

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105305	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Fairway Oaks Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13806 N 46th St Tampa, FL 33613	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>50434</p> <p>Based on record review and interview, the facility failed to provide Abuse/Neglect training to one (Staff X) of 10 employees reviewed.</p> <p>Findings Included:</p> <p>During an interview on 09/10/2024 4:30 p.m. the Director of Nursing (DON) stated Resident #100 had a lower BIMS score, and frequently wandered around the building. He stated on 03/14/2024 his Assistant Director of Nursing (ADON) and the Unit Manager (Staff G, Licensed Practical Nurse [LPN]), came and let him know that Resident #100's Resident Representative (RR) was reporting an allegation of neglect. The DON stated he went to Resident #100's room to speak with the family. He stated the family reported to him when they came in to visit Resident #100 on 03/13/2024 during the night, they found the resident in two briefs, the resident had a hospital gown on top of her clothes and was tucked in underneath her, the resident's hands were bound behind her, and that the resident's TV was not working. The DON stated once he spoke with the family, he went and notified the Nursing Home Administrator (NHA) and their regional. He stated when the Adult Protective Investigator (API) came in, they showed him pictures with a curtain with a call light and stated, There were no patient identifiers so this could have been any resident's room. He stated the API worker then showed him a picture of a brief and another brief being used as a chuck pad, and then a picture of Resident #100 with the sheets up to her arm pits and her arms outside of the sheet. The DON stated he provided a written copy of his statement to the NHA.</p> <p>(continued on next page)</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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/11/2024 at 12:39 p.m. the Nursing Home Administrator (NHA) stated on 03/13/2024 Resident #100's Resident Representative (RR) came in to visit the resident around 11:45 p.m., with a female companion. During this visit, staff stated the RR was not his usual self and smelt like alcohol. He stated the RR questioned Staff X, Certified Nursing Assistant (CNA) about why the call light was clipped to the curtain and why the TV was not working. He stated the Staff X, CNA went and got Staff Y, Licensed Practical Nurse (LPN), to let her know the RR was there and that he was not acting like his usual self. Staff Y, LPN, then went to the resident's room and noticed two people in Resident #100's room, she was told by the RR that the TV was not working. Staff Y tried to fix the tv, and the RR told her he would come back the next day. He stated on 03/14/2024, the Director of Nursing (DON) was approached by the Assistant Director of Nursing (ADON) and Staff G, LPN, notifying him the RR reported that when they came to see Resident #100 on 03/13/2024 her call light was out of reach, she was wearing two briefs, and she had a hospital gown tucked around her, where she could not move. He stated after the DON spoke with the RR; the DON reported the allegation to him (NHA). He stated, he then reported the allegation of neglect for double briefing and the call light being out of reach, he then had his staff call the abuse hotline, who accepted the case, and the Police who did not proceed. He then suspended the CNA pending investigation. They evaluated the resident by completing skin sweeps, a pain evaluation, psychosocial evaluation and reported the allegation of neglect to the physician. Resident #100 was found to be in no pain, had no skin impairments and remained at her baseline. He stated they did education on Abuse, Restraints, Call Lights, and double briefing. He stated they completed education on restraints because they wanted to rule out any type of restraint, since it was reported Resident #100 was dressed in a gown that was tucked underneath her, and they wanted to do a comprehensive education.</p> <p>During an interview on 09/10/2024 at 3:15 p.m., Staff X, CNA stated Resident #100 was a resident under her care. She stated on 03/13/2024 she worked a double shift, and Resident #100 was known to always be talking and moving about, she stated she never sits still. She stated one night, Resident #100's Resident Representative (RR) came in and was upset that the floor was dirty, and Resident #100 was soiled. She stated she went to change Resident #100, and the RR and his family member asked if they could stay in the room while she performed the care. She stated she agreed and began providing care for the resident. She stated she moved the call bell out of the way and placed it on the curtain. She stated as she began to change the resident, the RR's noticed the liner in the resident's brief and started accusing her of double briefing Resident #100. She stated the resident liked to dig her hands in her vagina, so she added a liner to the resident's brief to keep her from getting her hands in her pants. She stated the RR began shouting at her asking her why the floor was dirty and why the TV was also turned off. She stated she went and got a towel and cleaned up the floor right away. She stated she told the RR she was not sure why the TV was not working, but she would let maintenance know first thing in the morning. She stated the RR was not willing to hear her out, so she went and got the Unit Manger. She stated the RR left after speaking with the Unit Manager. She stated the next day the RR came in and reported Resident #100 was double briefed, and she (Staff X) had touched the resident inappropriately. She stated she was immediately suspended. She stated she spoke with the State's Adult Protective Agency and the police. She stated she was suspended for three days, and she had not completed any training before returning to work and has not received any retraining or education on abuse/neglect since returning to work in mid to late March of 2024.</p> <p>Review of the inservice education dated 03/14/2024, revealed staff was educated on abuse allegations and reporting timely, forms of abuse can include physical restraints, residents are not to be double briefed, and call lights are to be placed with in reach, the sign in sheet did not include Staff X, CNA.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's abuse, neglect, exploitation, misappropriation, mistreatment, and injury of unknown origin (ANEMMI) Policy dated 08/2022 revealed:</p> <p>Training</p> <p>Policy: The center will train all new and existing nursing home staff through orientation and ongoing end services in ANEMMI prevention and response. Nursing home staff includes employees, consultants, contractors, volunteers and other caregivers who provide care and services to residents on behalf of the facility.</p> <p>Procedure: In service training will include at a minimum:</p> <p>A. Regulatory requirements regarding freedom from abuse neglect and exploitation.</p> <p>C. What constitutes abuse neglect exploitation misappropriation mistreatment and injury of unknown origin.</p> <p>D. Reporting policies and procedures established by the center.</p> <p>E. Appropriate interventions to deal with aggressive behaviors.</p> <p>F. How to recognize signs of burnout frustration and stress and both residents and staff that might lead to abuse neglect exploitation misappropriation and mistreatment and how to effectively intervene.</p> <p>Prevention</p> <p>Policy: The center will provide supervision and staff support services designed to reduce the likelihood of abusive behaviors. This center will provide ongoing oversight and supervision of staff in order to assure that policies are implemented as written.</p> <p>Procedure only authorized staff directly involved in providing care and services for a resident should be present when care is provided unless the resident consents to other individuals being present during the delivery of care.</p> <p>All supervisory staff will identify inappropriate behaviors, including but not limited to the use of derogatory language; rough handling; ignoring residents while giving care; directing residents who need assistance with toileting to urinate or defecate in their beds; and will take immediate steps to correct such behaviors. Supervisors will be especially sensitive to signs and symptoms of acute frustration.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50434</p> <p>Based on record review and interview the facility failed to ensure all alleged violations of abuse to include physical restraints were reported to the State Survey Agency for 1 (#100) out of 23 residents sampled.</p> <p>Findings included:</p> <p>Review of Resident #100's Admission Record revealed she was originally admitted to the facility in 2020 with medical diagnoses of Alzheimer's disease, diabetes mellitus, non-Alzheimer's dementia, delusional disorders, chronic kidney disease, peripheral vascular disease, and depressive episodes.</p> <p>Review of Resident #100's Quarterly Minimum Data Set (MDS), dated [DATE], Section C - Cognitive Patterns revealed a Brief Interview for Mental Status (BIMS) score of 00 out of 15 showing Resident #100 was cognitively impaired. Functional Abilities and Goals, Section GG revealed Resident #100 required Partial/moderate assistance for Toileting hygiene, and Shower/bathe care, personal hygiene, upper body dressing, lower body dressing, and putting on/taking off footwear. According to the Self-Care Coding for Partial/Moderate assistance means helper does less than half the effort. A helper lifts or holds trunk or limbs and provides less than half the effort.</p> <p>During a phone interview on 09/10/2024 at 8:59 a.m. the Resident Representative (RR), stated he came in to see Resident #100 on 03/13/2024 around 1:00 a.m., he stated the resident was in bed with a hospital gown and sheet tucked around her. He stated his family member (FM), who was with him, removed the sheet from Resident #100 and saw that her hands were tied behind her back with a towel. He stated his FM untied Resident #100 before he was able to get a picture. He stated he and his FM removed the sheet and hospital gown from Resident #100 and saw she was double briefed and wet. He stated the call bell was also clipped to the curtain in her room and the TV was turned off. He stated he went and got Staff X, Certified Nursing Assistant (CNA) and asked her why Resident #100 was tied up in bed and in a wet brief, he stated Staff X, CNA had no explanation and exited the room and started talking to another staff member in the hallway in another language. He stated he stayed until around 3 a.m., to make sure Resident #100 was taken out of bed, given a bath and changed. He stated he came in the next morning spoke with the Director of Nursing (DON) and told him when he came in to see Resident #100, he found her in her room with a hospital gown and sheet tucked underneath her, with her hands tied behind her back, and her call light attached to the curtain. He stated after reporting the allegation to the facility no one has contacted him.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/10/2024 at 3:15 p.m., Staff X, CNA stated Resident #100 was a resident under her care. She stated the resident is known to always be talking and moving about, she stated she never sits still. She stated one night the resident's family came in and was upset that the floor was dirty, and Resident #100 was soiled. She stated she went to change Resident #100, and the RR and his FM asked if they could stay in the room while she performed the care. She stated she agreed and began providing care for the resident. She stated she moved the call bell out of the way and placed it on the curtain. She stated as she began to change the resident the RR's FM noticed the liner in the resident's brief and started accusing her of double briefing Resident #100. She stated the resident likes to dig her hands in her vagina so she added a liner to the resident's brief to keep her from getting her hands in her pants. She stated the RR began shouting at her asking her why the floor was dirty and why the TV was also turned off. She stated she went and got a towel and cleaned up the floor right away. She stated she told the RR she was not sure why the TV was not working but she would let maintenance know first thing in the morning. She stated RR was not willing to hear her out, so she went and got the Night Nurse assigned to Resident #100 (Staff Y, Licensed Practical Nurse [LPN]). She stated the RR left after speaking with the Staff Y, LPN. She stated the next day the RR came in and reported Resident #100 was double briefed, and she touched the resident inappropriately. She stated she was immediately suspended. She stated she spoke with the state's Adult Protective Agency and the police. She stated she was suspended for 3 days, and she had not completed any training before returning to work.</p> <p>During an interview on 09/10/2024 4:30 p.m. the DON stated Resident #100 had a lower BIMS score, and frequently wandered around the building. He stated on 03/14/2024 his Assistant Director or Nursing (ADON) and the Unit Manager (Staff G, Licensed Practical Nurse [LPN]), came and let him know that Resident #100's RR was reporting an allegation of neglect. He stated he went to Resident #100's room to speak with the family. He stated the family reported to him when they came in to visit Resident #100 on 03/13/2024 during the night and they found the resident in two briefs, the resident had a hospital gown on top of her clothes and was tucked in underneath her, the resident's hands were bound behind her, and that the resident's TV was not working. He stated once he spoke with the family he went and notified the Nursing Home Administrator (NHA) and their regional. He stated when the Adult Protective Investigator (API) came in, they showed him pictures with a curtain with a call light and stated, There were no patient identifiers so this could have been any resident's room. He stated the API worker then showed him a picture of a brief and another brief being used as a chuck pad, and then a picture of Resident #100 with the sheets up to her arm pits and her arms outside of the sheet. He stated he provided a written copy of his statement to the NHA.</p> <p>Review of the DON's statement dated 3/14/24 included the allegation of the resident in bed wrapped in a hospital gown with her clothes on under the gown so she could not move, and the residents hands being tied behind her back.</p> <p>A review of the federal immediate report submitted to the state agency on 3/14/24 at 4:15 PM and the federal 5 day report submitted by the facility on 3/19/24 at 1:46 PM revealed no information related to the resident being restrained with her hands bound behind her and either a hospital gown or sheets positioned in a way that could possibly restrict her movement.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/11/2024 at 12:39 p.m., the NHA, stated he believed this was the resident who had an allegation of being hog tied, he stated he was trying to locate the reportable because this was about the time the systems changed on where to report to and did not want to speak to anything that did not happen. He then stated on 03/13/2024 Resident #100's RR came in to see the resident around 11:45 p.m., with a female companion (the individual referred to as FM). During this visit, staff stated the RR was not his usual self and smelt like alcohol. He stated the RR questioned the CNA on why the call light was clipped to the curtain, and why the TV was not working. He stated the CNA went and got Staff Y, LPN, to let her know the RR was there and that he was not acting like his usual self. Staff Y, LPN, then went to the resident's room and noticed two people in Resident #100's room. Staff Y, LPN was told by the RR that the TV was not working. Staff Y, LPN tried to fix the TV, and the RR told her he would come back the next day. The NHA said on 03/14/2024, the DON was approached by the ADON and Staff G, LPN, notifying him that the RR reported when they came to see Resident #100 on 03/13/2024 her call light was out of reach, she was wearing two briefs, and she had a hospital gown tucked around her, where she could not move. He stated after the DON spoke with the RR; the DON reported the allegation to him. He stated, he then reported the allegation to the state agency through the online Report System, had his staff call the abuse hotline, who accepted the case, and the police who did not proceed. He then suspended the CNA pending investigation. They evaluated the resident by completing skin sweeps, a pain evaluation, psychosocial evaluation and reported the allegation of neglect to the physician. Resident #100 was found to be in no pain, had no skin impairments and remained at her baseline. He stated they did education on abuse, restraints, call lights, and double briefing. He stated they completed education on restraints because they wanted to rule out any type of restraint, since it was reported Resident #100 was dressed in a gown that was tucked underneath her, and they wanted to do a comprehensive education. He stated that he has the report now and would like to review it so that he does not speak to anything he is unsure of. He reviewed the report and stated, The resident's family did not report the restraint, it was never brought up until after the investigation. He then stated the allegation of the restraint was not added to the federal reportable because there was no skin breakdown. He then stated, We took what appeared to be coherent to us and put it in the report. He stated for allegation of abuse he has 2 hours to report it and, I would report every allegation of abuse or neglect. He stated the facility did not substantiate the complaint and when he tried to reach out to the RR he did not answer the phone or return his calls.</p> <p>Review of the facility's Abuse, Neglect, Exploitation, Misappropriation, Mistreatment and Injury of Unknown Origin (ANEMMI) Policy, dated 08/2022, and revised on 01/2024, revealed: The center will seek and accept concerns complaints or grievances from residents, resident families and staff without reprisal the right to report a concern or incident is not limited to a formal written grievance process but includes any verbalized complaint to any facility staff member, prompt efforts will be made to resolve concerns complaints or grievances</p> <p>Definitions: Physical Abuse Includes controlling behavior through corporal punishment or physical or chemical restraints.</p> <p>Reporting and Response</p> <p>Policy: All allegations of possible ANEMMI will be immediately reported to the abuse hotline by the administrator or designee and will be evaluated to determine the direction of the investigation</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procedure: Any and all staff observing or hearing about such events must report the event immediately to the administrator immediate supervisor and one of the following directors of nursing ANEMMI prevention coordinator or risk manager so that appropriate reporting and investigation procedures take place immediately it will also be reported to other officials in accordance with state and federal regulations</p> <p>A. Immediate Report in accordance with CFR 483.12 (1)(C) with response to allegations of abuse neglect exploitation or mistreatment the facility must</p> <p>1. Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment including injuries of unknown source and misappropriation of resident property are reported immediately but no later than two hours after the allegation is made if the events that caused the allegation involve abuse or result in serious bodily injury. The ANEMMI prevention coordinator will also submit to the Agency for Healthcare Administration federal immediate/5 day report.</p>		