

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 105588	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2020
NAME OF PROVIDER OF SUPPLIER CORAL TRACE HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP 216 SANTA BARBARA BLVD CAPE CORAL, FL 33991	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0880 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, 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: On 6/9/20 at 10:47 a.m., during a kitchen tour with the Director of Nursing (DON), Cook Staff A, was observed placing silverware in napkins. Staff A's face mask was pulled down below her chin, exposing her nose and mouth as she worked. The DON confirmed Staff A should be wearing the mask correctly while in the facility. On 6/9/20 at 10:53 a.m., during the tour with DON, Resident #1 and Resident #2 were observed sitting in wheelchairs across from the nurses' station. Neither resident was wearing a face mask. The DON confirmed they should be wearing face masks while out of their rooms. On 6/9/20 at 10:55 a.m., during the tour with DON, Resident #3 was observed sitting in a wheelchair in the hallway outside of room [ROOM NUMBER]. The resident was not wearing a face mask. The DON confirmed the resident should be wearing a face mask while out of her room.		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.