STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106042	A. BUILDING _____ B. WING _____	**05/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FREEDOM SQUARE REHABILITATION & NURSING SERVICES	**10801 JOHNSON BLVD SEMINOLE, FL 33772**

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 observation and interviews the facility failed to mitigate the spread of infections including COVID-19, by not enforcing their directives and not following the Centers for Disease Control (CDC) recommendations as follows: 1. Two of sixteen (Staff A & Staff B) direct care staff were not wearing the required personal protective equipment (PPE) supplied to them. 2. Staff failed to ensure doffing of PPE after leaving a room with an infection, and prior to entering another room. Findings included: 1. An observation and interview with Staff A, Licensed Practical Nurse (LPN) on 05/04/20 at 9:35 a.m. revealed that Staff A, LPN was caring for residents on C-High wing rooms 161-172. Staff A was asked about the signage on an outside door on the unit. Staff A, LPN explained that the staff used a single access entry and exit during their shift. While explaining the process, Staff A, LPN's maroon colored cloth facemask fell below her nose, Staff A, LPN did not reposition the facemask during the interview. An interview with the Nursing Home Administrator (NHA) on 05/04/20 at 9:15 a.m. revealed that the staff throughout the facility had been instructed to wear N95 facemasks. An interview with the Director of Nursing (DON) and the Infection Preventionist (IP) on 05/04/20 at 11:20 a.m. revealed they had instructed the staff to wear an N95 mask. The DON was asked if it was acceptable for a nurse on unit C to be wearing a cloth facemask and she replied that it was not. She stated, All of the staff are to wear the N95 facemasks that we have provided for them. On April 13, 2020 the Centers for Disease Control (CDC) provided this infection control guidance for healthcare settings. To address asymptomatic and pre-symptomatic transmission, implement source control for everyone entering a healthcare facility (e.g., healthcare personnel, patients, visitors), regardless of symptoms. Cloth face coverings are not considered PPE because their capacity to protect healthcare personnel (HCP) is unknown (CDC, 2020). Reference: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html. 2. An interview was conducted on 05/04/20 at 11:11 a.m. with the facility's Director of Nursing (DON) and the Infection Preventionist regarding isolation precautions within the facility's isolation unit. The DON stated that rooms 115 to 135 were separately isolated from the rest of the facility, including rooms 101 to 114 on the A-wing. Staff were to wear full personal protective equipment (PPE), including gloves, protective gown, N95 masks, and face shields while working on the unit. The Infection Preventionist stated that the isolation unit contained two rooms which required additional isolation precautions. The Infection Preventionist stated that when staff enter those rooms, they could wear the same PPE when providing care. However, when staff exit the room, they should change their gloves and gown and perform hand hygiene after caring for the resident. The Infection Preventionist also stated that staff were to sanitize their face shields and let the solution dry for two minutes before reapplying the face shield and caring for another resident. An observation was made on 05/04/20 at 12:05 p.m. during lunch service on the facility's isolation unit. Staff B, Certified Nurse's Aide (CNA), was observed entering room [ROOM NUMBER] to deliver a lunch tray to a resident. An isolation cart was observed outside of room [ROOM NUMBER] and signage that read droplet precautions was laying on the isolation cart with a box of gloves on top of the sign. Staff B, CNA, was observed wearing a protective gown, N95 mask, and face shield, but was not wearing gloves. Staff B, CNA, was observed moving the resident's bedside table closer to the resident and setting up the meal without wearing gloves. When care for the resident was completed, Staff B, CNA was observed performing hand hygiene before exiting the room. Staff B, CNA, applied clean gloves but did not change her gown or sanitize her face shield before delivering a beverage to a resident in room [ROOM NUMBER]. An interview was conducted on 05/04/20 at 12:20 p.m. with Staff B, CNA. The CNA was unable to state why the resident in room [ROOM NUMBER] was on precautions but stated, I can ask the nurse. Staff B, CNA, stated that when exiting an isolation room they should change their gown and gloves before caring for another resident on the unit. The CNA acknowledged that she did not change her gown after exiting room [ROOM NUMBER] and stated, I was just moving too fast. Staff B, CNA was not able to state why she was not wearing gloves inside of room [ROOM NUMBER] and stated, I thought I was wearing gloves. The CNA stated that she was educated on the proper use of PPE on the unit. Staff B, CNA, observed the signage that read droplet precautions underneath a box of gloves on the isolation cart and stated that she did not see it before entering room [ROOM NUMBER]. A follow up interview was conducted on 05/04/20 at 1:15 p.m. with the DON. The DON stated that staff were to change their gown and gloves before exiting the room of a resident on droplet precautions. The DON also stated that she would expect for staff to wear gloves inside the room of a resident on droplet precautions and to sanitize their face mask after exiting that room.

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.