

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 105864	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/10/2020
NAME OF PROVIDER OF SUPPLIER PAGE REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 2310 N AIRPORT ROAD FORT MYERS, FL 33907	
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 0584 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to ensure equipment for resident use was maintained in a sanitary manner on 1 (Dalton) of 4 units within the facility. The findings included: During the initial tour of the Dalton unit on [DATE] at 11:00 a.m., a portable telephone was observed at the nurse's station and available for resident use. Observation on [DATE] at 11:20 a.m., Resident #3 was using the portable telephone in her room. Observation on [DATE] at 11:23 a.m., Licensed Practical Nurse (LPN) Staff A cleaned the portable telephone with a disinfectant wipe for 30 seconds. On [DATE] at 11:23 a.m., LPN Staff A said, she does not know how to transfer calls from the nurse's station telephone to the resident's room, and it is easier to just use the portable telephone. She said the disinfectant only has to be in contact with the surface for 30 seconds. Review of the disinfectant label indicated the contact time should be 3 minutes to ensure complete disinfection of all organisms. *Photographic evidence obtained* On [DATE], at 10:45 a.m., the Assistant Director of Nursing confirmed the disinfectant contact time should be 3 minutes.		
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.