STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105491	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gandy FL Opco, LLC	4610 S Manhattan Ave Tampa, FL 33611

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 50732 Based on observations, record review, and interviews, the facility did not ensure one of two community shower rooms were maintained in a clean and sanitary condition. Findings included: On 01/14/2025 at 9:15 AM the following observations were made of the community shower room located on Unit 4: - Shower curtains on the two showers in the room had a black substance on the lower part of both the out-facing and in-facing portions of the curtain. - A caked black substance was observed on the tile floor behind the toilet and the floor in front of and around the toilet was also caked with black substance. - The rim under the toilet seat had a yellow liquid substance on it. The inside of the toilet bowl had a rust-colored stain in the portion where the water drains when flushed. - There were two shower stalls in the room. In the second shower stall closest to the far wall, the floor of the shower, the drain, and the shower head all had a yellow substance on them. There were areas of cement-like porous, uncleanable spots where the tiles were missing on the floor. - The wall vent fan for the room had a thick layer of dust on the fan blades. - Across from the showers there was a large area of cement-like, porous, uncleanable material on the floor along with missing tiles. This area also had a rust-colored stain on one side and parts of the cement-like material were crumbling. - The sink had rust-coloring around the drain and thin rust-colored streaking in the bowl of the sink. - There was one shower bed in the room. On top of the shower bed cushion, near the head portion, there was a comb and a pillow. Brownish-black spots were observed on the top of the shower bed cushion toward the foot end of the cushion. On the under-side of the cushion of the shower bed there were black, brown, and yellow dried substances. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On the top of the shower bed mesh covering there were dried yellow, brown, and black flaky substances. - There was one bedside commode next to the shower bed which had a dried brown substance on the lid. An interview was conducted with the Housekeeping Director on 01/16/2025 at 12:44 PM and she stated her expectation was for the housekeeper assigned to the shower room to spray and clean the walls, sink, toilet, mirror, and mop the floors. She said the shower curtains are cleaned every three weeks and wiped down daily. The Housekeeping Director said there is one housekeeper on each unit, and the shower rooms should be cleaned once per day and more often if needed. She said the Certified Nursing Assistants (CNA) are responsible for cleaning any shower equipment they use. Upon review of the pictures of the shower room on Unit 4, she agreed the shower room did not look appealing. An interview was conducted with Staff G, Registered Nurse/Unit Manager (RN/UM) on 01/16/2025 at 4:00 PM and he said the CNA's are responsible for and should be cleaning all of the equipment they use when giving residents showers. He said he has not been routinely looking at the shower room equipment to ensure the CNA's are cleaning them. An interview was conducted with the Maintenance Director on 01/16/2025 at 4:22 PM. The interview was conducted while viewing the pictures taken of the shower room on Unit 4. The Maintenance Director said the facility is in the process of renovating the facility, specifically Unit 3 and Unit 4, which will include the shower rooms. He said the units are being painted and new flooring will be installed. He agreed the floor of the shower room on Unit 4 is in poor condition and he said it will be a top priority in the renovation project. He said the time frame for completing the renovation of the shower room is projected to be at the end of February. He said he did not realize the shower room on Unit 4 was in such bad condition and he should check it more often. He said the Maintenance Department has three employees, two who work first shift and one on the second shift. The Maintenance Director said he has schedules of monthly and bi-monthly projects throughout the facility. Bi-monthly his staff will look at room conditions and right now the priority is batteries in the hand soap dispensers, clocks, and toilets. A review of the facility's Safe and Homelike Environment policy, undated, showed: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. Under the Definitions portion of the Safe and Homelike Environment policy, Sanitary is defined as includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used in the completion of the activities of daily living. The policy also revealed under Policy Explanation and Compliance Guidelines, Section 1 number 3: Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. Photographic Evidence Obtained

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50434 Based on observations, record review, and interviews, the facility failed to ensure resident's with diagnosed mental illness or suspected mental illness were referred to the State's Mental Health authority for a Level II Preadmission Screening and Resident Review (PASRR) screenings for four residents (#47, #79, #19, and #73) out of 29 residents sampled. Findings included: 1. Review of Resident #47's Admission Record revealed an admitted [DATE] and an initial admitted [DATE]. Resident #47 was admitted to the facility with diagnoses of paranoid schizophrenia, schizoaffective disorder, depressive type, major depressive disorder, recurrent, and anxiety disorder Review of the Level I PASRR screen dated 07/01/24 showed the following: Section I, Part A - MI (Mental Illness) or suspected MI: Anxiety Disorder, Depressive Disorder, Schizoaffective Disorder, and Schizophrenia were checked. Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption Not a Provisional Admission was marked no. Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required, was marked. 39866 2. Review of Resident #79's Admission Record revealed she was admitted to the facility on [DATE] with medical diagnoses of undifferentiated schizophrenia, bipolar disorder, and major depressive disorder. Review of Resident #79's Level I PASRR screen dated 5/31/24 revealed qualifying mental health diagnoses of bipolar disorder, depressive disorder, and schizophrenia with no recommendation for a Level II PASRR. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 01/13/25 at 10:23 a.m. with Resident #79. She said, the people throw dirt and water on me. The resident was observed wiping her sheet as she was interviewed and was observed clean without dirt or water on her or her sheets. Resident #79's roommate walked next to the resident's bedside and said, [Resident #79] thinks people put dirt and water on her, but they are people that aren't real. I have to threaten calling 911 on the imaginary people throwing dirt and water on her or I have to scare them. Resident #79 continued to repeat, they put dirt and water on me. Resident #79 was observed crying as she was repeating, they put dirt on me. She then looked at the television, stopped crying, and watched television. A follow up interview was conducted on 01/14/25 at 1:33 p.m. with Resident #79. Upon entering the resident's room, a physical therapist exited the room. The resident was observed in bed, clean, and without odors. She said she just got done exercising her legs, lunch was good and she was going to relax now after her exercising. Review of Resident #79's Psychiatry Subsequent Note dated 11/18/24 revealed: History of Present Illness: This is a [AGE] years old patient with a past psychiatric history of depression, bipolar disorder and schizophrenia. Prior to last visit, patient was screaming in hallways. Patient had mood swings. During last visit, patient was doing well. Patient was sleeping and eating well. No anxiety related symptoms noted. No medication changes were done. Today, I saw the patient as it was reported to me that patient is unstable requiring psychiatric assessment. As per collected information, resident continues yelling randomly and talking to herself. Patient denies sleep and appetite related problems. No other psychiatric symptoms are observed. No side effects to current psych meds were reported . Abnormal thought processes: Has hallucinations .Assessments and Plan: [patient] is unstable but requires no med changes: As per collected information and interview, it appears that the patient is unstable. I feel the symptoms are occurring due to exacerbation of underlying mood disorder. However, the symptoms are not causing significant distress to require psychiatric medication changes. Ongoing medical stabilization, emotional support, and closer monitoring from our side would be good enough. We will do follow-up appointments as needed Rational behind diagnoses: Bipolar disorder: The patient's history suggests that the patient has chronic episodes of depression and manic-like symptoms. These symptoms cause significant distress and functional impairment to the patient Schizophrenia (Confirmed [diagnosis]): The history of this patient shows that the patient has chronic and consistent psychosis. These symptoms cause significant distress and functional impairment to the patient . Review of Resident #79's care plan with an initiation date and a revision date of 1/3/22 revealed a Focus, [Resident #79] is here for Long Term placement d/t [due to] need for 24 hour supervision/care r/t [related to] type 2 dm [diabetes mellitus], bipolar, depression, morbid obesity, inability to care for self at former ALF [assisted living facility]. the Goal revealed, Resident's psychosocial needs will be met daily with assist from staff thru the next review date. The Interventions included, Encourage family and friends to visit or call as often as they can-as resident allows. Encourage socialization with peers in the facility. Invite and escort to activities of preference. Involve resident, family, or friends (as allowed) to participate with care as applicable. Praise the efforts of the resident participation in cares. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #79's Behavior Care Plan with a revision date of 11/30/23 revealed, Potential for impaired or inappropriate behaviors related to diagnosis of Bipolar and Schizophrenia. [Resident #79] talks out loud during the night. The Goal revealed, Resident will have a decrease in negative behaviors thru next review. The Interventions revealed, Administer medications as ordered. Observe/document for side effects and effectiveness. Anticipate and meet the resident's needs. If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Praise any indication of the resident's progress/improvement in behavior. An interview was conducted with the Assistant Director of Nursing (ADON) and Staff K, Social Services Director (SSD) on 1/16/25 at 10:28AM. The ADON said when she did the PASRR assessment for Resident #79 she completed the questions for that specific time. Staff K, SSD and the ADON confirmed Resident #79 does have behaviors of talking to herself at night and yelling out. They confirmed she had mental illnesses of depressive disorder, bipolar disorder, and schizophrenia and came to the facility from a mental disorder assisted living facility. They reviewed Resident #79's PASRR and Staff K, SSD said they can have a Level II PASRR assessment done for Resident #79. Staff K, SSD said the reason for the Level II assessment is to identify a resident with a mental illness, determine correct placement, and determine the resident is receiving the appropriate services for their mental illness. 37999 3. Review of Resident #19's Admission Record showed an admitted [DATE]. The record included diagnoses with onset dates including but not limited to cognitive communication deficit (CCD), onset date 12/5/24, unspecified bipolar disorder, onset date 12/4/24, unspecified recurrent major depressive disorder, onset 12/4/24, and generalized anxiety disorder, onset date 12/4/24. Review of Resident #19's Psychiatry Evaluation Note dated 12/30/24 showed the provider signed the document on 1/4/25. The evaluation revealed the resident's chief complaint as depression, anxiety, and bipolar disorder. The Assessments and Plan revealed, The patient's history suggests that the patient has chronic episodes of depression and manic-like symptoms. These symptoms cause significant distress and functional impairment to the patient. As bipolar disorder is a lifelong disorder, mood stabilizer medicine needs to be continued on a long-term basis. The patient is on psych meds because non-pharmacological interventions are not sufficient to manage the symptoms of the patient. The evaluation showed the provider recommended the resident to continue Bupropion and Sertraline to tackle depression and Alprazolam for anxiety. Review of Resident #19's Level I PASRR dated 1/13/25, completed by the facility's ADON, included mental illness diagnoses of anxiety disorder, bipolar disorder, depressive disorder, and schizophrenia. The screening did not include any intellectual disorders and showed the resident was receiving services for mental illness based on documented history and medications. The decision-making evaluation revealed the resident did not have any indication of having a disorder resulting in functional limitations of major life activities, no interpersonal functioning difficulties, no concentration, persistence, and pace difficulties, no adaptation to change difficulties, any recent outpatient/inpatient treatments, or have experienced an episode of significant disruptions. The screening completion showed the resident did not have a diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated and a Level II PASRR evaluation was not required. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of Resident #73's Admission Record showed the resident was admitted on [DATE]. The Admission Record included secondary diagnoses and onset dates including but not limited to cognitive communication deficit, onset 1/1/25, unspecified severity unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, onset 12/10/24, and brief psychotic disorder, onset 12/10/24. Review of Resident #73's acute care documentation revealed a consultation note from a physician dated 12/7/24, [Resident #73] has dementia and worsening memory loss. The note showed the resident was Positive for dementia and recent fall. An acute care facility physician note dated 12/9/24 revealed the resident presented to the emergency room (ER) from an assisted living facility with a past medical history including diagnoses of dementia and depression. The acute care facility's therapy note, dated 12/7/24, revealed the resident had a cognitive deficit and had previously resided on a memory care unit at an assisted living facility and normally utilized a rolling walker (RW) with supervision to ambulate. The therapy assessment, dated 12/7/24 revealed the resident's barrier to learning was cognitive deficit, [and] difficulty concentrating. Review of Resident #73's Level I PASRR screen dated 12/10/24 and completed at an acute care facility, revealed the resident did not have any mental illness, suspected mental illness, intellectual disability and/or suspected intellectual disability based on documented history. The decision-making screening showed the resident did not have any indication of having a disorder resulting in functional limitations of major life activities, no interpersonal functioning difficulties, no concentration, persistence, and pace difficulties, no adaptation to change difficulties, any recent outpatient/inpatient treatments, or had experienced an episode of significant disruptions. The screening revealed the resident had not exhibited actions or behaviors that may make them a danger to themselves or others or validating documentation to support the dementia diagnosis, and the admission was not provisional. The screening revealed the resident could be admitted to a Nursing facility as there was no diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated and a Level II PASRR evaluation was not required. Review of Resident #73's Psychiatry Evaluation Note dated 12/23/24 showed the provider was consulted for psychiatric evaluation and treatment of depressed mood, disorganized, and confused thinking. The note revealed the resident had a past psychiatric history of depression, anxiety, dementia, and brief psychotic disorder. The provider noted, As per collected information, resident has been anxious and confused. [Resident #73] is difficult to redirect due to increased confusion. The patient limitations were described as Being in the facility, Away from home. The assessment revealed, As per collected information and interview, it appears that the patient is unstable. I feel the symptoms are occurring due to exacerbation of underlying anxiety disorder. The history suggests that this patient has suffered from episodes of depression lasting for more than 2 weeks. The symptoms have caused significant distress and functional impairment to the patient. The rationale behind the dementia without behavioral disturbance diagnosis showed the resident had a gradual decline in memory, executive function, language, concentration, and fund of knowledge. These symptoms have caused distress and have affected the quality of life and activities of daily living. The resident's depression assessment revealed moderate depression, has situational exacerbation of depression due to health and situation of being in a facility and a Brief Interview of Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #73's comprehensive assessment dated [DATE] showed a BIMS score of 13 out of 15, indicating an intact cognition. The assessment also revealed the resident had disorganized thinking that was continuously present and does not fluctuate. Review of Resident #73's Level I PASSR completed by the facility's ADON on 1/13/25 showed the diagnoses of anxiety, depressive disorder, and brief psychotic disorders had been added as MI or suspected MI. The decision-making continued to indicate the resident had no disorder resulting in functional limitations in major life activities that would otherwise by age appropriate, did not have any continuing or intermittent issues with interpersonal functioning, concentration, persistence, and pace, or an issue with adapting to change. The revised Level I PASRR did not show the resident had any validating documentation to support the dementia diagnosis and the resident did not have a diagnosis or suspicion of Serious Mental Illness or Intellectual Disability and a Level II PASRR evaluation was not required. An interview was conducted on 1/16/25 at 10:16 a.m. with the ADON and SSD. The ADON reported reviewing psych notes whenever she gets them, the admission department reviews the hospital records to see if residents have a psych diagnosis, and the uploaded PASRR. She stated she looks at psych notes for diagnoses to ensure the PASRR's have the same diagnoses. The staff members revealed the resident's history is reviewed to see if they have been involuntarily hospitalized and see if they have anything that effects daily interactions, behaviors, and if a psych diagnosis placed them in the hospital. The SSD reported the facility has meetings daily and behaviors are discussed. The ADON reported validating dementia was any documentation the resident has and the hospital History & Physical (H&P) with documentation of a dementia diagnosis would be considered validating documentation. The ADON reported looking at psych notes and stated just because Resident #19 had bipolar and schizophrenia doesn't mean they need a Level II. She also stated a Level II was to identify anyone with a mental illness or behaviors and to see if they need to receive services or if they need extra ones. Review of the policy - Resident Assessment - Coordination with PASARR Program, implemented 9/7/22 showed the following: This facility coordinates assessments with the pre admission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. The compliance guidelines revealed the following: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the States Medicaid rules for screening. a. PASARR Level I - an initial prescreening that is completed prior to admission. i. Negative Level I screen - permit submission to proceed and ends the PASARR process unless if possible, serious mental disorder or intellectual disability arises later. ii. Positive Level I screen - necessitates a PASARR Level II evaluation prior to admission. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. PASARR Level II - a comprehensive evaluation by the appropriate state designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs. 2. The facility will only admit individuals with a mental disorder or intellectual disability who the state mental health or in the lateral disability authority has determined as appropriate for admission. 4. Exceptions to the pre admission screening program include those individuals who: a. Are readmitted directly from a hospital. b. Or admitted directly from any hospital requires nursing facility services for the condition of which the individual received here in the hospital and has been certified by the attending physician before admission that the individual is likely to require less than 30 days of nursing facility services. 5. If a resident who has not screened due to an exception above and the resident remains in the facility longer than 30 days: a. The facilities must screen the individual using the states Level I screening process and refer any resident who has or may have MD, ID or a related condition to the state designated authority for Level II PASARR evaluation and determination. b. The Level II resident review must be completed within 40 calendar days of admission. 6. The social service director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition would be referred promptly to the state mental health or intellectual disability authority for a Level II resident review. Examples include: a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis). b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR. c. Any resident transferred, admitted , or readmitted to the facility following an inpatient psychiatric state or equally intensive treatment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, record review, and interviews, the facility failed to develop and implement care plan interventions for four residents (#19, #24, #32, and #133) of thirty-nine sampled residents, related to; 1. Fluid restrictions, 2. Self-administration of oxygen, 3. Discharge planning, and 4. Fall interventions. Findings included: 1. On 1/14/25 at 3:40 p.m., Resident #19 was observed lying in bed. A 16 ounce (oz) foam cup and a wine-colored coffee cup was observed on the over-bed table. The resident picked the foam cup up and reported there was a little bit of fluid in it. On 1/15/25 at 1:31 p.m., Resident #19 was observed lying in bed, wearing street clothes and shoes with her eyes closed. A 16-oz foam cup was observed sitting on the resident's over-bed table next to the bed. Review of Resident #19's Admission Record revealed the resident was admitted on [DATE] with diagnoses including but not limited to hypo-osmolality and hyponatremia and essential (primary) hypertension. Review of Resident #19's care plan revealed Special Instructions: Fluid Restriction: 1500 milliliter (ML) every (q) 24 hours (24H). Dietary to provide a total of 840 ML/24H, Nursing to provide a total of 660 ML 24H: 7a-7p shift: 420 ML/24, 7p-7a shift: 240 ML/24H. The care plan showed the resident was at risk for impaired nutrition related to (r/t) diagnosis (dx) of hypertension (HTN), sprain lateral collateral ligament left knee, bipolar, depression, anxiety, HTN, hyperlipidemia (HLD), history (hx) hyponatremia, and weight changes and was on a fluid restriction. This Focus was initiated on 12/6/24 and revised on 1/10/25. The interventions informed Certified Nursing Assistants and Dietary staff of Fluid Restriction per physician orders. No bedside water cup. Nursing providing & Dietary as ordered per MD. Review of Resident #19's January 2025 physician orders revealed an order dated 12/5/24, Fluid Restriction: 1500 milliliter (ML) every (q) 24 hours (24H). Dietary to provide a total of 840 ML/24H, Nursing to provide a total of 660 ML 24H: 7a-7p shift: 420 ML/24, 7p-7a shift: 240 ML/24H. The dietary order showed the resident was on regular texture, thin liquids consistency, and *1500 mL Fluid Restriction. Review of Resident #19's Kardex included the following: - Activities: Additional Fluids. - Eating/Nutrition: Fluid Restriction per physician orders. No bedside water cup. Nursing providing & Dietary as ordered per MD. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Eating/Nutrition: Fluids offered every shift. - Eating/Nutrition: Resident on 1500 mL fluid restriction daily, no bedside fluids. An interview was conducted with Staff Q, Certified Nursing Assistant (CNA) on 1/15/25 at 2:02 p.m. The staff member reported staff can check the resident's Kardex for everything and the resident's care plans are in the computer. Staff Q, CNA explained the Kardex will let you know how to take care of the residents and will indicated if a resident is on a fluid restriction. An interview was conducted with Staff R, Registered Nurse (RN) on 1/15/25 at 2:08 p.m. The staff member confirmed being the nurse for the back portion of the hall, including Resident #19's room. The staff member stated a male resident (not Resident #19) was on fluid restrictions and no one else was on fluid restrictions. An interview and observation was conducted with Staff Q, CNA on 1/15/25 at 2:20 p.m. The staff member confirmed Resident #19 had a foam cup on the over bed table. Staff Q, CNA picked up the cup and said it was empty, removing the lid and straw, then confirmed the cup was empty with a few drops of clear liquid, stating it was empty now. An interview was conducted with the Director of Nursing (DON) on 1/16/25 at 8:43 a.m. The DON stated staff should be aware of a resident being on a fluid restriction, it should be in the Kardex for the aides and in the computer for nurses. The DON stated she was aware of Resident #19 having a cup at bedside and there should not be a cup left at the bedside. The DON provided on 1/16/25 at 9:31 a.m. a list of four residents in the facility on a fluid restriction. The list included Resident #19. An interview was conducted with the Minimum Data Set (MDS) Coordinator on 1/16/25 at 9:10 a.m. The coordinator stated of course staff should follow the Kardex and nurses should know the care plan. The MDS Coordinator confirmed Resident #19 was on a fluid restriction and had been on one since admission. The staff member acknowledged staff should follow the care plan. 50732 2. On 1/13/25 at 9:53 a.m., Resident #24 was observed in his room. An oxygen concentrator and oxygen tubing in a bag was observed sitting against a wall near the resident's bed . At the time of the observation the resident was not using oxygen and the oxygen concentrator was turned off. The resident stated he uses oxygen when he needs it and he puts on, takes off the nasal canula, and turns the oxygen concentrator on himself. On 1/16/25 at 12:13 p.m. Resident #24 was observed sitting in his motorized wheelchair in his room wearing his oxygen. He said he came to his room to relax for a little while before lunch was delivered. He said he turned on the concentrator himself and put the nasal canula in his nostrils without assistance. The resident said he wasn't short of breath or having any difficulty breathing, he just wanted to put the oxygen on. He said he will take the oxygen off when he feels better. (continued on next page)

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	105491	A. Building B. Wing	01/16/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Admission Record showed Resident #24's initial admitted to the facility was 1/17/23 with an additional admitted [DATE]. The admitting diagnoses included but not limited to chronic obstructive pulmonary disease (COPD) with acute exacerbation and chronic respiratory failure with hypoxia. Review of the MDS Quarterly assessment dated [DATE] for Resident #24 showed under Section C - Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of 15, showing the resident's cognition was intact. Review of Resident #24's Care Plan dated 1/18/23 showed: Focus: The resident has oxygen therapy related to COPD. Goal: The resident will have no signs or symptoms of poor oxygen absorption through the review date. Interventions: Give medications as ordered by physician. Monitor/document side effects and effectiveness. Monitor for signs and symptoms of respiratory distress and report to Medical Doctor (MD) as needed: respirations, pulse oximetry, increased heart rate (tachycardia), restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage, and skin color. OXYGEN SETTINGS: Oxygen via nasal canula as ordered. Review of Resident #24's Care Plan did not show an entry for self-administration of oxygen by the resident. Review of Resident #24's Evaluations did not show an evaluation for self-administration of medication or oxygen. Review of the January 2025 physician orders for Resident #24 showed: Oxygen 2 Liters via nasal canula as needed (PRN) related to COPD. Review of the physician orders for Resident #24 did not reveal a physician order to self-administer oxygen. An interview was conducted with Staff J, RN, on 1/15/25 at 11:13 a.m. Staff J, RN stated she regularly has Resident #24 on her assignment and is very familiar with him. She said the resident has an order for oxygen at two liters per minute (LPM) PRN. She said the resident does not ask to have the oxygen put on, he just takes it off and on himself. She said she was not sure if he had an order for self-administration. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Staff L, Licensed Practical Nurse/Unit Manager (LPN/UM) on 1/16/25 at 12:05 p.m. Staff L, LPN/UM said residents cannot self-administer medications unless they have a self-administration assessment to make sure the resident knows about the medication and how to administer it. She said sometimes they will find residents who are on oxygen will take their oxygen on and off without the order or assessment. When the staff discovers this is happening, it is corrected immediately. The doctor is called and if they write an order for self-administration, an assessment is done and the resident's care plan is updated. Staff L, LPN/UM said if the resident shows the capacity and understanding to do it, they can operate the concentrator and put on their oxygen themselves. She said if a staff member sees the resident taking on and off their oxygen they should document the observation and notify the doctor. She stated the facility would then go through the proper steps in order for the resident to be able to self-administer their oxygen. An interview was conducted with the DON on 1/16/25 at 1:15 p.m., who said residents are allowed to self-administer medication after they pass an assessment for self-administration and the physician must approve the self-administration, and if applicable, the medication will be put in a lockbox at the resident's bedside. She said the resident has to sign out the medication before taking it and the nurse would notify the resident when it was time to administer the medication. She said oxygen is a medication and it would be the same process as the self-administered medication, but it would not include a lockbox. The DON said she was alerted to the fact Resident #24 was self-administering his oxygen shortly before the interview began. 3. On 1/14/25 at 9:20 a.m., Resident #32 was observed in his room. The resident was dressed, groomed and independently walking around the room. The resident was alert, oriented, and pleasant. Resident #32 had a tracheostomy (trach) with a collar. An interview was conducted with Resident #32 during the observation. Resident #32 stated he can take care of the trach himself, and it was observed the trach and trach site was clean. He said he is getting physical therapy four times per week and because of the physical therapy he can walk longer distances with a walker. He said the facility is okay, but he is ready to go home. He feels he is able to take care of himself now and is mostly independent. Resident #32 stated he spoke to the Social Worker several times about finding an Assisted Living Facility (ALF) for him to transfer to, but nothing has happened yet. Review of the Admission Record showed Resident #32 was admitted to the facility on [DATE] with diagnoses including encounter for attention to tracheostomy, COPD, malignant neoplasm head/face/neck, dysphagia oral phase, acquired absence of larynx, muscle weakness, unsteadiness on feet, and dyspnea. Review of the MDS Quarterly assessment dated [DATE] for Resident #32, Section C - Cognitive Patterns showed the resident had a BIMS score of 14, showing the resident's cognition was intact. Review of Resident #32's care plan dated 5/7/24 did not show a Discharge Plan for the resident. Review of Resident #32's Social Service Progress Notes dated 6/10/24 revealed the Social Services Director (SSD) received a call from a representative from Elder Affairs informing her Resident #32 voiced interest in applying for Medicaid with the intent to transition to the community. The Social Service Progress Notes dated 7/9/24 revealed Resident #32 voiced interest in ALF placement. The SSD wrote she contacted a local ALF and the representative at that ALF said she would go to the facility that day to assess Resident #32 for possible placement. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/16/25 at 9:19 a.m., Staff E, LPN said she regularly takes care of Resident #32 and has taken care of him since he was admitted to the facility. She said the resident has been educated on his care and he is able to independently take care of his tracheostomy. She said the plan for Resident #32 is to have the trach removed, which will happen within the next several weeks. Staff E, LPN said the resident is independent and she knows he is ready to either go home or to an ALF as soon as possible. She said he has good family support and will do well in the community. An interview was conducted with the SSD on 1/16/25 at 9:44 a.m. The SSD said she had several conversations with Resident #32 regarding his discharge plan. She said the resident wants to discharge to an ALF. The SSD said she knows the resident is interested in discharging to a local ALF and the representative of the ALF has visited the resident several times in the facility. She said she doesn't remember the exact dates the ALF representative visited the resident, but she knows the representative has been in the facility several times. She said the representative from the ALF said the ALF can't take the resident because he still has the trach and once the trach is removed the ALF should be able to take him. The SSD said Resident #32 is aware of the decision of the ALF, but she will go back and speak to him again to make sure he would still like to discharge to the ALF. She said she did not remember if she put the discharge plan on Resident #32's care plan. During an interview on 1/16/25 at 1:10 p.m. with Staff C, Lead MDS Coordinator, she stated it is the responsibility of the SSD to enter a discharge plan onto the resident's care plan. 4. On 1/14/25 at 3:10 p.m. Resident #133 was observed sleeping in bed. The resident's enabler bars/side rails were in the down position and the resident's call light was on the floor under his wheelchair. A review of the Admission Record showed Resident #133 was admitted to the facility on [DATE] with diagnoses including pain in the left knee, muscle weakness, other reduced mobility, unspecified lack of coordination, cognitive communication deficit, repeated falls, and history of falling. A review of Resident #133's Baseline Care Plan dated 11/3/24 showed: Potential Concerns: Resident is at risk for falls box is checked and the related to section is filled in with hx of (history of). Goal: Risk factors will be decreased for fall related injury over next 30 days box is checked. Approach: no boxes are checked in this section which included: place call bell within easy reach, cue for safety awareness, assist for toileting/transfers PRN, bed in low position, safety devices and other. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #133's History and Physical completed in the hospital prior to admission to the facility revealed the resident was admitted to the hospital on 10/31/24 presenting to the Emergency Department with complaints of worsening positional lightheadedness over past many months. The resident was seen in the hospital in September 2024 or October 2024 for positional lightheadedness. Since he was discharged , he reported slowly progressive positional lightheadedness which is worse in the morning when he wakes up from bed. He fell from bed two days prior to this hospitalization after a fall where he injured his left upper extremity. Review of a Narrative Nurses note for Resident #133 dated 11/10/24 at 4:30 a.m. revealed Resident #133 was observed sitting on floor between the dresser and air conditioning unit with his back towards the wall. The resident stated he was trying to use the urinal while standing at bedside holding onto the bedside table when the table rolled away causing him to fall forward. The resident was noted with a laceration to the bridge of his nose with a moderate amount of bleeding. Pressure was applied and the bleeding was easily controlled. The resident was also noted with a small abrasion to the left inner elbow with scant bleeding. Review of Post Fall Review dated 11/10/24 at 11:38 a.m. for Resident #133 showed the resident's injuries were fracture to nose, skin tear to left antecubital, and bruising left eye. The interventions listed included bed in low position, call light within reach, and patient teaching to ask for assistance with Activities of Daily Living (ADL). An interview was conducted on 1/14/25 at 3:42 p.m. with Staff H, LPN. Staff H, LPN said he takes care of Resident #133 regularly and knows him well. He said he didn't know if Resident #133 was a fall risk, but after looking at the resident's record in the electronic medical record (EMR), Staff H, LPN said the resident was a fall risk. Staff H, LPN went to the resident's room and observed the resident sleeping and the call light on the floor under the resident's wheelchair. He also observed the resident's enabler bars/side rails in the down position. Staff H, LPN put the call light on the bed within the resident's reach and put the enabler bars/side rails in the up position. He agreed the call light should always be within reach of any resident and enabler bars/side rails should be in the correct position as ordered by the physician. During an interview with Staff E, LPN on 1/16/25 at 9:19 a.m., Staff E, LPN said she knows Resident #133 well and regularly takes care of him. She said he is a fall risk because of his decision making and safety is an issue. She said the resident needs reminding not go get up and walk without assistance. She said she uses the resident's Care Plan for the interventions, and she monitors him closely to see if anything changes with his mobility. An interview was conducted on 1/16/25 at 1:15 p.m. with the DON. She stated the nurse who admitted Resident #133 to the facility should have completed the Baseline Care Plan. She said the Baseline Care Plan was not completed correctly as the approach was not filled out. The DON said she was on call when Resident #133 fell and received a call informing her the resident had fallen. She said she was told the resident stood up to use the urinal, leaned over the bedside table, which is on wheels, and the bedside table rolled away from him. She said the maintenance person who was on call went to the facility immediately to install enabler bars/side rails to the resident's bed. She said the expectation for the admitting nurse is to completely fill out the Baseline Care Plan or get help if they need to. She said all RN's in the facility have been trained to complete the Baseline Care Plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Baseline Care Plan dated 8/25/22 and revised on 3/27/24 showed the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care. The policy also revealed the following Policy Explanation and Compliance Guidelines: 1. The baseline care plan will include the minimum healthcare information necessary to properly care for a resident including but not limited to: therapy services. 2. The admitting nurse or supervising nurse on duty shall gather information from the admission physical assessment, hospital transfer information, physician orders and discussion with the resident. Interventions shall be initiated that address the resident's current needs including: any health and safety concerns to prevent decline or injury such as fall.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, record review, and interviews, the facility failed to ensure one resident (#118) of two residents sampled for non-pressure related skin conditions received wound care as prescribed by the physician. Findings included: On 1/13/25 at 9:06 a.m., Resident #118 was observed lying in bed. The left lower extremity of the resident had been amputated below the knee and four to five steri-strips were covering the surgical incision. A brown/tan color elastic bandage was observed sitting on the resident's dresser wrapped up and not within reach of the resident. The right ankle was wrapped with white rolled gauze from the toes to above the ankle and secured with paper tape. The right ankle gauze was not dated as to when the dressing had been applied. Resident #118 stated staff changed it every couple of days. On 1/13/25 at 9:21 a.m., Resident #118's dressings were observed with Staff T, Registered Nurse/Unit Manager (RN/UM). The staff member lifted the resident's right ankle and confirmed the dressing was not dated and absolutely should be dated. Staff T, RN stated he would check when it was last done and believed the dressing was to be changed three times a week. On 1/13/25 at 9:26 a.m. Staff T stated the dressing change was documented on Saturday as being completed. Review of Resident #118's Admission Record showed the resident was admitted on [DATE] with diagnoses including but not limited to encounter for orthopedic aftercare following surgical amputation, other acute osteomyelitis (of) left ankle and foot, unspecified local infection of the skin and subcutaneous tissue, and acquired absence of left leg below knee. Review of Resident #118's January 2025 Treatment Administration Record (TAR) revealed Staff S, RN documented the right medial ankle treatment of skin prep and cover of rolled gauze was completed on Saturday 1/11/25. The dressing did not reveal the completed treatment date. Review of Resident #118's January TAR revealed an order for staff to cleanse surgical site with wound cleanser of choice, apply betadine paint, cover with 4x4 gauze, wrap with rolled gauze, and light (elastic) wrap every day shift for wound care. The documentation showed the dressing was completed daily. During an interview on 1/16/25 at 8:30 a.m. the Director of Nursing (DON) stated dressings should be dated when changed.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, record review, and interviews, the facility failed to ensure the intravenous (IV) access of one resident (#5) of three residents with IV access was maintained in accordance with professional standards. Findings included: On 1/13/25 at 10:35 a.m., Resident #5 was observed with a single lumen peripherally inserted central catheter (PICC) inserted into the right upper arm. The dressing was dated 1/9/(25) and not fully attached to the skin of the resident. Resident #5 reported having an infection in the spinal cord. Review of Resident #5's Admission Record showed the resident was admitted on [DATE] and diagnoses included but was not limited to pseudomonas (aeruginosa) (mallei) (pseudomallei) as the cause of disease classified elsewhere and unspecified gram-negative sepsis. Review of Resident #5's Admission/Readmission Nursing Evaluation, effective 12/27/24, revealed the admitting diagnosis was bacteremia and had a right upper extremity (RUE) midline. The evaluation did not include a measurement of the RUE midline external catheter or arm circumference. Review of Resident #5s January 2025 Medication Administration Record (MAR) included the following orders: - Piperacillin Sod-Tazobactam So Solution Reconstituted 3-0.375 gram (GM) - Use 3.375 gram intravenously every 6 hours for bacteremia until 2/7/25, started on 12/30/24 and discontinued on 1/5/25. - Piperacillin Sod-Tazobactam So Solution Reconstituted 3-0.375 GM - Use 3.375 gram intravenously every 6 hours for Bacteremia/Osteomyelitis of the spine until 2/7/25, started on 1/6/25. - Measure arm circumference 2 inches above insertion site with each dressing change, RUE every night shift every Thu[rsday] for Bacteremia. The order started on 1/2/25. The documentation showed staff were to use the measurement of centimeters (cm) for the resident's RUE circumference. Review of Resident #5's January 2025 MAR showed on 1/2/25 staff documented 30 and on 1/9/25 staff documented NA, which according to the chart codes meant medication not available, for the circumference of the resident's RUE circumference with no numerical measurement. Review of Resident #5s January Treatment Administration Record (TAR) included the following orders with documentation: - IV PICC change primary intermittent tubing every 24 hours every night shift for Bacteremia, started on 12/30/24. The documentation showed staff had completed every night shift. - IV PICC RUE change transparent dressing on admission, then weekly and as needed (prn) thereafter every night shift every Thu(rsday) for Bacteremia, started on 1/2/25 and discontinued on 1/9/25. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- IV PICC RUE change transparent dressing on admission, then weekly and as needed (prn) thereafter every night shift every Thu(rsday) for Bacteremia, started on 1/9/25. - IV PICC RUE Measure catheter length on admission and with each dressing change thereafter every night shift every Thu for Bacteremia, stated on 1/2/25. The documentation revealed the completion of task on 1/2/25 and 1/9/25, however, did not include measurement of the external catheter. - IV PICC RUE change transparent dressing on admission, then weekly and as needed (prn) thereafter every 24 hours as needed for when soiled or missing dressing, started on 1/9/25. The documentation showed the as needed dressing change was completed on 1/13/25 at 1:44 p.m. The order did not include an area to document the length of the external catheter. Review of Resident #5's December 2024 MAR did not include an order for dressing the RUE PICC on admission or to measure the external catheter length on admission. Review of Resident #5's December 2024 TAR included the following orders with corresponding documentation if applicable: - IV PICC - change primary intermittent tubing every 24 hours every night shift for Bacteremia, started on 12/30/24. The order was scheduled for night shift. The documentation had X throughout, without documentation of staff administering the order. - IV PICC RUE monitor site every (q) shift for signs/symptoms of infection and/or infiltration every shift for Bacteremia, started on 12/30/24. The documentation had X throughout, without documentation of staff administering the order. The documentation of the resident's scheduled treatments did not show the resident received any scheduled treatments after readmitting on 12/27/24. The as needed orders on the December 2024 TAR showed they did not start until 1/9/25 and 1/15/25. The TAR did not include orders to change the RUE PICC line dressing at the time of admission or to measure the external catheter. Review of Resident #5's progress notes revealed the following: - A late entry Skilled note 12/28/24 at 1:01 p.m. did not reveal documentation of the resident's PICC line. - A late entry Skin Observation progress note, effective 12/28/24 at 3:50 p.m. showed the resident did have existing pressure injuries but did not include documentation of the resident's IV external catheter or arm circumference. - A Skilled progress note, effective 12/29/24 at 11:31 p.m. revealed the resident's skin was not intact. The note did not mention the condition of the resident's PICC catheter. - A Skin Observation progress note effective 12/30/24 at 9:11 p.m. showed the resident had existing pressure injuries and a right ankle vascular wound. The staff member did not mention the resident had an IV site. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A Skilled progress note effective 12/30/24 at 9:18 p.m. revealed the resident had a PICC line, was receiving IV antibiotics, and the site was clean dry and intact. The note did not have a measurement of the PICC line external catheter or arm circumference. - An Antibiotic Time out note effective 12/30/24 at 9:30 p.m. revealed the resident was receiving an IV antibiotic. The resident had positive blood cultures on 12/21/24, was sent to hospital, then readmitted on [DATE]. The note did not include information regarding the condition of the IV site. - An Advanced Registered Nurse Practitioner (ARNP) note effective 12/31/24 at 11:00 a.m. revealed the resident was sent to the hospital on 12/21/24, returning to the facility on [DATE]. The note showed a PICC line was placed and the resident was started on IV antibiotics while at the hospital. - A Skilled progress note effective 1/2/25 at 12:29 a.m. revealed the resident was receiving IV antibiotics, but did not include a measurement of the external length of the resident's PICC, despite documentation (TAR) revealing the PICC dressing was changed and the catheter length was measured. - A Skilled Progress note effective 1/4/25 at 2:54 a.m. revealed the resident was receiving IV antibiotics via a PICC line, and the site was clean, dry, and intact. The note did not reveal the length of the external catheter. -A Skilled Progress note effective 1/5/25 at 2:21 p.m. showed the resident was receiving IV antibiotics, had a PICC line, and the site was clean, dry, and intact . The note did not include a measurement of the external catheter. -A Skin observation note effective 1/6/25 at 3:11 p.m. showed the resident had an existing skin impairment and a PICC line to the RUA. The note did not include a measurement of the length of the external IV catheter. - A general note dated 1/6/25 at 6:27 p.m. revealed the resident was on IV antibiotics and had a PICC line with no abnormal signs or symptoms displayed. The note did not include a measurement for the length of the external IV catheter. - A Skilled progress note effective 1/7/25 at 2:54 a.m. revealed the resident had a PICC line and was receiving IV antibiotics. The note did not include a measurement of the length of the external IV catheter. - A Skilled progress note dated 1/9/25 at 1:42 a.m. did not show the resident had an IV site. - A Skilled progress note effective 1/10/25 at 2:41 a.m. showed the resident had a PICC line and was receiving IV antibiotics. The note did not include a measurement of the length of the external IV catheter. - A Skilled progress note effective 1/11/25 at 2:18 a.m. did not reveal the resident had any skin impairments, any IV site, or was receiving an antibiotic. The note did not include a measurement of the external length of the IV catheter. - A Skilled progress note effective 1/12/25 at 2:08 a.m. revealed the resident was not receiving medications or antibiotics. (continued on next page)

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	105491	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gandy FL Opco, LLC	4610 S Manhattan Ave Tampa, FL 33611

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A Skilled progress note effective 1/13/25 at 2:41 a.m. showed the resident had no medications, antibiotics, or adverse med side effects. The note did not reveal the resident had a PICC line or was receiving IV antibiotics. - A Skilled progress note effective 1/14/25 at 2:14 a.m. revealed the resident had no current skilled nursing/rehab status including medications, antibiotics, and/or adverse med side effects. - A Skilled progress note effective 1/15/25 at 1:11 a.m. revealed the resident had a PICC line and was receiving IV antibiotics. The note did not include a measurement of the external IV catheter. - A Skilled progress note effective 1/16/25 at 1:41 a.m. revealed the resident had a PICC line and was receiving IV antibiotics. The note did not include a measurement of the external IV catheter. An interview was conducted with Staff S, Registered Nurse (RN) on 1/16/25 at 1:37 p.m. The staff member stated Resident #5's PICC dressing was becoming dislodged on 1/13/25. Staff S, RN reported measuring the external catheter, but did not document the numbers because she didn't think about it. The staff member stated the measurements were usually documented in the dressing change note. Staff S, RN stated the length of the catheter should be documented, but she would have to check the specific policy. An interview was conducted with Staff T, Unit Manager (UM) on 1/16/25 at 1:42 p.m. The staff member stated the documentation of the PICC line length would be in the hospital records and confirmed staff were documenting the length with the dressing change and as needed. Staff T, UM also stated staff should be documenting the length with the dressing changes. The staff member stated the order was not put in correctly and should have added ancillary information allowing for the documentation of the measurement. An interview was conducted with the Director of Nursing (DON) on 1/16/25 at 2:37 p.m. The DON state staff should be measuring PICC catheters and the stock orders do not ask for length. Review of the policy titled PICC/Midline/Central Venous Access Device (CVAD), copyrighted 2024, revealed, It is the policy of this facility to change peripheral inserted central catheter (PICC), midline or central venous access device (CVAD) dressing weekly or if soiled, in a manner to decrease potential for infection and/or cross contamination. Physician's orders will specify type of dressing and frequency of changes. The Compliance Guidelines included: 6. Inspect the catheter skin junction in surrounding area, palpating through the intact dressing for redness, tenderness, swelling, and drainage. Be attentive to any reports of pain, paresthesia, numbness, or tingling. 13. Use sterile measuring tape to measure external length of the catheter from hub to skin entry to ensure that it has not migrated. 24. Document the procedure.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observations, interviews, and record review, the facility failed to ensure effective communication with the Dialysis center that provides treatment services for one resident (#119) of three sampled residents. It was determined review of fourteen Dialysis service visits, the Dialysis nursing staff failed to collaborate with the nursing facility by not providing and documenting post weights, vital signs, Dialysis vascular access site status, and what Dialysis treatment was provided. Findings included: On 1/13/2025 at 8:50 a.m., Resident #119 was observed seated on the side of his bed in his room. The resident was alert and able to speak about his medical care and daily decision making. Resident #119 confirmed he goes to an End Stage Renal Disease (ESRD) Dialysis center three times a week for Dialysis treatment and he was getting ready to go to his chair treatment appointment today, which was at 12:00 p.m. Resident #119 confirmed he goes to the Dialysis center on Mondays, Wednesdays, and Fridays. Resident #119 revealed the nurse will give him a yellow book to have the Dialysis center document his care, upon his leaving the Nursing facility. He confirmed staff at the Dialysis center are supposed to fill out medical information in this book, but he does not remember the last time the Dialysis staff did that. Resident #119 revealed he just gets the yellow book back and takes it back to the Nursing center. On 1/14/2025 review of Resident #119's medical record revealed he was admitted to the facility on [DATE] and readmitted from the hospital on 3/13/2024. Review of the advance directives revealed Resident #119 was his own responsible party and able to make his own medical decisions. Review of the diagnosis sheet revealed diagnoses to include but no limited to end stage renal disease, anemia, and cognitive communication deficit. Review of Resident #119's current Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed; Cognition: Brief Interview Mental Status or BIMS score 10 of 15, which indicated Resident #119 had mild cognitive impairment. Active Diagnoses: Renal Insufficiency, Obstructive Uropathy Special treatment: Checked yes for Dialysis services. Review of Resident #119's progress notes dated from 11/1/2024 - 1/15/2025 did not indicate any documented concerns regarding Dialysis or Dialysis services. There was also no indication of refusals or missed Dialysis service days. Review of Resident #119's Physician's Order Sheet dated for January 2025 revealed orders to include but not limited to: 1. Complete Dialysis communication forms and send with resident to dialysis center, order date 1/15/2024. 2. Location Dialysis access site. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. If declines Dialysis refuses dialysis notify attending MD and nephrologist. 4. If Dialysis site bleeding, apply direct pressure to sit to help control bleeding and notify physician. 5. Monitor Dialysis catheter site to right chest for bleeding and monitor dressing is intact. 6. Check access site for signs and symptoms of infection when performing routine care. 7. Check access site post Dialysis. 8. May hold meds when resident is Leave Of Absences (LOA) to dialysis. 9. diagnosed for Dialysis: ESRD. 10. Send snack with resident on dialysis days. 11. Dialysis days are Mondays-Wednesdays-Fridays, medication times and schedule may be revised with Dialysis days. 12. Complete post communication dialysis form on return Mondays-Wednesdays-Fridays. 13. Liberal Renal diet, Regular textured, thin liquid diet. Review of Resident #119's SUN Dialysis Communication Book revealed: Please record post weight on worksheet everyday. The book contained only one Pre/Post Dialysis Evaluation dated 1/13/2025. The form was blank in section B. Dialysis Nursing Information. The book also contained informational sheets that read, 1. Please fill out Dialysis weight worksheet every dialysis day, 2. Dialysis book *Face sheet, *Most recent labs, *Dialysis information, *Pre and Post dialysis evaluations, *Medication list, * Weight sheet (pre and post). The last sheet in the book revealed a Dialysis weight worksheet for the month of 1/2025. Review of the book did not reveal any past SUN Pre/Post Dialysis Evaluations other than the last visit on 1/13/2025. This was verified by Staff B, Licensed Practical Nurse (LPN) on 1/14/2025. She revealed once the communication sheets are reviewed they are charted in the Electronic Medical Record and scanned into the Electronic Medical Record. Staff B, LPN also confirmed section B of the SUN Pre/Post Dialysis Evaluation, which was the section for the Dialysis center staff to fill in, was blank. She revealed often times they receive this section blank, and the Dialysis center will not fill this section in. She confirmed she and other Nursing facility nurses would not know what Resident #119's medical and vitals status would be while at the Dialysis center. On 1/15/2025 Resident #119's electronic medical record (EMR), to include the Evaluations tab, revealed all the past Dialysis visits SUN Pre/Post Dialysis Evaluations. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The past fourteen visits reviewed and all SUN Pre/Post Dialysis forms dated 1/13/25, 1/10/25, 1/8/25, 1/6/25, 1/3/25, 1/1/25, 12/30/24, 12/27/24, 12/25/24, 12/23/24, 12/20/24, 12/18/24, 12/16/24, 12/13/24 revealed only completed information from the Nursing facility, including pre and post weight, vitals, and notes. Section B did not reveal any information, nor any signature from Dialysis staff, to include assessment of weight, vital signs, or notes. Review of Resident #119's current care plans with a next review date 3/8/2025 revealed the following problems areas. Dialysis care plan: Dialysis 3 x week M-W-F (Monday-Wednesday-Friday) chair time 12 noon, with interventions in place to include: 1. Administer meds as ordered; 2. Complete Dialysis communication form and send with resident to dialysis center; 3. Complete post communication dialysis corm upon return, one time a day x Mon-Wed-Fri (Monday-Wednesday-Friday) complete [electronic health record brand] post Dialysis communication form if available; 4. Fill in complete dialysis portion based on return form save and lock; 5. Dialysis days M-W-F med times and schedule may be revised with Dialysis days; 6. Meds not to be given on Dialysis days M-W-F, prior to Dialysis; 7. Monitor dialysis catheter site for bleeding or signs of infection; 8. Notify MD (Medical Doctor) of signs and symptoms; 9. Observe dialysis site for infection, bleeding, edema; and 10. Observe labs as ordered. On 1/15/2025 at 9:40 a.m., an interview with the 200 Unit Manager Staff A, RN revealed for each resident who utilizes Dialysis services, there is a communication form sent with the resident from the facility to the Dialysis center and then brought back when the resident returns from Dialysis treatment. She revealed there is a section of the communication form the facility is responsible for and includes pre-weights, vital signs, medication notes, and other notes. She also revealed there is a second section of the form to be filled out by the Dialysis center staff to include weights, vital signs, medication notes, and other notes prior the resident leaving the center. Staff A, RN also revealed the form had a third section the facility staff must fill out to include post weights, vitals, medication notes, and other notes. Staff A, RN confirmed Resident #119's communication sheets dated from 12/12/2024 through to 1/13/2025 were not filled out by the Dialysis center staff. She revealed they have not been getting the Dialysis center information for Resident #119. Staff A, RN said she along with other nursing facility management have called the Dialysis center staff and they had told them they do not provide and send out information to include post weights, vitals, notes, access site evaluation, and signature of staff who cared for the resident. Staff A, RN revealed they are explained that the Dialysis center would not fill out the sheets and send them along in the communication book. On 1/16/2025 at 8:45 a.m. another interview with Staff A, RN revealed the expectation for receiving Dialysis information. While the resident is at the Dialysis center, the following happens: 1. A Dialysis communication book with a form to include nursing home evaluation expectations pre Dialysis center visit, Dialysis center evaluation expectations while at the Dialysis center, and post evaluation expectations when the resident returns to the facility from the Dialysis center; and Weight and vitals logs. Staff A, RN revealed the book with the evaluation page is carried to the facility by the resident. 2. Once the resident is at the Dialysis center, the Dialysis nursing staff are to take and record post-weights, vital stats, and any information related to the Dialysis access site. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Once the resident returns to the facility from the Dialysis center, the nursing staff are to fill out post-weights, vitals, and assess the Dialysis access site. Staff A, RN revealed the facility nursing staff are to evaluate the information from the Dialysis center in order to know how the resident was while at the Dialysis center. 4. After the communication form is completed by both the facility and Dialysis center, the form is uploaded into the Electronic Medical Record. On 1/15/2025 at 1:00 p.m., during an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON), both confirmed they have been having problems with the Dialysis center staff filling out their portion of the communication form and have been told they will not document medical information on that form. The DON and NHA also confirmed after they have communicated with the Dialysis Administrator on 1/15/2025, and was told State was in the nursing home facility, the Dialysis staff immediately faxed all the required communication information for review and sent that information to the facility. The DON confirmed they did not have any of this information prior to 1/15/2025. On 1/16/2025 at 9:45 a.m., the Director of Nursing provided the Hemodialysis policy and procedure with a last review date of 8/25/2022 for review. The Policy revealed; The facility will provide the necessary care and treatment, consistent with professional standards of practice, physician's orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis. The Purpose section of the policy revealed; The facility will assure that each resident receives care and services for the provision of Hemodialysis and/or peritoneal dialysis consistent with professional standards of practice. This will include: - The ongoing evaluation of the resident's condition and monitoring for complications before and after dialysis treatment received at a certified dialysis facility. - Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. The Compliance Guidelines section of the policy revealed; 1.) The facility will inform each resident before or at the time of admission of dialysis services available. 2.) The facility will coordinate and collaborate with the dialysis facility to assure that: a.) The resident's needs related to dialysis treatment are met; b.) There is ongoing communication and collaboration for the development and implementation of the dialysis care plan by nursing home and dialysis staff. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4.) The licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as a dialysis communication form or other form, that will include, but not limit itself to: a.) Timely medication administration (initiated, held or discontinued) by the nursing home and/or dialysis facility; b.) Physician/treatment orders, laboratory values, and vital signs; c.) Nutritional/fluid management including documentation of weights; d.) Dialysis treatment provided and resident's response; e.) Dialysis vascular access site status; f.) Changes and/or declines in condition related to dialysis; g.) The occurrence or risk of falls and any concerns related to transportation to and from the dialysis facility. On 1/16/2025 at 9:45 a.m., the Nursing Home Administrator provided the Long Term Care Facility Outpatient Dialysis Services Coordination Agreement, which was signed by both the Nursing Home Administrator and the Dialysis center Regional Operations Director on 2/15/2021. Section (E) Mutual Obligations of the agreement revealed; 1. Collaboration of Care. Both parties shall ensure that there is documented evidence of collaboration of care and communication between the Long Term Care Facility and ESRD Dialysis Unit. Documentation shall include, but not limited to, participation, as members of interdisciplinary team, in care conferences, continual quality improvements program, annual review of infection control of policies and procedures, and the signatures of team members from both parties on a Short Term Care Plan (STCP) and Long Term Care Plan (LTCP). Team members shall include the physician, nurse, social worker and dietitian from the ESRD Dialysis Unit and representative from the Long Term Care Facility. The ESRD Dialysis Unit shall keep the original STCP and LTCP in the medical record of the ESRD Resident and the Long Term Care Facility shall maintain a copy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, record review, and interviews, the facility failed to follow Enhanced Barrier Precautions and don Personal Protective Equipment in accordance with facility policy for one resident (#118) of thirty-nine sampled residents. Findings included: On 1/13/25 at 9:06 a.m., Resident #118 was observed lying in bed. The observation revealed a surgical incision with four to five steri-strips to a left below knee amputation and rolled gauze covering the right ankle from toes to above the ankle. The resident was wearing a nasal cannula delivering three liters per minute (lpm) of oxygen. The observation also revealed the room was not posted for Enhanced Barrier Precautions. On 1/13/25 at 12:28 p.m., Staff U, Certified Nursing Assistant (CNA) asked Staff V, CNA to assist in repositioning Resident #118 in bed for the noon meal. The observation showed the staff members repositioned the resident while wearing gloves, but neither staff member was observed donning a protective gown prior to lifting the resident. Staff U, CNA was observed adjusting the resident's blankets. Review of Resident #118's Admission Record showed the resident was admitted on [DATE] with diagnoses including but not limited to encounter for orthopedic aftercare following surgical amputation, sepsis due to methicillin susceptible staphylococcus aureus (MRSA), Methicillin resistant staphylococcus aureus infection as the cause of diseases classified elsewhere, unspecified local infection of the skin and subcutaneous, and sepsis due to other specified staphylococcus. Review of Resident #118's Admission/Readmission Nursing Evaluation dated 12/3/24 revealed the admitting diagnosis was sepsis left lower extremity (LLE) cellulitis with the special needs of intravenous (IV) therapy and wound care. Review of Resident #118s December 2024 Treatment Administration Record (TAR) revealed the following: - IV peripherally inserted central catheter (PICC) (all types) - change primary intermittent tubing every 24 hours every night shift. The treatment was discontinued on 12/10/24. - Apply skin prep to right medical ankle and wrap with (rolled gauze) 3 times weekly and as needed (prn), every day shift every Tuesday, Thursday, and Saturday for wound care. The order was started on 12/19/24 and discontinued on 1/13/25. - Cleanse surgical incision to left lower extremity with betadine, cover with abdominal (abd) pad, wrap with rolled gauze then wrap with elastic bandage daily and prn, every day shift for post-surgical care. The order started on 12/5/24 and continued to 1/3/25. Review of Resident #118s January 2025 TAR revealed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- LLE Below knee amputation (BKA): Cleanse surgical site with wound cleanser of choice. Apply Betadine paint, cover with 4x4 gauze, wrap with rolled gauze and light elastic wrap every day shift wound care. The order was started on 1/4/25 and discontinued on 1/15/25. - Apply skin prep to right medial ankle, wrap with rolled gauze three times weekly and prn, every day shift every Tuesday, Thursday, and Saturday for wound care. This order started on 12/19/24 and discontinued on 1/13/25 at 9:25 a.m. - Apply skin prep to right medial ankle and wrap with rolled gauze three times weekly and prn every day shift every Tuesday, Thursday, (and) Saturday for wound care. The order started on 1/14/25 and was discontinued on 1/15/25 at 7:29 a.m. The documentation showed the treatment was not completed on 1/14/25 due to the resident being hospitalized . Review of Resident #118's care plan revealed the following Focus areas: - Potential for alteration in comfort related to recent amputation/arthritis. - Altered skin integrity: non pressure location: right ankle, created on 1/5/25. - A focus created on 1/13/25 showed the resident required EBP (Enhanced Barrier Precautions): Risk for impaired psychosocial status and other complications. Enhanced Barrier Precautions per CDC (Centers for Disease Control and Prevention) guidelines due to : Colonized Multi-Drug Resistant Organism (MDRO)(MRSA). The interventions showed Persons caring for the resident and providing high contact resident care activities will require personal protective equipment (PPE), the use of gowns and gloves. The intervention was created by the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) on 1/13/25. On 1/13/25 at 3:13 p.m., Staff U, CNA stated during an interview regarding EBP, if working with residents or repositioning residents on EBP, staff needed to wear a gown and gloves. Staff U, CNA reported EBP were for residents with wounds, infections, and catheters. The staff member stated staff should have used PPE when repositioning Resident #118 at lunch and the understanding was the resident did not have wounds, so would not need to be on EBP. On 1/13/25 at 3:17 p.m., Staff S, Registered Nurse (RN) was observed standing at Resident #118's bedside with a pulse oximeter on the finger of the resident. The staff member stated residents require enhanced precautions for any sort of opening in the skin or have an increased potential for infection. Staff S, RN reported the resident had a closed surgical incision. A further review of Resident #118's clinical record showed an order for Enhanced Barrier Precautions was initiated on 1/13/25 at 4:29 p.m., Enhanced Barrier Precautions related to (r/t) MDRO (MRSA) every shift. During an interview on 1/16/25 at 8:30 a.m., the Director of Nursing (DON) stated residents were put on EBP for open wounds, gastrostomy tubes (g-tube), peripherally inserted central catheter (PICC) lines, suprapubic catheters, and did not know about indwelling catheters. The DON stated organisms had to have a way to get in and staff should be aware of EBP. The DON reported Resident #118 should have been on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 1/16/25 at 3:10 p.m. with the Assistant Director of Nursing/Infection Preventionist (ADON/IP). The IP reported EBP was for residents who may have a wound with heavy drainage, IV's, indwelling catheters, G-tubes, Dialysis catheters, or any type of invasive equipment or opening. The IP revised their statement, saying a wound doesn't necessarily needs heavy drainage or anything that has an opening in the skin. The staff member reported Resident #118 was originally on EBP due to being on IV therapy then it was discontinued. Treatment was only for skin prep due to no opening and the surgical incision was also healed and the dressing was for preventative measures. The ADON reported they did not have a chance to review diagnoses at time of the observation and staff members should have been wearing PPE when assisting Resident #118 due to the MDRO diagnosis. Review of the policy titled Enhanced Barrier Precautions, revised 9/1/22, revealed, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. The policy defines Enhanced Barrier Precautions as the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). The Compliance Guidelines included: 1. Prompt recognition of need: c. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gowns and gloves. 2. Initiation of Enhanced Barrier Precautions a. Nursing staff may place residents with certain conditions or devices on enhanced barrier precautions empirically while awaiting physician orders. b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/ or indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. ii. Infection or colonization of any resistant organisms targeted by the CDC and epidemiologically important MDRO when contact precautions do not apply. 3. Implementation of enhanced barrier precautions a. Make gowns and gloves available immediately outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray. b. Ensure access to alcohol based hand rub in every resident room (ideally both inside and outside of the room). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105491	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gandy FL Opco, LLC	4610 S Manhattan Ave Tampa, FL 33611

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