

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2025
NAME OF PROVIDER OR SUPPLIER Woodbridge Care Center and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 8720 Jackson Springs Rd Tampa, FL 33615	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, medical record review, and facility policy review, the facility failed to ensure the safe and secure storage of all medications and biologicals, including a Schedule II controlled substance for one resident (#78), in one of one medication room, and in four carts (100 front, 100 back, 200 front and 200 back) out of four treatment carts. Findings included: 1. On 8/3/25 at, starting at 8:50 a.m., during a brief initial tour of the facility, observations were made which revealed four out of four treatment carts left unlocked and unattended as follows: 100 hall front revealed a treatment cart marked WCC ST 1 FRONT TX CART which was observed to be unlocked and unattended at 8:59 a.m. Photographic evidence was obtained at 9:00 a.m. which shows observations of the lock not engaged and some of the unsecured items in the top drawer observed to included green pain-relieving gel with menthol and zinc oxide cream. This treatment cart was observed unlocked and attended during a second unit tour on 8/3/25 at 9:45 a.m. 100 hall back revealed a treatment cart marked WCC ST 1 BACK TX CART which was observed to be unlocked and unattended at 9:03 a.m. Photographic evidence was obtained at 9:05 a.m. which shows observations of the lock not engaged and some of the unsecured items in the top drawer observed to included silver sulfadiazine cream, nystatin powder, and triamcinolone cream. This treatment cart was observed unlocked and attended during a second unit tour on 8/3/25 at 9:45 a.m. and at 10:10 a.m. 200 hall back revealed a treatment cart marked WCC ST 2 BACK TX CART which was observed to be unlocked and unattended. Photographic evidence was obtained at 9:10 a.m. which shows observations of the lock not engaged and some of the unsecured items in the top drawer observed to included spf (Sun Protection Factor)50 sunscreen lotion, zinc oxide ointment, Santyl ointment, triamcinolone cream, and mupirocin ointment. This treatment cart was observed unlocked and attended during a second unit tour on 8/3/25 at 9:50 a.m. 200 hall front revealed a treatment cart marked WCC ST 2 FRONT TX CART which was observed to be unlocked and unattended at 9:20 a.m. Photographic evidence was obtained at 9:20 a.m. which shows observations of the lock not engaged and some of the unsecured items in the top drawer observed to included odor elimination drops, spf 30 sunscreen lotion, zinc oxide ointment, ketoconazole 2% cream, triamcinolone cream, and clotrimazole-betamethasone cream. This treatment cart was observed unlocked and attended during a second unit tour on 8/3/25 at 9:50 a.m. On 8/3/25 at 9:00 a.m., the medication room door on the 100 hall was observed to be propped open (continued on next page)		

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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and unattended. Photographic evidence obtained. An observation inside the unsecured medication room revealed cabinets used for storing bottled medication tablets was unlocked and accessible (photographic evidence obtained at 9:03 a.m.). During a second tour of the 100 hall, the medication room door was observed propped open at 9:45 a.m. On 8/3/25 at 9:15 a.m., after a short conversation across from the medication room with the door propped open visible with Staff W, Registered Nurse (RN) who stated he was a nurse supervisor, he was observed to leave the area without closing the medication room door. On 8/3/25 at 10:00 a.m., the assistant director of nursing (ADON) was observed to lock the treatment cart marked WCC ST 1 FRONT TX CART as she walked by. She was asked if she knew why the treatment cart had been left unlocked all morning. She stated it should be locked. The ADON stated someone must have forgotten to lock it. The ADON stated the medication room door should not be propped open, it should always be closed and locked. The DON stated she was unaware the medication room door was observed propped open, with unlocked cabinets containing bottled medication tablets, for approximately 45-55 minutes this morning. On 8/04/2025 at 6:05 a.m., the 200-hall treatment cart marked WCC ST 2 BACK TX CART which was observed unlocked and unattended. Photographic evidence was obtained at 6:05 a.m. which shows observations of the lock not engaged and some of the unsecured items in the top drawer observed to included spf 50 sunscreen lotion, zinc oxide ointment, Santyl ointment, triamcinolone cream, and mupirocin ointment. On 8/04/2025 at 6:10 a.m., while observing Staff G, RN perform her morning medication pass, she was observed to leave a pill cup containing 4 pills in it on top of the cart. She was observed to leave this pill cup unattended while she went to administer medications to three different residents. Photographic evidence was obtained at 6:31a.m. and at 7:23 a.m. when the medicine cup with 4 pills was still observed on top of the medication cart. Staff G, RN stated I was going to give him his medications earlier, but he had something in his mouth when I brought them, so he asked me to come back later. I was going to bring them to him later. She was asked if it was standard practice to leave medication out and unattended on top of the medication cart. She stated I should have locked them up. A review of a facility policy titled: Medication Labeling and Storage (undated) revealed: Policy: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to the keys. Medication storage: Medications and biologicals are stored on the packaging, containers, or other dispensing systems in which they are received. The nursing staff is responsible for maintaining storage and preparation areas in a clean, safe, and sanitary manner. Compartments (including but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of a facility policy titled: Administering Medications (undated) revealed: Policy: Medications are administered in a safe and timely manner, and as prescribed. Procedures: 15. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. No medications are kept on top of the cart. 16. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and use the correct code pertaining to that drug and dose. 2. On 8/3/25 at 10:00 a.m., an observation of the floor in room [ROOM NUMBER], between the resident's bed by the door and the bathroom, revealed a white circular tablet with, "K102," on it. On 8/3/25 at 2:32 p.m., an observation of room [ROOM NUMBER] was conducted with Staff H, Licensed Practical Nurse (LPN)/Unit Manager (UM). The white circular tablet with, "K102," on it was observed on the floor. An interview with Staff H, LPN/UM revealed he was not sure what medication it was or what resident the medication is prescribed for. He said four residents, in room [ROOM NUMBER] and 224, share that bathroom. He confirmed the tablet should not be on the floor. He was observed picking up the tablet with a napkin and said he was going to find out who had the prescribed medication. (Photographic Evidence Obtained) On 8/3/25 at 2:56 p.m., an interview was conducted with the Assistant Director of Nursing (ADON) and Staff H, LPN/UM. Staff H, LPN/UM said the tablet on the floor was methylphenidate. The ADON said it is for narcolepsy and it's a narcotic. Staff H, LPN/UM said the methylphenidate tablet was prescribed for Resident #76 and used for attention deficit. He said Resident #76's physician orders for methylphenidate is to take the medication at 6:30 a.m., 11:30 a.m., and 4:30 p.m. Staff H, LPN/UM said he asked the resident if she took all her medications at 6:30 a.m. and 11:30 a.m., and her response was that she did. He said Resident #76 told her the nurse did not leave the medications at the bedside. The ADON and Staff H, LPN/UM said they cannot confirm if the dose of methylphenidate at 6:30 a.m. or 11:30 a.m. was missing, but both doses were documented as provided in the medication administration record (MAR). Staff H, LPN/UM said he interviewed her nurse who said he watched the resident take her medications. The ADON said they are not sure if the medication was from the day before, from the 4:30 p.m. dose. She said they called Resident #76's provider who wanted to order labs and complete an assessment to include neurological checks. The ADON said the medical provider said it was okay to continue the same dose and orders for methylphenidate. Staff H, LPN/UM said he was not sure when the housekeeping staff had been in room [ROOM NUMBER]. He confirmed the housekeeping staff are supposed to clean the residents' rooms daily, to include the area where the tablet was found. A review of Resident #76's admission record revealed an initial admission date of 3/7/24 and a re-admission of 6/17/24. Further review of the admission record revealed diagnoses to include major depressive disorder, recurrent severe without psychotic features, other specified anxiety disorders, attention-deficit hyperactivity disorder, unspecified type, and narcolepsy without cataplexy. A review of Resident #76's physician orders revealed the following: (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Increase monitoring, every shift for one day every shift for prevention, with a start date of 8/3/25 and end date of 8/4/25. - Methylphenidate hydrochloride (HCl) oral tablet 20 milligrams (mg), controlled drug, give one tablet by mouth before meals related to attention-deficit hyperactivity disorder, unspecified type, with an order date of 8/2/24. A review of Resident #76's quarterly Minimum Data Set (MDS), dated [DATE], under section C &dash; cognitive patterns, revealed a Brief Interview for Mental Status (BIMS) score of 15, cognitively intact. A review of Resident #76's MAR on 8/2/25 and 8/3/25 revealed methylphenidate HCl tablet 20 mg was provided at 6:30 a.m., 11:30 a.m., and 4:30 p.m., as ordered. A review of Resident #76's care plan revealed the following: - &ldquo;[Resident name] has the potential for adverse side effects related to the use of stimulant medication for dx [diagnosis] of ADHD [attention deficit hyperactive disorder], antidepressant for dx depression Date Initiated: 03/08/2024 Revision on: 07/29/2025.&rdquo; with interventions to include, &ldquo;Administer medication as prescribed by the physician (See current MAR & Physician orders for current dosage) &rdquo; - &ldquo;Resident has complaints of difficulty sleeping and/or staying asleep and is currently receiving a sleeping aid Date Initiated: 07/29/2025.&rdquo; with interventions to include, &ldquo;&hellip; Administer medication as ordered, and observe for effectiveness and for SEs [side effects] &hellip;&rdquo; - &ldquo;[Resident name] has a strength in cognitive function AEB [as evidenced by] is oriented to person, place, and time. ST/LT [short term/long term] memory are intact. Is able to make daily decisions independently. Date Initiated: 03/11/2024 Revision on: 03/11/2024&hellip;&rdquo; On 8/3/25 at 3:30 p.m. a follow-up interview was conducted with Staff H, LPN/UM and the ADON. The ADON confirmed the housekeeping staff went to room [ROOM NUMBER] yesterday afternoon. She said the housekeeping staff had not gone to the room today until 2:30 p.m. Staff H, LPN/UM said he thinks the housekeeping shift was until 3:30 p.m. He confirmed the room had not been cleaned from 3:30 p.m. on 8/2/25 until today at 2:30 p.m. He confirmed Resident #176 had narcolepsy and ADHD, which is what methylphenidate is being used to treat. A review of the facility's policy titled, &ldquo;Medication Labeling and Storage,&rdquo; dated 3/23, revealed the following, &ldquo;The facility stores all medications and biologicals and locked compartments under proper storage, humidity and light controls. Only authorized personnel have access to keys.&rdquo; Further review of the policy, under medication storage, revealed the following, &ldquo; &hellip; 7. Controlled substances (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976) and other drugs subject to abuse are separately locked in permanently affixed compartments, except when using single unit packaged drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected &hellip;&rdquo;		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure resident spaces were maintained in a clean and sanitary manner related to community shower room equipment in 2 of 2 shower rooms and in five resident rooms (222, 225, 128, 226 and 228) in two halls (100 and 200) of four halls observed. Findings included: 1. On 8/3/2025 at 11:00 a.m., 8/5/2025 at 7:45 a.m., 2:00 p.m. and on 8/6/2025 at 8:45 a.m. tours of the facility revealed the following: Upon entering the 200-unit community shower room, there were multiple shower stalls and with one containing a plastic shower bed device. This device is used for residents who lay flat on their back when receiving showers. Observations of the undercarriage of the device was observed with heavy pink and black biogrowth, down near the wheel castors and white plastic tube fitting areas. There was a plastic shower chair in one of the shower stalls which was observed with black and pink biogrowth on three of the four plastic tube fittings near and at the wheel castors. Upon entering the 100- unit community shower room there were three shower stalls and two of them had plastic shower chairs in them. Further observation revealed black and pink biogrowth on two of the four legs near the wheel castors. Under the blue plastic seat, there was a tray guide that had heavy black biogrowth along the entire edge. On 8/6/2025 at 9:15 a.m. an interview and tour with the Housekeeping Director confirmed the above observations and revealed the staff was responsible for the daily cleaning of shower equipment as well as the responsibility for deep cleaning the shower equipment on a weekly schedule. The Housekeeping Director further revealed that the equipment should be clean and sanitized throughout. Th Housekeeping Director stated the staff would clean the equipment and the shower rooms immediately. (Photographic Evidence Obtained). 2. An observation of resident room [ROOM NUMBER] on 8/4/2025 at 9:26 A.M., revealed the room had several pieces of food on the walls, floor, and under the resident's bed. There were liquids spills on the resident's bed, bedside table, floor, and walls. An observation of the bathroom revealed the toilet seat was covered in spots of dark brownish liquid and the bowl had dark brown colored liquid. The walls and floor in the bathroom were observed with dirt. The resident's bedside table contained 3 empty Styrofoam cups. The resident's room and bathroom did not have a trash can. The room was warm upon entry. The resident's air conditioner was on the "heat" setting. It was unclear if this was the resident's preference. An observation of room [ROOM NUMBER] on 8/5/2025 at 3:52 P.M. after housekeeper was observed cleaning the room, revealed the floors and walls remained dirty. The resident did not allow an observation of the bathroom at this time. (Photographic evidence obtained). 3. On 8/3/25 at 10:00 a.m., an observation of the bathroom in room [ROOM NUMBER] revealed the tank lid of the toilet and the outside of the tank had a smeared dark brown colored substance. Further observations of the toilet revealed the bottom area had dust, small particles, and debris. On 8/3/25 at 10:24 a.m., an observation of the bathroom in room [ROOM NUMBER] revealed two wet (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	washcloths were clumped together behind the sink faucet. On 8/3/25 at 11:30 a.m., an observation of the bathroom in room [ROOM NUMBER] revealed the toilet had urine and multiple wads of toilet paper. The floor had multiple particles and small bits of debris scattered throughout. An interview with one of the residents in the room revealed the bathroom, "Had been like that for a while." At 2:37 p.m., a follow-up observation was conducted of room [ROOM NUMBER] with the same concerns observed previously. On 8/3/25 at 2:40 p.m., an observation of the bathroom shared by room [ROOM NUMBER] and 228 revealed a wet washcloth was draped over the left side of the sink. The bathroom had an odor of damp towels, mustiness and urine. On 8/4/25 at 9:08 a.m., an observation of the bathroom revealed the same concerns observed on 8/3/25. On 8/4/25 at 9:41 a.m., an interview was conducted with the Housekeeping Supervisor. She said housekeeping worked Monday to Sunday, from 7:00 a.m. – 3:00 p.m. The supervisor said the expectation is for the housekeeping staff to clean all rooms during their shift. The Housekeeping Supervisor said there was a sheet the housekeeping staff completed, which included checking off the rooms they cleaned by the end of the day. The supervisor stated not keeping the past completed assignment sheets and there were no cleaning sheets for 8/3/25. The Housekeeping Supervisor stated, "The rooms should have been cleaned." On 8/6/25 at 12:56 p.m., a follow-up interview was conducted with the Housekeeping Supervisor who stated not being sure why the bathroom was not cleaned in room [ROOM NUMBER] and thinks, "Someone may have been using the bathroom." She said the housekeeping staff member may have cleaned the room and forgotten to go back. She stated, "They are not supposed to forget." She said regarding the toilet and floor observations in room [ROOM NUMBER], the bottom of the toilet area and floor should have been cleaned. She said the housekeeping staff is supposed to clean that area and put the white caps back over the screws at the bottom of the toilet. Regarding the wet washcloths observed in the resident's bathroom, the housekeeping supervisor stated, "Housekeeping would not touch the washcloths." She said that it's the CNA's responsibility to remove the washcloths. (Photographic evidence obtained). The facility did not provide a policy on Housekeeping and equipment maintenance expectations.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and record review, the facility failed to ensure the medication error rate was not 5% or greater during two medication administration opportunities out of 27, resulting in a medication error rate of 7.41%. Findings included: While observing Staff G, Registered Nurse (RN) during medication pass on 8/4/25, starting at 6:10 a.m., she was observed to prepare medications for Resident #58. One of the medications observed to be prepared was Divalproex Sodium Capsule Sprinkle 125mg (milligrams): Give 5 capsules by mouth every 8 hours for mood disorder. Staff G was observed to remove one capsule from the pill card and add the contents of the capsule to a small cup with apple sauce. She was observed to pour the other medications as ordered. She was observed to administer the medications to the resident. She was observed to return to her medication cart and review the medication screen for Resident #58 and proceeded to sign off the medications she had administered. She was asked if she had completed the 6:00 a.m. medication pass for Resident #58. She stated yes. She was asked to read the order for Divalproex for Resident #58. She was observed to read the order, and she did not say anything. She was asked if she had administered the medication according to the physician's order. She stated, Oh! okay, I see, I need to give the rest of that dose, it's five capsules, I only gave one capsule. During the medication administration observation for Resident #58, Staff G, RN stated she was unable to locate the ordered medication Dextromethorphan capsule: Give 15mg by mouth every 12 hours. Upon reviewing the Medication Administration Record (MAR) for Resident #58 after Staff G verbally confirmed she had completed that resident's medication pass, it was revealed that she had signed off the medication as having been administered. On 8/4/25 at 8:25 a.m., Staff H, Licensed Practical Nurse (LPN)/Unit Manager (U/M), stated he called pharmacy regarding the Dextromethorphan that was not available. He was asked why the medication shows in the MAR as administered this morning if it had not been given yet. He stated it shouldn't be. He stated he would talk to the nurse. Staff H, LPN/UM then spoke to Staff G, RN and said to her, When you don't give a medication you call the doctor to let them know, and you don't sign it as given, you sign as not available. A review of the facility policy titled Administering Medications (undated) revealed: Policy: Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 9. The individual administering the medications checks the label to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before administering the medication. 16. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and use the correct code pertaining to that drug and dose.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on interviews, medical record review, and facility policy review the facility failed to ensure three residents (#10, #113, #114) out of 46 residents reviewed for medications were free from any significant medication errors. Findings included: 1. A record review of Resident #10's admission Record showed an original admit date of 9/12/2024 with a readmit date of 7/12/2025 and the following diagnoses to include but not limited to essential hypertension, end stage renal disease dependent on dialysis and paroxysmal atrial fibrillation. A record review of Resident #10's physician orders showed an order for Metoprolol 25 milligrams (mg) to give one tablet by mouth two times a day related to essential hypertension and paroxysmal atrial fibrillation and to hold for BP (blood pressure) less than 130/90 or HR (heart rate) less than 65, ordered on 7/13/2025. A record review of Resident #10's Medication Administration Record (MAR) for the month of July, 2025, showed 14 administrations of Metoprolol outside the ordered parameters out of 37 opportunities and one administration with no entry. A record review of Resident #10's MAR for the month of August, 2025 showed three administrations of Metoprolol outside the ordered parameters out of nine opportunities and two administrations with no entries. On 8/05/2025 at 9:28 a.m., an interview was conducted with Staff I, Registered Nurse/Unit Manager (RN/UM) for Unit One. Staff I, RN/UM stated the no entries were when Resident #10 left the facility by a physician order for LOA (Leave of Absence) with her family member. Staff I, RN/UM stated the resident will get a small supply of her medication prior to her leaving and stated Resident 10 is good about taking her medication while away from the facility and her family member will bring her back in the evening that day. Staff I, RN/UM, reviewed the MAR for the months of July and August 2025 and stated the medications should not have been given based on the physician orders. On 8/05/2025 at 9:36 a.m., the Director of Nursing (DON) arrived at Staff I's office and reviewed the MAR for the months of July and August 2025 and stated the medication should have been held and the physician should have been notified. The DON stated she will call the ordering provider, notify and clarify the order. On 08/06/2025 at 12:00 p.m., a telephone interview was conducted with Resident #10's primary physician. The primary physician stated he had received a phone call from the facility regarding Resident #10 Metoprolol order received out of the ordered parameters and stated he readjusted the parameters. 2. A review of the medication administration sheets (MAR) for Resident #113 revealed: The resident had an order which read: Midodrine 5 mg (milligrams): Give 1 tablet by mouth every 8 hours for hypotension. Hold for blood pressure (BP) greater than 120/90. Midodrine is used to treat low blood pressure (hypotension). It works by stimulating nerve endings in blood vessels, causing the blood vessels to tighten. As a result, blood pressure is increased. The dose (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of medicine will be different for different patients. Follow your doctor's orders or the directions on the label. (www.mayoclinic.org/drugs-supplements/midodrine-oral-route/description/drg-20064821) Further review of the MARs for Resident #113 revealed: In August 2025, the MAR showed 4 doses out of 13 doses that were signed off as administered showed a documented BP greater than 120/90: August 1 (6:00 a.m.) 124/78 August 1 (10:00 p.m.) 121/72 August 3 (6:00 a.m.) 123/72 August 4 (2:00 p.m.) 123/72 In July 2025, the MAR showed 30 doses out of 89 doses that were signed off as administered showed a documented BP greater than 120/90: July 1 (2:00 p.m.) 125/78 July 1 (10:00 p.m.) 123/72 July 3 (2:00 p.m.) 121/72 July 4 (2:00 p.m.) 123/72 July 4 (10:00 p.m.) 126/78 July 7 (2:00 p.m.) 121/72 July 8 (2:00 p.m.) 121/72 July 10 (10:00 p.m.) 122/76 July 11 (2:00 p.m.) 123/72 July 11 (10:00 p.m.) 125/75 July 14 (2:00 p.m.) 123/72 July 14 (10:00 p.m.) 121/68 July 15 (10:00 p.m.) 123/72 July 16 (10:00 p.m.) 123/71 July 18 (6:00 a.m.) 121/72 (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Woodbridge Care Center and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 8720 Jackson Springs Rd Tampa, FL 33615	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	July 18 (10:00 p.m.) 123/72 July 19 (6:00 a.m.) 122/86 July 21 (6:00 a.m.) 124/68 July 22 (2:00 p.m.) 121/72 July 22(10:00 p.m.) 123/67 July 23 (2:00 p.m.) 121/72 July 24 (2:00 p.m.) 123/72 July 24 (10:00 p.m.) 121/67 July 25 (6:00 a.m.) 124/58 July 25 (2:00 p.m.) 123/72 July 25 (10:00 p.m.) 123/72 July 26 (6:00 a.m.) 125/78 July 26 (2:00 p.m.) 123/74 July 27 (6:00 a.m.) 121/67 July 29 (2:00 p.m.) 121/72 July 29 (10:00 p.m.) 121/72 July 30 (2:00 p.m.) 123/72 July 31 (2:00 p.m.) 123/72 July 31 (10:00 p.m.) 121/72 In June 2025, the MAR showed 24 doses out of 89 doses that were signed off as administered showed a documented BP greater than 120/90: June 1 (2:00 p.m.) 121/75 June 1 (10:00 p.m.) 125/78 June 3 (6:00 a.m.) 125/69 June 3 (2:00 p.m.) 121/72 (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	June 3 (10:00 p.m.) 121/72 June 5 (6:00 a.m.) 123/67 June 5 (2:00 p.m.) 121/72 June 6 (2:00 p.m.) 121/72 June 9 (2:00 p.m.) 123/72 June 11 (2:00 p.m.) 123/72 June 11 (10:00 p.m.) 121/70 June 12 (6:00 a.m.) 124/74 June 12 (2:00 p.m.) 123/72 June 12 (10:00 p.m.) 121/69 June 13 (2:00 p.m.) 121/75 June 15 (6:00 a.m.) 121/75 June 16 (2:00 p.m.) 123/72 June 17 (2:00 p.m.) 123/72 June 18 (10:00 p.m.) 123/62 June 20 (2:00 p.m.) 123/72 June 23 (2:00 p.m.) 123/67 June 24 (6:00 a.m.) 125/71 June 24 (2:00 p.m.) 121/72 June 25 (2:00 p.m.) 123/72 June 25 (10:00 p.m.) 125/72 June 26 (2:00 p.m.) 121/72 June 27 (10:00 p.m.) 126/72 June 30 (2:00 p.m.) 121/67 On 8/06/2025 at 12:00 p.m. during a telephone interview with the assigned primary physician for (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2025
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #113, he confirmed Resident #113 was under his care. The physician stated the expectation is for this medication (Midodrine) to be given as prescribed with the parameters he ordered. He stated the medication should not be given if the blood pressure is over 120/90. He stated on rare occasions if the medication is given outside parameters, it could cause the blood pressure to go higher. 3. A review of the medication administration sheets (MAR) for Resident #114 revealed the resident had an order which read: Midodrine 10 mg: Give 1 tablet by mouth every 8 hours for hypotension. Hold for blood pressure (BP) greater than 110/90. Further review of the MARs for Resident #114 revealed in August 2025, the MAR showed 6 doses out of 11 doses that were signed off as administered showed a documented BP greater than 110/90 as follows: August 1 (6:00 a.m.) 129/78 August 1 (2:00 p.m.) 123/67 August 1 (10:00 p.m.) 123/67 August 2 (6:00 a.m.) 123/72 August 2 (2:00 p.m.) 127/90 August 3 (6:00 a.m.) 123/78 August 5 (10:00 p.m.) 121/67 In July 2025, the MAR showed 54 doses out of 69 doses that were signed off as administered showed a documented BP greater than 110/90: July 1 (2:00 p.m.) 123/72 July 1 (10:00 p.m.) 123/78 July 2 (2:00 p.m.) 121/72 July 3 (2:00 p.m.) 123/72 July 3 (10:00 p.m.) 119/75 July 4 (6:00 a.m.) 117/75 July 4 (2:00 p.m.) 121/72 July 4 (10:00 p.m.) 128/78 July 6 (2:00 p.m.) 117/69 July 6 (10:00 p.m.) 117/69 (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	July 7 (2:00 p.m.) 120/72 July 7 (10:00 p.m.) 121/68 July 8 (2:00 p.m.) 123/72 July 8 (10:00 p.m.) 120/72 July 9 (2:00 p.m.) 121/72 July 9 (10:00 p.m.) 120/72 July 10 (2:00 p.m.) 121/72 July 10 (10:00 p.m.) 120/72 July 11 (2:00 p.m.) 120/72 July 11 (10:00 p.m.) 121/75 July 12 (2:00 p.m.) 122/70 July 13 (2:00 p.m.) 112/67 July 13 (10:00 p.m.) 115/69 July 14 (2:00 p.m.) 121/72 July 14 (10:00 p.m.) 123/72 July 15 (6:00 a.m.) 123/72 July 15 (2:00 p.m.) 123/72 July 15 (10:00 p.m.) 120/72 July 16 (2:00 p.m.) 123/72 July 16 (10:00 p.m.) 120/75 July 17 (6:00 a.m.) 120/75 July 17 (2:00 p.m.) 128/76 July 17 (10:00 p.m.) 121/70 July 18 (6:00 a.m.) 120/72 July 18 (10:00 p.m.) 119/68 (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	July 20 (10:00 p.m.) 120/80 July 21 (2:00 p.m.) 120/72 July 21(10:00 p.m.) 120/69 July 22 (2:00 p.m.) 120/72 July 22(10:00 p.m.) 120/69 July 23 (2:00 p.m.) 121/67 July 23 (10:00 p.m.) 120/69 July 24 (2:00 p.m.) 123/72 July 24 (10:00 p.m.) 120/72 July 25 (2:00 p.m.) 120/72 July 25 (10:00 p.m.) 120/67 July 27 (6:00 a.m.) 120/67 July 28 (6:00 a.m.) 123/72 July 28 (2:00 p.m.) 123/72 July 29 (2:00 p.m.) 123/72 July 29 (10:00 p.m.) 120/69 July 30 (2:00 p.m.) 123/72 July 30(10:00 p.m.) 120/67 July 31 (6:00 a.m.) 121/60 July 31 (2:00 p.m.) 120/72 July 31 (10:00 p.m.) 120/67 In June 2025, the MAR showed 44 doses out of 69 doses that were signed off as administered showed a documented BP greater than 110/90: June 2 (6:00 a.m.) 128.72 June 2 (2:00 p.m.) 120/72 (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	June 2 (10:pm) 120/72 June 3 (2:00 p.m.) 120/72 June 3 (10:00 p.m.) 120/72 June 4 (2:00 p.m.) 123/67 June 4 (10:00 p.m.) 121/72 June 5 (6:00 a.m.) 123/72 June 5 (2:00 p.m.) 121/72 June 5 (10:00 p.m.) 120/72 June 6 (10:00 p.m.) 120/68 June 9 (2:00 p.m.) 116/78 June 9 (10:00 p.m.) 120/71 June 10 (6:00 a.m.) 112/65 June 10 (2:00 p.m.) 120/72 June 10 (10:00 p.m.) 120/72 June 11 (2:00 p.m.) 121/72 June 11 (10:00 p.m.) 120/68 June 12 (6:00 a.m.) 116/64 June 12 (2:00 p.m.) 123/72 June 12 (10:00 p.m.) 119/67 June 13 (2:00 p.m.) 117/78 June 13 (10:00 p.m.) 120/72 June 15 (6:00 a.m.) 120/68 June 16 (2:00 p.m.) 123/72 June 16 (10:00 p.m.) 119/69 June 17 (2:00 p.m.) 120/72 (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	June 17 (10:00 p.m.) 123/75 June 18 (2:00 p.m.) 121/72 June 18 (10:00 p.m.) 111/62 June 19 (6:00 a.m.) 123/72 June 19 (2:00 p.m.) 121/72 June 19 (10:00 p.m.) 123/67 June 20 (6:00 a.m.) 126/70 June 20 (2:00 p.m.) 123/72 June 20 (10:00 p.m.) 116/24 June 23 (2:00 p.m.) 121/67 June 23 (10:00 p.m.) 123/72 June 24 (2:00 p.m.) 121/72 June 25 (2:00 p.m.) 123/72 June 25 (10:00 p.m.) 116/62 June 26 (2:00 p.m.) 123/72 June 27 (2:00 p.m.) 123/78 June 27 (10:00 p.m.) 120/64 June 30 (2:00 p.m.) 121/67 During an interview with Staff G, Registered Nurse (RN) on 8/3/25 at 8:45am, she was asked to review a medication she had signed off that morning for Resident #114, which was Midodrine 10mg tablet. The parameters on the order stated hold for BP greater than 110/90. The nurse was asked if she had charted the patient's BP as 120/78. She stated yes. She was asked if she had administered the medication, as it had been signed off as administered. She stated yes. She was asked to read the order. She read the order and said nothing after reading it. She was asked if the medication should have been held according to the BP she charted. She stated oh, I see. yes. She was asked why she had given the medication when the physician ordered parameters showed it should have been held. She stated I made a mistake. On 8/06/2025 at 11:15 a.m., during an interview with the Director of Nursing (DON), She stated when administering medication with parameters ordered by the physician, the staff should hold medications according to the parameters in the orders. She stated staff are educated to look for parameters when (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they are doing their medication pass. On 8/06/2025 at 12:37 p.m., during a telephone interview with the assigned primary physician for Resident #114, he stated this resident is under his care. The Midodrine order was reviewed. He stated his expectation was obviously the staff should check the blood pressure every 8 hours and then decide whether to give the medication based according to the blood pressure. He stated regarding possible side effects if the medication is given outside parameters, "Well I don't want the medication to be given if it's not needed." The physician stated if the resident is given the medication every time when he doesn't need it, they needed to find out why it's being given, because if the blood pressure is higher than the parameter, they should hold the medication. A review of the facility policy titled Administering Medications revised July 2016, revealed: Policy: Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 9. The individual administering the medications checks the label to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before administering the medication. 10. The following information is checked/verified for each resident prior to administering medications: Vital signs, if necessary.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and facility records review, the facility failed to ensure the kitchen implemented safe defrosting methods of raw meat in one refrigerator walk in units of one reviewed. Findings included: Upon entering the Walk -in refrigerator unit on 8/3/2025 at 10:15 a.m., an observation was made of two sides of what appeared to be multi shelving. The back of the unit had a door that lead into a separate walk in freezer unit. Further observations revealed the walk in refrigerator was well stocked with food items. However, the right side of the walk in refrigerator unit revealed a multi tiered shelving system. The third shelf up from the ground, revealed a very large metal tray that contained two long plastic sleeves raw ground meat. Both sleeves of meat were found not covered and was left to defrost. There were several small pools of blood on the tray. Directly below the defrosting tray of raw ground meat, was a metal container of pre cooked and ready to eat food items such as many thick ham slices and cheese slices. The container was covered with a thin plastic film, located directly beneath the tray of raw ground meat. At 10:18 a.m. the refrigerator walk in unit was exited and the chef/cook, Staff Q was found near the dietary manager's office. He was asked to confirm the observation of raw ground meat being defrosted in the walk in refrigerator. Staff Q, immediately confirmed the metal tray of raw ground meat should not have been placed above pre cooked ready to eat food. He revealed he had been moving around food items and he had just placed that tray of food there for only a short time. However, he had not been observed in the walk in refrigerator since the kitchen tour was initiated at 10:00 a.m. Staff Q was noted to come into the kitchen from the outside at approximately 10:08 a.m. The way the tray of raw uncooked meat was placed and positioned on the third shelf, appeared it had been on that shelf for a long period of time. Staff Q was interviewed and confirmed raw uncooked meats should not be placed to defrost above ready to eat foods at any point of time. An interview with the Dietary Manager on 8/6/2025 at 9:55 a.m. revealed he was not at the facility on Sunday 8/3/2025, but overheard there was an observation of the walk in refrigerator with a tray of defrosting uncooked raw meat stacked on a shelf directly above pre cooked and ready to eat food to include thick ham slices and cheese slices. He revealed the cook/chef Staff Q was rearranging trays of food in the walk in refrigerator and that he would not have stored the raw uncooked food over ready to eat food for any period of time. The Dietary Manager was notified the cook was not around the walk in refrigerator upon the start of the kitchen tour and observation of the walk -in the unit on 8/3/2025. During the tour, there was no evidence of boxes and trays being moved around. It was noted that the way the tray of defrosting raw uncooked ground beef was positioned, it was positioned as if it were placed there for a long period of time. The Dietary Manager revealed the cook moved the tray of uncooked defrosting raw meat, only after he was sought out and asked by the State surveyor about the observation and the facility's defrosting methods. Further interview with the Dietary Manager revealed his last training and inservice to his staff related to food storage and food defrosting techniques was provided to all of his dietary staff in January of 2025. The Dietary Manager revealed the cook Staff Q does know that trays of uncooked raw meat cannot be for any period of time placed above any trays or containers of already cooked and ready to eat food items. The Dietary Manager did not provide copies/evidence of the last food handling/food defrosting techniques for review. The Dietary Manager did not have a specific food handling, food storage/defrosting policy and procedure fore review.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, and record review the facility failed to promote and maintain dignity for one resident (#121) of two residents sampled. Findings included: On 8/3/25 at 10:30 a.m. Resident #121 was observed sitting up in his bed. He was observed to be wearing a hospital gown. He stated he arrived at the facility on 8/1/25 and he had no clothes with him. He gave permission to look in his closet and drawers confirming there was no clothing items found. He stated he had to go to his dialysis appointment yesterday in a hospital gown, and he doesn't like that. Resident #121 stated he wants to wear a shirt and pants when he goes out to dialysis, and that he doesn't feel he should be going out to dialysis in just a gown. On 8/04/2025 at 9:15 a.m. Resident #121 was observed sitting outside his room in a wheelchair dressed in a white T-shirt and black shorts. He stated someone brought him these clothes to wear today, just a few minutes ago. He stated he didn't think they were his clothes, but he appreciated that they were given to him. He stated he would next go to dialysis tomorrow at 5:00 a.m. and he hoped they would have clothes for him to wear. On 8/5/25 at 12:40 p.m. Resident #121 was observed lying in his bed awake and wearing a white T-shirt, a brief, and red socks. He stated he had just returned from dialysis having worn a T-shirt, a brief, socks and no shorts or pants. The resident stated he did not know why they had a pair of shorts for him the day before but not today. Resident #121 gave permission to look in the closet revealing only a folded hospital gown, a package of adult briefs, and two empty drawers. During an interview on 8/5/25 at 12:53 p.m. Staff B, Registered Nurse (RN) confirmed caring for Resident #121 when he returned from dialysis today. He stated yes, I took his vital signs when he returned. Staff B, RN stated he could not remember what the resident was wearing stating the resident usually wears regular clothes and not his hospital gown. Staff B stated the resident's Certified Nurse's Assistant (CNA) changed him when he returned and might know what he was wearing. On 8/5/25 at 12:56 p.m. during an interview with Staff C, CNA confirmed assisting Resident #121 upon returning from dialysis. She stated the resident was wearing the white T-shirt, a brief and not a hospital gown. Staff C confirmed Resident #121 did not have any shorts or pants on. Review of a care plan for Resident #121 dated 8/1/25 revealed a focus - [Resident #121] has a strength in cognitive function as evidenced by is oriented to person, place, and time. Short term and long-term memory are intact. Is able to make decisions independently. Goals included: Resident will continue to make consistent, reasonable decisions through the next review date. Interventions included .Allow resident to make decisions regarding daily cares. A telephone interview was conducted on 8/05/2025 at 1:38 p.m., with Staff F, RN (a dialysis center employee). Staff F, RN stated she had cared for Resident #121 earlier today at the dialysis center. Staff F stated knowing Resident #121 very well as he had been coming to their dialysis center from home for quite some time. The dialysis employee stated the resident has been coming to dialysis the last two treatment from (the nursing facility) with no clothes. Staff F stated she was working on both Saturday, 8/2/25 and Tuesday, 8/5/25 when he came in. Staff F stated on Saturday Resident #121 came in wearing only a hospital gown, a brief, and red socks, and no shorts or pants. Staff F stated it can be very cold in the dialysis center because they keep the temperature at 67 degrees and said she sent back in the communication book to please send him with a blanket. Staff F stated today resident #121 arrived with a white T-shirt, a brief, and red socks. Staff F, RN confirmed Resident #121 did not have any pants or shorts on, but the facility did send him with a blanket. Staff F stated Resident #121 is alert and oriented and can advocate for self. The employee stated the resident had reported he did not like coming out without regular clothes. During an interview on 8/5/25 at 2:40 p.m. Staff D, RN/MDS (Minimum Data Set) stated she had updated the care plan for Resident #121 today. She stated, yes, I did. I am an MDS nurse, and I am here only prn (as needed) to help out. Staff D, RN stated she had added a focus, goal and intervention to the care plan for Resident #121 regarding a preference to wear a hospital gown to dialysis. She stated yes, I wrote the care plan about the (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospital gown. Staff D, RN stated she had not met Resident #121. She was asked how and when she gathered the information to make that care plan entry. Staff D, RN stated, one of the CNAs came to me, I believe it was a CNA who asked me if I could care plan Resident #121 for wearing a hospital gown to dialysis. Staff D, RN confirmed she updated the care plan but did not speak with Resident #121 regarding his clothing preferences. On 8/5/25 at 2:54 p.m., an interview with Employee E, Social Services Assistant (SSA) revealed if a resident is admitted to the facility with no clothing, they normally call the family to see if they can bring some clothes in. Staff E, SSA stated, while waiting they get some clothes from a donation bin. Staff E stated if it had been a few days and no one had brought clothes, they have the option of ordering clothes for the resident online. The SSA stated For residents who have no clothes, and they have an outside appointment to attend, they would help them get dressed appropriately. Staff E said the only way they would go out in a gown was if they refused to get dressed or if they preferred to wear the gown. Staff E stated they had contacted Resident #121's family member and had not heard back. Staff E said, If we don't hear back from the family member, we will have to see about ordering some clothes. Staff E stated having done an admission assessment for Resident #121 and the resident did not express needing clothes or a preference to only wear hospital gowns. Staff E denied knowing Resident #121 had attended dialysis twice in only a hospital gown and only a T-shirt. An interview was conducted on 8/05/2025 at 4:40 p.m. with Resident #121. The resident stated the family member was not able to bring him any clothing from home. The resident said, I hope they can get me something to wear here, it's embarrassing to go out to dialysis with no clothes and just wearing a brief and a hospital gown. I have never gone out in public like that in my entire life. On 8/06/2025 at 11:00 a.m., an interview with Employee A, Housekeeping/Laundry Aide revealed the facility had a donation clothing bin. An observation at the time revealed a standing cart holding many items of clothing on hangers. Staff A confirmed the cart is unlocked and nursing staff can come and take what they need at any time. A review of the facility policy titled, Dignity, dated 2/202, revealed: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy Interpretation and Implementation: 1. Residents are treated with dignity and respect at all times. 3. Individual needs and preferences of the resident are identified through the assessment process. 5. When assisting with care, residents are supported in exercising their rights. For example, residents are: c. Encouraged to dress in clothing that they prefer.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2025
NAME OF PROVIDER OR SUPPLIER Woodbridge Care Center and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 8720 Jackson Springs Rd Tampa, FL 33615	
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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure meal and equipment preferences were honored for one resident (#124) out of three residents reviewed. Findings included: On 8/3/25 at 11:59 a.m., an observation of Resident #124 revealed he was sitting in his bed. He expressed concerns related to his food preparation and utensils. Resident #124 stated he had been telling staff he needed, utensils specialty wrapped. He showed plastic utensils in a plastic bag and said his family member brought them as he has not been getting plastic utensils with meals. He stated he wanted to open all his food due to his, immunocompromised status, and to ensure he knew how it was prepared and who touched it. During the interview an observation of Resident #124's bedside table revealed a plastic bowl, with cereal inside, and a lid covering the bowl that was dated 8/3/25. He pointed to bowl of cereal and stated, I can't eat this, this could be hazardous to my health and recovery. He removed the insulated lid from the food on the bedside table to reveal eggs. He said he asked for cheese to put on his eggs that morning and a staff member told him, We don't have any cheese. Further observation of the meal tray revealed he had the menu filled out with his choices for today. Resident #124 said he was having difficulty communicating with facility staff and described the interactions as charades. On 8/3/25 at 12:59 p.m., an observation was conducted of Resident #124's lunch tray. He said it did not include what he had selected for lunch as he still had his menu. Resident #124 said the utensils were covered with a napkin and when he removed the napkin, they appeared to be wet with droplets on them. Resident #124 stated, I can't use those. During the interview with Resident #124, a staff member removed the menu from his bedside table and left the room. 8/4/25 at 10:40 a.m., an interview was conducted with Resident #124. He was sitting upright in bed. He stated he was told by staff that they could not provide liquids such as cranberry or lemon juice as he requested to take his, Essential anti-rejection transplant medication. He described the taste of the medication as, Horrible and disgusting. He said he needed a beverage with flavor to take the medication. A review of Residents #124 admissions record revealed an admission date of 7/31/25. [NAME] review of the admission record revealed diagnoses to include other complications of lung transplant, immunodeficiency due to external causes, and lung transplant status. A review of Residents #124 Minimum Data Set (MDS), section C- cognitive patterns, dated 7/31/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, cognitively intact. A review of the grievance log for July 2025 and August 2025 revealed no documentation of a grievance for Resident #124. A review of Resident #124's care plan revealed [Resident name] is at risk for an alteration in nutrition and/or hydration r/t [related to] ESRD [end stage renal disease] on HD [hemodialysis], DM [diabetes mellitus], TIA [transient ischemic attack], hepatitis C, HTN [hypertension], GERD [gastroesophageal reflux disease], chronic pain. Wt [weight] fluctuations may occur r/t dialysis. Supplements added d/t [due to] dialysis. Supplements added d/t poor po [by mouth] intake. Interventions included the following, . Provide diet and consistencies as ordered. Offer and provide alternate as needed. Honor food preferences. A review of a comprehensive progress note for Resident #124 dated 8/1/25 showed Resident #124 is alert and oriented able to communicate his wants and needs to staff. is able to voice his needs to staff without difficulty, independent in decision making. On 8/5/25 at 2:08 p.m., an interview was conducted with Staff M, Certified Nursing Assistant (CNA). She said she's worked with the Resident #124 for the past two days. Staff M, CNA, confirmed she was aware the resident preferred plastic wrapped utensils with meals. She said she gets plastic wrapped utensils for him and has not said anything to the kitchen or his nurse about his requests. Staff M, CNA stated she felt he was, Picky. Staff M, CNA said she told Resident #124 the kitchen can't bring him beverages or food in its original packaging. Staff M, CNA stated That's how some people are, they are picky. Staff M, CNA confirmed the resident had told her he wanted his food in its original container. Staff M, CNA stated she did not consider what the resident has told her as a concern or grievance (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Woodbridge Care Center and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 8720 Jackson Springs Rd Tampa, FL 33615	
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because, I just take care of it. On 8/5/25 at 3:21 p.m., an interview was conducted with Staff R, Dietary Manager. He confirmed that he completed Resident #124's dietary assessment. Staff R, Dietary Manager said the resident did not communicate to him about his specific needs and preferences. Staff R, Dietary Manager said if there was an order for plastic utensils and wanting food in its original packaging he would have been able to accommodate that. He confirmed no staff members have communicated with him regarding Resident #124 dietary concerns. A review of Residents #124's, Resident Profile Details, provided by Staff R, Dietary Manager, revealed no preferences related to plastic utensils and or food in its original packaging. On 8/5/25 at 4:16 p.m., an interview was conducted with the Social Service Director (SSD). She confirmed staff can file a grievance on behalf of a resident. The SSD confirmed that Resident #124's dietary concerns would have involved nursing and the kitchen manager and written as a grievance. The SSD said if a resident tells staff multiple times about a concern, then it should be reported and written as a grievance. Review of a facility policy titled, Dignity, revised February 2021 showed a statement -Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy Interpretation and Implementation 2. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facility stay. 3. Individual needs and preferences of the resident are identified through the assessment process. A review of the facility's policy titled, Grievances/Complaints, Filing revised April 2017, revealed the following, Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances (e.g. [such as], the State Ombudsman). The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative. (Photographic Evidence Obtained)		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observations and interviews, the facility did not ensure the daily nursing staffing form was updated with the correct date on one day (8/3/2025) of four days observed. Findings included: On 8/3/25 at 8:52 a.m., an observation of the hall by the dining room and in front of the social services office revealed a daily nursing staffing form dated 7/30/25. On 8/6/25 at 9:43 a.m., an interview was conducted with the Staffing Coordinator. She said Staff O, Licensed Practical Nurse (LPN)/Supervisor/Unit Manager (UM) completed the daily nursing staffing form during the 11:00 p.m. to 7:00 a.m. shift. The Staffing Coordinator said Staff P, Licensed Practical Nurse (LPN) completed the daily nursing staffing in Staff O's absence. She said the nursing staffing form is completed daily at midnight. The Staffing Coordinator said when she comes in at 6:30 a.m., she looks at the form every morning. She said on Sunday, 8/3/25, she came in and didn't see the nursing staffing form had a date from 7/30/25. She said she thought someone else updated the nursing staffing form on 8/3/25. She said as of 7/31/25, Staff O, LPN/Supervisor/UM and Staff P, LPN have not been working at the facility. A review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, revised August 2022, revealed the following, Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. Further review of the policy, under policy interpretation and implementation, revealed the following, .2. The information recorded on the form shall include the following: . b. The current date (the date for which the information is posted); .		