STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105725	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elon Manor Nursing and Rehabilitation Center	1203 E 22nd Ave Tampa, FL 33605

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure infection control practices were followed related to: 1) staff performing hand hygiene when completing medication administration, 2) cleaning of multi-use equipment, such as blood glucose monitors and blood pressure cuffs, in between uses on residents, and 3) an uncleanable surface in one of two resident shower rooms in the one west unit. Findings included: 1. On 2/23/26 at 9:20 a.m. during medication administration observation Staff A, Registered Nurse (RN) used her fingers to place vitamin D-3, aspirin, Iron, and sodium chloride pills into a medication cup to administer to Resident #62. On 2/23/26 at approximately 9:23 a.m. after preparing medications for Resident #62, Staff A, RN did not perform hand hygiene (HH) and entered room [ROOM NUMBER] put gloves on and resecured ace bandage on the resident's right arm. Staff A, RN removed gloves, did not perform HH, entered Resident #62's room and administered medications to the resident. On 2/23/26 at 9:39 a.m. Staff A, RN used a wrist blood pressure monitor to check Resident #41's blood pressure then placed the machine directly on top of the medication cart. When preparing medications to administer to Resident #41 Staff A, RN used her fingers to place iron, vitamin B-12, and sodium bicarbonate pills into the medication cup. When asked about cleaning and disinfecting multi resident use items Staff A, RN said red-top disinfectant wipes are available for use. When asked about the process of removing over the counter medications from containers, Staff A, RN said I touched them. In response to not consistently performing HH Staff A, RN said she performed HH, when reminded of the moments HH was not done there was no response. On 2/23/26 at 11:44 Staff J,RN left room [ROOM NUMBER] with a wrist blood pressure monitor and placed the machine in a bag with clean medical supplies. Staff J, RN said the blood pressure monitor should have been disinfected first with disinfectant wipes located in the bottom drawer of the medication cart. The National Library of Medicine provide the following directions when using multi-dose containers: When removing tablets or capsules from a multi-dose bottle, pour the necessary number into the bottle cap and then place the tablets or capsules in a medication cup. Cut scored tablets, if necessary, to obtain the proper dosage. If it is necessary to touch the tablets, wear gloves. https://www.ncbi.nlm.nih.gov/books/NBK593215/ retrieved on 2/27/26. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105725	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elon Manor Nursing and Rehabilitation Center	1203 E 22nd Ave Tampa, FL 33605

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 2/22/26 at 1:48 p.m., an observation of the one west bathroom, in front of room [ROOM NUMBER] and next to room [ROOM NUMBER], revealed the shower area had a long pipe, from the ceiling to the floor in length. Further observations of the pipe showed it was wrapped in cardboard. On 2/23/26 at 9:30 a.m., an observation of the bathroom/shower room, next to room [ROOM NUMBER], revealed a plunger next to the toilet did not have a bag covering it. Photographic evidence obtained. On 2/24/26 at 2:03 p.m., an interview was conducted with the Director of Nursing (DON). She said the pipe in the shower/bathroom should not have cardboard on it. She stated, Cleanable surfaces need to remain cleanable. The DON said the pipe is a heating pipe and the cardboard was put on there to prevent residents who use the shower from getting burned. She said the cardboard was replaced today with material, specifically for heating pipes, that could be cleaned. The DON said the expectation for plungers in the bathrooms is they should be covered. She stated, If a plunger is used, the expectation is that it be sanitized and put back in a bag. Review of facility policy titled, Infection Control Policy, revised 4/23/25 showed the following: Mission statement: Outbreaks of communicable diseases within the facility will be promptly identified and appropriately handled. Contagious diseases are spread every day. Oftentimes, they are transmitted unknowingly, leaving healthcare staff unprepared for outbreaks. Overview: Infections are a significant source of morbidity and mortality for nursing home residents. Emphasis for prevention and management of infections are a critical aspect. Program oversight includes planning, organizing, implementing, operating, monitoring, and maintaining all of the elements of the program and ensuring that the facility's interdisciplinary team is involved in infection prevention and control. Review of facility policy titled, Hand Hygiene, Nail Length, and Artificial Nails Policy, effective 1/12/26 showed the following: Purpose To outline a facility-wide policy on hand hygiene . Indications for hand hygiene Hand Washing with soap and water: Wash hands with soap and water when hands are visibly soiled or contaminated with patient's body fluids or excretions, mucous membranes, non-intact skin or if exposure to spore forming organisms is suspected or proven, and after using the bathroom. Hand Hygiene with Alcohol-based Hand Sanitizer: Alcohol-based Hand Sanitizer should be used if hands are not visibly soiled, for routinely decontaminating hands in clinical settings including: 1. Before entering resident's room. 2.Before donning gloves. 3. Upon exit of resident's room .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105725	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elon Manor Nursing and Rehabilitation Center	1203 E 22nd Ave Tampa, FL 33605

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 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, facility record review and staff interviews, the facility failed to ensure handrails were affixed to the wall in a safe and secure manner in two floors (200 and 100) of two floors observed, during three days (2/22/2026, 2/23/2026, and 2/24/2026) of four days observed. Findings included: During a facility wide tour on 2/22/2026 at 9:15 a.m., at 2:00 p.m. and on 9/23/2026 at 8:30 a.m., the following was observed: 1. The 2nd floor hallway handrail located before the shower room was not affixed tightly to the wall. 2. The 2nd floor hallway handrail located across from the nurse station and below the mirror and clock was not affixed tightly to the wall. 3. The 2nd floor hallway handrail located on the right side of the nurse's station door was not affixed tightly to the wall. 4. The 2nd floor hallway handrail located between resident rooms [ROOM NUMBERS] was not affixed tightly to the wall. 5. The 2nd floor hallway handrail located on the left side of resident room [ROOM NUMBER] was not affixed tightly to the wall. 6. The 2nd floor hallway handrail located between resident rooms [ROOM NUMBERS] was not affixed tightly to the wall. 7. The 2nd floor hallway handrail located between resident rooms [ROOM NUMBERS] was not affixed tightly to the wall. 8. The 2nd floor hallway handrail on the right side of the storage closet just before the dining room was not affixed tightly to the wall. 9. The 2nd floor hallway handrail on the right side of the soiled utility room and across from resident room [ROOM NUMBER] was not affixed tightly to the wall. The observations revealed the entire length of the above-mentioned wooden handrails moved and wiggled and had physical play when grabbed, creating a risk for accidents. The observations during the 7-3 a.m. shifts and 3-11p.m. shifts on days 2/22/2026, 2/23/2026 and 2/24/2026 revealed residents were utilizing the above listed handrails when ambulating around the building. On 2/22/2026 at 10:00 a.m. an interview was conducted with Staff D, Certified Nursing Assistant (CNA). Staff D confirmed the loose handrails but did not know about them being loose until at the time of the interview. She stated if she saw any handrails broken or loose, they are to report it immediately via the facility's work order system to maintenance. On 2/22/2026 at 10:05 a.m. an interview was conducted with Staff E, License Practical Nurse (LPN). Staff E stated handrails must be secured to the walls for the resident's safe use. Staff E stated there were times when they are knocked into and they get loose. She stated not knowing how often maintenance observed for the securing of the handrails. But if they are observed by staff being loose, they put in work orders for repairs. Staff E confirmed she had observed residents utilizing the handrails throughout her shift on the second and first floor, and they use the rails as a safety enabler so they can ambulate from one part of the facility to another. On 2/25/2026 at 2:20 p.m. an interview was conducted with Staff C, Maintenance Technician. Staff C revealed there was a process for work orders that included checking if there were any problems with the handrails. He revealed that he and other maintenance staff will try to look at all handrails daily and will pull on them to see if they were secure. Staff C did not have any documented evidence this was conducted daily, weekly, monthly or yearly. Staff C revealed if a staff member noted handrails were loose and not secured to the wall safely, they are to report it via a hand written work order form and it will get to the maintenance department for correction. Staff C confirmed there were loose wall handrails but stated not previously being aware of loose handrails. On 2/25/2026 at 3:00 p.m. an interview was conducted with the Nursing Home Administrator (NHA) about the handrails maintenance and how often they are observed for safe use. She confirmed maintenance department was responsible for the maintenance of the handrails and staff are to report any non-maintained handrails as they see them. The NHA stated they did not have any documentation to support handrails were (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105725	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elon Manor Nursing and Rehabilitation Center	1203 E 22nd Ave Tampa, FL 33605

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 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	audited for safety and maintenance. The NHA stated the facility did not have a specific handrail policy and procedure for review. She said, However, all handrails should be tightly affixed to the wall as residents do utilize them throughout the day/night for ambulating. 2. On 2/23/26 at 9:32 a.m., an observation of the one west hallway revealed a resident was ambulating in a wheelchair while holding onto the handrail with their right hand. While the resident was holding the handrail, the hand rail separated off the wall and was observed in their hands. Staff A, Registered Nurse (RN) was observed saying she would call maintenance.A facility policy related to handrails was requested. The facility did not provide a policy. (Photographic Evidence Obtained)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105725	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elon Manor Nursing and Rehabilitation Center	1203 E 22nd Ave Tampa, FL 33605

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to notify the Power of Attorney (POA) of a change in condition related to weight loss for one resident (#41) out of five residents reviewed for nutrition. Findings included: Review of the admission record revealed Resident #41 was admitted to the facility on [DATE] and was readmitted on [DATE]. Review of the advance directives revealed Resident #41had a medical and financial decisionmaker/ Power of Attorney (POA) to make his decisions. The medical diagnosis sheet revealed diagnoses to included but not limited to muscle weakness, quadriplegia, contracture of muscle unspecified on upper arm, need for assistance with personal care, contracture lower leg, disorder of bone density, and structure, dysphagia, protein calorie malnutrition, and gastrostomy.Review of the physician's orders for the month of 2/2026 revealed; Diet Order - NPO (nothing by mouth); Enteral feeding Jevity 1.5 75 ml (milliliters) per hour for 1500 liters bid (twice daily) start at 2 p.m.Review of the Minimum Data Set (MDS) assessment (5-day) dated 2/9/2026 revealed; a Brief Interview Mental Status (BIMS) score was not scored, but revealed short term memory problem, and long-term memory ok. Section GG showed the resident was dependent on staff for all ADLs (activities of daily living). Review of Resident #41's medical record on weight/vitals revealed the following weights:On 12/27/2025, 1/13/2026 and 2/10/2026 the resident weighed 195 lbs. (pounds).On 2/17/2026 he weighed 180 lbs.On 2/24/2026 he weighed 176 lbs.The record review revealed Resident #41 began losing weight as follows: 5 lbs. from 1/24/2026 to 2/10/2026, 10 lbs. from 2/10/2026 to 2/17/2026 and 4 lbs. from 2/17/2026 to 2/24/2026. Resident #41 lost a total of 19 lbs. between 1/24/2026 to 2/2/2026, a 7.37% weight loss in one month. On 2/22/2026 at 9:14 a.m. Resident #41 was observed in his room and lying in bed. Resident #41 was observed receiving nourishment via a tube feed system. The resident did not respond to the interview. An interview was conducted with Resident #41's family member/POA on 2/22/2026 at 9:35 a.m., and on 2/24/2026 at 9:15 a.m. The POA confirmed she is and was involved with his care and services and attends care plan meetings with the interdisciplinary team. She stated Resident #41 has been in and out from the Hospital several times the past month for other medical reasons and that he has been declining both physically and cognitively the past few months. The POA revealed she was not aware of any weight loss, much less than 5% or greater. The POA stated she had not been in contact with the facility's Registered Dietitian (RD) with relation to risk for weight loss and nutritional parameters. The POA confirmed she would be the person to be notified of changes, and she had been notified in the past of other changes, just not related to weight loss.Review of the nurse progress notes and dietary assessments from 2/07/2026 through 2/25/2026 revealed the following: On 2/17/2026 an IDT care plan review was conducted, invite sent no attendance. Current medication reviewed; no changes required at this time. Resident's weight reviewed (181), weight loss noted. Significant changes or new concerns noted. Nutrition status assessed and continues to meet resident needs are being followed by wound care for left buttocks and left leg. Current plan of care remains appropriate and will be continued. Plan to be reviewed at next scheduled quarterly review or as clinically indicated.On 2/24/2026 a nutrition/dietary note revealed - Resident with additional wt. (weight) loss which warrants adjustment of tube feeding support increase at this time. Currently being provided with Jevity 1.5 at 75 ml/h for total daily volume infusion of 1500 mLs. daily along with 30ml Prostat 2x/day via Peg. Will continue to monitor and provide additional recommendations as indicated pending clinical course. On 2/27/2026 a nutrition/dietary assessment was completed by the Registered Dietitian which revealed - Resident #41 has had weight loss with new interventions to decrease weight loss and increase weight.The documentation did not show Resident #41's POA was made aware of the weight loss/significant weight loss.On 2/25/2026 at 9:15 a.m. an interview with the Registered Dietitian was conducted. The RD stated he had completed various admission/readmission (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105725	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elon Manor Nursing and Rehabilitation Center	1203 E 22nd Ave Tampa, FL 33605

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nutrition assessments for Resident #41 and that he had multiple hospitalizations. The Registered Dietitian confirmed Resident #41 was currently being monitored and cared for related to a significant weight loss and he had not spoken with nor attempted communication with Resident #41's POA related to the weight loss. The Registered Dietitian confirmed this would be a significant weight loss and the POA should have been notified.On 2/25/2026 at 10:00 a.m. an interview with the facility's Director of Nursing (DON) confirmed Resident #41 has had a significant weight loss within the past one month and that he has had multiple hospitalizations that could have contributed to losing weight. She stated the Registered Dietitian had been working with Resident #41 in order to increase his weight back in an upward trend and should have also contacted his POA with relation to the change of condition. The DON confirmed the POA should have been contacted of the significant weight loss. On 2/25/2026 at 4:00 p.m. an interview with the facility's Nursing Home Administrator (NHA) revealed she did not have a specific notification of change policy and procedure but confirmed anytime there is a change of condition to include a resident's significant weight loss, the health care representative is to be notified of the change.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105725	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elon Manor Nursing and Rehabilitation Center	1203 E 22nd Ave Tampa, FL 33605

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not ensure a clean and home-like environment in two resident rooms (103 and 201) out of 25 rooms observed, and in one shower room (West Unit) of two observed.Findings included: On 2/22/26 at 9:38 a.m., an observation of the floor in room [ROOM NUMBER], by the resident's bed and bedside table, revealed a cockroach crawling next to the call light located on the floor. On 2/22/26 at 12:18 p.m., an observation of room [ROOM NUMBER] revealed the floor, between the resident's bed and dresser, had a large hole with wood and unidentifiable material exposed, as well as pieces of tile missing. Further observations of room [ROOM NUMBER] revealed the area under the sink had a large hole, that exposed pipes and wood, and cracked tile pieces. The area under the sink revealed multiple pieces of painter's tape that separated from the wall and a clear, thin sheet of plastic material was covering approximately half of the hole. The room further revealed a white dresser located against the wall with a long-broken piece of wood that was separated from the bottom area. An observation of the area surrounding the air conditioning (a/c) unit by the window revealed wood that was eroded and multiple areas with missing paint leaving the wood underneath exposed and bare. On 2/23/26 at 9:30 a.m., an observation of the bathroom/shower room next to room [ROOM NUMBER] revealed the toilet seat as well as the bar underneath had multiple black spots on it. Further observations of the shower area showed a small ledge on the floor had missing tile that exposed hardened, unidentifiable material underneath.On 2/25/26 at 5:15 p.m., an interview with the Nursing Home Administrator (NHA) revealed the facility was completing renovations to include replacing floor surfaces and resident room furniture, re-painting resident room walls, and repairing windowsills and window frames. She said the renovations were completed on the first-floor resident rooms and halls, and currently the facility is working on replacing floors on the second floor. The NHA confirmed she did not have documentation to show when the renovation was identified, as well as purchase orders and timeframes of completion. She said she was not aware of any environment-related concerns in room [ROOM NUMBER].On 2/25/26 at 6:00 p.m., a follow-up interview was conducted with the NHA. She said she verified the concerns in room [ROOM NUMBER] to include the windowsill and window frame, paint that was peeled away from the window frame, the bottom of the dresser door in disrepair and the area under the sink. The NHA said the resident will move out of room [ROOM NUMBER] until the environmental issues are corrected. She said she was not aware of the resident bathroom/shower rooms with flooring and tile concerns and the black spots on the toilet seat. She said that was something the maintenance department and housekeeping should have identified and corrected. The NHA confirmed she was not aware of and did not have documentation of work orders submitted for room [ROOM NUMBER] and the one west bathroom/shower area. A review of the daily work routine for the housekeeper revealed the following: .7:30 AM - Clean 1E[east]/1W[west] Nurse Station, Bathrooms, Hoppers . (High/Low Dusting , sinks, counters, trash cans, baseboards, corner and edges, wall . 1:35 PM - Continue cleaning Bathrooms, Hoppers . A facility policy related to a clean and home-like environment was requested. The facility did not provide a policy. (Photographic Evidence Obtained)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105725	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elon Manor Nursing and Rehabilitation Center	1203 E 22nd Ave Tampa, FL 33605

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 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** Based on record review and staff interview, the facility failed to complete/update the Pre-admission Screening and Resident Reviews (PASARRs) for residents with a mental disorder and individuals with intellectual disability following qualifying mental health diagnoses for one resident (#5) of 52 residents reviewed for PASARRsFindings included:Review of the admission record showed Resident #5 was admitted to the facility on [DATE] with a primary diagnosis of dementia. Other diagnoses included Parkinsonism, mood disorder, depression, psychosis and cognitive communication deficit.Review of a level I PASARR for Resident #5 dated 9/11/25 revealed a completed Level I PASARR with qualifying diagnoses. The review showed the Level I PASARR was complete, and a level II was not submitted for consideration following qualifying diagnoses.During an interview on 2/25/26 at 12:46 p.m. Staff A, Social Service Director (SSD) said Resident #5 did not need a Level II PASARR because the resident is functioning, able to explain everything going on and not refusing psychology services. She said if a resident was refusing care, services, medications or trying to harm themselves would be indication for a PASARR Level II referral. The SSD confirmed mood disorder and psychosis are serious mental illness diagnosis and said Resident #5 is high functioning. Review of the facility's policy titled PASRR Pre-admission Screen and Annual Review, revised 7/13/25 showed the following:POLICY: It is the policy that all residents must have a PASRR Screen upon admission to [Name of Facility]. In addition, any residents who have been previously identified through the PASRR process as having Serious Mental Illness and/or Intellectual Disability and have experienced a significant change in status will then require a new Patient Review Instrument (PRI) and SCREEN. If triggered, a new Level II PASRR evaluation will be done.RESPONSIBLE PARTY: Social Services and Nurse Managers (RN)PROCEDURE: 1. Prior to admission, a PASRR Screen is completed from a qualified Screener. The SCREEN is placed in the medical record/resident's chart. If the resident had triggered for a Level II, the determination and/or Mental Health Evaluation Report become part of the medical record. A copy of the determination and/ or new Mental Health Evaluation Report is also kept in the Social Services office. 2. All residents who qualify for a Level II with Mental Illness will be referred to [State designated provider] .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105725	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elon Manor Nursing and Rehabilitation Center	1203 E 22nd Ave Tampa, FL 33605

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure activities of daily living (ADLs) related to nail care were provided for one resident (#9) out of three residents sampled.Findings included:On 02/22/2026 at 12:55 PM, Resident #9 was observed to have brown and red substances underneath the fingernails. Resident #9's fingernails were about half an inch past the fingertips.Review of Resident #9's medical record revealed diagnoses of cerebral infarction, unspecified, muscle weakness (generalized), hereditary and idiopathic neuropathy, unspecified, other lack of coordination, and acquired absence of left and right legs above knees.Review of Resident #9's medical record revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating cognitive function was intact with little to no memory or thinking impairment.A review of Resident #9's ADL sheets did not show documented refusals of personal hygiene care for the month of January 2026. The ADL sheets for the month of February 2026 were not provided for review.A review of Resident #9's shower assessment sheets for December 2025 and January 2026 revealed fingernails were clean and did not need to be clipped on 12/11/2025, 12/15/2025, and 01/08/2026. On 12/22/2025 and 12/25/2025, Resident #9's fingernails were clean and documentation showed, needed to be clipped.Review of Resident #9's care plan revealed a focus area for requiring substantial to total staff assistance for ADL care needs related to generalized weakness and bilateral above the knee amputation. The interventions implemented included - Allow rest period between tasks as per needs, assist resident with ADL care as needed, break tasks into smaller steps to encourage self-tasks, give verbal cues as per resident's needs, keep call light within reach, and physical therapy and occupational therapy as per resident's needs and orders.During an interview on 02/23/2026 at 1:45 PM, Staff N, Certified Nursing Assistant (CNA), stated the personal hygiene care typically provided to residents is changing briefs, feeding assistance, nail trimming in the morning or afternoon during showers, hair washing, or bathing. Staff N stated if a resident refused ADL or personal hygiene care, Staff N would tell the resident's nurse, and the nurse would make attempts to provide the care. Staff N stated having never trimmed Resident #9's nails. Staff N observed Resident #9's nails and stated they were long and stated an intention to provide nail care on 02/23/2026. Staff N said it was a CNA's responsibility to trim a resident's nails. An interview was conducted on 02/24/2026 at 12:28 PM with Staff O, CNA. The interview revealed Resident #9 does not have any known refusals of care. Staff O said nail care is often provided for residents on Sundays as a part of interactive activities and residents should be provided with personal hygiene care every day. Staff O said Resident #9's nails are observed throughout the shift but Resident #9 is often very fatigued after dialysis, and requests to delay persona hygiene care until the following day. Staff O stated CNAs documented showers and personal hygiene care on paper shower sheets. An interview conducted with Staff A, Registered Nurse (RN), on 02/24/2026 at 12:35 PM. Staff A said CNAs are responsible for incontinence and personal hygiene care. Staff A said Resident #9 required set up and assistance with personal hygiene care. Staff O said Resident #9's nails were observed and could be cleaned and clipped. Staff O said nail care should be documented and provided during showers. An interview conducted with the Director of Nursing (DON) on 02/24/2026 at 1:21 PM revealed all residents should be washed, receive oral care, and hair care every morning. The DON said CNAs should document the care they provided for a resident once per shift. The DON said the paper shower sheets are used to document a resident's behaviors, pain, skin condition, and grooming. The DON said paper shower sheets do not specifically document nail care. The DON said if a resident refused personal hygiene care, it should be documented and the nurse should be alerted. The nurse should then attempt to provide the resident with personal hygiene care and educate them on the importance of receiving personal hygiene care. The DON said she did not observe Resident #9's nails and was unsure of the history of refusals.The facility did not provide a policy and procedure for ADL care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105725	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elon Manor Nursing and Rehabilitation Center	1203 E 22nd Ave Tampa, FL 33605

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation record review and interview, the facility failed to ensure physician orders for oxygen were followed for one resident (#24) out of two residents sampled and failed to ensure the resident had physician orders for oxygen use for one resident (#54) out of two residents sampled.Findings included: 1. On 02/22/2026 at 12:00 PM, Resident #24 was observed to have an oxygen concentrator set to a four-liter (L) flow rate. Resident #24 said the concentrator was set to a flow rate of four or five.A review of Resident #24's medical diagnoses revealed chronic obstructive pulmonary disease (COPD), unspecified, COPD with (acute) exacerbation, acute and chronic respiratory failure with hypoxia, centrilobular emphysema.A review of Resident #24's order summary report revealed an order to check oxygen saturation levels as needed and oxygen at 2L (liters) per minute via nasal cannula every shift related to COPD with (acute) exacerbation.An interview with Staff N, Registered Nurse (RN) on 02/24/2026 at 12:43 PM revealed Resident #24 had orders for oxygen via nasal cannula set at a 2L flow rate for COPD. Staff N said the settings on Resident #24's oxygen concentrator were observed this morning at 2L, and the resident does not like the flow rate to be any higher due to comfort. On 02/24/2026 at 1:00 PM, Staff N observed that Resident #24's oxygen concentrator was set to a 4L flow rate. Staff N immediately adjusted the flow rate to 2L.An interview with the Director of Nursing (DON) on 02/24/2026 at 3:46 PM revealed there was an order for oxygen set at 2L for Resident #24. The DON said if staff notices an oxygen concentrator is not set to the flow rate that is ordered, they should immediately return the oxygen concentrator to the ordered flow rate and investigate how the concentrator was adjusted. The DON said that Resident #24 was alert and oriented and should have been able to explain how the oxygen concentrator became set to a flow rate that was different than the physician ordered flow rate. 2. On 02/22/2026 at 12:26 PM, Resident #54 was observed wearing a nasal cannula with an oxygen concentrator set at a flow rate of 3L. A review of Resident #54's order summary report dated 2/24/2026 revealed the resident did not have physician orders for oxygen. or a care plan for oxygen.A review of Resident #54's admission record revealed an admission date of 02/04/2026 with diagnosis to include pneumonia, unspecified organism, unspecified atrial fibrillation, heart failure and essential hypertension.An interview with Staff N, RN on 02/24/2026 at 12:54 PM revealed an inability to produce orders or a care plan related to oxygen therapy for Resident #54. Staff N said Resident #54's oxygen concentrator was set to a flow rate of 3L.Staff N, RN said Resident #54's orders needed to be corrected and then notified the DON. At 1:00 PM on 02/24/2026, Staff N observed Resident #54's oxygen concentrator was set to a flow rate of 3L.An interview was conducted with the DON on 02/24/2026 at 3:46 PM regarding the observation of Resident #54 wearing a nasal cannula in a photo taken by the facility. The DON stated they could not confirm or deny if Resident #54 was wearing a nasal cannula upon arrival to the facility. The DON said according to Resident #54's admission screening on 02/04/2026, the resident was admitted to the facility with hospital orders for oxygen set at a flow rate of 2L via nasal cannula and was not in any respiratory distress upon admission. The DON confirmed Resident #54's orders did not reveal an order for oxygen. The DON did provide paper orders for oxygen for Resident #54.A follow -up interview was conducted with the DON on 02/24/2026 at 3:46 PM. The DON stated a resident would not experience negative physiological effects as a result of receiving an oxygen flow rate that is higher than the physician ordered flow rate unless the flow rate is above 5L. The DON said that education should be provided to staff on duty to verify the settings on residents' oxygen concentrator during morning medication passes. Review of a facility policy titled, Oxygen Therapy, dated 1121/24 revealed - Ordering oxygen therapy is critical process that requires careful consideration of various factors. The healthcare provider must assess the resident's condition, including their oxygen levels and specific respiratory needs. The oxygen therapy is not a one-size-fits all approach. It must be tailored to each individual's needs. Monitoring oxygen is another crucial aspect of its management, regular monitoring allows healthcare providers to Assess the effectiveness of the treatment and make necessary (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105725	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elon Manor Nursing and Rehabilitation Center	1203 E 22nd Ave Tampa, FL 33605

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	adjustments. This involves checking the residents oxygen levels, observing their response to the therapy, and adjusting the oxygen. It's important to note that the goal of oxygen therapy is not just to increase oxygen levels in the blood but also to improve the residents overall health and quality of life.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105725	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elon Manor Nursing and Rehabilitation Center	1203 E 22nd Ave Tampa, FL 33605

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record reviews, and interviews the facility failed to ensure a medication error rate of less than 5.00%. Thirty-three medication administration opportunities were observed, and two errors identified for two (#49 and #92) of five residents observed. These errors constituted a 6.06% medication error rate.Findings Include:On 2/24/2026 at 11:15 a.m. an observation of medication administration with Staff B, Licensed Practical Nurse (LPN) conducted with Resident #49. Staff B, LPN performed HH, removed an Novolog FlexPen injector pen from the medications cart. She verified the insulin type/expiration, attach a new needle and turned the dosage dial to administer 4 units. Cleaned the insertion site with alcohol and let it dry and administered the medication.Review of Resident #49 medication orders revealed an order for Novolog FlexPen 100 unit/ml inject as per sliding scale: if 150-199 = 2 units; 200 - 249 = 4 units; 250 - 299 = 6 units; 300 - 349 = 8 units ; 350 - 399 = 10 units, subcutaneously with meals for Diabetes Mellitus (DM) greater than 400, please notify providerReview of the Novolog FlexPen manufacturer instructions for use show the following steps: 1. Check pen, 2. Attach a new needle, 3. Prime pen (turn the does selector to 2 units, press and hold the dose button, make sure a drop appears) 4. Select the dose, 5. Inject the dose .https://www.novonordisk.com/content/dam/nncorp/global/en/our-products/pdf/flextouch/FlexTouch-generic-inj retrieved on 2/26/2026.During an interview conducted after administering the medication, Staff B, LPN, said she was nervous and acknowledged that the insulin pen should be primed.On 2/24/26 at 8:51 a.m. an observation of medication administration with Staff F, Licensed Practical Nurse (LPN) was conducted with Resident #92. Staff F, LPN administered the following medications -Aspirin 81 mg -Midodrine Hydrochloride 5 mg-Roflumilast 500 mcg-Prednisone 10 mg-Bumetanide 1 mg -Allopurinol 100 mg-Potassium Chloride ER 20 milliequivalents (Meq)-Dapagliflozin 10 mg-Guaifenesin 600 Mg and Dextromethorphan 30mg tabletA review of Resident #92's order summary report dated 2/24/26, showed orders for the following medications:-Aspirin 81mg daily-Midodrine Hydrochloride 5 mg three times daily hold If systolic blood pressure Is greater than 130-Roflumilast 500 Mcg daily-Prednisone 10 mg daily-Bumetanide 1 mg daily-Allopurinol 100 mg daily-Potassium Chloride ER 20 Milliequivalents (Meq) daily-Dapagliflozin 10 mg daily-Guaifenesin ER 600 mg two times daily.On 2/25/26 at 8:20 a.m., during an interview, the Director of Nursing (DON) said new orders are received for over-the-counter medications, staff are required to notify the physician of any medications currently on hand and obtain a corresponding order. She said staff are expected to prime the insulin injector pen prior to administration. (Photographic Evidence Obtained).Review of facility policy titled Medication Administration Policy showed the following: POLICY: Medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication.PREPARATION: . 2.Prior to administration, the medication and dosage schedule on the MAR is compared with the medication label. If the label and the MAR are different the physician's orders are checked for correct dosage schedule.