

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Tarpon Bayou Center		STREET ADDRESS, CITY, STATE, ZIP CODE 515 Chesapeake Dr Tarpon Springs, FL 34689	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>37999</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure 4 residents sitting at one of four tables were treated in manner of dignity and respect related to staff spraying cleaner directly onto the table in front of the residents, and failed to dress one (#107) out of 7 residents sampled on the memory care unit in clothing belonging to them.</p> <p>Findings included:</p> <p>1. On 4/9/24 at 8:41 a.m., Staff L, Certified Nursing Assistant (CNA), was observed spraying an unknown clear liquid onto a square table in the memory care unit where Resident #24, Resident #73, and 2 unknown others were sitting. The staff member wiped a cloth through the liquid, pushing crumbs towards one of the unknown residents. and off the edge of the table.</p> <p>On 4/9/24 at 8:58 a.m. Staff Q, Housekeeper was observed spraying a liquid onto a table in front of Resident #24 and another unknown resident; the staff member waited a few moments then wiped the liquid away.</p> <p>An interview was conducted with Staff Q on 4/9/24 at 9:02 a.m., the staff member reported the liquid was a name brand broad-spectrum disinfectant. Staff Q stated yes confirming she normally does spray the liquid in front of the residents.</p> <p>During an interview on 4/11/24 at 3:11 p.m., the Director of Nursing (DON) stated it was not appropriate to spray cleaner(s) on table in front of residents. She said they are supposed to spray the cleaner on a towel (demonstrated pumping trigger-motion in front of flattened hand).</p> <p>2. On 4/8/24 at 9:49 a.m. Resident #107, a male resident, was observed sitting at table on the secured memory care unit wearing an orange t-shirt and matching orange ankle socks. On 4/8/24 at 10:22 a.m., the orange socks worn by Resident #107 was observed as labeled with Resident #98's last name and first initial. , a female resident.</p> <p>An interview and observation was conducted with Staff M, Certified Nursing Assistant (CNA) on 4/8/23 at 10:34 a.m. The staff member confirmed the resident (#107) was wearing Resident #98's socks and reported not being Resident #107's aide on that day.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999</p> <p>Based on observations, record reviews, and interviews, the facility failed to maintain a homelike environment on one (300) of four units and failed to ensure one of two resident patios was not used for storage of facility housekeeping equipment, sunshade, rolled up mattresses, and an unused bed frame.</p> <p>Findings included:</p> <p>On 4/8/24 at 10:02 a.m., Resident #103 reported to this writer that the unit was cold. The observation of a hallway thermostat read 71 Fahrenheit (F). An observation of Resident #103's room revealed a bedside dresser without drawers beside the resident's bed, the window blinds in the window of room the room were broken, the string used to maneuver the blinds to an open/close position had been cut/frayed. Resident #103 was observed maneuvering the individual slats of the blinds into a closed position. The observation revealed in the bathroom shared with room [ROOM NUMBER] a roll of toilet paper on back of the toilet while a toilet paper holder attached to the wall above a safety handle on the mutual wall of room [ROOM NUMBER] did not have a tube and two tube holders were sticking out. Photographic evidence was obtained.</p> <p>An observation was conducted on 4/8/24 at 2:34 p.m. of the covered patio outside of the main Dining Room (DR). The observation of one side of the patio revealed 2 rolled mattresses with air pumps, a patio umbrella stand, an unfolded tan-colored piece of woven mesh, and two commercial floor buffers. The observation of the opposite side of the patio revealed an industrial floor scrubber. The middle area of the patio held multiple tables, along the bottom edge of the sliding door was a piece of rubber-type material with a black/brownish substance covering it. The area between the patio and smoking area contained a blue 5-gallon insulated water jug which held a minimal covering of water (well below spigot level) with pieces of unidentified substance floating in it, an insulated chest sat on the ground beside the hydration cart which had black and brown substances attached to the inside and outside of it, and a rusty industrial stand-up fan next to it. A sign posted next to the fan and above the dirty insulated chest read Sun Safety Center - Stay Hydrated. A bed frame was observed on the patio outside of the covered area.</p> <p>An observation was conducted on 4/9/24 at 3:12 p.m. of the covered patio area outside of the main dining room where 8 residents were participating in an activity of Charades. The bed frame observed outside of the area on 4/8/24 had a mattress lying on it. An extension ladder was propped against the railing of the uncovered patio area. An industrial floor scrubber continued to be stored near the entrance to the smoking patio under the covered patio, and the two rolled mattresses with pumps and the two previously viewed floor buffers were stored next to the sliding doors between the main dining room and covered porch. The rusty fan was observed in the Hydration area.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview and observations were conducted with the Environmental Director (ED) on 4/11/24 at 2:10 p.m., the ED stated the temperature on the secure unit had been turned down and the box covering the thermostat had been unlocked. The ED stated the dresser without drawers in room [ROOM NUMBER] was used as a television stand so it had been removed. During the observation of the covered and uncovered patio outside of the main dining room with Environmental Director, he reported not considering the patio area a resident area but did confirm residents did come out onto the covered patio with families and with therapy. The observation revealed a Physician Assistant sitting at one of tables with an unknown resident or representative. The ED stated the previously observed mattresses were to be picked up by a vendor and they needed an area accessible for unknown pickup, the brown/tan colored mesh was a sunscreen that had been taken down and the floor equipment was housekeeping. He stated the problem with this building was it didn't have any storage. The ED viewed the floor equipment, currently stored on the resident's patio and stated they probably shouldn't store them there, and confirmed the residents had an activity on the covered patio earlier in the week.</p> <p>A request was made on 4/9/24 for a policy regarding Maintaining a Homelike Environment. The facility wrote no policy on the returned request list.</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015</p> <p>Based on record review, interview and review of the facility's policy titled physician notification, the facility failed to ensure one Resident (#12) out of five residents reviewed for unnecessary medications had a significant change in condition assessment completed prior to antibiotic use.</p> <p>Findings included:</p> <p>A review of the Admission Record showed Resident #12 was admitted to the facility on [DATE] with diagnoses that included but was not limited to unspecified focal traumatic brain injury without loss of consciousness, major depressive disorder, other seizures, schizophrenia and anxiety disorder, unspecified.</p> <p>Review of the Order Summary Report revealed a physician order dated 04/03/24 for Doxycycline Hyclate Oral Tablet 100 MG [milligrams] (Doxycycline Hyclate)- Give 1 tablet by mouth every 12 hours for UTI [urinary tract infection] for 10 Days.</p> <p>Review of Resident #12's care plan revealed, Focus: ANTIBIOTIC: The resident is on Antibiotic Therapy r/t Has a Bacterial Infection (UTI). Goal: Minimize the risk of spread and Will be free of any discomfort or adverse side effects of antibiotic therapy through the review date. Interventions: Administer medication as ordered, Report pertinent lab results to MD, Standard Precautions, Observe for possible side effects every shift, Observe diarrhea, nausea, vomiting, anorexia, and hypersensitivity /allergic reactions. Monitor for adverse reaction, Offer and/or encourage fluids through out the day. Antibiotics are non-selective and may result in the eradication of beneficial microorganisms and the emergence of undesired ones, causing secondary infections such as oral thrush, colitis, and vaginitis and Monitor for presence or absence of pain; level & effectiveness of pain medication.</p> <p>Review of Resident #12's lab results showed no urinalysis (UA) available for the dates of 04/01/24-04/03/24 prior to the use of antibiotic treatment.</p> <p>Review of Resident #12's Standard Evaluations for change of condition (CoC) evaluations, showed one CoC dated 09/07/23. There were no CoC available for Resident #12's weakness and antibiotic use for symptom onset of 04/01/24.</p> <p>Review of Progress Notes revealed the following:</p> <p>-A progress note dated 04/8/2024 at 10:44 p.m., showed, Resident continued on [oral] PO [antibiotic] ABT for [urinary tract infection] UTI No adverse reaction noted on this shift. No sign of discomfort noted. Resident denied dysuria.</p> <p>-A progress note dated 04/7/2024 at 10:35 p.m., showed, Resident on [antibiotic] ABT for UTI no adverse reactions noted will continue with care plan.</p> <p>-A progress note dated 4/3/2024 at 5:20 a.m., showed, Unable to collect urine for testing. Had resident in bathroom but, he could not urinate at that time. Will ask 7-3 shift to try or get a cath order.</p> <p>(continued on next page)</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-A progress note dated 04/01/23 at 2:48 p.m., showed, MD [medical doctor] in to see resident noted with increased weakness. New order received for stat and routine labs.</p> <p>During an interview on 04/11/24 at 8:40 a.m., Staff E Registered Nurse (RN) Unit Manager (UM) stated Well here is the thing, we tried three times to get a urine sample and was unsuccessful. Staff E RN/UM stated the doctor decided to order Resident #12 Doxycycline as a preventive measure without confirming the urinary tract infection because Resident #12 looked pale and was weak.</p> <p>During an interview on 04/11/24 at 9:35 a.m., the Director of Nursing (DON) was asked for the facility's policy and procedure for urinary tract infection (UTI) protocol but stated, there was no policy or procedure for UTI.</p> <p>During an interview on 04/11/24 at 9:40 a.m., the Infection Preventionist (IP) confirmed the progress notes showed staff were going to straight cath Resident #12 but when Staff E RN/UM talked to the physician, the physician chose not to straight cath Resident #12 and just put him on an antibiotic. The IP confirmed there was no change of condition assessment completed which she would have expected there would have been one.</p> <p>Review of the facility's policy titled,Physician Notification dated October 2021 revealed,</p> <p>Procedure:</p> <p>1. Licensed nurses will ensure that physicians are notified of changes in diagnostic results that occur between visits. Changes may include but are not limited to:</p> <ul style="list-style-type: none"> - Change in condition, mental or physical - A change in the status of a wound - the development of a new wound -Laboratory Results - Diagnostic Results - Consultant reports and recommendations - Family concerns related to medical care - events - Resident's refusal to take medication - Any time a medication is not ordered or administered

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015</p> <p>Based on record review and interview, the facility failed to ensure multiple Minimum Data Set (MDS) assessments accurately reflected diagnoses of one Resident (#85) out of 33 sampled residents.</p> <p>Findings included:</p> <p>A review of the Admission Record showed Resident #85 had an admitted [DATE] with diagnoses that included but not limited to encounter for orthopedic aftercare following surgical amputation, acquired absence of left above the knee, lack of coordination, schizophrenia, and major depressive disorder, recurrent.</p> <p>A review of the Order Summary Report revealed a physician order dated 04/04/24 for Doxycycline Hyclate Oral Tablet 100 MG [milligrams] (Doxycycline Hyclate)- Give 1 tablet by mouth every 12 hours for UTI [urinary tract infection] for 10 Days.</p> <p>Review of Resident #85's care plan revealed, Focus: PSYCHOTROPIC MED: The resident uses psychotropic medications r/t Antidepressant to manage: depression Antipsychotic to manage: schizophrenia with initiated date of 10/13/24. Goals: Resident will be at the lowest doses required to reduce symptoms while minimizing adverse side effects to ensure maximum functional ability both mentally and physically through the next review with initiated date of 10/13/24. Interventions: Obtain and review lab/diagnostic work as ordered. report results to MD and follow up as indicated, Psychotropic Side Effects Monitoring, Administer medication as ordered and observe/document for side effects and effectiveness, Psychological services per order and as needed, Psychiatry services per order as needed per protocol, Consult with pharmacy, MD to consider dosage reduction when clinically appropriate and Report to physician negative outcomes associated with use of drug with initiated date of 10/13/24.</p> <p>Review of all available Minimum Data Sets (MDS) in Resident #85's medical record revealed the following:</p> <ul style="list-style-type: none"> -Review of the in progress Quarterly MDS dated [DATE] revealed Section I -Active Diagnoses under Psychiatric/Mood Disorder Schizophrenia was marked No with response locked. -Review of the Quarterly MDS dated [DATE] revealed, Section I -Active Diagnoses under Psychiatric/Mood Disorder Schizophrenia was marked No -Review of the Admission MDS dated [DATE] revealed, Section I -Active Diagnoses under Psychiatric/Mood Disorder Schizophrenia was marked No <p>During an interview on 04/10/24 at 4:50 p.m., the Regional Nurse Consultant (RNC) confirmed Resident #85 had Schizophrenia on admission with onset date of 10/11/23 shown on the admission record.</p> <p>During an interview on 04/11/24 at 5:00 p.m., the MDS Coordinator, Registered Nurse (RN) stated that Resident #85 did have schizophrenia upon admission to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/10/24 at 5:06 p.m. the Director of Nursing (DON) provided an admission document titled Chart Summary dated 10/08/23 from local area hospital and stated this was used during Resident #85's admission to show he had the diagnosis of schizophrenia at admission.</p> <p>Review of the Chart Summary dated 10/08/23 from [local area hospital] showed History of schizophrenia psychiatry following- Feels patient does not have capacity at the moment.</p> <p>During an interview on 04/11/24 at 10:15 a.m., the Clinical Reimbursement Director (CRD), Registered Nurse (RN) stated Resident #85 did have a diagnoses of Schizophrenia and the diagnosis was missed on the Admission MDS dated [DATE], the Quarterly MDS dated [DATE] and showed an answer of no for schizophrenia on the Quarterly MDS dated [DATE] in progress. The CRD, RN stated, Resident #85's diagnoses of Schizophrenia was just missed.</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536</p> <p>Based on observations, staff interviews and record review, the facility failed to ensure residents received either a timely or accurate Level 1 Pre-Admission Screening & Resident Review (PASRR) for eight (#96, #163, #28, #1, #32, #31, #25, and #85) of thirty-eight sampled residents.</p> <p>Findings included:</p> <p>1. On 4/8/2024 the medical record for resident #96 was reviewed and revealed Resident #96 was admitted to the facility on [DATE] for long term care services. Review of the Advance Directives revealed the resident had a decision maker in place to make her medical and financial decision. Review of the admission diagnosis sheet revealed mental illness/suspected mental illness (MI/SMI) diagnoses to include but not limited to: Anoxic Brain Disorder (onset 12/21/2023). Review of both the electronic and physical medical record did not include a Level 1 PASRR screen.</p> <p>On 4/11/2024, during an interview, the Director of Nursing (DON) provided a Level 1 PASRR screen completed by her on 4/10/2024. She confirmed there were no previous PASRR screens.</p> <p>On 4/8/2024 the medical record for resident #163 was reviewed and revealed Resident #163 was admitted to the facility on [DATE]. Review of the advance directives revealed the resident was her own responsible party. Review of the admission diagnosis sheet revealed MI/SMI diagnoses to include but not limited to: Anxiety (onset 3/29/24), Major Depression (onset 3/29/24), Mood Disorder (onset 3/29/2024). Review of the Level 1 PASRR screen revealed it was completed by a Registered Nurse (RN), while at the current facility, on 4/5/2024, (seven days after initial admission).</p> <p>On 4/8/2024 the medical record for Resident #28 was reviewed and revealed Resident #28 was admitted to the facility on [DATE] for long term care services. Review of the advance directives revealed the resident had a responsible party in place to make her medical and financial decisions. Review of the admission diagnosis sheet revealed MI/SMI diagnoses to include: Schizophrenia (onset 8/24/2021), Bipolar (onset 8/24/2021), Obsessive Compulsive Disorder OCD (onset 8/24/2021), Anxiety (onset 8/24/2021). Review of the Level 1 PASRR screen revealed it was completed by a Physician at the hospital on 9/23/2016. Section I of the Level 1 PASRR screen revealed diagnoses checked for Schizophrenia and other - Neurocognitive Disorder; the Screen did not include diagnoses of Bipolar, OCD, and Anxiety. Further, there was no evidence of a corrected or updated Level 1 PASRR screen to reflect these diagnoses.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/8/2024 the medical record for Resident #1 was reviewed and revealed Resident #1 was admitted to the facility on [DATE] for long term care services. Review of the advance directives revealed the resident had a responsible party in place to make her medical and financial decisions. Review of the admission diagnosis sheet revealed MI/SMI diagnoses to include: Alzheimer's disease (onset 01/21/2020), Major Depression (onset 3/8/2017), PTSD [post traumatic stress disorder] (onset 1/21/2020), Anxiety (onset 3/7/2017), Mood affective disorder (01/21/2020). Review of the Level 1 PASRR screen revealed it was completed by an RN at the current facility on 7/21/2023 (three years after admission.). Review of Section I of the PASRR revealed MI/SMI diagnoses did not include: Anxiety, PTSD, Alzheimer's disease, Mood disorder. A second Level 1 in the chart dated 1/5/2024 revealed it was completed by RN at the facility. Anxiety and depression MI/SMI were checked. However, PTSD, Alzheimer's disease and Mood disorder were not identified, as per Resident #1's admission diagnoses.</p> <p>On 4/8/2024 the medical record for Resident #32 was reviewed and revealed Resident #32 was admitted to the facility on [DATE] for long term care services. Review of the advance directives revealed the resident was her own decision maker. Review of the admission diagnosis sheet revealed MI/SMI diagnoses to include: Psychosis (onset 06/01/2018), Major Depression (onset 02/20/2018), Mood (onset 02/13/2018), Anxiety (onset 12/28/2017). Review of the Level 1 PASRR screen revealed it was completed by an RN at the current facility on 11/13/2013. Review of Section I did not include the resident's MI/SMI diagnosis of Psychosis.</p> <p>On 4/8/2024 the medical record for Resident #31 was reviewed and revealed Resident #31 was admitted to the facility on [DATE] for long term care services. Review of the advance directives revealed the resident was his own decision maker. Review of the admission diagnosis sheet revealed MI/SMI diagnoses to include: Parkinsonism (onset 10/01/2023), Anxiety (onset 01/09/2020), Bipolar (onset 08/31/2019), Schizophrenia (onset 08/31/2019), PTSD (onset 08/31/2019), Major Depression (08/31/2019). The Level 1 PASRR was reviewed as completed by an RN at the current facility on 04/15/2021. Section I did not indicate MI/SMI diagnoses including Parkinsonism, PTSD, Major Depression.</p> <p>On 4/11/2024 at 1:45 p.m. an interview was conducted with the Nursing Home Administrator (NHA), the Director of Nursing (DON), and the Assistant Director of Nursing (ADON). The NHA revealed it was the responsibility of the Admissions Director during normal business days and an admission nurse on the weekends to obtain PASRR screens. The DON and NHA both confirmed the Admissions Director has close contact with the weekend nurse when there are admissions on the weekends. The NHA and DON also confirmed the Interdisciplinary Team will all review new weekend admissions and Level 1 PASRR screens from the weekend, on the next business working day. The NHA and DON revealed if a Level 1 PASRR is found not accurate or not completed correctly after admission, they will correct one as soon as possible, usually within one business day, in order to have correct Level 1 PASRR screen.</p> <p>The DON and ADON confirmed it is their responsibility to ensure the accuracy of all Level 1 PASRR screens. The NHA and DON revealed they perform weekly and quarterly audits to ensure Level 1 PASRR screens are correct and completed timely. During this interview, the NHA revealed currently they did not have a Quality Assurance (QA) Performance Improvement Plan (PIP) in place with regards to Level 1 PASRR screen accuracy and submission timeframe. The NHA also confirmed that the facility staff (DON, ADON) are responsible to update with a new Level 1 PASRR screen should there be any MI or SMI diagnoses developed after the resident's admission. The NHA, DON and ADON all confirmed the above listed residents were not reflective with all current MI/SMI diagnoses, and they needed to be updated.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/11/2024 at 2:00 p.m. the Nursing Home Administrator provided the Pre-Admission Screening & Resident Review PASRR policy and procedure with an effective date 2/2021 for review.</p> <p>The policy revealed; Preadmission screening will be conducted prior to admission as the PASRR process is a federally mandated pre-admission screening program, required to be performed on all individuals prior to admission to the Nursing Home. The screening is reviewed by Admissions for suspicion of serious mental illness & intellectual disability to ensure appropriate placement in the least restrictive environment & to identify the need to provide applicants with needed specialized services. PASRR screening applies to all new admissions into a Medicaid certified nursing facility & includes private pay, Medicare, & Medicaid admissions regardless of payor source.</p> <p>- The screening is typically done by discharge planners & hospital staff as a step in the discharge process. It is separate from a medical needs assessment, which most often occurs after a person applies for Medicaid, & is required step to qualify for Medicaid long-term care assistance.</p> <p>The procedure section revealed the following but not limited information;</p> <ol style="list-style-type: none"> 1. During the admission process, Business Development will communicate with the facility regarding prospective admissions. A level 1 PASRR will be provided prior to admission to the skilled nursing facility. The facility administration will confirm that a Level 1 review has been completed prior to transfer to the SNF setting. 2. Determine if a serious mental illness &/or intellectual disability or a related condition exists while reviewing the PASRR form completed by the Acute Care Facility for Level 2 completion. 3. If a serious Mental Illness or ID is indicated, determine if the resident/patient will be admitted for m a hospital for an acute care stay and the attending physician has certified that the individual is likely to require less than 30-days of Nursing Facility services. Assure that the certification is signs and dated. <p>A second PASRR Requirements Level 1 and 2 policy and procedure with an effective date 2/2021 revealed; Assure that sections 1-5 are completed prior to admission.</p> <p>41015</p> <ol style="list-style-type: none"> 2. A review of the Admission Record showed Resident #85 had an admitted [DATE] with diagnoses that included but not limited to encounter for orthopedic aftercare following surgical amputation, acquired absence of left above the knee, lack of coordination, schizophrenia, and major depressive disorder, recurrent. <p>A review of Resident #85's level I PASRR assessment, dated 01/05/24 revealed, under the section titled A. MI (Mental Illness) or suspected MI (check all that apply), the checkboxes for the selections schizophrenia was not checked.</p> <p>48441</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. A review of Resident #25 Admission Record shows a primary diagnosis of diffuse traumatic brain injury (TBI) with loss of unconsciousness of unspecified duration subsequent encounter with a secondary diagnosis of unspecified mood [affective] disorder both dated 11/07/2015.</p> <p>A review of the Minimum Data Set for Section I- Active Diagnoses dated February 05, 2024, for Neurological Section, 15500 [Traumatic Brain Injury] has a check mark.</p> <p>A review of the Pre-Admission Screening and Annual Resident Review, dated 7/17/2023, revealed TBI or unspecified mood [affective] disorder not checked.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999</p> <p>Based on observations, record reviews, and interviews, the facility failed to revise the care plan for one (#52) of thirty-two initially sampled residents in regards to the Advance Directive of code status, failed to revise the care plan of one (#107) out of twenty-five final sampled residents, and failed to revise the care plan of one (#15) of one resident sampled for the diagnosis of Post-Traumatic Stress Disorder.</p> <p>Findings included:</p> <p>1. On 4/8/24 at 10:39 a.m. Resident #52 was observed sitting at a table with others in the common area of the secured memory care unit.</p> <p>Review of Resident #52's electronic record, on 4/8/24 at 3:31 p.m., revealed a Do Not Resuscitate Order signed by resident's Power of Attorney (POA) on 3/13/24 and signed by the physician on 3/18/24.</p> <p>Review of Resident #52's care plan revealed a focus for Advance Directives as follows: Resident/authorized responsible party request FULL CODE wish to be honored, initiated 10/9/23. The goal was the resident's Advance Directives would be honored through next review, initiated 10/9/23, revised on 1/3/24, and a target date of 6/19/24. The related interventions included Request resident and/or appointed health care representative to provide copies to the facility of any updated Advance Directives initiated 10/9/23.</p> <p>During an interview with the Clinical Reimbursement Director (CRD) on 4/11/24 at 10:14 a.m., the CRD reported their responsibility were Minimum Data Set (MDS) assessments and to update care plans.</p> <p>An interview was conducted with the CRD, on 4/11/24 at 11:45 a.m., the CRD reported just fixed Resident #52's care plan regarding Advance Directives.</p> <p>2. On 4/8/24 at 9:49 a.m.,Resident #107 was observed sitting at one of four tables in the common area of the secured memory care unit with right leg resting on the table. Multiple observations were made of the resident between 4/8/24 and 4/11/24 that did not show the resident was wearing an electronic wander bracelet.</p> <p>Review of Resident #107's Admission Record showed the resident was admitted on [DATE] and readmitted on [DATE]. The record included diagnoses not limited to metabolic encephalopathy, unspecified altered mental status, unspecified mood disorder due to unknown physiological condition, and mild protein-calorie malnutrition.</p> <p>Review of Resident #107's care plan showed the resident was at risk for elopement, initiated 3/10/24 and interventions included: Apply electronic wander bracelet (check function after placed), date Initiated: 03/10/2024, Apply electronic wander bracelet due to elopement risk, date Initiated: 03/10/2024, and Verify the location of the electronic wander bracelet during routine care, date Initiated: 03/10/2024.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #107's Admission Minimum Data Set assessment, dated 3/12/24 did not reveal a wander/elopement alarm was utilized to monitor the resident's movements.</p> <p>Review of the Order Listing Report for Wander Bracelets, as of 4/10/24 at 11:15 a.m., revealed Resident #107 was amongst the twenty-eight residents listed as having a wander bracelet.</p> <p>Review of Resident #107's Elopement Risk Evaluation, dated 3/10/24, revealed Resident #107 was exit-seeking and wandering. The evaluation showed the nurse was to place an electronic wander bracelet, staff were to check function of bracelet after placement, verify the location of bracelet, and to check placement every shift and functioning daily.</p> <p>Review of Resident #107's April Medication and Treatment Administration Records revealed no documentation related to checking the placement, functioning or verifying the location of Resident #107's electronic wander bracelet.</p> <p>The facility did not provide March Medication and Treatment Administration Records as requested.</p> <p>An interview was conducted with Staff L, Certified Nursing Assistant (CNA) on 4/10/24 at 11:12 a.m., the staff member stated no one on the secured unit had a Wanderguard except for one who went off the unit (not Resident #107).</p> <p>An interview was conducted with the Clinical Reimbursement Director (CRD) on 4/11/24 at 10:14 a.m., the CRD reviewed Resident #107's care plan and elopement risk then stated it (wander bracelet) should have been resolved, sometimes if a resident was on the primary unit staff put a bracelet on then the resident is moved to the secured unit. A review of the Resident #107 placement within the facility showed the resident had not been on the primary unit but was admitted to secure unit. The CRD stated someone must have gotten click happy while doing the Admission Elopement Risk evaluation.</p> <p>Review of the policy - Care Plan - Interdisciplinary Plan of Care from Interim to Meeting, effective February 2024, The facility shall support that each resident must receive, and the facility must provide the necessary care, and services to attain or maintain the highest practical physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The facility shall assess and address care issues that are relevant to individual residents, to include, but may not be limited to, monitoring resident condition, and responding with appropriate interventions.</p> <p>The overall care plan should be oriented towards:</p> <ol style="list-style-type: none"> 1. Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence (e.g., palliative approaches and end of life situation, coordination with Hospice plan of care). Managing risk factors to the extent possible or indicating the limits of such interventions. d. Respecting the resident's right to choose to decline treatment, request treatment, or discontinue treatment. 2. Using an appropriate interdisciplinary approach to care plan development to improve the resident's functional abilities. <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Assessing and planning for care to meet their residents medical, nursing, mental, and psychosocial needs.</p> <p>Procedure 2. Update to Care Plans:</p> <p>a. The procedure showed I'm going updates to care plans are added by a member of the interdisciplinary team (IDT) as needed.</p> <p>Procedure 3. Dates and documentation on the care plan:</p> <p>a. New, revised, or discontinued Problems, Goals, or Interventions are dated for the date the documentation was made.</p> <p>Procedure 5. Comprehensive Plan of Care:</p> <p>b. The comprehensive care plan describes or includes:</p> <p>i. The services that are furnished in goals that reflect the residents wishes, choices, in the exercise of rights.</p> <p>ii. Any services that would normally be provided but are not provided due to the residents exercise of rights, including the right to refuse treatment, and any alternative means or options to address the problem.</p> <p>48441</p> <p>3. Record review of Resident #15 admission face sheet included a diagnosis of post-traumatic stress disorder (PTSD), chronic dated 01/04/2020. Review of the Pre-Admission Screening and Annual Resident Review signature dated 7/27/2023 in Section 1: PASRR Screen Decision-Making has other (specify) checked for PTSD.</p> <p>A review of Resident 15's care plan has a focus area of Trauma Informed Care initiated 10/28/2022 with a revision date of 11/22/2023 and a target date of 4/29/2024. The goal for focus is as follows:</p> <p>-Staff will assist in managing the resident's response to the trigger initiated on 10/28/2022, revised on 11/22/2023 with target date of 4/29/2024.</p> <p>-Staff will make efforts to avoid the flashback or trigger initiated on 10/28/2022, revised on 11/22/2023 with a target date of 4/29/2024.</p> <p>-The frequency or severity of my trauma related signs and symptoms will not increase initiated on 10/28/2022, revised on 11/22/2023 with a target date of 4/29/2024.</p> <p>Interventions for focused area of trauma informed care include the following for Resident #15:</p> <p>o Coordinate psychology or psychiatric services on admission and as needed, Initiated 10/28/2022.</p> <p>o Coordinate support groups as requested, initiated 10/28/2022.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> o Encourage to express feelings, concerns, and thoughts, initiated 10/28/2022. o Know what triggers are and minimize exposure, if possible, initiated 10/28/2022. o Observe for reported symptoms of a trigger, initiated 10/28/2022. o Provide with meaningful activities, initiated 10/28/2022. <p>A review of Resident #15 Minimum Data Set Section C- Cognitive Patterns, dated February 1, 2024, shows a Brief Interview for Mental Status of 15, indicating resident is cognitively intact. Section I- Active Diagnoses has PTSD checked in the Psychiatric/Mood Disorder (I6100).</p> <p>On 4/10/24 at 09:59 a.m., an interview was conducted with Staff R, Certified Nursing Assistant (CNA). Staff R, CNA was not able to recall the triggers for Resident #15 in relation to PTSD.</p> <p>On 4/10/24 at 11:10 a.m., an interview was conducted with Staff F, Certified Nursing Assistant. Staff F, CNA was not able to recall the triggers for Resident #15 in relation to PTSD.</p> <p>On 4/10/24 at 11:15 a.m., an interview was conducted with Staff D, Licensed Practical Nurse/ Unit Manager, (LPN/UM). Staff D, LPN was not able to recall the triggers for Resident #15 in relation to PTSD.</p> <p>On 4/10/24 at 1:30 p.m., an interview was conducted with the Director of Nursing, Assistant Director of Nursing and the Regional Nurse Consultant. All were unable to state how the diagnosis of PTSD was placed into the chart other than in error by a past hospitalization . Resident #15 was hospitalized on [DATE] for three days and readmitted to their facility on 1/04/2020. The hospital discharge summary was reviewed by all three and verbally acknowledged PTSD was not listed as a discharge diagnosis.</p> <p>On 4/11/24 at 10:59 a.m., an interview was conducted with the Clinical Reimbursement Director/Registered Nurse (CRD/RN). The CRD/RN stated Resident #15's chart was thoroughly reviewed last night for any clinical documentation from a hospital and current chart. CRD/RN stated, I even called the former staff member in this role to see if they had any information but she could not recall any information regarding Resident #15. The CRD/RN stated the initial care plan is initiated or driven by diagnoses placed in the resident's medical records. A generalized care plan is electronically implemented with interventions initiated in a drop-down box. It is when the care plan is updated and revised by the Interdisciplinary Team (IDT) to become a more resident-centered care plan.</p> <p>A review of the facility's policy on Care Plans- Interdisciplinary Plan of Care from Interim to Meeting, effective February 2024, revealed the following for their policy the facility shall support each resident must receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The facility shall assess and address care issues relevant to individual residents, to include, but not be limited to, monitoring resident condition, and responding with appropriate interventions.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The comprehensive care plan is an interdisciplinary communication tool. It includes measurable objectives and time frames and describes the services to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The care plan is reviewed and revised periodically and the services provided or arranged are consistent with each resident's written plan of care.</p> <p>Procedure</p> <p>1. Interim plan of care</p> <p>a. The immediate needs of the resident are addressed following admission by initiating an interim plan of care.</p> <p>b. An interim plan of care is developed by nursing and / or other interdisciplinary team (IDT) members.</p> <p>c. The interim plan of care is developed utilizing the Admission Data Collection format or other data collected to include the admission physician orders, medication, treatment, therapy orders, social services, diet orders, and any specialized services indicated from PASRR evaluations, when applicable, and is completed hard copy or electronically.</p> <p>2. Update to Care Plans</p> <p>a. Ongoing updates to care plans are added by a member of the IDT, as needed.</p> <p>6. Quarterly Update of the Plan of Care</p> <p>a. The comprehensive care plan is reviewed and revised by members of the IDT and the resident, resident's family, or representative, as appropriate, in consultation with completion of the quarterly assessment.</p> <p>b. The IDT members make a quarterly care plan review note within the designated disciplines progress notes which includes:</p> <p>i. If goals are met or unmet</p> <p>ii. If care plan will remain in effect for resident period</p> <p>8. Care Plan Meeting</p> <p>e. Care plans are discussed aloud, to include discussion goals, interventions, and evaluations.</p> <p>9. Care Plan Meeting Participation Record</p> <p>a. The copy of the care plan meeting invitation letter is also the participation record. Attendees signed names, indicated relationship, or title and date of attendance at care planned meetings.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. If the resident or resident representatives cannot participate in the care plan meeting, the reason is documented on the copy of the letter in the indicated section.</p> <p>c. The completed care plan meeting invitations last participation record is maintained in the medical record under the care plan tab.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536</p> <p>Based on observations, resident/staff interviews, and record review, the facility failed to provide Activities of Daily Living (ADL) care, to include feet nail care for one (#163) of thirty-eight sampled residents (#163).</p> <p>Findings included:</p> <p>On 4/8/2024 at 10:20 a.m. Resident #163 was observed in her room and seated on the edge of her bed and facing the door. Upon entering the room, she was noted with both feet bare and touching the floor tiles. Further observations revealed both of her feet were swollen, red and with all ten toenails elongated and curled inward. Some of the nails were observed approximately one inch past the tip of her nail beds. All her nails were also a dark yellowish color. The resident, through interview, revealed her feet hurt as well as her hip. She confirmed both of her feet had very long nails and that her feet felt uncomfortable as a result. Resident #163 revealed she had been residing at the facility about two weeks and she planned on going back to the community after her rehabilitation. Resident #163 said she was unable to cut her fingernails and toenails herself. Resident #163 denied she was diabetic but confirmed staff would have to help her with some of her Activities of Daily Living (ADL) to include shower/bathing assistance, and nail care. Resident #163 was asked if staff had offered to cut any of her toenails and she denied any staff offering. She explained since her admission, she had spoken to night shift aides several times to have them help cut her toenails. She could not remember who she spoke to but remembered they were Certified Nursing Assistants (CNAs). Resident #163 revealed she was told by the CNAs that they would get back to her, but they never did. Resident #163 confirmed since her admission, she had never had any staff do any type of foot care to include trimming of any toenails. Resident #163 was observed to slip both of her feet in what appeared to be open toed sandals. She had some discomfort slipping on the sandals and then stood up and utilized her walker device to ambulate out from her room and out into the main hallway.</p> <p>On 4/9/2024 at 9:30 a.m. Resident #163 was observed walking to the nurse station. Upon using the phone, she was observed wearing open toed sandals and her toenails on both of her feet were observed in the same condition as seen the day before on 4/8/2024.</p> <p>On 4/10/2024 at 7:39 a.m. Resident #163 was observed in her room and seated on the edge of her bed. Her feet were noted on the floor and with no shoes or socks on. Both of her feet were exposed and all ten toenails were yellowed, elongated and some curled inward. Resident #163 confirmed her nails were still long and that nobody will cut them for her. She revealed both her feet hurt but not just because of her nails being long. The floor next to the over the bed table and next to Resident #163's Left foot, was observed with white/tan slip on deck shoes. Further observations revealed approximately a four inch slit/cut into the toe box of both shoes. Resident #163 revealed that she had to cut slits in both of these closed toed shoes due to her toenail feet discomfort, and that it eliminated pressure. She was observed to slip on both of these closed toe shoes and exhibited some discomfort in doing so. She then stood up and used her walker device to leave the room and go outside to the smoking area/back porch area.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #163's medical record revealed she was admitted to the facility on [DATE]. Review of the Diagnosis sheet revealed Resident #163 had diagnoses to include but not limited to: Cognitive Communication Deficit, Muscle wasting and atrophy, Lack of coordination, Anxiety, Mood disorder.</p> <p>Review of the most current Minimum Data Set (MDS) Admission assessment, dated 3/31/2024 revealed; (Cognition/Brief Interview Mental Score or BIMS score - 14 of 15, which indicated resident #163 was cognitively intact.</p> <p>Review of the most current skin sheets last dated 4/8/2024 did not list any concerns with skin areas near and or at feet. Review of the admission assessment/not dated 3/29/2024 21:39 did not have any documentation related to toenails or toe ADL care. Review of daily skilled notes dated 4/1/2024 09:46, 4/2/2024 09:38, 4/3/2024 06:30, all did not indicate any documentation related to elongated toe nails or foot concerns. There were no nurse progress notes or daily skilled notes documented after 4/5/2024.</p> <p>Review of the facility ADL tasks section of the electronic record revealed:</p> <p>(d) NAIL CARE = only date indicated was on 3/31/2024 at 03:26 a.m. and revealed nail care was provided. There were no other dates documented related to nail care.</p> <p>Review of the current care plans with a next review date 7/3/2024 revealed the following but not limited to:</p> <ul style="list-style-type: none"> - Communication the resident has a problem with communication: Usually understood - usually expresses ideas or want, usually understands others, with interventions in place - ADL - Resident has an ADL self care performance deficit due to fall prior to admission which resulted in a back fracture, unsteady gait, weakness, with interventions in place to include but not limited to: Bathing = Check nail length and trim and clean on bath day and as necessary. - Pain the resident has pain or a potential for pain receives/requires PRN pain meds for pain management, fx [fracture]., with interventions in place. <p>On 4/10/2024 at 1:20 p.m. an interview with the resident's 7-3 Certified Nursing Assistant (CNA) Staff B who revealed she was a floating aide and she does not routinely have the resident on her schedule. She further revealed she had just returned from leave and did not know the resident well. Staff B revealed she was assigned to the resident today and the resident has as scheduled shower plan for today.</p> <p>At 2:20 p.m. on 4/10/2024 a follow-up was conducted with Staff B. She confirmed she had seen the resident's feet today and thought her nails were long and did not know what type of care and services were in place and who was responsible for nail care. Staff B revealed she did not know who was responsible for nail care for the resident.</p> <p>On 4/11/2024 at 8:30 a.m. an interview with the Social Service Director revealed she was knowledgeable about the resident. The Social Service Director confirmed she has been assisting with the goal of discharge planning with both the resident and her daughter.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Social Service Director was asked if she knew anything related to the resident's ADL care and what type of assistance she requires. The Social Service Director explained she did not know what type of assistance the resident required related to her ADLs, but explained the resident was able to do most things with supervision. She did not know if the resident required any assistance with personal hygiene to include nail care (both hands and feet).</p> <p>On 4/11/2024 at 9:25 a.m. an interview with Staff C, Licensed Practical Nurse (LPN) revealed he had Resident #163 on his assignment routinely and knows her and her care expectations. He confirmed he was aware of her feet toenails that were elongated and knew that podiatry was coming out within the next few days. He revealed she has presented with both foot pain and her feet are swollen as well, and this has been since admission. He confirmed that CNAs are responsible for assessing and doing body checks for long nails and other skin areas, and they are to report that to the nurse for further evaluation. Staff C also confirmed CNAs and/or Nurses can clip nails and if the resident is Diabetic, only a Registered Nurse can clip nails. He confirmed Resident #163 was not a Diabetic, and that either CNA or Nurse could clip her nails. Staff C also confirmed he has not been aware of Resident #163 ever refusing care and services and did not know why her nails were not clipped.</p> <p>On 4/11/2024 at 1:10 p.m. an interview with the 200 Unit Manager Staff D revealed she was knowledgeable of Resident #163 and her care needs. She confirmed Resident #163 has been at the facility for about two weeks and that her daughter comes in routinely and lives nearby. She further revealed the resident does ambulate using a rolling walker and she normally goes outside and in the dining room and then hangs out in her room. Staff D revealed she was aware Resident #163 had elongated toe nails and that she tried to assist her with nail care yesterday (4/10/2024). She revealed that she did not have the type of clippers to clip all the nails to the end of the nail bed. She revealed the resident's toe nails were so long and thick, some needed a different type of clipper to trim. Staff D was not aware the resident was not comfortable and had toe pain when she wore her shoes. She also confirmed that staff to include Aides and Nurses would evaluate and observe the resident for any skin issues and nail maintenance during daily care and shower/bathing opportunities.</p> <p>On 4/11/2024 at 1:00 p.m. both Staff D and the Nursing Home Administrator confirmed the facility did not have any specific Activities of Daily Living (ADL), and/or Nail care maintenance policy and procedure for review. Staff D revealed that nail care would be a standard of practice for staff.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999</p> <p>Based on observations, record review, and interviews, the facility failed to provide activities in an appropriate and stimulating manner on one of one (secured memory care) unit.</p> <p>Findings included:</p> <p>Review of an April 2024 calendar located on the facility's secure memory care unit, revealed the activities on April 8th was 9:00 a.m. - Easy Listening, 9:30 a.m. - Arts & Crafts Time, 10:00 a.m. - Morning Social, and at 1:00 p.m. - Move and Groove.</p> <p>An observation on 4/8/24 at 10:18 a.m. of the secured memory care unit revealed 13 residents sitting in the common area at four 4-person tables in each corner of the room, stacks of magazines had been placed each of the tables. One female resident appeared interested in a magazine, a cooking show was playing on television which was muted and a radio was playing, no other resident appeared to be interested in any of these activities. Two tables were placed in corners on each side of the television which was hung in the center of the wall.</p> <p>An observation on 4/8/24 at 10:36 a.m. showed Resident #24 sitting in the common area of the unit at table with 3 other residents looking at a magazine.</p> <p>An observation on 4/8/24 at 10:39 a.m. showed Resident #52 was sitting at a table in the common area with 3 other residents, Resident #52 was eating crackers.</p> <p>An observation on 4/8/24 at 1:17 p.m., revealed 13 residents sitting at 4 tables in the common area of the secured memory care unit, a television was muted, radio was playing, and no interaction between staff and residents was occurring.</p> <p>An observation on 4/8/24 at 1:21 p.m., showed Resident #52 was sitting in the common area of the unit, in a corner, facing the nursing station perpendicular to the television. Staff P, Registered Nurse (RN), woke resident up to administer medications.</p> <p>An observation on 4/8/24 at 1:26 p.m. revealed Staff O, Certified Nursing Assistant (CNA) moved to the music, playing lowly, for a few movements without interacting with any resident. The observation showed 14 residents in the unit's common area and 2 magazines were available to two of the four tables.</p> <p>An interview was conducted with Staff P, Registered Nurse (RN) on 4/8/24 at 1:36 p.m. The staff member stated normally they have an activity person back here who throws parties and the activity person must not be here today. During the interview, Staff O stated the activity person was off on Mondays. During the interview the music changed to a [NAME] song, Staff M, CNA, while sitting next to Resident #52 asked who was the singer, the resident did not answer. Staff O left the area and Staff P continued to administer medications to other residents, and Staff I (RN/Unit Manager) was sitting in the nursing station and Staff L was at an unknown location. The schedule showed one nurse and three aides were assigned to the unit.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/8/24 at 1:40 p.m., Resident #107 was observed sitting at a table in the secured memory care unit with 3 other residents. The observation revealed no activity was occurring, television was playing and muted, with a low-volume radio was playing.</p> <p>On 4/9/24 at 10:34 a.m., Resident #107 was observed sitting at table facing exterior wall with head bowed, other residents were coloring at nearby tables (Resident #24), and little to no interaction with staff members.</p> <p>An observation on 4/10/24 at 9:07 a.m., revealed 13 residents sitting in the common area of the secured Melody unit, music was playing and some residents were interested in magazines.</p> <p>An interview was conducted with the Activity Director (AD) on 4/10/24 at 9:32 a.m The AD reported having an assistant that came in on weekends but was generally the only activity staff member at the facility. The AD stated some of the activities provided on the secured unit was sensory stimulating, music and dance, arts and crafts, adult coloring, and admitted sometimes planned activities get thrown out due to the resident's preferences. The AD stated the assistant was in the facility on 4/8/24, as the AD was not in the facility. The AD stated the assistant was on the main unit's patio on Tuesday (4/9) doing Charades (with AD) and probably should have had the assistant doing something on the secured unit. The AD stated the residents' on the secured unit need stimulation, tries to provide the stimulation, and expectation was for staff to interact with the residents if activity staff were not on the unit.</p> <p>During an interview on 4/11/24 at 2:57 p.m., the Director of Nursing (DON) reported the resident's were usually very active on the secured unit, stating, they usually have puzzles on the table.</p> <p>Review of Resident #24's Admission Record showed the resident was admitted on [DATE] and readmitted on [DATE]. The resident's Quarterly Brief Interview of Mental Status (BIMS), dated 3/22/24, showed a score of 3 out of 15, indicating severe cognitive impairment.</p> <p>Review of Resident #24's Quarterly Activity Assessment, dated 2/15/24, showed the resident preferred morning activities and required assistance with activity pursuit. The assessment revealed the resident enjoyed socializing with peers, painting, arts and crafts, music and dance. Also the resident loved singing and dancing, enjoyed visits from the therapy dogs, and enjoyed having nails painted. The resident enjoyed helping others and participating in a wide variety of activities presented. The assessment revealed goals were exceeded and changes were to continue to stimulate the resident socially, spiritually, physically, and cognitively.</p> <p>Review of Resident #24's care plan showed the resident required staff assistance with involvement of activities related to cognitive deficits. The interventions revealed the resident prefers/would benefit from: General Activities Program.</p> <p>Review of Resident #52's Admission Record showed the resident was admitted on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #52's other Activity Assessment, dated 4/1/24, revealed the resident preferred afternoon activities and required assistance with activity pursuit. The resident's passive activities included sitting outside, listening to music and pet interaction. The creative activities was cooking and showed the resident loved pasta and lasagna, country music, and liked snacking and socializing with peers. The previous goals were met and changes were to continue to stimulate the resident physically, socially, spiritually, and cognitively.</p> <p>Review of Resident #107's Admission Record revealed the resident had been admitted on [DATE].</p> <p>Review of the re-entry Activity Assessment, dated 4/2/24, showed the resident preferred activities during the afternoon and required assistance with activity pursuit. The assessment revealed the resident preferred sitting outside, watching TV, listening to music, and building projects. The description of favorite activities showed the resident enjoyed socializing with peers, listening to music and was curious about how things were put together. The previous activity goals were met and changes to goal were to continue to stimulate the resident physically, socially, spiritually, and cognitively.</p> <p>Review of the facility policy - Activities Overview, effective October 2021, revealed Activities Department employees will provide activities that include sensitivity and an understanding of each individual resident's needs and requirements including medical, emotional, spiritual, therapeutic, and recreational needs. The Activity Programs will reflect individual needs and provide/promote the following:</p> <ul style="list-style-type: none"> -Stimulation or solace -Physical, cognitive, and/ or emotional health - Enhancement, to the extent practicable, of each resident is physical and mental status - Resident Self-respect by providing activities that support self-expression, social and personal responsibility, and choice. <p>Programs will be designed to meet the resident at their level of functioning.</p> <ul style="list-style-type: none"> - Support activities - for residents who may be severely impaired or unable to tolerate the stimulation of a group. - Maintenance activities- schedule events that promote the highest level of physical, emotional, cognitive, psychosocial, and spiritual well-being. - Empowerment activities- designed to promote self-expression, social and personal responsibility, and a sense of purpose in their daily lives. <p>Activities will be provided at a frequency to meet the individual needs of the residents.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Programs are designed to meet the interests and the physical, mental, and psychosocial well-being of each resident. Programs are developed for the specialized groups and those with unique or special recreational/ activity needs. Each program developed is also designed to ensure maximum flexibility and responsiveness to individual needs. Residents are encouraged, but not required, to attend and participate in recreational and therapeutic activities on a 1:1 basis or in a group.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure the catheter of one (#107) out of one resident sampled with an urinary catheter was stored in a manner that promoted proper infection control.</p> <p>Findings included:</p> <p>On 4/8/24 at 9:49 a.m., Resident #107 was observed sitting in a wheelchair at a table in the common area of the secured memory care unit. The observation revealed a urinary catheter drainage bag with a privacy device was hanging from the below the resident's wheelchair seat with the catheter tubing lying on the floor.</p> <p>On 4/8/24 at 10:22 a.m., Resident #107 was observed with catheter tubing coming from the end of ankle-length pant leg with the tubing lying on the floor underneath the wheelchair.</p> <p>On 4/8/24 at 10:46 a.m., Resident #107 was observed with catheter tubing coming from under left ankle-length swear pants with the tubing lying on the floor of the unit's common area.</p> <p>On 4/9/24 at 8:46 a.m., Resident #107 was observed sitting in the common area of the secured memory care unit with urinary catheter tubing lying on floor under the resident's wheelchair.</p> <p>On 4/9/24 at 8:46 a.m., Resident #107 was observed sitting at table with 3 other residents in the common area. The resident's catheter tubing containing pale yellow urine was observed lying on the floor.</p> <p>On 4/9/24 at 10:35 a.m., Resident #107 was observed sitting in the common area of the unit with catheter tubing lying on the floor.</p> <p>On 4/9/24 at 11:37 a.m., Resident #107 was observed in the common area with the catheter tubing lying on the floor which had remnants of food on it.</p> <p>On 4/10/24 at 9:20 a.m., Resident #107 was observed sitting in wheelchair in the common area of the unit, the urinary catheter drainage bag was seen dragging on floor. Staff I, Registered Nurse/Unit Manager, confirmed the bag was on the floor and should not be. Staff N, Certified Nursing Assistant (CNA) stated the drainage bag should not be on the floor. A small amount of blood-tinged urine was observed in the bag.</p> <p>Review of Resident #107's Admission Record showed the resident was admitted on [DATE]. The record revealed the resident's diagnoses included not limited to metabolic encephalopathy, unspecified altered mental status, and generalized muscle weakness.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #107's Medication Administration Record (MAR) showed the resident was being administered Finasteride and Tamsulosin for benign prostatic hyperplasia (BPH). The resident's Treatment Administration Record (TAR) showed staff were performing daily and as needed (prn) urinary catheter care.</p> <p>Review of the facility-provided - Competency: Perineal Care/Catheter Care, undated, described the technique for performing perineal care on female and male residents and the cleaning of a catheter for both male and females. The competency did not show where the staff should hang the drainage bag or if tubing and bag of the resident's urinary catheter should be stored on the floor.</p> <p>During an interview on 4/11/24 at 9:27 a.m., the Nursing Home Administrator (NHA), in regards to a request for the facility's policy regarding Care and Maintenance of urinary catheters, the NHA reported not thinking the facility had a policy on urinary catheters just the competency but would check. The facility did not provide the requested policy.</p> <p>During an interview on 4/11/24 at 2:55 p.m., the Director of Nursing stated neither the tubing or (drainage) bag should be on the floor.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999</p> <p>Based on observations, record reviews, and interviews, the facility failed to document and monitor the behaviors of two (#24 and #83) out of five residents reviewed for unnecessary medications resulting in the physician being notified and orders for additional as needed psychotropic medications were obtained.</p> <p>Findings included:</p> <p>1. On 4/8/24 at 10:36 a.m., Resident #24 was observed sitting at one of four tables in the common area of Melody unit, a secured memory care unit. The observation showed the resident was looking at a magazine while sitting with 3 other residents at the table.</p> <p>On 4/9/24 at 10:29 a.m., Resident #24 was observed sitting at table in common area coloring with markers. On 4/9/24 at 11:14 a.m., the resident's Power of Attorney (POA) was visiting with the resident.</p> <p>On 4/11/24 at 11:15 a.m., Resident #24 was observed sitting at table in common area with three other residents drinking coffee.</p> <p>Review of Resident #24's Admission Record revealed the resident was readmitted on [DATE]. The diagnoses included unspecified severity unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, unspecified recurrent major depressive disorder, generalized anxiety disorder, and other bipolar disorders.</p> <p>Review Resident #24's April Medication Administration Record (MAR) revealed a physician order had been obtained for the resident on 4/9/24 at 3:21 p.m., for the anxiolytic medication Alprazolam. The order read Alprazolam 0.5 milligram (mg) - Give 1 tablet by mouth every 8 hours as needed for anxiety for 14 days. The MAR revealed Staff J, Registered Nurse (RN), had administered the psychotropic medication at 4:13 p.m. on 4/9/23.</p> <p>Review of Resident #24's April MAR did not reveal behaviors associated with the resident's use of the psychotropic medications: Alprazolam as needed, Duloxetine daily, Mirtazapine at bedtime, Quetiapine at bedtime, Trazodone at bedtime, Buspirone twice daily, Lithium twice daily, and Risperdal twice daily were monitored and documented by licensed nursing staff. The MAR showed a list of side effects were being monitored for by nurses every shift however did not reveal the medication(s) associated with the side effects listed.</p> <p>The electronic Behavior Monitoring Form (BMF) had no data and when requested it was not received from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #24's progress notes, dated 3/12/24 to 4/11/24 showed a note dated 3/13/24 at 4:04 p.m. , revealing activities had painted the resident's nails, on 4/9/24 at 7:47 p.m., the as needed administration of Alprazolam was effective, and on 4/10/24 at 2:57 p.m., dietary services documented the resident had a significant weight change. The review revealed no other progress notes during 3/12/24 to 4/11/24. The notes did not reveal the behavior exhibited, the amount of times the behavior had been exhibited, if any non-pharmaceutical interventions had been attempted, or the outcome of the those non-pharmaceutical interventions had occurred, and if the resident's representative had been notified of the behavior that occurred requiring a physician order for as needed Alprazolam.</p> <p>Review of Resident #24's care plan revealed the following focuses, goals, and interventions:</p> <ul style="list-style-type: none"> - Behavioral: The resident is noted with the following behaviors: placing self on the floor. Can be aggressive at times, refuses labs at times, refuses therapy at times, refuses medications at times, and sometimes can be physically aggressive to staff, initiated 10/4/23 and revised 1/19/24. The goal was to risk for complications r/t behavior will be minimized through review date. The interventions instructed staff to encourage as much participation/interaction by the resident as possible during care activities and Medication as ordered, report missed or refused meds to physician, discuss possible alternatives with MD and resident. - Psychotropic Med: resident uses psychotropic medications r/t antidepressant to manage depression, antianxiety to manage anxiety, (and) antipsychotic to manage bipolar, initiated and revised 9/20/23. The goal was the resident would be at the lowest dose required to reduce symptoms while minimizing adverse effects to ensure maximum functional ability both mentally and physically through the next review. The interventions included instructions to staff to monitor for psychotropic side effects and to administer medications as ordered - observe/document for side effects and effectiveness. <p>An interview was conducted with Staff J. Registered Nurse (RN), on 4/11/24 at 3:45 p.m. The staff member stated the reason for the as needed Alprazolam order on 4/9/24 was Resident #24 had been screaming and agitated so Staff I, RN/Unit Manager (UM), had called the Nurse Practitioner and received an order for Xanax (Alprazolam) 0.5 milligrams.</p> <p>During an interview on 4/11/24 at 2:52 p.m., the Director of Nursing (DON) reported the facility uses a blanket consent to treat, not specific to use of psychotropic medications, staff talk to the families for new medications, and psychiatry was really good about speaking with families.</p> <p>2. On 4/8/24 at 10:41 a.m., Resident #83 was observed sitting outside on the covered patio of the secured memory care unit with 3 other residents. On 4/8/24 at 1:32 p.m., Resident #83 was observed sitting on covered patio with no activity.</p> <p>On 4/9/24 at 8:38 a.m., Resident #83 was observed sitting in patio area by self with no activity.</p> <p>On 4/11/24 at 10:59 a.m., Resident #83 was observed sitting on patio of secure unit and appeared to be asleep in chair.</p> <p>Review of Resident #83's Admission Record revealed a re-admitted [DATE] and included diagnoses not limited to unspecified severity unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, unspecified recurrent major depressive disorder, unspecified mood (affective) disorder, and unspecified anxiety disorder.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #83's Medication Administration Record (MAR) revealed an order for 5 mgs of Diazepam every 12 hours for anxiety for 14 days had been obtained on 4/9/24 at 3:24 p.m. The MAR showed Staff J, RN administered the anxiolytic medication, Diazepam at 3:30 p.m. on 4/9/24.</p> <p>Review of Resident #83's MAR revealed the resident was administered: Remeron 7.5 mg at bedtime, Two tablets of Depakote three times daily (increased from twice on 4/5/24), Valium (Diazepam) 5 mg twice daily, and Quetiapine 25 mg three times a day. The MAR showed staff were monitoring for a list of side effects every shift. The MAR did not show licensed nursing staff were monitoring for the target behaviors associated with the use of the resident's psychotropic medications.</p> <p>Review of Resident #83's physician orders did not reveal an order for the monitoring of behaviors related to the use of anxiolytic's, antidepressants, and antipsychotic medications.</p> <p>A request was made to the facility to provide Resident #83's April Behavior Monitoring Flowsheet (BMF) it was not provided. A previous review of the resident's March and April BMF showed no data.</p> <p>Review of Resident #83's progress notes revealed on 4/9/24 no behaviors were documented requiring the necessity to obtain an order for as needed Diazepam. The progress notes did not reveal if Resident #83's responsible party was notified of the behavior or the order for Diazepam, amount of times the behavior had been exhibited, and did not reveal if any non-pharmaceutical interventions had been attempted and the outcome.</p> <p>During an interview with Staff I, Unit Manager and Staff J, RN on 4/10/24 at 3:48 p.m., Staff I stated Resident #83 had behaviors and was just yelling (on 4/9/24). The Unit Manager, Staff I, stated staff document (behaviors) in progress notes or with the medication. The staff member stated she didn't give the medications, she just calls the doctor. Staff I stated Resident #83 normally will pull at things and staff tries to minimize with activities, I believe that was (resident) was doing, (resident) gets in that mode and they order sometimes an extra dose or 14 days. Staff I stated the expectation was for staff to document the type of behavior(s) exhibited. Staff J admitted to administering the medication (Diazepam) for behaviors but did not document the behavior exhibited yesterday (4/9/24) prior to the as needed Diazepam order.</p> <p>Review of Resident #83's progress notes printed on 4/10/24 at 5:55 p.m. revealed a LATE ENTRY note effective 4/9/24 at 3:25 p.m., documenting the resident with agitation. Grabbing chairs and attempting to throw. Nurse Practitioner (NP) called and notified. New order for Diazepam prn received.</p> <p>Review of the late entry note and prior notes did not reveal if Resident #83's responsible party was notified of the behavior or the order for Diazepam, the amount of times the behavior was exhibited, and did not reveal if any non-pharmaceutical intervention had been attempted.</p> <p>Review of the Interdisciplinary (IDT) Notes regarding behaviors showed the latest note 2/20/24 revealed medications and behaviors reviewed. A IDT note dated 1/18/24 showed resident played with fecal matter and was combative at times.</p> <p>Review of Resident #83's care plan revealed the following focuses, goals, and interventions:</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- The resident is noted with following behaviors: combative towards staff and other residents. Resident will play with/handle feces at times. Resident will state that the demons are coming. The goal showed the resident was at risk for complications related to (r/t) behavior will minimized through review date (target date 2/16/25). The interventions included Enhanced monitoring and Observe/document for side effects and effectiveness.</p> <p>- The resident uses psychotropic medications related to (r/t) antidepressant to manage: depression, Antianxiety to manage: anxiety, antipsychotic related to mood disorder, anticonvulsant to manage: behaviors. The goal was for resident will be at the lowest dose required to reduce symptoms while minimizing adverse effects to ensure maximum functional ability both mentally and physically through the next review. The interventions instructed to administer medications as ordered. Observe/ document for side effects and effectiveness and use of psychotropic medications will be reviewed at least quarterly with the IDT/ MD to review continued need for the medication and ensure lowest dose.</p> <p>During an interview on 4/9/24 at approximately 5:00 p.m., the Regional Nurse Consultant (RNC) reported looking for a policy regarding the use of psychotropic medications.</p> <p>A request was made on 4/9/24 for the facility's policy regarding Psychotropic Use, on 4/10/24 the facility responded no specific policy.</p> <p>A request was made for a policy regarding Behavior Documenting, the facility responded no policy.</p> <p>During an interview on 4/10/24 at 5:19 p.m., the Director of Nursing stated the expectation was whenever there is a behavior they (staff) should be documenting, in progress notes, in the behavior monitoring form, and document why they are giving the prn (medication). The DON reviewed the progress notes for Resident #83 and was informed the late entry note was made after a conversation with Staff I and Staff J. The DON confirmed the note should have been made prior to the conversation.</p> <p>An interview was conducted with the Assistant Director of Nursing (ADON) and Regional Nurse Consultant (RNC) on 4/11/24 at 4:24 p.m. The ADON stated expectation was for nurses to document reason for obtaining as needed (prn) psychotropic medication. The RNC stated she wished they could make it that when putting in an prn order staff have to document the reason.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>37999</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure the medication error rate was less than 5.00%. Twenty-seven medication administration opportunities were observed and two errors were identified for two (#31 and #13) of five residents observed. These errors constituted a 7.41% medication error rate.</p> <p>Findings included:</p> <p>1. On 4/10/24 at 8:05 a.m. an observation of medication administration with Staff E, Registered Nurse/Unit Manager (RN/UM), was conducted with Resident #31. The staff member dispensed the following medications:</p> <ul style="list-style-type: none"> - chewable Aspirin 81 milligram (mg) over-the-counter (otc) (placed in separate medication cup) - Docusate sodium 100 mg otc softgel tablet - Fluticasone propionate 50 microgram (mcg) nasal spray (she documented it was administered) - Sodium chloride 1 gram (gm) otc tablet - Risperidone 3 mg tablet - Carbamazepine 100 mg chewable - Lisinopril 5 mg - 2 tablets - Benztropine 1 mg tablet - Divalproex delayed release (DR) 250 mg tablet - Spironolactone 50 mg tablet - Terazosin 5 mg capsule <p>The staff member confirmed dispensing 11 tablets. The staff member sat the Fluticasone of the over-bed table and resident refused it. Staff E placed a blood pressure wrist cuff on the resident's left wrist and was unsuccessful twice to obtain blood pressure. The staff member retrieved a manual BP cuff and stethoscope successfully obtaining a BP of 138/90 and radial pulse of 67. Staff E went to the medication cart and dispensed a half 25 mg tablet of Metoprolol. The staff member informed the resident to chew the aspirin however the resident swallowed it.</p> <p>Immediately following the observation with Resident #31 Staff E confirmed the Carbamazepine tablets were chewable and should have been in with the aspirin, despite resident swallowing the aspirin and while holding cell phone in hand reported was going to call doctor to notify them the resident had refused the nasal spray.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #31's Medication Administration Record (MAR) revealed a chart/follow up code legend showing a checkmark equaled Administered. The MAR revealed Staff E had documented a checkmark for Fluticasone nasal spray on 4/10/24, showing the nasal spray had been administered prior to its discontinuation.</p> <p>2. On 4/10/24 at 8:31 a.m. an observation of medication administration with Staff C, Licensed Practical Nurse (LPN) was conducted with Resident #13. Staff C obtained a pain level of 8 out of 10 from the resident. The staff member dispensed the following medications:</p> <ul style="list-style-type: none"> - Nicotine 14 mg transdermal patch - dated patch and initialed - Oxycodone Immediate Release (IR) 10 mg tablet - Famotidine 20 mg tablet - Celecoxib 100 mg capsule - Memantine 10 mg tablet - Buspirone 30 mg tablet - Sertraline 100 mg tablet <p>The staff member confirmed dispensing 6 tablets and one patch. Staff C administered the medications, removed a nicotine patch from the right should and placed the new one on the left shoulder. The resident returned to the cart.</p> <p>Review of Resident #13's Medication Administration Record showed Staff C had documented a 25 mg tablet of Metoprolol Tartrate had also been administered in addition to the observed medications. This medication had not been observed.</p> <p>Review of the Medication Admin Audit Report revealed Staff C had documented the observed medications and the tablet of Metoprolol had been administered at 8:41 a.m. on 4/10 and documented as given at 8:45 a. m.</p> <p>An interview was conducted with the Director of Nursing (DON) on 4/11/24 at 8:35 a.m., the DON reviewed the Audit Report for Resident #13, the observed medications, and the confirmation of Staff C dispensing 6 tablets and one patch. The DON confirmed the resident's scheduled Metoprolol as documented as given at the same time of other medications. The DON reviewed Resident #31's MAR and stated if the resident had refused it (Fluticasone) it should be documented as a refusal not as administered.</p> <p>An interview was conducted with Staff C, LPN on 4/11/24 at 1:30 p.m. The staff member reported giving all the medications to Resident #13 during the medication observation. Staff C reported giving all the medication cards to this writer other than the narcotic (which was noted from the narcotic box). The staff member stated all medications were in the same cup and when the confirmation of 6 tablets was made, the narcotic hadn't been counted, there was 7 medications.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the policy - Medication Administration, dated 9/18, showed Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication.</p> <p>-3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. Compare the medication and dosage schedule on the resident's MAR with the medication label. If the label and the MAR are different, and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the Prescriber's orders are checked for the correct dosage schedule. Apply a direction change sticker to apply if directions have changed from the current label.</p> <p>The documentation section of the policy revealed:</p> <p>-2. If a dosage of regular scheduled medication is withheld, refused, or given at other than the scheduled time (for example, the resident is not in the nursing care center at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for as needed (PRN) documentation. If two consecutive doses of a vital medication are withheld or refused, the physician is notified.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999</p> <p>Based on observations, record reviews, and interviews, the facility failed to maintain two (#107 and #31) out of fifty (50) resident records accurately related to documenting a medication was administered when refused by the resident and to obtain vital signs daily for the skilled notes.</p> <p>Findings included:</p> <p>1. On 4/8/24 at 1:40 p.m., Resident #107 was observed sitting at a table in the secured memory care unit, Melody, with three other residents.</p> <p>On 4/9/24 at 8:48 a.m., Resident #107 was observed sitting a table with three other residents, no activities were occurring and the resident's catheter tubing was lying on the floor under the wheelchair.</p> <p>Review of Resident #107's Admission Record revealed an admitted [DATE] and diagnoses of metabolic encephalopathy, generalized muscle weakness, mild protein-calorie malnutrition, and multiple sites muscle wasting and atrophy not elsewhere classified.</p> <p>Review of Resident #107's Daily Skilled Note, dated 4/1/24 at 2:21 p.m., revealed a temperature 98.9 taken on 3/31/24 at 12:25 a.m., blood pressure 132/70 taken on 3/31/24 at 2:15 p.m., pulse of 78 on 3/31/24 at 2:15 p.m., respiration of 18 on 3/31/24 at 12:25 a.m., and oxygen saturation (O2 sat) of 97% room air on 3/30/24 at 5:30 p.m. The note revealed the resident continued to participate in Physical Therapy (PT).</p> <p>Review of Resident #107's Daily Skilled Note, dated 4/3/24 at 2:09 a.m., revealed a temperature obtained on 3/31/24 of 98.9, blood pressure obtained on 3/31/24 of 132/70, a pulse of 78 obtained on 3/31/24 at 2:15 p.m., a respiration rate of 18 obtained at 12:25 a.m. on 3/31/24, and O2 sat of 97% obtained on 3/30/24. The note revealed the resident continued to participate in PT.</p> <p>Review of Resident #107's Daily Skilled Note, dated 4/3/24 at 2:50 p.m. showed a temperature 98.9 taken on 3/31/24 at 12:25 a.m., blood pressure 132/70 taken on 3/31/24 at 2:15 p.m., 78 pulse 3/31/24 at 2:15 p.m., respiration of 18 on 3/31/24 at 12:25 a.m., and oxygen saturation (O2 sat) of 97% room air on 3/30/24 at 5:30 p.m. The note revealed the resident participated in PT.</p> <p>Review of Resident #107's Daily Skilled Note, dated 4/3/24 at 8:33 p.m., revealed a temperature obtained on 3/31/24 at 12:25 a.m. of 98.9, blood pressure obtained on 3/31/24 of 132/70, a pulse of 78 obtained on 3/31/24 at 2:15 p.m., a respiration rate of 18 obtained at 12:25 a.m. on 3/31/24, and O2 sat of 97% obtained on 3/30/24. The note revealed the resident continued to participate in PT.</p> <p>Review of Resident #107's Daily Skilled Note, dated 4/4/24 at 12:53 a.m., showed a temperature of 98.9 was obtained on 3/31/24 at 12:25 a.m., a blood pressure of 132/70 was obtained on 3/31/24 at 2:15 p.m., a pulse of 78 was obtained on 3/31/24 at 2:15 p.m., a respiration rate of 18 had been obtained on 3/31/24 at 12:25 a.m., and an oxygen saturation level of 97% had been obtained at 5:30 p.m. on 3/30/24. The note showed the resident continued to participate PT.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #107's Daily Skilled Note, dated 4/4/24 at 2:26 p.m., revealed a temperature of 98.9 was obtained on 3/31/24 at 12:25 a.m., a blood pressure of 132/70 and pulse of 78 was obtained on 3/31/24 at 2:15 p.m., a respiration rate of 18 had been obtained on 3/31/24 at 12:25 a.m., and an O2 saturation of 97% had been obtained at 5:30 p.m. on 3/30/24. The note showed the resident continued to participate PT.</p> <p>Review of Resident #107's Daily Skilled Note, dated 4/4/24 at 9:03 p.m., showed a temperature of 98.9 was obtained on 3/31/24 at 12:25 a.m., a blood pressure of 132/70 was obtained on 3/31/24 at 2:15 p.m., a pulse of 78 was obtained on 3/31/24 at 2:15 p.m., a respiration rate of 18 had been obtained on 3/31/24 at 12:25 a. m., and an oxygen saturation level of 97% had been obtained at 5:30 p.m. on 3/30/24. The note showed the resident continued to participate PT.</p> <p>Review of Resident #107's Daily Skilled Note, dated 4/5/24 at 12:40 a.m., revealed a temperature of 98.9 was obtained on 3/31/24 at 12:25 a.m., a blood pressure of 132/70 and pulse of 78 was obtained on 3/31/24 at 2:15 p.m., a respiration rate of 18 had been obtained on 3/31/24 at 12:25 a.m., and an O2 saturation of 97% had been obtained at 5:30 p.m. on 3/30/24. The note showed the resident continued to participate PT.</p> <p>Review of Resident #107's Daily Skilled Note, dated 4/5/24 at 12:31 p.m., showed a temperature of 98.9 was obtained on 3/31/24 at 12:25 a.m., a blood pressure of 132/70 was obtained on 3/31/24 at 2:15 p.m., a pulse of 78 was obtained on 3/31/24 at 2:15 p.m., a respiration rate of 18 had been obtained on 3/31/24 at 12:25 a. m., and an oxygen saturation level of 97% had been obtained at 5:30 p.m. on 3/30/24. The note showed the resident continued to participate PT.</p> <p>Review of Resident #107's Daily Skilled Note, dated 4/6/24 at 2:56 p.m., revealed a temperature of 98.9 was obtained on 3/31/24 at 12:25 a.m., a blood pressure of 132/70 and pulse of 78 was obtained on 3/31/24 at 2:15 p.m., a respiration rate of 18 had been obtained on 3/31/24 at 12:25 a.m., and an O2 saturation of 97% had been obtained at 5:30 p.m. on 3/30/24. The note showed the resident continued to participate PT.</p> <p>Review of Resident #107's Daily Skilled Note, dated 4/7/24 at 4:12 p.m., showed a temperature of 98.9 was obtained on 3/31/24 at 12:25 a.m., a blood pressure of 110/68 was obtained on 4/7/24 at 12:03 p.m., a pulse of 81 was obtained on 4/7/24 at 12:03 p.m., a respiration rate of 18 had been obtained on 3/31/24 at 12:25 a. m., and an oxygen saturation level of 97% had been obtained at 5:30 p.m. on 3/30/24. The note showed the resident continued to participate PT.</p> <p>Review of Resident #107's Daily Skilled Note, dated 4/8/24 at 12:49 a.m., revealed a temperature of 98.9 had been obtained on 3/31/24 at 12:25 a.m., a blood pressure of 110/68 was obtained on 4/7/24 at 12:03 p. m., a pulse of 81 was obtained on 4/7/24 at 12:03 p.m., a respiration rate of 18 was obtained on 3/31/24 at 12:25 a.m., and an oxygen saturation level of 97% had been obtained at 5:30 p.m. on 3/30/24. The note showed the resident continued to participate PT.</p> <p>Review of Resident #107's Daily Skilled Note, dated 4/9/24 at 12:17 a.m., showed a temperature of 98.9 was obtained on 3/31/24 at 12:25 a.m., a blood pressure of 110/68 and a pulse of 81 was obtained on 4/7/24 at 12:03 p.m., a respiration rate of 18 had been obtained on 3/31/24 at 12:25 a.m., and an oxygen saturation level of 97% had been obtained at 5:30 p.m. on 3/30/24. The note showed the resident continued to participate PT.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #107's Daily Skilled Note, dated 4/10/24 at 12:12 a.m., revealed a temperature of 97.8, a blood pressure of 118/68, pulse of 68, a respiration rate of 18, and an oxygen level of 96% had been obtained at 7:27 a.m. on 4/9/24. The note showed the resident continued to participate PT.</p> <p>During an interview with the Director of Nursing (DON) on 4/11/24 at 2:57 p.m., the DON stated Daily Skilled Notes were for anyone getting therapy and vital signs should be updated daily in the skilled notes.</p> <p>An interview was conducted with the Assistant Director of Nursing (ADON) and Regional Nurse Consultant (RNC) on 4/11/24 at 4:24 p.m., the RNC stated the facility did not have a policy for Daily Skilled notes.</p> <p>2. On 4/10/24 at 8:05 a.m., Staff E, Registered Nurse/Unit Manager (RN/UM), was observed for medication administration with Resident #31. The staff member dispensed the following: chewable Aspirin 81 milligram (mg) over-the-counter (otc), Docusate sodium 100 mg otc softgel tablet, Fluticasone propionate 50 microgram (mcg) nasal spray, Sodium chloride 1 gram (gm) otc tablet, Risperidone 3 mg tablet, Carbamazepine 100 mg chewable, 2 tablets of Lisinopril 5 mg, Benztropine 1 mg tablet, Divalproex delayed release (DR) 250 mg tablet, Spironolactone 50 mg tablet, and Terazosin 5 mg capsule.</p> <p>On 4/10/24 after Staff E dispensed the medication, the staff member entered Resident #31's room and sat the box of Fluticasone on the over-bed table. The resident immediately refused it. Staff E administered the medication, obtained a blood pressure then administered a half tablet of 25 mg of Metoprolol .</p> <p>Immediately following the observation with Resident #31 Staff E confirmed the Carbamazepine tablets were chewable and should have been in with the aspirin, despite resident swallowing the aspirin and while holding cell phone in hand reported was going to call doctor to notify them the resident had refused the nasal spray.</p> <p>Review of Resident #31's Medication Administration Record (MAR) revealed a chart/follow up code legend showing a checkmark equaled Administered. The MAR revealed Staff E had documented a checkmark for Fluticasone nasal spray on 4/10/24, showing the nasal spray had been administered prior to its discontinuation.</p> <p>An interview was conducted with the Director of Nursing (DON) on 4/11/24 at 8:35 a.m., the DON reviewed Resident #31's MAR and stated if the resident had refused it (Fluticasone) it should be documented as a refusal not as administered.</p> <p>Review of the policy - Medication Administration, dated 9/18, showed Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication.</p> <p>(continued on next page)</p>		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2. If a dosage of regular scheduled medication is withheld, refused, or given at other than the scheduled time (for example, the resident is not in the nursing care center at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for as needed (PRN) documentation. If two consecutive doses of a vital medication are withheld or refused, the physician is notified.		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015</p> <p>Based on observation, record review and interview, the facility failed to ensure hand hygiene was provided before and after meal service on four (100, 200, 300 and Melody-secured) of four units, and the facility failed to ensure hand hygiene was available after toileting for one unit (Melody-secured) out of four units observed.</p> <p>Findings included:</p> <p>An observation on 04/08/24 at 12:00 p.m., revealed a hydration cart was being utilized down 400 hallway. The staff provided hydration prior to meal but did not provide hand hygiene.</p> <p>An observation on 04/08/24 at approximately 12:30 p.m., the tray cart was delivered to 400 hallway. Staff were observed knocking on Residents' doors and delivering trays to each Resident. No hand hygiene was observed being conducted at tray delivery service.</p> <p>During an interview on 04/08/24 at 12:45 p.m. Staff E, Registered Nurse (RN)Unit Manager (UM) stated she did not know when hand hygiene was provided but she thought it was after lunch.</p> <p>During an interview on 04/08/24 at 12:50 p.m. Staff F, Certified Nursing Assistant (CNA) stated, I personally wash all my Residents hands during morning care. Staff F CNA was asked when Residents hand hygiene was expected to be conducted before meals? Staff F CNA again replied, I did all my residents hand hygiene during morning care.</p> <p>During an interview on 04/08/24 at 12:55 p.m. Staff H, Certified Nursing Assistant (CNA) stated Residents are to be provided hand hygiene both before and after the meal. Staff H CNA stated she always provided hand hygiene for her residents before lunch but today she was on break during that time.</p> <p>During an interview on 04/08/24 at 1:00 p.m. Staff G, Certified Nursing Assistant (CNA) stated Residents are to be provided hand hygiene during morning activities of daily living (ADL) care and then after lunch.</p> <p>During an interview on 04/08/24 at 1:05 p.m. Staff B, Certified Nursing Assistant (CNA) stated, Residents are to be provided hand hygiene care first thing in the morning and after lunch.</p> <p>An observation on 04/10/24 at 11:55 a.m., revealed a hydration cart was being utilized down 400 hallway. The staff provided hydration prior to meal but did not provide hand hygiene.</p> <p>During an interview on 04/10/24 at 12:20 p.m., Resident #93 stated she was not provided hand hygiene before each meal.</p> <p>During an interview on 04/10/24 at 12:35 p.m., Resident #16 stated she was not provided any hand hygiene prior to lunch today, but stated the staff do provide it sometimes before meals.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 04/11/24 at 3:15 p.m. , the Director of Nursing (DON) stated I would expect hand hygiene to be provided before meals. The DON stated, We heard this through the grapevine and we will be QAPI hand hygiene at the next meeting.</p> <p>48441</p> <p>2. An observation on 04/08/24 at 12:12 p.m., revealed twelve residents in the main dining room. The main dining room consisted of Residents who resided on 100 and 200 hallways. Staff were observed passing hydration to the Residents prior to meal service with no hand hygiene provided. Two residents were observed using their hands/fingers to eat independently. On 04/08/24 at approximately 12:30 p.m., tray pass was observed on the 100 and 200 halls, no hand hygiene was offered to the residents prior to tray service.</p> <p>37999</p> <p>3. On 4/8/24 at 11:01 a.m., Staff I, Registered Nurse/Unit Manager (RN/UM) was observed cleaning the table where Resident #107 had been resting leg on a table in the secured memory care unit. The observation revealed on 4/8/24 at 11:03 a.m. of Staff M, Certified Nursing Assistant (CNA) of emptying artificial sweetener and milk into coffee cups then took the cups to resident's sitting in the common area.</p> <p>On 4/8/24 at 11:14 a.m., Staff P, RN stated the two meal carts (for Melody - memory care unit) come at different times, only four staff members to pass trays so may have some residents sitting without trays while some have them so the residents may say that's mine and demonstrated with outstretched hands and pulling back to chest.</p> <p>On 4/8/24 at 11:47 a.m. a meal cart arrived to the Melody care and Staff P informed Staff I of not knowing everything about the meal service so did not want to mess it up. The trays contained foam plates and plastic utensils.</p> <p>On 4/8/24 at 11:50 a.m., Staff L was observed taking meal tray into room [ROOM NUMBER]. Staff M and O, CNA's, were observed washing their hands at sink in common area of Melody unit.</p> <p>On 4/8/24 between times of 11:01 a.m. and 12:04 p.m., Staff L, M, and O were observed passing lunch meals, which included handheld bread, to 21 residents sitting in the common area and covered patio. During the observation on 4/8/24 of hydration and noon meal service residents were not offered hand hygiene prior to eating lunch.</p> <p>Review of the policy - Dining Services, effective January 2021, revealed To provide Residents a pleasurable dining experience by offering nutritious, attractive meals served in a courteous and dignified manner. The service procedure showed the dining room should be cleaned after each meal by nursing, dietary of other designated staff. The policy did not show resident's should be encouraged or assisted with hand hygiene prior to or after eating.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>4. On 4/9/24 at 11:29 a.m. while observing the memory care unit, writer was approached by Resident #213 who reported would like to have towels in the bathroom. The resident stated after toileting would wash hands and had to wipe hand on clothes afterwards, demonstrating wiping hands across front of shirt. An observation was made with the resident, immediately following the interview, an observation was made of the resident's bathroom which was shared with 3 other residents. The observation revealed an empty towel wall dispenser and toilet paper sitting on edge of sink. The resident stated when the toilet paper sat on the back of the toilet it would end up in the toilet. Photographic evidence was obtained.</p> <p>An interview was conducted with Staff L, Certified Nursing Assistant (CNA) on 4/10/24 at 9:11 a.m., the staff member reported Resident #213 and Resident # 103 (a resident who shared bathroom with Resident #213) were continent (of bowel and bladder) during the day. The staff member stated residents who toilet can ask staff to assist in washing hands or they have tissues, which the staff member pointed out on top of Resident #213's dresser. Resident #213 asked Staff L and writer if they can get brown towels. The staff member stated if they fill the dispenser on the wall the towels end up in the toilet.</p> <p>During an interview on 4/10/24 at 3:56 p.m., Staff I, Registered Nurse/Unit Manager reported being unaware Resident #213 or #103 was asking for towels to dry hands. Staff I stated both residents were continent and it was tricky because of the shared bathroom. The staff member stated wiping hands on clothing was not appropriate and agreed if the residents were able to voice and identify something was missing (towels) they should have the opportunity to wash hands.</p> <p>Review of Resident #213's Admission Record revealed the resident was admitted on [DATE] with diagnoses not limited to Parkinson's disease without dyskinesia without mention of fluctuations and mild dementia in other diseases classified elsewhere without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety.</p> <p>Review of Resident #213's Brief Interview of Mental Status (BIMS) evaluation completed on 4/3/24 by Staff I revealed a score of 6 indicating a severe cognitive impairment.</p> <p>Review of Resident #213's Continence report revealed the resident had been continent of urine 10 out 18 documentation's and continent of bowel 13 out of 18 documentation's.</p> <p>Review of Resident #213's care plan revealed the resident had an Activities of Daily Living (ADL) self care performance deficit related to recent hospitalization , history of falls, weakness, diagnoses of Parkinson. The goal was for the resident to improve level of self-performance by next review. The interventions showed the resident was incontinent of bowel and bladder, utilized the bathroom for toileting, praise efforts for participating in task, and self-performance level may fluctuate through out the course of the day, provided assistance as appropriate.</p> <p>Review of Resident #103's Admission Record revealed the resident was admitted on [DATE] with diagnoses not limited to mild dementia in other diseases classified elsewhere with other behavioral disturbance and unspecified heart failure.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of Resident #103's Cognitive Pattern assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 9, indicated moderate cognitive impairment and an Admission Cognitive Pattern assessment, on 2/3/24 revealed a BIMS score 3, indicative of a severe cognitive impairment. Review of Resident #103's Bladder and Bowel 5-day assessment, dated 1/31/24 revealed the resident was frequently incontinent of bladder and bowel.</p> <p>Review of Resident #103's March Continence report revealed the resident was continent of bladder 52 out of 80 documentation's and was continent of bowel 55 out of 79 documentation's. Review of the resident's April Continence report revealed the resident was continent of bladder 16 out of twenty-five documentation's and continent of bowel 20 out of 25 documentation's.</p> <p>Review of Resident #103's care plan revealed the resident had an ADL self-care performance deficit due to recent hospitalization , unsteady gait, (and) generalized weakness. The goal was for the resident improve level of self performance by next review. The related interventions included self performance level may fluctuate through out the course of the day, provide assistance as appropriate , resident was incontinent of bladder and bowel with toileting assistance of 1, and staff would praise efforts for participating in task.</p> <p>The policy - Hand Hygiene, effective October 2021, revealed The facility considers hand hygiene the primary means to prevent the spread of infections. The policy showed the following:</p> <ol style="list-style-type: none"> 1. Personnel shall be trained and regularly in-serviced on the importance of hand hygiene and preventing the transmission of healthcare-associated infections. 2. Personnel shall follow the handwashing/ hand hygiene guidelines to prevent the spread of infections to other personnel, residents, and visitors. 4. Residents, family members, visitors, volunteers and those who provide services under a contractual agreement will be encouraged to practice hand hygiene through the use of fact sheets, pamphlets, and other written materials provided at the time of admission and posted throughout the facility. <p>The policy did not address when a resident should be encouraged or assisted with hand hygiene however did instruct employees when it was necessary for them to perform hand hygiene:</p> <ul style="list-style-type: none"> - When hands are visibly soiled (hand washing with soap and water); - Before and after eating or handling food (hand washing with soap and water); - Before and after assisting a resident with meals (hand washing with soap and water); - After personal use of the toilet (hand washing with soap and water); - After blowing or wiping nose; - After performing your personal hygiene (hand washing with soap and water). 		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015</p> <p>Based on record review, interview and review of facility's policies titled, Infection Prevention and Control Program, Tracking: Monitoring, Antibiotic Prescribing, Use and Resistance, Individuals Accountable for Antibiotic Stewardship Activities, and Antibiotic Stewardship, the facility failed to ensure one Resident (#12) out of one Resident reviewed for antibiotics was appropriately assessed for the use of an antibiotic.</p> <p>Findings included:</p> <p>A review of the Admission Record showed Resident #12 was admitted to the facility on [DATE] with diagnoses that included but was not limited to unspecified focal traumatic brain injury without loss of consciousness, major depressive disorder, recurrent , other seizures, schizophrenia and anxiety disorder, unspecified.</p> <p>Review of the Order Summary Report revealed a physician order dated 04/03/24 for Doxycycline Hyclate Oral Tablet 100 MG[milligrams] (Doxycycline Hyclate)- Give 1 tablet by mouth every 12 hours for UTI [urinary tract infection] for 10 Days.</p> <p>Review of Resident #12's care plan revealed, Focus: ANTIBIOTIC: The resident is on Antibiotic Therapy r/t Has a Bacterial Infection (UTI). Goal: Minimize the risk of spread and Will be free of any discomfort or adverse side effects of antibiotic therapy through the review date. Interventions: Administer medication as ordered, Report pertinent lab results to MD, Standard Precautions, Observe for possible side effects every shift, Observe diarrhea, nausea, vomiting, anorexia, and hypersensitivity /allergic reactions. Monitor for adverse reaction, Offer and/or encourage fluids through out the day. Antibiotics are non-selective and may result in the eradication of beneficial microorganisms and the emergence of undesired ones, causing secondary infections such as oral thrush, colitis, and vaginitis and Monitor for presence or absence of pain; level & effectiveness of pain medication.</p> <p>Review of Resident #12's lab results showed no urinalysis (UA) available for the dates of 04/01/24-04/03/24 prior to the use of antibiotic treatment.</p> <p>Review of Resident #12's Standard Evaluations for change of condition (CoC) evaluations, showed one CoC dated 09/07/23.</p> <p>Review of Progress Notes revealed the following:</p> <p>-A progress note dated 04/8/2024 at 10:44 p.m., showed, Resident continued on PO [antibiotic] ABT for [urinary tract infection] UTI No adverse reaction noted on this shift. No sign of discomfort noted. Resident denied dysuria.</p> <p>-A progress note dated 04/7/2024 at 10:35 p.m., showed, Resident on ABT for UTI no adverse reactions noted will continue with care plan.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-A progress note dated 4/3/2024 at 5:20 a.m., showed, Unable to collect urine for testing. Had resident in bathroom but, he could not urinate at that time. Will ask 7-3 shift to try or get a cath order.</p> <p>-A progress note dated 04/01/23 at 2:48 p.m., showed, MD [medical doctor] in to see resident noted with increased weakness. New order received for stat and routine labs.</p> <p>During an interview on 04/11/24 at 8:40 a.m., Staff E Registered Nurse (RN) Unit Manager (UM) stated Well here is the thing, We tried three times to get a urine sample and was unsuccessful. Staff E RN/UM stated the doctor decided to order Resident #12 Doxycycline as a preventive measure without confirming the urinary tract infection because Resident #12 looked pale and was weak.</p> <p>During an interview on 04/11/24 at 9:35 a.m., the Director of Nursing (DON) was asked for the facility's policy and procedure for urinary tract infection (UTI) protocol but stated, there was no policy or procedure for UTI.</p> <p>During an interview on 04/11/24 at 9:40 a.m., the Infection Preventionist (IP) stated that the progress notes stated that they would straight cath him but when Staff E RN/UM talked to the physician, the physician chose not to straight cath Resident #12 and just put him on an antibiotic. The IP confirmed there was no change of condition assessment completed which she would have expected there would have been one. The IP was asked if the McGreer Criteria was used for antibiotics ordered and administered to Residents and the IP stated, this situation is not going to meet the McGreer Criteria as it would not be considered an infection because there was no UA to look at for antibiotic resistance. The IP did not talk with the physician regarding antibiotic stewardship program as IP stated Staff E RN/UM was the one who talked to the doctor about this situation.</p> <p>Review of the Monthly Line Listing Worksheet dated April 2024 showed Resident #12 had on onset date of 04/01/24 with symptoms included as increased weakness. The worksheet also revealed no culture obtained with Results and Pathogens not applicable na. The antibiotic ordered was Doxycycline.</p> <p>Review of the facility's policy titled, Infection Prevention and Control Program dated May 2020 showed, Antibiotic Stewardship is an ongoing tracking of antibiotic prescribing, antibiotic use and developing antibiotic resistance patterns with documentation and education.</p> <p>Review of the facility's policy on Antibiotic Stewardship titled, Tracking: Monitoring, Antibiotic Prescribing, Use and Resistance dated April 2017 showed, The infection Preventionist has information to provide strategies to improve antibiotic use. This includes tracking of antibiotic start, evaluation an management of treated infections and reviewing antibiotic resistance patterns. Provide education relating to antibiotic stewardship questions and act as a resource .Antibiotic prescribing elements will be addressed for a presence:</p> <ol style="list-style-type: none"> 1.) Dose 2.) Route 3.) Duration 4.) Start date <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5.) End date</p> <p>6.) Planned days of therapy</p> <p>7.) Indication</p> <p>Review of the facility's policy on Antibiotic Stewardship titled, Individuals Accountable for Antibiotic Stewardship Activities dated March 2017 showed, Infection Preventionist has information to provide strategies to improve antibiotic use. This includes tracking of antibiotic starts, evaluations, and management of treated infections and reviewing antibiotic resistance patterns. Provide education to antibiotic stewardship questions and act as a resource.</p> <p>Review of the facility's policy on Antibiotic Stewardship titled, Policy and Procedure dated March 2017 showed, Policy: Facility administration will be committed to improving antibiotic use. Administration will include, but not limited to, the Administrator, Director of Nursing, Infection Preventionist, and Risk Manager. Procedure: 5.) Administration and the Infection Preventionist will communicate with nursing staff and the prescribing clinicians the facility's expectations regarding use of antibiotics and the monitoring and enforcement of stewardship policies.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>20536</p> <p>Based on observations, staff interviews and facility record review, the facility failed to ensure the kitchen's low temperature dish washing machine was operating effectively to include provision of correct chemical sanitizer during one of four days observed (4/8/2024).</p> <p>Findings included:</p> <p>On 4/8/2024 at 9:10 a.m. the main kitchen was toured with the Dietary Manager. The Dietary Manager was asked if she and her staff were at the time operating the dish washing machine. She confirmed they were and she noted the machine was a Low Temperature dish washing machine and operated with wash temperature expectation of 120 degrees F (Fahrenheit). and above, and with rinse temperature expectation of 120 degrees F. and above. She further revealed the chemical sanitizer should always test between 50 and 100 Parts Per Million (PPM). The Dietary Manager pointed out that Dietary Aide Staff A was running crates of dishes through the machine. An interview at that time with Staff A revealed she has been operating the dish washing machine for awhile and was knowledgeable on how it needs to operate. Staff A noted the machine operates with a wash cycle temperature of 120 degrees F., and with a rinse cycle temperature of 120 degrees F. Staff A also noted that the machine has a chemical sanitizer that runs through the machine and the sanitizer when tested , should read between 50 and 100 PPM. Staff A was asked how she knew the machine was a Low Temperature dish washing machine and what the temperature expectations were. She pointed at the front of the machine where there was a sticker that read; Wash Cycle 120 degrees F., Rinse Cycle 120 degrees F. She also revealed she had been inserviced by the dietary manager upon her hire date. She also confirmed she had been inserviced and educated on what the chemical sanitizer should be between; which was 50 to 100 PPM.</p> <p>At 9:17 a.m. on 4/8/2024 Staff A was asked to demonstrate the dish machine operation. She confirmed she had ran several crates of dishes through the machine already and there was no need to prime the machine to operate. After she pushed a crate of soiled dishes through the soiled side of the machine, the wash cycle revealed a temperature of 120 degrees for over ten seconds. The machine clicked and the rinse cycle revealed a temperature of 124 degrees F. for over ten seconds. The machine had an analog temperature gauge attached to the lower front portion of it. The Dietary Manager brought over to the machine a small cylindrical container with litmus paper test strips, (white in color). The Dietary Manager took out a white colored test strip and opened the slot door to the clean side of the machine and dipped the test strip into an internal water catch can. The strip was held for at least five seconds and when she brought the strip out from the machine, the white color test strip was now a deep dark blue/purple color. She took the test strip and placed it on the color legend on the cylindrical container and the color of the strip indicated the sanitizer PPM was well over 100. The Dietary Manager confirmed the machine was allocating too much chemical sanitizer, per the test strip read. Photographic evidence was taken of the test strip and the color legend on the cylindrical container.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>At 9:20 a.m. on 4/8/2024 Staff A was asked to do a second dish washing machine demonstration. Once she ran another crate of soiled dishes through the soiled side of the dish machine, the wash cycle temperature reached 123 degrees F. for over ten seconds, and the rinse cycle temperature reached 123 degrees F. for over ten seconds. The Dietary Manager then lifted the door lid and placed another new white in color test strip in the machine and placed it on a water spot on one of the clean dishes. The Dietary Manager held the strip in place for about five seconds and then removed it. The test strip was observed to be a very dark blue/purple in color and again, the strip indicated the sanitizer PPM was well over 100. The Dietary Manager again confirmed the strip color was way to dark and she would call the dish machine maintenance company to come out and take a look at the chemical sanitizer delivery system. The Dietary Manger also confirmed she would need to wash all dishes by way of the three compartment sink and they would also use paper and plastic for the next lunch meal service.</p> <p>On 4/9/2024 at 8:30 a.m. the Dietary Manager provided a dish machine maintenance company work order dated 4/8/2024, with a time of 7:21 p.m. The work order revealed; The chlorine sanitizer is reading too strong, and the machine has been shut down until fixed. The service comments revealed; Adjusted the cam timer to get the sanitizer at 75 PPM. The work order also included a pre work photo with a litmus paper sanitizer test strip reading well over 100 PPM and a post work photo with a litmus paper sanitizer test strip reading between 50 - 100 PPM.</p> <p>The Dietary Manager provided the last two months (3/2024 and 4/2024) dish machine temperature log and chemical sanitizer log for review. There were no indications the machine was not running correctly per the review of those logs.</p> <p>Further interview with Staff A at that time confirmed she had not tested the sanitizer this morning and did not know the machine was putting out too much. She revealed she and other kitchen staff will usually test the machine prior to washing dishes and then will document on the dish machine temperature log. She confirmed she had been inserviced to do so, but had not done so this a.m.</p> <p>On 4/11/2024 at 11:00 a.m. the Dietary Manager provided a photocopy of the dish washing machine specification plate, located on the machine itself. The specification plate read; Minimum Wash temperature 120 degrees F., Minimum Rinse temperature 120 degrees F., and Minimum Chlorine Sanitizer 50 PPM. Photographic evidence obtained.</p> <p>On 4/11/2024 at 11:00 a.m. the Dietary Manager also provided the Dish Machine Temperature Log policy and procedure with an effective date of 1/2021.</p> <p>The policy revealed; To monitor dish machine temperatures and chemical saturation (parts per million PPM for both high and low temperature machines at each meal prior to dishwashing to assure proper cleaning and sanitizing of dishes.</p> <p>The procedure continued;</p> <ol style="list-style-type: none"> 1. Record month and year at the top of the form 2. Send an empty dish rack through the dish machine prior to recording temperature. <ol style="list-style-type: none"> (a) This allows the water to reach the appropriate temperature. <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>(b) May take 3-4 times.</p> <p>3. Record wash and rinse temperatures under appropriate meal column and initial.</p> <p>4. Record chemical saturation level by indicating PPM using the appropriate litmus paper.</p> <p>(a) Required for low temperature/chemical sanitizing dish machines only.</p> <p>5. Report discrepancies from standard temperatures and chemical saturation to the Food Service Manager.</p> <p>6. Record action taken in the Comments/Action box if the temperature/PPM is not appropriate.</p> <p>7. File form in the Food and Nutrition Services Department for one year.</p>