| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105891 | A. Building<br>B. Wing | 11/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ybor City Center for Rehabilitation and Healing | 1709 Taliaferro Ave<br>Tampa, FL 33602 |

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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>37999<br><br>Based on observations, record reviews, and interviews the facility failed to ensure four (#5, #6, #9, and #10) residents of seventy-three had access to the call light system as evidence by call light pull strings were not within their reach.<br><br>Findings included:<br><br>On 11/7/24 at 9:30 a.m. Resident #5 was observed lying in bed wearing a hospital gown. The resident's head of bed was raised greater than 45 degrees. The observation revealed the resident's call light pull string was lying on the bedside dresser, which was pushed up against the wall behind and next to the resident's bed, the end of the cord was observed under boxes sitting on top of dresser. Photographic evidence was obtained.<br><br>On 11/7/24 at 9:30 a.m. Resident #6 was observed lying in bed, curled up and facing the door. The resident's call light pull string was at the resident's head of bed and dropped through the mattress holder onto the floor. The resident would have had to reach behind and above him to reach the cord/string.<br><br>An interview and observation was conducted with Staff B, Licensed Practical Nurse (LPN) on 11/7/24 at 9:39 a.m. The staff member confirmed Resident #5 and #6 could not reach their call light pull string/cords.<br><br>Review of the Admission Record for Resident #5 revealed the resident had diagnoses not limited to need for assistance with personal care, unspecified cataract, and mild dementia in other diseases classified elsewhere without behavioral disturbance, psychotic disturbance mood disturbance, and anxiety.<br><br>Review of the quarterly Minimum Data Set (MDS) for Resident #5 dated 8/12/24 showed a Brief Interview of Mental Status (BIMS) score of 13 of 15, which indicated intact cognition.<br><br>Review of the Admission Record for Resident #6 showed the resident had diagnoses not limited to need for assistance with personal care, Parkinson's disease without dyskinesia without mention of fluctuations, and unspecified severity unspecified dementia without behavioral disturbance, psychotic disturbance mood disturbance and anxiety.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the quarterly MDS for Resident #6 dated 7/1/24 showed a BIMS score of 6 of 15 which indicated severe cognition impairment.<br><br>On 11/7/24 at 10:00 a.m., Resident #9 was observed lying in bed with head of bed slightly raised. The observation revealed the resident's call light pull string/cord was lying on the floor behind the resident, near the wall. The end of it was wrapped around the bed control cord.<br><br>On 11/7/24 at 10:02 a.m. Resident #10 was observed lying with the head of the bed raised higher than 45 degrees. The call light pull string/cord was observed lying on the bedside dresser located to the side of the resident's bed and against the wall. The resident reported being blind and needing it.<br><br>On 11/7/24 at approximately 10:05 a.m. the Director of Nursing (DON) observed the location of Resident #9 and #10's call lights, confirming they were not within reach of the residents. The DON confirmed call light strings/cords should be within reach.<br><br>Review of the Admission Record for Resident #9 revealed the resident had diagnoses not limited to other lack of coordination, unspecified chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, and generalized muscle weakness.<br><br>Review of the Comprehensive MDS for Resident #9 showed a BIMS score of 13 of 15, which indicated intact cognition.<br><br>Review of the Admission Record for Resident #10 revealed the resident had diagnoses not limited to unspecified glaucoma, unspecified cataract, and unspecified severity unspecified dementia without behavioral disturbance, psychotic disturbance mood disturbance, and anxiety.<br><br>Review of the quarterly MDS for Resident #10 showed the resident's vision was severely impaired and the resident's BIMS score was 14 of 15 which indicated intact cognition.<br><br>Review of the facility's job description for Certified Nursing Assistant's showed the basic function was to provide routine daily nursing care and services that support the care delivered to patients/ residents requiring long-term or rehabilitative care, in accordance with the established nursing care procedures and as directed by your supervisor. The minimum performance standards showed patient/ resident call lights are promptly answered. Appropriate responses to requests are provided. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768<br><br>Based on observation, interview, and record review. the facility failed to provide Activities of Daily Living (ADLs) related to showering for two (#2, #4) of three residents sampled and related to incontinence care for two (#2, #3) of three residents sampled.<br><br>Findings included:<br><br>1. Review of Resident #2's Admission Record showed diagnoses included but not limited to acute respiratory failure with hypoxia, Urinary Tract Infection (UTI), Chronic Obstructive Pulmonary Disease (COPD), anemia, diabetes, hypertension, myocardium infarction sleep apnea, and muscle weakness.<br><br>Review of the admission Minimum Data Set (MDS) dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. Under Section GG - Functional Abilities showed the resident needed moderate assistance for toileting hygiene and maximal assistance for toilet transfer. Section O, Special Treatments, Procedures and Programs showed Occupational Therapy (OT) started on 10/14/2024 and Physical Therapy (PT) started on 10/12/2024.<br><br>Review of Resident #2's care plans showed a care plan for an Activities of Daily Living (ADL) self-care performance deficit related to that decline in health status. She was admitted from the hospital for respiratory failure with hypoxia, collapsed lung, COPD, obstructive sleep apnea, neoplasm of left lung, and obesity. She had a port to the right chest for chemotherapy. She was at risk for further decline secondary to muscle weakness and unsteadiness on feet. Skilled therapy is in progress as scheduled to improve level of function initiated on 10/17/2024. Interventions included but not limited to bathing / showering: provide sponge bath when a full bath or shower cannot be tolerated as of 10/17/2024; PT/OT evaluation and treatment as per MD orders date initiated 10/17/2024.<br><br>Review of a Care plan for Resident #2 revised on 10/17/2024 showed the resident was incontinent of bladder function related to impaired mobility, history of UTI and endometrial cancer. The resident was at risk for complications associated with incontinence and dehydration. The goal for the resident was to remain free from skin breakdown due to incontinence and brief use through the review date of 1/20/2025. Interventions included but were not limited to brief use: the resident uses adult disposable briefs. Check for incontinence change as needed initiated on 10/17/2024; clean Peri-area with each incontinence episode initiated on 10/17/2024; incontinent: check for incontinence. Wash rinse and dry perineum. Change clothing PRN after incontinence episodes initiated on 10/17/2024.<br><br>Review of the Documentation Survey Report for Bladder Elimination log for Resident #2 for dates 10/07/24 to 10/24/24 showed 29 out of 52 opportunities or 56% Bladder Elimination documentation was not documented.<br><br>Review of the Documentation Survey Report for ADL - Toilet Use log for Resident #2 dates 10/07/2024 to 10/24/2024, showed 34 out of 52 opportunities or 65% Toilet Use was not documented<br><br>Review of the 30 days look back Bath/Shower log for the month of October 2024 showed Resident #2 received only two showers on 10/12/2024 and 10/21/2024.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 11/07/2024 at 2:00 p.m., Staff A, CNA stated, You document providing incontinence care by pulling up assignment on the computer and it gives you options. Under toilet-use you document incontinence care was provided. The documentation shows if they are dependent or independent and if bladder care for incontinent or not. Staff A stated every shift should be documenting this information. Staff A verified that the documentation was not present on every shift. Staff A stated Resident #2 was to have showers 3 times a week or as requested. She was to have showers on Tuesday, Thursday, and Saturday on the 3 p.m. to 11 p.m. shift. Staff A verified Resident #2 received showers on the 12th and the 21st only. Staff A stated they should have documented she was refusing showers if she was. She confirmed documentation was not there. Staff A stated when the aide came in for their shift, they were given a shower sheet for the shift.<br><br>During an interview on 11/07/2024 at 3:45 p.m. with the DON, she stated there was to be documentation every shift from the CNAs. The CNA was to document ADL care. The DON stated the residents got showered three times a week, ideally, and could have more. The DON stated, If they want, we offer bed bath in the mornings. The residents were scheduled for showers 3 times a week. If a shower was not given, it should be documented as bed bath, if given. The DON stated there should be some documentation daily about bathing. If the resident refused a shower, they should notify the nurse and document refusal. The DON verified ADL care was not documented on Resident #2.<br><br>During an interview on 11/07/2024 at 4:20 p.m. with the Nursing Home Administrator (NHA) and Social Services Director (SSD), the NHA stated the DOR (Director of Rehabilitation) was out ill. The NHA verified incontinence care and showers documentation was missing. She stated the residents got showers three times a week and if refused it should be documented.<br><br>Review of an undated facility policy titled, Perineal Care, showed the purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident skin condition. Reporting and documentation: The following information should be reported to the staff / charge nurse and should be documented in the residence medical record. 1. The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. Any skin care problems noted. 7. If the resident refused the treatment and the reasons why. 8. The signature and title of the person recording the data.<br><br>2. Review of the Admission Record for Resident #3 showed diagnoses not limited to encounter for other orthopedic aftercare, presence of left artificial knee joint, and difficulty in walking not elsewhere classified.<br><br>Review of the Admission/Readmission Screening/History evaluation for Resident #3 dated 11/01/2024 revealed Resident #3 was admitted for rehab, was alert and oriented x 4, spoke Spanish. The form did not show the resident was incontinent of bladder (urine) or of bowel and had steri-strips on left leg and was able to bear weight to this extremity. The ADL evaluation revealed bed mobility, transfers, walking, locomotion, and toilet use was not assessed and for dressing, personal hygiene and bathing the resident required assistance of staff.<br><br>Review of a Continence Evaluation for Resident #3 dated 11/01/2024 showed under mobility status, the resident required assist with transfer/standing. Under Bladder, the assessment showed the perception of the need to void was present, able to tell of need to void, did not wear a pad to keep undergarments clean, and was continent of urine. The evaluation for bowel function had not been completed.<br><br>(continued on next page) |

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of the Physical Therapy (PT) evaluation and Plan of Treatment, with a start of care date of 11/02/2204 showed Resident #3's baseline was partial/moderate assist for chair/bed-to-chair transfers, lying to sitting on side of bed, was weight bearing as tolerated status post (s/p) left knee total arthroplasty. The Functional Mobility Assessment showed a toilet transfer had not been attempted due to medical conditions or safety concerns, with partial/moderate assistance resident could walk 10 feet, with substantial/maximal assistance could walk 50 feet with 2 turns, and used a manual wheelchair or scooter. The reason for therapy showed the patient presented with balance deficits, strength impairments, pain, (and) postural alignment/control and decreased dynamic balance.

Review of Resident #3's Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form, dated 10/31/24 showed the resident was weight-bearing as tolerated (WBAT) with a walker.

Review of the November 2024 Documentation Survey Report for ADL - Toilet Use log for Resident #3 did not show any bladder or bowel elimination during the 3 p.m. - 11 p.m. shift on 11/01/2024 or 11/02/2024 or on the 11 p.m. - 7 a.m. shift on 11/01/2024 or 11/02/2024. The record did not show the resident received any assistance for toilet use during the period of 3 p.m. to 7 a.m. on 11/01/2024 or 11/02/2024 or if the resident had been incontinent/continent of bowel and/or bladder during those same shifts.

An interview was conducted on 11/07/2024 at 12:19 p.m. with the Director of Rehabilitation (DOR). The DOR stated the facility generally knew who was coming in/(admitted ) and new admissions were evaluated the next day. The DOR stated residents who had a total knee replacement should be evaluated, but staff did not necessarily have to wait for residents to be evaluated if they had already been receiving PT in the hospital, if they had documentation from the hospital, and were continent and wanted to get up for the bathroom.

An interview was conducted on 11/7/24 at 2:10 p.m. with Staff A, CNA/Medical Records. The staff member reported CNAs enter documentation in the electronic record. Staff A said they logged into the resident's name, pull up the assignment, bowel and bladder elimination should be under toilet use. Staff A stated staff would document the resident's performance, if they were continent/incontinent, and they should document every shift as to what type of care they provided to the resident. Staff A reviewed the CNA documentation for Resident #3 and confirmed the resident had not received assistance from staff during five of seven shifts.

During an interview on 11/07/2024 at 3:44 p.m., the Director of Nursing (DON) reported Resident #3 was not at the facility very long, was Spanish-speaking but thought the resident was able to understand a little English. The staff member reported CNAs should document every shift anything that fell under the plan of care (POC). The DON stated she did not know whether the resident was continent or incontinent and reported she had worked the cart during the 11 p.m. - 7 a.m. shift on 11/02/2024 (Saturday into Sunday morning).

3. On 11/7/24 at 12:05 p.m., Resident #4 was observed sitting on edge of bed, wearing a hospital gown, eating the noon meal. The resident reported not being bathed since getting to the facility.

Review of the Admission Record for Resident #4 showed the resident was admitted with diagnoses included but not limited to generalized muscle weakness, unspecified altered mental status (AMS), unsteadiness on feet, and unspecified severity unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the admission Minimum Data Set (MDS) for Resident #4 dated 9/17/24, showed a Brief Interview of Mental Status (BIMS) score of 11 of 15, which indicated a moderate impairment of cognition. The review of section F0800 Staff Assessment of Daily and Activity Preferences, showed the resident preferred to receive showers and bed baths.<br><br>Review of the care plan for Resident #4 showed a focus revised on 09/23/2024, the resident required total assistance with Activities of Daily Living (ADLs), transfers, and bed mobility related to (r/t) muscle weakness, AMS (Altered Mental Status), cerebral vascular accident (CVA) with poor prognosis, and impaired mobility. Skilled therapy is ongoing to improve level of function. The interventions included instructions for CNAs to assist with bathing, dressing, personal hygiene daily and as needed (prn).<br><br>Review of the 100 & 200 Hall Shower List showed Resident #4 was to receive showers on Tuesday, Thursday, and Saturdays during the 11 p.m. - 7 a.m. shift. The schedule instructed CNAs to provide showers as scheduled (and as needed (prn)) and sign after each shower is given.<br><br>Review of the September 2024 Documentation Survey Report for ADL - Bathing log for Resident #4 showed the resident received three bed baths on 09/10/24, 09/11/2024 and 09/25/2024. The record showed the resident missed 6 shower/bath opportunities. The documentation did not reveal the resident had any other bathing type (shower) during the month of September 2024.<br><br>Review of the October 2024 Documentation Survey Report for ADL - Bathing log for Resident #4 showed the resident had not received any showers and had received five bed baths. The record showed the resident missed 10 shower/bath opportunities. The documentation did not reveal the resident had any other bathing type (shower) during the month of October 2024.<br><br>Review of the November 2024 CNA documentation for Resident #4 bathing task showed the resident had missed a shower/bath on 11/05/2024. The documentation revealed self-performance (how (the) resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (excludes washing of back and hair) was NA = not applicable.<br><br>An interview was conducted on 11/07/24 at 2:24 p.m. with Staff A, CNA. The staff member reported Resident #4 was to receive a bath three times a week. Staff A reviewed the CNA documentation for November and confirmed the resident had missed a bath/shower on the previous Tuesday.<br><br>An interview was conducted on 11/07/2024 at 3:44 p.m. with the DON. The DON stated residents could shower when they want, and the facility scheduled showers three times a week and bed baths daily. She stated she knew Resident #4, and the resident could answer yes or no questions appropriately. The DON stated staff should document a resident's refusal (of care).<br><br>Review of the Documentation Survey Report for ADL - Bathing log for Resident #4 from 09/10/2024 to 11/06/2024 did not show the resident had refused any bathing/showering.<br><br>Review of the Certified Nursing Assistant (CNA) job description showed the basic function was To provide routine daily nursing care and services that support the care delivered to patients/ residents requiring long-term or rehabilitative care, in accordance with the established nursing care procedures and directed by your supervisor. The essential functions included:<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1. Provides care as directed by the professional nurse to patients/ residents requiring long-term, rehabilitative care or restorative care.<br><br>3. Documents objective information related to patient/resident care.<br><br>4. Provides services that support the care delivered to the patient/ resident.<br><br>10. Performs other related duties as assigned or requested.<br><br>Review of an undated facility policy titled, Restorative Nursing - ADL's assistance (Bathing, Dressing, and Grooming), revealed The facility will provide restorative programming to assist residents in attaining and maintaining the highest practicable level of function. A resident/patient will be eligible for restorative ADL programming if he/she demonstrates interest in improving or participating in self-performance of activities of daily living and requires skill practice and/or training and dressing, bathing, or grooming. The policy revealed the following under documentation:<br><br>1. All entries on charts, notes, flow sheets, etc. (etcetera), are recorded in an informative and descriptive manner.<br><br>5. Nursing care flow sheet (if applicable) is maintained.<br><br>37999 |

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| F 0825<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or get specialized rehabilitative services as required for a resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768<br><br>Based on interview and record review, the facility failed to provide therapy services in a timely manner for one (#2) of three sampled residents.<br><br>Findings included:<br><br>1. Review of the Admission Record for Resident #2 showed she was admitted to the facility on ,d+[DATE] with diagnoses included but not limited to acute respiratory failure with hypoxia, Urinary Tract Infection, Chronic Obstructive Pulmonary Disease (COPD), myocardial infarction, and muscle weakness.<br><br>Review of the admission Minimum Data Set (MDS) dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. Section GG Functional Abilities showed she needed moderate assistance for toileting hygiene and maximal assistance for toilet transfer. Section O, Special Treatments, Procedures and Programs showed Occupational Therapy (OT) started on 10/14/2024 and Physical Therapy (PT) started on 10/12/2024.<br><br>Review of the Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form dated 10/7/24, showed treatments and frequency:<br><br>PT 5 times a week<br><br>OT 5 times a week<br><br>Ambulates with assistive device (4 wheeled bariatric walker) and required assistance with transfers<br><br>Review of the physician orders showed<br><br>Therapy: Physical Therapy to evaluate and treat as indicated as of 10/12/20204<br><br>Therapy: Occupational Therapy to evaluate and treat as indicated as of 10/14/20204<br><br>Physical Therapy clarification order: 5 times a week for 4 weeks for unsteadiness on feet, weakness, with focus on therapeutic activity, therapeutic exercise, neuromuscular re-education, gait training, group treatment / concurrent /individual whichever is applicable and discharge planning as of 10/12/2024.<br><br>Occupational Therapy clarification order, 5 times a week for 4 weeks for weakness with focus on therapeutic activity, therapeutic exercises, neuromuscular re-education, and self-care training, group treatment / concurrent /individual whichever is applicable and discharge planning as of 10/14/2024.<br><br>Review of the APRN (Advanced Practice Registered Nurse) note written on 10/08/2024 showed Assessment / Plan included Physical deconditioning: admit to SNF, Continue PT/OT as indicated, Fall precaution, Skin assessment per facility protocol and Supportive care; ADL assistance.<br><br>(continued on next page) |

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| F 0825<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the PT evaluation dated 10/12/24 showed the reason for therapy: based on examination pt's body regions, systems and structures, patient presents with balance deficits, strength impairments, unilateral weakness, pain, proximal instability, body awareness deficits and gross motor coordination deficits and in consideration of history, personal factors, and functional limitations documented in this eval summary, patient requires skilled PT services to increase LE ROM (Lower Extremity range of motion) and strength, increase independence with gait, increase functional activity tolerance, facilitate independence with hall functional mobility and enhance rehab potential, in order to safely return home, decrease level of assistance from caregivers and facilitate safe transition to next level of care. Due to the documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient is at risk for pneumonia, limited out of bed activity, falls, immobility, decreased skin integrity, anxiety and pulmonary insufficiency.<br><br>Review of the OT evaluation dated 10/14/2024 showed clinical impressions / reason for skilled services: patient exhibits new onset of fall / fall risk, reduced dynamic balance, reduced static balance and reduced ADL participation: patient is a [AGE] year old female who has admitted to ED (Emergency Department) after suffering a fall. Patient has also collapsed lung and COPD. Patient presents to current facility with aforementioned deficits and could benefit from skilled services at this time.<br><br>Review of Resident #2's care plans showed a care plan that the resident was a new admission to the facility and was here for short term rehab therapy and plans to discharge back to home when able with home health services, if indicated initiated on 10/18/24. The goal was for the resident to attend therapy as scheduled and participate in the treatment program to enable discharge back to home with a target date of 01/2025. Interventions included but not limited to encourage resident to attend therapy to regain strength as of 10/18/2024.<br><br>The Care plan showed: resident denied history of fall prior to admission. She was at risk for falls related to muscle weakness, unsteadiness on feet as of 10/17/2024. Interventions included but not limited to PT evaluate and treat as ordered or PRN (as needed) as of 10/17/2024.<br><br>During an interview on 11/07/2024 at 12:19 p.m., the Director of Rehabilitation (DOR) stated Resident #2 had therapy, PT and OT. The DOR reviewed the evaluations, for PT on the 10/12/2024, and OT on the 10/14/2024. DOR stated she made the schedules but was out ill. DOR stated it was possible Resident #2 was missed, she could not say. The DOR stated the normal time frame for evaluating a new resident was the next day in the p.m. She stated she had a PRN therapist which worked in the evening and did the evaluations. The DOR stated she had a PRN therapist in the evening and a part-time therapist that came in during the day. She stated mainly in the p.m. The DOR stated residents were normally evaluated the next day (after admission). The DOR stated, unless (admission) was on the weekend, if I can get a therapist to come in on the weekend. I have COTAS (Certified Occupational Therapy Assistant[s]) and a stand-by therapist for the weekend, not routinely. DOR stated, I was not here, the regional may have been covering. I did not have anyone covering for me. Generally, what happens I know ahead of time for a 'total knee' and will schedule ahead of time. I would say we slipped through the cracks with it. The DOR verified the physician orders. The DOR stated, Under Medicare guidelines it (evaluation) should be within 48 hours. I had a therapist here on the 12th and they noticed she (Resident #2) was not on the schedule. The DOR stated the negative outcome for not receiving therapy during that timeline, don't know, she should have been seen more timely.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105891 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/07/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ybor City Center for Rehabilitation and Healing | 1709 Taliaferro Ave<br>Tampa, FL 33602 |

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

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| F 0825<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/07/2024 at 3:45 p.m. with the DON. When asked if it was acceptable for a resident to go 5 days without ordered therapy, the DON stated, she was not a therapist. She did not put anyone in charge while she (DOR) was gone. When asked as the DON was it acceptable to her for a resident to not get ordered therapy timely? She stated, I understand what you are getting at, and exited the interview.<br><br>During an interview on 11/07/2024 at 4:20 p.m. with the Nursing Home Administrator (NHA) and Social Services Director (SSD), the NHA stated the DOR typically scheduled while she was out. The NHA stated they only had therapy which work with us part time. The NHA stated, When she (DOR) was out, the NHA covers or regional comes and helps. The NHA stated she was not aware Resident #2 did not get her therapy for 5 days.<br><br>Review of the facility's policy, Therapy: Physician Orders, not dated showed therapy services require physician orders validated by therapists prior to initiating therapy services and for any interventions. The licensed therapist may request written or verbal orders. Additional circumstances if there is a physician order for evaluation, and in order to trade must be obtained. Components of the order 1. Specific description of services being ordered. 2. Treatment orders to include the following frequency, duration, treatment interventions and modes of treatment; 3. Ensure steps were taken based on EHR to ensure validation have orders by the physician or NPP. |

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| NAME OF PROVIDER OR SUPPLIER: Ybor City Center for Rehabilitation and Healing | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1709 Taliaferro Ave Tampa, FL 33602 | |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999<br><br>Based on observation, record review. and interview. the facility failed to maintain the medical record of one (#3) of three residents sampled in an appropriate manner related to complete and accuracy of the records.<br><br>Findings included:<br><br>Review of the Admission Record for Resident #3 showed the resident was admitted on [DATE] following a hospital stay. The Admission Record revealed diagnoses not limited to presence of left artificial knee joint, unilateral primary osteoarthritis of left knee, difficulty in walking not elsewhere classified, unspecified anxiety disorder, and recurrent unspecified major depressive disorder. The record revealed the resident's primary language was English.<br><br>Review of the Nursing Admission/ Readmission Screening/ History, effective 11/1/2024 at 12:04 p.m. for Resident #3 revealed the other language spoken by resident #4 was Spanish. The screening did not reveal the resident spoke English.<br><br>Review of the Continence Evaluation for Resident #3 showed the resident was oriented x 3 (person, place, and time) for cognition and required assistance with transfers/standing. The evaluation revealed the resident was continent of bladder and the bowel assessment was not completed.<br><br>Review of the Certified Nursing Assistant (CNA) documentation for Resident #3 showed no documentation had been completed for the resident's Activities of Daily Living (ADLs) during the 3 p.m. - 11 p.m. shift on 11/1 and 11/2, and the 11 p.m. - 7 a.m. shift on 11/1/ and 11/2/24.<br><br>Review of the progress notes for Resident #3 showed no nursing documentation was completed for the resident from 11/1 at 8:06 p.m. to 11/3/24 at 1:11 p.m. The record did not include any skilled nursing or progress notes for 11/2/24. The one note on 11/3/24 revealed a family member had requested to take resident home Against Medical Advice (AMA), this writer notified the MD on call Services and left voicemail to return call to our facility. The family member (who was not listed as the responsible party or Emergency Contact) signed the AMA paperwork. The record did not reveal if the physician had returned the call, if the Director of Nursing and/or Administrator had been contacted, or if any conversation had happened between the resident, family member, and staff member(s).<br><br>Review of the facility's Grievance/Concern log for November 2024 revealed no concerns had been voiced by either a resident of the facility or a resident representative.<br><br>Review of the facility's Incident logs for November 2024 did not reveal Resident #3 had an incident at the facility.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105891 | A. Building<br>B. Wing | 11/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ybor City Center for Rehabilitation and Healing | 1709 Taliaferro Ave<br>Tampa, FL 33602 |

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

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/7/24 at 3:44 p.m., the Director of Nursing (DON) revealed Resident #3 had not been in the facility very long. She stated she had worked the cart on the 11 p.m. - 7 a.m. shift, Saturday to Sunday on 11/2/24. The DON reported Resident #3 seemed to be pleasant, did not ask for much, CNAs offered water, and asked if changing was needed. The DON stated she had given the resident medications during the shift but could not remember which ones. The DON reported not knowing why the resident had left AMA, however had asked the nurse and was told the resident or family believed there was going to be a Spanish-speaking staff member 24 hours a day to translate for the resident. She stated she believed the resident could understand a little English.<br><br>An interview was conducted on 11/7/24 at 4:20 p.m. with the Nursing Home Administrator (NHA) and Social Services Director (SSD). The SSD reported not being at the facility from 10/18 to 11/4/24 and had a lot piled up. She reported she would not have made a follow up call to Resident #3, the Risk Manager (RM) would have. The NHA reported the RM was let go on Monday (11/4) and a new one started on 11/5/24. The NHA reviewed the progress notes and evaluations confirming there was no note or evaluation completed for Resident #3 on 11/2/24 and there should be a skilled nursing note. The NHA read the note on 11/3/24 regarding Resident #3's AMA discharge and stated it was a pretty generic note.<br><br>An interview was conducted on 11/7/24 at 4:58 p.m. with the NHA and DON. The NHA reported the facility did not have a skilled nursing policy and the DON stated it would be a follow physician orders policy. |