STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105443	A. BUILDING _____ B. WING _____	**06/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BAY BREEZE HEALTH AND REHABILITATION CENTER	**1026 ALBEE FARM RD VENICE, FL 34292**

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, interview, and record review the facility failed to safeguard residents' well-being by failing to follow current infection control standards related to COVID-19 recommendations set forth by Centers for Disease Control and Prevention (CDC). Refer to https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html The findings included: The facility's policy COVID-19 Pandemic Plan (revised 5/14/20) documented Receptionist/designee to provide visitor/vendor self-report questionnaire to complete .visitors will be screened and allowed in only if all criteria is met. On 6/1/20 at 9:00 a.m., during an observation three visitors were escorted by the Administrator, into the facility and were provided unrestricted access to all resident care areas without being screened by the receptionist at the front desk. On 6/1/20 at 9:30 a.m., during an initial tour of the facility, the following observations were made: 1. There were two residents observed ambulating in the hallway near the kitchen and were not wearing a face mask. 2. At the entrance of facility door #4 there were two storage carts containing paper face masks used by staff. The face masks were stored in brown paper bags labeled with employee names. Three of the masks were hanging from different shelves and were not labeled or in a paper bag. 3. At nurse Station #2, a resident was seated in a wheelchair and was not wearing her face mask that was located on the back of her wheelchair. Two staff members walked past the resident and did not encourage or assist her to apply the face mask. 4. There were two staff members observed in the hallway of Station #1 wearing face masks improperly and only covering their mouth. 5. There were two residents in the Activity Room seated less than six feet apart and they were not wearing a face mask. Certified Nursing Assistant (CNA) Staff J was in attendance and did not encourage or assist the residents to apply their face masks. 6. Resident #88 was ambulating in the hallway on the Memory Care Unit and was not wearing a face mask. 7. CNA Staff B was observed ambulating a resident in the hallway on the Memory Care Unit and the resident was not wearing a face mask. 8. In the Memory Care dining room, five residents were seated at tables and they were not wearing a face mask. Staff B said, we have no masks. I have had the same one on for 4 days now. On 6/1/20 at 10:10 a.m., during an initial tour of the laundry room, the following observations were made: 1. Laundry Aide Staff C was observed wearing a face mask improperly and it did not cover her nose. Staff C confirmed the face mask should have been applied to cover her mouth and nose. 2. Staff C was observed removing clean linen from the dryer. The linen was in contact with her clothing. 3. The emergency eye wash sink located in the laundry room, had a layer of grime and dust. There was a bottle containing cleaning solution in the eye wash sink. Staff C said she did not know who was responsible to clean the sink. 4. The personal protective equipment (PPE), including rubber gloves, a face shield and two pair of goggles was hanging from a rack on the wall next to the eye wash sink. The rubber gloves had a layer of dust. The goggles and face shield had a thick layer of grime and residue. Staff C said she did not know who was responsible to clean the PPE. 5. There were five large, clear, plastic bags containing clean laundry, stored on the laundry room floor. Staff C said, the bags contained clean laundry belonging to the residents. On 6/1/20 at 11:00 a.m., in an interview, the Administrator said the staff and residents are required to wear a face mask but confirmed some of the residents did not wear the face masks. The Administrator said, the Department of Health said the staff could use the same disposal surgical mask for three days. We keep them covered in paper bags and each staff has their own shelf located at door #4. The Administrator confirmed there were three masks on the cart that were not in labeled, paper bags. The Administrator said, the facility had a screening process for staff and visitors that included checking temperatures at the front entrance and had everyone fill out a questionnaire. She said the receptionist was responsible to ensure visitors were screened when entering the facility. On 6/1/20 at 11:10 a.m., in an interview the Receptionist confirmed three visitors had access to resident care areas and were not screened. On 6/2/20 at 9:00 a.m., during an observation of Shower room [ROOM NUMBER], the sharps container (a puncture resistant container) was filled to capacity and had 12 razors protruding from the top, preventing the lid from closing. On 6/2/20 at 9:40 a.m., the Director of Nursing confirmed the sharps container was filled beyond the recommended capacity of the container. Photographic evidence obtained

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