STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105089	A. BUILDING _____ B. WING _____	05/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANOR PINES CONVALESCENT CENTER	1701 NE 26TH ST FORT LAUDERDALE, FL 33305

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 -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews and review of the Centers for Disease Control and Prevention (CDC) and Florida Department of Health (FL DOH) Novel Coronavirus-19 (COVID-19) infection prevention guidance, the facility failed to ensure the health and safety of their residents when confirmed cases of the COVID-19 Coronavirus were identified in the facility putting all 162 residents in the facility at risk for the potential to contract or transmit the COVID-19 virus by not isolating residents to their rooms per CDC and FL DOH infection prevention guidance with 3 confirmed positive COVID-19 cases as of 04/13/2020 affecting Resident #1, Resident #2, and Resident #3. On 04/19/2020 it was reported the facility had 16 confirmed positive COVID-19 residents, 19 confirmed positive COVID-19 staff and 1 confirmed resident death related to COVID-19. On 04/27/20, it was reported the facility had 39 in-house confirmed positive COVID-19 residents, 11 confirmed positive COVID-19 residents in the hospital and 26 confirmed positive COVID-19 staff. On 04/30/20, it was reported the facility had 38 in-house confirmed positive COVID-19 residents, 24 confirmed positive COVID-19 residents in the hospital and 27 confirmed positive COVID-19 staff. There were 5 reported deaths related to COVID-19. On May 08, 2020, there were 48 in-house positive residents, 9 positive residents in the hospital and 28 positive staff. There were 15 reported resident deaths. On May 09, 2020, the Florida Department of Health identified a need for the removal of positive COVID-19 infected residents to the hospital for a higher level of care. On May 13, 2020 it was identified that the facility's non-compliance on April 13, 2020 created a situation where residents health and safety was in jeopardy of serious harm, serious impairment or death was likely to occur as a result of the non-compliance. The Immediate Jeopardy was determined to have begun on April 13, 2020, during the Infection Control visit with the Agency for Health Care Administration (AHCA) and it was identified that the facility failed to follow the Center for Disease Control and Prevention (CDC) and DOH infection control guidelines to isolate residents when a positive COVID-19 case was confirmed in the facility. The facility's Administrative staff was notified of the Immediate Jeopardy on May 13, 2020 at 10:45 am and the Immediate Jeopardy templates were given to the facility's administrative staff. The Immediate Jeopardy was determined to be removed on April 30, 2020. The findings included: Individuals who are [AGE] years and older, those with chronic underlying medical conditions, and those living in nursing homes are at high risk for developing serious complications from COVID-19 illness. Individuals who are infected could develop serious disease with difficulty breathing, and might require intensive care for the treatment of [REDACTED]. COVID-19 infection can lead to death. COVID-19 is a new disease, caused be a new Coronavirus that has not previously been seen in humans. Currently, there is no vaccine and no approved treatment for [REDACTED]. On March 1, 2020, The Office of the Governor of Florida issued Executive Order Number 20-51 directing the Florida Department of Health to issue a Public Health Emergency. The Executive Order documented, Coronavirus Disease 2019 (COVID-19) is a severe acute respiratory illness that can spread among humans through respiratory transmission and presents with symptoms similar to those of influenza. Section 2 directed the State Health Officer to take any action necessary to protect the public health. Section 3 directed the State Health Officer to follow the guidelines established by the CDC (Centers for Disease Control and Prevention) in establishing protocols to control the spread of COVID-19. Section 4 designated the Florida Department of Health as the lead state agency to coordinate emergency response activities among the various state agencies and local governments. On March 9, 2020, The Office of the Governor of Florida issued Executive Order Number 20-52 declaring a state of emergency for the entire State of Florida as a result of COVID-19. The President of the United States declared a Nationwide emergency for COVID-19 on March 13, 2020 and approved a major disaster declaration for Florida on March 27, 2020. Review of the Assessment of Long Term Care Facility Guidance available from the Florida Department of Health on 04/01/20 documents in part, 'The DOH has provided the following clarification regarding Long Term Care facilities: In Counties where there is community spread - In facilities located where there is known COVID-19 community spread the county health departments may direct additional isolation measures. At this time Broward County is requiring residents be isolated in their rooms with the door closed. If residents come out of their rooms for any reason, they should be wearing a mask if available. All activities and dining in common areas are suspended. This is in addition to all other infection control procedures that have been communicated through AHCA (Agency for Health Care Administration - State licensing and regulatory agency), FL DOH, CDC and CMS.' Review of an email communication from AHCA forwarded to all long term care facility providers in the state of Florida dated April 6, 2020 and titled, 'April 6 Update: Consolidation of Conference Calls for Nursing Homes and Health/Regulatory Partners', notifies long term care facility providers (informational) conference calls with an email link to the CDC infection control guidance site. Review of the CDC guidance for Nursing Home providers documents under Things Facilities Should Do Now 'Cancel communal dining and all group activities, such as internal and external activities. Remind residents to practice social distancing and perform frequent hand hygiene. Have residents wear a cloth face covering or facemask whenever they leave their room, including for procedures outside of the facility. Healthcare Personnel (HCP) Monitoring and Restrictions: Because of the higher risk of unrecognized infection among residents, universal use of all recommended PPE (personal protective equipment) for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP is identified in the facility. 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). On 04/13/20 at 10:50 AM, the facility was entered via the front door. Observed from the front entry down the 3 halls visible, were residents in wheelchairs moving about freely or in their wheelchairs in close proximity to each other. Some had facial masks on, some were holding the masks and some were wearing their masks below their noses. More than 10 residents were observed parked outside of the therapy gyms at the end of the hallway. From a distance, some were wearing masks and some were not. Facility staff to include nursing, therapy, housekeeping and maintenance were observed walking past residents with no attempts to redirect residents to their rooms. On 04/13/20 at 10:53 AM, an interview was conducted with the facility Administrator who stated he was informed 2 residents had tested positive for COVID-19. He stated the first positive case, Resident #1 residing on the West 300's unit, was relayed to him by her primary physician on 04/08/20. Review of the facility's Infection Control Tracking form revealed Resident #1 was sent to the hospital on [DATE] with a fever and abdominal pain. The second case, Resident #2 residing on the West 300's unit, positive result was relayed to him by her primary physician on 04/11/20. Review of the facility's Infection Control Tracking form revealed Resident #2 was sent to the hospital on [DATE] with a fever. The Administrator stated there is a third resident, Resident #3 who was sent out to the hospital on [DATE], has been tested for [MEDICAL CONDITION] at the hospital and that result is pending. Resident #3 resided on the South 200's unit. Review of the facility's Infection Control Tracking form revealed Resident #3 was sent to the hospital on [DATE] [MEDICAL CONDITION]. The Administrator stated when they were informed of the positive results, they notified the FL DOH. He further stated the roommates of Resident #1 and #2 were moved to the South 200's unit, considered their isolation unit, and will be quarantined for 14 days. The

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) Administrator stated they have designated the South 200's unit as their isolation unit as the fire doors can be closed and residents can be isolated from the general population. The Administrator stated they are following the CDC guidance and have ceased all out of room activities including dining and are delivering meals to the resident's rooms. On 04/13/20 at 11:00 AM, a facility tour was commenced with the Director of Nurses (DON). Numerous staff to include nursing, therapy, housekeeping and maintenance were observed walking the hallways. Observation was made of more than 10 residents down the East 100's hall and South 200's hall freely moving about in their wheelchairs or ambulating. Some had masks on, some did not, and some were wearing the mask under their noses. A resident was observed in the large television/activity room in her wheelchair. She was wearing her mask under her nose. Near the end of the main hallway outside of the therapy gyms, more than 10 residents were observed seated in wheelchairs against the walls. Some were receiving occupational or physical therapy, some were just seated there and not [MEDICATION NAME] social distancing of 6 feet apart. A resident was observed seated in a wheelchair outside of the therapy gym with her mask around her chin. A member of the Physical Therapy staff walking by was advised the resident's mask had to be covering her mouth and nose. He proceeded to place the mask on the resident's face and did not sanitize his hands after touching the resident's mask. Observed on the outside courtyard across from the therapy gyms were more than 10 residents in wheelchairs. Some were receiving a therapy session, some were just seated there. Some were wearing masks, some were holding their masks and some had their masks below their nose. The DON was reminded they have 2 confirmed positive cases in the building and the residents need to be placed back in their rooms per the CDC and DOH infection control guidance. The DON immediately instructed nursing staff and therapy staff to escort residents back to their rooms. The observation of the North 400's unit was conducted next with residents observed also moving freely about, some wearing masks, some holding their masks and some with the mask under their noses. The DON began to instruct nursing and therapy staff present to escort residents back to their rooms. Observation of the West 300's unit revealed residents also moving about freely, some wearing masks, some holding their masks and some with the mask under their noses. The DON continued to instruct staff to escort residents back to their rooms. On 04/13/20 at 11:25 AM, an interview was conducted with a housekeeper dedicated to the West 300's unit who was standing at her cart in the hall outside of room [ROOM NUMBER]. An inquiry was made about any additional cleaning or sanitizing practices that have been implemented to prevent the spread of [MEDICAL CONDITION] to which she reached inside the door of the room and retrieved a bottle of cleanser that had been sitting on top of a resident's overbed table, proceeded to read the concentration of the cleanser and placed the bottle, which had been sitting on top of a resident's overbed table, into the slot on her cart without cleansing the bottom of the bottle which had been in contact with a resident's overbed table. An inquiry was made if she was aware of any restrictions for residents to remain in their rooms to which she stated she was not aware of any and if the resident wants to leave their room that is their right. On 04/13/20 at 12:00 PM, an interview was conducted with the Administrator, DON and Chief Financial Officer (CFO). They stated they are following all CDC guidance for screening of staff and essential visitors, are using the appropriate PPE and have ceased all communal activities and dining. Of note, these activities have been suspended however residents have been allowed to roam the hallways freely and have not been isolated to their rooms. The Administrator and DON stated they encouraged residents to wear masks when they are outside of their rooms. The Administrator and DON were apprised of the CDC and DOH infection control guidance for isolating all facility residents if there is a confirmed positive case of [MEDICAL CONDITION] in the building. The Administrator stated he was not aware of that directive. On 04/13/20 at 12:30 PM during the exit conference, the Administrator, DON and CFO stated they will do their best to keep the residents isolated. Upon exiting the facility, an overhead page was heard for a STAT response for a Respiratory Therapist to go to a room on the South 200's unit. On 04/13/20 at 3:30 PM, a telephone interview was conducted with the DON and an inquiry made about the status of the resident on the South 200's unit that required a STAT response. The DON stated Resident #4 was being assessed by her physician and she was presenting with crackles to bilateral lungs and [MEDICAL CONDITION] symptoms. She stated Resident #4 was started on antibiotic therapy for symptoms on 04/11/20. The DON stated they transferred Resident #4 out 911 to the hospital for evaluation. Review of the facility's Infection Control Tracking form revealed Resident #4 was sent to the hospital on [DATE] with a [DIAGNOSES REDACTED]. The DON further stated she received a call this afternoon from the hospital that Resident #3's COVID-19 test has come back positive from 04/10/20. Resident #3 remained hospitalized . Further, the DON stated she also received a call from a Registered Nurse (RN) who worked a shift on 04/09/20 and called off the following day with flu like symptoms. She stated the RN was tested for COVID-19 on 04/10/20 and today, 04/13/20, received a positive result. The DON stated the RN worked with Resident #3. The DON stated she will be notifying the FL DOH of the 2 additional positive COVID-19 cases, one resident and one staff member. The DON was advised the staff must be vigilant in keeping residents isolated to their rooms as the initial exposure to the COVID-19 virus in the facility was unknown. The first positive case was confirmed on 04/08/20 from the 300's West unit; the second case was confirmed on 04/11/20 from the 300's West unit; the third case was confirmed on 04/13/20 from the 200's South unit; a RN working on the 200's South unit, and who worked with Resident #3, was confirmed positive on 04/13/20. There had been a 5 day window from the first confirmed case to the fourth confirmed positive case where residents on all units have been allowed to co-mingle, increasing the potential for contracting or transmitting [MEDICAL CONDITION]. On 04/18/20 through 04/19/20, FL DOH representatives conducted an onsite visit to the facility which included their presence onsite for 24 hours a day for the 2 days to cover all shifts to provide education and training on infection control practices related to mitigating the COVID-19 virus. Review of a report compiled by the Florida DOH Infection Control Preventionist dated 04/18/20 and 04/19/20, stated in part, At time of visit there were 16 positive results for residents and 19 positive results for staff with a large portion of the results still pending All staff members observed wearing face masks, some with surgical mask under N95 mask (this doesn't allow the N95 to appropriately seal as it is intended to do). Observation of staff practices and isolation rooms identified gaps in infection control. Observed failed handwashing of one staff member upon leaving resident room after contact with patient and surfaces, then proceeded around the corner into the nurses station. Observed PPE (personal protective equipment) including gowns worn outside of the rooms in the hallway. Isolation rooms have hanging storage device on the door. Staff member Isolation rooms do not have appropriate isolation precaution signs. DON reports that training and education has been provided but that the staff need constant reminding. Suggest donning/doffing signs at isolation rooms and additional training to help facilitate comfort, familiarity, and competency Given the number of results available that are positive among staff and residents, decontamination is thought to be beneficial for this facility. On 04/19/20, per the FL DOH report, the facility had 35 confirmed positive cases of COVID-19 between residents and staff. A FL DOH representative conducted an onsite visit to the facility on [DATE] to review the facilities compliance with infection control guidelines related to mitigating the COVID-19 virus. Review of the report compiled by the FL DOH Infection Control Preventionist dated 04/29/20 stated in part, The census of the facility on 04/29/20 was 131. At the time of previous visit (04/18/20 - 04/19/20) there were 16 positive results for residents and 19 positive results for staff with a large portion of the results still pending. At the time of this visit they report 35 COVID + residents/patients in house with 12 COVID+ residents in the hospital The entire COVID wing is segregated and considered to be a dirty area, and PPE is worn at all times, however there isn't continuity in the practices of PPE in common areas among the staff. Some have gloves off and utilizing nursing carts and keyboards after using hand sanitizer, some noted to have full gear and gloves on while using the phone at the nurses desk, while yet another is using a med/nurse cart in a manner consistent with the whole cart being contaminated, using gloves to type, and access different items within the cart. Overall this creates risks for further infection of the staff with COVID19 via self and staff contamination/transmission. **CONSIDER**-Establish singular practice among staff regarding what is considered contaminated and what is considered clean space or areas or items to mitigate risk of staff contamination/infection Donning (putting on) of PPE is set up inside entry of the COVID unit with additional PPE stations set up outside each of the rooms available for necessary changes. Doffing (taking off) is performed prior to exiting the unit. **CONSIDER** - move initial PPE donning station to just outside the COVID unit to establish a designated CLEAN area for donning before entering the dirty unit. This was advised at the time of visit, and DON reported she could easily do this and would be glad to do so. On 04/30/20 at 12:00 PM, an infection control special visit was conducted at the facility. The facility census on 04/30/20 was 129 residents. Review of the facility's Infection Control Tracking form revealed there were 38 confirmed in-house positive residents; 24 confirmed positive residents in the hospital; and 27 confirmed positive staff. There were now 5 reported deaths related to the COVID-19 virus. These confirmed positive COVID-19 results revealed 90 residents and staff had contracted [MEDICAL CONDITION]. The confirmed positive residents resided on 3 of the 4 units of the facility. On 04/30/20 at 2:00 PM, during an interview with the DON, she stated they have made the 200s south unit their isolation unit for all confirmed positive residents. At 2:15 PM, the 200s south unit was observed

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) with the DON. The PPE table for staff use entering the COVID unit was located inside the double doors and not outside of the double doors before entry per the FL DOH recommendations during their visit on 04/29/20, to delineate the outside of the unit as clean and inside beyond the double doors 'dirty'. Nursing staff were observed donning clean PPE inside the designated COVID unit, thus donning clean PPE in a potentially contaminated area. On 04/30/20 at 2:20 PM, a further inquiry was made to the DON if any additional education or in-services have been provided to facility staff related to the mitigation of the COVID-19 virus in their facility. The DON stated the FL DOH was here on 04/18/20 and 04/19/20 and they provided education to the nurses and if they observed any wrong practice they addressed it with the nurse on the spot. An inquiry was made to the DON if she kept a log or inquired to the DOH representatives what staff they spoke to and what issues or breaks in infection control practices were identified to which she stated if the DOH saw something wrong they addressed it on the spot. She confirmed she did not obtain a list of staff the DOH representatives spoke to and has not received a report from the DOH's visit on 04/18/20 and 04/19/20. The DON further confirmed they have not had any formal in-services conducted after the FL DOH left, however the Administrator conducts weekly staff meetings and discusses infection control practices. On 04/30/20 at approximately 2:40 PM, an interview was conducted with the Administrator and an inquiry made if there were any plans to decontaminate the building by a decontamination company to which he stated his housekeepers do a good job, they have a special spray they use. A further inquiry was made to the Administrator during the interview on 04/30/20 at 2:40 PM when the last facility Quality Assurance Performance Improvement (QAPI) meeting was conducted. After review of his documentation, the Administrator stated the last QAPI meeting was held on March 25 which was for the February meeting which was not held, further confirming they have not conducted a QAPI meeting in April as it has been very busy. He stated they have been having weekly staff meetings and other in-services in lieu of QAPI and discuss infection control. Review of a Nursing Meeting in-service conducted by the DON on 04/17/20, topics included employees stay in the units; avoid going unit to unit; double doors will be closed leading to other units; hydrate residents to prevent dehydration, electrolyte imbalance and urinary tract infections. Review of the sign in log revealed 24 nursing and certified nursing assistant staff attended the in-service. There was no evidence of any other discipline or department attending the in-service. Review of an Employee Meeting sign in sheet dated 04/22/20, documents the facility Administrator conducted the meeting which consisted of 18 nursing staff, 1 activities staff, 1 physical therapy staff, 1 housekeeper, 1 maintenance staff and 1 business office staff for a total of 22 staff members who attended the weekly meeting. Review of the facility employee roster provided by the DON on 04/30/20, revealed the facility employs 235 full time and part time staff across all disciplines and departments. On 04/30/20 at 2:50 PM a review of the facility's policy for Coronavirus Surveillance date implemented 03/10/20, revealed no CDC or FL DOH guidance related to isolating residents in their rooms if a confirmed positive case was identified in the building. On 04/30/20 at 3:00 PM an interview was conducted with the Administrator and an inquiry made if they revised their current Coronavirus Surveillance policy to reflect the CDC and FL DOH guidance to isolate residents if a confirmed positive COVID-19 case is identified in the building as they were informed and directed on 04/13/20 by this surveyor. The Administrator confirmed they had not, stating he did not write that into their policy. Further, the Administrator and DON produced a Florida Health information sheet, not dated, for Skilled Nursing Facilities. Review of the guidance revealed in part under Prevent Spread of COVID-19: Cancel all group activities and communal dining; Enforce social distancing among residents; Restrict all residents to their room. This guidance was reviewed with the Administrator and DON who indicated they were not familiar with this guidance. Further during the interview on 04/30/20 at 3:00 PM with the Administrator and DON, an inquiry was made if any additional education or in-services had been provided to all staff, not just nursing staff, after the 2 day visit from the FL DOH on 04/18/20 and 04/19/20. The Administrator stated while the FL DOH was here, the FL DOH conducted observations and provided education. An inquiry was made to the DON, who the FL DOH representatives spoke to and if they spoke to any other staff besides nursing to which she stated she was not sure who they spoke to and did not get a list. Further review of the FL DOH report dated 04/18/20-04/19/20 documented 'Given the number of results available that are positive among staff and residents, decontamination is thought to be beneficial for this facility.' As of 04/30/20, the facility had not heeded this guidance and still had not taken measures to sanitize the facility's environment by contacting a company to come in and conduct a decontamination process. Information obtained from local newspapers and news stations on 05/10/20, reported as of 05/10/20, 56 residents with confirmed or suspected COVID-19 virus had been removed from the facility by the FL DOH and relocated to local hospitals. It was confirmed on 05/13/20 during an interview with the Administrator at approximately 11:00 AM, the facility had hired a decontamination company who started the decontamination process on 05/11/20, 3 weeks after the FL DOH visit, and had sprayed all resident rooms and common areas with one unit still to be done, the 100s East unit and one day after 56 residents had been removed from the facility by the FL DOH. Review of the facility's Infection Control Tracking form revealed as of 05/08/20, there were 48 confirmed COVID-19 positive inhouse residents; 9 confirmed COVID-19 positive residents in the hospital; 28 confirmed COVID-19 positive staff members; and 17 resident deaths related to the COVID-19 virus, to include Resident #1 who passed away on 04/19/20 and Resident #4 who passed away on 04/27/20. These confirmed positive COVID-19 results revealed 102 residents and staff had contracted [MEDICAL CONDITION]. The confirmed positive residents resided on all 4 units of the facility. The facility's Immediate Jeopardy removal plan dated 05/13/20 compiled by the Administrator and Director of Nursing included the following: Identification of other residents to be affected by deficient practice - All residents residing in the facility and all staff who provide care and services to the residents have the potential to be affected. Systemic Corrective Actions received by the facility Administrator and Director of Nursing on 05/13/20 included: On 04/10-04/11 the first 2 positive COVID cases were reported to facility Director of Nurses by the hospital. Rooms where residents resided completely sanitized by Housekeeping Department. Residents residing in those rooms and in the rooms adjoined by bathrooms placed on immediate isolation precautions. All rooms where COVID positive patient the Administrator directed the Director of Housekeeping to completely sanitize all Therapy Rooms on Saturday evening. On 04/13 the Director of Therapy organizes system to perform Therapy Services in resident rooms. On 04/11/20: Resident tracking log initiated by Director of Nurses of residents with positive COVID results, with ongoing communication and coordination with the Department of Health. On 04/11/20: Disposable tray service instituted in all resident areas and ongoing. On 04/13/20: Infection Control monitoring visit made by AHCA Surveyor all recommendations followed immediately for assuring all residents placed in rooms ongoing, Therapy services to be conducted in resident rooms. On 04/13/20: Activities Director met with all alert/oriented and residents to discuss the importance of staying in rooms with doors closed to prevent the spread on [MEDICAL CONDITION]. Oriented staff. On 04/13/20: All residents isolated in rooms. Therapy gym closed. Therapy services provided in resident rooms. All staff directed to keep residents in room with door closed. Department Managers/ Nursing Administration and Administrator to enforce on daily rounds. Fire doors to all units will be kept closed ongoing. On 04/13/20 per documentation from the Director of Nursing provided on 05/13/20: In-services conducted with Nursing staff, Certified Nursing Assistants, Rehabilitation Department, Dietary Department and Housekeeping. Topics included keep residents inside their rooms with door closed; rehabilitation department will do their therapies in the resident's rooms; activities will be done in resident's rooms. On 04/16-17/20: Facility tests all residents and staff for the COVID-19 virus. First results received 4/18-4/19. Facility takes immediate action to remove all positive staff for 14 days or until two negatives results are received and with no symptoms. On 04/17/20 (DOH Visit) per documentation from the Director of Nursing provided on 05/13/20: In-services conducted with Nursing staff, Certified Nursing Assistants, Rehabilitation Department, Dietary Department and Housekeeping. Topics included employees stay in the units, avoid going unit to unit. Double doors will be closed leading to other units. Hydrate residents to prevent dehydration and other complications. On 04/18/20: (DOH Visit) per documentation from the Director of Nursing: In-services conducted with Nursing staff, Certified Nursing Assistants, Rehabilitation Department and Housekeeping. Topics included wearing N95 masks by staff in the COVID unit. Keeping residents in rooms. Extended use of gowns. On 4/18/20: Director of Nurses places all positive residents on designated isolation unit (South Wing). Residents who are not positive are moved to West and East Wing and monitored appropriately for signs and symptoms. Vital signs on all residents on each shift continues to be enforced by Director of Nurses for all residents. Special monitoring of residents moved from Unit initiated by DON. Strict isolation protocol was instituted on the COVID 19 Unit. The Unit is monitored daily by Nursing Department Administrators to assure proper procedures are followed for appropriate use of PPE. Families and residents notified of room moves by the Director of Nurses and Social services staff. Families of residents who tested positive are notified by the Director. Retesting of all residents and staff taking place from 5/1-5/8. And approximately every 2 weeks thereafter. With the same procedures followed for placing positive patients on isolation and removing room mates who are negative to the observation rooms on East Wing for focused monitoring by the Nursing Department (vital signs completed every shift). On 04/18/20: DON, ADON

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) (Assistant Director of Nursing), Staff Development Coordinator and Administrator met with Infection Control Preventionists from the Florida Department of Health task force to address further strategies to prevent the spread of [MEDICAL CONDITION] within the facility. She recommended N95 masks to be worn by all employees. Staff in-serviced accordingly by Staff Development and Nursing Department Administrators. Procedure enforced by Nursing Department Administrators daily. On 04/19/20: Florida Department Health task force conducted 24 hours monitoring and observation with the Director of Nurses, Nursing Department Administrators, and Administrator. Also, they suggested placing a COVID -19 guide outside of each room where COVID positive residents resided. Which has been completed ongoing. Recommendation made to place doffing/donning area at exit doors to the COVID which has been completed and will be ongoing. On 04/20/20: DOH Visit per documentation from the Director of Nursing provided on 05/13/20: In-services conducted with Nursing staff, Certified Nursing Assistants, Rehabilitation Department, Housekeeping/Laundry, Maintenance and Dietary. Topics included putting all PPEs in front of resident's room in the COVID unit. Post signs for PPE Healthcare Personnel in each room. Donning and doffing area in COVID entrance and exit was do