

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/10/2024
NAME OF PROVIDER OR SUPPLIER  Concordia Village of Tampa		STREET ADDRESS, CITY, STATE, ZIP CODE  4100 E Fletcher Ave 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 0584</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 safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43453</p> <p>Based on observations, interviews and review of facility policy, the facility failed to ensure four resident rooms (212, 216, 217 and 218) were maintained in a clean and sanitary for one of two floors.</p> <p>Findings included:</p> <p>During a tour of Resident room [ROOM NUMBER] on 04/08/24 at 10:16 a.m., an observation was made of the resident's bathroom with dirt and dust on the floor corners. The floors and bathroom walls were stained with brown and dark matter and the toilet was observed with brown stains around the base. A plastic storage bin under the toilet was observed with dust on the surface. The resident in the window bed stated the cleaning could be better. She stated she had seen a cockroach in the bathroom. She stated the toilet was always dirty. She stated they had a nice housekeeping staff member who was no longer there. She stated it had not been the same. An observation of the resident's drinking cup was made with a small insect on the drinking straw. The resident stated she had observed the insects in her room before.</p> <p>During a tour of Resident room [ROOM NUMBER] on 04/08/24 at 10:30 a.m. the toilet was observed with dust, debris, and particles around the floor corners. The floors were observed with stains and the toilet base with brown matter on the surface. The resident in the door bed stated they did not clean very well, the bathroom was always dirty.</p> <p>During an interview on 04/09/24 at 11:10 a.m. with Staff P, Housekeeping, she stated she cleaned all the rooms. She stated if the floors were stained and if she could not get the stains off, she would notify her supervisor. She stated if there were bugs anywhere, she would notify her supervisor.</p> <p>During a tour of Resident room [ROOM NUMBER] on 04/09/24 at 11:17 a.m., two urinals were observed on the resident's head of bed, hooked to the bedside rail. They were observed with urine, stained and with a foul order. The resident in the window bed stated it was always like that.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 04/10/24 at 9:06 a.m. with Staff M, Housekeeping, Staff P, Housekeeping, and the Housekeeping Manager (Manager). The Manager stated sometimes they have problems with the caulking around the toilet bases in the bathrooms. She said, There is a rust appearance on the toilets' bases, it is hard to come off. Staff P said, I try to use bleach and brush to get it off. Staff M stated it was the first time she saw the small flying insects. The Manager stated no one said anything about the flying insects. She stated she would call maintenance to come and spray. She stated the facility had a pest control contractor who comes on Wednesdays. She stated the problem with the small flying insects was because the showers don't get used often and it could be the drain issue.</p> <p>On 04/10/24 at 10:09 a.m. an interview was conducted with Staff E, Licensed Practical Nurse (LPN)/ Unit Manager. She stated the small flying insects were all around the building. She stated there should not be flying insects on residents' drinking cups, on themselves or in their spaces. She stated the CNAs (Certified Nursing Assistants), and nurses should replace the residents' urinals daily if needed. Staff E observed photographic evidence and said, Insects on resident's plate, that is gross, I can't imagine about the residents who cannot swish the insects off themselves. Staff E stated maintenance knew. She said, We told them. I am not sure what they have done about it. I spoke to him last week Wednesday.</p> <p>Review of a facility policy titled, Daily Resident Room Cleaning Procedure, dated 1/30/23, showed to (b.) clean the bathroom (see bathroom cleaning policy). [This policy was not provided.] (d.) Utilize bathroom cleaner to disinfect the sink, handrails, toilet, and all other surfaces in the bathroom. (l.) Mop the floor if it is not carpeted.</p> <p>46234</p> <p>An observation was made on 04/08/24 at 1:47 p.m. of Resident room [ROOM NUMBER]. The wall behind the head of the bed had long scrape marks and baseboards that were cracked with several chunks of wood missing.</p> <p>Review of a facility policy titled, Resident Environment Quality, dated 10/17/22, showed it was the policy of this facility to be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.</p> <p>(Photographic Evidence Obtained)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43453</p> <p>Based on observations, interviews with residents and facility staff, and review of the facility's records and policies, the facility failed to provide sufficient staff to provide meal assistance on one floor (second floor) of two floors for six (#32, #15, #30, #3, #18 and #54) of 17 dependent residents, and failed to respond to a call light for Resident #20 for two days (04/09/2024 and 04/10/2024) of a three day survey.</p> <p>Findings included:</p> <p>An observation on 04/09/24 of the lunch meal service revealed the residents in the dining room received their trays starting at 11:34 a.m. Resident #32 was the last one to receive her tray in her room at 12:45 p.m., having waited approximately one hour and twenty minutes.</p> <p>During a facility tour on 04/09/24 at 11:43 a.m. an observation was made of staff distributing trays on the facility's second floor dining room. The residents who eat in their rooms were observed waiting for their trays.</p> <p>An observation was made of Staff R, Certified Nursing Assistant (CNA) on 04/09/24 at 12:25 p.m. passing resident lunch trays on the 200 hall. He stated (Resident #15) was a feeder and he would be feeding him shortly. He walked into the resident's room with the tray, dropped off the tray and walked out. Staff R stated he did not assist him with the meal because (Hospice Staff-1) took over. Staff R stated (Hospice Staff-1) was willing to help feed the resident.</p> <p>On 04/09/24 at 12:38 p.m. an interview was conducted with Hospice Staff #1. She stated she did not know this resident (#15). She stated she did not know how much he normally ate, she said, I'm here to see him for other things. I decided to assist with his meal because he was waiting.</p> <p>On 04/09/24 at 12:27 p.m. Staff R, CNA dropped off a tray for Resident #48. The resident was waiting to be assisted with meal. After approximately 5 minutes, the resident was observed being assisted by Hospice Staff-2. Staff R stated the Hospice staff was willing to feed the resident.</p> <p>On 04/09/24 at 12:28 p.m. Hospice Staff-1 was observed looking for towels. She was observed walking down the halls looking for linen carts. She asked, Where are the staff? Hospice Staff-1 found the towels and a gown and returned to change Resident #15.</p> <p>During this timeframe, Staff T, Licensed Practical Nurse (LPN) was observed on 04/09/24 from 12:11 p.m. to 12:35 p.m. at the nurses' station on the phone.</p> <p>On 04/09/24 at 12:29 p.m. Staff Q, CNA was observed grabbing a tray from the cart. She stated she was going to feed Resident #30. She stated there were two CNAs and one nurse working in this hall. She stated there were about seven residents that needed to be assisted with meals on her assignment. She stated sometimes it takes them a long time to feed all the residents. She stated she did not know if the food was cold. She stated the residents did not say anything about the food being cold.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/09/24 at 12:30 p.m. the Director of Nursing (DON) was observed assisting Resident #18 with a meal while standing. She was heard saying to the resident, It's the blind leading the blind. The DON stated she had come to assist with lunch.</p> <p>On 04/09/24 at 12:36 p.m. an observation was made of two residents' meal trays still waiting to be delivered. Resident #32 was one of the recipients. She was observed sitting in her wheelchair in the middle of her room. Resident #32 was not interviewable. She had not had lunch.</p> <p>An immediate interview was conducted with Staff S, Registered Nurse (RN) on 04/09/24 at 12:37 p.m The nurse confirmed Resident #32 was waiting to be assisted. He pulled the tray out, confirmed the meal ticket and put the tray back in the cart. He stated he had about six residents who needed to be assisted with their meal on his assignment. He stated it was tight during meals. He said, There are not enough hands.</p> <p>On 04/09/24 at 12:39 p.m. an interview was conducted with Staff C, CNA. She confirmed Resident #32 was still waiting to be assisted with her meal. She looked inside the meal cart and saw two trays. She said, Yes, they are still waiting to be assisted. The CNAs on this floor had been assisting other residents in the dining room. They just have to wait.</p> <p>On 04/09/24 at 12:41 p.m. Staff R, CNA stated Resident #32 waited over 45 minutes today. Staff R said, Yes, sometimes they wait an hour. There are too many residents that need assistance. There is no way to get everyone in a timely manner. The CNA stated they needed more help, especially during meal service.</p> <p>On 04/09/24 at 12:45 p.m. Staff R, CNA was observed grabbing a chair from the nurses' station and proceeded to Resident #32's room. He was observed assisting her with the meal.</p> <p>An observation on 04/10/24 of the breakfast meal service revealed the residents on the second floor received their trays starting at 7:30 a.m. Resident #54 was the last one to receive his tray in his room at 9:01 a.m. having waited 1.5 hours.</p> <p>On 04/10/24 at 8:23 a.m. Resident #3 was observed receiving meal assistance from Staff U, CNA. The resident's roommate, Resident #30, was observed waiting to receive her breakfast meal.</p> <p>On 04/10/23 at 8:24 a.m. Resident #32 was observed sitting on her bed, awake. The resident was waiting for her breakfast meal.</p> <p>On 04/10/24 at 8:26 a.m. an observation was made of Staff C, CNA grabbing a meal tray and going into room [ROOM NUMBER]. She stated both residents were still waiting to be assisted with their breakfast meal. Staff C set a tray by the door bed. She walked back to the cart and grabbed another tray and set it by the window bed. On 04/10/24 08:43 AM an observation was made of Staff C assisting the resident in the door bed with her meal. Her roommate was observed waiting for her breakfast meal.</p> <p>On 04/10/24 at 8:29 a.m. an observation was made of Staff R, CNA assisting Resident #17 with her meal. Her roommate, Resident #18 was observed waiting for her breakfast meal.</p> <p>On 04/10/24 at 8:31 a.m. an interview was conducted with Staff A, CNA. She stated Resident #51 had been assisted with her breakfast, but they still had a few trays left.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted with Staff E, Licensed Practical Nurse/Unit Manager (LPN/ Unit Manager) on 04/10/24 at 9:45 a.m. She stated they had 17 assisted diners on the second floor and provided the list. She stated the expectation was for the CNAs and nurses to identify who needed to be assisted with dining and provide them the assistance. She stated the trays should not be left in the room until the resident is ready to receive assistance with the meal. Staff E LPN/UM said, We usually have about five to six CNAs. This morning, we had four CNAs and the unit secretary who is also a CNA should help. She stated it should take 30-45 minutes to have everyone fed from the time the trays come up. She said, There were a lot of assisted diners. She said, I can see how there can be short without the additional help. Staff E stated they looked at this issue in the past and decided certain staff should go upstairs and assist. She stated that a staff member who was supposed to help was out of the office and another one was in a meeting. Staff E said, We did not get them to help this week. The residents should not wait that long for their meal.</p> <p>On 04/10/24 at 9:53 a.m. an interview was conducted with the Food Service Coordinator (FSC). She said, We try to get the trays to the resident as quick as possible. There is a little interruptions. She stated they start with the independent people then the assisted residents. She stated the meal trays should be distributed within 10 minutes of receipt. She confirmed an hour, or more was not acceptable wait time.</p> <p>An interview was conducted with the Staffing Coordinator on 04/10/24 at 1:12 p.m She stated residents' acuity did not determine staffing numbers. She said, No, I go by what they tell me. I have a calculation sheet. I split the staff among the whole day. For the CNAs, the ratio is 1-20 and for the nurses the ratio is 1-40. She stated they were running with the new staffing mandate. She said every once in a while, I don't meet it, but it is never two days back to back. She stated this only happened when they had a late call -in and were unsuccessful trying to cover it. She stated they did not use agency staff. She stated if there were staffing shortages, she would always communicate with the Director of Nursing (DON) and the Nursing Home Administrator (NHA). She said, If staff haven't picked up or I have a lot of open shifts I let them know ahead of time. She stated she was a CNA and she assisted if they were short or if we cannot get someone to come in. The Staffing Coordinator said, During meals other staff take turns assisting on the floor, including department heads. She stated they split up between the first and second floors. She stated there was no schedule. She said, We all jump in and pitch. I was not there yesterday for lunch, and was not here to assist with breakfast. She stated there were two staff members who could have assisted, but they were absent. She stated she had been told as long as they hit the numbers, they were okay. The Staffing Coordinator said, I understand we also need to be aware about the quality of care and meeting the residents' needs.</p> <p>On 04/10/24 at 1:40 p.m. an interview was conducted with the NHA, Regional Clinical nurses (RNC)- 1 and RNC- 2. The NHA stated he was notified as of yesterday there were meal assistance concerns. He said, I became aware as of yesterday. They said it is taking a long time, we have someone that is off, therapy should be assisting. It will be a true practice going forward. He stated on 03/11/24 they did not meet the staffing numbers due to call offs. It was not two days in a row. He said in that case they try and replace as best as they can. Leadership should step in and assist. He stated he had not been notified of concerns with residents waiting to be assisted with toileting. He stated he did not know. The NHA said, That is not our practice.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of an undated facility document titled, Facility Assessment showed on page 15 of 46, B.2. Acuity - care requirements, [name of facility] staffs above state minimum requirements, with the specific focus on adequate CNA staffing to accommodate this greater need for additional assistance with the number of ADL's including daily care, bed mobility, transfers walk in room, toilet use, eating, dressing, and hygiene/grooming. The population at [name of facility] and the staffing levels provided are deemed sufficient based on resident satisfaction, QA/compliance committee data, resident council feedback, resident interviews and observations, clinical outcomes, and functional improvements.</p> <p>Review of a facility policy titled, Serving a Meal, dated 10/17/22, showed (12.) Remember that some residents take a long time to eat. Provide adequate time for the resident to consume the meal and offer to reheat foods as needed.</p> <p>Review of a facility policy titled, Nursing Services and Sufficient Staff, dated 10/17/22, showed it is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure residents safety and attain or maintain the highest practicable physical mental and psychosocial well-being of each resident. The facility's census, acuity and diagnosis of the resident population will be considered based on the facility assessment. Under policy explanation and compliance guidelines, (1) the facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with the resident care plans. A. Except when waved licensed nurses and B. Other nursing personnel including but not limited to nurse aides. (5) providing care includes but is not limited to assessing evaluating planning and implementing resident care plans and responding to resident's needs.</p> <p>46234</p> <p>An observation was made on 4/9/24 at 12:09 p.m. of the call light being activated in Resident #20's room. The call light remained on until Staff Q, CNA went to the room at 12:27 p.m., 18 minutes after it was activated. The call light was turned off and the CNA immediately exited Resident #20's room. A nurse was observed sitting at the nurses' station during this time.</p> <p>An interview was conducted on 4/9/24 at 12:28 p.m. with Resident #20. He said he needed to be changed because he was soiled. He said he is a quick change he just needed assistance. Resident #20 said the CNA came in and turned the call light off and told him staff were doing something with lunch and she would be back. Resident #20 said it always takes a while for call bells to be answered. Resident #20 reactivated his call light.</p> <p>An observation was made on 4/9/24 at 12:31 p.m. of Staff Q, CNA entering Resident #20's room, turning the light off. The resident was asked what the staff member told him. He said the CNA didn't say a word to him, they just turned the light off and walked back out.</p> <p>An observation was made on 4/9/24 at 12:48 p.m. of Staff R, CNA entering Resident #20's room to pick up his lunch tray. The resident was overheard asking the CNA if he was going to change him. The CNA said, Let me check and see which one [CNA] is down here. The CNA left the room and walked away.</p> <p>An observation was made on 4/9/24 at 12:54 p.m. of Resident #20 yelling out hello repeatedly from his bed. At 12:56 p.m. the Activities Director stopped and asked Resident #20 what he needed. He said, I've been waiting a while and he explained he needed to be changed. The Activities Director walked out of the room to find a CNA.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43453</p> <p>Based on observations, interviews and review of facility policy, the facility failed to maintain an effective pest control program related to small flying insects observed in three resident rooms (212, 216, and 218) on one of two floors.</p> <p>Findings included:</p> <p>During a tour of Resident room [ROOM NUMBER] on 04/08/24 at 10:16 a.m. an observation was made of small flying insects on the resident's water cup. The resident in the window bed stated the cleaning could be better. She stated she had seen a cockroach in the bathroom. The resident stated she had observed the insects in her room before.</p> <p>On 04/09/24 at 11:10 a.m. an interview was conducted with Staff P, Housekeeping. She stated she cleaned all the rooms. She stated if there were bugs anywhere, she would notify her supervisor.</p> <p>During a tour of Resident room [ROOM NUMBER] on 04/09/24 at 11:17 a.m., two urinals were observed on the resident's head of bed, hooked to the bedside rail. They were observed with urine, stained and with a foul order. An observation was made of small flying insects, approximately 20 of them on the resident's trash can and around surfaces in the room. An observation was made of the small flying insects on the resident's water cup and on his bed. The resident in the window bed stated it was always like that.</p> <p>During a tour of Resident room [ROOM NUMBER] on 04/10/24 at 8:42 a.m. an observation was made of small flying insects on the resident's plate and on their bed.</p> <p>An interview was conducted on 04/10/24 at 9:06 a.m. with Staff M, Housekeeping, Staff P, Housekeeping, and the Housekeeping Manager (Manager). Staff M stated it was the first time she saw the small flying insects. The Manager stated no one had said anything about the flying insects. She stated would call maintenance to come and spray. She stated the facility had a pest control contractor who comes on Wednesdays. She stated the problem with the small flying insects was because the showers don't get used often and it could be the drain issue.</p> <p>On 04/10/24 at 10:09 .m. an interview was conducted with Staff E, Licensed Practical Nurse (LPN)/Unit Manager. She stated the small flying insects were all around the building. She stated there should not be flying insects on residents' drinking cups, on themselves or their spaces. She stated the CNAs (Certified Nursing Assistants), and nurses should replace the residents' urinals daily if needed. Staff E observed the photographic evidence and said, Insects on residents' plate, that is gross. I can't imagine about the residents who cannot swish the insects off themselves. Staff E stated maintenance knew. She said, We told them. I am not sure what they have done about it. I spoke to him last week Wednesday.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/10/2024
NAME OF PROVIDER OR SUPPLIER  Concordia Village of Tampa		STREET ADDRESS, CITY, STATE, ZIP CODE  4100 E Fletcher Ave 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 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/10/24 at 3:38 p.m. an interview was conducted with the Director of Facilities. He stated he was made aware of flying insects the previous week. He said, My pest control guys came last week. He said some residents have fruits and flowers which might be causing the flying insects. He stated he could not find any breeding place. He stated if staff observed any pests, they should notify the receptionist to put in a work order. He said, If there is an issue I expect to be notified.</p> <p>Review of the facility's pest log showed no evidence of any insects being reported. The log did not show any work orders or treatments related to pests.</p> <p>46234</p> <p>An observation was made on 04/8/24 at 1:47 p.m. in Resident room [ROOM NUMBER] of several small flying insects around the resident's room. A small flying insect was observed landing on a resident's face while she was sleeping. The small flying insects were observed in the same room on 4/9/24.</p> <p>Review of a facility policy titled, Resident Environment Quality, dated 10/17/22, showed it was the policy of this facility to be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.</p> <p>(10.) Maintain an effective pest control program so the facility is free of pests and rodents.</p> <p>(Photographic Evidence Obtained)</p>		