

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 105178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/07/2020
NAME OF PROVIDER OF SUPPLIER HERITAGE HEALTHCARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 777 9TH ST N NAPLES, FL 33940	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0727 Level of harm - Minimal harm or potential for actual harm Residents Affected - Many F 0880 Level of harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on interview and record review, the facility failed to designate a full-time Director of Nursing (DON) from 5/31/20 to 6/6/20. The findings included: On 6/6/20 at 1:45 p.m., the Administrator said the Director of Nursing was terminated on 5/30/20. The Administrator said there was currently no DON designated at the facility. A review of the facility most recent staff roster, updated 6/4/20, failed to reveal a person designated as the DON.</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review the facility failed to safeguard residents' well-being by failing to follow current infection control standards related to COVID-19 recommendations set forth by Centers for Disease Control and Prevention (CDC). Refer to https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html The findings included: 1. On 6/5/20 at 4:12 p.m., Certified Nursing Assistant (CNA) Staff I was observed on the 2nd floor COVID unit dining area with his N95 respirator positioned under his chin exposing both his nose and mouth. On 6/5/20 at 4:13 p.m., in an interview CNA Staff I acknowledged the N95 respirator should cover both his nose and mouth. 2. On 6/5/20 at 4:15 p.m., an observation on the second floor North COVID unit revealed a mix of COVID positive residents with residents of undetermined COVID status (PUI). Resident #43 and Resident #44 had room doors open to the common corridor. A review of the facility COVID-19 roster revealed Resident #43 and Resident #44 have both tested positive for COVID-19. Resident #50 and Resident #51 had room door open to the common corridor. A review of the facility COVID-19 roster revealed Resident #50 and Resident #51 are PUIs. 3. On 6/5/20 at 4:20 p.m., an observation on the second floor South COVID unit revealed a mix of COVID positive residents with residents of undetermined COVID status (PUI). Resident #17, Resident #39, Resident #42, Resident #46, Resident #47, and Resident #48 had room doors open to the common corridor. A review of the facility COVID-19 roster revealed Resident #17, Resident #39, Resident #42, Resident #46, Resident #47, and Resident #48 have all tested positive for COVID-19. Resident #52, Resident #54, and Resident #55 had room doors open to the common corridor. A review of the facility COVID-19 roster revealed Resident #52, Resident #54, and Resident #55 are PUIs. On 6/5/20 at 4:22 p.m., in an interview the Regional Nurse acknowledged the residents' room doors should be closed. 4. On 6/6/20 at 1:15 p.m., the North COVID unit had isolation caddies (storage devices for isolation supplies) on Resident #3, Resident #5, Resident #8, Resident #12, and Resident #23 room doors. A review of the facility COVID-19 roster revealed Resident #23 was COVID positive. The caddie lacked the necessary personal protective equipment for treating a COVID positive resident. On 6/6/20 at 1:17 p.m., observed the resident standing lift was soiled in the North COVID unit. On 6/6/20 at 1:18 p.m. in an interview the Regional Nurse said the caddies would be removed and the lift would be cleaned.</p>		

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