DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105390	A. BUILDING _____ B. WING _____	C 07/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACARANDA MANOR	4250 66TH ST N SAINT PETERSBURG, FL 33709

(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) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Focused Control COVID-19 intervening survey was conducted on at Jacaranda Manor in conjunction with a complaint investigation for #2020012112. The facility was not in compliance with 42 CFR 483, Requirements for Long Term Care Facilities related to deficiencies cited on the visit.	F 000		

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

Electronically Signed /2020

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.

Agency for Health Care Administration

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N 000	INITIAL COMMENTS An unannounced Focused Control COVID-19 survey was conducted on . . . . . at Jacaranda Manor in conjunction with a complaint investigation for #2020012112. The facility had deficncies identified at the time of the visit.	N 000		
N 201 SS=E	400.022(1)(l), FS Right to Adequate and Appropriate Health Care The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on observations, policy and record reviews, and interviews the facility failed to provide adequate and appropriate health care and protective and support services consistent with established and recognized practice standards within the community, and with rules as adopted by the agency in regards to control practices to prevent the development and spread of COVID-19. The facility failed to ensure 1. residents were wearing masks or encouraged to wear masks for 6 (#7, #8, #9, #10, #11, #12) of 50 residents in the facility who could move about on their own, 2. staff practiced hygiene as necessary, 3. two of two housekeeping staff interviewed were aware of cleaning techniques needed to kill microorganisms, 4. staff were wearing PPE (personal protective equipment) correctly regarding 4 staff observed during the visit, and 5. staff maintained procedures for	N 201	N 201 1. Residents 7, 8, 9, 10, 11 & 12 were not identified. Nursing staff re-educated to remind/encourage and offer residents a mask by ADON or designee by . Staff Q was not identified. ADON/Designee re-educated Nursing staff to don gloves when placing mask on residents by . Staff O was not identified. ADON/designee re-educated Nursing staff regarding control standards and guidelines related to proper PPE use by . Staff D was not identified. ADON/designee reeducated nursing staff on proper use of spray and proper kill-time by . . . . . Staff A was not identified. ADON/Designee re-educated nursing staff on control standards and	

AHCA Form 3020-0001

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N 201	Continued From page 1 reverse isolation for one (#4) of one residents requiring reverse isolation. Findings included: Review of the ESS (Emergency Status System) facility submitted information for . . . revealed the facility census was 191 with 87 COVID19 positive residents in-house and a total of 38 COVID19 positive staff members. 1. During the initial tour of the facility on from 8:26 AM to 8:55 AM the following residents were noted to be either sitting or ambulating around the hallways of the L2 and 2E Units. The units did not contain COVID 19 positive residents or residents suspected of having COVID 19. Resident #8 was noted to be walking around the nurse's station and the hall with no . . . mask. Resident #9 was noted to be walking around the unit, with no . . . mask on. Resident #10 was noted to be sitting in the hallway with no . . . mask on. Resident #11 was sitting in the hallway with no . . . mask on. Resident #12 was observed in the hallway with no . . . mask on. Resident #7 was noted ambulating around the halls with no . . . mask on. During the observation staff were noted to walk and forth through the hallway attending to their tasks. At no time during this observation were staff observed to encourage or assist residents #7, #8, #9, #10, and #11 to wear a . . . mask. During an interview on at 8:42 AM with Staff "O", LPN he was asked why the residents in the hallway were not wearing masks. He	N 201	guidelines for proper use of PPE. by . DON re-educated ADON on the facility's process for room changes and transfers to minimize potential exposure to COVID if bed not immediately available by . StaffS was not identified. ADON/designee re-educated Nursing staff on -hygiene by - 2020. Staff member F was not identified. ADON/designee re-educated Nursing staff on proper donning and doffing of N95 mask by . ADON/designee re-educated Staff G on . . . . Control standards and guidelines of wearing an N95 mask when entering the COVID unit by . 2.DON/ADON or designee to conduct Quality Audit all 3 shifts of COVID Unit to ensure Nursing staff is donning N95 Masks and PPE per standards and guidelines. Follow up based on findings. 3.DON re-educated ADON on facility process for transfers and room changes to minimize risk of potential exposure if COVID Unit bed not immediately available by . ADON re-educated Staff G on donning N95 mask and protocol if unable wear an N95. ADON/designee re-educated nursing staff on reminding, encouraging and offering residents a mask by . . . . . ADON/designee re-educated nursing staff on control standards and guidelines for proper use of PPE by . ADON/designee re-educated Nursing staff on proper handwashing/ hygiene by	

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N 201	Continued From page 2 answered "Oh sometimes they take them off, I will put one on now." He obtained a surgical mask and placed it on a resident who was close by. Observation on [redacted] at 8:55 AM revealed that Resident #7 was ambulating through the hallway of unit 2E. The resident was observed to be not wearing a [redacted] mask and to be walking around with bare [redacted]. Continued observation of Resident #7 on [redacted] at 11:45 AM revealed that he was still roaming the halls with no [redacted] mask on and with bare [redacted]. At 12:10 PM this surveyor questioned why the resident had no mask on and nothing on his [redacted]. Staff "Q", CNA with ungloved [redacted] obtained a surgical mask and faced the resident and put the mask on the resident covering his [redacted] and [redacted]. She then directed the resident to go into his room while she went to get some socks for the resident. At this time the resident continued to pace the halls until she returned with a pair of non-skid socks. She held the resident by the [redacted] and directed him to his room. It was noted that this room was one that was identified as being on droplet precautions. Interview at 12:40 PM with the ADON revealed that Resident #7 was positive for COVID-19, and that the facility was aware that the resident had tested positive this morning. She reported that there is nowhere to put the resident as the two COVID-19 units in the facility were full. She reported that the residents COVID 19 test results came [redacted] this morning prior to the survey team's arrival. She was unable to verbalize what the facility's process was to minimize the risk of exposure while waiting for a bed on the facility's positive COVID-19 unit. 2. Observations of the L2 hallway revealed 6 rooms with signs on the door identifying that the	N 201	4.DON/ADON/designee to conduct Quality Audits 3x week times 4 weeks, then weekly for 4 weeks than Monthly. Quality Audit monitoring schedule will be modified based on findings. Audits will be reported to the QAPI committee.	

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N 201	Continued From page 3 rooms were on droplet precautions: 201E, 204E, 205E, 206E, 207E, 208E. Continued observations revealed that Staff "O", LPN was in the hallway passing medications. He was noted to be wearing PPE in the form of a KN95 mask, gown and . . . shield. He was not wearing any gloves. He prepared medications at the medication cart, entered (room on isolation for droplet precautions), gave the resident her medication, placed a cup of liquid on the resident's over bed table, retrieved the empty medication cup and the empty juice cup and carried it out of the room. Staff "O", LPN was observed to not be wearing gloves, he left the , stopped and assisted another resident in the hallway with putting on his mask, with the same ungloved . . . , and then utilize the wall mounted sanitizer to clean his , then discarded the medication cup and juice cup in the garbage can attached to the medication cart. Interview with Staff "O"LPN at this time revealed that the rooms with signs were all on droplet precautions. He reported that he was unsure of the actual organism. He reported that all staff should be wearing mask and gloves. He did confirm that he was not wearing gloves when he entered the room on isolation, when he administered the medication and when he exited the room and assisted another resident in the hall. He reported that he should have been wearing gloves. During a 10:45 AM Interview with the ADON she revealed that the L2 and 2E were regular units and not COVID-19 units and were not PUI units. She reported that the signs on room doors 201,204, 205, 206, 207, and 208 were precautionary. 3. On at 8:59 AM an interview with	N 201		

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N 201	Continued From page 4 Housekeeping Staff D assigned to 1 East, revealed that she uses Virex to surfaces. She said first she wets her cloth and wipes the surface and forth, then uses a clean dry cloth to dry the surface. She stated the wet contact time is 2 to 3 minutes for Virex. She uses the bleach (10:1) to remove stains. She said that when she cleans the resident rooms, she cleans the dresser, doorknobs, blinds, windowsills, and everything they touch. Then she uses Virex to clean handrails. On at 7:40 a.m. Staff A, housekeeper entered a non-patient care area used by staff as a meeting room wearing personal protective equipment. She approached the large sized table in the room and began spraying a chemical substance on the table. As she sprayed the table she would immediately dry off the area that was just sprayed. She was asked what the contact time was for the cleaner. She stated, "I don't know" (photographic evidence obtained). She was then asked what unit she had been on prior to entering the conference room. She stated, "two west" and confirmed that two west was the COVID19 unit that currently housed residents positive for the . Staff A was asked if she had changed her gown, gloves, and mask after she left the isolation unit. She said that she had not. At 7:45 a.m. the Unit Manager of the Life Style two unit entered the conference room and was asked about the contact time on the cleaning product staff A was using on the conference room table. She stated "2 minutes. That's what we were told when we got that spray". Review of the product information on the spray used by Staff A revealed: "Virex II 246 One Step Cleaner and	N 201		

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N 201	Continued From page 5 Deodorant. Contact time: allow surface to remain wet for 1 minute to kill 1, 5 minutes to kill & , and for 10 minutes to kill all other organisms cited on the label. Using approved AOAC test methods (under Good Laboratory Practices, [GLP'sll, in the presence of 400 ppm hard water, 5% load and 10 minutes contact time, VIREX~ II/ 256 kills the following on hard non-porous inanimate surfaces: Viruses (·Virucidal Activity) - (kills on hard non-porous inanimate surfaces:) , , (VR-538) , , Type 1, (VR-733), , Type 2, (VR-734) Human Coronavirus, (VR~ 7 40), Type A, {Hong Kong), (VR-544), Type 3, (VR-93), , (VR-26), (Strain WA), ( ), (VR-119), Yeast: , (ATCC 10231) For Use as a One-Step Cleaner/ : 1. Pre-clean heavily soiled areas. 2. Apply Use Solution to hard, non-porous environmental surfaces. 3. To , all surfaces must remain wet for ten (10) minutes. 4. Wipe surfaces (and let air dry). https://diversey.com/en/product-catalogue/virex-ii-256-one-step- -cleaner-and-deodorant -54334. 4. At 8:15 a.m. Staff F, housekeeper was on the 2 middle East unit and was observed wearing an N95 mask. The top strap was of the mask was not positioned on top of the but inside of the mask. Staff F also had hair that was over one-half inch in length that prevented the mask from forming an appropriate seal on his . Staff F was asked about the N95 mask and he stated, "no one told me anything about having hair".	N 201		

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N 201	Continued From page 6 At 8:20 a.m. Staff G, dietary personnel exited the elevator on the 2 middle East unit pushing a large metal food cart toward the COVID 19 West unit. He walked through the closed double doors and then unzipped the plastic barrier that separated the east from the west unit. He then pushed the food cart into the COVID 19 positive west unit. Staff G was asked why he was not wearing an N95 mask. He stated "I can't breathe with it on. And I have . . . .". He confirmed that he delivered all of the food carts to all of the units in the facility. At 12:22 p.m. Staff Q, CNA (certified nursing assistant) was observed walking on the 2 East middle unit wearing an N95 mask on top of a surgical mask. Staff Q was asked if she had training on wearing the N95 mask and she said she had. She stated "N95 mask hurts my . That's why I put on the surgical mask first". At 8:30 a.m. during observation of the 2 west COVID 19 positive unit Staff H, housekeeper was standing just across from the nursing station. She was wearing an N95 mask with a surgical mask on top of it. The surgical mask appeared to hold the N95 mask in place. As the N95 mask straps were tucked inside of the mask. Staff H was asked why the N95 masks straps were not being used. She stated, "its hard to breath when the straps are on". She confirmed that she goes into the resident bedrooms on the COVID positive unit and cleans the rooms. At 9:58 a.m. an interview was conducted with the Regional Director of Nursing as she confirmed that it is her expectation staff members are wearing the N95 masks while in the facility, and confirmed that they should be worn appropriately	N 201		

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N 201	Continued From page 7 indicating the straps should be utilized. The Regional nurse was informed at approximately 2:00 p.m. of observations on the 2 west COVID-19 unit. 5. An observation was made, on at 8:12 a.m., of a yellow fabric PPE (personal protective equipment) container hanging from Resident #4's door on 1 East, a regular nursing unit without COVID19 positive residents. ID-19 observation unit. A clear pocket of the container held a sign that read, "STOP - Droplet Precautions" and "To prevent the spread of , ANYONE ENTERING THIS ROOM MUST", - Hygiene, - Surgical Mask, - Gloves, - Gown Resident #4's room was the only room on the unit, 1 East, with Droplet Precautions. At 8:50 a.m., Staff Member S, Licensed Practical Nurse/Unit Manager (LPN/UM) was asked a question about the percentage of breakfast Resident #4 had eaten, while she was sitting at her desk beside the nursing station of 1 East and wearing a pink, snap-closured, disposable isolation gown. The staff member stated that the CNA staff had not charted the percentage in the computer. She left her office, walked down the hallway, and entered Resident #4's room. The LPN/UM walked to the bedside dresser where the resident's breakfast tray was sitting while the resident was lying on the bed next to the dresser. The Resident #4 was not wearing a mask. She stated the resident liked to take his time eating as she was leaving the resident's room. When asked about disposing of or changing the PPE she was wearing, she stated the resident was COVID-19 negative, was on Droplet Precautions due to and treatments, and she did not have to change	N 201		

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N 201	Continued From page 8 gowns. Staff Member S then proceeded to walk towards where her office was located. The LPN/UM did not perform hygiene before entering or after leaving Resident #4's room. At 10:02 a.m., Staff Member D, Housekeeper, was observed standing outside of Resident #4's room, which continued to be posted with Droplet Precautions. She stated Resident #4 was on Droplet Precautions due to treatment and stated she did not need to change her gown when entering the resident's room. A review of Resident #4's Physician Orders identified an order, dated , for Contact and Droplet Isolation due to . The sheet for Resident #4 included diagnoses not limited to of unspecified part of unspecified or and unspecified. The facility provided a paper that indicated Resident #4 was, "on droplet Precautions (Reverse Isolation) diagnosis (dx:) ". The paper indicated the resident finished treatment on . An interview was conducted, at 3:30 p.m., with the Assistant Director of Nursing/ Control Preventionist (ADON/). When asked about Resident #4's precautions, she stated Resident #4's Droplet Precautions were so staff protected the resident when going into the room. She stated staff should wear a gown, N95 mask, shield, and gloves when caring from Resident #4 inside his room. The ADON/ stated staff should change their gowns when they go into the room and was on reverse isolation due to and . She stated the observation of staff going in then out of Resident	N 201		

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N	Continued From page 9 #4's room with the same gown that was worn in other parts of the facility was not appropriate. According to the Centers of Control and Prevention (CDC) guidance titled, , updated , , . If You Are , , , Protect Yourself From COVID-19, identified, "many conditions and treatments can weaken a person ' s system (making them " ")", which included . This guidance can be located at https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/ .html. The CDC guidance titled, How to Protect Yourself & Others (https://www.cdc.gov/coronavirus/2019-ncov/prev -getting-sick/prevention.html), updated , , , indicated, "Older adults and people who have severe underlying medical conditions like or or seem to be at higher risk for developing serious complications from COVID-19 illness." The guidance identified, that the COVID-19 is thought to spread mainly from person-to-person, between people who are in close contact with one another (within about 6), and "the best way to prevent illness is to avoid being exposed to this ". During an interview, at 3:30 p.m., the ADON/ stated staff should be wearing while on the COVID-19 positive units, a gown, N95, shield, hair covering, and shoe coverings. When asked if staff should encourage residents to wear masks or stay in rooms, she confirmed that yes, staff should be encouraging. The ADON stated she would have to look at the policy regarding the allowable length of staff The Regional Nurse stated if looking at the palm of the , should not be seen.	N 201		

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N 201	Continued From page 10 The facility policy titled, Coronavirus (COVID-19) - Prevention and Control Measures, dated 2001 and , indicated, "This facility follows recommended standard and transmission-based precautions, environmental cleaning, and social distancing practices to prevent the transmission of COVID-19 within the facility. The policy identified that while in the building, personnel are required to strictly adhere to established prevention and control policies that included appropriate use of Personal Protective Equipment (PPE) and transmission-based precautions. The Interpretation and Implementation of the policy included: - If there are COVID-19 cases in the facility: -- Staff wear all recommended PPE (i.e. gloves, gown , , protection, and , or facemask) for the care of all residents on the unit (or facility-wide based on the location of affected residents), regardless of symptoms (based on availability); -- Residents are restricted (to the extent possible) to their rooms except for medically necessary purposes.; --When residents have to leave their room, they wear a facemask, perform hygiene, limit their movement in the facility, and perform social distancing (efforts are made to keep them at least 6 away from others). Class III	N 201		
N 203 SS=D	400.022(1)(n), FS Right to be Treated with Dignity The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement and an oral explanation of the services provided by the licensee, including those	N 203		

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N 203	Continued From page 11 required to be offered on an as-needed basis. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and policy review the facility failed to provide a dignified environment for one (#14) resident during two observations of medication administration. Findings included: At 8:12 a.m. on [redacted], an observation of medication administration was conducted with Staff Member P, Licensed Practical Nurse (LPN). The LPN dispensed the medication for Resident #13 and entered the residents' room. After administering the medications, Staff P walked to the sink in the resident's room, washed [redacted], then stated, "no towels". The staff member [redacted] shook her wet [redacted], left Resident #13's room, leaving the water running, and entered the resident's room next door. Resident #14 was observed sitting in a wheelchair at the sink, putting water on hair. Staff Member P leaned over Resident #14, pulled out paper towels from the dispenser on the other side of the sink, wiped her [redacted], took a paper towel into Resident #13's room, and shut the water off in the sink. The staff member returned to Resident #14's room, leaned over the resident again, and obtained another paper towel. She entered Resident #13's room and with the paper towel turned the emergency knob on the paper towel dispenser. During the observation, the nurse did not knock or ask permission to enter Resident #14's room, she leaned over the resident as she was readying herself on two occasions, and did not knock or identify self upon re-entering Resident #13's room after retrieving paper towels.	N 203	N 203 1.Staff" P" was not identified. Nursing staff re-educated on Residents' Rights and right to dignity and access to handwashing by ADON or designee by [redacted]. 2.Administrator and DON/designee completed Quality Audit by observation for staff respecting resident rights when entering Resident Rooms including the need to knock on doo, introduce self and request permission to enter room. Social Services interviewed residents with [redacted] Score of 9 or above for concerns related to Resident Rights and Dignity. Follow up on findings. 3.ADON/designee re-educated Nursing staff on Residents' Rights, Dignity, Respecting residents' privacy & property, including the need to knock on the door, introduce yourself and request permission to enter the resident's room and will be completed by [redacted]. New hires educated on Resident Rights during orientation. 4.DON and or Unit Managers/designee to conduct Quality Audits/observations on "Entering residents' rooms" to l be conducted 3 times per week times 4 weeks than weekly times 4 weeks than monthly by ADON or designee and results will be reported to the QAPI. Quality Audit schedule to be modified based on findings	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55229	A. BUILDING: _____ B. WING _____	C 07/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 203	Continued From page 12 At 8:25 a.m., Staff P stated she says "knock knock" when entering a room. She stated, "maybe I didn't, so used to doing it". The Assistant Director of Nursing/ Control Preventionist (ADON/) stated, during an interview at 3:30 p.m., staff should knock first and introduce self before entering a resident's room. A review of the policy titled, Quality of Life - Dignity, dated 2001 and revised , indicated the following: 6. Residents' private space and property shall be respected at all times. -a. Staff will knock and request permission before entering residents' rooms. Class III	N 203		