| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **106017** | A. BUILDING _____ B. WING _____ | **04/23/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **BRADENTON HEALTH CARE** | **6305 CORTEZ RD W BRADENTON, FL 34210** |

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) |
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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations, staff interview, local county Department of Health (DOH) staff interviews, facility and resident record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of a communicable diseases to reduce the risk for COVID-19 infections during two of two days observed ([DATE], [DATE]), to include: 1. Staff not properly sanitizing/disinfecting Personal Protective Equipment (PPE) when leaving a suspected COVID-19 isolation resident room and also prior to entering a non-isolation resident room, 2. Administration not aware of a staff members with symptoms of COVID-19 including an employee who worked the isolation hall for a week with symptoms of COVID-19, 3. Administration not reporting sick staff members as suspected COVID-19 to the Emergency Status System, by 10:00 a.m. on a daily basis, 4. Staff not utilizing proper Personal Protective Equipment on an isolation hall with resident rooms who were on suspected COVID-19 isolation precautions, 5. Staff as a whole not being made aware in a timely manner from administration of cases of staff and residents who had tested positive for COVID-19, 6. Staff not separating soiled laundry from isolation rooms from non-isolation rooms, leaving laundry room staff not knowing which soiled laundry came from the isolation and suspected COVID-19 rooms and 7. Further, The facility failed to ensure that residents suspected with COVID 19 were provided with appropriate nursing assessments and evaluations in a timely manner for six (# 7, 1, 2, 3, 5, 6) out of nine residents identified with a change in condition. Findings included: 1. On [DATE] and again on [DATE] resident rooms [ROOM NUMBER] were on the isolation hall and were also observed with PPE (Personal Protective Equipment) storage located on the doors. rooms [ROOM NUMBERS] doors were all the way open and room [ROOM NUMBER] door was closed shut. All storage containers on the door had items to include reusable soft plastic goggles, gowns, gloves, stethoscopes, face shields and surgical masks. The storage containers on all three room doors did not contain any sanitation/disinfectant wipes or solution. On [DATE] at 1:50 p.m., a CNA (Certified Nursing Assistant) Employee A. was observed to come out of resident room [ROOM NUMBER], which was observed as one of the isolation precaution rooms. Employee A. was observed carrying two clear plastic bags of soiled linen and placed them in the regular soiled linen cart and closed the lid. He was observed wearing an N95 face mask, gloves and clear soft plastic goggles. After placing the bags in the cart, he went into the same room bathroom and removed his gloves and washed his hands. He then walked out from the room, still wearing the goggles and face mask, and walked approximately sixty feet down the hall to the unit station desk. He was observed to throw up his hands and was looking for something. He then returned and walked to the soiled linen cart and pulled it across from resident room [ROOM NUMBER] door area, and pulled it to resident room [ROOM NUMBER], which was directly across from room [ROOM NUMBER]. He went inside room [ROOM NUMBER], which was not on isolation precautions, nor did it have any residents in the room who were suspected of symptoms related to COVID-19. Residents in room [ROOM NUMBER] however, were on infection control precautions for symptoms suspected of COVID-19. Employee A. after observed to go into room [ROOM NUMBER], was then approached by this State surveyor. He was asked about his goggles and asked where he just came from. Employee A. indicated that he came from room [ROOM NUMBER], which was on isolation precautions, placed his soiled linen in the cart and then left the room. He was asked about the goggles he was wearing and he indicated that he got the goggles from the storage container on the room door and has been wearing them since the beginning of the shift. He was asked how and when he cleans and sanitizes them. Employee A. expressed that he sanitized the goggles with chlorine wipes at the beginning of the shift and he tries to sanitize them every two hours after that. He was asked who directed and educated him to do that. He said he just knows. He then said that he will sometimes in between rooms utilize soap and water to clean them. He was asked what type of soap he used and how long he washes the goggles during that process. He could not answer of how long he sanitizes or disinfects the goggles after use and after being in an isolation precaution room. Employee A. was then asked if he either sanitized or disinfected the goggles after leaving resident room [ROOM NUMBER], which was on isolation precautions. He revealed that he left the room and did not find chlorine wipes on the door. He then said he walked to the unit station to find them and that is why he threw up his hands. He did so because he could not find any wipes. Employee A. then confirmed he walked back down the hall and entered room [ROOM NUMBER], which was not on isolation precautions, and did so without disinfecting his goggles and without changing his N95 mask. Employee A. indicated that he does not normally work on this hall and is doing so to fill in for a staff member who had called in sick. Employee A. confirmed that he had not been provided with education from staff on how to clean and sanitize goggles, when to change his mask, when entering and leaving COVID-19 suspected rooms, and was not provided with any education to treat all three resident rooms [ROOM NUMBER] as if suspected COVID-19 infection. Employee A. also confirmed that administration has not told him of any residents or staff who had been on that unit recently, and tested positive for COVID-19. He was unaware of any positive cases and was unaware to treat symptomatic residents as suspected for COVID-19. At 2:00 p.m. an interview with the East Unit Manager, Licensed Practical Nurse Employee D was told about Employee A going in and out from isolation rooms to regular rooms wearing same goggles and mask without first changing or properly disinfecting them. She indicated that they do have wipes and then got them out and then walked down the hall and placed the wipes on the PPE container bag on each isolation room, to include rooms [ROOM NUMBER]. She did not have an answer as to why the room doors were not fitted with chlorine disinfectant wipes. She did confirm that employees should be disinfecting goggles after leaving isolation rooms and was unsure about changing masks though. She further confirmed that they did have the chlorine wipes, they were just not out at the time. She indicated she would provide additional education to the floor nursing staff and that residents in rooms [ROOM NUMBER] are to be treated as suspected COVID-19, due to their symptoms. On [DATE] at 2:17 p.m. CNA A was noted standing just outside Resident #4's bedroom cleaning his goggles with a bleach wipe. He wiped the outside of the mask and then the inside of the mask with the same wipe. For a total of 6 seconds. He then placed the goggles inside of one of the pockets of the PPE that hung on the doorway. CNA A was asked at that time about the cleaning process of the goggles. He said I wipe them down and put them back on the door to dry. The container of the wipes Micro Kill bleach germicidal bleach wipes included directions on the cleaning and disinfection process. The cleaning process included to wipe with the bleach wipe, and to use a second bleach wipe for the disinfection process. The instructions also included that a total wet (contact) time of 3 minutes was required for proper disinfection. The facility failed to ensure that the manufactures' recommended contact time was utilized. An interview with the Director of Nursing at approximately 3:45 p.m. confirmed that staff should be sanitizing goggles for three minutes, utilizing Chlorine wipes after each use and especially after leaving an isolation room. He was not aware that the isolation hall rooms with PPE storage on the doors, lacked these wipes for staff to use. The facility provided a copy of their policy titled Personal Protective Equipment (PPE) Conservative fact sheet that was dated on [DATE]. Goggles/Eye Protection/face shields Expended use -worn through-out shift If it becomes soiled, remove and disinfect (using a disinfectant wipe clean the inside then the outside of the goggles/face shields. Allow to air dry-may use water or alcohol wipe to remove residue.) A second policy was provided by the facility that was titled Covid-19 Pandemic Plan, dated [DATE]. Policy: COVID-19 is a respiratory illness thought to be spread mainly from person to person, between people who |

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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>have come in close contact to one another (about 6 feet). [MEDICAL CONDITION] is spread through droplets produced when an infected person coughs or sneezes. Symptoms include fever, cough, and shortness of breath, and in some causes vomiting and diarrhea. Disinfecting works by using chemicals, for example EPA-registered disinfectants, to kill germs on surfaces. This process does not necessarily clean dirty surfaces or remove germs. But killing germs remaining on a surface after cleaning further reduces any risk of spreading infection. https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html#PPE. 2. On [DATE] at 12:23 p.m. during tour, State surveyors toured the isolation hall and spoke with CNA (Certified Nursing Assistant) Employee C. She told the surveyors the same information she gave the Department of Health team. She explained she could not taste or smell her food and had body aches for about a week now. She indicated she told her management staff, including the Director of Nursing when she first experienced the symptoms. She has not been told anything about needing to be tested for COVID -19, and was not turned away from doing her job. Employee C indicated she was told that DOH would be coming to the facility to do COVID-19 testing, but was not made aware of when they would come. She did not know if the Nursing Home Administrator was made aware of her symptoms but did express she told the Director of Nursing. During further tour at approximately 12:30 p.m. on the same East isolation hallway, interview with RN Employee E revealed she does not normally work this hallway. She was asked to work the hallway this morning when staff member RN Employee B called in sick. Employee E said that Employee B reported a fever this morning at 7:00 a.m. today and did not report to work. Employee E also said that Employee B worked predominantly on the East isolation hallway, which included suspected COVID-19 residents. Employee CNA C also worked predominately on the East Isolation Hallway. At 4:45 p.m. on [DATE] during an interview with the Director of Nursing, who oversees all nursing employees to include the infection control nurse, was told from this State surveyor about Employee C. presenting with symptoms that were suspect to COVID-19. He revealed that this was the first time he heard about it and that nobody told him about it. He was unaware that she was presenting with lack of taste/smell and with body aches for a week. He confirmed that this is something that should have been brought to his attention. The Director of Nursing further confirmed that he was not aware of Employee B. calling in sick with a fever earlier today before the start of the ,[DATE] shift. During same interview with the Nursing Home Administrator on [DATE] at 1:50 p.m., he was asked about RN Employee B. He indicated that he was not made aware Employee B called in sick this morning until just recently. He was asked if he should have known about the employee this morning, prior to 10:00 a.m. when he had to make his daily ESS (Emergency Status System) report. He agreed that he should have been made aware but he was not. He indicated that Employee B. will not be returning to work until after COVID-19 test and results come back negative. At 4:45 p.m. an interview with the DON confirmed that Employee B. worked the hall where there are residents suspected of COVID-19, and who have tested positive, and also worked the same hall with Employee C., as well as two other staff who had recently tested positive for COVID-19. The Director of Nursing revealed this was the first time he heard about Employee B and that the information should have been brought to his attention. At approximately 1:50 p.m. an interview with the Nursing Home Administrator indicated that he was aware of CNA Employee C having some symptoms but he felt they were not the type that should be reported to DOH. He did not follow up with Employee C after the first time she reported to him, which was approximately one week ago. He first indicated that he was aware of the employee presenting with aches, but not loss of taste or smell. At 2:45 p.m. on [DATE] it was found that CNA Employee C. was still working with residents after the Administrator was made aware of AHCA and DOH concerns. Then on [DATE] at approximately 3:00 p.m. with the Administrator and during a second follow up interview, he indicated he was not aware of any symptoms at all, and only that employee C was not feeling well. He did not feel she presented with any type of suspected symptoms of COVID-19. He and his administration allowed her to continue to work at the facility from the first day she reported the symptoms approximately one week ago. He indicated that he had told her and other staff that representatives from the Department of Health with the assistance from the National Guard were coming to the facility at some point to test employees and residents for COVID-19. However, interview with the team from the local county Department of Health revealed testing was being discussed but there were no specific plans to come to this facility in the coming days to test residents and employees. The Nursing Home Administrator further indicated that he was not aware that suspected COVID-19 symptoms included loss of taste or smell. However, Centers for Disease Control had put out suspected symptoms of COVID-19 to include loss of taste and smell as of [DATE]. On [DATE] during day two of the complaint investigation, and during tour around 1:40 p.m., the East isolation hall was observed with staffing in place and with nursing providing care and service to residents, who were staying in their rooms, [MEDICATION NAME] social distancing. On [DATE] at 1:30 p.m. an interview was conducted with the East unit supervisor Employee D., she confirmed the schedule that was posted for [DATE] included Employee B. She stated Employee B. came to work today but he was sent home. She said that he had come onto the East isolation unit and had received report from the third shift unit nurse. Around 7:10 a.m. the Infection Control Nurse came on the unit and told him he needed to leave the facility. An interview with the Director of Nursing and Nursing Home Administrator when asked, revealed that Employee B. had not come into the facility. However, after it was pointed out that unit managers and other staff said he came into the building and was on the isolation hall, the DON then revealed that yes, Employee B. had indeed come into the building but only for a few minutes before having been turned away. The Nursing Home Administrator did not think this was a concern that Employee B., who called in the day before with a fever, and then came in without them knowing the next day. He indicated that he was not in the building very long. The Director of Nursing indicated that Employee B. may not have gotten the phone message to not to return to work. The DON was asked if they notified staff of employees who presented with symptoms in order to not allow the staff with symptoms to come back into the building. He indicated that the check-in staff, that do the screening should know, but he did not provide how that information was filtered to check-in staff. Review was conducted of the Staff Screening form that did not contain a date. The facility confirmed that the staff members answer all of the questions daily before they start their job. The questions that were asked of the staff related to their medical symptoms and included: Do you have a new or change in cough? Do you have a new of change in sore throat? Are you short of breath? Have you vomited or diarrhea within the last 24 hours? The Screening Forms reviewed did not include the symptoms of fever, muscle pain, New loss of taste or smell, chills, repeated shaking with chills or headache. On [DATE] the Centers for Disease Control and Prevention posted; Symptoms of Coronavirus People with COVID-19 have had a wide range of symptoms reported - ranging from mild symptoms to severe illness. These symptoms may appear ,[DATE] days after exposure to [MEDICAL CONDITION]: Fever Cough Shortness of breath or difficulty breathing Chills Repeated shaking with chills Muscle pain Headache Sore throat New loss of taste or smell https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html. The facility had provided a copy of their policy titled Covid19-Pandemic Plan that contained a revised date on [DATE]. Employee Health Staff are educated to self-assess and report symptoms of COVID-19 before reporting to work. 3. On [DATE] at 11:00 p.m. the NHA (Nursing Home Administrator) provided a face sheet/screen shot of previously submitted ESS (Emergency Status System) reports for review and to include: a. [DATE] submitted at 9:39 a.m.; b. [DATE] submitted at 10:00 a.m.; c. [DATE] (Friday and no evidence that it was submitted); d. [DATE] submitted at 6:32 a.m.; e. [DATE] (Sunday and no evidence that it was submitted; f. [DATE] submitted at 10:00 a.m.; g. [DATE] submitted at 9:42 a.m. and; h. [DATE] submitted at 9:53 a.m. (Photographic evidence was taken of the ESS report submissions) On [DATE] at 11:50 a.m. an interview with the NHA revealed that he was submitting the ESS report electronically, daily by 10:00 a.m. He then indicated that there was one day [DATE] he did not submit it. He indicated that he worked the entire day before [DATE] and through the next day [DATE] and he just did not think it was a different day until it was past 10:00 a.m. He confirmed he totally missed sending the report on [DATE]. The NHA was asked about [DATE] and he then remembered he did not send for that day either. He did not have a reason as to why that report was not sent electronically either. On [DATE] later in the day around 12:30 p.m., it was found that Employee B. called in sick prior to the 7:00 a.m. shift start. It was later found that Employee B. called in sick at around 6:45 a.m. and indicated he had a fever. The NHA confirmed because he was not made aware until around 1:50 p.m. that Employee B. called in sick prior to the start of 7:00 a.m. shift, he did not submit electronically the ESS report accurately to indicate this information. The Nursing Home Administrator confirmed that when he did his ESS report today [DATE] by 10:00 a.m., it did not include staff Employees B. and C. as calling off sick with symptoms of COVID-19. He said he was not aware of that information, though Employee B. had called in sick before 7:00 a.m. today. 4. On [DATE] at 1:20 p.m. the Unit Manager of the west (UMW) wing was on the east isolation hallway wearing a surgical paper mask. She was walking with the four members from the Department of Health (DOH). She said she was taking them for a tour of the unit. The four members from the DOH were wearing Personal Protective Equipment (PPE) that included N95 masks, faceshields, gowns, gloves and foot covers. She was asked why she was only wearing a surgical mask as the facility had earlier indicated they had more than enough of N 95 masks available for the staff members. UMW stated I don't need an N 95 mask. No one with or suspected COVID 19 is on the unit, |

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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 2)<br>and I am not going in anyone's room. Shortly afterwards the DON (Director of Nurses) was observed using the entrance to the east isolation hallway and walked past the isolation rooms with the doors open. He was noted wearing only a surgical paper mask. The entrance to the east isolation unit consisted only of the doors being closed. No signage was posted on the doors that would indicate isolation precautions for the hallway as had been recommended by the DOH the day prior. Review of the CDC Coronavirus Disease 2019 (COVID-19), Key Strategies to Prepare for COVID-19 in Long-term Care Facilities, [DATE] showed: 3. Prevent spread of COVID-19: If COVID-19 is identified in the facility, restrict all residents to their rooms and have HCP (healthcare personnel) wear all recommended PPE for care of all residents (regardless of symptoms) on the affected unit (or facility-wide depending on the situation). This includes: an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown. 5. On [DATE] at 2:50 p.m. a small group meeting was held in the main dining room with nursing staff to include employees F., G., H., I., J., K., L., and M. The group comprised of Nurses and Certified Nursing Assistants. Upon interview, the entire group indicated that the administration had never talked to them or spoken about employees or residents testing positive for COVID-19 in the facility. They all indicated that they found out through newspapers or news reports. They felt administration was not being forthright with them when it came to who needed to be tested for COVID-19. One aide, employee F. indicated that she has compromised family members at home and asked administration when she will be tested . She was asked if she was symptomatic and she indicated that she was not but wanted to be tested anyway. The entire group agreed and indicated that they were told by management that the DOH (Department of Health) and the National Guard were coming today to do testing on all staff. The group was asked who told them that and they all indicated it came from administrator about a week ago. The entire group thought that today's visit from the State AHCA and Department of Health would include staff testing. However, that was not true and there is no evidence that testing was going to happen in the coming days. Further, an interview with the local county DOH indicated that there were no plans to come to the facility to test all staff and residents at this time and no testing was planned at this time. The employees felt that they all needed to be given N95 masks and said they were only given surgical masks. They said they must wear these surgical masks several times before getting new surgical masks. They all know that the administrator has many N95 masks but they are not being handed out and they do not know why. The group felt other PPE supplies were adequate. Several of the group to include employees G., F., and J. had heard one staff member had symptoms and continued to work for a week. They heard it through various floor staff and not from the administration. The group indicated that their temperatures were checked every four hours and they fill out a questionnaire every morning before work or coming in building. The group assembled expressed fear and felt they were not being given correct information, and that the administrator and DON were not being forthright with them. 6. On [DATE] at 1:45 p.m. an interview was conducted with Certified Nursing Assistant A (CNA A), he indicated at that time his assignment included the east isolation hallway with suspected COVID-19 residents. He was asked about the sorting of the residents' linen, and asked if he had been informed of placing the linen in different colored bags. He stated, no one has told me anything different. On [DATE] at 3:30 p.m. the DOH was at the facility and indicated they had given the facility thirty recommendations yesterday ([DATE]). A DOH staff member said one of the recommendations included staff should be separating the residents' laundry and not co-mingling it with another residents' linen. Which would include using a different colored bag so the linen of suspected and positive residents was easily identified. The facility on [DATE] continued mixing laundry together. Infection Prevention and Control Guidance for Long Term Care Facilities in the Context of COVID 19, Interim guidance 21 [DATE] Would Health Organization, Laundry: Soiled linen should be placed in clearly labeled, leak proof bags or containers, after carefully removing any soiled excrement and putting it in a covered bucket to be disposed of in a toilet or latrine. Machine wash them with warm temperature at 60 to 90 Celsius (140 to 194 Fahrenheit) with laundry detergent is recommended the laundry can then be dried according to routine procedures. CDC about Educating Personnel from [DATE] for more support. The facility staff should handle all used laundry as potentially contaminated and use standard precautions (i.e., gloves). Alternatively, if not all used linens are handled as potentially contaminated, staff would provide separation with special identification of bags and containers for contaminated linens with labels, color coding, or other alternative means of separation of the laundry for appropriate handling and processing. CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007) Does not require separation. II.K. Textiles and Laundry Soiled textiles, including bedding, towels, and patient or resident clothing may be contaminated with pathogenic microorganisms. However, the risk of disease transmission is negligible if they are handled, transported, and laundered in a safe manner11, 855, 856. Key principles for handling soiled laundry are 1. not shaking the items or handling them in any way that may aerosolize infectious agents; 2. avoiding contact of one's body and personal clothing with the soiled items being handled; and 3. containing soiled items in a laundry bag or designated bin. When laundry chutes are used, they must be maintained to minimize dispersion of aerosols from contaminated items 11. The methods for handling, transporting, and laundering soiled textiles are determined by organizational policy and any applicable regulations 739; guidance is provided in the Guidelines for Environmental Infection Control 11. Rather than rigid rules and regulations, hygienic and common sense storage and processing of clean textiles is recommended 11, 857. When laundering occurs outside of a healthcare facility, the clean items must be packaged or completely covered and placed in an enclosed space during transport to prevent contamination with outside air or construction dust that could contain infectious fungal spores that are a risk for immunocompromised patients. 7. The Director of nursing had indicated that residents' vital signs are taken up to three times a day and more frequently if there was a change in condition. 7. On [DATE] on 10:30 a.m. on entrance to the facility the Director of Nursing (DON) was asked if any resident had any changes in condition related to fever, and or shortness of breath. He indicated that no one at the facility had those changes. On [DATE] at 1:30 p.m. the facility identified the census number had not changed. One resident went to the hospital with a change in condition and that they received a new admission. Resident # 7 had been sent to the hospital. The resident's room number revealed she was on the east isolation hallway. Resident #7's medical record revealed her oxygen saturation (O2 Sat) level on [DATE] was 95 % on room air. Levels were reviewed back to [DATE] that ranged from 98 to 96%. On [DATE] at 1:45 p.m. the resident's oxygen level was documented at 90% on room air, on [DATE] at 12:02 p.m. her oxygen level dropped to 82% in room air. Resident #7 temperature summary dated on [DATE] at 5:19 p.m. showed 99.5 degrees Fahrenheit. Nursing notes dated on [DATE] at 10:59 p.m. stats spo2 82% at room air. Pulse 115 coughing wheezing, episodes of loose stools x 2 temp this was 99.5 new orders from md for prn O2 via NC(nasal cannula) 2Lmin(2 liters of oxygen per minute), neb tx Q 6 h (nebulizer treatment every 6 hours) and cxr (chest x ray). Nursing notes on [DATE] at 3:36 p.m. (15:36) Chest x-ray was done, no results yet. On [DATE] at 12:22 a.m. (00:22) nine hours later nursing note stated new orders from md r/t(related to) labs results. Kayexolte 30 gm, start IV fluids, start [MEDICATION NAME], and bmp(basic metabolic profile lab test) tomorrow. Nurse went to give kayexolte to patient. Observed patient clammy with flushed checks, rapid breathing, lung sound full of fluid, spo2 87% on 4L/min bp ,[DATE] pulse 114 RR 26 unable to arouse patient, unable to give kayexolte. Afebrile new orders to send to ER(emergency room ). On [DATE] at 3:30 p.m. the DON with the Nursing Home Administrator were present was asked if they had contacted DOH about Resident #7's transfer yesterday. They were heard talking amongst themselves and never responded to the question prior to the exit from facility. On [DATE] at 1:15 p.m. the east isolation hallway was toured that was identified as a long-term care unit. The unit revealed a small clustered area of a total of twelve rooms. Three rooms were observed with personal protective equipment in place and an Isolation sign that was posted indicated it was for droplet precautions. Certified Nursing Assistant C (CNAC) indicated that a room had also been on isolation as she pointed across the hallway directly across from one of three isolated bedrooms. The bedroom door was half open with two unmade beds. One plastic bag was on the floor with what appeared as personnel clothing in it. The Director of Nursing said that the resident in the bedroom had died this morning. He stated, he was just on hospice. The DON was asked if he had a roommate, he said that he did. But he was sent out to the hospital. Resident #2 medical record was reviewed that stated he was sent to the hospital on [DATE].<br>The Admission Record form revealed he had been readmitted date two years ago and was geriatric in age. His primary [DIAGNOSES REDACTED]. Nursing notes were reviewed for Resident #2 that were dated on [DATE] at 1:01 a.m. patient with a non-productive cough, lung sounds congested, fever 99.8. no sob, pulse 102. b/p ,[DATE] Tylenol given raised head of bead (HOB) put cool cloth on head. new orders for small volume nebulizer respiratory treatments (nebs) every 6 hours (q 6), chest X ray two view (2v) and prn (as needed) [MEDICATION NAME] will continue to monitor. Nursing notes on [DATE] at 9:44 a.m. T 102.6, and O2 Sat 88% and labored respiration, oxygen was put in place and O2 Sat 93%. Mediation administer and started [MEDICATION NAME] for 7 days, no sighs of adverse effects. Family aware of the situation. At 2:37 p.m. oxygen 95%. The next vital signs documented for resident # 2 was on [DATE] at 5:12 a.m. fifteen hours later. Vital signs at that time only reflected his temperature at 97.9. At 1:37 p.m. (13:27) nursing note stated nurse spoke to daughter . poa (power of |

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| | **106017** | A. BUILDING _____ B. WING _____ | **04/23/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **BRADENTON HEALTH CARE** | **6305 CORTEZ RD W BRADENTON, FL 34210** |

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 -** Some | (continued... from page 3)<br>attorney) regarding current condition over the phone. Pt. de-stating in am 88% on 3L/min via NC. Md orders to put to 4L now currently 89% on 4L/min via NC. Daughter requested for Dad to go to ER and d/c (discontinue) orders for do not hospitalize md agreed with orders. Pt being sent to ER for Eval and treat. Further record review was conducted for resident #2 that did not reveal a history of respiratory issues. Resident #1's (who was residing in the same room as resident #2) nursing documentation dated on [DATE] at 8:24 a.m. (7 hours later) was documented as having an elevated temperature 99.8. Medical record review for the hospice Resident (#1) revealed outside services were ordered on [DATE]. And on [DATE] hospice services were started. Resident #1 Admission Record form stated he was admitted to the facility three years ago with his primary [DIAGNOSES REDACTED]. Nursing notes additionally that his O2 Sat was 90, had a decreased app |