STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105426	A. BUILDING _____ B. WING _____	**08/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WOODBRIDGE CARE CENTER	**8720 JACKSON SPRINGS RD TAMPA, FL 33615**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and policy review, the facility did not ensure respect and dignity were provided in a manner that promoted and enhanced the quality of life for residents related to direct care staff speaking in their preferred language in common areas of the facility and in the presence of residents that did not understand the language spoken. Findings included: On 8/2/2020 at 10:55 a.m. Resident #6 was seated in his wheelchair in the doorway to his room. During the interview he said that the CNAs (certified nursing assistants) talk Spanish in his room all the time. The resident said that when one (CNA) comes in to help him, others come in and they speak Spanish to each other, holding side conversations he does not understand. The resident said that he has asked them to please not speak Spanish in his room while they are caring for him because he doesn't speak Spanish, But they keep doing it. He said that staff will stand in the hallway and speak Spanish to each other as well. A review of the Admission Record for Resident #6 revealed an initial admitted to the facility on [DATE] and a readmission on 6/17/17. The [DIAGNOSES REDACTED]. Resident #6's current care plan focus showed, (Resident #6) has strength in communication AEB is able to hear at normal tones, speech is clear and easily understood, Communicates needs to staff with an initiated date of 3/17/17. The interventions included, Speak to resident in clear tones. During a tour of the facility with the Unit Manager at 11:40 a.m., Staff G, Registered Nurse (RN); Staff C, RN; and Staff F, RN were overheard speaking Spanish to each other while sitting at the nurses' station. In an interview at 11:42 a.m. of Staff D, Certified Nursing Assistant (CNA) revealed that Staff D, had limited English communication skills. When Staff D was asked if she wiped down resident equipment after each use, she answered, We use two people when we use the lift. She was then asked, with hand motions to imitate wiping, if she wiped the lift with bleach wipes. She smiled and said, Yes, two people. In an interview at 12:25 p.m., Staff E, CNA was asked about the placement of call lights. When asked if she was the CNA responsible for the residents in room [ROOM NUMBER], whose call lights were previously observed not within reach of the residents, she said, Si and pointed to the room and then to herself. When asked where she puts the call lights for residents, she nodded her head and said, They are mine. The CNA was asked again, Where do you put the call lights for the residents? She nodded her head again and said, Si. In an interview at 11:20 a.m. with Staff B, Licensed Practical Nurse (LPN), UM, she said that the staff have been educated multiple times about speaking Spanish in front of the residents who only speak English. She said that staff was allowed to speak Spanish in front of Spanish speaking residents, and in the employee break areas. She said that she has observed staff talking in Spanish, and that she reminds them to speak in English in any area a resident may be, unless they are speaking directly to a resident who speaks Spanish. She said, We do a lot of in-services about it. We talk to them all the time about it. A review of the facility policy titled, Quality of Life-Dignity, with a revision date of August 2009, showed the policy statement as, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that the call light was within reach for 3 residents (#5, #6, and #7) of 75 residents in the facility. Findings included: On 8/2/2020 at 10:55 a.m. Resident #6 was seated in his wheelchair in the doorway to his room and said that his call light was usually on the floor, and that when he is up in his chair it is never within reach. At the time of the interview, the resident's call light was observed lying on the floor (Photographic Evidence Obtained). The resident said that when he is up in his chair, he usually has to come out into the hallway to get someone's attention. He said that when he is in bed and can reach the call light, It takes a long time for anyone to answer, and when they do, they say they'll be right back, and then don't ever come back. A review of the Admission Record for Resident #6 revealed an initial admitted to the facility on [DATE] and a readmission on 6/17/17. The [DIAGNOSES REDACTED]. Resident #6's current care plan focus for falls and/or fall related injury initiated on 6/13/17 revealed the interventions to include, Keep call light within reach. During an interview and observations at 12:07 p.m., with the Nursing Home Administrator (NHA), Resident #5 and Resident #7 could be seen in their shared room from the hallway. The observation revealed that neither resident had their call light within reach. Resident #5's call light was clipped to the privacy curtain between the beds, and the curtain was pulled in such a way that the call light was behind the resident on the right side. Resident #7 was up in her wheelchair, on the right side of her bed, and the call light could not be seen. When asked about the placement of the call lights, the NHA donned personal protection equipment (PPE), entered the room and moved Resident #5's call light within reach. When the NHA was asked where Resident #7's call light was, she found it clipped to the left side of the bed and tucked underneath the resident's pillow. The NHA placed the call light on the right side of the bed where the resident was sitting and clipped it to the bed, so it would not fall. The NHA came out of the room, doffed her PPE, and said that it was her expectation for call lights to be within reach of residents at all times. In an interview at 11:20 a.m., with Staff B, Licensed Practical Nurse (LPN)/Unit Manager (UM) she said that all call lights should be within reach of the resident. If they are up in their wheelchair, the call light should be in a position so that the resident can reach and use it. If the resident is in bed, then the call light should be pinned close to the resident. She said that some residents like it pinned to their blankets or their gown. A review of the Admission Record for Resident #5 revealed an initial admission date of [DATE] and a readmission date of [DATE]. The [DIAGNOSES REDACTED]. Resident #5' care plan focus for risk for falls and/or fall injury initiated on 7/14/16 revealed the interventions to include, Keep call light within reach. A review of the Admission Record for Resident #7 revealed an initial admission date of [DATE] and a readmission date of [DATE]. The [DIAGNOSES REDACTED]. Resident #7's care plan focus for alteration in communication ability initiated on 4/19/20 revealed the interventions to include, Keep call light within reach; respond to communicated needs prn (as needed). In an interview at 3:13 p.m., the NHA said, We don't have a policy about call lights, but we just go by standards of practice. Answer the call lights within 5-10 minutes and then when placing the call light, it should be within reach for resident use.
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	Based on interview and record review the facility failed to inform residents, the representatives and families of suspected or confirmed COVID-19 cases in the facility from 7/09/20 to 8/02/2020 related to the 13 staff members (H, I , J ,K,L,M,N,O,P,Q, R,S and T) of 13 staff members that had positive COVID-19 results. Findings included: During an interview with the Nursing Home Administrator at 2:12 p.m. on 8/2/2020, she was asked to provide documented evidence that family and residents were notified of the 13 staff members (H, I , J ,K,L,M,N,O,P,Q, R,S and T) that had tested positive for COVID-19 from July 9, 2020 thru July 30, 2020. The NHA confirmed that she had not informed the residents that were alert and oriented of the results for the 13 staff members that had positive COVID-19 results. A review of the policy titled,

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.

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F 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Reporting Confirmed or Suspected COVID-19 Cases, dated June 2020 indicated, The purpose of this policy is to guide reporting of suspected and confirmed COVID-19 to the appropriate governmental agency. In addition, to guide reporting of all confirmed COVID-19 cases to residents, their representatives and families according to the requirements set forth. Under General Guidelines #2 showed, Inform residents, their representatives, and families of those residing in the facility by 5:00 p.m. the next calendar day following the occurrence of either a signal confirm infection of COVID-19, or three or more residents or staff with a new on-set of respiratory symptoms occurring within 72 hours of each other.