STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105530	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VISTA MANOR	**1550 JESS PARRISH CT TITUSVILLE, FL 32796**

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 -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow the infection prevention and control plan by not conducting required screenings for symptoms of Coronavirus disease (COVID-19) and risk factors for transmitting [MEDICAL CONDITION] prior to permitting entrance to the facility, for 2 of 2 State Survey Agency (SSA) staff and 6 of 9 direct-care staff on the night shift, (Certified Nursing Assistants E, F, G, H, I & J). Findings: On 8/16/20 at 4 AM, Registered Nurse (RN) A unlocked the facility's after-hours entrance door for 2 SSA staff members to enter the building. RN A explained he worked for a staffing agency and would notify a facility staff nurse who was on the other unit. On 8/16/20 at 4:07 AM, staff nurse Licensed Practical Nurse (LPN) B arrived at the after-hours entrance door. Neither RN A nor LPN B provided COVID-19 screening questionnaires, checked temperatures or directed SSA staff to perform hand hygiene prior to entering the facility and passing through resident care units. On 8/16/20 at 4:18 AM, Certified Nursing Assistant (CNA) E stated she did not recall if there was a staff member assigned to do COVID-screening at the start of the shift at 11 PM. CNA E confirmed she worked in other facilities and knew her temperature should be checked. She pointed to a thermometer at the nurses' station and said, We checked our temperature, but I didn't fill out a form. On 8/16/20 at 4:20 AM, CNA F stated she also worked in multiple facilities. She confirmed all staff should be screened at the start of the shift but did not recall having to answer questions from a screening questionnaire at the start of the night shift. On 8/16/20 at 4:22 AM, RN A explained this was his first shift in the facility. He was asked about COVID-19 screening on the night shift. RN A said, I don't know who screens at night. I'm sure they have a system. I would hope so. He stated he did not screen CNAs or anyone else and was not aware he should have screened SSA staff before permitting them to enter the facility. On 8/16/20 at 4:27 AM, LPN D stated she worked for a staffing agency and was occasionally assigned to the facility. LPN D stated to her knowledge, she was not responsible for performing COVID-19 screenings on the night shift. On 8/16/20 at 5 AM, CNA G stated when she arrived at the facility on the previous night, she entered through the after-hours door at about 11 PM. CNA G said, I was not screened. She stated there was no questionnaire provided regarding presence of COVID-19 symptoms and nobody checked her temperature. On 8/16/20 at 5:12 AM, CNA C stated she was the assigned morning screener and she started work at 5 AM. CNA C held a thermometer and a clipboard with blank screening questionnaires. She asked if she could conduct the COVID-19 screening for the SSA staff at that time. CNA C explained her responsibilities included filling out the questionnaire for anyone who entered the facility and checking temperatures. She stated if anyone answered yes to a question or had a temperature above 100 degrees, she could not allow that person into the facility. CNA C stated she would have to inform the Director of Nursing (DON) or a nurse. CNA C said, Screening is important to keep [MEDICAL CONDITION] out of the building. She stated the facility had assigned COVID-19 screeners on the day and evening shifts and nurses were responsible on the night shift. On 8/16/20 at 5:26 AM, the DON was informed by SSA staff that they were not screened for COVID-19 signs and symptoms prior to entering the facility. The DON stated all staff, including night shift staff, had been educated to perform COVID-19 screening. She explained the agency RN might not have been aware, but there was always at least 1 staff nurse in the building who had been educated on the screening process. When asked what instructions agency nurses were given regarding COVID-19 screening responsibilities, she stated she was not sure. The DON said, It's common sense that agency staff would know it had to be done. The breakdown probably occurred because the agency nurse was new. The DON explained a nurse on the 3 PM to 11 PM shift should screen on-coming night shift staff as they arrived. On 8/16/20 at 5:30 AM, CNA C was asked to provide COVID-19 screening forms for the 11 PM to 7 AM shift staff who were currently in the facility. She provided Staff Screening - Florida Only forms for RN A and LPN B, but could not locate screening forms for LPN D and CNAs E, F, G, H, I and J who were all assigned to resident care tasks during the shift. On 8/16/20 at 5:40 AM, the DON located a form at the receptionist's desk for LPN D who was screened at the front lobby entrance the previous afternoon at 3:38 PM when she arrived to do a double shift. Review of the forms at the receptionist's desk revealed none for the 6 CNAs who worked the night shift. On 8/16/20 at 1:09 PM, the DON confirmed she could not find COVID-19 screening forms for the 6 CNAs who worked the previous night shift. She said, There has been a problem with screening on the night shift. She recalled the concern was discussed at a Quality Assurance and Performance Improvement (QAPI) committee meeting about 2 to 3 weeks before. The DON was asked why SSA staff and CNAs were not screened for COVID-19 symptoms and risk factors if the facility was aware of concerns in that area. The DON stated her assistant was responsible for addressing the screening issue, and she was not sure of the details. On 8/17/20 at 9:30 AM, the Assistant Director of Nursing (ADON) / Infection Control nurse explained anyone who entered the facility must be screened for COVID-19 symptoms and risk factors. She stated the same questionnaire was used for staff and authorized visitors. The Infection Control nurse stated the procedure was for COVID-19 screening to be done outside the building, prior to entering through the facility's doors. She stated entrance was permitted if the responses to the screening questions were negative and temperature was 100.4 degrees or less. She explained screening forms were kept in a filing cabinet at the after-hours entrance door and acknowledged she was not able to find proof of screening for the 6 CNAs who worked on the previous Sunday night shift. The Infection Control nurse stated night shift staff and anyone who entered the facility after 11 PM should be screened outside the after-hours entrance door. She stated one of the night shift nurses was to ensure screening was completed for every staff member at the start of the night shift. The Infection Control nurse stated she preferred COVID-19 screening done by facility staff, but nurses had been instructed to ensure agency staff were aware and able to do screening if necessary. The Infection Control nurse said, Being in this pandemic, screening is extremely important. I would like to explain how it happened that you were not screened, but I cannot. I am not happy it happened, and I am very upset. She acknowledged she was already aware of lapses in screening on the night shift but could not provide any information on any specific plans to ensure this situation did not continue. On 8/17/20 at 9:50 AM, the Regional Director of Clinical Services stated she could not find any evidence the facility had discussed or implemented a plan to ensure COVID-19 screening was conducted as required on the night shift. She stated the front lobby had assigned staff to perform screening for 17 hours daily, but the facility had a pocket of opportunity to be addressed regarding the night shift hours. Review of the Staff Screening - Florida Only questionnaire revealed detailed questions on the presence of COVID-19 symptoms including cough, sore throat, shortness of breath, headache and repeated shaking with chills. If there was an affirmative response, instructions on the form read, STOP the employee cannot enter or Infection Preventionist / designee and DON to evaluate If anyone had a temperature above 100 degrees, he/she could not enter the facility. In addition, the questionnaire required information on previous confirmed COVID infection, possible close contact with an infected person, recent COVID testing and travel associated risks. As per the Center for Disease Control, (CDC) guidelines, Preparing for COVID-19 in Nursing Homes - https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html: Screen all HCP (health care personnel) at the beginning of their shift for fever and symptoms of COVID-19. Actively take their temperature* and document absence of symptoms consistent with COVID-19. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace. The facility's COVID-19 - Pandemic Plan revised on 8/04/20, revealed staff would be trained on the Plan and related policy

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 -** Some	(continued... from page 1) and procedures. All visitors and vendors were to complete a self-report questionnaire. The document read, Employees including contract employees, should be evaluated at the beginning of each shift for signs and symptoms Visitors were to be screened and allowed to enter the facility if criteria were met. The policy indicated after being screened, staff and visitors were required to perform hand hygiene and apply appropriate personal protective equipment.