STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105302	A. BUILDING _____ B. WING _____	**09/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAK HAVEN REHAB AND NURSING CENTER	**919 OLD WINTER HAVEN RD AUBURNDALE, FL 33823**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0561 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with the resident and facility staff, and review of the resident's medical record and facility documents, the facility failed to ensure a request for frequent showers was accommodated for one resident (#34) of 41 sampled residents. Findings included: During an initial interview, on 09/02/2020 at 10:48 a.m., Resident #34 reported that he had requested frequent showers. According to posted notices in his room, the showers were to be given on Sunday, Monday, Wednesday and Friday. During the interview, the resident reported that he had not had a shower since March (2020), only bed baths, which he commented that it was hard to get clean and get your hair washed with a bed bath. A review of the nursing aides' documentation for Resident #34 documented the task of showers as, Showers on Monday, Wednesday, Friday, and Sunday during the 7-3 shift and PRN (as needed). The documentation of when Resident #34 had been given a shower from 08/06/2020 to 09/03/2020, of the 11 possible days that he was to be given a shower (the resident was in the hospital from 08/10 - 08/17/20), showed that he received four showers. The showers were given on 08/07, 08/24, 08/26, and 09/02/20. No shower, but rather a sponge or bed bath, was documented as given on 08/09, 08/19, 08/21, 08/23, 08/30, and no shower, sponge or bed bath was documented for 08/28 or 08/31/20. An interview was conducted with Staff HH, Unit Manager on 09/03/2020 at 1:10 p.m. and he reported that showers were never curtailed on the 200 unit. Resident #34 resided on the 200 unit. An interview was conducted with the restorative aides, on 09/03/2020 beginning at 1:40 p.m. One of the two aides present during the interview, Staff DD, reported that residents were getting bed baths rather than showers. A review of the Admission Record for Resident #34 revealed an admission date of [DATE] with an initial admission date of [DATE] and [DIAGNOSES REDACTED]. A review was conducted of the care plan for Resident #34. The care plan (undated) had as a Focus area, Resident has a psychosocial well - being problem adjustment to new dx's (diagnoses). Preference of shower and bed bath days Monday, Wednesday, Friday and Sunday's are shower days alternate days bed bath Tuesday, Thursday, Saturday.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based upon observation, interview, and record review the facility failed to securely store medications in four of four medication carts; and failed to store Medication (Bubble Pack) Punch Cards in the correct location in three of the four medication carts. Findings included: A review of the facility's policy titled, Medication Storage In The Facility, with Revision Date April 2018, Page 47 of 55, reads under Storage of medications: [REDACTED]. On 9/03/2020 at 10:07 a.m., an observation of the medication cart two (2) on 200 Hall included three (3) loose tablets in the third drawer from the top of the medication cart. Observation of area behind the fourth drawer revealed one (1) medication (Bubble Pack) Punch Card. Staff H, Licensed Practical Nurse (LPN), confirmed the presence of the unsecured white, yellow and blue tablet, and Medication (Bubble Pack) Punch Card. (Photographic Evidence Obtained). On 9/03/2020 at 10:25 a.m., an observation of medication cart one (1) on the 200 Hall included a loose capsule in the second drawer, and a loose medication (Bubble Pack) Punch card located behind the fourth bottom drawer. Staff G (LPN) confirmed the presence of the unsecured tablet and Medication (Bubble Pack) Punch card. (Photographic Evidence Obtained). On 09/03/2020 at 10:40 a.m., an observation of the medication cart two (2) on 400 Hall included in the second drawer from the top, one loose white tablet, one clear capsule. Two (2) Medication (Bubble Pack) Punch cards were observed to be behind the 4th drawer, with one having an expiration date of 8/22/2020. Staff F confirmed the presence of the unsecured tablet, capsule and two (2) Medication (Bubble Pack) Punch Cards. (Photographic Evidence Obtained). On 09/03/2020 at 10:55 a.m., an observation of the medication cart one (1) on 400 Hall Included one (1) loose tablet located in the back of the second drawer. Staff E confirmed the presence of the unsecured tablet. On 09/03/20 at 11:15 a.m., an interview with the Director of Nursing (DON) was conducted. The DON was informed of observations made in all four medication carts. The DON stated, There should be no loose pills or medications in the medication carts and no medication punch cards behind the drawers. On 09/04/2020 at 03:23 p.m., a telephone interview was conducted with facility Pharmacy Consultant from Polaris Pharmacy Services. The pharmacist was informed that six (6) loose pills were found in total from all four medications carts, and four (4) Medication (Bubble Pack) Punch Cards one that was past expiration date, that were observed to be at the bottom (behind the fourth drawer), of the medication cart, and not where they were supposed to be stored. He stated No loose medications in the medication carts, that is something we do not like to see. I guess it is an education thing for the nurses to be more careful.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews with facility staff, and review of documentation provided by the dietary staff, the facility failed to: 1) ensure that the dish machine was tested and documentation was completed for the required temperatures and parts per million of the sanitizing solution, and 2) discard resident labeled snacks past their expiration date observed in the walk-in cooler, and 3) maintain one of two nourishment pantries (400 wing) in a sanitary manner related to stored open containers of applesauce and pudding. Findings included: 1. During the initial tour of the main kitchen on 09/01/2020 beginning at 10:15 a.m., Staff AA, Dietary Aide explained the process for washing dishes. Staff AA reported that the dish machine was a low temperature dish machine. She reported that prior to washing any dishes, the staff are to run the dish machine until the right temperatures and parts per million (ppm) of sanitizer are reached and then document those numbers. Staff AA, Dietary Aide ran the dish machine and pointed out the wash and rinse temperatures on the machine's thermometer dials. When she attempted to test the ppm of the sanitizer, the chemical test strips were not registering any level of chemical. The Dietary Aide attempted several times to run the machine and test the chemical but was not able to get any reading of the sanitizer ppm. The Dietary Aide changed out the bucket of sanitizing chemical and tested a strip directly with the chemical from the bucket to ensure the test strips would register the ppm of the chemical. This test demonstrated that the test strips were able to correctly test the chemical. The Dietary Manager approached the Dietary Aide while she was trying to figure out why the ppm of the sanitizer wasn't registering on the test

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

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) strips and reported that he would notify the company who monitored the dish machine and have maintenance performed to repair the machine. The Dietary Manager reported that he would have the dietary staff serve meals on disposable dishware until the machine was repaired. On 09/03/2020 at 9:45 a.m., Staff BB, Dietary Aide ran the dish machine and pointed out the correct temperatures on the dish machine's thermometers and using the chemical test strips was able to demonstrate the appropriate ppm of sanitizing solution. The Dietary Manager provided the visit report from the repair of the dish machine, dated 09/01/2020, which indicated, The sanitizer was not reading between 50-100 ppm due to tie wrap too tight at pick up stick. Cut off and taped with yellow tape. tested at 100 ppm now. OK. A review of the Dish Machine Log for September 2020 was conducted during an additional visit to the kitchen on 09/03/2020 at 9:45 a.m. The log recorded the temperatures and ppm levels for the dish machine and the 09/01/2020 breakfast entry was not completed. In an interview on 09/04/2020 beginning at 1:30 p.m. Staff CC, Dietary Aide, who had been identified as the staff who washed the breakfast dishes on 09/01/2020, confirmed that she had run all the breakfast dishes through the dish machine, but had forgotten to check that the temperatures and the sanitizer ppms had met the manufacturer's guidelines as posted on the machine. She confirmed that she had forgotten to check the temperatures and the ppms, not just that she had forgotten to document the temperatures and ppms. 2. On 09/01/2020 during the initial tour of the main kitchen, which began at 10:15 a.m., an observation was made of the contents of the walk-in cooler. Directly across from the door to the cooler, on a top shelf inside of the cooler, was a tray of snacks that were labeled with residents' names and the date when the snack was prepared and labeled. The tray contained snacks that were labeled 08/20/20, and included a half of a meat sandwich, two 4 ounce cups of ice cream (one labeled 08/17, one 08/20) which were liquid in form, one 4 ounce cup of pudding and a 4 ounce Mighty Shake both labeled 08/20, and a banana with skin that had turned black and was soft to the touch, labeled 08/17. The Dietary Manager confirmed that the snacks should have been discarded before 09/01/2020 and called a dietary staff member over to discard the items. 3. During an observation of the nourishment pantry on the 400-wing, on 09/03/2020 beginning at 10:10 a.m., the refrigerator door was opened to observe the temperature and contents. A 4-ounce container of applesauce had spilled, and applesauce was splattered on the floor and the bottom ledge of the refrigerator. Additional 4-ounce containers of applesauce and pudding (one of each) were noted to have been opened, with their foil lids having been pulled open and then [MEDICATION NAME] down over the opening, but not completely securing the lid. (Photographic Evidence Obtained) The applesauce and pudding containers were dated 09/02. Staff II, Unit Manager was asked to observe the spilled applesauce and open containers at that time. In an interview with Staff II, Unit Manager of the 400-wing, on 09/04/2020 beginning at 10:00 a.m., it was confirmed that the nursing staff (aides, nurses and herself) are responsible for keeping the nourishment pantry refrigerator clean. She reported that when she saw the spilled applesauce, it looked to her as if the opened applesauce container had been stored on the door of the refrigerator and when the door was pushed shut, the applesauce probably fell off the shelf and spilled. She reported that open containers of pudding or applesauce shouldn't be returned to the refrigerator, they should be discarded.
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	Based on record review, staff interviews and policy review the facility failed to inform residents, their representatives, and families of confirmed COVID-19 cases in the month of August 2020 for 10 staff members reviewed (A, B,C,D,I, J, N,P,Q and R) for the following 19 resident records reviewed for notification: #37,#27,#223,#57,#56,#174,#224,#227,#8,#25,#38,#226,#24,#175,#55,#62,#225,#51 and #34. The facility failed to inform representatives, and families by 5:00 p.m. the next calendar day, that related to the occurrence of the one resident confirmed to be positive for COVID-19 on 9/1/2020, of three residents (Resident #174, #223 and #226) of four residents reviewed. Findings included: The facility policy titled, COVID-19 (health screening, surveillance, restrictions on visitation, PPE's (personal protective equipment), hand hygiene, resident discharge/admissions, education, administrative & engineering controls), with an effective date of 1/1/2020 and last revision date of 6/17/2020 was reviewed. Under the heading Communicating with residents and their designated representatives, the policy showed the facility will notify residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new onset of respiratory symptoms occurring within 72 hours of each hour other. An interview was conducted with the Activities Director (AD) on 9/3/2020 at 10:12 a.m. The AD reported that the Director of Admissions started making calls yesterday (9/2/2020) regarding the resident who tested positive for COVID-19 on 9/1/2020. The resident was no longer in the building. The AD provided a copy of the letter that she provided to the residents on 9/2/2020 regarding the update related to visitors and an additional letter that indicated there was a resident who tested positive for COVID-19 and was no longer in the facility. She was asked if she notified family members for those residents that had a cognitive deficit, she replied that she wouldn't be responsible for notification to family/representatives. On 9/3/2020 at 12:45 P.M. the Admissions Director was interviewed about conducting notifications to resident family/representatives of a resident testing positive for COVID-19 on 9/1/2020. The Director of Admissions confirmed that she had been instructed by the Director of Nursing late evening on 9/2/2020 to begin making telephone calls to family members. She was still in the process of conducting these calls today, 9/3/2020. She confirmed that she had never made any type of notifications for positive COVID-19 resident or staff members until last evening. The Admissions Director was provided with random residents to verify the time she had made the telephone call to inform the residents/representative of the positive COVID-19 resident. A review of the record revealed that Resident #174's family was left a voice message on 9/3/2020 at 11:25 A.M., Resident #226's family was left a voice message on 9/3/2020 at 11:37 A.M., Resident #223's family was contacted on 9/3/2020 at 10:19 A.M. The Director of Admissions was asked if she was aware of the required timeframe for notification of a single confirmed COVID-19 case, she responded that she was not. On 9/3/2020 at 2:00 P.M. the Nursing Home Administrator (NHA), Corporate Vice President of Clinical Services and the Director of Nursing (DON) were interviewed. A list with names of staff members that tested positive for COVID-19 for the month of August 2020 was reviewed and a request was made to have the facility provide documented evidence of the notification of 10 staff members that had positive results for COVID-19 to residents and family representatives. The following 10 staff members who tested positive for COVID-19 in August 2020 are as follows: Staff member (A) tested positive on 8/27/2020 Staff member (B) tested positive on 8/12/2020 Staff member (C) tested positive on 8/12/2020 Staff member (D) tested positive on 8/19/2020 Staff member (I) tested positive on 8/12/2020 Staff member (J) tested positive on 8/12/2020 Staff member (N) tested positive on 8/02/2020 Staff member (P) tested positive on 8/02/2020 Staff member (Q) tested positive on 8/05/2020 Staff member (R) tested positive on 8/02/2020 The NHA was provided with nineteen names of residents and asked to provide documentation that these residents and family representatives were notified of the positive cases of the 10 staff members. The NHA stated, The notification is documented in each of the resident medical records under nursing notes. Residents that were reviewed for notification of the 10 positive COVID-19 staff members were Residents: #37, #27, #223, #57, #56, #174, #224, #227, #8, #25, #38, #226, #24, #175, #55, #62, #225, #51 and #34. The review revealed no notification or documentation was provided to the residents or family representatives regarding the 10 positive COVID-19 staff members in the month of August 2020. On 9/3/2020 at 2:13 P.M. the NHA confirmed that notification had not been made to the families or representatives for the 10 staff members that had tested positive for COVID-19 in August 2020, or for the one resident that had tested positive on 9/1/2020. The NHA provided the daily census for the following dates: 8/2/2020-83 residents, 8/5/2020-76 residents, 8/12/2020-74 residents, 8/19/2020-70 residents and 8/27/2020-70 residents. On 9/4/2020 at 4:26 P.M. the NHA provided a copy of an e-mail dated 9/04/2020 at 11:00 A.M. from their Corporate Chief Nursing Officer indicating that on the following dates and times a notification was sent out via alert media from the corporate offices, We have had a team member test positive for COVID-19 virus on 8/7/2020 5:02 P.M., 8/10/2020 1:17 P.M., 8/11/2020 3:40 P.M.8/21/2020 5:02 P.M. and 8/22/2020 at 4:40 P.M. The NHA was asked if she had notifications for the staff members that tested positive as follows: Staff member (A) tested positive on 8/27/2020 Staff member (B) tested positive on 8/12/2020 Staff member (C) tested positive on 8/12/2020 Staff member (D) tested positive on 8/19/2020 Staff member (I) tested positive on 8/12/2020 Staff member (J) tested positive on 8/12/2020 Staff member (N) tested positive on 8/02/2020 Staff member (P) tested positive on 8/02/2020 Staff member (Q) tested positive on 8/05/2020 Staff member (R) tested positive on 8/02/2020 The NHA confirmed that she had no other documentation to offer.