STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105172	A. BUILDING _____ B. WING _____	**07/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOUNTAIN MANOR HEALTH & REHABILITATION CENTER	**390 NE 135TH ST NORTH MIAMI, FL 33161**

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, interview and record review, the facility failed to implement infection control and prevention as evidenced by 1) failure to perform hand hygiene before and after touching face mask, 2) failure to correctly wear face mask 3) failure to handle clean linen in a manner that will avoid the risk of cross-contamination in the clean laundry area and 4) failure to follow the facility's procedures for the handling of used food trays removed from isolation rooms. There were 112 residents residing in the facility at the time of the survey. The findings included: Observation on 07/07/2020 at 9:11 a.m. in the clean laundry revealed that the Staff A, Laundry Aide was wearing a face mask with her nose uncovered. Staff A touched the front the mask twice to cover her nose and did not perform hand hygiene and after touching the front of the mask. Further observation of the clean laundry area revealed no Alcohol Based Hand Rub (ABHR) or hand washing station observed in the clean laundry. On 07/07/2020 at 9:17 a.m. Staff A, Laundry Aide, was asked why the face mask was not covering her nose. Staff A, at that time that acknowledged that the face mask was not covering her nose. Staff A then removed the mask by touching the front of the mask, made a knot on the elastic ear loop area of the mask and placed the mask back on her face. Staff A did not perform hand hygiene. Staff A proceeded to continue folding the clean linen. While folding, a bed linen fell on the floor and Staff A, picked up the line from the floor folded it and placed it and placed it with the clean linen. Staff A was asked about the above concerns with handling of the laundry that fell on the floor and hand hygiene. Staff A explained that in case she dropped the clean laundry on the floor, it was supposed to be wash again and, by mistake, she placed the linen that dropped on the floor together with the clean linens. Staff A acknowledged that she did not perform hand hygiene and explained that she should have used hand sanitizer on her hands after she touched her mask. On 07/07/2020 at 9:28 am the Housekeeping Director stated, staff should have the nose covered by the face mask and hand hygiene must be done after they touch the mask. The Housekeeping Director confirmed that they did not have hand sanitizer in the clean laundry area nor area to perform hand hygiene and that he was going to install one wall hand sanitizer inside the clean laundry area . The housekeeping Director stated that in case the staff had dropped the clean linen on the floor, they should put it back to be rewashed. On 07/07/2020 at 12:37 PM during an interview with Staff B, Registered Nurse (RN) , a food tray was observed on a cart containing clean Personal Protective Equipment (PPE) on the hallway. Staff C a Certified Nursing Assistant (CNA) was observed removing a used non-disposable uncovered food tray from the room of a resident on contact and droplet isolation precautions for COVID-19, Staff C placed the used tray on the top of the cart that contained clean PPE. (Photographic evidence). The trays stayed on the cart outside of the isolation room for about 10 minutes. The RN explained noted that the staff should have placed the kitchen tray in a plastic bag inside the isolation room and send them back to the kitchen. On 07/07/2020 at 12:47 PM, Staff C, CNA stated that she should have placed the food trays inside a plastic bag before she left the resident's room and acknowledged she should not have place them on a clean PPE cart. On 07/07/20 at 12:59 PM the concerns were discussed with the Assistant Director of Nursing (ADON). The ADON stated that staff should put the used trays from the isolation rooms inside a plastic bag before they come out of the isolation rooms. The ADON explained that the staff had in-service regarding hand hygiene and an in-services that mask should cover nose and mouth. Interview on 07/07/2020 at 1:17 PM with Infection Preventionist revealed that if the staff was folding the linen and the linen dropped on the floor, the linen should be rewashed. The mask should be covering the nose and the mouth all times. About the food trays, the staff are supposed to place the used trays inside the bag before they leave the isolation room. Record review of the in-service sign-in sheet on 06/30/2020 provided by facility noted following Center for Disease Control and Prevention (CDC) regarding Face masks Do's and Don'ts, dated 06/02/2020, indicating mask should cover nose and mouth. It further showed that staff should not touch or adjust the facemask without cleaning their hands before and after. Record review of the Infection Prevention and Control Program, not dated, revealed properly store, handle, process, and transport linens to minimize contamination. Review of the in-service sign-in sheet dated 04/01/2020 showed indicated. The used food trays that go inside COVID-19 unit (isolation area) must be covered by a plastic bag when being removed.

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