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 _____	**05/08/2020**

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 -** Few	**Provide and implement an infection prevention and control program.** Based on observations, interviews and record reviews, the facility did not consistently follow infection control guidance for four of four sampled residents of a total reported census of 142 (1, 2, 3, and 4) including: 1) Lack of COVID 19 status in the transport and receiving facility documentation of Residents #1 and 2 to an acute care setting; 2) lack of precautions signage and use of appropriate staff PPE wear for Residents #3 and #4; and 3) appropriate containment of used PPE. Findings included: 1. While at the facility, on 05/08/2020 at 1:50 p.m., five emergency transport vehicles were observed in the driveway of the facility. The Administrator, who was outside with the surveyor, confirmed that positive test results had been received and per their policy, the facility was transferring those residents with positive COVID 19 test results to local hospitals. While Resident #1 was being loaded onto the transport van, the surveyor reviewed the transferring documents to ensure the hospital was receiving documentation that the resident had tested positive for COVID-19. There was no document that notified the hospital of the resident's positive status. The AHCA Form 3120-0002, Nursing Home Transfer and Discharge Notice documented that the resident had had a change in condition and his needs could not be met in the facility. When the packet was handed back to the transport staff, the missing document and information was reported. The transport staff asked who she could talk with to get that document as she knew the hospital would look for it. A second resident, Resident #2, was being loaded into the transport van for transport to the hospital after receiving a positive test result for COVID-19. His discharge packet was reviewed and noted there was no document indicating that the resident had tested positive for COVID-19. In an interview with the Director of Nursing, on 05/08/2020 beginning at 3:45 p.m., she confirmed that the packets of information should include the resident's COVID-19 status. She reported that someone else had taken her place to compile the packets and that nurse must not have known to include the COVID+ status document. 2. An interview was conducted on 05/08/2020 at 12:19 PM with Staff C, Unit Manager (UM) during a tour of the 300 hall of the facility (Northeast). Staff C, UM stated that two residents tested positive for COVID-19 and were sent to the hospital around 10:00 PM on 05/07/2020. Staff C, UM also stated that the roommate of those residents, Resident #3, remained in the facility and was on quarantine. An observation was made of the outside of Resident #3's room. No isolation equipment or signage indicating that the resident was on any sort of isolation was observed. Staff C, UM addressed that absence of signage postings and isolation equipment and stated, I'll put some signage outside of the door. 3. An observation was made on 05/08/2020 at 12:32 PM of Staff D, Social Services Director (SSD) distributing protective gowns to Resident #3's room. Staff D, SSD was observed going into Resident #3's room and closing the door. Staff D, SSD was wearing an N95 mask and no other Personal Protective Equipment (PPE) at the time of the observation. An interview was conducted with Staff D, SSD following the observation. Staff D, SSD stated that she was not aware that Resident #3 was on any type of precautions before entering the room. Staff D, SSD addressed that there was no signage posted on the outside of Resident #3's door. An interview was conducted on 05/08/2020 at 01:09 PM with the facility's Director of Nursing (DON). The DON stated that Resident #3 should have been placed on isolation precautions once the positive COVID-19 test was confirmed for the two roommates that were sent to the hospital. The DON also stated that staff should be wearing an N95 mask, gown, gloves, and a face shield before entering Resident #3's room due to potential exposure. The DON stated that Resident #3 should have PPE and signage outside of the room to inform staff, but it was not done. 4. An observation was made on 05/08/2020 at 01:52 PM during a tour of the facility's Central unit of Staff F, CNA assisting Resident #4 with eating her lunch meal. Staff F, CNA was observed sitting approximately 2 feet away from Resident #4 and was not wearing a mask or face covering while assisting. A mask was observed hanging from Staff F, CNA's ears. Staff F, CNA was observed putting her N95 mask back on following the initial observation. An interview was conducted on 05/08/2020 at 02:04 PM with Staff E, Registered Nurse (RN). Staff E, RN stated that all staff on the unit have been directed to wear an N95 mask and should not remove the mask for any reason while still on the unit. An interview was conducted on 05/08/2020 at 02:10 PM with Staff F, CNA. Staff F, CNA stated that all staff on the unit wear N95 masks, hair protection, foot coverings, eye protection, a protective gown, and gloves due to possible COVID-19 exposure. Staff F, CNA also stated that staff are not to take their masks off while on the unit for any reason and that education was conducted regarding proper mask use. Staff F, CNA addressed that she was not wearing a mask while assisting Resident #4 with her lunch meal. Staff F, CNA stated that she took her mask off in order to talk to Resident #4's roommate and that she had to take the mask off so the resident could hear her. Staff F, CNA addressed that the N95 mask is used to prevent possible COVID-19 exposure to either herself or any residents on the unit and stated that she knew that she was not supposed to remove the mask, 5. An observation was made on 05/08/2020 at 02:17 PM at the exit doors of the facility's Central unit of a cardboard box that read therapy filled with used PPE, including several used isolation gowns, foot coverings, and hair coverings inside. Several items of used PPE were observed to be laying on the floor next to a clear plastic garbage bag with used PPE inside. Staff E, RN addressed that the items looked like trash and that it should not be on the floor of the unit. An interview was conducted on 05/08/2020 at 03:26 PM with the facility's Housekeeping Supervisor. The Housekeeping Supervisor stated that staff are to put used PPE inside of a red biohazard bag when disposing of it and then into the proper biohazard container for disposal. The Housekeeping Supervisor also stated that used PPE should not be put into a cardboard box and that housekeeping staff should be checking trash cans twice daily to ensure they are not overflowing onto the floor. An interview was conducted on 05/08/2020 at 05:20 PM with the facility's DON. The DON stated that staff are not to remove their face masks for any reason and stated that it is absolutely unacceptable for a staff member to remove their mask while feeding a resident.

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