STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105037	A. BUILDING _____ B. WING _____	10/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALMS OF SEBRING, THE	725 S PINE ST SEBRING, FL 33870

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 observations, interviews, and review of Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to implement an infection control and prevention program to prevent possible transmission of COVID-19 as evidenced by not ensuring staff and residents were properly donning protective masks and maintaining social distancing in one of one activity room observed on one (second) of two floors. Findings included: An observation was made on 10/8/20 at 11:04 AM in a small activity area on the 2nd floor of the facility. A staff member was observed seated at a small table with 2 residents of the facility. The staff member was observed to have her protective surgical mask pulled down underneath her chin while speaking to the 2 residents. One of the residents at the table also had his protective surgical mask underneath his chin. The staff member and the 2 residents were sitting less than 6 feet apart at the small table. The staff member then placed her surgical mask on properly and exited the room. The 2 residents remained at the table within 6 feet of each other. A follow-up tour of the 2nd floor of the facility was conducted on 10/8/20 beginning at 2:20 PM that revealed a small activity area at the end of the hallway where a group Bingo activity was being conducted. A staff member was observed to have her protective surgical mask pulled underneath her chin while calling out Bingo numbers to the 5 residents inside of the room. 3 residents were observed sitting at one table and 2 residents were observed sitting at another table. The residents at each table were not properly distanced and were sitting within 6 feet of each other during the observation. 3 of the 5 residents observed in the room had protective surgical masks underneath their chins. An infection control interview was conducted on 10/8/20 at 3:27 PM with the facility's Nursing Home Administrator (NHA) and Director of Nursing (DON). The NHA stated that residents are encouraged to wear masks when they are outside of their rooms and during activities. Residents should be appropriately distanced, at least 6 feet, during activities. The NHA stated that she did not think that staff were using the small activity area on the 2nd floor of the facility for activities and would expect staff to use the unit dining room to accommodate for social distancing. The NHA would not expect to see staff members pulling down their masks to speak to residents or during activities. A review of the CDC's website (https://www.cdc.gov) revealed guidelines to help prepare long term care facilities for COVID-19. The guidance revealed, under the section titled Implement Source Control Measures that Health Care Providers (HCP) should wear a facemask at all times while they are in the facility and that residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility. The guidance also revealed, under the section title Implement Social Distancing Measures that facilities should implement aggressive social distancing measures (remaining at least 6 feet apart from others), cancel communal dining and group activities, such as internal and external activities, and remind residents to practice social distancing, wear a cloth face covering (if tolerated), and perform hand hygiene.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of information from the Environmental Protection Agency (EPA), the facility failed to ensure a sanitary environment as evidenced by 1) not ensuring staff on one (second) of two floors were properly sanitizing reusable equipment and maintaining cleanliness of resident rooms in the facility, 2) not ensuring staff on one (second) of two floors were performing hand hygiene at appropriate opportunities, and 3) not maintaining cleanliness of one of one facility laundry room. Findings included: An interview was conducted on 10/08/2020 at 10:24 AM with Staff A, Patient Care Assistant (PCA). Staff A, PCA stated that after checking resident vital signs using the vital signs machine on the unit, she then sanitized the machine using Aero Linen Fresh, Surface Disinfectant and Deodorizer Spray. Staff A, PCA stated that the spray does not have to contact the surfaces of the machine in order to sanitize it and stated that she just wipes the machine until it dries. Staff A, PCA also stated that she was not trained on the contact time of disinfectant agents in the facility, but they have had team meetings with return demonstration on proper sanitizing process. An observation was made of Staff A, PCA sanitizing the vital signs machine after the interview. Staff A, PCA was observed spraying Aero Linen Fresh, Surface Disinfectant and Deodorizer Spray on various parts of the machine and immediately wiping it off with a paper towel. Staff A, PCA then stored the machine in the unit hallway. This machine was not being used for residents on Transmission Based Precautions. A review of the Environmental Protection Agency (EPA) website (www.epa.gov) revealed under List N Advanced Search Page: Disinfectants for Coronavirus (COVID-19) that Aero Linen Fresh, Surface Disinfectant and Deodorizer Spray required a contact time of 10 minutes in order to proper sanitize surfaces against COVID-19. An interview was conducted at 10:41 AM with Staff B, Housekeeper who was observed cleaning resident rooms. Staff B, Housekeeper stated that she used a solution of bleach and water in order to sanitize surfaces in the resident rooms. Staff B, Housekeeper was not able to state the ratio used in the bleach to water solution and stated that she put in just a little bit of bleach and the rest was water. Staff B, Housekeeper also stated that she used the same bleach water solution to sanitize hand rails throughout the facility. An interview was conducted at 11:16 AM with Staff C, Housekeeper. Staff C, Housekeeper stated that she used a solution of bleach and water to sanitize surfaces in the resident rooms. Staff C, Housekeeper was not able to state the ratio of bleach to water in the solution and that she poured a little bit of bleach in the bottom of the bucket and filled the rest with water. An observation was made during the interview of a disposable glove inside of the bleach water bucket on Staff C, Housekeeper's cart. Staff C, Housekeeper reached into the bleach water bucket to remove the glove and stated it's clean. Staff C, Housekeeper then put the glove into the trash can and did not perform hand hygiene after. An observation was made during the interview of room [ROOM NUMBER], which was not occupied by any residents. A half full beverage bottle containing blue liquid was observed on the counter near the sink in the room. A white binder, which appeared to be a book used for resident charting and an object wrapped in foil were observed on the bed of the room. Staff C, Housekeeper stated that sometimes staff will sit inside of the empty resident rooms and do their charting and that she checked the empty rooms daily to ensure staff was not leaving items in the clean resident rooms. A tour was conducted at 1:39 PM of the facility laundry room with the facility's Director of Environmental Services (DES). An observation was made of the floor on the soiled side of the laundry area. Six pillows, a white laundry basket, a white laundry hamper, and a bag of hangers were observed on top of 3 floor fans in the corner of the room. The DES stated that the pillows were dirty and waiting to be laundered and that the pillows should be in a laundry bin, not stacked on top of items in the laundry room. The DES stated that housekeeping staff can use Virex or a 10 to 1 bleach water solution to clean surfaces in the resident rooms. The DES also stated that the housekeeping staff were probably not measuring the amount of bleach that they were putting into the bleach water solution, but they're probably using more than enough. The DES was not able to verify if the amount of bleach the housekeeping staff was using for the bleach water solution. An observation was made during the tour of the laundry area of 2 folding tables used to fold resident linens and personal clothing. One of the folding tables had a

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.

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F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) staff member's cell phone and a floral print water bottle on the table with clean resident linens. The DES addressed that no personal items of staff should be on the folding table. A follow up tour of the 2nd floor of the facility was conducted at 2:20 PM of a sit-to-stand lift in the unit hallway with a blue sling draped over the lift. The sling appeared to have a small amount of a white substance on the backside of it. An observation was made in the same hallway of a Hoyer lift sling sitting in a resident's wheelchair in the unit hallway. An interview was conducted at 2:30 PM with Staff D, Licensed Practical Nurse (LPN). Staff D, LPN stated that the lift slings were sanitized in between resident use by using HDX All Purpose Cleaner and Disinfectant Spray according to the directions on the can. Staff D, LPN observed the white substance on the sling that was on top of the sit-to-stand lift in the unit. Staff D, LPN stated that if a sling appeared soiled then it was to be sent to laundry to be cleaned. Staff D, LPN removed the sling from the sit-to-stand lift. Staff D indicated that this sling was used for multiple residents. An observation was made at 2:34 PM of Staff Member E, Certified Nurse's Aide (CNA) picking up a Hoyer lift sling, which was draped over a resident's wheelchair in the unit hallway. Staff E, CNA then put the Hoyer lift sling back onto the resident's wheelchair and walked away. Staff E, CNA was then observed using a keypad to enter the employee restroom. Staff E, CNA did not perform hand hygiene after touching the Hoyer lift sling. An observation was made at 2:53 PM of a staff member exiting room [ROOM NUMBER] with a bag of trash. The staff member was observed placing the trash bag into a gray bin in the unit hallway. The staff member was observed walking down the hallway and entered a room marked as Resident Spa. The staff member did not perform hand hygiene before touching the door knob to the Resident Spa room before entering. An infection control interview was conducted at 3:27 PM with the facility's Nursing Home Administrator (NHA) and Director of Nursing (DON). The NHA stated that she would expect a staff member to perform hand hygiene after removing trash from a resident's room by going back to the room that they came out of and using soap and water. She would not expect to see a staff member walk the length of the hallway and into another room before performing hand hygiene. The NHA also stated that she would expect staff to perform hand hygiene after handling a lift sling. Staff should be using disinfectant wipes and contact times should be on the labels to clean reusable equipment. Staff have been in-serviced on contact times and agents used to disinfect items. The NHA stated that their corporate office has been sending different disinfectant agents, but it may not be what the staff is used to using. The DON stated that staff members should be cleaning equipment based on the contact time labeled on the container. The NHA stated that staff should not have cell phones out during work hours and that staff personal items should not be on the folding table in the laundry room. The NHA also stated that staff should not be using clean resident rooms for charting and that using the clean area could cause cross-contamination, which would require the room to be cleaned again. Photographic evidence was obtained.