STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106038	A. BUILDING _____ B. WING _____	06/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALEXANDER "SANDY" NININGER STATE VETERANS NURSING	8401 W CYPRESS DR PEMBROKE PINES, FL 33025

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 observation, interview, and record review, the facility failed to implement droplet and contact precautions between residents who had been exposed to residents or staff with COVID-19 to prevent further transmission. This affected 19 of 19 residents on the Delta Blue unit and 11 of 11 residents on the Delta Green unit. The facility also failed to monitor all points of entrance to the facility, which has the potential to affect all 79 residents in the facility. The findings included: The facility's Policy and Procedure titled Emergency Infectious Disease, Pandemic and Other Extreme Emergency Management, effective date 03/03/20, documents under Procedures, Local Threat/Coordination with Agencies, Activate quarantine interventions for residents and staff with suspected exposure as directed by local and state public health authorities, and in keeping with guidance from the CDC (Centers for Disease Control and Prevention). The Centers for Disease Control and Prevention (CDC) guidance titled Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, Update May 18, 2020 documents, Patients and visitors should, ideally, be wearing their own cloth face covering upon arrival to the facility. If not, they should be offered a facemask or cloth face covering as supplies allow, which should be worn while they are in the facility (if tolerated). They should also be instructed that if they must touch or adjust their cloth face covering they should perform hand hygiene immediately before and after. Facemasks and cloth face coverings should not be placed on .anyone who has trouble breathing, or anyone who is unconscious, incapacitated or otherwise unable to remove the mask without assistance. Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., HCP (health care providers), visitors) enter the room. The CDC guidance titled Preparing for COVID-19 in Nursing Homes, Update May 19, 2020 documents .In addition to the actions described above, these are things facilities should do when there are COVID-19 cases in their facility or sustained transmission in the community. .Resident Monitoring and Restrictions: Encourage residents to remain in their room. If there are cases in the facility, restrict residents (to the extent possible) to their rooms except for medically necessary purposes. If they leave their room they should wear a cloth face covering or facemask, perform hand hygiene, limit their movement in the facility, and perform social distancing (stay at least 6 feet away from others). The CDC guidance titled Preparing for COVID-19 in Nursing Homes, documents Implement Source Control Measures .Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility. Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance . During continuous observation on Delta Blue, a memory care unit, on 06/02/20 beginning at 10:55 AM until 11:48 AM, signage on doors to all Delta Blue resident rooms indicated they were on droplet and contact precautions. Residents #11 and #12 were found seated facing each other next to a 4-person table directly in front of the nursing station at 10:55 AM. As Resident #11 talked to Resident #12, neither resident was wearing a face mask or face covering. Two staff present at the nursing station as well as other staff walking through the area were observed not to make any attempt to address the residents' close proximity or lack of face coverings until the surveyor inquired to the identities of those residents at 10:59 AM. A staff member then wheeled Resident #11 away and out of sight. Resident #12 remained in place with his face mask hanging by a strap from around his left elbow. All residents' rooms on the unit had open doors. An interview was conducted on 06/02/20 at 11:15 AM with Delta Blue charge nurse, Staff A during continued observation of the Delta Blue table area and Resident #12. Staff A stated it was difficult to keep residents in their rooms and stated Resident #11 spits as he talks so she has to watch him, and that he also wanders about the unit, and has a tendency to be exit-seeking. Staff A reported all of the residents on that unit wear masks when staff are doing care with them. During this interview Resident #13 wheeled himself to another empty table directly in front of the nurses desk without a mask or face covering in place. At 11:21 AM Resident #14 came out of his room with a rolling walker and no mask or face covering in place, walked directly in front of and past a staff member standing at his doorway without being asked to stay in his room or reminded to cover his face, and approached Staff A and the surveyor. Resident #14 spoke to Staff A without Staff A or any staff making any effort to remind him to wear a face covering or return to his room. Upon questioning to Staff A that none of the residents observed in the common area were wearing masks, Staff A said the residents take them off. After surveyor comment that throughout the observation no staff have reminded them, Staff A opened Resident #14's walker compartment, pulled out his mask and asked him to wear it, upon which it was placed. Upon inquiry that Resident #11, who she described as a spit-talker, was speaking to Resident #12 in close proximity with neither wearing face coverings with various staff passing them several times without any effort to intervene, she said Resident #11 was taken to his room but gave no explanation for why herself and other staff did not intervene until surveyor inquiry of those residents. Upon inquiry that all of the residents' doors on the unit were open, Staff A stated the residents open the doors and that 2 of the rooms need to be watched due to residents with fall and/or [MEDICAL CONDITION] precautions. Staff A provided no further explanation for the other 8 rooms that remained open since 10:55 AM until after 11:21 AM. By 11:45 AM, 5 out of 10 resident doors were closed. Review of facility documentation revealed a person who tested positive for COVID-19 had close contact with Residents #11, #12, and #13, who had been observed in the common area unmasked as noted above, as well as 9 other residents on Delta Blue in the 2 days prior to the person's positive test on 05/29/20. During telephonic interview on 06/04/20 at 3:26 PM with the Infection Control Preventionist/Assistant Director Nursing, she reported the 12 residents on Delta Blue with potential exposure to a person who tested positive to COVID-19, including Residents #11, #12, and #13, were placed on transmission-based precautions on 05/30/20 when the result became known; and that all residents on Delta Blue and Delta Green were placed on contact and droplet isolation as of 06/01/20 by Department of Health recommendation since they determined residents on those units were interacting, resulting in potential exposure to all residents on those units. During observation of Delta Green unit on 06/02/20 at 12:23 PM, one resident was observed in the common area with no facial covering. Staff were observed repositioning Resident #15 in a chair in his room and leaning over his chair talking to him although Resident #15's face was not covered. After looking at the surveyor, staff pulled the curtain, placed a procedure mask on Resident #15 and closed the door. Out of 9 occupied resident rooms, doors were open to 7 on 06/02/20 at 12:28 PM. At 12:31 one resident was observed in the common area with a mask under his chin instead of covering his mouth and nose. On 06/02/20 at 4:25 PM the rear entrance to the facility overlooking a parking lot was observed propped open. During interview with the Administrator on 06/02/20 at 4:25 PM he stated the back door is used in the morning for day shift to come in, during which time someone is stationed there to screen staff for their temperature and report of any COVID-19 symptoms, and that door is closed at 9:15 AM, after which all staff must use the front door. He reported 2nd and 3rd shift staff park in front of the building and only use the front entrance. The Administrator saw and confirmed the back door was propped open, stated it should not be propped open and that someone should be monitoring the door if not locked. Although there was a desk with blank screening forms by that door, it was observed not attended and no staff were in the hall at that time. After the Administrator closed the door, a dietary staff member came down the hall, used the time-clock, and exited the

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) back door to the parking lot at 4:30 PM without being approached or asked about end of shift screening and a temperature check. A staff member opened a door near the exit and came into the hallway, upon which the Administrator asked if he was watching that door, which that staff confirmed he was, but was unable to answer whether the person who just left was leaving for the day or had been screened. Upon inquiry by the Administrator to staff in the kitchen, they confirmed the dietary staff member observed had just left for the day. At 4:34 PM another staff came down the hall from the central common area and used the time-clock, walking past the Administrator and staff member who had just confirmed he was watching the exit, and exited the unlocked back door without being screened or asked about screening. Although further review revealed the 2 observed staff documented screening paperwork and temperature checks at the front reception desk before leaving, there was no monitoring in place to ensure staff compliance during the afternoon change of shift. During observation on 06/03/20 at 3:09 PM, 3 staff came in the unattended back door which was again propped all the way open. Although they proceeded to the reception area at the front of the building after entrance, the back door cannot be seen from the reception desk and the back door was not monitored. Between the back hallway and reception area is a large central common area with regular foot traffic between units and central facility support services, the kitchen, and administration. Without monitoring of the back door, incoming staff have a likelihood of encountering and interacting with other staff, and/or the occasional resident who has left their unit, before they have been screened for signs and symptoms of, and/or exposure to, COVID-19.