STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105588	A. BUILDING _____ B. WING _____	**06/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CORAL TRACE HEALTH CARE	**216 SANTA BARBARA BLVD CAPE CORAL, FL 33991**

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 observation and interview, the facility failed to safeguard residents' well-being by failing to follow current infection control standards related to COVID-19 recommendations set forth by Centers for Disease Control and Prevention (CDC). Refer to: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html The findings included: On 6/9/20 at 10:47 a.m., during a kitchen tour with the Director of Nursing (DON), Cook Staff A, was observed placing silverware in napkins. Staff A's face mask was pulled down below her chin, exposing her nose and mouth as she worked. The DON confirmed Staff A should be wearing the mask correctly while in the facility. On 6/9/20 at 10:53 a.m., during the tour with DON, Resident #1 and Resident #2 were observed sitting in wheelchairs across from the nurses' station. Neither resident was wearing a face mask. The DON confirmed they should be wearing face masks while out of their rooms. On 6/9/20 at 10:55 a.m., during the tour with DON, Resident #3 was observed sitting in a wheelchair in the hallway outside of room [ROOM NUMBER]. The resident was not wearing a face mask. The DON confirmed the resident should be wearing a face mask while out of her room.

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