STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105267	A. BUILDING _____ B. WING _____	05/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BAYSIDE HEALTH AND REHABILITATION CENTER	4343 LANGLEY AVENUE PENSACOLA, FL 32504

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 observations, staff interviews, policy review, and review of Centers for Disease Control and Prevention (CDC) guidance, the facility failed to maintain infection prevention standards when staff failed to change gowns worn with Coronavirus Disease 2019 (COVID-19) infected (positive) residents before entering rooms of COVID-19 negative residents to deliver meal trays, gowns which were reused and worn during care of COVID-19 infected residents were stored close together with gowns worn during the care of COVID-19 negative residents, and staff failed to wash hands between passing meal trays and donning gloves to provide resident care creating the potential for cross-contamination. The findings include: On March 1, 2020, The Office of the Governor issued Executive Order Number 20-51 directing the Florida Department of Health to issue a Public Health Emergency. The Executive Order documented, Coronavirus Disease 2019 (COVID-19) is a severe acute respiratory illness that can spread among humans through respiratory transmission and presents with symptoms similar to those of influenza. On March 9, 2020, The Office of the Governor issued Executive Order Number 20-52 declaring a state of emergency for the entire State of Florida as a result of COVID-19. On 5/26/20 at approximately 8:45 AM, the Director of Nursing (DON) explained that the first floor housed residents who were COVID-19 negative and had no known exposure to COVID-19 infection. The entire second floor was designated as an isolation unit. The second floor housed both COVID-19 infected (positive) residents on the B hall, and residents who had previously tested positive and were now negative or who had a known exposure to a COVID-19 infected resident on the A hall. On 5/26/20 starting at approximately 9:50am a tour was conducted of the 2nd floor isolation area. Upon entering the second-floor resident care area past an isolation barrier set up to prevent the spread of COVID 19, a covered rolling linen cart was observed to contain previously used disposable isolation gowns. The gowns were for all staff on the second floor to include both halls A (COVID-19 negative residents) and hall B (COVID-19 positive residents). On 5/26/20 at approximately 1:32 PM, an interview was conducted with the DON who stated that the linen cart was set up after the cloth PPE (Personal Protective Equipment) gowns began to disappear. At this time the facility started to use disposable gowns, write staff names on them and store them in the linen cart for reuse. The DON reported that staff wear the gowns for a few days until they become soiled or torn when they would get a new one. Gowns for the entire 2nd floor were stored in the linen cart. On 5/26/20 at approximately 10:15am, an interview was conducted with Certified Nursing Assistant (CNA) A and CNA B on the second-floor isolation unit. Both CNAs confirmed that residents on hall B are identified as COVID-19 positive and residents on hall A are confirmed as COVID-19 negative and explained that staff are dedicated to care only for residents on one hall or the other and do not go between the two areas except at mealtime. CNA A confirmed staff from both halls go into all rooms on the second floor during meal tray delivery. CNA C approached the desk and confirmed staff assigned to hall A deliver meal trays on hall B and vice versa. On 5/26/2020 at approximately 10:55AM, the Assistant Director of Nursing (ADON) for the COVID-19 isolation area on the 2nd floor described the set-up of the floor stating one side housed the residents that were positive for COVID-19 and the other side that was utilized for residents whom had transitioned from a positive to negative status or who had been exposed to a positive resident. The ADON described the nurses and CNA's being assigned to just positive or negative residents. One nurse/CNA would not be assigned both COVID-19 positive and negative residents. On 5/26/2020 at approximately 12:19 PM, an observation was made of staff members A & B, both CNAs delivering lunch trays on the 2nd floor of the facility. CNA A delivered a lunch tray to room [ROOM NUMBER] (A hall) and then room [ROOM NUMBER] (B hall) - the rooms were divided by a large Solarium which served as the divider between the two halls. The resident in room [ROOM NUMBER] was noted to be negative and the resident on 218 was documented as positive. The CNAs were observed to change gloves and wash hands between residents, but the CNA did not change or remove her gown. A review of CDC guidelines for extended use of personal protective equipment, isolation gowns, published 4/30/20 and retrieved on 5/28/20 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html indicated that isolation gowns may be reused for more than one patient known to be infected with the same infectious disease when these patients are housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). The CDC also recommended the isolation unit should be physically separated from other rooms or units housing residents without confirmed COVID-19 and recommended a separate floor, wing, or cluster of rooms when possible and to assign dedicated HCP (health care personnel) to work only on the COVID-19 care unit. Meal Tray Delivery - 1st floor On 5/26/20 at approximately 12:29pm, observations were made of lunch tray delivery on the first floor which housed only COVID-19 negative residents. CNA D was observed delivering a meal tray to room [ROOM NUMBER], upon exiting the room, CNA D did not perform hand hygiene. CNA D then obtained a meal tray from a cart in the hall and delivered the meal tray to room [ROOM NUMBER], bed B and exited the room again without performing hand hygiene. While leaving room [ROOM NUMBER], the resident in bed A requested assistance and CNA D returned to room [ROOM NUMBER] and donned gloves without performing hand hygiene and was observed to move her gloved hands toward the resident in bed A to assist in repositioning the resident. At this time, CNA D was asked to step out of the room by the surveyor and asked about expectations for hand hygiene when performing resident care and passing meal trays. CNA D said hand hygiene should be performed between each task and confirmed hand hygiene was not performed between passing trays in rooms [ROOM NUMBERS] or before donning gloves to assist a resident. Immediately following this observation, CNA E was observed to deliver a meal tray to room [ROOM NUMBER] and exit the room without performing hand hygiene. CNA E was interviewed after leaving the room and said hand hygiene should be performed after every 2-3 trays or rooms. Another staff member was present in the hall during the interview and CNA E asked the other staff member if hand hygiene should be performed after every tray and the other staff member said, yes. A review of Meals, Serving policy, Nutritional Services; Nursing Services Procedure dated on October 2019, on page 25 and 26 the manual indicated washing hands was required when finished serving the meal or if it becomes necessary to attend to the needs of another resident during meal service.

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