STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105029	A. BUILDING _____ B. WING _____	**05/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COMMUNITY CONVALESCENT CENTER	**2202 W OAK AVE PLANT CITY, FL 33563**

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 -** 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 observations, interviews and record reviews, the facility failed to maintain an infection prevention and control program to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases. The facility failed to 1) ensure staff donned personal protective equipment and performed hand hygiene prior to entering and exiting an isolation area for 1 of 1 isolation areas. 2) The facility failed to follow the Center for Disease Control Prevention (CDC) guidelines to contact their local health department when a resident presented with signs and symptoms of COVID-19 and did not follow their facility policy for monitoring and detection, triage and isolation of potentially infectious residents that could have prevented unnecessary exposure among their residents, and healthcare personnel for the facility for 2 of 2 reviewed, 3) Failed to clean shared areas and shared items on 1 of 2 floors. 4) The facility failed to use an approved cleaner for shared equipment on 2 of 2 floors, 5) Failed to ensure staff entering and exiting resident rooms performed hand hygiene on 1 of 2 floors and 6) Failed to ensure that medical equipment used for suctioning, which comes into contact with mucus membranes, was stored correctly, and that a sterile tracheotomy kit, which is used to clean around the airway, was unopened in the resident's room for 1 (#21) out of 4 tracheotomy residents. 7) The facility did not ensure that foam cups, used for resident consumption of fluids, were stored correctly underneath an ice chest on 2 of 2 hydration carts. These failures in infection control practices contributed to 49 vulnerable residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #23, #27, #29, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61), testing positive for the COVID19 virus and one (#1) confirmed death out of 49 positive sampled residents and contributed to 17 staff members testing positive for COVID19 out of 122 staff members tested . Findings included: 1) An observation on [DATE] at 10:35 a.m., Staff S, Certified Nurse's Aide (CNA), was observed entering the building and walking up the hall towards a plastic barrier. Staff C, without washing or sanitizing her hands, walked up to and unzipped the plastic isolation barrier, entered, zipped the barrier closed and began donning personal protective equipment (PPE), gown, gloves and a N95 mask and walked into an isolation room. A second observation was conducted at 10:53 a.m., Staff S, CNA was inside the isolation area at the opposite end of the hall than the zippered plastic barrier with a bag of dirty linen in her hand. Staff S did not have on gloves or a gown. Staff S, CNA, used her un-gloved right hand to push open the emergency exit door at the end of the hallway, walked out, placed the soiled linen in a gray plastic bin, then walked back into the isolation area and closed the door. An interview was conducted on ,[DATE] at 10:53 a.m., Staff S, CNA said, When I came in this morning, I came in the side door that staff are supposed to come in and checked in. Then I walked down here and unzipped the plastic barrier, Yes for isolation. Yes, then I put on my PPE. If I have to leave or go to lunch, I have to go out of the door down there, (pointing to the emergency exit door at the end of the hall). No, there is not any PPE set up outside that exit door. I remove my gloves and gown after leaving the room. An interview was conducted on [DATE] at 11:03 a.m., the ADON (Assistant Director of Nursing) said, They should put on their PPE before going into the isolation area. I need to re-think how to do that when they exit the isolation hall by going out of the emergency door on the end of the hall. No, there is not any PPE set up out there. 2) A review of facility deaths from [DATE] through [DATE] revealed Resident #35 had expired in the facility on [DATE] at 19:45(7:45 pm). Resident #35 was admitted to the facility on [DATE] with relevant medical history for [MEDICAL CONDITIONS] and Diabetes. A review of the facility documentation for Resident and Staff Change of Condition log reflected documentation on [DATE] for Resident #35 with signs and symptoms of Temp, SOB(shortness of breath), Low O2 sats(Oxygen Saturation of the blood, normal ,[DATE]%). Tests: Flu for A and B (-) Negative, chest x-ray and CBC (complete blood count) normal. Details: Resident is being followed closely by the ARNP (Advanced Registered Nurse Practitioner). A review of the nurses note on [DATE] at 21:47 (9:47 pm) (4 hours after presenting with symptoms of elevated temperature, respirations and oxygen desaturated to 77% on room air). Resident had stat (immediate) labs and stat chest x-ray. Chest x-ray Negative. [MEDICATION NAME] 1 gram x 3 days. Negative for flu [MEDICATION NAME] 1 and 2. Resident (O2) sats at 93%, bp (blood pressure),[DATE], pulse 98 at this time. The nurses note dated [DATE] at 16:59 (4:59 pm) documented, Resident had stat labs and stat chest x-ray. Chest x-ray Negative. [MEDICATION NAME] 1 gram x 3 days. Negative for flu [MEDICATION NAME] 1 and 2. Resident sats at 93% bp ,[DATE], pulse 98 at this time. Review of a change in condition, SBAR(situation, background, assessment, recommendations) note dated [DATE] at 16:59(4:59 pm) revealed: Pulse: 148, [DATE] 17:01 Pulse Type: Irregular - new onset, Respirations 24 - [DATE] 17:03, Temp: T 102.5 - [DATE] 17:02 Route: Oral, Pulse Oximetry(O2 Saturation): O2 77% - [DATE] 17:03 Method: Room Air Code Status: DNR Nursing observations, evaluation, and recommendations are: (O2) Sats at 77%, p-148, temp 102.5, crackles (sound heard in the lungs caused by excess fluid) Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: Recommendations: ARNP B. New Testing Orders: X-ray. Review of a change in condition, SBAR note dated [DATE] at 8:46 am: Temp: T 97.0 - [DATE] 14:31 Route: Axilla Pulse Oximetry: O2 93.0 % - [DATE] 13:15 Method: Oxygen via Nasal Cannula. Primary Care Provider responded with the following feedback: Recommendations: [MEDICATION NAME] solution for pain, [MEDICATION NAME] for increased oral secretions, continued comfort measures. [MEDICATION NAME] 1 gm IM x 7 days for pneumonia. A review of the resident Change in Condition assessment dated [DATE] documented under Respiratory Status Evaluation boxes checked on the form were: Shortness of breath, abnormal lung sounds, symptoms of a common cold. Describe shortness of breath: Abrupt onset of SOB with pain, fever, or respiratory distress. Describe respiratory signs and symptoms: congestion, sob (shortness of breath), increased temp. A review of the vital signs documented in the medical record revealed: [DATE] at 17:01 Pulse 148 bpm (beats per minute) documented: Irregular-new onset [DATE] at 17:02 Temperature documented at 102.5 F [DATE] at 17:03 Respirations of 24 [DATE] at 17:03 Oxygen saturation at 77% room air [DATE] at 17:45 Pulse 150 bpm Regular [DATE] at 18:02 Pulse 154 bpm Regular [DATE] at 03:14 Oxygen saturation at 88% oxygen via nasal cannula [DATE] at 13:15 Pulse 112 bpm Regular [DATE] at 13:50 Pulse 99 bpm Regular [DATE] at 17:17 Pulse 68 bpm Regular [DATE] at 18:48 Pulse 0 bpm Irregular-new onset. A review of the facility infection control line item revealed no documentation for Resident #35. A review of the physician orders and treatments revealed there were no orders or telephone orders for isolation for Resident #35. A review of the care plan for resident #35 revealed nothing in place for monitoring, isolation or potential for infection. A review of the Medication Administration Record [REDACTED]. An interview was conducted on [DATE] at 3:58 p.m., the Director of Nursing (DON), said, I don't remember Resident #35. The DON reviewed the information in the medical record for Resident #35 and said, Wow. I never heard anything about Resident #35. He definitely could have been COVID19 with those symptoms. That was in the beginning of all of this. No, I do not see that we notified the DOH (Department of Health). An interview was conducted on [DATE] at 4:00 p.m., the Assistant Director of Nursing (ADON), said, As you can see, we notified his physician. If the physician did not order testing or feel he should have been tested then we did not. We followed physician orders. A return call was received on [DATE] at 12:14 p.m., the interested family member said, I was there that day at the facility when he died . I tried to feed him and he would not eat. I heard him make a noise so I went and got the nurse and she told me you probably just heard him take his last breath. I don't know if he had [MEDICAL CONDITION]. They told me they did not test him. A

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 -** Actual harm **Residents Affected -** Some	(continued... from page 1) review of the CMS (Centers for Medicare & Medicaid Services), Guidelines for [DATE], Ref: QSO-,[DATE]-NH, revealed .Guidance for Limiting the Transmission of COVID-19 for Nursing Homes: Additional guidance: 2. Implement active screening of residents and staff for fever and respiratory symptoms. . Nursing homes with residents suspected of having COVID-19 infection should contact their local health department. Residents infected with COVID-19 may vary in severity from lack of symptoms to mild or severe symptoms or fatality. A review of the medical record showed Resident #3 was admitted to the facility on [DATE]. On admission Resident #3 was not placed in a private room or put on isolation precautions for 14 days or placed in a step-down unit designed to isolate new residents for a length of time to make sure they do not develop symptoms of COVID19 and infect a current resident. A review of the facility infection control line item revealed documentation for Resident #3 with an onset of symptoms on [DATE] with documentation of fever. The medical record revealed Resident #3 developed respiratory symptoms on [DATE] and was tested . The resident was positive for COVID19. The medical record revealed on [DATE] at 17:07 (5:07 pm) a change in condition, SBAR assessment showing: Situation: The Change in Condition reported Evaluation are/were: Fever Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were: Nursing observations, evaluation, and recommendations are: Resident noted with a fever. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: COVID19 swab B. New Testing Orders: COVID19 swab. A review of the physician orders and treatments revealed there were no orders or telephone orders for isolation after [DIAGNOSES REDACTED]. Since she had already been tested and was negative, why would we have placed her in isolation when she got here? An interview was conducted on [DATE] at 3:41 p.m., the ADON said, No, we have not isolated any new admissions (on a step-down unit) or residents returning from the hospital. At the time, it is just enhanced monitoring of their vital signs. This is what we were told to do. An interview was conducted on [DATE] at 4:04 p.m., the DON said, No, we have not isolated any new admissions or residents returning from the hospital. It was just enhanced monitoring of their vital signs. This is what we were told from our corporate office. I will have to check who the directive was from. Yes, it was for enhanced monitoring for anybody coming in like new admissions or re-admissions. An interview was conducted on [DATE] at 3:45 p.m., The ADON when asked if she was aware of the CDC guidelines said, I do not know. I am drowning right now. I don't know. An interview was conducted on [DATE] at 10:50 a.m., the Medical Director said, We should follow the CDC guidelines and my expectations are that if the facility receives a resident from the hospital, they should place them in a private room if possible. They must follow the CDC guidelines. I do recommend we follow the CDC guidelines with the step-down recommendation when a resident is transferred to the facility. An interview was conducted on [DATE] at 1:19 p.m., Admissions Coordinator said, I complete a pre-admission screening. All of it is done by phone and electronic process. I call the patient or the family and introduce myself, tell them about our facility. I tell them I have a video about the facility and can send it to them if they like. Most of them want to look at the video. I ask them a series of questions like where they have been the last month. Admissions Coordinator said, I tell the potential residents or families that we have a step-down area. An interview was conducted by phone with the ADON on [DATE] at 9:48 am who said that the current census was 56. All residents had been tested which began on Thursday [DATE] and was completed that same evening. The facility received the results on [DATE] at approximately 10:00 pm, 29 of 85 residents tested were positive for COVID-19. She said that on [DATE] they transferred 30 residents with (+) results, 10 to one hospital, 19 to another hospital (One resident was already at the hospital). Our plan is we are shifting all residents that were in with roommates that the roommate had tested positive, they will be moving to our COVID Unit (1 WEST) this morning, a total of 16 residents. We are in the process of expanding the unit this morning. We have informed families via phone. She said that the DON notified the Medical Director during a telephone conference call at 9:00 a.m. today. A visit to the facility was conducted on [DATE] at approximately 11:30 am. At 2:10 p.m. the COVID Unit (1 West) was observed and found to be empty. The ADON was interviewed and said I am not sure why we have not started moving residents down to the isolation area. I am not sure where the breakdown in communication was. An interview was conducted on [DATE] at 2:20 p.m., with the Director of Housekeeping and Laundry who said, No one has told me yet to clean that area.(1 West) We have to wait at least ,[DATE] hours before we go into clean and then another 2 hours before anyone can be moved down into those rooms. On [DATE] at 2:31 p.m., observed the DON, ADON and the Director of Housekeeping and Laundry come out of an office and the DON said, We will get the residents moved today. I know I said this morning that we were in the process of moving residents to the isolation area. We will all have to help her get it clean down there. She is the only one here. It was observed that only one housekeeping employee was in the facility, the director. An observation was conducted on [DATE] at 3:31 p.m., the Director of Housekeeping and Laundry with PPE on, was cleaning a room on the isolation hall. The next day on [DATE] at 1:08 p.m., the DON said We have the area set up now. We moved the last resident over there to PUI (Persons Under Investigation for COVID) unit on 1 West, at 11:00 p.m., last night. A review of the CMS (Centers for Medicare & Medicaid Services), Guidelines for [DATE], Ref: Ref: QSO-,[DATE]-Pertinent for Nursing Homes: . We remind facilities that they are required to have a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility, and when and to whom possible incidents of communicable disease or infections should be reported (42 CFR 483.80(a)(2)(i) and (ii)). CDC recommends that nursing homes notify their health department about residents with severe respiratory infection, or a cluster of respiratory illness (e.g., > or = 3 residents or HCP with new-onset respiratory symptoms within 72 hours). Local and state reporting guidelines or requirements may vary. Monitor the CDC website for information and resources to help prevent the introduction and spread of COVID-19 in nursing homes . A review of the Facility policy titled COVID-19 Guidance provided by the Director of Nursing (DON), on [DATE] (without an effective date or implementation date noted). Documentation revealed: Standard: In order to reduce the risk of infectious disease exposure in the facility the following guidance will be a utilized. This guidance is being utilized in conjunction with the visitors and visitation directive policy. Communication/education: Provide Resident Council education about COVID-19 and measures the facility is taking to identify risks and reduce risk of transmissions. Provide all staff education including contractors about COVID-19 and measures the facility is taking, including signs and symptoms to report: Sick and employees should stay home. If you're experiencing the following symptoms, you should contact your health care practitioner: cough, fever, sore throat, runny nose, and/or shortness of breath. Notify the infection prevention nurse or nursing supervisor if you develop respiratory symptoms while at work. These include; cough, fever, sore throat, runny nose, and/or shortness of breath. Practice proper Handwashing hygiene. All employees should clean their hands before and after interactions with residents and their environment with an alcohol-based hand sanitizer that contains at least 60 to 95% alcohol or wash their hands with soap and water for at least 20 seconds. Soap and water should be use preferentially if hands are visibly dirty. Cover your mouth and nose with a tissue and coughing or sneezing. Perform routine environmental cleaning. Routinely clean all frequently touch surfaces in the workplace, such as workstations, countertops, and door knobs. Use the cleaning agents that are usually used in these areas and follow the directions on the label. No special cleaning is necessary for COVID-19. Screeners to be educated on their role and how to complete the COVID-19 screening and report findings. Screening: Will be conducted for all employees, contractors, vendors, and visitors. Monitoring: After initial screening, employees and healthcare contractors that have received the education will only be screened again upon return from vacation, and prior to return to work after sick leave. Visitors will be screened every visit. A review of the facility process titled Enhanced Monitoring: Admissions/readmissions, with no effective date or revision date. The process was provided by the Director of Nursing (DON), on [DATE] at 5:00 p.m. Documented in hand writing at the top of the page, Templates and computer implemented on [DATE]. The process documented the following Order template: enhanced monitoring: Re-admissions to include vital signs and notifications every shift time 14 days then daily. Description: Enhanced monitoring: risk for COVID-19 infections every shift for 14 days then daily to include vital signs, oxygen saturations and notifications of abnormal findings. Details: every (Q) shift eight hours for enhanced monitoring infection prevention for 14 days guidance: notify practitioner if resident exhibits a temperature greater than 100 or a cute drop in oxygen saturation. Schedule: every shift (8 hour range) for 14 days then switches over to daily and open for the user to choose which shift to monitor on, Q shift (eight hour range) supplementary documentation: blood pressure, temperature, pulse, respirations, 02. Order set: enhanced monitoring: suspected: Order template: enhanced monitoring: suspected/confirm to include vital signs and notifications every four hours for 14 days then daily Description: enhanced monitoring: suspected a confirmed COVID-19 infection every four hours for 14 days then daily to include vital signs, oxygen saturation and notification of abnormal findings. Schedule: every four hours for 14 days then switches over to daily and open for the user to choose which shift to monitor on Every four hours supplementary documentation: blood pressure, temperature, pulse, respirations, O2 Daily supplementary documentation: temperature, O2. The process provided by the DON reflected several available templates within their electronic medical record system for clinicians to choose from for documentation purposes.

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F 0880 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 2) 3 & 4) On [DATE] the survey team entered the facility and walked to the reception desk at 10:30 a.m. Staff V, Registered Nurse (RN), and Staff W, Receptionist assisted with screening to include checking the visitors' temperatures with a temporal thermometer (The directions for use of a temporal thermometer include: Slide the thermometer in a reasonably straight line across the forehead, midway between the eyebrows and the upper hairline. Do not slide down the side of the face. Midway on the forehead area, the temporal artery is less than 2 millimeters below the skin surface. Exergen.com) Neither Staff V nor W were wearing gloves. Staff V was observed cleaning the temporal thermometer with a bacterial wipe manufactured for cleaning hands not medical equipment. An interview was conducted on [DATE] at 10:49 a.m., Staff V, Wearing gloves like that goes against everything we were taught. Why would we wear them if we are not coming in contact with the person, we are screening? I guess you're right. We could accidentally touch their forehead or other areas when checking their temperatures. Upon arrival to the facility, on [DATE] at 12:34 p.m., the DON was present and initiated the health assessment and temperature. The screening items included a temporal thermometer and a large container of hand wipes (bacterial wipes manufactured for cleaning hands not medical equipment), sitting on a bed side table that had been rolled out of the facility placed out at the front entrance. The DON was not wearing gloves after each temperature check and the thermometer was not cleaned. On [DATE] at 9:30 a.m., the surveyors entered the facility and walked up to the reception desk. The ADON conducted temperature screening, and was observed cleaning the temporal thermometer with a bacterial wipe manufactured for cleaning hands not medical equipment. On [DATE], [DATE] and [DATE] observed large containers of bacterial hand wipes on the nurse's station on the first and the second floor and on 1 medication cart on the 2nd floor. An interview was conducted on [DATE] at 4:00 p.m., a corporate representative looked at the bottle of the hand wipes and said, No, this should not be used to clean medical equipment. It is not the right thing to use. The hand wipes used were Sani-Hands Instant Hand Sanitizing Wipes, A non-alcohol based Hands Antibacterial Wipes, a hand wipe that is perfect for foodservice settings, retail operations, offices, and locations where access to soap and running water is limited. An interview was conducted on [DATE] at 10:58 a.m., the Director of Nursing (DON) confirmed that staff entered the facility through the door close to the breakroom. We have two points of entry. We have all visitors come through the front entrance. Staff enter through the door close to the breakroom (pointing to the door), and they come to this table to be screened, and if no one is here they ring the bell and a staff member will come out and screen them. Well, we hope all staff come through and do what they are supposed to do. An interview was conducted on [DATE] at 2;05 p.m., with the ADON and DON who said, Yes, that is where the employees enter the building. They are screened there; you saw the table in the hallway outside of the employee break room. As far as only having one point of entry, the Department of Health never made that recommendation. The ADON spoke up and said, Can you give me a copy of the CDC guide lines? On [DATE] at 2:57 p.m., Staff X, Educator confirmed that all staff should have their temperatures taken twice per shift and is unable to provide evidence to that effect. Staff X, Educator was unable to provide proof that the agency staff's temperature was taken 2 x a day are required. The only documented proof provided was screening of staff at the beginning of their shifts, with temperature taken. An observation was conducted on the second floor at 11:28 a.m., a computer tablet was observed uncovered propped up between the rail on the wall and the wall touching the inside of the wall rails on the outside of room [ROOM NUMBER] that was covered with a yellow substance. An observation was conducted on [DATE] at 11:31 a.m., on the 2nd floor air conditioner air handler vents with large clumps of gray debris hanging out of the vent towards the floor from the vent cover. An observation was conducted on [DATE] at 1:34 p.m., a fitted sheet was observed on the top of a clean covered linen cart. An interview was conducted on [DATE] at 1:34 p.m., Staff U, Registered Nurse (RN), reached up on the top of the clean linen cart and pulled the fitted sheet off of the top of the cart and said, No, that should not be up there. An observation was conducted on [DATE] at 11:33 p.m., observed a treatment cart on the 2nd floor without a trash bag in the bin on the cart for trash and inside the bin were pairs of dirty gloves that had been disposed of in the bin. An interview was conducted on [DATE] at 11:35 p.m., Staff U, RN said, No, those used gloves should not have been put in there without a bag in there. We are trying to send out 4 more residents. Yes, all of them are COVID19 positive. A tour of the laundry area was conducted on [DATE] at 12:12 p.m., Staff T, Laundry Aide said, Yes, this area is where we keep all of the clean linen. The top of the table is where we fold laundry. On the bottom shelf are bedspreads. Yes, they are clean. Observed a long silver metal table with a top shelf and another shelf underneath, with bedspreads and bed covers stored underneath the metal table that were not covered. Observed on the 2nd shelf, with the clean bedspreads and covers was a green and orange camouflaged lunch bag. Next to the lunch bag was a pair of used clear plastic gloves. Once the staff lunch bag was removed from the bottom shelf, resting on top of clean bedspreads observed several pairs of used gloves, Kleenex, condiment containers and lids. The shelve and wall behind was full of gray fuzzy debris. An interview was conducted on [DATE] at 12:14 p.m., the Director of Housekeeping and Laundry said, That lunch bag should not be there. The metal table was moved out away from the wall and the Director of Housekeeping and Laundry said, Oh wow. I did not know all of that was there. No, I will get it cleaned immediately. An observation was conducted on [DATE] at 1:08 p.m., Staff T, Laundry Aide was observed coming out of the laundry room door (door in hallway that leads to the area where clean linen is kept), with a bag of trash. An interview was conducted with Staff T, Laundry Aide on [DATE] at 1:08 p.m., as she was walking in the hall with the bag of trash and she said, Sorry, Yes, I should have gloves on. An interview was conducted on [DATE] at 1:30 p.m., the Maintenance Director said, Yes, the air conditioner vents should have been dusted. At 1:53 p.m., the Maintenance Director said, They are cleaned now. Based on tours of the facility on [DATE] and [DATE] there were no observations of housekeeping staff in the building either day. An interview was conducted on [DATE] at 1:40 p.m., during the tour with the DOH the Director of Housekeeping and Laundry stated that she was here. An observation was conducted on [DATE] at 12:45 p.m., Staff Y, nurse was observed on the 2nd floor going from room to room without washing her hands or using hand sanitizer before or after entering the resident rooms. An interview with Staff Y said, Ok, I will do that. An interview was conducted on [DATE] at 1:18 p.m., the ADON stated, Yes, I expect staff to perform hand hygiene whenever they enter or leave a resident room. 6) During a tour of the facility on [DATE] at 11 am, two pieces of equipment were seen on the floor of Resident #21's room. Upon walking closer to the room, the equipment could be identified as suction machines. (Photographic evidence obtained.) The resident could be seen from the hallway, and without entering the room, the resident was noted to have a [MEDICAL CONDITION] (a surgically created hole through the front of the neck and into the windpipe to provide an airway for breathing). While writing down the resident's information, the sink inside the room could be visualized. On top of a stack of brown cardboard boxes, which were on the counter next to the sink, was a plastic white container with the paper lid partially peeled off. Staff R, Registered Nurse (RN), was walking down the hallway at that time and was asked if the suction machines were supposed to be on the floor. She said that they should not be there. She said that they are broken, so she will bag them and take them where they need to go. She confirmed that the resident did have a working suction machine in the room. Staff R was also asked if the white plastic container on the boxes near the sink was an open [MEDICAL CONDITION] kit. She confirmed that it was, and that nothing had been taken out of it. When asked if that should be there, or if it should be open and, on the sink, she said that it should not be there, and she isn't sure why someone would open it, and then leave it there. She said that she will throw it away, because she could not guarantee that it was still sterile. Resident #21 was initially admitted to the facility on [DATE] with the most recent re-Admission being [DATE] for a [DIAGNOSES REDACTED]. The resident was care planned to have a [MEDICAL CONDITION] due to impaired breathing mechanics. In an annual MDS dated [DATE], the resident was assessed to have a brief interview for mental status (BIMS) of 15, indicating the resident had no cognition deficits, and to have a tracheotomy. Resident #21 has had multiple prescriptions for upper respiratory infections in the past year, with the most recent being [MEDICATION NAME] Tablet ([MEDICATION NAME]), Give 500 mg by mouth one time a day for URI for 10 Days beginning [DATE] and ending on [DATE], and [MEDICATION NAME] Solution Reconstituted ([MEDICATION NAME] Sodium) Inject 1 gram intramuscularly one time a day for URI (Upper respiratory infection) on [DATE]. The one previous to that was [MEDICATION NAME] Solution Reconstituted (Ertapenem Sodium), Use 1 gram intravenously one time a day for URI for 7 Days starting [DATE] and ending [DATE]. The resident also had an order to [MEDICAL CONDITION] needed dated [DATE]. On [DATE] at 1:40 p.m., the ADON (assistant director of nursing) said that the suction machines should not have been left on the floor, that they should be bagged and taken care of immediately. She also said that the [MEDICAL CONDITION] kit should have just been thrown away. There was no reason for it to be open in the room. At 4:09 p.m., in an interview the DON (director of nursing) said that he does not know of any policy that addresses the open [MEDICAL CONDITION] kit in the residents room, but he said the kit should have been thrown away, and it is his expectation that they be used when they are taken into the room. In a policy and procedure titled Equipment-cleaning/disinfecting dated as effective [DATE], under the topic Critical Items it reveals Instruments or objects that are introduced directly into the bloodstream or into other normally sterile areas of the body. The facility utilized disposable items. Examples include .[MEDICAL CONDITION]. Under Semi-critical Items

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	105029	A. BUILDING _____ B. WING _____	**05/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COMMUNITY CONVALESCENT CENTER	**2202 W OAK AVE PLANT CITY, FL 33563**

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 -** Actual harm **Residents Affected -** Some	(continued... from page 3) it reads Items that come in contact with intact mucus membranes. .require high-level disinfections. 7) During a tour of the facility on [DATE], at 11:18 a.m., on the second floor at the nurse's station was an ice cart. The lid to the ice chest was closed. Underneath the ice chest, on a shelf were multiple white foam cups. There were several sleeves of cups that were open on one end in the plastic covering that they were shipped in, but there were also multiple cups that had fallen out of the plastic covering and were no longer covered. There were multiple nurses behind the nurse's station, and CNA's (certified nurse's aides) walking around the hallways. There was also a resident, Resident #22 ambulating