STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105271	A. BUILDING _____ B. WING _____	**06/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BOCA CIEGA CENTER	**1414 59TH ST S GULFPORT, FL 33707**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to timely schedule a physician ordered outside appointment for one resident (Resident #2) out of 11 sampled residents. Findings included: On 06/22/2020 at 1:50 p.m., Resident #2 reported that he was still waiting for a referral from the doctor to see the urologist and that an appointment had not been scheduled. On 06/23/2020 at 10:50 a.m., Resident #2 reported he had a burning sensation at the meatus and that it had been ongoing. A review of the Admission Record revealed that Resident #2 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the active physician orders [REDACTED]. A progress note dated 06/01/2020 at 16:12 (4:12 p.m.) indicated that a call was made to the urologist to schedule a new patient appointment. The writer was directed to leave information on the new patient coordinator's voicemail, and she will get back with the writer within 48 hours. A progress note dated 06/02/2020 at 13:43 (1:43 p.m.) the urologist office stated they did not accept the resident's insurance and that the Unit Manager was going to look for another urologist that would accept the resident's insurance. A medication administration note dated 06/12/2020 at 12:56 (12:56 p.m.) indicated to schedule a follow up with the urologist for a tear in the meatus. The note documented the Resident's insurance was trying to help with a provider nearby. All providers in the insurance website does not accept the resident's insurance, that the resident was made aware and they will continue to search for a local provider and follow up with the insurance. On 06/22/2020 at 2:23 p.m., the Social Services Director (SSD) reported that she was not aware that Resident #2 was having difficulty getting the appointment scheduled and that she could definitely make it happen. She stated that the nurses did not put her in the loop. The SSD reported that nursing should check in with her for help with insurance issues. On 06/22/2020 at 3:07 p.m., the Director of Nursing (DON) reported that initially they tried to make an appointment, but they did not take Resident #2's insurance. They were trying to find a provider to take his insurance. That was the hold up, stated the DON. The DON stated that she would expect the SSD to get involved. She stated that her expectation would be to schedule appointments as soon as possible.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review the facility failed to ensure that care and services were provided for the treatment of [REDACTED].#9) out of three sampled residents with a pressure wound as evidenced by not performing a wound care treatment as ordered by the physician due to a resident refusing and documenting in the medical record it had been performed when it had not been. Findings included: On 6/23/2020 at 10:05 a.m. Resident #9 was in bed while Staff B, Certified Nursing Assistant (CNA) was providing care. Resident #9 smiled and appeared comfortable lying in his bed. The resident was covered with a towel and his lower extremities exposed. His legs were crossed upon each other with noted contractures present. His right leg contained a Kerlix dressing to the lower portion of the calf. The paper tape that held the dressing together contained a handwritten date of 6/19/2020. A second Kerlix dressing was noted to his left lower leg resting above the ankle. Staff B commented at that time by saying, It slides up. I have to slide it down to cover the wound. The second dressing contained the same date of 6/19/2020 written on the paper tape. Resident #9 was asked if he gets his dressing changed daily and he said, No, every other day. Review of the Admission Record for Resident #9 stated he had been residing at the facility for close to three years. His primary [DIAGNOSES REDACTED]. A review of the physician orders [REDACTED]. dressing every other day and PRN, - Treatment as follows: cleanse_ Right Lateral Distal Calf area with normal saline, apply Skin Barrier Wipe to periwound area, apply Xeroform Cover foam and wrap with dry dressing every other day and PRN. The Treatment Administration Record (TAR) for June 2020 contained documentation that the dressings were last changed on 6/21/2020. The observation of the dated dressing revealed it had been last performed on 6/19/2020. The Director of Nursing (DON) was asked for copies of the last two evaluations titled, Skin and Wound Evaluation V5.0, dated 6/9/2020 and 6/16/2020 for the right lateral calf, and the left lateral malleolus. A review of the Skin and Wound Evaluation V5.0, dated 6/09/2020, revealed, right lateral calf Type: pressure, acquired: In House, and unknown how long the wound had been present, wound measurements area 2.9 cm2 (centimeters), length 1.4 cm width 2.3 cm, and depth 0.2 cm. A review of the Skin and Wound Evaluation V5.0, dated 6/16/2020, revealed, left lateral malleolus Type: pressure, acquired: In House, and unknown how long the wound had been present, wound measurements area 2.9 cm2, length 2.4 cm width 1.7 cm, and depth 0.2 cm. The Skin and Wound Evaluation V5.0, dated 6/09/2020, for the left lateral malleolus had not been provided prior to exiting the facility. The Skin and Wound Evaluation V5.0, dated 6/16/2020, for the right lateral calf had not been provided prior to exiting the facility. At 12:20 p.m. the Assistant Director of Nursing (ADON) stated, I was on the cart that day (6/21/2020), and I had worked part of the second shift. I went to his room and tried to do his treatment, but he told me no, he was too tired. The ADON then stated, I had already signed it out in the TAR. She was asked if he refuses his treatments. She stated, I never had a problem with Resident #9 before, and I use to be the wound nurse here. She confirmed that it was later in the evening and Resident #9 was already sleeping. She stated, It may have been some involvement to him not wanting it done. She was then asked why the treatment was scheduled to be done in the evening, and not when he was awake during the day. She did not respond. The ADON was then asked why the treatment had not been reattempted the next day. She stated it was forgotten. The ADON confirmed she had not written a progress note in the medical record indicating he had refused his treatment on 6/21/2020. As the TAR still indicated that the treatment to his lower extremities had been performed. The ADON added, I'll write a note now.
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, interviews, policy review, and review of the Centers for Disease Control and Prevention (CDC) guidelines the facility failed to maintain an infection prevention and control program to provide a safe and sanitary environment to help prevent the development of and transmission of diseases and infection to include COVID-19 as evidenced by: 1. staff members wearing artificial fingernails, 2. staff wearing personal protective equipment (PPE) incorrectly, 3. soiled resident linen inappropriately discarded for one resident (#9), and 4. housekeeping staff not wearing PPE required while cleaning resident rooms identified for isolation on one Step-Down Unit (200 hallway) of one Step-Down Unit and one of one COVID-19 unit (400 hallway), and 5. not maintaining an indwelling catheter bag off the floor for one resident (#7) of seven residents with indwelling catheters. Findings included: 1. The 200 hallway in the facility was used as the Step-Down Unit. The facility defined the criteria for use of the Step-Down Unit as all residents on this unit were newly admitted from the hospital and had to be quarantined for 14 days after admission. On 6/22/2020 at 9:14 a.m., the Unit Manager (UM) was in the Step-down Unit (200 hallway) as she entered resident room [ROOM NUMBER] and was observed holding a souffle cup that contained different shapes, and sizes of medications. The resident room door was noted with signs posted that

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) displayed, Full Personal Protective Equipment. As the UM stood inside of the doorway entrance and holding on to the cup for a few minutes, she was noted without gloves on. Her hands presented with artificial fingernails that were over an inch past the fingertips. She said that she normally doesn't pass medications, when asked about her fingernails. She indicated a staff member had called off for the shift. On 6/22/2020 at 10:48 a.m. Staff D, Certified Nursing Assistant (CNA) was the CNA for the two residents who were suspected to have COVID-19 at that facility who resided in room [ROOM NUMBER]. As she exited the designated area on the 400 hallway (COVID-19 unit), she was observed to have long fingernails that were over an inch past the top of her fingers, pointed tips, with multiple diamonds studs on all digits. She stated, I don't normally work the COVID unit. I'm going to get the nails removed today. Additionally, during the tour on 6/23/2020 at 10:31 a.m. Staff H, Staffing Coordinator was observed wearing a surgical mask under a N95 mask. She confirmed that it was not the appropriate way to wear the mask. A review of the CDC document titled, Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf, updated July 2019, showed: The effectiveness of hand hygiene can be reduced by the type and length of fingernails 559, 718, 719. Individuals wearing artificial nails have been shown to harbor more pathogenic organisms, especially gram-negative bacilli and yeasts, on the nails and in the subungual area than those with native nails720, 721. In 2002, CDC/HICPAC recommended (Category IA) that artificial fingernails and extenders not be worn by healthcare personnel who have contact with high-risk patients due to the association with outbreaks of gram-negative bacillus and [MEDICAL CONDITION] as confirmed by molecular typing of isolates30, 31, 559, 722-725. The facility provided a copy of their policy titled, Personal Appearance, Hygiene & Dress Code, dated April 2019. It showed: Personal Hygiene: 3) fingernails should be kept neat, clean, and of conservative length. Employees providing patient care must keep nails short so not to create safety or infection control issues. No artificial nails, appliques or studs on nails may be worn by any clinical staff who provided patient care. 2. On 6/22/2020 at 9:30 a.m. Staff E, CNA was on the Step-Down Unit (200 hallway) and was observed to be wearing a surgical mask under a N95 mask. She was asked about her N95 mask, and the paper surgical mask she was observed wearing at that time. She stated, You wear the surgical mask under the N95 mask to maintain it longer. She denied being fit tested for the N95 mask. A review of the definition of a N95 mask revealed: An N95 respirator is a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles. Note that the edges of the respirator are designed to form a seal around the nose and mouth. Surgical N95 Respirators are commonly used in healthcare settings and are a subset of N95 Filtering Facepiece Respirators (FFRs), often referred to as N95s https://www.fda.gov/medical-devices/personal-protective-equipment-infection-control/n95-respirators-surgical-masks-and-face-masks. Surgical Mask Testing and Approval Cleared by the U.S. Food and Drug Intended Use and Purpose: Fluid resistant and provides the wearer protection against large droplets, splashes, or sprays of bodily or other hazardous fluids. Protects the patient from the wearer's respiratory emissions. Leakage occurs around the edge of the mask when user inhales. Filtration Does NOT provide the wearer with a reliable level of protection from inhaling smaller airborne particles and is not considered respiratory protection https://www.cdc.gov/niosh/npptl/pdfs/UnderstandDifferenceInfographic-508.pdf. 3. On 6/23/2020 at 10:05 a.m. Resident #9 was in bed while Staff B, Certified Nursing Assistant (CNA) was providing care. The resident was covered with a towel and his lower extremities exposed. His legs were crossed upon each other with noted contractures present. His right leg contained a dressing to the lower portion of the calf and a second dressing was noted to his left lower leg resting above the ankle. After the room was entered a large heaping pile of soiled linen, a hospital gown, a washcloth and towels were observed lying on the floor at the foot of the resident's bed. Staff B, CNA stated, I know it's not supposed to be on the floor. (Photographic Evidence Obtained) Review of the Admission Record for Resident #9 stated he had been residing at the facility for close to three years. His primary [DIAGNOSES REDACTED]. 4. On 06/23/20 at 10:08 a.m., Staff A, Housekeeper, was observed cleaning resident room [ROOM NUMBER]. Staff A was wearing a gown and a surgical mask. There was signage posted next to the door that revealed the following, Stop you must wear full PPE before entering this unit. There was also another sign next to the door that indicated the sequence for putting on personal protective equipment (PPE): 1. Gown, 2. Mask or Respirator, Goggles or Face Shield, and 4. Gloves (Photographic Evidence Obtained). At 10:10 a.m., Staff A reported she had not been issued a N95 mask and no one told her to wear goggles or a face shield when cleaning the rooms. She reported that she only works on the 200 hall one day a week and had not been educated on what to wear when entering rooms that were on isolation. Staff A reported that she had cleaned resident rooms [ROOM NUMBERS]. Those two rooms also had signage posted that indicated that the rooms were on isolation (Photographic Evidence Obtained). Following the observation, the Accounts Manager reported that housekeepers do not touch the residents, so they do not need full PPE to enter rooms on isolation. 5. On 06/23/20 at 10:54 a.m., Resident #7 was observed sitting in the main dining area. Resident #7's catheter bag was observed on the floor. At 10:56 a.m. Staff C, (CNA) stated that the catheter bag should not be on the floor. At 10:58 a.m. Staff D, Licensed Practical Nurse (LPN), confirmed that the catheter bag was on the floor. Staff D stated that the catheter was not supposed to be on the floor and proceeded to lift the catheter bag from the floor. A review of the Admission Record for Resident #7 revealed an admission date of [DATE] with [DIAGNOSES REDACTED].