STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105140	A. BUILDING _____ B. WING _____	04/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRISTOL AT TAMPA REHAB AND NURSING CENTER LLC	1818 E FLETCHER AVE TAMPA, FL 33612

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** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, policy review, interviews and review of QSO 20-14-NH (Revised), the facility did not ensure that practices were consistent with current standards and guidance to prevent and control the development and transmission of communicable diseases and infections including the [MEDICAL CONDITION] including 1) appropriate PPE (personal protective equipment) was not available on a designated COVID nursing unit, 2) the resident room doors were not closed on the designated COVID nursing unit for 5 of 24 resident rooms, 3) that unnecessary staff were not restricted from entering and moving through the designated COVID unit, 4) that residents were not transferred to the designated COVID nursing unit in a timely manner for 3 residents (#2, #3, and #4) of 27 sampled residents, 5) inappropriate mask placement (Staff A); 6) residents observed not social distancing (#23; #24); 7) cleaning products not readily available (Staff C); 8) inconsistent donning and doffing of personal protection equipment (PPE) for the Central Unit Staff, Lack of PPE education to Dietary staff (H) and visiting Health Care Providers (Staff R, S, Q, J); 9), lack of designated PPE disposal containers for staff/visitors exiting the Central Unit; Lack of a PPE requirement signage for the Central Unit; Lack of coordination of availability or dispersion of PPE at the Central Unit entrance; Lack of implementation of a comprehensive isolation precaution program to protect staff and residents on the Central Unit (census of 47) that had residents exhibiting signs of increased temperature (fever), decrease in oxygen saturation rates, and/or lethargy. These practices had the potential to affect all residents residing in the facility. Findings included: On 4/22/20 at 9:15 a.m. surveyors approached the entryway to the facility front doors, where two staff members were seated at a table wearing masks, doing screenings and taking temperatures. An observation was conducted and there were five cases of gowns and a case of faceshields sitting near the table where the staff were doing the screenings. A review of the facility census on 04/22/20 reflected that the facility had 228 residents. A review of the facility floor plan reflected the facility has 5 units as follows: North West (NW), (400# rooms); North East (NE), (300# rooms); Central CU (rooms 1-28); South West/Designated COVID unit (SW) (200# rooms); South East (SE) (100# rooms). 1) An observation was conducted during the initial tour on the 4/22/20 at 9:30 a.m. on the designated Covid unit, the South West wing. There was a sign on the entry door indicting the unit was restricted to excess traffic. There was also a sign on the door indicating the unit was quarantined. After entering the unit through the double doors, marked with signs indicting the unit had restricted access, there were two PPE (personal protective equipment) kits made up from plastic bins containing drawers. The kits contained gloves, goggles, hand sanitizer, and red and yellow biohazard bags. There weren't any gowns or N95 masks available. At 9:50 a.m. on 4/22/20 in an interview with Agency Staff M, CNA, she said they were not restocking the isolation kits. There are no gowns and goggles. She said central supply was supposed to restock the PPE. She said she feels safe working on the quarantine unit, as long as they keep the isolation kits stocked. She had been working at the facility for a week. Today was her first day on the quarantined unit. At 10:12 a.m. on 4/22/20 an interview was conducted with Staff N, CNA. Staff N, CNA said they were supposed to wear two gowns in the isolation rooms, but there are not enough gowns. They were having us hang them outside the door to reuse them. They stopped that Monday. She said she was scared and doesn't feel protected. They didn't ask us to work on this unit. We didn't know this was quarantined. These residents are from Central. We all took care of one of the residents before she tested positive. On 4/22/20 at 10:15 a.m. an interview was conducted with Staff O, CNA. Staff O, CNA said the DON (director of nursing) and the ADON (assistant director of nursing) get mad when staff ask for more gowns. She said she doesn't feel safe because it took too long to get organized. Staff had training after they were already exposed. They didn't offer to get them tested . They said if we don't have symptoms we don't need it. We have families. At 10:25 a.m. on 4/22/20 an interview was conducted with Staff P, RN. Staff P, RN said she was still passing medication because she and the other nurse are very behind since there were no gowns this morning. They had to wait for gowns before they could start working. On 4/22/20 at 10:39 a.m. an observation was conducted. Staff G, CNA transportation personnel entered through the double doors on the South West wing Covid unit, wearing a surgical mask. He checked three isolation kits for gowns and couldn't find one. He was wearing a regular surgical mask. He finally located a gown and an N95 particulate mask from an isolation kit at the end of the hallway near the exit by the isolation/Covid positive rooms. An observation was conducted at 10:51 a.m. on 4/22/20. Staff IP, RN was standing in the hallway outside a resident doorway without a gown. She said she was waiting for someone to bring her one because hers was torn. Central supply is supposed to stock them. The isolation kits near the double door entry still had not been restocked with gowns. A staff member had to retrieve a gown for Staff P, RN from one of the kits near the isolation rooms. A review of the facility inventory list provided by the NHA on 04/22/20, documented that for isolation gowns, the weekly usage was 245, and the current inventory was 950. The amount that the facility estimated for a 2-week lock down was 490. The facility was estimating that it still needed 215 and the days on hand were 27.14. 2) An observation of the hallways on the South West wing during the initial tour on 4/22/20 at 9:30 a.m. revealed resident rooms 219, 222, 224, and 225 had the doors open. At 10:10 a.m. an observation of resident room [ROOM NUMBER] revealed the door was also open with two residents observed in the room. room [ROOM NUMBER] was located in the same hallway as isolation rooms were located. Review of the facility's Covid-19 action plan, undated, provided after a joint visit with the Department of Health conducted on 4/18/20, found the South West unit was designated a red zone for residents with new onset respiratory symptoms and known positive residents. Further review showed the following: 2. Symptomatic designated resident area 1 requires: b. Resident door closed 6. Keep staffing of affected residents the same as much as possible, do not assign to other unaffected resident areas. 3) Resident #27 was admitted to the facility with a [DIAGNOSES REDACTED]. Resident #27 resided on the South West nursing unit known as the red zone. At 10:31 a.m. an observation and interview was conducted with Staff L, Medicaid transport personnel. During the observation Staff L, with Medicaid transportation was observed standing in the hallway donning an N95 mask with a surgical mask over it, a gown, and gloves. The gown was not tied on. He removed a cell phone from his pants pocket and began texting on it while donning the gloves. He returned the phone to his pocket. In an interview, Staff L said some residents are brought out front to him. Sometimes, he comes in and picks up residents from their rooms. He said he was informed this was a quarantine unit. He said he was screened at the front door. He came here to pick up Resident #27 for [MEDICAL TREATMENT]. Staff L reported that he makes sure Resident #27 is wearing a mask. He wipes down her wheel chair before she gets in his vehicle, and he wipes it down again when she gets out of his vehicle. Staff L said he was waiting for the nurse to give Resident #27 her medication. The nurse brought Resident #27 out of her room with a mask on. Staff L placed his contaminated gloved hands on the wheel chair handle bars, and wheeled Resident #27 out of the facility through the back door at the end of the isolation hallway. On 4/22/20 at 2:44 p.m. an interview was conducted with the DON (Director of Nursing). They don't have to wear PPE. The DON confirmed it is preferable to keep resident room doors closed. If transportation services have to enter the facility for residents going out on a stretcher, then they are screened at the front. They do handwashing, and they have to take the resident out the back door. When they are in a wheel chair the resident can be brought to the front, and transport is outside waiting for them. The resident in a wheel chair from the quarantine unit would be delivered to the back glass door to the transport

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** - Many	(continued... from page 1) personnel. The DON agreed the Medicaid transport personnel should not have been in the building. She also said, I would have an issue with someone using their cell phone while wearing gloves. Their cell phone would be considered dirty. It's been a bit of challenge to coordinate delivery to the unit. We stock the isolation kits. Nursing is calling when they need stock. We hand the supplies to them through the doors. The DON also said they began having staff wear full PPE Monday afternoon. They were using full PPE for isolation rooms. We added washable gowns in addition to the N95's and gloves, yesterday. Anyone coming to that unit should be wearing PPE: a gown, N95 mask, and gloves during care. The surveyor asked if room mates of suspected or positive residents were being isolated, and she replied that they were moving to that now; initially we were doing screening and monitoring. Again, we consulted with our Medical Director. We started providing the barrier gown and disposable gown for the isolated residents. They started that yesterday. Review of the CMS memorandum, QSO 20-14-NH, (Revised) dated 3/14/20, Limiting Visitors and Individuals: Expanded Recommendations, revealed the following: Facilities should review and revise how they interact with volunteers, vendors and receiving supplies, agency staff, EMS personnel and equipment, transportation providers (e.g., when taking residents to offsite appointments, etc.), and other non-health care providers (e.g., food delivery,etc.), and take necessary actions to prevent any potential transmission. For example, do not have supply vendors transport supplies inside the facility. Have them dropped off at a dedicated location (e.g., loading dock). Facilities can allow entry of these visitors as long as they are following the appropriate CDC guidelines for Transmission-Based Precautions. 4) Resident #2 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Review of the census list showed Resident #2 resided on the Central wing at the facility until 4/2/20 when she was moved to the South West, designated Covid nursing unit. She returned to the Central unit on 4/13/20, and was moved, again, on 4/19/20 to the designated Covid unit. A review of the nursing progress notes in the medical record revealed that, on 4/14/20, the writer was in pt (patient)room for pt care and noted that the pt face was red, writer took temp and tympanic temp 102.0, writer administered suppository Tylenol, writer notified the UM (unit manager). An SBAR (situation, background, assessment, recommendation) note dated the same day, 4/14/20, indicated the PCP (primary care physician) was notified of the fever. The SBAR indicated the PCP ordered CMO (comfort measures only) with [MEDICATION NAME] and [MEDICATION NAME], and no testing. Additional comfort measure medications were ordered according to a subsequent progress note also dated 4/14/20, and the family was notified of the resident's condition and agreed not to perform any further labs or medications. A note entered by a nurse on the night shift of 4/14/20 indicated Resident #2 continued to have a fever of 100.0 and [MEDICATION NAME] (Tylenol) suppository administered. Further review of the nurse's notes showed that isolation had not been ordered or implemented until 4/19/20 when a progress note indicated Resident #2 was moved to the south west wing. Resident #3 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. A review of the Census List reflected that Resident #3 was admitted to the South West wing at the facility. On 4/1/20 Resident #3 was moved to another unit at the facility. Then on 4/14/20 Resident #12 was moved back to the South West unit, which was the designated Covid unit. Review of nursing progress notes in the medical record revealed that, on 4/10/20, this writer was notified by therapy that resident was observed coughing, and ARNP (Advanced Registered Nurse Practitioner) aware. A progress note, dated 4/11/20, revealed Resident #12 had a temperature of 102.4. The ARNP was notified by telephone. Appropriate diagnostic and treatment orders were obtained and Resident #3 was placed on isolation precautions. However, there weren't any notes indicating a Covid swab was offered until 4/16/20. A progress note also dated 4/11/20 at 22:20 (10:20 p.m.) noted a temperature of 100.9. The progress note dated 4/12/20 4:26 a.m. showed a temperature of 100.4. A subsequent progress note on 4/12/20 at 16:10 (4:10 p.m.) reflected a temperature of 100.1. At 21:45 (9:45 p.m.) the nurse's note indicated Resident #3 had a temperature of 100.1. On 4/13/20 the 2:16 am nurse's note reflected a temperature of 100.1. The next progress note, dated 4/13/20, showed Resident #3 had a temperature of 99.1. At 14:01 (2:01 p.m.) on 4/13/20 Resident #3 had a temperature of 99.1. The progress note dated 4/14/20 00:23 (12:23 a.m.), reflected a temperature of 102.2. The 4/15/20 16:07 (4:07 p.m.) progress note indicated Resident #3 had a temperature of 100.6 and was now on oxygen via nasal cannula with an oxygen saturation at 91%. At 16:11 (4:11 p.m.) of the same day, a progress note indicated Resident #3 assessed for DIB (difficulty in breathing). 80 % on RA (room air). ARNP notified during facility visit. Lung assessment clear. O2 (oxygen) orders given. 91% on 5 L (liters). The 4/16/20 00:06 (12:06 a.m.) note reflected a temperature of 101.2 and oxygen saturation of 90% via nasal cannula. The 4/16/20 15:45 (3:45 p.m.) progress note indicated the resident's daughter was notified of the resident's condition and pending Covid-19 test. The next nursing progress note dated 4/16/20 23:13 (11:13 p.m.) showed a temperature of 100.6. The oxygen saturation was not documented in that note. The 4/17/20 nursing note 14:30 (2:30 p.m.) revealed the resident's daughter was notified Resident #13 had increased SOB (shortness of breath) and respiratory distress and was seen by the physician. Resident #3 was transferred to the hospital. A subsequent note at 14:50 (2:50 p.m.) indicated Resident #3 was on 5 liters of oxygen via nasal cannula with an oxygen saturation of 76%. Resident #3 was placed on a non-rebreather mask at 10 liters with an oxygen saturation of 90%. The line listing provided by the facility revealed Resident #3 went to the hospital where she tested positive for Covid-19. Additionally, the line listing reflected a symptom onset date of 4/14/20, when the previously mentioned nurse's notes showed a symptom onset of 4/10/20. Resident #4 was admitted to the facility on [DATE] with a left femur fracture, according to the face sheet in the admission record. Review of the Census List showed Resident # 4 resided on Central. Further review of the Census List showed Resident #4 was moved to the South West Covid unit on 4/18/20. Review of an SBAR, dated 4/17/20. revealed Resident #4 Food and/or fluid intake (decreased or unable to eat and/or drink adequate amounts). Functional decline (worsening function and/or mobility). Skin wound or ulcer. At the time of evaluation resident/patient vital signs, weight and blood sugar were: Temp: 99.6. Route:tympanic. Outcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were: Mental Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse). Functional Status Evaluation: Needs more assistance with ADLs (activities of daily living). General weakness Decreased mobility, Swallowing difficulty. The Primary Care Provider (PCP) Feedback included orders for fluids and labs. A review of a nursing progress note, dated 4/18/20 7:34 a.m., showed Resident #4's oxygen saturation was 91% on room air. The nurse applied a nasal cannula at 2 liters and Resident #4's saturation went up to 97%. The progress note, dated the same day at 20:33 (8:33 p.m.), reflected the resident was observed lethargic, O2 (oxygen) =91% with oxygen at 2 liters. A subsequent note, dated 4/18/20 at 23:00 (9:00 p.m.), indicated that During rounds at the change of shift with the 3 to 11 nurse, upon entering the resident's room, this writer notified the 3-11 nurse and and evening supervisor the resident didn't look good. VS (vital signs) were taken by the evening nurse, called the on-call ARNP and she gave orders to the evening nurse to send the resident to the hospital for evaluation. Evening nurse sent the resident to the hospital as ordered. Further review of the facility's Covid-19 Action Plan, undated, reflected the following: 1. Red Zone-Create a unit to isolate/cohort symptomatic residents and those who are positive. Additional Guidance: (decisions need to be made on clinical judgement and available PPE). 1. All residents affected that are exhibiting new onset respiratory symptoms and known positive will be moved to the designated area 1-Red Zone. 2. Symptomatic designated resident area #1-Red Zone requires: a. if available, N95 mask (may be used form room to room to preserve PPE) b. Gown-priority goes to caregivers giving direct patient care (may be used from room to room to preserve PPE on affected unit) 5) At 9:50 a.m. 4/22/20, during the tour of the North West Unit, an observation was conducted of Staff A, Licensed Practical Nurse (LPN). Staff A was standing at her medication cart and had just exited Resident #26's room. Staff A was observed to have a medical mask on her face, she was observed to be conducting a chewing motion with her mouth, that during the motion of her jaw, (as if she were chewing gum), the top of the mask would dip to expose her nose. Staff A made no readjustment of her mask. 6) At approximately 10:00 a.m., the North East (NE) unit was reviewed. Resident #25 was observed sitting at a table in a common room across from the nursing station. Resident #25 was observed to leave her position at the table and go to her room down the hall. At the corner of the room, were 2 residents, Resident #24, and Resident #23. Resident #24 was sitting in a wheelchair, at a table, with her elbows on the table. Resident #23 was sitting in her wheelchair approximately 3 feet from Resident #24. At 10:05, an interview was conducted at this time with Staff C, Certified Nursing Assistant (CNA). She was asked if she had received training regarding social distancing. She stated that she had, and she proceeded to approach and talk to Resident #23 and ask if she could move her to a different location in the room. Resident #23 refused, and so Staff C approached Resident #24 and asked if she could move her. Resident #24 agreed, and Staff C moved the resident to the location that Resident #25 had been sitting at. No cleaning of the table was observed. Staff C was asked if there was a process that should take place for the tables when one resident is removed, and another is set up at the same table spot. She stated that she could wipe the table off. She proceeded to look and ask for cleaner. 7) At 10:10 a.m., Staff D, Registered Nurse, (RN) approached the surveyor. Staff D, RN stated that she was

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) floating and that she was in charge of the unit. Staff D, RN stated that the wipes were locked up. We keep everything locked. Staff D, RN, went into the bio-hazard room and came out with spray bottle. Staff D, RN, then went to the nurse in the hall, with medication cart, Staff E, Licensed Practical Nurse (LPN), and asked if he had wipes in his cart. Staff E, LPN, unlocked his cart and removed a canister of wipes. Staff C, CNA, used a wipe from the canister to wipe off the table that Resident #24 was sitting at. Staff D, RN was asked if locking up the wipes was a problem. She stated, yes, it is a problem. While exiting the NE Unit, approximately 10:15 a.m., an interview was conducted with a Hospice Representative, RN, (Staff R). She identified the 5 residents that she was at the facility to visit, of which none were located on the Central Unit. 8) On the Central Unit (CU): At 10:18 a.m., an observation conducted of the closed doors to the Central Unit (CU), entering from the main hall, revealed no signage present on the closed doors to reflect that isolation precautions were in effect on the unit. The surveyor entered the unit. At 10:18 a.m., the Central Unit was observed. Nursing staff and CNAs were observed to be wearing yellow gowns upon the entrance to the unit. Gloves were not observed on the nursing staff or CNAs hands at the time of entrance to the unit. At 10:20 a.m., an interview was conducted with Staff F, RN. She stated that she was acting as unit manager for rooms 1-29 (CU). She stated that she was working 9:00 a.m.-5:00 p.m. that day. She was asked what the census was of the unit. She stated that she could find that information out, that she just got there. She was asked why the staff were wearing gowns on the unit. This is called the yellow zone, all staff on the unit are to wear the gowns. When asked if there were any COVID + cases on the unit, she stated, No. When asked if there were any residents that were suspicion COVID cases on the unit, she stated, Can find out, just got here. She was asked what the yellow zone meant. She did not have an answer. At 10:20 a.m., the Hospice Nurse, RN, (Staff R) was observed to enter the CU hall from the north end, she was walking up the hall. She was observed not to have a gown or gloves on. She was observed to walk pass the nursing station. No staff were observed to interrupt her to educate her to wear gown and gloves on the unit. At 10:22 a.m., a staff member was observed behind the nursing station talking to nurses. He was observed to have a mask on, but no gown. He was interviewed, Staff G (Transportation). He stated that he was transportation, he worked 7 a.m.-3 p.m. Staff G stated he did not know that the CU was a yellow zone or that he needed a gown. Staff F, RN, was observed to then direct Staff G to go see the ADON (Assistant Director of Nursing). At 10:24 a.m., during an observation in front of the CU nurses' station Staff Q, RN was standing, she was observed to have a lab coat on, mask on, no gown or gloves. She stated that she was a Health Care Provider, that she was at the facility to visit residents and some of the residents were located on CU. She stated that she had been in the building for 1.5 hours. Staff Q, RN, was asked if anyone at the facility had talked to her about wearing PPE (gowns and gloves) on CU this morning. She stated that they did not talk to me about PPE on this unit. She stated that she did not know where they kept the gowns. At 10:25 a.m., an observation was conducted of Staff H, Dietary Aid. Staff H was pushing a dietary cart through the CU hall. Staff H was observed to have a mask and gloves on. Staff H was observed not to have a gown on. Staff H was interviewed, she stated that she had not received any training about putting on a gown. She stated that no one had told her to use a gown on the unit. She stated that the staff had just started to use the gowns this morning because the surveyors were in the building and that they were not using the gowns yesterday. At 10:40 a.m., the surveyor exited the west end of the unit. No signage regarding disposal of PPE was posted at the exit, nor was there any biohazard containers present to dispose PPE in prior to exiting the CU. At 10:41 a.m. an observation was conducted in the main hall entrance area, just outside of the CU. About to enter the CU, standing with Staff F, RN, was an outside Health Provider, Staff S, a Radiologist technician. He was observed wearing a mask, fabric. He confirmed that the mask was his own. He was observed to be wearing scrubs, no other PPE (gown or gloves). Staff S stated that he was going to go on CU, that he was seeing Resident #21 for a chest X-ray and EKG. He stated that on the SW (South West) unit, he was seeing Resident #17 and Resident #13 also. He stated that he had been in the facility yesterday, that he had asked if any of the residents were COVID (+) , I could not get a straight answer. Staff S was observed to move forward to the doors of the CU. Staff F, RN was observed not to offer the Staff S any PPE, nor was she observed to educate Staff S about wearing PPE on the unit. As, Staff S was about to enter the CU, the surveyor turned and asked Staff F, RN, Is everyone supposed to wear a gown on the unit? She answered, I can give him a gown. She was observed to leave the area and then return with a gown and provided it to the Staff S. Staff S was asked if anyone had told him to don PPE prior to entering the CU, he stated no. At 10:45 a.m., the CU was observed again. An observation of Staff J, an Advanced Nurse Practitioner (ARNP), she was standing in the hallway at the CU nurses' station with no PPE on, talking to nurses behind the station. (The nurses' station is located in the center of 4 adjoining hallways of the unit). Staff F, RN was observed to approach and speak to Staff J, ARNP, and they moved to the nurse's office, where the Staff J, ARNP put on a gown. The surveyor asked Staff J, ARNP why she was putting a gown on. She stated that the unit is a hot spot , there are residents with fevers and [MEDICAL CONDITION] from over night. I have a list of residents to review. Staff J, ARNP, provided a printed list, dated 04/22/20 at 7:55 a.m., which listed 52 residents' names of which 9 residents had stars beside the name. She stated that the ones that had the marks (stars) were the ones that she was going to review. The list reflected a vitals review, which had oxygen saturation rates, and temperatures. In addition, the form had 7 residents (#8, #10, #11, #12, #13, #14, and #15.) identified with swab done 04/21 p.m.-no results. Resident #15 resided on the CU. Residents #8, #10, #11, #12, #13, #14 resided on the SW Unit. At 10:47 a.m., Staff F, RN was asked about being outside of the CU with Staff S, the Radiology tech and if she had told him about putting on PPE for working on the CU. She stated, No, I was not instructed to tell him to put on a gown. At 10:50 a.m., on 4/22/20, an interview was conducted with Staff I, CNA. She stated that normally she works 3:00 p.m.-11:00 p.m., but they called me, and I came in this morning at 9:00 a.m., they gave me a gown and mask to wear. I do not know if there are any COVID (+) residents on the unit (CU). A review of the residents on the Central Unit who were suspected COVID cases: The residents were exhibiting signs of increased temperature (fever), decrease in oxygen saturation rates, lethargy (#19, #21, #22). COVID-tests had been ordered or had been completed for the residents (#19, #20, #21, #22 and #10). A review of Resident #19's clinical chart, the Admission Record, documented an admission of 03/25/20. Admission [DIAGNOSES REDACTED]. Resident #19 resided in the Central Unit. A review of Resident #19's Progress Notes: 04/22/20, 12:32, Nurse Practitioner Note: Spoke at length about plan of care. Patient is aware he has pneumonia and that we will be screening for COVID-19, risks and benefit discussed, he would like to start [MEDICATION NAME] therapy 04/21/20, 14:20: resident c/o cough/congestion spoke with NP received new order for a 2 view CXR for cough congestion. A review of the vitals sheet, print date of 04/22/20 at 7:55 a.m., that was obtained from the ARNP documented Resident #19 had an O2 saturation 95 dipped to 90%. This resident had a star beside his name for the ARNP to review. A review of the facility COVID-19 Line List for Residents reflected an entry for Resident #19: SX (symptoms) onset=04/21/20, temperature=96; Droplet Precautions; treatment details: isolation, labs, EKD; test date=04/22/20; notified DOH on 04/22/20. A review of Resident #20's clinical chart, the Admission Record, documented an admission of 02/15/20. Admission [DIAGNOSES REDACTED]. Resident #20 resided on the South East Unit. Review of Progress Notes: 04/22/20, 13:05, Nurse Practitioner Note: EKG reviewed and demonstrates sinus [MEDICAL CONDITION]. Patient has had a fever and [MEDICAL CONDITION]. Lethargy and confusion noted along with shortness of breath. CXR pending. Attempted to call (family member) . Will follow up to update on plan of care. 04/17/20, 16:30: Resident being transferred over from SW unit, meds received including 5 [MEDICATION NAME] 5-325 mg. A review of the vitals sheet, print date of 04/22/20 at 7:55 a.m., that was obtained from the ARNP documented Resident #20 had an O2 saturation level of 87%. This resident had a star beside his name for the ARNP to review. A review of the facility COVID-19 Line List for Residents reflected an entry for Resident #20: SX onset=04/21/20, temperature=96.8; No respiratory symptoms; Droplet Precautions; treatment details: isolation, labs, EKG; test date=04/22/20; notified DOH on 04/22/20. A review of Resident #21's clinical chart, the Admission Record, documented admission in 01/2020. [DIAGNOSES REDACTED]. Resident #21 resided on the CU. A review of Resident #21's progress notes: 04/22/20, 16:52: Reviewed labs and no new orders ordered. Continue to monitor. 04/22/20, 12:45: Nurse Practitioner Note: Stat labs includes CBC, CMP, RSV panel, COVID 19. 04/22/20, 12:33: Reviewed CXR and noted Pneumonia, resident appearing lethargic, but arousable, able to make his needs known, .[MEDICATION NAME], . 04/22/20, 10:20: Resident noted with fever of 100.2 overnight. He was observed at bedside and noted this morning with temp of 100, he denies headache, N/V, dizziness, no persistent cough . 04/22/20, 10:19: Resident was observed with temp 100.2. ARNP notified new order for stat labs, X-ray, EKG, Midline. Call placed to i/v department for the i/v insertion. Awaiting i/v team. 04/17/20, 16:33: Resident being transferred over from SW unit, meds received, no narc received. A review of the vitals sheet, print date of 04/22/20 at 7:55 a.m., that was obtained from the ARNP documented Resident #21 had an O2 saturation level of 93% and temperature of 100.7. This resident had a star beside his name for the ARNP to review. A review of the facility COVID-19 Line List for Residents reflected an entry for Resident #21: SX onset=04/21/20, temperature=98.1; no cough, No respiratory symptoms; Droplet Precautions; treatment details: isolation, labs, EKG; test date=04/22/20; notified DOH on 04/22/20. A review of Resident #22's clinical chart, Admission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105140	A. BUILDING _____ B. WING _____	**04/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRISTOL AT TAMPA REHAB AND NURSING CENTER LLC	**1818 E FLETCHER AVE TAMPA, FL 33612**

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 -** Many	(continued... from page 3) Record, documented an admission of 02/17/20. DX information included [MEDICAL CONDITION] and unspecified systolic (congestive) heart failure. Resident #22 resided on CU. A review of Resident #22's progress notes: 04/22/20, 12:59, Nurse Practitioner Note: spoke with (family member) about patient's condition and the COVID-19 cases in the facility. She agrees with the CXR and IV antibiotics for potential pneumonia. [MEDICATION NAME] therapy discussed at length, but she does not want to start therapy at this time. Will continue to monitor. 04/22/20, 10:56: NP present received new orders for 2-view CXR, EKG-pneumonia. A review of the vitals sheet, print date of 04/22/20 at 7:55 a.m., that was obtained from the ARNP documented Resident #22 had an 02 sat=87% and temperature 99.1 x 2. A review of the facility COVID-19 Line List for Residents re