

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER St. Andrew Post-Acute Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 16702 North Dale Mabry Hwy Tampa, FL 33618	
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 - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, record reviews, and interviews the facility failed to ensure Pre-Admission Screening and Resident Reviews (PASRRs) for six residents (#2, #9, #10, #15, #27, and #28) out of twenty sampled residents were accurate at the time of admission and updated when necessary. Findings included: 1. Review of Resident #2's Admission Record revealed the resident was admitted on [DATE] and 8/19/24. The record included diagnoses not limited to unspecified recurrent major depressive disorder (onset 3/27/22), generalized anxiety disorder (onset 4/25/22), and unspecified insomnia (7/23/22). Review of Resident #2's PASRR, dated 3/26/22, showed the resident did not have a mental illness (MI) or suspected mental illness (SMI), an intellectual disability (ID) or suspected intellectual disability (SID) per documented history. The screening revealed a Level II PASRR was not required due to no diagnosis or suspicion of a serious MI or ID. Review of Resident #2's medication list documented on the Psychology Subsequent Note report, dated 8/26/24, revealed the resident was receiving the antidepressants Bupropion Extended Release and Sertraline, as well as the sedative-hypnotic medication, Zolpidem as needed for insomnia. During an interview on 9/5/24 at 9:54 a.m. the Social Service Director (SSD) reviewed Resident #2's diagnoses and PASRR then stated it definitely should have been redone. 2. Review of Resident #9's Admission Record revealed the resident was admitted on [DATE] and 10/1/19. The record included diagnoses not limited to unspecified severity unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (primary diagnosis with onset date of 8/20/14) and unspecified recurrent major depressive disorder (onset 10/1/19). (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #9's PASRR, dated 10/1/19, showed the resident had the mental illness of depressive disorder and other (specify): dementia. The decision-making revealed the resident was receiving services for MI and the findings were based on medications. The other indications for decision-making revealed the resident did not have a primary diagnosis of dementia, related neurocognitive disorder (including Alzheimer's disease) and the resident did have a secondary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease) and the primary diagnosis was a SMI or ID. The screening showed the resident had validating documentation to support the dementia or related neurocognitive disorder (including Alzheimer's disease). The validating documentation was the resident's Brief Interview of Mental Status (BIMS). The instructions showed A Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder, and a suspicion or diagnosis of an SMI, ID, or both. A Level II may only be terminated by the Level II PASRR evaluator and accordance with 42 CFR 483. 128(m)(2)(i) or 42 CFR 483.128(m)(2)(ii). The completed screen revealed a Level II PASRR evaluation was not required. An interview was conducted on 9/5/24 at 9:48 a.m. with the SSD. The SSD reported doing the PASRR screenings and MDS (Minimum Data Set team) inputs them. The PASRR was reviewed and the SSD stated a Level II should have been done. 3. Review of Resident #10's Admission Record revealed the resident was admitted on [DATE] and included diagnoses not limited to unspecified severity unspecified dementia with other behavioral disturbance (primary diagnosis with an onset date of 7/26/24), cognitive communication deficit, brief psychotic disorder, and mild recurrent major depressive disorder. Review of Resident #10's PASRR, dated 6/28/24, revealed the resident did not have any MI or SMIs, and no IDs or SIDs based on documented history. The decision-making showed the resident had no disorder resulting in functional limitations in major life activities, no interpersonal functioning difficulty, no difficulty in sustaining focused attention for a period long enough to accomplish tasks, or any difficulty in adapting to typical changes. The decision-making showed the resident did not have a primary diagnosis of dementia or related neurocognitive disorder. The completion of the screening determined a Level II evaluation was not required. During an interview with the SSD on 9/5/24 at 9:58 a.m. the SSD reviewed Resident #10's diagnoses and PASRR stating they (the facility) was going through new admissions as a team. The SSD confirmed Resident #10's primary diagnosis was dementia and should have had a Level II done. 20536 4. On 9/3/2024 at 10:00 a.m. Resident #15 was heard yelling out and moaning aloud from behind her closed room door. During an interview at this time, the resident stopped yelling aloud and revealed she wanted staff to come and take her to the shower. Review of Resident #15's Admission Record revealed she was admitted to the facility on [DATE]. Review of the Admission Record revealed Resident #15's diagnoses to include altered mental status, cognitive communication deficit, dementia, major depression, mood disorder, and schizoaffective disorder. In addition, the medical chart contained a Level 1 PASRR. Further review of the Level I PASRR revealed the MI, Suspected MI Section I (a) showed Resident #15 was checked for diagnoses to include bipolar and schizophrenia. However, major depression was not checked. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/5/24 at 10:00 a.m. an interview with the SSD confirmed the current completed Level I PASSR screen did not reflect all the MI, Suspected MI diagnoses. She revealed Resident #15 did show a diagnosis of major depression and the facility should have completed a new PASRR Level 1 to reflect that. 50570 5. A review of Resident #27's Admission Record revealed an admitted [DATE]. Further review of Resident #27's Admission Record revealed diagnoses to include: major depressive disorder with an onset date of 7/19/22. A review of Resident #27's active physician orders, as of 9/5/24, revealed medications to include: Sertraline HCl (hydrochloride) 50 MG (milligrams) for depression. Start date 8/1/23. A review of Resident #27's current care plan revealed a focus of, Antidepressant Care Plan, with a date initiated and created on 7/20/22. Further review of the Antidepressant Care Plan focus revealed the following, Resident is at risk for adverse side effects related to use of antidepressant medications, Baseline care plan date 7/20/22. Interventions included the following, Administer ANTIDEPRESSANT medications as ordered by physicians. Monitor/document side effects and effectiveness Q-SHIFT [every shift]. A review of Resident #27's PASRR Level 1, dated 7/22/22, revealed no documentation of a qualifying mental health diagnosis, to include depression. A review of Resident #27's electronic medical record revealed no evidence of an updated PASRR, Level 1 to include the qualifying mental health diagnosis of depression. On 9/5/24 at 9:48 a.m. an interview with the SSD revealed she does the screening for PASRRs and the MDS Coordinator puts them into the electronic medical record. She stated the facility is in the process of auditing PASRRs. The SSD stated Resident #27's PASSR Level 1 should have been updated with the diagnosis of depression. 6. A review of Resident #28's Admission Record revealed an admitted [DATE]. Further review of Resident #28's Admission Record revealed diagnoses to include: major depressive disorder with an onset date of 2/3/23. A review of Resident #28's active physician orders, as of 9/5/24, revealed medications to include: Mirtazapine Tablet 7.5 MG for MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED. Start date 8/5/24. A review of Resident #28's current care plan revealed a focus of, Antidepressant Care Plan, with a date initiated and created on 2/6/23. Further review of the Antidepressant Care Plan focus revealed the following, Resident is at risk for adverse side effects related to use of antidepressant medications. Interventions included the following, Administer ANTIDEPRESSANT medications as ordered by physicians. Monitor/document side effects and effectiveness Q-SHIFT. A review of Resident #28's PASRR Level 1, dated 1/6/23, revealed no documentation of a qualifying mental health diagnosis, to include depression. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #28's electronic medical record revealed no evidence of an updated PASRR Level 1 to include the qualifying mental health diagnosis of depression. On 9/5/24 at 9:48 a.m. an interview with the SSD stated Resident #28's PASSR Level 1 needs to be updated with the diagnosis of depression. A review of the facility's policy titled, Resident Assessment - Coordination with PASARR Program, implemented on 9/7/22, revealed the following, This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Further review of the policy under the Policy Explanation and Compliance Guidelines, revealed the following, . 6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observations, staff and resident interviews, and record review, the facility failed to provide three of twenty sampled residents (#15, #10, and #28) with activities of daily living related to showers/baths (#10, #15) and personal hygiene related to shaving (#15) and eating assistance (#28) as per their request and scheduled timeframes. Findings included: 1. On 9/3/2024 at 10:00 a.m. Resident #15 was heard yelling out and moaning aloud from behind her closed room door. During an interview at this time, the resident stopped yelling aloud and revealed she wanted staff to come and take her to the shower. She revealed she yells out rather than uses the call light, because they (staff) respond faster. Resident #15 revealed she has missed her shower days the past few days, and she has missed many shower days the past couple of months. Resident #15 appeared with disheveled hair and she had long hair growing around her mouth and chin area. Some of the hair on her chin were approximately one inch to one and a half inches long. She was also noted to be wearing a hospital gown. On 9/3/2024 at 12:20 p.m. Resident #15 was in her room. She was still noted lying in bed and wearing a hospital gown. Resident #15's hair was still observed disheveled and she still had long facial and chin hair. Resident #15 stated, I just need a razor if they (staff) won't help me. She replied, I don't like having face hair and I have not had a shower in three days. She revealed there is never enough staff to help her with her personal hygiene or showers. On 9/4/2024 (Wednesday) at 9:30 a.m. Resident #15 was in her room. She was noted in bed lying flat with her head on a pillow and the linen pulled up over her head. She removed the linen from her face area and she was still noted with long facial hair around her mouth and chin area. Resident #15 revealed she still had not bathed. She again confirmed she does not like having mouth and chin hair, and that she could not remove it herself. On 9/4/2024 at 1:32 p.m. Resident #15 was in her room and confirmed again that she had not had a shower or bath yet and someone told her earlier she may get one today. She could not remember who that was. Resident #15 stated she needed a razor so she could shave. She started to tear up and revealed she does not like hair on her face and she could shave it if she had a razor. On 9/4/2024 at 12:40 p.m. Staff C, Certified Nursing Assistant (CNA) explained that she does shower/bathing today for a list of residents. She revealed that she does not assist with showers during meal services and that she will resume with showers/bathing after lunch. Staff C confirmed her entire assignment today was showers/bathing only. She also confirmed she will be giving Resident #15 a shower in a little while and that she is on her list. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/5/2024 at 8:07 a.m. Resident #15 was overheard calling out from her room. She was observed wearing a hospital gown and still had a lot of long facial and chin hair. She confirmed she had a shower yesterday (9/4/2024). She was asked if staff offered to clean up the hair on her face and chin and she revealed that the aide did not. She teared up and stated she wanted no hair on her face. She mentioned she has spoken to staff about it, but there are rare times when she is even given a bath/shower. She confirmed she does not like bed baths and would want only showers. She confirmed staff miss her shower days often. Review of Resident #15's Admission Record revealed she was admitted to the facility on [DATE]. Resident #15's diagnoses included sepsis, pressure ulcer unspecified stage, cognitive communication deficit, contracture, muscle weakness, abnormalities of gait, altered mental status, dementia, major depression, mood disorder, and schizoaffective disorder. Review of the Admission Minimum Data Sheet (MDS) assessment, dated 7/11/2024, revealed in Section E - Behaviors rejection of care was not exhibited. Section GG Functional Abilities and Goals revealed Resident #15 was dependent with substantial/maximal assistance for Shower/Bathing, and dependent on staff for personal hygiene. Review of the nurse progress notes dated from admission on 7/11/2024 to the current date of 9/5/2024 revealed no documentation that reflected missed showers or refusal of showers/personal hygiene. Review of the current care plan, with a next review date of 7/5/2024, revealed the following Focus areas: - ADL the resident has an ADL self - care performance deficit r/t (related to) weakness, AMS (altered mental status), multiple wounds. Interventions included: Bathing/Showers: Resident is totally dependent on 1 staff to provide bathing activity. - Personal Hygiene/Oral Care: The resident is totally dependent on 1 staff for personal hygiene and oral care. Review of the electronic medical record under the Tasks section revealed: Showers scheduled for Wednesdays/Saturdays. Last shower documented was documented on 8/24/2024 at 17:59 (5:59 p.m.). The medical chart contained a skin sheet that identified the resident was provided with a bed bath on 8/24/24. There was no documentation in the medical record to support the resident received a shower on Wednesday 8/28/2024, nor documentation to support the resident received a shower on Saturday 8/31/24. Further review of the Task section revealed no documentation to support Resident #15 was provided with a shower/bath since her admission on Saturday 7/27/24 to include the days of Wednesday 7/31/24, Saturday 8/3/24, Saturday 8/10/24, Wednesday 8/14/24. 2. On 9/3/2024 at 2:00 p.m. Resident #10 was observed seated in her wheelchair and waiting to attend a group activity. An attempted interview was conducted and Resident #10 was able to answer some simple yes and no questions related to her day but was not able to speak to her medical care and services. (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 Resident #10's Admission Record revealed she was admitted to the facility on [DATE]. The Admission Record revealed diagnoses to include: dementia, muscle weakness, Parkinsonism. Review of the electronic medical record under Tasks section revealed: Receive Showers/Baths on Tuesdays/Fridays. Review of the shower task sheet dated from 7/26/2024 - 9/5/2024 did not support Resident #10 was given a shower/bath on; Tuesday 7/30/2024, Friday 8/2/2024, Tuesday 8/20/2024, There were no notes on this sheet, nor in any nurse progress note of Resident #10 refusing a bath or shower. Review of the current care plan, with a next review date of 10/9/2024, revealed the following Focus areas: - Resident requires assistance with activity participation related to: Cog (cognitive) deficits, Physical limitations, with interventions in place. - ADL the resident has an ADL self- care performance deficit r/t the following areas; Transfer resident utilizes transfer equipment with 2 care givers physical help; Bathing/Showering - Resident is totally dependent on 1 staff to provide bathing activity; Personal Hygiene the resident requires assistance by 1 staff with personal hygiene and oral care. On 9/5/2024 at 10:00 a.m. an interview with Staff A, Registered Nurse/Unit Manager (RN/UM) revealed upon admission, residents are provided with a shower schedule based on their room number. She stated a resident could change the day or add shower days if they request. Staff K explained the direct care staff will look into the resident's record under the Task section or Kardex, to see when the resident is to have their shower/bath. After the shower, staff are to document in that record of completion, or refusal. Staff K revealed if there is a refusal, a nurse will reflect that in the nurse progress notes. Staff K will follow up and monitor a resident's record to see if staff have documented completed or not completed for showers/baths. She revealed there has been a documentation problem the past few months and she, along with the Director of Nursing have been trying to educate staff that they need to document a completed shower, otherwise if it is not documented, it did not happen. Staff K could not provide any other documentation to support Resident #15 and Resident #10 had showers for the above listed showers missed. She also could not provide evidence that Resident #15 and #10 ever refused showers on those days. 50570 3. On 9/3/2024 at 11:08 a.m. an observation of Resident #28 revealed he was laying down in bed, with the bedsheets pulled to slightly over his waist, and his hands were over the bedsheets. An observation of his hands revealed long fingernails. Observations of his right hand revealed his ring fingernail was splitting horizontally, in the middle of his nail bed. The ring fingernail on his right hand was lifted up from splitting. An observation of Resident #28's left hand revealed his thumb nail was jagged and splitting horizontally from about half of the nail. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/4/2024 at 1:24 p.m. Resident #28 was observed sitting in a wheelchair with the bedside table in front of him. Resident #28's family member was observed sitting on the bed beside him. An observation of his hands revealed long fingernails. Observations of his right hand revealed his ring fingernail was splitting horizontally, in the middle of his nail bed. The ring fingernail on his right hand was lifted up from splitting. An observation of Resident #28's left hand revealed his thumb nail was jagged and splitting horizontally from about half of the nail. He stated he didn't want his nails long. Resident #28 stated staff will cut his nails, When they have time. He stated he receives a shower twice a week. Resident #28 stated he received a shower today and his nails were not cut. He stated his nails that are splitting get caught when he's running his hands through his hair. A review of Resident #28's Admission Record revealed an admitted [DATE]. A review of Resident #28's Order Summary Report revealed the following diagnoses to include: muscle weakness, major depressive disorder, cognitive communication deficit, and Post-Traumatic Stress Disorder, Chronic. A review of Resident #28's Minimum Data Set (MDS) Quarterly Assessment - Section C, Cognitive Patterns, dated 7/22/24, revealed a Brief Interview Mental Score (BIMS) of 13, cognitively intact. A review of Resident #28's current care plan for Activities of Daily Living (ADL) revealed the following, The resident has an ADL self-care performance deficit r/t [related to] weakness, date initiated and created on 02/15/23. Further review of Resident #28's ADL care plan revealed the following interventions, BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Date Initiated: 02/03/2023. A review of Resident #28's current care plan revealed a behavior care plan to include the following, Potential for impaired or inappropriate behaviors related to . Refuses hygiene care (cutting nails), date initiated and created on 06/15/23. Further review of the skin integrity focus revealed the following interventions to include, Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short, date initiated and created on 2/6/23. On 9/4/2024 at 1:59 p.m. an interview with the MDS Coordinator revealed Resident #28's nails have been long since he was admitted to the facility. She stated he refuses that staff trim his nails. The MDS Coordinator said he does allow staff to clean his nails. The MDS Coordinator stated Resident #28's care plan related to nail cutting refusals was created because he will not let anyone cut his nails. She stated the resident doesn't participate in care plan meetings. She said as far as she knows, Resident #28 has never had his nails cut. The MDS coordinator stated staff have never informed her they've cut his fingernails. A review of Resident #28's progress notes, from 8/2/24 to 9/5/24, revealed the following: a) A Skin observation progress note, dated 9/2/24, Resident skin is clear no impairment. Resident nails cleaned and trimmed. Resident prefers long nails. b) A Skin observation progress note, dated 8/30/24, Resident nails cleaned and trimmed Resolved Abrasion Skin impairment resolved on. c) A Skin observation progress note, dated 8/25/24, Resident skin is clear no impairment. resident prefers his nails long. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Activities of Daily Living (ADLs) policy, reviewed on 9/7/22, revealed the following, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADL's do not deteriorate unless deterioration is unavoidable. Further review of the policy revealed the following, Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care; . Further review of the ADLs policy under Policy Explanation and Compliance Guidelines revealed the following, . 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 37999 4. On 9/3/2024 at 12:25 p.m. Resident #9 was observed lying in bed with eyes closed. An over-bed table was located out of reach of the resident on the left-side of the bed with a meal tray on top of it. The meal tray contained a covered plate and clear plastic wrapped cups of liquids. On 9/3/2024 at 12:32 p.m. Resident #9 was observed in the same position with the tray covered. The observation revealed no staff member entered the room to assist the resident with the noon meal. On 9/3/2024 at 12:46 p.m. Resident #9 continued to lay in bed with eyes closed, the nearby meal tray was observed with a covered plate, one clear plastic wrapped cup of opaque liquid and one containing a red-colored liquid. The observation revealed no staff member entered the room. On 9/3/2024 at 12:53 p.m. Resident #9 was observed lying in bed with eyes closed, the plate and liquids continued to be covered, and no staff member had entered the room. On 9/3/2024 at 12:58 p.m. Staff C, CNA was observed in the hallway of Resident #9's room picking up lunch trays from residents who had eaten in their rooms. On 9/3/2024 at 1:01 p.m. (36 minutes after the first observation), Staff C entered Resident #9's room and began to verbally and tactile stimulate the resident. The staff member informed the resident it was lunchtime and called out the resident's name. Staff C stated whoever had time was to assist residents with eating and feeding residents. The staff member reported Resident #9 required 100% assistance with eating and was the staff member's only assisted diner but she passing trays on another hall. Review of Resident #9's Admission Record revealed the resident was admitted on [DATE] and 10/1/2019. The record included diagnoses of unspecified severity unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of Resident #9's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident was rarely/never understood and did not have a BIMS score. The assessment showed the resident required partial/moderate assistance with eating. Review of the CNA Assignment sheet, provided by the facility on 9/5/2024 at 9:41 a.m., showed the resident was one of four dependent/full assist diners, which was confirmed at that time by the Director of Nursing (DON). (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 9/5/2024 at 9:08 a.m. with the DON. The DON stated (meal) trays for dependent diners should be left on the tray cart until staff could assist (them). The DON provided documentation showing Resident #9 had eaten 76-100% of the observed lunch meal on 9/3/2024 and stated the resident's meal sitting in the room for 36 minutes was not acceptable. During an interview on 9/5/2024 at 9:41 a.m. the DON stated the facility did not have a policy regarding assisting residents with eating or a policy related to dining. On 9/5/2024 at 5:22 p.m. Resident #9's dinner tray was observed, with a covered plate, drink cups covered with a clear plastic wrap, and the resident's eating utensils continued to be wrapped in a paper napkin. The observation showed no staff member was in the room. Staff K, Licensed Practical Nurse (LPN) observed the meal tray a moment later and stated staff were passing (meal) trays and it was the policy for them to pass trays then return to the room and assist the resident. A review of the facility's Activities of Daily Living (ADLs) policy, reviewed on 9/7/22, revealed the following, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADL's do not deteriorate unless deterioration is unavoidable. Further review of the policy revealed the following, Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care; . Further review of the ADLs policy under Policy Explanation and Compliance Guidelines revealed the following, . 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observations, interviews and record review, the facility failed to provide administration of intravenous medication in accordance with professional standards of practices for one resident (#11) of four residents sampled. Findings included: On 9/3/2024 at 9:55 a.m. a loud alarm sound was overheard close to the nurse station area. The alarm sound was observed to be emitting from an Intravenous (IV) therapy system pump, which was at Resident #11's bedside down the hallway. At this time, Resident #11 was observed lying flat in bed and with his head propped up on a pillow. Resident #11 stated, The [explicative] thing goes on all the time. He stated the IV system provided an antibiotic to heal a wound infection, and he could not remember exactly how long he has been treated with IV antibiotic therapy. Resident #11 stated the IV machine must have problems to alarm that way. He stated, They [staff] take a long time [to respond]; it happens enough. Further observations, at this time, of the alarming IV therapy system revealed a hanging liquid medication bag with a line leading from it to a pump. The line continued from the pump to the resident's right arm. The loud alarming pump had a read out that showed, Air in the line. Following the interview on 9/3/2024 with Resident #11, the alarm was still sounding and the resident was overheard yelling nurse at 10:13 a.m. Then at 10:14 a.m. the Staff A, Registered Nurse/Unit Manager (RN/UM) walked out from another resident's room over to Resident #11's room. An interview was conducted on 9/3/24 at 10:15 a.m. with Staff A, RN/UM, who exited Resident #11's room. She stated the alarm was sounding and she had to get the air out from the line. She revealed it happens at times and only IV trained nurses can remove the air from the line when air builds up. She was not sure how long the resident was on the IV therapy and was not sure what the medication was or what type of infection he had. On 9/3/2024 at 10:46 a.m. Resident #11's IV pump was again observed and overheard alarming. The pump read, Air in the line. The alarm kept sounding and there were no staff in the area to report to the room to fix the alarm. At 11:00 a.m., 11:02 a.m., and 11:03 a.m. Resident #11 was again overheard calling out loud, Nurse. There were no staff in the area to answer. On 9/3/2024 at 11:06 a.m. a Staff O, Licensed Practical Nurse (LPN) was observed walking down the hallway from another hall, and then went into Resident #11's room to fix the alarm. Staff O was interviewed and replied, I did hear the alarm and I fixed the air line alarm. He was not sure how long the alarm was sounding and expressed that if aides hear the alarm, they are to report it to a nurse immediately. During the interviews with both Staff O, LPN and Staff A, RN/UM on 9/3/2024 they revealed when the alarm sounds and there is air in the line, the system does not provide the fluid antibiotic to the resident. They both confirmed the air in the line has to be flushed out in order for the medication to flow again. (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #11's Admission Record revealed he was admitted to the facility on [DATE] and readmitted from hospital on 8/23/2024. Resident #11's diagnoses included osteomyelitis, urinary tract infection, and prostatic hyperplasia with lower urinary tract symptoms. Review of the Order Summary Report for the month of 9/2024 revealed the following active physician orders: - Vancomycin HCl IV solution Reconstituted 1 GM (gram) - 1 dose IV BID (two times a day) for infuse 1.25 into vein until 9/9/2024. (Order start date - 9/2/2024). - Cleanse and irrigate wound in Right heel area with normal saline pat dry with gauze, and apply Dakins moistened gauze to wound bed and cover with boarder dressing x shift for wound and as need for if soiled or falling off. (Order date 9/2/2024) - Cefepime HCL IV solution Reconstituted 2 gm - Use 2 gm times 12 hours for wound infection until 9/9/2024. (Order start date - 8/29/2024). - IV - PICC (peripherally inserted central catheter) all types change primary intermittent tubing x 24 hrs (hours) x day shift. (Order date 8/26/2024). - IV - PICC all types change needleless connector on admission, weekly and PRN (as needed) x day shift x Tue and as need (Start date 8/26/2024). - IV - PICC all types monitor site Q (every) shift for signs/symptoms of infection and or infiltration x shift. (Start date 8/26/2024). - IV - PICC change transparent dressing on admission, then weekly and PRN thereafter x day shift and Tue and as need. (Start order date 8/27/2024). Review of the nurse progress notes dated from date of admission 8/6/2024 through to current date 9/5/2024 did not indicate any documentation of concerns related to the IV therapy system, nor any documentation of Resident #11 ever refusing the IV antibiotic therapy. Review of the current care plan, with a next review date 11/19/2024, revealed the following Focus areas: - Diagnosis of Osteomyelitis with interventions in place to include administer IV antibiotics as ordered, monitor for adverse side effects and report findings to MD. - Infection on the right heel/sacrum, with interventions in place to include administer antibiotic as per MD orders. - Infection care plan the resident is on IV antibiotic therapy r/t (related to) infection to right foot. Interventions included administer antibiotic medications as ordered by physician. (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/5/2024 at 10:00 a.m. an interview was conducted with Staff A, RN/UM. She confirmed Resident #11 has an IV therapy system that provides a liquid antibiotic. She revealed only qualified nurses are able to hang and operate the IV therapy system. Staff A revealed the IV pump will walk you through each step on how to operate it. She was asked what it means when the pump read out reveals; Air in the line. She stated; It means air has accumulated in the line and the line needs to be cleared. Staff A also confirmed that once the IV machine tubing has air accumulated in it, the medication will not flow at all to the resident. She revealed the air has to be flushed for the medication to flow again. Staff A revealed if the air is in the line, a very loud alarm will sound and it will not stop until the air has been flushed properly. She also confirmed the alarm can be overheard outside the room, down the hall and if other staff hear it, they should report it a nurse or herself immediately. A review of the policy titled, Intravenous Therapy, implementation date of 12/2/2022, documented, The facility will adhere to accepted standards of practice regarding infusion practices. Definitions included; Intravenous (IV) therapy is the administration of parenteral fluids or medications through an IV catheter to treat a condition. The compliance guidelines of the policy revealed the following: 8. Whenever possible, an infusion pump will be used when administering intravenous fluid or medications. 9. When an infusion pump is not used, a mechanical flow control device will be used. 10. A doctor's order is obtained before starting IV therapy. 11. IV documentation is recorded in the nurses' notes and/or Medication Administration Record. Under the Procedures Continuous Infusion section following was documented: 8. Spike solution/medication and prime tubing, maintaining spike sterility. Clamp tubing when primed and all air is out of tubing. 13. Observe infusion site for any adverse reactions and stop infusion, if so noted, and notify practitioner. Under the Intermittent Medication Infusion section of the policy, it revealed the following: 5. Check medication expiration date, leaks, cracks, change in clarity, or particulate matter. 9. Prepare infusion by spiking medications, priming tubing, ensuring all air is out of tubing.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, record reviews, and interviews the facility failed to monitor the oxygen saturation level for one resident (#9) of one resident sampled for respiratory care. Findings included: On 9/3/24 at 12:25 p.m. Resident #9 was observed lying in bed with eyes closed. An oxygen concentrator was sitting on the floor next to the bedside dresser. Review of Resident #9's Admission Record revealed the resident was admitted on [DATE] and 10/1/19. The record included diagnoses not limited to unspecified severity unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, shortness of breath, and unspecified organism other pneumonia. Review of Resident #9's Minimum Data Set assessment, dated 6/16/24, revealed in Section C - Cognitive Patterns the resident was rarely/never understood and had a no score for the Brief Interview for Mental Status. Review of Resident #9's September 2024 Medication Administration Record (MAR) revealed a physician order for Resident with history of shortness of breath while lying flat. Head of bed was elevated this shift to prevent shortness of breath. every shift, start date 3/20/24. The MAR showed for the 12 Da (day shift) and 12 Ng (night shift) from 9/1/24 to 9/4/24 the staff documented four out of seven shifts that the resident's head of bed was elevated and three times it was not. The MAR showed the resident was to be administered oxygen at 2 lpm (liters per minute) via n/c (nasal cannula) as needed for SOB (shortness of breath) related to shortness of breath. The MAR did not reveal the resident had been administered oxygen. Review of Resident #9's June 2024 through September 2024 Treatment Administration Records (TAR) showed an order for Check oxygen saturations q (every) shift every shift. The TAR revealed staff documented a checkmark on each 12 Da and 12Ng shift, without documentation of an oxygen saturation level. The TAR did not have an area to document the saturation level with the order. According to the chart codes, a checkmark equaled administered. Review of Resident #9's care plan revealed a focus showing the resident had oxygen therapy r/t (related to) SOB when lying flat. The interventions included, Give medications as ordered by physician. Observe/document side effects and effectiveness. Review of the policy - Medication Administration, implemented on 3/24/23, instructed staff to Obtain and record vital signs, when applicable or per physician's orders. The policy showed staff were to Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR. An interview was conducted with the Director of Nursing on 9/4/24 at 4:21 p.m. The DON stated staff should be documenting oxygen saturation levels if they have an order and if the nurse thought the order need to be clarified, the physician should be contacted.		

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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. 37999 Based on observations, record reviews, and interviews the facility failed to ensure the medication error rate was less than 5.00%. Thirty-six medication administration opportunities were observed and nine errors were identified for two (#27 and #7) of three residents observed. These errors constituted a 25% medication error rate. Findings included: 1. On 9/4/24 at 8:04 a.m. an observation of medication administration with Staff D, Registered Nurse (RN) was conducted with Resident #27. The staff member dispensed the following medications: - Acidophilus lactobacillus otc (over-the-counter) capsule - Amlodipine 10 mg (milligram) tablet - Biotin 1000 mcg (microgram) otc tablet - Loratadine 10 mg otc tablet - Cranberry 2- 450 mg otc tablets - Doxycycline 50 mg capsule - Methenam hiprex 1 gram tablet - Montelukast 10 mg tablet - Valsartan 40 mg tablet - Amoxicillin/Potassium clavulanic 875-125 mg tablet - Tamsulosin 0.4 mg capsule - Lactulose 10 gram/15 milliliter (gm/mL) - 30 mLs. Staff D, RN searched through multiple bottles in the medication cart and reported having to reorder Resident #27's Lactulose. Staff D removed a bottle of Lactulose labeled with a female resident's name (#12) on it and poured 30 mLs of it into a medication cup. The staff member confirmed dispensing 12 tablets and one liquid. The staff member reported on 9/4/24 at 8:15 a.m. of having to borrow Lactulose from Resident #12 as Resident #27 did not have any. The staff member was dressed in personal protective equipment (PPE) necessary for entering the resident's room, Resident #27 was observed swallowing the oral tablets and drinking the liquid medication Lactulose. Review of Resident #27's September 2024 Medication Administration Record (MAR) showed the following order: (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Biotin - Give 500 mcg by mouth one time a day for hair and nails. 2. On 9/4/24 at 8:25 a.m. an observation of medication administration with Staff E, RN was conducted with Resident #7. The staff member dispensed the following medications: - Amoxicillin/Potassium clavulanic 875-125 mg tablet - Eliquis 5 mg tablet - Jardiance 10 mg tablet - Metoprolol Succinate 50 mg Extended Release (ER) - Acidophilus lactobacillus 20 mg otc capsule - Felodipine 10 mg ER - Gabapentin 300 mg - 2 capsules - Xifaxan 550 mg tablet - Spirolactone 50 mg tablet - Cranberry 450 mg otc tablet - Cetirizine 10 mg otc tablet - Docusate sodium 100 mg gelcap - Acetazolamide 125 mg tablet - Zinc 50 mg otc tablet - Meclizine 12.5 mg otc tablet - Benzonatate 100 mg capsule Staff E stated the resident was to receive Lactulose, however the resident did not like liquid (medications) and did not have any (Lactulose), but staff were still supposed to offer it. The staff member confirmed dispensing 17 tablets (did not count them), mixed oral medications with applesauce at bedside and assisted the resident with taking them. The resident asked for eye drops. Staff E returned to the cart and removed a bottle of generic Tetrahydrozoline 0.05%, sanitized hands at the cart, donned gloves while standing in the hallway then entered the room. Staff E placed one drop in the right eye and one drop in the left eye. The staff member returned to the cart and documented the Silver Sulfamide cream had been applied, saying they come and get the staff member to apply it when they assist the resident with hygiene. Staff E documented under Lactulose awaiting pharmacy and confirmed the resident was to receive Furosemide, Oyster Shell Calcium, and Vitamin B12 but did not have any and was waiting for pharmacy to deliver. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #7's September 2024 Medication Administration Record (MAR) revealed the following medications were to be administered: - Lactulose 10 gm/15 mL - Give 30 mL by mouth three times a day for constipation. The nurse documented 5. Review of the chart codes showed 5=Hold/See Nurse Notes. The order was discontinued on 9/4/24 at 10:08 a.m., approximately 1 hour and 30 minutes after the observation. The order was reinstated to begin on 9/5/24 at 9:00 a.m. - Silver Sulfadiazine Cream 1% - Apply to bilateral buttocks topically every shift for Moisture-Associated Skin Damage (MASD). The Medication Administration Audit Report revealed the cream was applied on 9/4/24 at 8:56 a.m., during the observation period. - Cholecalciferol 1000 unit (Vitamin D3) - Give 1 tablet by mouth in the morning for Vitamin D deficiency. This medication was scheduled during the liberalized medication administration time of 7:15 a.m. to 11 a.m. The Medication Administration Audit Report revealed the medication was administered on 9/4/24 at 2:57 p.m. - Metoprolol Succinate ER tablet 24-hour 50 mg - Give 1 tablet by mouth one time a day for hypertension. Hold if less than systolic blood pressure (SBP) 100, diastolic blood pressure (DBP) 60, heart rate 60. A review of the MAR showed no area to document either blood pressure or pulse. The observation did not reveal Staff E, RN obtained a blood pressure or pulse prior to the administration. An interview was conducted on 9/4/24 at 10:06 a.m. with Staff E. The staff member stated that night shift takes Resident #7's blood pressure and Resident #7 takes it when the resident asks or doesn't feel good. The staff member was unable to provide a blood pressure for the resident. - Oyster Shell Calcium 500 mg tablet - Give 1 tablet by mouth in the morning for Vitamin D deficiency, take with food. This order was discontinued on 9/4/24 at 10:14 a.m., approximately 1 hour and 46 minutes after the observation of medication administration. The September MAR did not show the medication was administered on 9/4/24. - Refresh Tears Ophthalmic solution (Carboxymethylcellulose sodium) - Instill 1 drop in both eyes every 12 hours for dry eyes. The observation revealed Tetrahydrozoline 0.05% eye drops had been administered. - Vitamin B12 500 microgram (mcg) tablet (Cyanocobalamin) - Give 1 tablet by mouth in the morning for Vitamin B12 deficiency. The observation did not show this medication was administered. The Medication Admin Audit Report showed Cyanocobalamin was administered on 9/4/24 at 2:57 p.m. Review of Resident #7's progress notes, on 9/4/24 at 4:10 p.m., did not show the physician had been notified of the lateness of medications or the unavailability of Lactulose. An interview was conducted on 9/4/24 at 4:00 p.m. with the Director of Nursing (DON). The DON was notified of the observation for Resident #27. The DON was notified of the observation with Resident #7 and stated vital signs should be taken within one hour of the Metoprolol. After reviewing the Vital Summary and MAR for Resident #7, the DON confirmed there were no blood pressures recorded for the resident's Metoprolol. The DON stated the physician had been notified at 11:00 a.m. (on 9/4/24) of Resident #7's late medications, confirming there was no note revealing the notification. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Liberalized and Standardized Medication Administration Schedules, approved on 4/24/24, revealed, In keeping with the philosophy of person centered care and resident rights, medications will be delivered in a manner that is least restrictive and intrusive while allowing for optimal therapeutic effect of medications. This practice minimizes the number of times the resident's/ patient's schedule must be interrupted for Drug Administration and allows person centered choices as to when to receive their medication unless specific hour of administration is ordered by the medical provider. The liberalized schedules well allow for medication administration during the defined window of time; these are represented by a descriptor (e.g. in the morning) or time frame (e.g. 0400-0700) on the MAR/EMAR. Medications scheduled are considered timely as long as they are administered within one (1) hour before or after the define time or window of time. Review of the policy titled, Medication Administration, implemented 3/24/23, revealed Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. - 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. - 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name form, dose, route, and time. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. - 15. If any medication is not available, or the possibility of late administration, the nurse will contact the attending physician. - 18. Sign MAR after administered. For those medications requiring vital signs, record the vital signs on to the MAR.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50570 Based on observations, interviews, and record review, the facility failed to store, prepare and follow professional standards for food service safety in two (main and satellite) of two kitchens, as evidenced by: 1. two trash cans were not sanitarily maintained; 2. food was not maintained for safe consumption to include improper food handling practices; 3. kitchen shelving used for storage of food was observed rusted/oxidized, 4. temperature logs for the refrigerator and freezer were not documented accurately, and 5. one staff member (Q) not donning a hairnet upon entry to the kitchen during two (9/3/24 and 9/5/24) of three days of the survey. Findings included: On 9/3/24 at 9:20 a.m. a tour of the facility's main kitchen was conducted with Staff M, Certified Dietary Manager (CDM). From 9:24 a.m. to 9:38 a.m. observations of trash cans and refuse containers revealed a stand-up trash container with a double flap lid was open with trash/refuse overflowing from it. The trash container was against a food preparation/service table, where were observed preparing food on the stove. The lid and sides of the same trash container were observed with an unidentified liquid and hard food debris. (Photographic Evidence Obtained) An additional observation revealed the trash can near the hand washing sink was gray in color, round and stood approximately three and a half feet high. The lid was observed with a circular cut out to put the garbage/refuse through. Further observations revealed the entire outer container and lid contained a black, brown, and green sticky substance that covered many areas. (Photographic Evidence Obtained) On 9/3/24 at 9:38 a.m. observations of the walk-in refrigerator revealed an uncovered box of four whole cabbages. Staff M, CDM removed one cabbage that appeared wilted and damaged with black coloring on the outside layers. (Photographic Evidence Obtained) He handled the cabbage with ungloved hands, while peeling back the outer parts of it. Further observations revealed Staff M, CDM dropped the cabbage on the refrigerator floor, which appeared soiled with various small particles and debris. He picked up the cabbage and put it back in the box with the other three. During the observation, Staff M, CDM did not discard or wash the cabbage prior to putting it back in the box. On 9/3/24 an observation at 9:39 a.m. of the entry way of the walk-in refrigerator revealed a multi-shelf cart with various pans of prepared food. One of the pans of prepared food items was a sheet cake with approximately three quarters of the cake missing. There was clear plastic wrap on the remaining sheet cake, however, the plastic wrap did not cover the food entirely leaving it exposed to the air. (Photographic Evidence Obtained). Further observations of the walk-in refrigerator revealed multiple shelves on each side. Observations of the shelf racks revealed they were green, plastic coated, and slotted. Further observations of the shelves revealed the green coating on parts of the shelves were worn away and appeared rusted/oxidized. There were no barriers between the rusted/oxidized shelves, and the containers and boxes of food items. (Photographic Evidence Obtained) On 9/3/24 an observation at 9:40 a.m. of the walk-in freezer, located inside the walk-in refrigerator, revealed two frozen pie crusts stacked on top of each other were not covered and exposed to the air. Staff M, CDM confirmed the frozen pie crusts should have been covered, as well as, labeled/dated. He proceeded to remove them. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER St. Andrew Post-Acute Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 16702 North Dale Mabry Hwy Tampa, FL 33618	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/3/24 at 9:42 a.m. a review of the refrigerator and freezer temperature logs revealed no documentation. Staff M, CDM stated the morning documentation of the refrigerator and freezer temperatures should have been completed by the cook. Staff M, CDM handed the log to Staff P, [NAME] to be completed. On 9/3/24 observations at 9:20 a.m. and 9:43 a.m. of the food preparation table revealed two yellow, whole honeydew melons. One melon was observed with a flat level surface that contained grey and black mold-like debris and spores growing on it. (Photographic Evidence Obtained) An interview with Staff M, CDM revealed the melon was okay to consume and he proceeded to cut off the top of the fruit where the mold spores and debris were located. Further observations revealed, he cut open the melon which appeared to have no mold inside. He stated he received a delivery of fresh produce to include the two melons, and it would be used for consumption on 9/3/24. Staff M, CDM discarded the melon although he confirmed he intended to use it. Further observations of the cutting board on the food preparation table revealed black residue, which derived from the top part of the melon that Staff M, CDM cut off. He attempted to wipe away the black residue with his ungloved hand, however, there were smudges of black residue left on the cutting board. On 9/5/24 at 10:55 a.m. observations in the satellite kitchen revealed a cellphone was laying on the drying rack with items such as cups, portion scoops, and other kitchenware. An interview with Staff G, Dietary Aide revealed it was her cellphone. She stated she knows the phone was not supposed to be there as the dish rack contained clean kitchenware and items that residents utilize during meals. An observation of the main kitchen on 9/5/24 at 11:28 a.m. revealed Staff Q, [NAME] entered the kitchen without a hair restraint. Staff Q, [NAME] was observed walking to what appeared to be a utility closet to include mops and cleaning products. She was observed leaving the closet, shortly after entering, and went to Staff M, Certified Dietary Manager (CDM)'s office. She was observed putting on a hair restraint while in the CDM's office. On 9/5/24 at 11:32 a.m. an observation in the main kitchen of Staff R, Dishwasher and another staff member, revealed a demonstration of the process for determining the sanitizing temperature of the dish machine. Staff R, Dishwasher took a plate out of the dish washing machine that was in the middle of a wash cycle. He tested the sanitizing solution by pressing the litmus strip to the plate, which was wet. Further observations revealed Staff R, Dishwasher put the same plate back in the machine to continue the cycle. During the observation, Staff R, Dishwasher was not wearing gloves, and he did not wash his hands or use a hand sanitizer. An observation at 11:34 a.m. of the dish machine temperature log revealed there was documentation for breakfast, lunch, and dinner on 9/5/24. (Photographic Evidence Obtained) An interview with Staff R, Dishwasher revealed he made a mistake and documented lunch and dinner temperatures before testing the sanitizing solution. He stated he should not have done that. An interview with Staff M, CDM stated he was not aware Staff R, Dishwasher had filled out the dish machine temperatures for lunch and dinner before testing the sanitizing solution. At 11:35 a.m. an observation of the dish machine area revealed a disposable beverage cup from a fast-food establishment located near the three-compartment sink. Staff R, Dishwasher, was observed taking a sip of the beverage and putting it on a cart next to the three-compartment sink, then he proceeded to continue using the dish machine. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER St. Andrew Post-Acute Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 16702 North Dale Mabry Hwy Tampa, FL 33618	
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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/5/24 at 11:45 a.m. a review of the refrigerator and freezer temperature log, in the main kitchen, revealed no evidence of morning documentation for that day. Staff M, CDM observed the log and stated the cook should have documented the morning refrigerator and freezer temperatures. Staff M, CDM handed the log to Staff Q, [NAME] and another staff member, to be completed and stated, Second day in a row. On 9/5/24 at 11:03 a.m. an interview with the Registered Dietitian (RD) revealed it is expected if produce has mold, it should be thrown away. She stated the CDM should have called the food supplier company to request a refund for the produce that was damaged and had mold. The RD stated she would have discarded the food that was damaged and had mold. She confirmed it was not safe food handling practices to put food back that fell on the floor. The RD stated the produce that fell on the floor should have been thrown away. A review of the policy regarding receiving food and supplies, revised 4/1/14, contained the following information, Food items should be received and handled in accordance with good sanitary practice. Further review of the policy titled, Receiving Food and Supplies, under procedure, revealed the following, . b. Check for quantity, quality, weight, labels, etc. of all foods ordered. Do not accept and return to the supplier, any item that is: . 4) Damaged produce . A review of the policy titled, Food Preparation, revealed the following, Employees must use appropriate tools to identify and prevent potential hazards in the preparation of food process. Further review of the policy, under procedure, included the following, . 2. The proper cleaning and sanitizing of equipment and work surfaces are key to safe food preparation . A review of the policy titled, Food Storage, revealed the following, Employees use appropriate tools to identify and prevent potential hazards in the storing of food process. Further review of the policy, under procedure, included the following, . 4. In a freezer, for longer-term storage of perishable foods. D. Store frozen foods in their original containers or wrap tightly in moisture-proof material or containers to minimize loss of flavor, as well as discoloration, dehydration (drying out), and absorption of odors. Clearly label containers with the contents, delivery date, and/or use-by date.		

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NAME OF PROVIDER OR SUPPLIER St. Andrew Post-Acute Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 16702 North Dale Mabry Hwy Tampa, FL 33618	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50570 Based on observations, interviews and record review the facility failed to implement and maintain an infection prevention and control program to mitigate the spread of infection related to staff not offering hand hygiene to residents prior to a meal and two staff members (R, and G) not performing hand hygiene with the potential to affect a census of 41 residents. Findings included: On 9/3/24 observations of the lunch service in the dining room from 11:51 a.m. to 12:55 p.m. revealed no hand hygiene was offered to multiple residents prior to eating. At 12:01 p.m. Staff E, Registered Nurse (RN) entered the dining room area. At 12:27 p.m. an observation of Staff E, RN revealed she sat down and attempted to assist a resident by setting them up to eat, which included touching utensils and other items on the table and did not perform hand hygiene prior to assisting this resident. At 12:33 p.m. Staff E, RN was observed serving beverages without performing hand hygiene before and after handling the beverages. At 12:38 p.m. an observation of Staff E, RN revealed she was feeding Resident #10, stopped feeding her at 12:41 p.m., and then resumed at 12:48 p.m. Observations of Staff, E feeding Resident #10 revealed she was standing up next to her and no hand hygiene was observed before and after feeding the resident. From 12:51 p.m. to 12:53 p.m. Staff E, RN was observed assisting another resident at a different table with dining. Observations of Staff E, RN revealed no hand hygiene was performed before and after feeding this resident. On 9/4/24 at 11:29 a.m. testing and recording of food temperatures were observed in the satellite kitchen. Staff G, Dietary Aide was designated to test the food temperatures. At 11:36 a.m. observations of Staff G, Dietary Aide revealed she entered the satellite kitchen pushing the meal cart with the food items for lunch. Further observations of Staff G, Dietary Aide, as she prepared to test the food temperatures, revealed she did not practice hand hygiene such as using hand sanitizer or washing her hands. At 11:39 a.m. observations of Staff G, Dietary Aide revealed she handled food on the steam table to include removing a clear, plastic film that was covering the items. Throughout the observation of testing and recording the lunch meal temperatures, Staff G, Dietary Aide touched approximately nine food items and surrounding surfaces/areas without gloves or proper hand hygiene practices. A review of facility policy titled, Infection Prevention and Control Program, last revised July 2023, revealed under the section titled Policy: The facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.		