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	12/17/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility did not ensure the prevention and development of pressure wounds for one resident (#1) out of three residents reviewed.Fundings included: Review of Resident #1's admission history and physical, dated 11/26/25 showed under chief complaint: R (right) foot infection. History of present illness: [Resident #1] is an [AGE] year-old patient with Alzheimer's, dementia, hx. (history of CVA (Cerebrovascular Accident) with R lower and upper contracture, RLE (right Lower Extremity) osteomyelitis, . who presents for worsening right foot wound. Pt. unable to contribute to history due to underlying dementia and fatigue. History obtained from [family member] over the phone. Reportedly patient was put in an ALF (adult Living Facility) on 11/18 as [family member} was out of state. When she returned yesterday she visited [Resident #1]. she noted an infected R foot with open wounds on R foot, R heel and R knee. Prior to the ALF, Pt. reportedly had no ulcers whatsoever. His foot was completely normal.Patient was neglected and sitting on his foot (due to contractures) for most of the week.In the ED (emergency Department) Pt. was febrile to 101.2 HR (heart rate 120, BP Pt admitted to medicine for severe sepsis due to a R foot infection.Assessment plan:Severe sepsis 2/2 R footLactic acidosis, resolved.Hx. of R foot osteomyelitisMeets severe sepsis criteria with T 101.2S/P (Status Post) Vancomycin, cefepime and 2L IVF in ED.Plan:Vancomycin and Zosyn750 ml (milliliters) IVF ordered for 30cc/kg sepsis level fluids.F/U (follow -up) foot X-ray.CT RLE (Right Lower Extremity) with contrast ordered.RLE arterial NIVS (Non-invasive Vascular Study) ordered for poor chronic wound healing.Podiatry consulted,F/U blood culturesPT/OT (physical Therapy/Occupational Therapy)wound care consulted.Review of a physician order for Resident #1 dated 12/8/25 revealed resident #1's R foot was amputated with orders to use pas on skin every day for wound care, apply povidone /betadine paint to incision line, wrap amputation site in Kerlix loosely to prevent soiling, change as needed to keep clean and dry. Review of a physician note for Resident #1 dated 11/21/25, signed by the facility's MD on 12/17/25 showed an assessment plan:3. Frailty Clinical Frailty Score =7 severely frail, at very high risk of unavoidable wounds due to bedbound status, PVD (peripheral vascular disease), senile purpura and frailty. Patient is completely dependent for personal care, but prognosis greater than six months Patient has increased vulnerability and functional impairment due to cumulative declines among multiple body systems. Increased risk of adverse health outcomes including falls, hospitalization and death. Risk factors include advanced age, medications, lack of regular exercise, poor nutrition, weight loss, cognitive impairment and CAD, dementia senile purpura , frail skin peripheral vascular disease. Needs close monitoring for medication reviews, fall prevention strategies, nutritional interventions etc.-Daily wound care as recommended, wound care physician following ,notes reviewed today-Turn and reposition every 2 hours if patient is unable to turn self.-Use positioning supports including positioning wedge and heel protectors as needed.-Foam chair cushion when sitting up if needed.-Keep head of bed less than 30 degrees if not contraindicated.-Float heels off of bed with pillows under calves if needed.-Pressure redistributing mattress or specialty bed.-Barrier creams with incontinence care .-Use white incontinence pads in lieu of adult diapers. -Daily moisturizers after bath.-Nutritional support. Review of Resident #1's medical record revealed these assessment plan recommendations were not transcribed for follow -up. On 12/17/2025 at 10:42 a.m., an interview was conducted with the Resident Representative (RR) for Resident #1. The RR stated she had Resident #1 in the facility for respite care for a planned two- weeks stay. The respite care started on 11/18/2025. The RR stated she was gone for one week to then returned to her home and she went to visit Resident #1 on 11/26/2025 and requested the assistance of his nurse who was at the medication cart, to straighten his right leg. The RR stated Resident #1's right foot was positioned under the resident's bottom. The RR stated she observed black spots on both sides of Resident #1's foot. The RR stated on the right side of his foot, the pinky toe and the toe next to it were black and the black discoloration was going down towards the top part of his foot. The RR stated on the inside of his right foot was an opening of his skin. The RR stated she immediately went to her car to obtain supplies for dressing changes and requested the nurse to attend to his wounds with the provided dressings. The RR stated Resident #1 had a breakdown on his foot a year ago during respite care at another facility and the same breakdown occurred then. The RR stated she was able to take the resident home where she was able to treat and resolve the wound herself. The RR stated the resident, under her care, required a pillow to be placed between his legs and under his feet to offset pressure. The RR stated she did not see Resident #1 on an air mattress, pillows for offloading, socks