

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>105553</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/02/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>CARROLLWOOD CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP <b>15002 HUTCHINSON RD TAMPA, FL 33625</b>	
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  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<p><b>Provide and implement an infection prevention and control program.</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on interview and record review, the facility failed to implement the facility's process for monitoring of residents' temperatures to identify possible symptoms of COVID-19 for two (R1 and R2) of four residents reviewed for monitoring after admission or readmission to the facility during a COVID-19 Focused Infection Control Survey. Findings include: 1. Review of R1's Progress Note, dated 3/19/20 at 10:58 pm, revealed, Resident admitted from VA Hospital after treatment for [REDACTED]. Vital signs stables (sic). Review of R1's documented temperatures from 3/19/20- 3/27/20, revealed R1 had no documented temperature readings 3/20/20, 3/21/20, 3/22/20, and 3/23/20. Further review of R1's progress notes revealed: 3/25/20 at 12:04 pm, .The resident has a respiratory infection. The resident is on isolation. This was newly identified this shift .The resident is on droplet precautions. Room type is private. The resident is on strict isolation and may not leave the room . 3/27/20 at 6:08 am, .on isolation for possible exposure to COVID 19 . 2. Review of R2's Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form, dated 3/27/20, revealed that R2 was readmitted to the facility following a hospitalization . R2's [DIAGNOSES REDACTED]. Review of R2's Care Plan Intervention, dated 3/30/20, revealed, Observe for s/sx (signs and symptoms) of COVID-19 - document and promptly report s/sx: COVID S/S (signs and symptoms) are sudden onset of fever 100.4&gt; (or greater), COUGH and/or SOB (shortness of breath). Review of R2's documented temperatures from 3/27/20- 4/2/20, revealed that R2 had no documented temperature readings on 3/29/20 and 4/1/20. During an interview on 4/2/20 at 3:23 pm with the Regional Consultant, Registered Nurse (RN1), and the Administrator, when asked about R1, the Regional Consultant revealed, This is our gentlemen that was exposed (to COVID-19). The department of health called on the 24th (of March) . During the same interview, when asked when the facility initiated the increased surveillance of residents for signs and symptoms of COVID-19, the Regional Consultant revealed, the facility began increased monitoring of residents on 3/24/20. When asked how often the facility is monitoring residents for signs and symptoms of COVID-19, the Regional Consultant revealed, .with respiratory symptoms temperatures are done twice per shift. Everyone else has vital signs every day. During review of R1's electronic medical record, when asked if temperatures had been documented per the facility's protocol for new admissions from 3/19/20 - 3/24/20, the Regional Consultant stated, From the weights and vitals listing, I did not see it. During an interview on 4/3/20 at 10 am, the Regional Consultant and the Administrator were unable to provide further documentation of temperatures being performed on R1 or R2. During the same interview, the Administrator stated, I am not sure exactly what the problem is here, if it's new staff or agency staff, but we are rolling out more education and developed an audit tool. Review of the facility's Vital Sign Protocol, dated 2/2020, revealed, .The following circumstances require the completion of vital signs as a standard protocol .72 hours after admission, minimum of one time per shift (3x's per day if using 12 hour shifts) . Review of the facility's Guidance for step down unit/co-horting upon Return from Hospital/other location, no date, revealed, Enhanced Monitoring: Vital Signs and oxygen saturation will be taken every shift with temperatures twice a shift along with a quick respiratory assessment (Shortness of Breath, cough, and/ or sore throat), as clinically indicated. Deviations in vital signs will be reported to the practitioner .</p>		
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.