DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/15/2020 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		105202	B. WING			05/	15/2020
	ROVIDER OR SUPPLIER HEALTH AND REHABILI	TATION CENTER		10	REET ADDRESS, CITY, STATE, ZIP CODE 00 24TH ST N UNT PETERSBURG, FL 33713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
		to at Apollo ation. The facility was not in FR 483, Requirements for					
F 880 SS=E	Prevention (CFR(s): 483.80(a)(1)		F	088			
	The facility must esta prevention a designed to provide a comfortable environn	ntrol blish and maintain an and control program a safe, sanitary and nent and to help prevent the sensission of communicable					
	program. The facility must esta	(IPCP) that must include, at					
	reporting, investigatir and communicable staff, volunteers, visit providing services un arrangement based u	for all residents, ors, and other individuals der a contractual upon the facility assessment to §483.70(e) and following					
	procedures for the pr but are not limited to: (i) A system of survei possible communicat	llance designed to identify					
ABORATORY	DIRECTOR'S OR PROVIDERA	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Electronically Signed /2020

Any deficiency statement ending with an asteriak (1) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safequards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings and stated above are disclossable 90 days following the date of survey whether or not a plan of correction is provided. For unsing homes, the above findings and plans of correction are disclossable 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 participant.

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DETTINCTION OF THE RETURN OF	D HOME OF CELLANDED			FURW APPROVE
CENTERS FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
FATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105202	B. WING		05/15/2020
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	

NAME OF PE	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
			1	000 24TH ST N	
APOLLO I	HEALTH AND REHABILITATION CENTER		s	AINT PETERSBURG, FL 33713	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1	F	880		
F 000	Continue From page 1 persons in the facility; (ii) When and to whom possible incidents of communicable or should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of ; (iii) Standard and transmission-based precautions to be followed to prevent spread of ; (iii) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable or skin from direct contact with residents or their food, if direct contact will transmit the and (v))The _yigene procedures to be followed by staff involved in direct resident contact. \$483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. \$483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of \$483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REGUIREMENT is not met as evidenced by:	F	a80		
	Based on observations, interviews, record review, policy review, and review of the Center for Control and Prevention guidelines, the			Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of	

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CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	105202	B. WING	05/45/2020

		105202	B. WING			05/	15/2020
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	00/	10,2020
			- 1	100	00 24TH ST N		
APOLLO I	HEALTH AND REHABILIT	TATION CENTER			JNT PETERSBURG, FL 33713		
(X4) ID	CUBMAADV CT	ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	-	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 880	Continued From page	2	F 88	30			
		in an prevention			the facts alleged or conclusions set fort	h	
		related to not properly			on the statement of deficiencies. This p		
		ementing best practices for			of correction is prepared and/or execute		
		ce by: 1. a screening device			solely because required.	au	
		d for staff and persons from			solely because required.		
	outside services was				(1) What corrective action(s) will be		
		ended contact			accomplished for those residents found	to	
		shing after leaving a			have been affected by the deficient		
		Staff not following posted			practice:		
		y not donning required			•		
	personal protective ed	quipment (PPE) for two			1. On Staff Member A was		
	residents (#6 and #7)	of four residents on			re-educated by the Clinical		
	isolation for droplet pr	recautions, 4. not providing			Educator/Designee on the components	of	
	dedicated resident eq	uipment on droplet			this regulation with an emphasis on faci	lity	
	precautions and not o	cleaning a reusable			standards as it relates to process for		
		recommended contact time			screening employees and cleaning of		
		ng a utilized N95 mask			equipment. Validation of competency		
		donning required PPE to			completed by visual observation.		
	assist two residents (
		aintaining tubing for an				?)	
		nd the drainage bag off the			was assessed by a licensed nurse, and		
		ss contamination for one			sustained no ill effects related to potent		
	resident (#12) of 14 re				related to safe handling of linen.		
		having appropriate PPE the isolation caddies for			On Staff Member C was		
	three of three residen				re-educated by the Clinical		
	#_, and #_) ii				Educator/Designee on the components	of	
	precautions.	naicated as droplet			this regulation with an emphasis on	OI .	
	preductions.				proper hygiene and safe handling	of	
	Findings included:				linen. Validation of competency comple		
					by visual observation.		
	1. On at 9:15	a.m. the survey team					
		Staff A, Transportation			3. On		
	Coordinator/Certified	Nursing Assistant (CNA),			were assessed by a licensed nurse and		
	donned in gloves and	a mask, stood at the			sustained no ill effects related to potent	ial	
	entrance telling the su	urveyors to use the			failure of staff to don shield.		
	sanitizer. She picked	up a touchless thermometer					
		that lay on top of a			On Staff Member D was		
	white foam tray. The	temperature was taken			re-educated by the Clinical		

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FORM APPROVED
OMB NO. 0938-0391

		ID HUMAN SERVICES					M APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					OMB NO. 0938-0391		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION		E SURVEY IPLETED
		105202	B. WING _			05	5/15/2020
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
4 DOLLO	EALTH AND REHABILI	TATION CENTED	- 1	18	00 24TH ST N		
AFOLLO	TEALTH AND REHABILI	IATION CENTER		S	AINT PETERSBURG, FL 33713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	without cleaning the to completed the questic asked at that time if s person that performed that she was the Trar was only filling in unit at the waster that she was the Trar was only filling in unit at the term of the ter		F8	80	Educator/Designee on the componenthis regulation with an emphasis on fishandards regulating Transmission Ba Precautions, and proper donning and doffing of Personal Protective Equiprivalidation of competency completed insulation of competency completed visual observation. 4. On	ucility sed	

from a hospice agency. Staff A placed her phone

sustained no ill effects related to potential

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA			
OND PERM OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105202	B. WING		05/15/2020
NAME OF PROVIDER OR SUPPLIER		8	TREET ADDRESS, CITY, STATE, ZIP CODE	
APOLLO HEALTH AND REHABILITAT	TION CENTER	1	000 24TH ST N SAINT PETERSBURG, FL 33713	
PREFIX (EACH DEFICIENCY N	MENT OF DEFICIENCIES JUST BE PRECEDED BY FULL (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
over to the front door ar to open the door. Staff A performed the se thermometer, hospice nurse. Staff A cleaning process of a to thermometer. Staff A donned a pair of bleach wipe from the co wipe to clean two therm for a total of was never cleaned, nor where the thermometer The container of the ble directions fe wipe surface with wipe to allow surface time: "30 secon and (minutes. Cleaning Proc include vigorous wiping visible soil is removed." needed for high-touch s soiled clothes. Contact remain wet for 1 minute organisms, see direction (Photographic evidence The Regional Nurse wa approximately 2:00 p. m contact time for the ble had been utilizing during. She indicated that the fe	otionist desk and walked dused her ungloved right and questionnaire with the and questionnaire with the erformed the same tall of 3 seconds with the gloves and removed one natainer. She used the one ometers and two traces and two traces of the desk sand were set. ach wipes contained or use that revealed: 2. until completely wet. 3. To to remain wet for contact ds, Viruses - 1 minute	F 880	failure of staff to don shield. 6. On Resident #12 assessed by licensed nurse, and sustained no lil effects drair bag/fubring was not in contact with the floor during this review. On Staff member H and re staff member re-educated by the Clinical and a competency was completed for care and emptying of a beds drainage bag. Follow up education an competency completed by Clinical Educator on resident isolation 7. On resident isolation 7. On resident isolation addles were visualized, and all appropriate PPE in place as indicated accordance with transmission based precautions (B) How you will identify other residentaning potential to be affected by the same practice and what corrective ac will be taken; 1. By a quality review of screenings completed to ensure appropriate process in place for prevention of spread of No issues or concerns identified. 2. By a quality review of residents assessments completed to ensure no S/S of related to shandling of linen present. No issues or concerns identified.	hab ical 9 9 1 In nts tions staff

three-minute wet time did not need to be used.

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TATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 24TH ST N SAINT PETERSBURG, FL 33713	
CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE COMPLETION
at the one-minute contact an observed for viruses process upon entry to the it Nurse did not respond. Staff C, Certified NA) was observed as she left y closing the door behind hallway and removed gloves in cart was just outside of the inside of cart, without en, and removed a en returned to resident he door. She opened the side of the doorway and h to the resident. Staff C, he hall and used a 	F 88	3. By	coems f
	IDENTIFICATION NUMBER: 105202 ITATION CENTER TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) 10: 5 tat the one-minute contact en observed for viruses process upon entry to the all Nurse did not respond.	MEDICAID SERVICES [X1] PROVIDERCUPPLERCILA [X2] MULTIL 105202 ITATION CENTER 105202 ITATION CENTER TUBBLEY OF DEPLICIPATION (PARTICLE) 105 10 10 10 10 10 10 10 10 10 10 10 10 10	MEDICAID SERVICES [X1] PROVIDERSUPPLERCILIA IDENTIFICATION NAMEER 105202 ITATION CENTER 105202 ITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 24TH ST N SAINT PETERSBURG, FL 33713 TABBLEST OF DEPLICATIONS SAINT PETERSBURG, FL 33713 TABBLEST OF DEPLICATIONS VALUES THE PROCESSED BY TALL LSC IDENTIFYING INFORMATION) F 880 18 By a quality review or residents assessments completed to ensure no S/S of undiagnosed In cart was just outside of the Identified of cart, without ene, and removed a len returned to resident he door. She opened the side of the door was had the to the resident. Staff C, the hall and used a 0.35 a.m. Resident #6's & dosed. The door was alton caddy holding personal

precautions. Just then the room door was opened and Staff D. CNA exited the room holding two clear colored bags. One of the bags was observed with a yellow gown and the second bag contained resident personal clothing. She was asked as she entered the hallway where her shield was. She stated, "I was wearing one," She was asked where her ... shield was again. She did not respond as she walked down the hallway. Staff D walked the length of the North hall to a set of double doors at the end of the unit and continued to another set of double doors that lead to the outside of the facility. Staff D, CNA was asked if she had to leave the facility to dispose of the garbage and residents' personal clothing daily. She stated, "Yes, they moved our dirty linen

completed to ensure care system in place and functioning as designed and bedside drainage bags/tubing are not in contact with the floor. Issues or concerns were addressed as they were identified.

7. On _____ facility wide quality review of residents receiving transmission based precautions completed to ensure isolation caddles have appropriate personal protective equipment. No issues

or what systematic changes you will make to ensure that the practice does not recur;

(3) What measures will be put into place

or concerns identified.

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CENTERS	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO). 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		105202	B. WING _		05/	15/2020
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		TATION SENTER	- 1	1900 24TH ST N		
APULLU H	EALTH AND REHABILIT	IATION CENTER		SAINT PETERSBURG, FL 33713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	wear a shield in room," as she confirm protective equipment	e 6 e then added, "I forgot to (Resident #6's and #7's) ned the isolation personal (PPE) posted for their room included to wear a	F8	By Staff were re-educ by the Clinical Educator/Designee on components of this regulation with an emphasis on facility standards as it relates to process for screening	the	

A review of the Order Listing Reports dated and ... revealed Residents #6 and #7 were on droplet precautions as of DON revealed that both residents receive outside services and all residents that receive outside services are put on droplet precautions.

The DON identified a total of four residents (#6. #7, #10 and #11) that received outside services. Additionally, the facility provided a list that contained all of the four residents' names that revealed they had come in contact with the receptionist that was currently out of work after being tested positive for COVID-19.

4. At 10:50 a.m. Staff G, Licensed Practical Nurse (LPN) was observed standing in Resident #8's room, as the resident was noted sitting on the edge of his bed facing the nurse. On top of the over the bed side table an electronic machine with an attached cuff lay on its bare surface. Staff G, LPN removed her personal PPE equipment of gown and gloves, and exited the room carrying the electronic machine. She placed the machine next to two monitors that were sitting on the medication cart in the hall. Staff G. LPN returned to her medication cart after washing her for 3 seconds and opened up the right second drawer. which revealed a brown paper bag. She removed her N95 mask and placed it inside of the bag.

employees and cleaning/ equipment with adherence to recommended wet time, and competency with return demonstration conducted

- Staff were re-educated by the Clinical Educator/Designee on the components of this regulation with an emphasis on proper hygiene, and safe handling of linen, and competency with return demonstration conducted.
- 3. By Staff were re-educated by the Clinical Educator/Designee on the components of this regulation with an emphasis on facility standards regarding Transmission Based Precautions, and proper donning and doffing of Personal Protective Equipment, Competency with return demonstration conducted.
- , staff were re-educated by the Clinical Educator/Designee on the components of this regulation with an emphasis on Transmission Based Precautions inclusive of dedicated equipment, adherence to wet times during cleaning of shared equipment, and Universal Masking and Mask Conservation. Competency with return demonstration conducted.

.... Staff were re-educated

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	1 APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	
		105202	B. WING _			05/	15/2020
NAME OF P	ROVIDER OR SUPPLIER			51	FREET ADDRESS, CITY, STATE, ZIP CODE		
APOLLO I	HEALTH AND REHABILIT	TATION CENTER			000 24TH ST N AINT PETERSBURG, FL 33713		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	•	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Just at that time the F and was overheard te store the mask inside Medical record review Resident #8 and the A he had been a long-te facility with a history of failure. A review of his	tegional Nurse approached of the drawer. was conducted for Admission Record indicated arm care resident at the of	FE	380	by the Clinical Educator/Designee on tomponents of this regulation with an emphasis on facility standards regarding transmission Based Precautions, and proper donning and doffing of Persona Protective Equipment with an emphasion universal masking and shield utilization. Competency with return demonstration conducted. 6. By the Clinical	ng I	

time) 2 puff inhale orally every 4 hours as needed for () or with a start date of Resident #9 was the roommate for Resident #8 and his Admission Record was reviewed and

(90 Base) MCG/ACT (microgram/active clotting

revealed a readmission date of diagnoses of , failure and In review of his physician orders for ..., an indicated a routine .. that was performed four times a day (, . . . , . . -Solution 0. .5 (3) MG/3ML

..... with (acute) exacerbation started on , and Pullout suspension 0.25 MG/2 ML 4 ml inhale orally two times a day for _____ with (acute) exacerbation started on The was given by a small volume

(milligrams/milliliters) 3 ml inhale orally every 4

The Director of Nursing and the Regional Nurse had indicated that all residents that on receive are put on droplet

6. By ..., the Clinical Educator/designee reeducated facility staff on the components of this regulation with an emphasis on ensuring care system in place and functioning as designed for residents with . and bedside drainage bags/tubing are not in contact with the

7. By .. . the Clinical Educator/designee re-educated facility staff on the components of this regulation with an emphasis on personal protective equipment required for transmission based precautions, and locations/availability of PPE in the facility if items unavailable on isolation caddle.

Newly hired employees will receive education in orientation

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place; Area will be routinely monitored by IDT

members while performing their daily

hours related to

.... machine

floor.

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TABLEMENT OF DEFICIENCIES (XT) PROVIDER OR SUPPLER 105202 B. WING			ID HUMAN SERVICES			FORM APPR OMB NO. 0938	
APOLLO HEALTH AND REHABILITATION CENTER APOLLO HEALTH AND REHABILITATION CENTER (A4) ID PRETX (READ RESEARCH STATEMENT OF DERICISATION) FROM (REGULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 8 precautions and confirmed that shields need to be utilized upon entrance to the resident rooms. Review of the CDC and the World Health Organization hygiene guidelines revealed: Standard Precautions hygiene guidelines revealed: Standard Precautions handwashing with Soap and Water: O Apply soap to O Rub vigorously for at least 15 seconds, covering all surfaces of and O Rinse with water and dry thoroughly with paper towel O Use paper towel to turn off water faucet 2. Indications for Hygiene Always perform hygiene in the following situations: O Before touching a patient, even if gloves will be worn O Before exiting the patient's care area after touching the patient or the patient's immediate environment.	TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY	
APOLLO HEALTH AND REHABILITATION CENTER APOLLO HEALTH AND REHABILITATION CENTER SAINT PETERSBURG, FL 33713 SAINT PETERSBURG, FL 33713 SAINT PETERSBURG, FL 33713 B PROWIDERS PLAN OF CORRECTION OF PRICE PRIC			105202	B. WING _		05/15/202	0
APOLLO HEALTH AND REHABILITATION CENTER (CA) ID SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 8 precautions and confirmed that shields need to be utilized upon entrance to the resident rooms. Review of the CDC and the World Health Organization hygiene guidelines revealed: Standard Precautions Handwashing with Soap and Water: O Wet first with water (avoid using hot water) O Apply soap to O Rub vigorously for at least 15 seconds, covering all surfaces of and o Rinse with water and dry thoroughly with paper towel to Varie of Staffor Hygiene Always perform hygiene in the following situations: O Before touching a patient, even if gloves will be worn O Gefore exiting the patient's care area after touching the patient or the patient's immediate environment 2 months. SAINT PETERSBURG, FL 33713 PROVIDER'S PLAN OF CORRECTION DID COMPAN (CARCHON SHOULD BE (EACH OTION SHOULD BE CARDS SHOULD BE (EACH OTION SHOULD BE (EACH OTION SHOULD BE (EAC	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
F 880 Continued From page 8 precautions and confirmed that shields need to be utilized upon entrance to the resident rooms. Review of the CDC and the World Health Organization hygiene guidelines revealed: Standard Precautions Handwashing with Soap and Water: O Rot Water (a) O Rob vigorously for at least 15 seconds, covering all surfaces of and O Rinse with water and dry thoroughly with paper towel O Use paper towel to turn off water faucet 2. Indications for Hygiene a patient, even if gloves will be worn 0 Before exiting the patient or the patient's remediate environment SMANT PETERSBURG, L. 33713 PROMOBERS PLAN OF CONNECTION (EACH CORRECTION SHOULD BE COMPANY TO PREFIX AND A CONNECTION STATE AND A CRASS-REFERENCED TO THE APPROPRIATE ON A CRASS-REFERENCED TO THE APPROPRIATE OF A CRASS-REFE				1	1000 24TH ST N		
F 880 Continued From page 8 precautions and confirmed that shields need to be utilized upon entrance to the resident rooms. Review of the CDC and the World Health Organization hygiene guidelines revealed: Standard Precautions Handwashing with Soap and Water: O Wet first with water (avoid using hot water) O Rub vigorously for at least 15 seconds, covering all surfaces of and O Rinse with water and dry thoroughly with paper towel O Use paper towel to turn off water faucet 2. Indications for Hygiene Always perform hygiene in the following situations: O Before touching a patient, even if gloves will be worn O Before exiting the patient or the patient's immediate environment.	APOLLO I	HEALTH AND REHABILIT	TATION CENTER	1	SAINT PETERSBURG, FL 33713		
precautions and confirmed that shields need to be utilized upon entrance to the resident rooms. Review of the CDC and the World Health Organization hygiene guidelines revealed: Standard Precautions Handwashing with Soap and Water: O Wet first with water (avoid using hot water) O Rub vigorously for at least 15 seconds, covering all surfaces of and O Rinse with water and dry thoroughly with paper towel to turn off water faucet 2. Indications for Hygiene Always perform hygiene in the following situations: O Before touching a patient, even if gloves will be worn o Before exiting the patient's care area after touching the patient or the patient's immediate environment assigned area rounds, and during weekly Control Rowds. Staff will report any issues observed during morning meeting; with follow-up being validated daily by Executive Director/Designee. 1. The facility Director of Nursing Services/designee will conduct a Quality Review on alternating shifts to ensure staff are maintaining proper control practices during screening or construing or equipment with adherence to recommended wet time Daily x 4 weeks, and then 3 times weekly x 2 months. 2. The facility Director of Nursing Services/designee will conduct a Quality Review to staff or bearration of 5 staff on each unit to ensure staff are maintaining proper control practices 3 times weekly x 4 weeks, and then every week x 2 months.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP	D BE COMPL	ETION
O After contact with, or or of staff maintaining proper hygiene, and safe handling of linen. O Prior to performing an task (e.g., accessing a port, preparing an injection) O if will be moving from a contaminated-body site to a clean-body site during patient care. O After glove removal CDC Guideline for Hygiene in Health-Care Settings (available at: http://www.cdc.gov/mmwr/PDF/rr/ri5116.pdf) WHO Guidelines on Hygiene in Healthcare observation of staff maintaining proper	F 880	precautions and confit to be utilized upon en rooms. Review of the CDC at Organization his properties of the confidence	immed that shields need trance to the resident shields need trance to the resident shields need trance to the resident shields need shields	F8	assigned area rounds, and during w Control Rounds. Staff will it any issues observed during morning meeting; with follow-up being validat adily by Executive Director/Designed 1. The facility Director of Nursing Services/designee will conduct a Qu Review on alternating shifts to ensu staff are meintraining proper control practices during screening process, with an emphasis on cleaning/ of equipment v adherence to recommended wet tim Daily x 4 weeks, and then 3 times w x 2 months. 2. The facility Director of Nursing Services/designee will conduct a Qu Review via staff observation of 5 sts each unit to ensure staff are maintal proper control practices 3 1 weekly x 4 weeks, and then every w 2 months. Quality Review to include observation of staff maintaining prope fygiene, and safe handling of 3. The facility Director of Nursing Services/designee will conduct a Qu Review of residents receiving transmission based precautions to e staff are maintaining proper control practices 3 times weekly x 4 weeks, and then every week x 2 mo Quality Review to include visual	report ted autity re with eeekly stality aff on ning smess seek x visual visual iner. stality matity matity	

http://whqlibdoc.who.int/publications/2009/978924

appropriately donning and doffing PPE.

Facility ID: 55224

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CENTERS FOR MEDICARE & MEDICAID SERVICES					
ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED		
	105202	B. WING	05/15/2020		

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

1000 24TH ST N APOLLO HEALTH AND REHABILITATION CENTER SAINT PETERSBURG, FL 33713 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 880 | Continued From page 9 F 880 4. The facility Director of Nursing At 11:00 a.m. the Regional Nurse was Services/designee will conduct a Quality asked about bringing equipment into residents' Review of residents receiving rooms that are on droplet precautions. She transmission based precautions to ensure indicated that the residents should have their own staff are maintaining proper equipment, and if it were to be used it needed to control practices 3 times weekly x 4 be cleaned and prior to reuse. The weeks, and then every week x 2 months. Regional Nurse was asked about the Quality Review to include visual machine that still remained on the observation of staff maintaining proper medication cart that had not been cleaned after it. transmission based precautions inclusive was in an isolation room. Staff G, LPN confirmed of dedicated equipment, adherence to she had not cleaned it vet. At that time, she recommended wet times during cleansing removed a single bleach wipe from the of shared equipment, and maintaining medication cart. She first cleaned the bottom of control practices with appropriate the machine by swiping it one time. Then the top universal masking/mask conservation. of the machine was cleaned by one swipe. She then followed the same technique by the outside 5. The facility Director of Nursing of the cuff and the inside of the cuff with one Services/designee will conduct a Quality Review of 5 staff on each unit to ensure swipe. staff are maintaining proper The bleach wipe instructions indicated a contact control practices 3 times weekly x 4 time of one minute for viruses and a three-minute weeks, and then every week x 2 months. contact time for Neither of the two contact Quality Review to include visual times were observed. observation of staff maintaining proper transmission based precautions inclusive At 11:40 a m. Staff G, LPN was observed shield/ protection, and as she opened up and exited the room of maintaining appropriate control Resident #4 & #5, which was located directly practices with universal masking/mask

across from the conference room where the survey team was located. She immediately hung up a shield on the door and left the area. shield was not cleaned after it was brought out into the hallway on the North hall, as shield surface was observed dry. This observation was told to the Nursing Home Administrator as she walked into the conference

5. At 11:44 a.m. the call light went on for Resident

conservation. 6. The facility Director of Nursing

Services/designee will conduct a weekly

every 2 weeks x 2 months to ensure care

x 4 weeks, and then

quality review of residents with an

system in place and functioning as designed, with an emphasis on ensuring bag/tubing secured and not in

AN

FORM APPROVED

PRINTED: 06/15/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES EORM ARREOVED

CENTERS	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	. 0938-0391
	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105202	B. WING_		05/1	15/2020
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
APOLLO H	EALTH AND REHABILIT	TATION CENTER		1000 24TH ST N SAINT PETERSBURG, FL 33713		
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			F			
	droplet precautions by sign on the resident name was in the hallway and answer the call light, donning a gown, glow to entering the reside	in a room identified for y the "Stop. See Nurse," oom door. A staff member id directed Staff A, CNA to Staff A, CNA was observed es and surgical mask prior nts' room. The room door e was speaking with the		7. The facility Director of Nursing Services/designee will conduct a Qual Review of residents with transmission based precautions to ensure approprie personal protective equipment readily accessible in isolation caddles and sto appropriately daily x 4 weeks then 3 til	ate	

A medical record review was conducted for Resident #4 and the Admission Record indicated he had been at the facility for two months. His primary diagnosis was of Nursing Progress notes were reviewed and

resident and assisting with an article on the

opposite side of his bed. She removed her PPE

COVID." Staff A. CNA was asked if there were

bleach wipes in the room. She stated, no, they

are not kept in bedrooms or in the hallways. If

something needs to be cleaned, you need to go

at the doorway and exited the room. She was

asked at that time why neither a N95 mask had been worn when she entered the room. She stated. "Didn't know that room was

to the desk to get the wipes.

at 9:34 p.m. (21:34): "T (temperature) 100.8, c/o (complaint of) painful , 02 (, ,) sat (saturation) 95% on room air, no abnormal __ sounds are auscultated. Resident denied discomfort, provided prn (as needed) med (medication) with positive result (t 100), informed MD (medical doctor), ordered lab, Continue to monitor."

at 3:08 p.m. (15:08); " informed ... ARNP (Advanced Registered Nurse Practitioner) of cmp, (standard tests) and , results and members temp.97.6 this time, having loose stools x 3 today and

appropriately daily x 4 weeks then 3 times weekly x 2 months to ensure systematic process is in place and functioning as designed.

The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met and recommends quarterly monitoring by the Regional Director of Clinical Operations when completing their quality systems review.

revealed:

DEPARTMENT OF HEALTH AND HUMAN SERVICES STA

EFACTIVENT OF HEALTT AND HOWAN SERVICES						
ENTERS FOR MEDICARE & MEDICAID SERVICES CONTROL OF THE SERVICES						
STEMENT OF DEFICIENCIES O PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED			

105202 B. WING 05/15/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 24TH ST N APOLLO HEALTH AND REHABILITATION CENTER SAINT PETERSBURG, FL 33713 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES. COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 880 Continued From page 11 F 880 complains of at night received new orders: 500 mg po x 5 days, and screen swab. Hold colase x 3 days." at 10:01 p.m. (22:01): " (vitals), informed MD, ordered consult with at 1:53 a.m. vitals note Temperature Warning: " value: 100.0" " ... at 3:25 p.m. (15:25); "spoke with dr. ... regarding orders. Received orders to start resident on NS at 75ml/hr (milliliters per hour) x 2 liters, , specimen, , 2 gm (grams) q8hrs (daily) x 7 days, continue with 500 mg po (500 milligrams by times per day) x 7 days and stop ," at 2:51 a.m. vitals note: temperature 100.2. Physician orders for . . , . . . revealed that Resident #4 was started on droplet precautions on A medical record review was conducted for Resident #5 and the Admission Record indicated he was admitted to the facility on with a primary diagnosis of and type II with , . , . A review of the Order Listing Report dated revealed that Resident #5 was placed on droplet isolation - presumptive every shift with a revision on On around 10:03 a.m. an interview was conducted with the Director of Nursing (DON) and he confirmed that residents #4 and #5 were tested for COVID-19 and the results remained pending as of today (. . .). He was then asked about the delay in starting droplet precautions for Resident #4. His medical record indicated a

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STATEMENT C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER HEALTH AND REHABILIT	TATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 24TH ST N SAINT PETERSBURG, FL 33713		
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F 880	change in condition o "It was on a weekend orders. Even on the w weekend I didn't look" He confin 6. At 11:40 a.m. on observed from her do Her tubing al	e 12 n The DON stated, 1. I usually look at all the new weekend. That was one at the orders until Monday med that it was missed. "Resident #12 was porway entrance lying in bed. long with the drainage bag (photographic evidence	F 88	0		

observed sitting up in a chair in her bedroom she was positioned toward the television screen. Her lunch tray was sitting in front of her as she smiled at the surveyor standing outside of her room door. Resident #12 appeared comfortable and when she was asked how she was feeling today. She stated, "Better, after they finally got me out of bed. I don't like being in bed all the time." Resident #12's tubing and bag laid on the floor next to the chair. Staff H, LPN was in the hallway and she was asked if normal practice was to have tubing lie on the floor next to the bag. She stated, "No, it should not be on the floor."

At 1:10 p.m. on ... , Resident #12 was

Resident #12's Admission Record indicated that she had been readmitted to the facility on with primary diagnoses of ____ and ___, retention.

-Associated

III. Proper Techniques for , Keep the collecting bag below the level of the ... at all times. Do not rest the bag on the

... (CAUTI) revealed:

A review of the

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	0. 0938-0391
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 24TH ST N		
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F 880	floor.	/guidelines/	F 8	80		
	9:55 a.m. on the East had an isolation kit or showing, "Stop, see r	was conducted at t hall. Resident # n the door with a sign nurse before entering."				

There were gloves, gowns, and surgical masks in the kit. On the North hall, Resident . . #. had an isolation kit with gowns, surgical masks, gloves, and a sign on the door indicating, "Stop. Please see nurse before entering," and Resident # had a sign indicating, "Stop. Please see nurse before entering." There were gowns, surgical masks, gloves, and wipes in the isolation kit on the door. There were no goggles or

at 11:31 a.m. an interview was conducted with the Clinical Educator. She said . . , . . patients are all on isolation because they go in and out of the building. They are cohorted on the North wing. There are five. She reported they were located in

shields in any of the kits.

At 12:05 p.m. on an interview was conducted with the DON. He said all the residents are on droplet precautions presumptively.

At 2:26 p.m. on an interview was conducted with the DON. He said they check the isolation kits several times a day to ensure they are stocked and that whatever is listed on the signs should be in the caddy.

Event ID: 5C2U11

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	0. 0938-0391
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AFOLLO	TEALTH AND REHABILI	IATION CENTER		SAINT PETERSBURG, FL 33713		
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						<u> </u>
F 880	Continued From page	∋ 14	F 88	0		
	An additional observa	ation on at 9:13 a.m.				
		or for Resident #.				
		urse before entering." The				
		ing droplet precautions. The				
	PPE, indicted on the					
		and shield or goggles.				
		ation of the sign on Resident				
		ting, "Stop. Please see nurse				
		ealed it was green, indicating				
		The PPE indicated on the				
		a gown, gloves, mask, and				
		s. An additional observation				
		he door above the isolation				
		# indicated the need				
	for gloves, gowns, ma	ask, goggles or a				
	shield.					
	Davious of Attachmos	nt A. Centers for Medicare				}
		es (CMS) Long Term Care				
		ol Worksheet LTC Facility				
	Self-Assessment Too					
	the following:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
		ies necessary for adherence				
		otective equipment use				
	(e.g., gloves, gowns,					
		t care areas (i.e., nursing				
		and resident rooms). The				
	box was checked 'yes					
	A review of the Coror					
		ness Checklist for Nursing				
		ng-term Care Settings,				
		e following information:				
	Supplies and Resour					
		supplies necessary to adhere				
	to recommended IPC					
	(bullet 5) Necessary I	PPE is available immediately				1

outside of the resident room and in other areas

Facility ID: 55224

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CENTERS FOR MEDICARE & MEDICAID SERVICES				
D DI AN DE CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED	
	105202	B. WING	05/15/2020	

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

APOLLO HEALTH AND REHABILITATION CENTER			1000 24TH ST N SAINT PETERSBURG, FL 33713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
F 880	Continued From page 15 where resident care is provided. The box was marked "completed." (bullet 6) Facilities should have supplies of facemasks, (if available and the facility has a , protection program with trained, medically cleared, and fit-tested HCP), gowns, glowes, and . , protection (i.e., shield or goggles). The box was marked "completed." A review of the facility's policy titled, "Manual: Control Standards and Guidelines: Transmission Based Precautions," with an issue date of , revealed: "Droplet - small droplets that contain organisms that can be expelled for up to 3 by coughing or sneezing. A susceptible host can contract the by inhaling these organisms or through contact with (, , , and), (Utilize Green "Stop and See Nurse" signage outside resident room or on door," and "It is important to use the standard approaches, as defined by the CDC for transmission-based precautions: airborne, contact, and droplet precautions. The category of	F 880			
	transmission-based precaution determines the type of PET to be used. Communication (e.g., verbal reports, signage) regarding the , type of precaution to be utilized is important. When transmission-based precautions are in place, PPE should be readily available. Proper washing remains a key preventive measure.			***************************************	

precaution employed."

regardless of the type of transmission-based

The section titled, "Guidelines for Contact Precautions, Gloves," revealed: 5. Wearing gloves is not a substitute for Gloves will be removed and discarded before leaving the resident's room, . . will immediately

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PRINTED: 06/15/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL(ER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 105202 B. WING 05/15/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 24TH ST N APOLLO HEALTH AND REHABILITATION CENTER SAINT PETERSBURG, FL 33713 PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 880 Continued From page 16 F 880 be washed with soap, and water or a waterless will be used.

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Agency for	or Health Care Adminis	tration				
AND DEAN OF CODDICATION INTERIOR SERVICE AND AN INDEED.		1 ' '	E CONSTRUCTION	(X3) DATE S COMPLI		
		55224	B. WING		05/1	5/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	ATE, ZIP CODE		
APOLLO	HEALTH AND REHABILIT	TATION CENTER 1000 24T SAINT P	M S I N ETERSBURG, FI	L 33713		
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N 000	INITIAL COMMENTS		N 000			
N 201 SS=E	Rehabilitation. There the time of the visit.	at Apolio Health and were deficiencies found at ht to Adequate and	N 201			
	health care and prote including social servic if available; planned r therapeutic and rehat with the resident care recognized practice s	dequate and appropriate ctive and support services, ess, mental health services, ecreational activities; and olititative services consistent plan, with established and tandards within the rules as adopted by the				
	Based on observation policy review, and rev Control and I facility did not provide health care related to and implement best evidence by: 1. a scre services was not clea following the recomm time, 2. Staff not was resident care area, 3.	Prevention guidelines, the a dequate and appropriate not properly maintaining practices for COVID-19 as sening device (,		Preparation and/or execution of this does not constitute admission or agreement by the provider of the trut the facts alleged or conclusions set for on the statement of deficiencies. This of correction is prepared and/or exec solely because required. (1) What corrective action(s) will be accomplished for those residents four have been affected by the deficient practice;	h of orth s plan outed	

and not properly storing a utilized N95 mask

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

personal protective equipment (PPE) for two

dedicated resident equipment on droplet

precautions and not cleaning a reusable

residents (#6 and #7) of four residents on

device by its recommended contact time

isolation for droplet precautions, 4, not providing

Electronically Signed /20

1. On

re-educated by the Clinical

Educator/Designee on the components of

this regulation with an emphasis on facility

standards as it relates to process for

screening employees and cleaning of

equipment. Validation of competency

TITLE

Staff Member A was

(X6) DATE

STATE FORM 5C2U11 If continuation sheet 1 of 15

PRINTED: 06/15/2020 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 55224 05/15/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 24TH ST N APOLLO HEALTH AND REHABILITATION CENTER SAINT PETERSBURG, FL 33713 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 201 Continued From page 1 N 201 appropriately, 5. not donning required PPE to completed by visual observation. assist two residents (#4 and #5) on droplet On Resident (# .?) precautions, 6. not maintaining tubing for an and the drainage bag off the was assessed by a licensed nurse, and floor to potentiate cross contamination for one sustained no ill effects related to potential resident (#12) of 14 residents with related to safe handling of linen. ..., and 7. not having appropriate PPE readily accessible in the isolation caddies for On Staff Member C was three of three resident rooms (#_, ... re-educated by the Clinical # .and #) indicated as droplet Educator/Designee on the components of this regulation with an emphasis on proper precautions. hygiene and safe handling of linen. Findings included: Validation of competency completed by visual observation. Review of the CDC and the World Health Organization hygiene guidelines revealed: , Residents # 6 and #7 Standard Precautions were assessed by a licensed nurse and Handwashing with Soap and Water: sustained no ill effects related to potential o Wet . . . first with water (avoid using hot failure of staff to don shield. water) o Apply soap to On Staff Member D was o Rub vigorously for at least 15 seconds. re-educated by the Clinical covering all surfaces of and Educator/Designee on the components of with water and dry thoroughly with this regulation with an emphasis on facility standards regarding Transmission Based paper towel

contaminated-body site to a clean-body site

o Use paper towel to turn off water faucet

o Before touching a patient, even if gloves will be

o Before exiting the patient's care area after

o After contact with , or

o Prior to performing an . . . , . . task (e.g.,

accessing a port, preparing an injection)

. will be moving from a

touching the patient or the patient's immediate

hygiene in the following

2. Indications for . . . Hygiene

Always perform

situations:

environment

Precautions, and proper donning and

visual observation.

doffing of Personal Protective Equipment. Validation of competency completed by

4. On, Staff Member G was

re-educated by the Clinical Educator and

the components of this regulation with an

Validation of competencies completed by

visual observation. Additionally, identified

emphasis on Transmission Based Precautions, cleaning of shared

equipment, and Universal Masking.

items and med cart were

Regional Director of Clinical Operations on

PRINTED: 06/15/2020 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 55224 05/15/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 24TH ST N APOLLO HEALTH AND REHABILITATION CENTER SAINT PETERSBURG, FL 33713 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG DEFICIENCY) N 201 | Continued From page 2 N 201 during patient care cleansed with adherence to appropriate o After glove removal wet time CDC Guideline for . Hygiene in Health-Care Settings (available at: On . Residents #4 and #5 were http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf) assessed by a licensed nurse and WHO Guidelines on Hygiene in Healthcare sustained no ill effects related to potential 2009 (available at: failure of staff to don shield. http://whqlibdoc.who.int/publications/2009/978924 5. On, Staff Member A was 1597906 eng.pdf) re-educated by the Clinical 1. On ... at 9:15 a.m. the survey team Educator/Designee on the components of entered the facility as Staff A. Transportation this regulation with an emphasis on facility Coordinator/Certified Nursing Assistant (CNA). standards regarding Transmission Based donned in gloves and a mask, stood at the Precautions, and proper donning and entrance telling the surveyors to use the doffing of Personal Protective Equipment. sanitizer. She picked up a touchless thermometer Validation of competency completed by and . __ , that lay on top of a visual observation. white foam tray. The temperature was taken followed by the After the On , Residents #4 and #5 were temperature and were used, she placed assessed by a licensed nurse and them directly on top of the receptionist desktop sustained no ill effects related to potential without cleaning the equipment. Staff A then failure of staff to don shield completed the questioning process. She was asked at that time if she was the designated 6. On , Resident #12 assessed person that performed the screening. She said by licensed nurse, and sustained no ill that she was the Transportation Coordinator and effects drainage bag/tubing was

pair of purple gloves over the top of his utility

sanitizer.

was only filling in until the receptionist arrived.

At 9:18 a.m. Staff A was observed as she donned

the thermometer for a total of three seconds. She

At 9:20 a.m. an outside vendor was allowed to enter the front entrance. He was observed

he waited at the receptionist desk, he donned a

... and

While

a pair of gloves. She removed one bleach wipe

from a container and cleaned the

wearing cloth utility gloves on both

then removed the gloves and used .

not in contact with the floor during this

staff member re-educated by the Clinical

care and emptying of a bedside drainage bag. Follow up education and competency completed by Clinical Educator on _

appropriate PPE in place as indicated in

accordance with transmission based

. resident isolation

a competency was completed for ...

caddies were visualized, and all

Educator on appropriate

Staff member H and rehab

care and

review.

Ωn

STATEMENT	or Health Care Adminis	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	FORM (X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
		55224	B. WING		05/1	5/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ATE, ZIP CODE		
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N 201	Continued From page	3	N 201			
	the that has seconds, letting the w glove off. He removed as as he placed it in the placed both the the directly on it desktop. A cell phone observed lying on top the used as the vendor donner exception area. The ewere not cleaned. A nurse was standing entrance with her unif from a hospice agence.	ne bare surface of the began to ring as it was of the desk positioned next Staff A picked up the phone this gloves and left the equipment and desktop		precautions (B) How you will identify other reside having potential to be affected by the same practice and what corrective ac will be taken; 1. By a quality review of screenings completed to ensure appropriate process in place for prevention of spread of No issues or concerns identified. 2. By a quality review of residents assessments completed to ensure no S/S of related to shandling of linen present. No issues or concerns identified.	tions staff	
	to open the doo Staff A performed the thermometer, hospice nurse. Staff A	same process with the and questionnaire with the		By a quality review of residents assessments completed to ensure no S/S of undiagnosed symptoms present. No issues or concidentified. 4. By a quality review of	:erns	

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and

Staff A donned a pair of gloves and removed one

bleach wipe from the container. She used the one

was never cleaned, nor the surface of the desk where the thermometers and were set.

The container of the bleach wipes contained

. (

wipe surface with wipe until completely wet. 3. To

directions for use that revealed: 2.

, allow surface to remain wet for contact time: -30 seconds, Viruses - 1 minute

) spores- 3

wipe to clean two thermometers and two, for a total of 12 seconds. The phone

STATE FORM caso 5C2U11 If continuation sheet 4 of 15

residents assessments completed to

5. By a quality review of residents assessments completed to

ensure no S/S of undiagnosed

symptoms present. No issues or concerns

....., facility wide quality

ensure no S/S of undiagnosed symptoms present. No issues or concerns

identified

identified.

6. On .

review of residents with

Agency for Health Care Administ	ration			PRINTED: 06/15/2020 FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 201 Continued From page	4	N 201		AAC MAAA MAAA
visible soil is removed needed for high-touch soiled clothes. Contac remain wet for 1 minur organisms, see directi (Photographic evident. The Regional Nurse w approximately 2:00 p. contact time for the bit had been utilizing duri She indicated that the anyone with three-minute wet time She was informed that time had also not beel during the screening p facility. The Regional 2. At 10:10 a.m. on Nursing Assistant (CM. Resident by her. She stood in the I to both A linen room as she reached practicing hygier washolds. Staff C the	g and/or scrubbing, until all . Special attention is surfaces. Do not reuse t time: allow surfaces to test, let air dry, for all other ons for contact times. Zee obtained) as asked on at m. for the manufacturer's beach wipes that the facility ng the screening process. facility does not have		completed to ensure care system in place and functioning as designed and bedside drainage bags/tubing are not in contact with the floor. Issues or concerns were addres as they were identified. 7. On facility wide quality review of residents receiving transmis based precautions completed to ensuisolation caddies have appropriate personal protective equipment. No isso or concerns identified. (3) What measures will be put into pla or what systematic changes you will in one ensure that the practice does not result to ensure that the practice does not result to ensure that the practice does not result to ensure the clinical Educator/Designee on components of this regulation with an emphasis on facility standards as it re to process for screening employees a cleaning/ of equipment will adherence to recommended wet time, competency with return demonstration conducted. 2. By Staff were re-educe by the Clinical Educator/Designee on	sed / / sion re uses ce nake socur; the lates nd h and

precautions. Just then the room door was opened AHCA Form 3020-0001

sanitizer to her

3. On

handed the washcloth to the resident. Staff C.

at 10:35 a.m. Resident #6's &

CNA walked across the hall and used a

#7's room door was closed. The door was

observed with an isolation caddy holding personal protective equipment and a sign indicating droplet

STATE FORM caso 5C2U11 If continuation sheet 5 of 15

components of this regulation with an

components of this regulation with an

emphasis on facility standards regarding

emphasis on proper . . hygiene, and

safe handling of linen, and competency with return demonstration conducted.

3. By Staff were re-educated by the Clinical Educator/Designee on the

PRINTED: 06 FORM API STATEMENT OF DEFICIENCIES (X1) PROVIDENSUPPLIERCLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
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N 201	Continued From page	5	N 201			
	clear colored bags. O observed with a yello contained resident pe asked as she entered shield was. She state was asked where her will not respond as sh Staff D walked the ler of double doors at the continued to another to the outside of the f asked if she had to le the garbage and residually. She stated, "Ye room for "She wear a shield in room," as she confirm rotective equipment (droplet precautions) shield upon entry. A review of the Order and "7 were on droplet for were on droplet for the order and "# of were on droplet for the Order and "# of were on droplet for one of the order and "# of were on droplet for the order and "# of were on droplet for the order and "# of were on droplet for ONO revealed that be	w gown and the second bag resonal clothing. She was the hallway where herd., "I was wearing one," Sheshield was again. She is walked down the hallway. I was good the unit and set of double doors that lead sacility. Staff D. CNA was ave the facility to dispose of fents' personal clothing s, they moved our dirty linen then side of the unit and set of double doors that lead sacility. Staff D. CNA was ave the facility to dispose of fents' personal clothing s, they moved our dirty linen then sided. "I forgot to (Resident #6's and #7's) led the isolation personal ((PPE) posted for their room included to wear a Listing Reports dated evealed Residents #6 and ecautions as of The thresidents receive outside		Transmission Based Precautions, and proper donning and doffing of Person Protective Equipment. Competency w return demonstration conducted. 4. By , staff were re-educe by the Clinical Educator/Designee on components of this regulation with an emphasis on Transmission Based Precautions inclusive of dedicated equipment, adharence to wet times do cleaning of shared equipment, and Universal Masking and Mask Conservation. Competency with return demonstration conducted. 5. By Staff were re-educe by the Clinical Educator/Designee on components of this regulation with an emphasis on facility standards regard Transmission Based Precautions, and proper donning and doffing of Person protective Equipment with an emphase universal masking and shield utilization. Competency with return demonstration conducted.	al ith ated the uring n ated the ing	
		all residents that receive out on droplet precautions.		6. By , the Clinical		

The DON identified a total of four residents (#6.

services. Additionally, the facility provided a list

that revealed they had come in contact with the receptionist that was currently out of work after

Practical Nurse (LPN) was observed standing in

Resident #8's room, as the resident was noted

, Staff G, Licensed

#7. #10 and #11) that received outside

that contained all of the four residents' names

being tested positive for COVID-19.

4. At 10:50 a.m.

STATE FORM caso 5C2U11 If continuation sheet 6 of 15

Educator/designee reeducated facility staff

on the components of this regulation with

an emphasis on ensuring care system in

place and functioning as designed for

contact with the floor.

residents with , and bedside drainage bags/tubing are not in

..... the Clinical

staff on the components of this regulation

with an emphasis on personal protective

Educator/designee re-educated facility

Agency f	or Health Care Adminis	tration				0: 06/15/2020 1 APPROVES
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
55224		B. WING		05/15/2020		
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APOLLO	HEALTH AND REHABILIT	TATION CENTER 1000 24TH				
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N 201	Continued From page	6	N 201			
	sitting on the edge of On top of the over the electronic attached cuff lay on it. LPN removed her per gown and gloves, and the electronic placed the machine in monitors that were sit in the hall. Staff G, LF medication cart after seconds and opened which revealed a brown her NS5 mask and plaust at that time the F and was overheard te store the mask inside Medical record review	his bed facing the nurse. It bed side table an machine with an same surface. Staff G, sonal PPE equipment of the exited the room carrying machine. She exit to two ting on the medication cart in returned to her washing her for 3 up the right second drawer, wn paper bag. She removed aced it inside of the bag. tegional Nurse approached tiling Staff G, LPN you can't of the drawer.		equipment required for transmission based precautions, and locations/availability of PPE in the facilems unavailable on isolation caddle. Newly hired employees will receive education in orientation (4) How the corrective action(s) will be monitored to ensure the practice will recur, i.e., what qualify assurance pro will be put in place; Area will be routinely monitored by ID members while performing their daily assigned area rounds, and during we control Rounds. Staff will re any issues observed during morning meeting; with follow-up being validate daily by Executive Director/Designee.	e not gram T T ekly	
	facility with a history of failure. A review of his indicated ProAir (90 Base) MCG/ACT time) 2 puff inhale ora for (and sphysician orders for HFA Aerosol Solution 108 (microgram/active clotting ally every 4 hours as needed of the second		The facility Director of Nursing Services/designee will conduct a Qua Review on alternating shifts to ensure are maintaining proper contr practices during screening process, w an emphasis on cleaning/. equipment with adherence to recommended wet time Daily x 4 we and then 3 times weekly x 2 months.	staff ol ith of	

Solution 0. .5 (3) MG/3ML AHCA Form 3020-0001

Resident #9 was the roommate for Resident #8

and his Admission Record was reviewed and

revealed a readmission date of and

diagnoses of ______, failure and

indicated a routine

In review of his physician orders for ..., an

performed four times a day (, ...,

that was

2. The facility Director of Nursing

Services/designee will conduct a Quality

Review via staff observation of 5 staff on

each unit to ensure staff are maintaining proper control practices 3 times

weekly x 4 weeks, and then every week x

2 months. Quality Review to include visual

hygiene, and safe handling of linen.

observation of staff maintaining proper

Agency for	Health Care Adminis	tration				: 06/15/2020 APPROVE
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		55224	B. WING		05/1	5/2020
NAME OF PRO	VIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
APOLLO HE	ALTH AND REHABILIT	ATION CENTER 1000 24TH SAINT PE	I ST N TERSBURG, F	L 33713		
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	nours related to with (acute) e and Pullouts un in hade orally two tire elated to with (acute) exacerba with (acute) exacerba machine. The Director of Nursir on thad indica eceive precautions and confine or be utilized upon en commons. At 11:00 a.m. saked about bringing common that indicated that the resignation of the production of t	a mi inhale orally every 4 exacerbation started on spension 0.25 MG/2 ML 4 mess a day for	N 201	3. The facility Director of Nursing Services/designee will conduct a Qua Review of residents receiving transmission based precautions to en staff are maintaining proper control practices 3 times weekly x 4 weeks, and then every week x 2 mond Quality Review to include visual observation of staff maintaining prope transmission based precautions, and appropriately donning and doffing PPI 4. The facility Director of Nursing Services/designee will conduct a Qua Review of residents receiving transmission based precautions to en staff are maintaining proper control practices 3 times weekly x 4 weeks, and then every week x 2 mond Quality Review to include visual observation of staff maintaining proper transmission based precautions included by the control practices of the properties	sure hs. f sure hs. r sive sive sing with	

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swipe.

contact time for

times were observed.

the machine by swiping it one time. Then the top

of the machine was cleaned by one swipe. She

of the cuff and the inside of the cuff with one

then followed the same technique by the outside

The bleach wipe instructions indicated a contact

time of one minute for viruses and a three-minute

. Neither of the two contact

Services/designee will conduct a Quality

weeks, and then every week x 2 months. Quality Review to include visual

transmission based precautions inclusive

shield/__, protection, and

control

observation of staff maintaining proper

Review of 5 staff on each unit to ensure

control practices 3 times weekly x 4

staff are maintaining proper

maintaining appropriate

Agency f	or Health Care Adminis	tration): 06/15/202 1 APPROVE
Agency for Health Care Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AND PLAN OF CORRECTION BETTI OF THE PROVIDER'S SUPPLIER'CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		55224	B. WING		05/1	5/2020
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APOLLO	HEALTH AND REHABILIT	TATION CENTER 1000 24TH SAINT PE	H ST N ETERSBURG, F	L 33713		
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N 201	across from the confe survey team was loca up a shield on the shield was reported to the shield was reported to the shield was reported to the shield surfactors. 5. At 11.44 a.m. the c #4 & #5, who resided droplet precautions by sign on the resident read was in the hallway an answer the call light. donning a gown, glove entering the resident resident and assisting opposite side of his b at the doorway and et asked at that time who have the saked at that the saked at that time who have the saked at that the saked at that the saked at the saked at that the saked at the saked at that the saked at the saked at that the saked at that the saked at that the saked at the saked	Staff G, LPN was observed of exited the room of ich was located directly rence room where the ted. She immediately hung e door and left the area. In the content of the area of cleaned after it was allway on the North hall, as e was observed dry. This to the Nursing Home walked into the conference all light went on for Resident in a room identified for the "Stop. See Nurse." oom door. A staff member of directed Staff A, CNA to Staff A, CNA to Staff A, CNA to so observed es and surgical mask prior nts' room. The room door ewas speaking with the	N 201	practices with universal masking/mas conservation. 6. The facility Director of Nursing Services/designee will conduct a wee quality review of residents with an every 2 weeks x 2 months to ensure c system in place and functioning as designed, with an emphasis on ensure in bag/tubing secured and not it contact with the floor. 7. The facility Director of Nursing Services/designee will conduct a Qua Review of residents with transmission based precautions to ensure appropripersonal protective equipment readily accessible in isolation caddies and st appropriately daily x 4 weeks then 3 the appropriately daily x 6 weekly x 2 months to ensure systems process is in place and functioning as designed.	kly en are ing n lity ate ored mes tic	

room. She stated, "Didn't know that room was

COVID." Staff A. CNA was asked if there were

bleach wipes in the room. She stated, no, they

are not kept in bedrooms or in the hallways. If

something needs to be cleaned, you need to go

A medical record review was conducted for Resident #4 and the Admission Record indicated he had been at the facility for two months. His primary diagnosis was of . Nursing Progress notes were reviewed and

to the desk to get the wipes.

Committee monthly until committee

determines substantial compliance has

been met and recommends quarterly

quality systems review.

monitoring by the Regional Director of

Clinical Operations when completing their

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND FLAN OF CORRECTION

STATEMENT OF DEFICIENCY

STATEME

NAME OF PROVIDER OR SUPPLIER		STREET ADDRES	S, CITY, STAT	E, ZIP CODE	1
APOLLO HEALTH AND REHABILITATION CENTER		1000 24TH ST N SAINT PETERSBURG, FL 33713			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY TU REGULATORY OR LSC IDENTIFYING INFORMATIC		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
N 201	Continue to monitor." at 3.08 p.m. (15.08); "informed ARNP (Advanced Registered Nurse Practitio of crip. (slandard tests) and results and members temp.97.6 this time, having loose stools x 3 today and complains of to this time, having loose stools x 3 today and complains of to make the complains of to make the complains of to make the complains of at 1.00.1 p.m. (22.01); " (vitals), informed MD, ordered consult with " at 1.53 a.m. vitals note Temperature Warning; "value: 100.0" " at 3:25 p.m. (15.25); "spoke with dregarding orders. Received orders to store stresslent on NS at 75mi/hr (millitiers per hour litters per day) x 7 days, continue with 500 mg po (500 milligrams by two times per day) x 7 days, continue with " at 2:51 a.m. vitals note: temperature 100.2. Physician orders for revealed that Resident #4 was started on droplet precaution A medical record review was conducted for Resident #5 and the Admission Record indic-	a) D D dent med	1 201		
	he was admitted to the facility on with primary diagnosis of	n a stage			vanious.

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PRIN' Agency for Health Care Administration						
AND DI AN OF CODDECTION INCIDENTIFICATION NUMBERS		1 ' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		55224	B. WING		05/1	15/2020
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APOLLO	HEALTH AND REHABILIT	TATION CENTER 1000 24	TH ST N ETERSBURG, FL	33713		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
N 201	Report dated was placed on drople every shift will on around 10 conducted with the Dihe confirmed that res tested for COVID-19 . pending as of today (about the delay in star Resident #A. His med change in condition o'll was on a weekend o'll was on a weekend I didn't look weekend I didn't look delay in star weekend I didn't look delay in star weekend I didn't look delay in the confirmed	with with with Corder Listing revealed that Resident #5 tisolation - presumptive th a revision on	N 201			

AHCA Form 3020-0001

was to have

should not be on the floor."

lunch tray was sitting in front of her as she smiled at the surveyor standing outside of her room door. Resident #12 appeared comfortable and when she was asked how she was feeling today. She stated, "Better, after they finally got me out of bed. I don't like being in bed all the time." Resident #12's tubing and bag laid on the floor next to the chair. Staff H, LPN was in the hallway and she was asked if normal practice

was to have tubing lie on the floor next to the bag. She stated, "No, it

tubing lie on the

PRINTED: 06/15/2020 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 55224 05/15/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 24TH ST N APOLLO HEALTH AND REHABILITATION CENTER SAINT PETERSBURG, FL 33713 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 201 Continued From page 11 N 201 Resident #12's Admission Record indicated that she had been readmitted to the facility on with primary diagnoses of and . . retention. A review of the-Associated . . . , . (CAUTI) revealed: Maintenance Keep the collecting bag below the level of the at all times. Do not rest the bag on the floor https://www.cdc.gov/ /guidelines/ /index.html#anchor 1552413731. 7. An observation on was conducted at 9:55 a.m. on the East hall, Resident had an isolation kit on the door with a sign showing, "Stop, see nurse before entering," There were gloves, gowns, and surgical masks in the kit. On the North hall, Resident an isolation kit with gowns, surgical masks, gloves, and a sign on the door indicating, "Stop. Please see nurse before entering," and Resident # had a sign indicating, "Stop. Please see nurse before entering." There were gowns,

surgical masks, gloves, and wipes in the isolation kit on the door. There were no goggles or

at 11:31 a.m. an interview was conducted with the Clinical Educator. She said patients are all on isolation because they go in and out of the building. They are cohorted on the North wing. There are five. She reported they were located in At 12:05 p.m. on ... an interview was conducted with the DON. He said all the

shields in any of the kits.

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 55224 B. WING ____ 05/15/2020

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

APOLLO HEALTH AND REHABILITATION CENTER SAINT PETERSBURG, FL 33713							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
N 201	Continued From page 12 residents are on droplet precautions presumptively. At 2:26 p.m. on an interview was conducted with the DON. He said they check the isolation kits several times a day to ensure they are stocked and that whatever is listed on the signs should be in the caddy. An additional observation on of the sign on the door for Resident #. indicated "Stop see nurse before entering." The sign was green indicting droplet precautions. The PPE, indicated on the of the sign, was a gown, gloves, mask, and shield or goggles. An additional observation of the sign on Resident # door indicating, "Stop. Please see nurse before entering," revealed it the sign on Resident # door indicating, "Stop. Please see nurse before entering," revealed it was green, indicating droplet precautions. The PPE indicated on the of the sign was a gown, gloves, mask, and	N 201					
	shield or goggles. An additional observation of the green sign on the door above the isolation caddy for Resident # indicated the need for gloves, gowns, mask, goggles or a shield. Review of Attachment A, Centers for Medicare and Medicaid Services (CMS) Long Term Care and Medicaid Services (CMS) Long Term Care (LTC) Control Worksheel LTC Facility Self-Assessment Tool, dated revealed the following: (page 16) G.1. Supplies necessary for adherence to proper personal protective equipment use (e.g., gloves, gowns, masks) are readily accessible in resident care areas (i.e., nursing units, , rooms, and resident rooms). The box was checked 'yes'.						
	A review of the Coronavirus 2019 (Covid-19) Preparedness Checklist for Nursing			and the same of th			

05/15/2020

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ____

55224

B MING STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER 1000 24TH ST N APOLLO HEALTH AND REHABILITATION CENTER SAINT PETERSBURG, FL 33713 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 201 | Continued From page 13 N 201 Homes and other Long-term Care Settings, undated, reflected the following information: Supplies and Resources The facility provides supplies necessary to adhere to recommended IPC practices including: (bullet 5) Necessary PPF is available immediately outside of the resident room and in other areas where resident care is provided. The box was marked "completed." (bullet 6) Facilities should have supplies of facemasks, ... (if available and the facility has a , protection program with trained, medically cleared, and fit-tested HCP). gowns, gloves, and protection (i.e., shield or goggles). The box was marked "completed." A review of the facility's policy titled, "Manual: Control Standards and Guidelines: Transmission Based Precautions," with an issue date of , revealed: "Droplet - small droplets that contain organisms that can be expelled for up to 3 ... by coughing or sneezing. A susceptible host can contract the by inhaling these organisms or through contact with (., ..., and). (Utilize Green "Stop and See Nurse" signage outside resident room or on door)," and "It is important to use the standard approaches, as defined by the CDC for transmission-based precautions: airborne, contact, and droplet precautions. The category of transmission-based precaution determines the type of PPE to be used. Communication (e.g., verbal reports, signage) regarding the type of precaution to be utilized is important. When transmission-based precautions are in place, PPE should be readily available. Proper washing remains a key preventive measure, regardless of the type of transmission-based

Agency 1	for Health Care Adminis	tration				: 06/15/2020 I APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		URVEY	
		55224	B. WING		05/1	5/2020
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
APOLLO	HEALTH AND REHABILIT	SAINT P	H ST N ETERSBURG, FL			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES AMUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
N 201	precaution employed. The section titled, "Grecautions, Gloves," gloves is not a substit Gloves will be remove leaving the resident's be washed with soap.	" uidelines for Contact revealed: 5. Wearing ute for ed and discarded before	N 201			

AHCA Form 3020-0001