STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106020	A. BUILDING _____ B. WING _____	**10/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES	**13881 EAGLE RIDGE DRIVE FORT MYERS, FL 33912**

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 and interview the facility failed to store resident care items in a sanitary manner and failed to safeguard residents well-being in the Thalia Dementia Unit by failure 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: 1. Observation on 10/12/20 at 10:15 a.m., showed 11 residents (Residents #32, #64, #76, #69, #34, #63, #54, #66, #20, #15, #74) in the memory care unit of the facility. The residents were seated in their wheelchairs, at the tables having breakfast. They were seated 3 to 4 at a table approximately 2 feet apart from each other. They were able to reach out and touch one another. On 10/12/20 at 10:30 a.m., observed Resident #65's urinary catheter collection bag resting on the floor. On 10/13/20 at 1:14 p.m., in an interview the Thalia Memory Care Program Director said the residents on the memory care unit declined cognitively and physically when the facility attempted to maintain social distancing during meals and activities. The Program Director confirmed there was no documentation the facility attempted to maintain social distancing and no documentation to show a decline in cognition and function with the residents in the Thalia Memory Care Unit. 2. On 10/12/20 at 10:22 a.m., during an initial tour on the Thalia Memory Care Unit the following observations were made: - room [ROOM NUMBER] in the shared bathroom there was a wash basin on the floor next to the toilet. - room [ROOM NUMBER] in the shared bathroom there was a wash basin in the handrail that was not covered and was not labeled with a resident name. - room [ROOM NUMBER] in the shared bathroom there was a washbasin on the floor behind the toilet that was not covered or labeled with a resident name. There were two bottles of personal hygiene supplies on the sink that were accessible to wandering residents on the Thalia Memory Care Unit. - room [ROOM NUMBER] in the shared bathroom there was a razor, an open bottle of liquid soap and a can of shaving cream that did not have a resident name. On top of the glove dispenser there was a tube of tooth paste and three cans of personal care items that did not have a resident name and were accessible to wandering residents on the Thalia Memory Care Unit. - room [ROOM NUMBER] there was a wash basin on top of the toilet, and a toothbrush in a plastic cup on top of the glove dispenser. On 10/13/20 at 11:18 a.m., observed in room [ROOM NUMBER] a piece of metal with jagged edges on the floor that was protruding from the air conditioning unit. 3. Review of the facility's nursing procedure for Bedpan/Urinal dated 12/2009 revealed after assisting the resident using a bedpan or urinal to Empty bedpan/urinal and disinfect following standard precautions .Return bedpan/urinal to patient room and store in plastic bag or, if urinal, with lid attached. On 10/12/20 at 10:30 a.m., during an initial tour of the South Wing the following observations were made: - room [ROOM NUMBER]'s shared bathroom had an unlabeled bed pan stored uncovered on the toilet. An uncovered, unlabeled urinal hung from the handrail. - room [ROOM NUMBER]'s shared bathroom had an unlabeled, uncovered bedpan stored in a wash basin on the floor. - room [ROOM NUMBER]'s shared bathroom had an unlabeled, uncovered wash basin stored on the toilet. An uncovered bedpan and emesis basin were stored on the floor next to the toilet. - room [ROOM NUMBER]'s shared bathroom had an unlabeled, uncovered bedpan stored between the handrail and the wall behind the toilet. - room [ROOM NUMBER]'s shared bathroom had two unlabeled, uncovered stacked washbasins and a bedpan stored on the floor next to the toilet. - room [ROOM NUMBER]'s shared bathroom had a wash basin and a bed pan uncovered and stored on the floor next to the toilet. A graduated urine container was stored inverted on a paper towel on top of the toilet. - room [ROOM NUMBER]'s shared bathroom had a graduated urine cup inverted on a wet paper towel on top of the toilet. The same observations were made on 10/13/20 and 10/14/20 throughout the survey. On 10/14/20 at 2:05 p.m., during an interview the South Unit Manager said all resident care equipment such as bedpans, basins and urinals should be stored in the Resident's room in a plastic bag. On 10/14/20 at 2:10 p.m., a tour of room [ROOM NUMBER] through room [ROOM NUMBER] was done with the South Unit Manager. The same observations were made. The South Unit Manager verified the residents' care equipment were not stored in a sanitary manner causing a potential to spread disease and infection. 4. On 10/13/20 at 2:45 p.m., observation of the bathroom on the South Wing revealed the following: - The baseboard was detached from the wall exposing the wall behind it. - The floor had large black stains. - The floor next to the toilet had a large crack making it impossible to clean and sanitize it. - The grout around the toilet with large accumulation of black substance. On 10/14/20 at 2:10 p.m., The South Wing Unit Manager said the bathroom had looked that way since she started employment at the facility 6 months ago. Photographic evidence obtained

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.