STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105891	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ybor City Center for Rehabilitation and Healing	1709 Taliaferro Ave 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to honor a residents right to refuse medications for one resident (#2) out of four residents sampled. Findings included: During an observation on 06/09/2025 at 10:40 a.m., Resident #2 was observed dressed for the day sitting in a wheelchair on the back patio. Review of Resident #2's admission record revealed an admission date of 03/25/2025. Resident #2 was admitted to the facility with diagnoses to include vascular dementia, unspecified severity, with other behavioral disturbance, unspecified psychosis not due to a substance or known physiological condition, and major depressive disorder, recurrent, moderate. Review of Resident #2's admission Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 03 out of 15, indicating severe cognitive impairment. Review of Resident #2's Care Plan, dated 04/01/2025, revealed the following: Focus: The resident has a behavior problem related to refusing to allow vital signs to be taken, refusing medications at times, throwing plate up against the wall and combative during care diagnosis: Dementia Goal: The resident will have no evidence of behavior problems of resisting vital signs, medication and care by review date Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness, explain all procedures to the resident before starting and allow the resident time to adjust to changes, If resident resists care, leave and return later to try again, and Psych (psychiatric) eval as needed. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: Resident #2 has impaired communication secondary to dementia. She sometimes understands others, and sometimes expressing ideas and wants, she has disorganized thinking. She is at risk for missing communication r/t impaired cognition. Goal: The residents will maintain current level of communication function through the review date. Interventions: Anticipate and meet needs, communication: Allow adequate time to respond, Repeat as necessary, Do not rush, Request clarification from the resident to ensure understanding, Face when speaking, make eye contact, Turn off TV/radio to reduce environmental noise, Ask yes/no questions if appropriate, Use simple, brief, consistent words/cues, Use alternative communication tools as needed, Refer to speech therapy for evaluation and treatment as ordered. Speak on an adult level, speaking clearly and slower than normal. Focus: Resident #2 has impaired cognitive function/dementia or impaired thought processes r/t Dementia short- and long-term memory loss and is moderately impaired in decision making. Unaware of where about's Goal: Resident #2 will be able to communicate basic needs on a daily basis through the review date. All of resident needs will be met and anticipated by staff Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Ask yes/no questions in order to determine the resident's needs, communicate with the resident/family/caregivers regarding residents capabilities and needs. Cue, reorient and supervise as needed. Discuss concerns about confusion, disease process, nursing home placement with resident/family/caregivers). Explain all procedures. Use simple, one-word requests if possible. Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Observe for signs of frustration and anxiety and change activity if observed. If the resident is having an episode of anxiety or agitation, gently attempt to calm resident and refocus attention. Provide cueing and prompting for personal care. Review of Resident #2's Psych Note, dated 06/05/2025, revealed the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.female with a history psychotic disorder, dementia and comorbid stroke currently overall at baseline in terms of her mood and behaviors. Nursing reports resident can be resistive to care at times. Resident with an expressive aphasia with resultant difficulty communicating. Nursing reports that a nurse pinched her nose in the process of medications administration to encourage the patient to take her medication. This was witnessed and reported. The medication nurse admitted the incident. Patient noted having no change in her mood and behaviors after the incident. Met with the resident in her room. She is awake and alert to person. Difficult to fully assess her cognition due to her aphasia. She does respond appropriately to most yes/no questions, other times appears confused. She shakes her head yes within asked if she is comfortable with her care partners and in the facility. She shakes her head no when asked if she feels depressed. She denies urgent concerns. Physically the patient appeared their stated age, awake and alert. Emotionally the patient appeared calm and less guarded. The patient showed no signs of psychomotor agitation, retardation or bizarre behavior. The patient presented with non-fluent speech. Mood was normal. During an interview on 06/09/2025 at 2:07 p.m., Staff B, Certified Nursing Assistant (CNA) stated she was helping Staff C, CNA provide care to Resident #2. She stated, while providing care Staff D, Licensed Practical Nurse (LPN) came in Resident #2's room to give Resident #2 her medications. She stated, the first time Staff D, LPN gave the medication to Resident #2 she spit it out. She stated, the nurse tried again, and Resident #2 spit the medication out again. Staff B stated, the third time Staff D, LPN left the room and came back with a syringe, and while giving Resident #2 the medication from the syringe the nurse held Resident #2's nose and mouth closed until Resident #2 swallowed the medication. Staff B stated, Resident #2 kept saying, I don't want it, I don't want it. [Staff D, LPN] told us you don't need to go tell on me because I'm going down there myself. I told [Staff C, CNA] if you ever get a chance to be a nurse do not do that because that is abuse. During an interview on 06/09/2025 at 2:59 p.m., Staff C, CNA, stated she was in Resident #2's room getting her ready to give her a bath. Resident #2 looked a little agitated, so I asked Staff D, LPN to give her something. Staff D, LPN left the room and returned with medication for Resident #2. The first time Staff D, LPN gave Resident #2 the medication with a spoon and Resident #2 spit it out. Staff D, LPN tried again with the medication on the spoon and Resident #2 spit it out again. Staff D, LPN said Wait don't touch her I have something for her. Staff D, LPN left the room and came back with a syringe. When she gave Resident #2 the medication this time, She held Resident #2's nose and mouth closed. Staff D, LPN told me that's how I get my kids to take their medicine. During a phone interview on 06/09/2025 at 4:27 p.m., Staff D, LPN stated last Monday (06/02/2025), she walked into give Resident #2 her morning medication and saw Staff C, CNA holding Resident #2's hands and wrestling with the resident. She told Staff C, CNA she had Resident #2's medications. Resident #2 takes her medication crushed with pudding. She tried giving Resident #2 the crushed medication and pudding twice and Resident #2 spit it out both times. She left the room and mixed what was left in the medicine cup with water and put it in a syringe. I gave her the medication with the syringe and held her nose so that she would swallow the medication. I did not do it maliciously. [Resident #2] has a history of being combative when she does not get her medicine. That is the reason she is on the medications. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/10/2025 at 12:30 p.m., the Director of Nursing (DON) stated neither Staff B, CNA or Staff C, CNA reported to her Resident #2 was being combative at the time of the incident. When the CNA's notified her of the incident, she immediately removed the nurse from the assignment. She stated, if a resident is refusing their medications nurses should try to redirect the resident or try to notify family. Resident families can get them to take their medications. She said the resident ultimately has the right to refuse and it is even more important for the residents who are not alert and oriented for those rights to be honored. Review of the facilities undated policy titled Resident Rights revealed the following: .A. Resident rights. The resident has a right to a dignified existence, self-determination, and communication with and access to people and services inside and outside the facility, including those specified in this section. 1. A facility must treat each resident with respect and dignity and care for each resident in a manner of and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident B. Exercise of rights. The resident has the right to exercise his or her rights as a resident of the facility and a citizen or resident of the United States. 1. The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed protect a residents right to be free from abuse for one resident (#2) out of four residents sampled. Findings included: During an observation on 06/09/2025 at 10:40 a.m., Resident #2 was observed dressed for the day sitting in a wheelchair on the back patio. Review of Resident #2's admission record revealed an admission date of 03/25/2025. Resident #2 was admitted to the facility with diagnoses to include vascular dementia, unspecified severity, with other behavioral disturbance, unspecified psychosis not due to a substance or known physiological condition, and major depressive disorder, recurrent, moderate. Review of Resident #2's admission Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 03 out of 15, indicating severe cognitive impairment. Review of Resident #2's Care Plan, dated 04/01/2025, revealed the following: Focus: The resident has a behavior problem related to refusing to allow vital signs to be taken, refusing medications at times, throwing plate up against the wall and combative during care diagnosis: Dementia Goal: The resident will have no evidence of behavior problems of resisting vital signs, medication and care by review date Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness, explain all procedures to the resident before starting and allow the resident time to adjust to changes, If resident resists care, leave and return later to try again, and Psych (psychiatric) eval as needed. Focus: Resident #2 has impaired communication secondary to dementia. She sometimes understands others, and sometimes expressing ideas and wants, she has disorganized thinking. She is at risk for missing communication r/t impaired cognition. Goal: The residents will maintain current level of communication function through the review date. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions: Anticipate and meet needs, communication: Allow adequate time to respond, Repeat as necessary, Do not rush, Request clarification from the resident to ensure understanding, Face when speaking, make eye contact, Turn off TV/radio to reduce environmental noise, Ask yes/no questions if appropriate, Use simple, brief, consistent words/cues, Use alternative communication tools as needed, Refer to speech therapy for evaluation and treatment as ordered. Speak on an adult level, speaking clearly and slower than normal. Focus: Resident #2 has impaired cognitive function/dementia or impaired thought processes r/t Dementia short- and long-term memory loss and is moderately impaired in decision making. Unaware of where about's Goal: Resident #2 will be able to communicate basic needs on a daily basis through the review date. All of resident needs will be met and anticipated by staff Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Ask yes/no questions in order to determine the resident's needs, communicate with the resident/family/caregivers regarding residents capabilities and needs. Cue, reorient and supervise as needed. Discuss concerns about confusion, disease process, nursing home placement with resident/family/caregivers). Explain all procedures. Use simple, one-word requests if possible. Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Observe for signs of frustration and anxiety and change activity if observed. If the resident is having an episode of anxiety or agitation, gently attempt to calm resident and refocus attention. Provide cueing and prompting for personal care. Review of Resident #2's Psych Note, dated 06/05/2025, revealed the following: .female with a history psychotic disorder, dementia and comorbid stroke currently overall at baseline in terms of her mood and behaviors. Nursing reports resident can be resistive to care at times. Resident with an expressive aphasia with resultant difficulty communicating. Nursing reports that a nurse pinched her nose in the process of medications administration to encourage the patient to take her medication. This was witnessed and reported. The medication nurse admitted the incident. Patient noted having no change in her mood and behaviors after the incident. Met with the resident in her room. She is awake and alert to person. Difficult to fully assess her cognition due to her aphasia. She does respond appropriately to most yes/no questions, other times appears confused. She shakes her head yes within asked if she is comfortable with her care partners and in the facility. She shakes her head no when asked if she feels depressed. She denies urgent concerns. Physically the patient appeared their stated age, awake and alert. Emotionally the patient appeared calm and less guarded. The patient showed no signs of psychomotor agitation, retardation or bizarre behavior. The patient presented with non-fluent speech. Mood was normal. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/09/2025 at 2:07 p.m., Staff B, Certified Nursing Assistant (CNA) stated she was helping Staff C, CNA provide care to Resident #2. She stated, while providing care Staff D, Licensed Practical Nurse (LPN) came in Resident #2's room to give Resident #2 her medications. She stated, the first time Staff D, LPN gave the medication to Resident #2 she spit it out. She stated, the nurse tried again, and Resident #2 spit the medication out again. Staff B stated, the third time Staff D, LPN left the room and came back with a syringe, and while giving Resident #2 the medication from the syringe the nurse held Resident #2's nose and mouth closed until Resident #2 swallowed the medication. Staff B stated, Resident #2 kept saying, I don't want it, I don't want it. [Staff D, LPN] told us you don't need to go tell on me because I'm going down there myself. I told [Staff C, CNA] if you ever get a chance to be a nurse do not do that because that is abuse. During an interview on 06/09/2025 at 2:59 p.m., Staff C, CNA, stated she was in Resident #2's room getting her ready to give her a bath. Resident #2 looked a little agitated, so I asked Staff D, LPN to give her something. Staff D, LPN left the room and returned with medication for Resident #2. The first time Staff D, LPN gave Resident #2 the medication with a spoon and Resident #2 spit it out. Staff D, LPN tried again with the medication on the spoon and Resident #2 spit it out again. Staff D, LPN said Wait don't touch her I have something for her. Staff D, LPN left the room and came back with a syringe. When she gave Resident #2 the medication this time, She held Resident #2's nose and mouth closed. Staff D, LPN told me that's how I get my kids to take their medicine. During a phone interview on 06/09/2025 at 4:27 p.m., Staff D, LPN stated last Monday (06/02/2025), she walked into give Resident #2 her morning medication and saw Staff C, CNA holding Resident #2's hands and wrestling with the resident. She told Staff C, CNA she had Resident #2's medications. Resident #2 takes her medication crushed with pudding. She tried giving Resident #2 the crushed medication and pudding twice and Resident #2 spit it out both times. She left the room and mixed what was left in the medicine cup with water and put it in a syringe. I gave her the medication with the syringe and held her nose so that she would swallow the medication. I did not do it maliciously. [Resident #2] has a history of being combative when she does not get her medicine. That is the reason she is on the medications. During an interview on 06/10/2025 at 12:30 p.m., the Director of Nursing (DON) stated neither Staff B, CNA or Staff C, CNA reported to her Resident #2 was being combative at the time of the incident. When the CNA's notified her of the incident, she immediately removed the nurse from the assignment. She stated, if a resident is refusing their medications nurses should try to redirect the resident or try to notify family. Resident families can get them to take their medications. She said the resident ultimately has the right to refuse and it is even more important for the residents who are not alert and oriented for those rights to be honored. Review of the facilities undated policy titled Abuse Neglect Exploitation And Misappropriation revealed the following: Policy: It is the policy of this facility to take appropriate steps to prevent abuse (be it verbal, sexual, physical, or mental), neglect, exploitation and misappropriation and the occurrence of an injury of an unknown source, and to ensure that all alleged violations of federal and or state laws are reported immediately to the administrator, the risk manager, the social service director, and the director of nursing.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record review, the facility failed to ensure medications were properly stored and secured on two units (300 and 400) out of four units in the facility. Findings included: An observation was conducted on 6/9/25 at 9:25 a.m. at the 400-unit nurses' station. The door to the nurses' station was open, no staff were in sight, and the medication refrigerator in the station was observed to be unlocked. There were floor to ceiling cabinets next to the refrigerator that were also unlocked, and the top cabinet was full of over-the-counter (OTC) medications. The medications were accessible to residents, visitors, or unlicensed staff. An observation was conducted on 6/9/25 at 9:32 a.m. in the 300-unit common area. There was a treatment cart sitting in the resident common area unlocked. No staff were in sight at the time. The treatment cart was observed to contain prescription medications and wound care supplies. A follow-up observation was conducted on 6/9/25 at 12:46 at the 400-unit nurses' station. The medication refrigerator and cabinet with the OTC medications remained unlocked. The nurses' station door was open, and a resident was sitting just outside the door with no staff members in sight. An observation and interview was conducted on 6/9/25 at 3:15 p.m. with Staff A, Licensed Practical Nurse (LPN). The medication refrigerator and cabinet at the 400-unit nurses' station remained unlocked. Staff A was sitting at the nurses' station and confirmed she was the nurse working on the 400 unit from 7:00 a.m. to 3:00 p.m. Staff A said a nurse had just gotten something out of the OTC cabinet. She said it should be locked and any key works to lock it. In reference to the medication refrigerator being unlocked, she said, There isn't anything in there but insulin, but it should be locked. Staff A stated, I just haven't gotten to it. Staff A agreed both the refrigerator and the cabinet with OTC medication should have been locked at all times so they were not accessible. An interview was conducted on 6/10/25 at 11:28 a.m. with the Director of Nursing (DON). She stated medication should not be left unsecured for any reason. The DON said it is her expectation the medication refrigerator and the cabinet with OTC medications would be locked when not being accessed by the nurse. She stated treatment and medication carts should remain locked when not being used by the nurse. Review of a facility policy titled Medication Storage, undated, showed: Policy: Medications will be stored in a manner that maintains the integrity of the product and ensures the safety of the residents and is in accordance with FL Department of Health guidelines. Procedure: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. With the exception of Emergency Drug Kits, all medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel, as defined by facility policy. . (Photographic evidence obtained.)