STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106006	A. BUILDING _____ B. WING _____	**04/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BALDOMERO LOPEZ MEMORIAL VETERANS NURSING HOME	**6919 PARKWAY BLVD LAND O LAKES, FL 34639**

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.** Based on observation and interviews with facility staff, the facility failed to ensure that proper isolation of positive COVID-19 residents was maintained for 1 (Room A 101) of 4 isolation rooms on a wing of 10 rooms. Findings included: During a co-visit with the Department of Health, occurring on 04/30/2020 beginning at 2:30 p.m., the Administrator confirmed facility residents and staff had been tested for COVID-19 on 04/22/20. The facility had been notified on 04/29/20 of a positive result for five residents and one nurse. The Administrator reported that the facility had isolated the five residents to one wing in the facility. Sixteen residents lived on the wing identified as the isolation wing. Of the sixteen residents, two had refused to be tested for COVID 19, nine had tested negative and five had tested positive. Observation of the isolation wing began on 04/30/20 at 3:00 p.m. The fire doors leading to the wing were in the open position. Staff from the day shift and the evening shift were observed huddled together in the hall endorsing resident status. All staff were noted to be wearing surgical masks. A 'bump-out' made of a plastic material was noted at the second door on the left side of the A 100 hall just past the nurses station. There was no sign indicating the reason for the isolation or what protection staff should take. The plastic material was identified as Visqueen, and described by the Administrator as providing isolation for the resident in the private room (A 101). She reported that inside the bump-out were the PPE (Personal Protective Equipment) supplies required to be worn by anyone who entered the resident's room, as the resident had tested positive for COVID 19. Further observation of the area behind the Visqueen, which was secured closed with a zipper but outside of the resident's room, revealed a table that held masks: N95 and surgical, gloves, gowns, head coverings, goggles and sanitizer. The Infection Preventionist (IP) pointed out a poster on the wall with instructions on donning and doffing PPE. She confirmed that each staff member that entered the isolation room had their own N95 mask . (photo evidence obtained) The plastic sheeting creating the isolation area was kept shut with a zipper. It was confirmed by the IP that the room was not under negative pressure and air from the room could be felt leaving the isolated area when the zipper was opened. There were 5 rooms on either side, of the hall including the isolation rooms. Two aides were noted to walk into a room, past the first isolation room, without having to open the door first, and then returned to the hall. Other aides were noted to enter resident rooms, again without opening the doors to the rooms. The Administrator confirmed during the observation that when the aides or nurse provided care to the residents not in isolation, they only had to wear the surgical mask and gloves. At the end of the hall another sheet of the Visqueen was noted to go diagonally across the hall, isolating three resident rooms (Rooms A 108, A 109, A 110) with the hall ending in double doors leading to the outside. (photo evidence and map obtained) The isolated rooms were approached at the end of the hall. Residents could be observed in their rooms, either in bed or in chairs next to their beds, most without masks on, but easily observed as their doors were open. The isolated end of the hall was noted with a shelving unit tucked into a niche in the hall with PPE supplies in three columns. (photo evidence obtained) The IP explained that the columns represented the three shifts with dedicated PPE for each shift and the aide who worked that shift. The Administrator confirmed during the observation that an aide was assigned to work with the five residents who had tested positive and those aides had N95 masks to wear when they cared for the residents. It was unclear whether the aide wore the same N95 mask while caring for each resident. The Administrator reported that there was one nurse assigned to the wing who administered medications and completed assessments on all the residents, including the residents who had tested positive. She confirmed that the nurse would don her PPE inside of the isolation barrier prior to seeing to the resident. Two of the three rooms isolated at the end of the hall were occupied and had a total of four residents, who shared one bathroom. The IP reported that all of the four residents had cognitive concerns. All four residents required assistance with toileting. She also reported that the four residents needed some assistance at meals and required the aide to remain with them at meals. After the visit to the isolation wing, at 4:00 p.m., the COVID 19 Focused Survey for Nursing Homes (self assessment), was provided to the IP for reference. When asked if the facility had completed the Focused Survey/self assessment the IP reported, after confirming with the Administrator, that since it wasn't required they hadn't completed it nor submitted it to the state agencies. She reported that the areas of concern (the critical elements) included in the self assessment were all areas that they had discussed, but hadn't used the self assessment to make notes or 'check off' each area as completed. Attention was drawn to the first section of the Focused Survey document which discussed Standard and Transmission Based Precautions. Under the section discussing Transmission - Based Precautions, the fifth bullet point included guidance that read, When COVID-19 is identified in the facility, staff wear all recommended PPE (i.e., gloves, gown, eye protection and respirator or facemask) for the care of all residents on the unit (or facility wide based on the location of affected residents), regardless of symptoms.

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.