STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105679	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Park of Sunrise	9711 W Oakland Park Blvd Sunrise, FL 33351

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observation, interviews, record and policy review, the facility failed to implement an effective infection control program as evidenced by the facility failed to follow recommendations by the Centers for Disease Control (CDC) and failed to follow through with N95 mask recommendations by the Florida Department of Health (DOH) after 3 visits by DOH were made to the facility following a COVID-19 outbreak, affecting 3 of 5 Personal Protective Equipement (PPE) linen carts on the first and 2nd floor of the facility. The findings included: 1. Review of the CDC recommendations for Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, Updated March 18, 2024, recommended, Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed (if safe to do so). Ideally, the patient should have a dedicated bathroom. HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Respirators should be used in the context of a comprehensive respiratory protection program, which includes medical evaluations, fit testing and training in accordance with the Occupational Safety and Health Administration's (OSHA) Respiratory Protection standard (29 CFR 1910.134) On 07/08/24 at 9:09 AM, an initial tour of the facility was conducted which focused on the isolation carts. The surveyor observed the 100 unit, which revealed a three (3) drawer isolation cart outsideof room [ROOM NUMBER]. The sign by the door read Special Droplet / Contact precautions. Photographic Evidence Obtained. Further observation revealed a box of KN95 and a box of surgical facial masks in the cart first drawer. The observation revealed no N95 respirators (mask) in any of the cart drawers or eye protection. Photographic Evidence Obtained. Three of the five PPE carts observed throughout the facility did not have N95 masks or face shields in the carts upon the initial tour of the facility. (continued on next page)

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.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the Florida Department of Health (DOH) recommendations provided to the facility post DOH visit on 06/29/24 revealed during the facility tour, the Personal Protective Equipment (PPE) carts were not readily accessible near the room of residents on isolation for COVID-19. The PPE carts were not stocked with N95 masks. Addionally, DOH had observed that staff exited a resident's isolation room wearing a KN95 mask instead of a National Institute for Occupational Safety and Health (NIOSH) approved particulate N95 mask. An interview was conducted with the Director of Nurses (DON) on 07/08/24 at 10:30 AM. She stated an Infection Preventionist (IP) from the Florida Department of Health (DOH) visited the facility on 06/28/24, 07/01/24 and 07/02/24 and made the following recomendations. She made recommendations that the N95 masks needed to be in the isolation carts, and they needed more carts out. On 07/02/24, the DOH emailed the DON and IP stating she was able to obtain a Fit Testing kit for the facility free of charge and to let her know when they are ready to do that. The DON stated that she put more carts out and put N95 masks on the carts. She stated that everyone is responsible for making sure the carts are stocked with N95 masks but she and the IP from the facility make sure when they come in that the carts are stocked. The DON stated that on the weekend, the supervisor stocks the carts, and during the week central supply stocks when she starts her shift at 2:00 PM and when she leaves for the day. The DON was asked who is ultimately responsible for keeping the carts stocked and she replied that we all are. All nurses have access to central supply where the masks are kept and there are plenty of masks. Discussed with the DON that some carts have 3 different types of masks in them. She stated that she was making it easier for the staff to obtain all types of masks available if they do not need an N95 for an isolation room. Discussed how staff know what type of mask to wear upon entering an isolation room and she replied that she did constant education for the staff regarding the type of mask and handed each one an N95 mask as an example of the mask to wear when they enter an isolation room. Discussed with the DON that upon the initial tour of the facility, N95 masks were not available in 3 of 5 carts and no eye protection was available in the carts. She stated she was surprised that that was true but when she looked at the pictures taken, she acknowledged that there were no N95 masks or eye protection in 3 of the carts. The DON was then asked about the start of the COVID-19 outbreak. She stated on 06/24/24, she became aware that one of the residents had tested positive for COVID-19 when they went to the hospital for a urinary tract infection (UTI). She then tested the whole facility and found that 18 residents tested positive on 06/24/24. Eight (8) residents tested positive on 06/26/24. Four (4) residents tested positive on 07/02/24. One (1) resident tested positive on 07/03/24. At that time, a total of 39 residents had tested positive and 16 staff had tested positive from 06/24/24 to 07/05/24. They immediately closed the dining room down and did room visits for activities on 06/24/24. After today (07/08/24), there are 6 residents positvie with COVID-19. Two (2) residents were admitted from the hospital with COVID-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/08/24 at 11:40 AM, an interview was conducted with Staff A, Certified Nursing Assistant (CNA). Staff A stated she had in-services about how to wear a mask and make sure before they enter the room that that put on a mask and gloves and gown. She was asked what type of mask she would wear to enter a resident's room with COVID-19. She chose a KN95 mask that she was wearing at the time of the interview. The surveyor pointed to an N95 mask on the table in front of her and asked her if she would ever put that mask on and she said she would not. She has no residents with COVID-19 now, but she had residents with COVID-19 previously. She stated there were always masks available and she would ask a supervisor if she did not see any masks in the cart. She is a full-time employee. An interview was conducted with the IP on 07/08/24 at 2:33 PM. She stated she returned to work on July 1 after being on leave for 6 weeks. When she returned, the COVID-19 positive residents were isolated in their rooms, testing and notification was done to the DOH. She was aware that the IP from the DOH was here. She said she was coming in early to do staff in-services. Central supply was accountable for putting the masks in the carts, but she starts her shift at 2 PM. In the mornings her and the DON were putting masks in. The Supervisor stocks on the weekend. The surveyor asked why all of the carts were not stocked this morning with N95 masks and she stated that she was doing other tasks this morning and the DON was not scheduled to come in today. She felt she was caught up to speed with the COVID-19 outbreak when she returned. She was asked about the Fit testing recommendations and she stated that she would have to bring this up to the Regional Nurse. When asked if she had discussed this with her yet, she replied that she did not. An interview was conducted with Staff K, Central Supply person, on 07/08/24 at 3:13 PM. She stated she has worked in central supply for about a year. When she comes in, she makes sure everything is in the carts. Face shield, gloves and the KN95 and the N95 and the surgical masks are stocked. Then she checks in between and when she leaves. She works Monday through Friday. On the weekend the supervisor does it for her. The DON helps in the daytime. She always had enough N95 masks even before the outbreak. There are usually 1-2 masks left when she comes in. She does not track how many are used. She puts a full box of N95 in the carts before she leaves at night. She does not get complaints about lack of supplies. 36057 3. Review of the facility's Standards and Guidelines: Screening, Testing, Return to Work (HCP), Personal Protective Equipment, Isolation, Reporting- Section Infection Control COVID-19 issued on 01/15/24 provided by the Director of Nursing documented under PPE (Personal Protective Equipment) Hand Hygiene, . Transmission Based Precautions will be implemented and signage instructing the appropriate use of PPE's will be posted outside the resident's door. Hand hygiene should be performed for at least 20 seconds with soap and water: before donning and doffing PPE . On 07/08/24 at 9:13 AM, observation revealed a three (3) drawer isolation cart outside room [ROOM NUMBER]. Further observation revealed a box of KN95 and a box of surgical facial masks in the cart first drawer. Further observation revealed no N95 respirators (mask) in any of the cart drawers (Photographic evidence). On 07/08/24 at 9:18 AM, observation revealed two isolation cart next to room [ROOM NUMBER]'s door. Further observation revealed neither cart contained N95 masks or eye protection gears /face shields. Photographic Evidence Obtained. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/08/24 at 9:21 AM, observation revealed Staff E, Licensed Practical Nurse (LPN), wearing a KN95 mask. An interview was conducted with Staff E who stated she had residents in room [ROOM NUMBER] and 226 on isolation due to a positive COVID-19 testing. Staff E stated she wore a KN95 mask and switch to an N95 mask when entering a resident's room who was positive for COVID-19. Staff E was asked where she would get the N95 mask from and pointed to room [ROOM NUMBER] isolation cart. A side by side observations with Staff E of room [ROOM NUMBER]'s isolation cart was conducted and Staff E confirmed there was no N95 masks in the cart. On 07/08/24 at 9:24 AM, observations revealed room [ROOM NUMBER]'s door wide open, no isolation cart noted outside the room. The room door had a sign that read Special Droplet / Contact Precaution - Personal Protective Equipment .put on mask and eye protection . Further observation revealed the lack of an isolation cart next to room [ROOM NUMBER]'s door. Observation of room [ROOM NUMBER] door's sign read Special Droplet / Contact Precaution - Personal Protective Equipment .everyone MUST clean hands when entering and leaving the room .wear a NIOSH-approved N95 wear an eye protection .keep door close . Further observation revealed that there was no consistent with the door signs for residents on Droplet / Contact Precautions as evidenced by one sign specified the use of N95 and the other sign did not. On 07/08/24 at 9:26 AM, an interview was conducted with Unit Manager (UM) who stated that residents in room [ROOM NUMBER] and 215 recovered and would be removed from isolation today. Observation revealed the isolation cart for room [ROOM NUMBER] did not contain any eye protection gear / face shields. On 07/08/24 at 9:08 AM, a tour to the facility's C-wing revealed Staff B, Registered Nurse, at the nurses station wearing a KN95 facial mask. An interview was conducted with Staff B who stated she worked the night shift (11:00 PM to 7:00 AM) and finishing up her documentation. Staff B was asked how many residents she had that were on precautions due to a positive test for COVID-19 infection and replied five (5). Staff B was asked which facial mask she wore when she entered those residents' room and pointed to the one she wearing. On 07/08/24 at 9:15 AM, observation revealed Staff C, Certified Nursing Assistant / CNA, wearing a KN95 facial mask. An interview was conducted with Staff C who stated she used an N95 mask for a week when the COVID-19 outbreak started, then was out due to COVID-19 infection. Staff C stated on her return she was told she did not have to use an N95 mask. Staff C was asked if she was assigned to any residents that were currently on precautions due to a positive test for COVID-19 infection and replied she had residents in room [ROOM NUMBER] and room [ROOM NUMBER]. Staff C was asked which mask she wore while caring for those residents and pointed to the one she was wearing (KN95). Staff C was asked why she was not wearing an N95 when taking care of a resident positive with COVID-19 and replied the residents were in the facility for a while and she did not have to use an N95 mask to work with them. Staff C was stated she did not change her KN95 mask every time she enter room [ROOM NUMBER] or 230 and added, foe example, like when she answered a call light for residents positive for COVID-19 infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/08/24 at 9:18 AM, observation revealed Staff D, CNA, wearing a surgical mask, then she removed the surgical mask and put on a KN95 mask. Staff D stated she had a resident in room [ROOM NUMBER] who was positive for COVID-19. When asked which mask she uses when taking care of a resident on isolation due to COVID-19, Staff D pointed to the mask she had just changed to, a KN95 mask. On 07/08/24 at 9:27 AM, observation revealed Staff F, CNA, walking down the C wing hallway and wearing a surgical mask. Staff F stated she wore a surgical mask while on break and just came back from break. Staff F was asked which mask she would use when taking care of a resident positive for COVID and stated she would use a KN95 mask. Staff F then pulled a KN95 from her uniform pocket. Staff F was assigned to rooms [ROOM NUMBERS], who had residents who were positive for COVID-19. On 07/08/24 at 11:50 AM, observation revealed Staff E, LPN, in room [ROOM NUMBER]. The door was slightly opened and Staff E was observed wearing a gown, gloves and an N95 mask. Further observation revealed an isolation cart with N95 masks and surgical mask on the first drawer next to room [ROOM NUMBER]'s door. This cart was not there earlier during the morning tour. On 07/08/24 at 11:57 AM, observation revealed a random resident in the facility's gymnasium exercising, not wearing a facial mask and Staff G, Occupational Therapist (OT), sitting by her desk apart from the resident and was not wearing a facial mask. An interview was conducted with Staff G who stated the resident was not on contact isolation and she was more than six feet apart from the resident. Observation revealed a KN95 mask on top of her desk. Staff G was asked when she would use a facial mask and replied that she would use a KN95, while picking up the KN95 on top of her desk, when she goes to an isolation room then would change it to a regular, surgical mask. Staff G stated she attended the facility's in-service provided related to COVID-19 and what personal protective equipment to use when providing care to a resident on isolation due to COVID infection. On 07/08/24 at 12:04 PM, observation revealed Staff H, Physical Therapist (PT), in the therapy gymnasium wearing a KN95 mask. An interview was conducted with Staff H who stated she had been using a KN95 mask since the facility's COVID-19 outbreak. Staff H stated that she wore a KN95 when treating residents positive for COVID-19 in their room. Staff H stated she attended the facility's in-service provided related to COVID-19 and what personal protective equipment to use when providing care to a resident on isolation due to COVID infection. 3a. Review of Resident #1's clinical record documented an admission to the facility on [DATE] with no readmissions. The resident's physician order dated 07/03/24 documented, Transmission Based Precautions due to r/o [related to] COVID-19 and/or possible exposure every shift. The resident nursing progress note dated 07/03/24 documented Aware of COVID positive status. Sister too. On 07/08/24 at 12:35 PM, observation revealed Staff I, CNA, standing by room [ROOM NUMBER] with a sign of Droplet / Contact Precautions, with the door wide open, wearing a disposable yellow gown and a KN95 mask, and no eye protection was noted. Staff I came out of the room and rummaged through the isolation cart's first drawer. The isolation cart was now next to room [ROOM NUMBER]'s door which it was not there before. Staff I then moved to rummaged through isolation cart next to room [ROOM NUMBER]'s door and retrieved an N95 mask. Further observation revealed Staff I placed the two N95 mask's straps and left them on top of her head, rather that placing one over her neck to obtain a good seal. Further observation revealed Staff I asked for both residents' lunch tray to be delivered at the same time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/08/24 at 12:36 PM, observation revealed Staff I, CNA, entered Resident #1's room and delivered his lunch tray. At 12:37 PM, Staff I came out of the room wearing the yellow gown, and N95, and kept the room door wide open while waiting for Staff E to bring the roommate's tray. On 07/08/24 at 12:47 PM, observation revealed Staff J, Occupational Therapist Assistant (OTA), donning a PPE gown, gloves and wearing KN95 mask. Staff J entered Resident #1's without donning an N95 mask. At 1:06 PM, observation revealed Staff J in the residnet's room, who stated he was treating Resident #1 and had 7 more minutes to go of treatment. On 07/08/24 at 3:36 PM, a telephone interview was conducted with Staff J, OTA, who stated he was supposed to wear an N95 when he was providing therapy session today to Resident #1. He added it slipped on me and stated he was aware that they have to use an N95 when in room with resident positive with COVID-19. 3b. Review of Resident #2's clinical record documented an admission to the facility on [DATE] with no readmissions. The resident's physician order dated 07/03/24 documented, Transmission Based Precautions due to r/o COVID-19 and/or possible exposure every shift. The resident nursing progress note dated 07/02/24 documented, Late Entry: wife and MD [medical doctor] notified of COVID positive status. On 07/08/24 at 12:39 PM, observation revealed Staff E, LPN, brought Resident #2's lunch tray and handed it to Staff I, CNA, who then proceeded to set up the food for the resident, the room door was open from 12:35 PM to 12:45 PM. Staff I did not change her gown or N95 mask before caring for Resident #2. Staff I removed the yellow gown at the resident's room door, and walked away with the N95 mask on. An interview was conducted with Staff I who stated she was supposed to take the N95 mask off and forgot. On 07/08/24 at 12:42 PM, an interview was conducted with Staff E, LPN, who stated Resident #1's door was supposed to be closed at all times and the staff had to change gowns between resident care and confirmed Staff I did not keep the door closed or change the gown between the 2 residents' lunch tray's set up. On 07/08/24 at 12:57 PM, observation revealed Staff I, CNA, wearing a gown, delivered a lunch tray to room [ROOM NUMBER] and kept the room door wide open. On 07/08/24 at 1:02 PM, observation revealed the Unit Manager stated Staff I, CNA, did not need a red bag and instructed her to drop the yellow gown in a regular trash bag. Staff I then performed hand hygiene by using hand sanitizer from the canister outside room [ROOM NUMBER] rather than soap and water as per the facility's guidelines. Staff I then retrieved a resident's lunch tray from the trays cart.