puddle on the floor. An interview was conducted at 11:15 AM with the facility's Maintenance Director. The Maintenance Director stated that sometimes leaks pop up around the facility after it rains and that he had been patching holes in the roof in order to keep the problem under control. The heating, ventilation, and air conditioning (HVAC) system also creates condensation at times, which causes a small amount of water to leak from the ceiling. The Maintenance Director was observed inspecting the water leakage in the ceiling of the facility conference room using a ladder and stated that the moisture was coming from the HVAC system. The Maintenance Director was observed wiping the moisture from the drop ceiling and the HVAC system with a towel before exiting the room. The ceiling appeared to have water leaking shortly after the Maintenance Director left the room which left a small puddle on the floor in the spot where the water previously gathered (photographic evidence available). A small drip of water appeared to remain on the drop ceiling frame above the water puddle on the floor (photographic evidence available). An interview was conducted at 11:30 AM with Staff B, Certified Nurse's Aide (CNA). Staff B, CNA stated that she has seen water coming from the ceiling near the front entrance of the facility and near the front of room [ROOM NUMBER] but has not seen leaks anywhere else in the facility. An observation was made of the ceiling near the entrance of room [ROOM NUMBER]. The ceiling tile to the left of room [ROOM NUMBER] appeared stained from moisture but had no water leaking from it (photographic evidence available). A tour of the facility was conducted at 11:38 AM. An observation was made near the front entrance of the facility of a yellow caution sign with a small amount of water underneath the sign (photographic evidence available). The drop ceiling above the caution sign was observed with small water drops on it (photographic evidence available). The facility's Director of Nursing (DON) was notified of the leaking water and was not able to explain why there was water pooling underneath the yellow caution sign near the front entrance of the facility. The DON then left to gather supplies to clean up the water. Another spot in the ceiling was observed dripping water next to the 100 and 200 unit nurse's station which formed a small puddle of water on the floor (photographic evidence available). A small amount of water was observed dripping from an HVAC intake vent in the facility dining room, which formed a small puddle on the floor of the dining room (photographic evidence available). A small amount of water was observed dripping from an HVAC intake vent near the 300 and 400 nurse's station, which formed a small puddle onto the floor (photographic evidence available). An observation was made at 11:50 AM of Resident #5's room. A moderate amount of water was observed pooled inside of a light fixture above the entrance of Resident #5's room (photographic evidence available). An interview was conducted with Resident #5 at the time of the observation. Resident #5 stated that he had seen the leakage before and that it dripped onto the floor when it rained. Resident #5 also stated that staff was recently in the room and mopped the floor due to the water on the floor. The floor of Resident #5's room appeared damp, but no visible puddles of water were observed on the floor of the room. An observation was made of the HVAC intake vent above the bed next to Resident #5's bed. A small amount of water was observed around the HVAC intake vent (photographic evidence available). No resident was observed in the bed at the time of the observation. An observation was made at 11:55 AM near the back of the 200 unit hallway of a visibly wet ceiling tile, which also contained a small access door (photographic evidence available). No water was observed on the floor. An interview was conducted at 11:58 AM with Staff C, CNA. Staff C, CNA stated that she informed the Maintenance Director of the leak in Resident #5's ceiling around 9:00 AM that morning. Staff C, CNA also stated that she informed the housekeeping department of the leak because there was water on the floor in front of Resident #5's bed. A tour was conducted at 12:09 PM with the facility's Nursing Home Administrator (NHA) and Maintenance Director. The Maintenance Director stated that some leaks have been coming from the roof, which he has been trying to patch up. Condensation also builds up from the HVAC system, which is why there are leaks around some of the intake vents. The facility has a system where employees can log any problems that need the attention of maintenance but most people just tell him directly, so most repairs are not logged anywhere. The Maintenance Director stated that he did not keep a log of the ceiling repairs and had no way of tracking the repairs that he had already made. The NHA stated that the company's Senior Maintenance Director was notified of the problem today and would be in the facility to assess the roof. During the interview, a visibly wet ceiling tile was discovered in front of the 300 and 400 nurse's station (photographic evidence available). An interview was conducted at 04:08 PM with the Senior Maintenance Director. The Senior Maintenance Director stated that he was on the roof of the facility with the Maintenance Director to inspect and repair any areas that were damaged. He scheduled for a roofing contractor and an HVAC contractor to assess the problem areas on the morning of 09/02/2020. The Senior Maintenance Director stated that he would expect the Maintenance Director to inform him of any major problems in the facility so that they could be properly addressed. The Senior Maintenance Director also stated that he would expect the Maintenance Director to maintain a maintenance log of any repairs that were made in order to identify any chronic issues in the facility.
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 observation, interview, policy review, 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 as evidenced by their failure to define and implement their process for resident dedicated vital sign monitoring equipment and failure to ensure that re-used vital sign equipment was decontaminated between use for residents on the facility's persons under investigation (PUI) for Coronavirus Disease 2019 (COVID-19) unit potentially affecting 24 (residents on PUI unit) of the 95 total residents in the facility. Findings Included: An initial tour of the facility's PUI unit was conducted on 09/01/20 at 11:10 a.m. Two carts containing personal protective equipment (PPE) were observed: one outside room [ROOM NUMBER] and one outside room [ROOM NUMBER]. There were four resident names listed on the wall-plate next to the door for room [ROOM NUMBER]. An unlabeled plastic bag containing a thermometer, stethoscope, and blood pressure cuff was observed on top of the PPE cart outside of room [ROOM NUMBER]. room [ROOM NUMBER] had two resident names listed on the wall-plate next to the door. The PPE cart outside of room [ROOM NUMBER] had one unlabeled plastic container with a lid sitting on top to the left side that contained a thermometer, stethoscope, and blood pressure cuff. On top of the cart to the right side was an unlabeled empty plastic container with a lid. An unlabeled plastic bag containing a thermometer, stethoscope, and blood

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) pressure cuff was observed on top of the nurse's medication cart. A mechanical vital signs machine was observed uncovered next to the medication cart. Photographic evidence obtained. At 11:15 a.m. on 09/01/20 the facility Assistant Director of Nursing was encountered on the PUI unit and she confirmed that she was the facility Infection Control Preventionist (ICP). She reported residents residing on the PUI unit were those who had been recently admitted to the facility, were PUIs for COVID-19 due to exposure to other residents in the facility who had tested positive for COVID-19, or were residents who received [MEDICAL TREATMENT] which meant they had to regularly leave the facility for treatment. She stated that all residents on the unit were under droplet transmission-based precautions. The ICP could not explain the process for vital sign equipment on the unit regarding why some equipment was observed separated into unlabeled receptacles. She initially stated that it must be for a resident in room [ROOM NUMBER] or a resident in room [ROOM NUMBER] but then confirmed that was not clear given that both rooms housed multiple residents. She confirmed that if vital sign equipment was intended for resident-dedicated use it should be labeled to identify that. She did confirm that any equipment that was used for multiple residents must be disinfected between use. At 11:30 a.m. Staff A, Registered Nurse (RN) was interviewed. He could not explain the process on the unit for dedicated vital signs equipment and could not identify whether the equipment observed in separate receptacles was resident-designated, stating that the equipment in the plastic bags and containers was for residents with COVID. He confirmed that the mechanical vital sign machine was re-used for the residents on the unit and needed to be disinfected between use. He confirmed that he could not say by looking it that the uncovered mechanical vital sign machine next to his medication cart was clean. He initially stated he would use alcohol to disinfect the equipment but after prompting from the ICP who was present he said, no, a wipe. He said the wipes were kept in the medication cart but was unable to produce any from the cart and then confirmed that there were no disinfecting wipes on the unit. During a second observation of the PUI unit on 09/01/20 at 1:30 p.m. rooms 102, 104, 106, and 101 were observed to have signs posted at the door that included the following content: special droplet/contact precautions .Use patient dedicated or disposable equipment. Clean and disinfect shared equipment .Use dedicated or disposable equipment when available .Clean and disinfect reusable equipment .Ensure blood pressure cuff and stethoscope are cleaned and disinfected between patients. No other rooms on the unit had these signs at the door. A review of the facility in-service training records revealed that on 08/17/20 education had been provided to nursing staff on Disinfectant and wipes .Dwell time kill time contact time wet time. There was an associated hand-out that revealed disinfectant wipe products and the required contact time for disinfecting. The (brand name A) germicidal wipe was listed with a 3-minute wet time for disinfection. An in-service training record dated 08/07/20 on COVID Updates revealed: Know contact time of disinfecting wipes/sprays .2 minutes for Purple Top Wipes .4 minutes for (brand name B) wipes. On 09/01/20 at 12:17 p.m. the facility Director of Nursing (DON) was interviewed. He confirmed that the PUI unit housed residents who were new admissions, residents who received [MEDICAL TREATMENT], and residents who had been exposed to other facility residents that had tested positive for COVID-19. He revealed that room [ROOM NUMBER] bed A was assigned to a new admission, room [ROOM NUMBER] bed B was assigned to a resident on [MEDICAL TREATMENT], and room [ROOM NUMBER] beds A and B were assigned to residents on [MEDICAL TREATMENT]. All other rooms on the PUI unit were designated as residents who had been exposed to another resident who had tested positive for COVID-19. The DON confirmed that all residents on the unit were under droplet isolation transmission-based precautions. Regarding the signs observed posted at some of the resident room doors he stated, signs are just to educate the staff on what to do prior to entering the room. Regarding the vital signs equipment that was observed in plastic bags and plastic containers on the unit he stated, every PUI resident should have their own vital signs equipment .each resident in the room should have their own vital signs equipment. Regarding the lack of labels on the bags and containers, the DON agreed that in those cases it could not be confirmed that the equipment was designated to a specific resident and said, probably should just put the room number on the bag or container because of HIPAA (Health Insurance Portability and Accountability Act) and said, we have done education on this. He confirmed that the mechanical vital signs machine, the big one in the hall was shared equipment and said, every time they (staff) use it they should clean it between use and stated that a plastic bag should be placed over the machine to signal that it had been disinfected. The DON identified that (brand name A) germicidal wipes were approved for use for disinfecting vital signs equipment between use. He could not confirm the contact time for disinfection stating, 2-4 minutes I can check. He reported that the wipes were kept in the nurse's medication carts and that every nurse was responsible to ensure that their medication cart was stocked at the start of their shift. The DON confirmed that either he or the facility ICP were responsible for providing staff education on infection prevention and control in the facility. At 2:10 p.m. on 09/01/20 the DON reported that since the time he made his previous statements that all residents on the PUI unit should have designated vital signs equipment, his regional corporate consultant had informed him that the facility should be following what the signs posted on the unit directed regarding vitals signs equipment and revealed the sign and the following specific content on the sign: Clean and disinfect reusable equipment .Ensure blood pressure cuff and stethoscope are cleaned and disinfected between patients. Review of the facility policy titled COVID-19 Guidance dated July 2020 revealed: Use approved cleaning agents and follow the directions on the label .Educate staff on special unit setup. According to the CDC guidelines for environmental infection control when providing care for individuals with suspected or confirmed COVID-19, Dedicated medical equipment should be used when caring for patients with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection. All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies. Retrieved September 2, 2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html.