STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105140	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bristol Care Center	1818 E Fletcher Ave Tampa, FL 33612

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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	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** 3. An observation on 06/23/2025 at 1:07 p.m. revealed Resident #55 was lying in his bed on the right side in his room. Both the door and the curtain were open. The sheet was not covering his backside, and his buttocks were exposed to the hallway. The APRN (Advanced Practice Registered Nurse) and Staff A, Licensed Practical Nurse (LPN) the wound care nurse were observed providing wound care to the resident. Resident #55's bottom was able to be observed from the room across the hall, as well as by anyone walking down the hallway. Review of the admission Record revealed Resident #55 was admitted on [DATE] and readmitted on [DATE] with diagnoses included but not limited to osteoarthritis of left and right knee, Chronic Obstructive Pulmonary Disease (COPD), chronic venous hypertension with ulcer of right lower extremity, non-pressure chronic ulcer of right lower leg, and chronic venous hypertension with ulcer of left lower extremity among other diagnoses. Review of the Annual Minimum Data Set (MDS) for Resident #55 dated 05/10/2025 showed a Brief Interview for Mental Status (BIMS) score of 15, meaning the resident was cognitively intact. Section GG showed the resident was dependent for showers. Review of the physician orders showed cleanse left posterior thigh with normal saline, pat dry, apply silver alginate and border gauze daily. Review of skin and wound note by Advanced Practice Registered Nurse (APRN) progress notes dated 6/23/2025 showed patient was evaluated today for evaluated of LLE (Left Lower Extremity) at request of nurses due to patient complaints of drainage. Patient remains on palliative care. Left Lower extremity rolled gauze wrap noted to be urine soaked with strong ammonia malodor to dressing. Patient has skin tear to left posterior thigh, patient endorses difficulty with bed mobility and frequently sliding to maneuver. and refuses to wear pants or clothing to protect lower limbs. No other complaints per nursing staff. During an interview on 06/25/2025 at 10:16 a.m. Resident #55 stated they [staff] normally close the door and curtain during care. Resident #55 stated the ARNP was standing in the door at the time of my care. Resident #55 stated, It is upsetting that they did not shut the door. Resident #55 stated he expected the staff to close the door and curtain. Resident stated, I don't' want to moon anybody. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/2025 at 12:46 p.m. the Director of Nursing (DON) stated she expected the staff to knock on the door, introduce themselves, inform the resident of services to be rendered. The DON stated she expected the staff to close the curtain and the door before providing care. The DON stated not closing the curtain and door was a breach in privacy and a dignity issue. Review of the facility's policy, Resident Rights, revised February 2011 showed Employees shall treat all residents with kindness, respect, and dignity. Policy and Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness and dignity. Based on observation, interview, and record review the facility failed to ensure dignity was maintained for residents requiring meal assistance for two residents (#141 and #204) out of 36 sampled residents and did not ensure dignity was maintained during care for one resident (#55) out of 36 residents sampled. Findings included: 1. An observation was conducted on 06/23/25 at 11:58 a.m. in the Central Unit dining room with a table of three residents and a table of four residents. Two Certified Nursing Assistants (CNAs) and a Speech Language Pathologist (SLP) were present. Resident #141 was observed sitting at the table with two other residents. Resident #141 was observed utilizing their fingers dipping into a bowl of pudding. Resident #141 returned fingers to their mouth, the pudding dropped from their fingers on the way to their mouth. The SLP stated to Resident #141, Eating with your fingers is ok as long as you are eating. No other staff members were observed to assist or encourage Resident #141 with their meal. Review of admission Record showed Resident #141 was admitted on [DATE] and readmitted on [DATE] with diagnoses including dementia, need for assistance with personal care, adult failure to thrive and anxiety. Review of Resident #141's Minimum Data Set (MDS), dated [DATE], Section C, Cognitive Patterns, showed her Brief Interview for Mental Status (BIMS) score is 99, indicating impaired cognition. Review of Resident #141's Activities of Daily Living (ADL) care plan, revised 07/11/22, showed resident exhibits behavior of eating with hands instead of using utensils and the interventions listed included: Staff to anticipate care needs and provide them before resident becomes overly stressed, approach resident in a calm manner and explain actions, and provide positive reinforcement for successful interactions/efforts. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An observation was conducted on 06/24/25 at 11:45 a.m. in the Central Unit dining room. Two tables of four residents each were in the dining room. Two residents (141 and 204) were observed sitting at a table with two other residents between each resident. Three staff members were present (two CNAs and one nurse). Resident #141 was observed to pick up a hot dog bun with chopped meat, the meat fell onto the resident's plate. Staff G, CNA started to assist Resident #141 with the remainder of the meal. Resident #204 was observed at the table with a plate, bowl, cup and silverware placed just to the lower right of the plate. Resident #204 was observed to pick up the bowl, brought the bowl to their mouth and started licking the contents from the bowl. The resident next to Resident #204's right side, kept telling Resident #204 to stop. The resident to Resident #204's right started to reach out and push Resident #204's forearm to the table, while saying, don't do that. The resident next to Resident #204 reached for Resident #204's pudding bowl and started to take the pudding away from Resident #204. Staff G, CNA who was assisting Resident #141 stood up and took the bowl from the resident and placed the bowl in the middle of the table, out of the reach of all the residents. Resident #204 cried out. Resident #204 then reached for the hot dog bun with chopped meat, which was on their plate. Resident #204 picked up the bun and the chopped meat fell off into their lap and plate. Resident #204 sighed heavily and put the bun back down on the plate, then proceeded to pick up the entire plate, brought the plate to their mouth and tried to eat the bun with chopped meat from the plate. Resident #204 was struggling while doing this and the resident to the right continued to discourage Resident #204. No staff member encouraged or assisted Resident #204 to try to utilize utensils or assisted the resident with the meal. Review of admission Record showed Resident #204 was admitted on [DATE] with diagnoses including dementia with agitation, adult failure to thrive, anxiety and need for assistance with personal care. Review of Resident #204's Minimum Data Set (MDS), dated [DATE], Section C, Cognitive Patterns, showed her Brief Interview for Mental Status (BIMS) score is 00, indicating impaired cognition. Review of Resident #204's Activities of Daily Living (ADL) care plan, revised 12/05/24, showed Resident #204 has a self-care deficit with . eating, . related to: impaired mobility, fracture of humerus, generalized weakness, has dx (diagnosis) of failure to thrive, Demetia, requires staff assistance with ADL'S. Staff interventions included: Cue/encourage resident to participate in ADL tasks, allow resident ample time to attempt/complete ADL tasks before intervening, staff to anticipate resident's needs with ADLs. During an interview on 06/24/25 at 02:25 p.m. Staff G, CNA confirmed Resident #141 and #204 were eating with their fingers during lunch. Staff G, CNA confirmed the resident next to Resident #204 took the pudding away. Staff G, CNA stated not being sure what to do with Resident #204 behavior as the nurse did not intervene and while they were assisting Resident #141. Staff G, CNA stated the staff should have encouraged Resident #204 to use the utensils or assisted Resident #204 sooner. During an interview on 06/26/25 at 09:46 a.m. the Director of Nursing (DON) stated the staff should have intervened and encouraged the residents to utilize utensils or assisted the residents if needed.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to provide language assistance to a resident with limited English proficiency for one resident (#210) of 65 sampled residents. Findings included: An observation on 06/23/2025 at 12:40 p.m. revealed Resident #210 sitting at bedside in a wheelchair eating her lunch. The resident was only able to speak Spanish. Surveyor went to the nursing station to find a bilingual staff member to assist with the interview. The resident's aide came down and stated she was unable to speak Spanish. The aide stated she was able to understand if the resident had pain or not. The aide went to get Staff B, Registered Nurse (RN) and told her the resident was in pain. The surveyor went to the conference room to get another surveyor who speaks Spanish. The resident was saying in Spanish, Oh my God I'm in a lot of pain, help me please, they don't understand me. The resident appeared to be tearful and visibly in pain. The resident was observed speaking Spanish to her family member on the phone. The family member said in Spanish, They don't speak Spanish and they don't understand her. The nurse (Staff B) walked in shortly after observation and provided medication to the resident. The resident was telling the nurse in Spanish she is in a lot of pain. The nurse looked at surveyor and asked, what is the resident saying. The nurse went to get another staff member, a second aide, who assisted resident with getting into bed. A follow-up interview with resident once she was in bed revealed she primarily speaks Spanish and stated the staff don't understand her and she does not understand them. Review of the admission Record showed Resident #210 was admitted to the facility on [DATE]. The diagnoses included but not limited to disorder of brain, benign neoplasm of cerebra meninges, Diabetes with neuropathy, muscle spasm, polyneuropathy, major depressive recurrent, hypertension, repeated falls, generalized anxiety disorder, bipolar disorder, schizophrenia cervicalgia. Review of the progress note dated 06/13/2025 showed, Social Determinants of Health: Resident is [NAME] Rican. Language: Spanish Resident does need or want an interpreter to communicate with a doctor or health care staff. Lack of transportation has not kept Resident from medical appointments, meetings, work or from getting things needed for daily living. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy: Sometimes. How often do you feel lonely or isolated from those around you: Never. Review of the care plans showed Resident #210 has an alteration in communication ability related to language barrier. She does not speak English; primary language is Spanish. She understands some English speaking and able to voice some needs in English. Spanish speaking staff is available to assist with translation as needed as of 03/19/2025. Interventions included but not limited to repeat/rephrase messages as needed if resident misses part of intended message; speak to resident in simple, direct terms; ask resident yes/no questions; provide interpreter prn; ask family to interpret as able; keep call light within reach; respond to communicated needs prn. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/2025 at 12:46 p.m. the Director of Nursing (DON) stated depending on the language, they have someone who can interpret. The DON stated we have some Spanish speaking residents and try to place them on the station with the Spanish speaking staff. The DON stated the needs will depend on their cognition. The DON stated we can provide communication boards. The DON stated they do not have a list of staff members who are bilingual. The DON stated, We kind of know. She stated the SSD (Social Services Director) is bilingual, therapy staff is bilingual, nursing and aide staff. The DON stated she thought Resident #210 had a communication board. The DON stated we have therapy and one of our nurses' who floats over there (400 Hallway) on the 3-11 shift. The DON stated the resident calls her loved one to interpret also. Review of the facility's policy, Policy and Procedure: Right to Communication with Privacy, dated 1/2019 showed: 5. The resident has the right to have interpretive assistance for communication in another language. Facility will provide communication boards, staff interpreters or other means of communication as needed.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to accommodate residents needs related to 1.) Not having call light buttons placed within reach when in bed for five residents (#135, #79, #208, #15 and #25) out of sixty-five sampled residents and 2.) Not providing a wheelchair in order for resident (#135) to get up out from bed and out of her room per the resident's preference. Findings included: 1. On 6/25/2025 at 6:35 a.m., and 8:45 a.m. on Resident #208 was observed in bed lying under the covers. Further observations revealed the call light cord wrapped around the left upper bed rail, with the call button hanging down towards the floor. The cord and button were out of the resident's reach. On 6/26/2025 at 7:40 a.m. and 8:30 a.m. Resident #208 was observed in bed, her call light button was hanging below the bed mattress on the right side of the bed. The call light cord and button was in a position out from her reach. Review of Resident #208's medical record revealed she was admitted to the facility on [DATE]. 2. On 6/25/2025 at 6:45 a.m. Resident #15 was noted in bed with the call light button not placed within his reach. The call button and cord were lying on the floor back and behind the resident. On 6/25/2025 at 8:3 a.m. Resident #15's was noted in the same position in bed and the call light button was observed still on the floor, back behind his bed and out from his reach. On 6/26/2025 at 7:45 a.m. Resident #15's was observed in bed, the call light button and cord were positioned on the back of the bed and hanging down over the head of the bed, and out from his reach. Review of Resident #15's medical record revealed he was admitted to the facility on [DATE] and readmitted on [DATE]. 3.On 6/25/2025 at 6:45 a.m. Resident #25 was observed in bed with the call light button not placed within his reach. The call button and cord were lying on the floor back and behind the resident. On 6/25/2025 at 8:30 a.m. Resident #25 was observed in bed, the call light button was observed still on the floor, back behind his bed and out from his reach. On 6/26/2025 at 7:45 a.m. Resident #25 was observed in bed with the call light button and cord positioned on the back of the bed and hanging down over the head of the bed, and out from his reach. Review of Resident #25's medical record revealed he was admitted to the facility on [DATE] and readmitted on [DATE]. Review of the current care plans with next review date 8/19/2025 revealed the following areas: Resident #25 is at risk for falls and fall related injuries with interventions to include but not limited to: Keep call light within reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/2025 at 10:00 a.m. an interview with Staff X Licensed Practical Nurse (LPN)/ Unit Manager (UM) revealed she was not aware the call light cords/buttons were not within the resident's reach. She stated the call light button should always be within the resident's when they are in bed and that staff are to observe for proper placement during each visit, every two hours. The Unit Manager revealed even if the resident does not routinely use the call light button, or rarely uses it, it still needs to be placed within his/her reach. 4. On 6/24/2025 at 10:00 a.m. an interview was conducted with Resident #135 which revealed she was having issues with the facility not getting her a wheelchair since her admission on [DATE]. She revealed she is at the facility for short term rehabilitation services, and she does receive therapy, and the facility has not provided her with any wheelchair in order to get out from bed and to go out from her room or to attend activities. Resident #135 revealed she had asked the facility staff about one month ago to include various nurses, the social service person and the Nursing Home Administrator (NHA). She revealed they came to her with a wheelchair during the first week or so of her admission and it did not fit her. She stated she needed a larger one to help her feel more comfortable in the seat. She revealed nobody ever responded back up until about a month ago, when she requested for a wheelchair again. She stated she has yet to receive one. Resident #135 confirmed had she had a wheelchair, she would get up out from bed. On 6/26/2025 at 9:30 a.m. an interview was conducted with Resident #135. She confirmed she had yet to get a wheelchair to be transferred into. She revealed she had not received any follow -up from the NHA and the Social Service Department (SSD). She revealed she had spoken with an unknown therapy staff member, and they too did not provide her with a wheelchair to use. Resident #135 revealed her aides tell her every day they did not have any wheelchairs that fit her, and she would just have to wait until they get one. Review of the medical record revealed Resident #135 was admitted to the facility on [DATE] with diagnoses to include Obesity, Adult failure to thrive, and Major depression, Anxiety. Review of the current Quarterly MDS assessment for Resident #135 dated 6/1/2025, revealed; Cognition/Brief Interview Mental Status score of 15 of 15, which indicated the resident was able to be interviewed related to her medical care and services. ADL - No impairment on both lower and upper extremities- toileting, requires substantial/Maximal assistance and was dependent for transfers. The assessment showed it was checked Yes for wheelchair as mobility device. Review of the current care plans for Resident #135 with a next review date 8/30/2025 revealed - Risk for falls and/or fall related injury related to generalized weakness, is non ambulatory, uses wheelchair as primary mode of locomotion, receives psych. meds, narcotics, with interventions in place to include but not limited to: Assist to wheel to destinations. On 6/26/2025 at 10:00 a.m. an interview was conducted with Staff X LPN/UM. She revealed the resident was assessed for a wheelchair during the first part of her admission and found that the resident did not want that wheelchair because she preferred a larger one. The Unit Manager revealed she believed Therapy had ordered another one but was not sure. The Unit Manager confirmed there was no documentation in the record to support the resident ever refused the wheelchair. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/2025 at 10:40 a.m. an interview with the Rehabilitation Director Staff Q revealed the resident was assessed and provided with a wheelchair when she was first admitted but she had heard the resident refused it and wanted another one. Staff Q revealed it was only brought to her attention yesterday (6/25/2025). She revealed the resident will be assessed and provided with a wheelchair that fits her. Staff Q could not provide any documentation to support a wheelchair was provided to the resident upon her admission, nor did she have any documentation to support the resident refused said wheelchair. Review of a facility policy titled, Call System, Resident revised September 2022 showed, the policy heading showed - Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. The policy further revealed 1.) Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to notify the physician and/or family of changes in condition (CIC) and treatment and care changes for three residents (#50 #18, #5) of 65 sampled residents. Findings included: 1. Resident #50 was admitted on [DATE]. Review of the admission showed diagnoses included but not limited to fibromyalgia, muscle weakness, emphysema, acute myocardium Infarction, pulmonary hypertension, Chronic Obstructive Pulmonary Disease, chronic respiratory failure with hypercapnia, asthma, chronic bronchitis, generalized anxiety disorder, opioid dependence, major depressive disorder recurrent, hypertension. Review of the quarterly, Minimum Data Set (MDS) dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). Review of the physician orders for Resident #50 showed Triamterene-HCTZ Capsule 37.5-25 MG (milligram) give 0.5 mg daily for edema as of 06/22/2025 and discontinued on 6/25/25 and triamterene-HCTZ Capsule 37.5-25 MG give 0.5 mg daily for edema as of 06/25/2025 Review of the June 2025 Medication Administration Record (MAR) for Resident #50 showed Triamterene-HCTZ Capsule 37.5-25 MG (milligram) give 0.5 mg daily for edema had not been administered as of 06/25/2026. Review of the progress notes for Resident #50 showed the following: On 06/25/2025 at 4:05 p.m. Unit Manager (UM) placed a call to pharmacy to check status of medication. Pharmacy stated the prescription form was put in incorrectly and needed a new order. UM placed call to MD to advise medication form was incorrect and the delay of medication delivery. MD provided new order. UM called pharmacy and have order being sent stat to facility and MD okay new administration date. On 6/25/25, 1539, Change in Condition for edema (new or worsening), Recommendations: Triamterene 37. 5/25 mg tab to take 0.5 daily. On 06/25/2025, Triamterene-HCTZ Capsule 37.5-25 MG, Give 0.5 tablet by mouth one time a day for edema half tab daily, on order. will call pharmacy to follow up. On 06/24/2025, Triamterene-HCTZ Capsule 37.5-25 MG, Give 0.5 tablet by mouth one time a day for edema half tab daily, on order. On 06/23/2025, Triamterene-HCTZ Capsule 37.5-25 MG, Give 0.5 tablet by mouth one time a day for edema half tab daily, Ordered. On 06/19/2025, MD note, late entry, scanned in on 6/25/25, reason for appointment edema. complains of LLE radicular pain, improved on muscle relaxants. Complains of edema. She has Coronary Artery Disease (CAD). she does not have Congestive Heart Failure (CHF). No dyspnea, orthopnea. Localized edema. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plans for Resident #50 showed - Resident #50 has potential for complications related to an alteration in cardiac function related to hypertension, and Coronary Artery Disease as of 01/29/2025. Interventions included but not limited to administer medications as ordered, observe for effectiveness and for side effects. Observe for new presences of or increase in edema; notify physician if noted. During an interview on 06/25/2025 at 2:45 p.m. the Director of Nursing (DON) stated she would look into why Triamterene-HCTZ had not been given to the resident and why the Medical Doctor (MD) was not informed. During an interview on 06/26/2025 at 9:18 a.m. Staff U, Licensed Practical Nurse (LPN)/ Unit Manager (UM) stated the physician inputted the Triamterene-HCTZ Capsule 37.5-25 mg. give 0.5 tablet by mouth. The UM stated the original order was placed on 06/23/2025 at 2:23 a.m. and the nurse confirmed it on 06/23/2025 at 3:09 p.m. The UM stated because it was written as a capsule, it could not be cut in half per the order. The UM stated she called the pharmacy on 06/25/2025 and the pharmacy informed her of above. The UM then called the MD, and he put in another order for tablets not capsules. The UM stated she put it in as a stat order. She stated the medication came in this morning for administration. The UM stated the procedure was to call the MD if a medication was not administered as per orders. The UM verified there was no documentation the nurses had informed the MD the medication had not been given for three days on 06/23/25, 06/24,25, 06/25/25. The UM stated she expected to see the MD notification. 2. During an interview on 06/23/25 at 02:45 p.m. the Responsible Party (RP) for Resident #5 stated the facility is terrible about notifying me of anything. The RP explained being contacted at 2:00 a.m. once and notified Resident #5 was back safely. The RP stated no one contacted me to let me know Resident #18 needed to go out to the hospital. The RP stated, didn't even know Resident #5 was gone. The RP stated not knowing Resident #5 had pneumonia or was being treated with antibiotics before one of the hospitalizations. The RP stated they didn't know she went to the hospital. They stated they were was aware of a hospitalization but was left to believe it was due to a feeding tube placement. Review of Resident #5's face sheet revealed the resident was admitted on [DATE] and readmitted on [DATE]. Review of the admission showed diagnoses included but not limited to pneumonitis due to inhalation of food and vomit; severe sepsis, dysphagia, muscle weakness, type 2 diabetes mellitus, chronic obstructive pulmonary disease. Review of the quarterly, Minimum Data Set (MDS) dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 00 severe cognitive deficit. Review of Resident #5's physician orders revealed resident received Amoxicillin-Pot Clavulanate Oral Tablet 875-236 MG by G-tube two times a day for aspiration pneumonia for 7 days dated 05/06/25. Review of the progress notes for May 2025 did not reveal the RP was notified. During an interview on 06/25/25 at 11:37 a.m. Staff K, Registered Nurse (RN) stated the family, or RP should be notified when anything out of the ordinary occurs with the resident. The RP/family should definitely be contacted if a resident has an infection or has to go to the hospital. During an interview on 06/25/25 at 01:00 p.m. the Director of Nursing (DON) stated the expectation is for family/RP notifications to occur with a medication and transfer to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105140	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bristol Care Center	1818 E Fletcher Ave Tampa, FL 33612

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #18's face sheet revealed resident admitted on [DATE] with diagnoses including but not limited to protein-calorie malnutrition, cirrhosis of the liver, muscle weakness, Chronic Obstructive Pulmonary Disease, anxiety disorder, major depressive disorder recurrent, hypertension, type 2 diabetes mellitus, need for assistance with personal care and schizoaffective disorder. Review of the quarterly, Minimum Data Set (MDS) dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). Review of the Resident #18's weight log revealed: On 05/08/2025, the resident weighed 200 lbs. On 06/18/2025, the resident weighed 182 pounds which is a -9.00 % Loss. On 03/06/2025, the resident weighed 192 lbs. On 06/18/2025, the resident weighed 182 pounds which is a -5. 21 % Loss. On 01/03/2025, the resident weighed 203 lbs. On 06/18/2025, the resident weighed 182 pounds which is a -10.34 % Loss. Review of Resident #18's Registered Dietitian (RD) Nutrition Risk Evaluation dated 6/22/25 revealed: Risk score 9, meaning at risk for malnutrition and weight warning: Value: 182.4, Vital Date: 2025-06-11 10:40:00.0 -10.5% , 21.4# [pound] x 2 days. -11% , 22.6# x 7 days. -8.8% , 17.6# x 34 days. -10.1% , 20.6# x 5 1/3 months. Erratic wt. [weight] changes, unknown etiology except different scales, no change in diuretic doses. Review of Resident #18's Registered Dietitian (RD) Nutrition Risk Evaluation dated 3/21/25 revealed: weight warning: Value: 192.6, Vital Date: 2025-03-06 09:47:00.0 -7.5% change [9.3% , 19.8#] x 3 months. -10% change [10.4% , 22.3#] x 6 months. Wt. stabilizing. The record did not reveal the physician had been notified of the weight loss for Resident #18. Review of the physician documentation available at the time of the survey did not reveal a documentation showing notification of Resident #18's weight loss status. During an interview on 06/25/25 at 01:33 p.m. Staff F, Licensed Practical Nurse (LPN) stated nurses don't notify the physician of weight loss. Staff F stated she thinks the dietary department does. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/25 at 09:31 a.m. the DON confirmed the physician should have been notified of the resident's weight loss and would need to investigate why there was no documentation. Review of the facility's policy and procedure titled Notification of Changes dated 10/2024 revealed: Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification. Examples for notification include: 1. Accidents. a. Resulting in injury. b. Potential to require physician intervention. 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. Life-threatening conditions, or b. Clinical complications. 3. Circumstances that require a need to alter treatment. This may include: a. New treatment. b. Discontinuation of current treatment due to: i. Adverse consequences. ii. Acute condition. iii. (continued on next page)

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	105140	A. Building B. Wing	06/26/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Exacerbation of a chronic condition. 4. A transfer or discharge of the resident from the facility. 5. A change of room or roommate assignment. 6. A change in resident rights. Review of an undated facility policy and procedure titled, Change of Condition Process revealed: intent: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notify, consistent with his or her authority, resident's representative when there is a change requiring notification. Procedure: The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification. Situations requiring notification include: 1. An accident involving the resident which: a. Resulting in injury. b. Potential to require physician intervention. 2. A significant change in the resident's physical, mental, or psychosocial status that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications. This may include: a. life-threatening conditions, or b. Clinical complications. 3. A need to alter treatment significantly; that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment. This may include: a. A new infection or wound. (continued on next page)

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	105140	A. Building B. Wing	06/26/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Discontinuing a treatment or changing a medication due to: . 4. A decision to transfer or discharge the resident from the facility. 5. The facility must also promptly notify the resident and the resident representative, if any, when there is: a. A change in room or roommate assignment, or b. A change in resident rights under Federal or State law or regulations. 4. Upon the identification of a change in condition in a resident the Nurse will complete an evaluation of the resident's status, and document findings on the SBER Change in Condition in the resident's electronic medical record.

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	105140	A. Building B. Wing	06/26/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure resident rooms, common areas, equipment and furnishings were maintained in a clean, safe and sanitary manner in four units (Northeast, Southwest, Southeast and Central) out of five units during four days (6/23/25, 6/24/25, 6/25/25, and 6/26/25) out of four days observed. Findings included: On 6/23/2025 at 10:20 a.m., 6/24/2025 at 7:50 a.m., 1:00 p.m., 6/25/2025 at 8:00 a.m. and 12:30 p.m., and on 6/26/2025 at 1:00 p.m. the following observations were made: 1.The following was observed in the North East Unit: Resident room [ROOM NUMBER] room air conditioner unit was observed with filters that were heavily caked with dust and debris. Resident room [ROOM NUMBER] was observed with the left air conditioning filter missing from the unit. The Community shower room was observed with insufficient lighting with one ceiling light not working. The lower left side and right-side walls of the shower stall were observed in disrepair with holes. There was black bio growth on the lower wall base tiles and grout. Resident room [ROOM NUMBER] was observed with several blind slats cut away measuring approximately four inches by four inches. Room air conditioner unit was observed with filters that were heavily caked with dust and debris. Resident room [ROOM NUMBER] room sink area was observed with the sink lip missing caulking and leaving an exposed space that was not cleanable. The room air conditioner unit was observed with filters that were heavily caked with dust and debris. The bed frame for bed was observed with heavily rusted surface leaving a non-cleanable space. Resident room [ROOM NUMBER] window was observed with blinds in disrepair Resident rooms 302, 301, 305, 306, 307, 308, 309, 315, 316, 319, 322, and 325 room air conditioner units were observed with filters that were heavily caked with dust and debris. Resident room [ROOM NUMBER] Call light system in the bathroom was observed torn off the wall with exposed wiring. The bed - A metal frame was observed with heavy rusting leaving a non-cleanable surface, a metal over-the-commode device was observed with grey paint peeled up leaving heavy rusting. This was an uncleanable surface. Resident room [ROOM NUMBER] bathroom was observed with a call light box off the wall, leaving exposed wires. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident room [ROOM NUMBER] was observed with a wall in disrepair leaving a hole near the B-bed, a large red dresser was observed positioned in a manner to block the bathroom door and leaving it inaccessible. The over-the-commode device was observed with grey paint peeled up leaving heavy rusting and uncleanable surface. The blinds were observed soiled. Resident room [ROOM NUMBER] was missing a call light system in the private bathroom, three floor tiles under the room sink area were observed with heavy water damage and were not affixed to the floor. 2. In the South [NAME] Unit, the following was observed: Resident room [ROOM NUMBER]-bathroom metal over-the-commode device was observed with grey paint peeled and rusted, leaving a non-cleanable surface. Resident rooms 210, 214, 216, 218, and 219 air conditioner units were observed with filters that were heavily caked with dust and debris. The community shower room was observed with one of two stalls with black bio growth on floor tiles and lower will tiles and grouting. Resident room [ROOM NUMBER] shared bathroom was observed with a toilet paper holder missing the roll holder and there was no toilet paper observed in the bathroom. 3. In the South East Unit, the following was observed: In Resident room [ROOM NUMBER] the bathroom was blocked by furniture. Resident rooms 101, 102, 108, and 117 room air conditioner units were observed with filters that were heavily caked with dust and debris. Resident room [ROOM NUMBER] the room area sink was observed with missing caulking between the sink bowl and counter, leaving an exposed area that was non cleanable. Resident room [ROOM NUMBER] had three broken window blind slats and the bathroom door scrapped, making it hard to pull open. Resident room [ROOM NUMBER], room area vanity counter was observed to be in disrepair, along with the bathroom toilet paper holder. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/2025 at 2:09 p.m. an interview was conducted with the Maintenance Director who revealed there are two maintenance workers to include himself and the facility is very large in size accommodating two hundred and fifty plus beds. The Maintenance Director revealed he operates with work orders through an electronic record base system. He revealed if there are any issues with resident rooms, equipment, etc. He stated staff are to go into the electronic work order system and he will receive those orders. He revealed he does look at the orders to decide what things need to be fixed or repaired on a priority level. The Maintenance Director stated the residents' rooms have two air filters and they are to be changed approximately every month, per the facility's electronic maintenance system. He confirmed he and his staff have not been able to get to the air conditioner filters on monthly basis and confirmed the filters were caked with dust and debris. On 06/26/2025 at 02:23 p.m., an interview was conducted with the Director of Housekeeping. She stated housekeeping in rooms and spaces are performed daily. She stated showers and floors are cleaned by hand and with a machine. She stated maintenance vacuums the vents to clean them. She stated that she and her staff reports maintenance issues via the electronic maintenance system. (Photographic Evidence Obtained) 4. During a facility tour on 06/23/25 at 09:27 a.m. to 02:03 p.m., the following was observations were made in the central unit: room [ROOM NUMBER]'s bathroom toilet was dripping water from the pipe, at the back of the toilet connecting into the wall, down to the floor, a puddle was formed at the toilet base. The toilet bowl had an orange ring in the bowl. room [ROOM NUMBER]'s bathroom had two screws protruding from the tile next to the toilet, where the toilet paper holder should have been. The bathroom emergency call cord was on the floor and ran through a rusty screw. room [ROOM NUMBER]'s toilet bowl had multiple black rings inside. room [ROOM NUMBER]'s in room sink counter was cracked, resulting in an unfinished sharp edge and the sink bowl was not grouted to the counter, creating an uncleanable surface. In the southeast unit at the back hallway was an unlocked breaker box. room [ROOM NUMBER]'s toilet bowl had multiple black rings inside. The Central unit's day room Packaged Terminal Air Conditioning (PTAC) unit was separating from the wall and the section of wall between the unit and the window had black bio growth, white spots and the paint was peeling. room [ROOM NUMBER]'s blinds were bent, cracked, and pieces were missing. The wall by the toilet had a black bio growth. room [ROOM NUMBER]'s bathroom door handle was missing. (continued on next page)

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	105140	A. Building B. Wing	06/26/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/24/25 at 08:15 a.m. Staff C, Certified Nursing Assistant (CNA) stated the floor was wet and the water appeared to be coming from the bathroom. Staff C confirmed water was slowly dripping from the toilet pipe. Staff C stated when an issue is noted a note would be made into the electronic maintenance system for repair. During an interview on 06/24/25 at 02:15 p.m. the Maintenance Director confirmed the electric panel should be locked at all times and the toilet would need repair. During an interview on 06/24/25 at 02:15 p.m. Staff E, Housekeeping Aide (HA) stated when cleaning in the rooms if they note an issue they should place the report in the electronic maintenance system. During an interview on 06/24/25 at 08:05 a.m. the Housekeeping Director (HD) confirmed the black rings in the toilets. The HD stated there was nothing that could be done about the rings. The HD confirmed the toilet paper holder was missing in room [ROOM NUMBER]. On 06/26/2025 at 02:00 P. M., the NHA and DON provided the Cleaning and Disinfecting Residents' Rooms policy and procedure, with a revision date of August 2013, revealing the purpose of this procedure is to provide guidelines for cleaning and disinfecting residents' rooms. The guidelines revealed: 1. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. 2. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled. 4. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled. Steps in the procedure, resident room cleaning. 6. Clean horizontal surfaces (e.g., bedside tables, overbed tables, and chairs) daily with a cloth moistened with disinfectant solution. Do not use feather dusters. 7. Clean personal use items (e.g., lights, phones, call bells, bedrails, etc.) with disinfectant solution at least twice weekly. 11. Clean curtains, window blinds, and walls when they are visibly soiled or dusty. On 06/26/2025 at 02:00 P. M., the NHA and DON provided the Resident Rights - Safe/Clean/Comfortable/ Homelike Environment policy and procedure, with no last review date. The intent showed it is the policy of the facility to provide a safe, clean, comfortable homelike environment such a manner to acknowledge and respect resident rights. The procedure revealed: (continued on next page)

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	105140	A. Building B. Wing	06/26/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The resident has a right to a safe, clean, comfortable and home-like environment, including but not limited to receiving treatment and supports for daily living safely. 2. The facility must provide a safe, clean, comfortable, and home-like environment, allowing the resident to use his or her personal belongings to the extent possible. a. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. 3. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. (Photographic Evidence Obtained)

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	105140	A. Building B. Wing	06/26/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to provide enteral nutrition according to physician orders for one resident (#79) out of fourteen residents sampled. Finding included: On 6/24/2025 at 7:09 a.m. Resident #79 was observed in her room and lying in bed with her head over bed approximately thirty-five to forty degrees. The observations revealed she was receiving nourishment via tube feeding system with the pump on and bottle hung. The label on the bottle read Jevity 1.5 hang date 6/24/2025, hang time 6:00 a.m., run time 40 ml/hr (milliliter/hour), and with the resident's name. The bottle was observed with approximately 800 ml of nourishment. On 6/24/2025 at 3:00 p.m. Resident #79 was observed in her room with the tube feeding bottle still hung but the system/pump was turned off. The tube line was hanging/draped over the bottle. The bottle was labeled/dated as earlier. During this observation, there was 500 ml of nourishment left in the bottle. On 6/25/2025 at 8:00 a.m., 2:00 p.m., and 3:00 p.m. Resident #79 was observed with the same bottle from 6/24/2025 and still with 500 ml of nourishment left. The observation revealed the resident had not received nourishment since 3:00 p.m. the previous day, on 6/24/2025. On 6/26/2025 at 7:10 a.m. and 9:00 a.m. Resident #79 was observed with the tube feeding system pole at bedside, with the same bottle of nourishment from 6/24/2025 (two days prior). The tubing/line was observed draped over the bottle and it was determined there still 500 ml of nourishment left in the bottle. The observation revealed the resident had not received nourishment for two days, since 3:00 p.m. on 6/24/2025. On 06/26/2025 at 8:16 a.m. an interview was conducted with Staff Y, Licensed Practical Nurse (LPN). Staff Y. When asked about the resident's tube nutrition bottle, Staff Y stated the date listed on the nutrition bottle was 06/25/2025. When she went into the room to check the nutrition bottle date and time, an observation was made in which the nutrition bottle had been thrown in the trash bin. Staff Y, LPN then stated she saw the bottle showed 6/24/2025, during the interview. She stated there may have been a mistake when entering the date on the nutrition bottle. She pulled the nutrition bottle out of the trash bin. She stated the tube nutrition bottle should be used within twenty-four hours of being hung and used. She stated if the twenty- four hours are exceeded, a new feed bottle must be hung. She stated that the resident was on the feed throughout the night. Review of Resident #79's medical record reveled she was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include but not limited to Depression, Dysphagia, GERD, Cognition Communication deficit. Review of the current Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Section C-Cognition/Brief Interview Mental Status or BIMS score of 2 of 15, which indicated the resident was not interviewable related to her medical care and services. The ADL section showed the resident was dependent with most ADLs. The Nutrition was checked, Yes showing she receives tube feeding. (continued on next page)

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	105140	A. Building B. Wing	06/26/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the current Physician's Order Sheet (POS) for the month of 6/2025 revealed orders: Enteral feed ever shift for enteral support; Start Jevity 1.5: To run at 40ml/hr. May hold for services and care. Flush feeding tube with 100ml of water every 4 hrs. and every shift for enteral support verify Jevity 1.5 tube feeding is running at 40ml hr. Flush feeding tube with 100 ml of water every 4 hrs. Order date: 6/11/2025. Review of the current care plan with next review date 9/9/2025 revealed Resident #79 was at risk for altered nutrition/hydration and unavoidable weight fluctuation/loss Dx/HX (diagnosis/history), CVA (cerebrovascular accident), R (right) hemiplegia/contracture, Aphasia, Dysphagia, Missing some dentition, Altered Consciousness, Cognitive Communication deficit, Depression, HTN (hypertension), Diuretic, Self feeding difficulty, History. Significant weight loss followed by gain, with interventions in place to include: Administer enteral feeding and flushes as ordered, observe for tolerance; Encourage adequate intake at meals. - Resident is at risk for complications associated with enteral feedings; also receiving po (by mouth) diet, at risk for aspiration, at risk for skin impairment to site, GI (gastrointestinal) distress related to tolerance of enteral formula, with interventions in place to include: Verify tube feeding placement as ordered, Check enteral feeding residuals as ordered, Administer enteral feeding and flushes as ordered, observe for tolerance, Keep Head Over Bed (HOB) elevated while feeding in process. On 6/26/2025 at 10:00 a.m. an interview with the Northeast Unit Manager, Staff X, LPN who confirmed Resident #79 was ordered for Tube Feed nourishment and also eats regular food by mouth. The Unit Manager revealed Resident #79's weights had fluctuated up and down and the dietician has been monitoring her weights and nourishment parameters. The Unit Manager was not aware the Jevity nourishment bottle was hanging in the room on the pole for 48 hours and had not been changed. She revealed once a bottle is hung and started, it should not be on the pole greater than 24 hours. She was not sure why the bottle was there and not being used. The Unit Manager was notified the bottle was hung and started on 6/24/2025 at 6:00 a.m. and left for forty-eight hours. The Unit Manager confirmed it should not have been opened, used and kept on the pole for more than twenty-four hours. Staff X, LPN was not sure why the MAR (Medication Administration) /TAR (Treatment Administration Record) were documented as Tube Feeding nourishment having been provided for the day of 6/26/2025. On 6/26/2025 at 1:00 p.m. the Nursing Home Administrator (NHA) and Director of Nursing provided the Enteral Nutrition policy and procedure with a revised date of 2018 for review. The Policy Statement revealed; Adequate Nutritional support through enteral nutrition is provided to residents as ordered. The Policy Interpretation and Implementation section revealed: 4 . Enteral nutrition is ordered by the provider based on the recommendations of the dietitian. If a feeding tube is ordered, the provider and interdisciplinary team document why enteral nutrition is medically necessary. 8 . The dietitian monitors residents who are receiving enteral nutrition and makes appropriate recommendations for interventions to enhance tolerance and nutritional adequacy of enteral feedings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105140	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bristol Care Center	1818 E Fletcher Ave Tampa, FL 33612

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 . Enteral feeding s are scheduled to try to optimize resident independence whenever possible (e.g., at night or during hours that do not interfere with the resident's ability to participate in facility activities). 11 . The nurse confirms that orders for enteral nutrition are complete. Complete orders include: a. The enteral nutrition product. b. Delivery sit (tip placement). c. The specific enteral access device (nasogastric, gastric, jejunostomy tube, etc. d. Administration method (continuous, bolus, intermittent). e. Volume and rate of administration. f. The volume/rate goals and recommendations for advancement towards these; and g. Instructions for flushing (solution, volume, frequency, timing and 24-hour volume).

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 4. A review of Resident #50's admission record revealed an initial admission date of 01/29/2025with diagnoses included but not limited to fibromyalgia, muscle weakness, emphysema, acute myocardium Infarction, pulmonary hypertension, Chronic Obstructive Pulmonary Disease (COPD), chronic respiratory failure with hypercapnia, asthma, chronic bronchitis, generalized anxiety disorder, opioid dependence, major depressive disorder recurrent, hypertension. Review of a progress note for Resident #50 dated 06/19/2025, showed MD (Medical Doctor) note, marked [late entry] scanned in on 06/25/25, reason for appointment . A second progress note dated 06/12/2025, MD note, marked [ate entry], scanned in on 6/25/25, showed, Reason for Appointment . During an interview on 06/26/2025 at 9:18 a.m. with Staff U, Licensed Practical Nurse (LPN), Unit Manager (UM) stated the MD usually comes in weekly and he has 2 or 3 ARNPs (Advanced Registered Nurse Practitioners) who come in frequently. The UM stated they come most days, but their notes are not in the system timely. During an interview on 06/25/2025 at 2:45 p.m. the Director of Nursing (DON) stated she would look in medical records for the MD notes. The DON was aware the MD notes were not in the chart and available for nursing. Review of the undated facility's policy titled Physician Services showed:11. The Physician will: (a.) Review the resident's total program of care, including medications and treatments, at each visit; (b.) Write, sign, and date progress notes at each visit. 2. A review of Resident #5's admission record revealed an initial admission date of 03/05/2018 and a re-admission date of 6/19/2025 with diagnoses included but not limited to pneumonitis due to inhalation of food and vomit; severe sepsis, dysphagia, muscle weakness, type 2 diabetes mellitus, chronic obstructive pulmonary disease. Review of Resident #5's medical record from 05/01/25 to 06/24/25 did not reveal any physician documentation. 3. A review of Resident #18's admission record revealed an admission date of 09/08/2021 with diagnoses included but not limited to protein-calorie malnutrition, cirrhosis of the liver, muscle weakness, Chronic Obstructive Pulmonary Disease, anxiety disorder, major depressive disorder recurrent, hypertension, type 2 diabetes mellitus, need for assistance with personal care and schizoaffective disorder. Review of Resident #18's medical record from 05/01/25 to 06/24/25 did not reveal any physician documentation. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/25/25 at 3:00 p.m. the Director of Nursing (DON) confirmed the physician documentation was not in the medical record for Resident #5 and #18. Based on record review and interviews, the facility did not ensure physician notes were available to the facility in a timely manner for four residents (#142, #5, #18, and #50) of thirty-six residents reviewed. Findings included: 1. A review of Resident #142's admission record revealed an initial admission date of 03/18/24 and re-admission date of 05/24/25 with diagnoses to include unspecified fracture of left patella subsequent encounter for closed fracture with routine healing, unspecified fracture of left femur, subsequent encounter for closed fracture with routine healing, pain in left hip, other specified disorders of bone density and structure, multiple sites, quadriplegia, unspecified, periprosthetic fracture around internal prosthetic left hip joint, subsequent encounter, other fracture of lower end of right femur subsequent encounter for closed fracture with routine healing, pain in unspecified knee, and chronic pain syndrome. An attempt to review Resident #142's physician notes from 04/2025 to 06/2025 was conducted on 6/23/25 and 6/24/25. There were no physician records available for record review. On 6/25/25 at 5:32 p.m., an interview was conducted with the Director of Nursing (DON). She stated Resident #142's physician's notes were uploaded to the progress notes section today, (6/25/25). The DON confirmed the physician notes were previously not in the medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews and record review the facility failed to follow infection control standards related to hand sanitizing during medication administration and use of gloves when cleaning equipment for five residents (#52, #63, #58, #31, and #219) out of sixty-five residents sampled. Findings included: During an observation on 06/23/2025 at 9:05 a.m., Staff B, Registered Nurse (RN) was administering medications to Resident #52. Staff B stated she had already washed her hands. She opened her computer, then the medication drawer and removed the Dorzolamide HCL solution 2% eye drops inside a baggie. She removed the eye drop bottle from the baggie and placed it on a plate/barrier. Staff B applied gloves and entered the resident's room. She gave the resident a tissue. She placed a drop of eye medicine into each eye. She placed the eye drop medication back on a plate/barrier. She took the tissue from the resident and threw it away. Staff B, RN removed her gloves and threw them away, she did not perform hand hygiene. Staff B, RN exited the room to the medication cart. She inputted the information into the computer. Staff B removed the disinfectant wipe from the bottom drawer and wiped the eye drop bottle off (without applying gloves). She replaced the eye drop bottle into the baggie and placed in the medication drawer. She inputted into the computer. On 06/23/2025 at 9:10 a.m. Staff B, RN poured supplement for Resident #63. She entered Resident #63's room and handed the supplement to the resident. She did not hand sanitize before or after medication administration. Staff B, RN moved the medication cart to the next room. On 06/23/2025 at 9:15 a.m. Staff B stated Resident #58 had his other oral medications but needed his Nitroglycerin patch 0.1 mg/hour. Staff B applied gloves without hand sanitizing and opened the medication cart and removed the Nitro patch. Staff B entered the resident's room. She overlooked the resident's body for the old patch. She removed the Nitro patch and rolled it into one of the gloves and removed the second glove and threw them into the trash. Staff B reapplied gloves without hand sanitizing. She removed the Nitro patch from the packet and placed it on Resident #58's right chest area. Staff B removed her gloves and washed her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/23/2025 at 9:20 a.m., a medication administration observation was conducted for Resident #31. Staff B, RN gathered all medications for administration. Staff B put the pills and nasal sprays onto a plate/barrier and set them on the overbed table. The nasal sprays were administered first. Staff B applied gloves without hand sanitizing and examined Resident #31's right knee. Staff B removed her gloves and reapplied gloves after hand sanitizing. Staff B applied the pain patch to the right knee. Staff B removed her gloves and reapplied her gloves without hand sanitizing. Staff B repositioned the resident's knee, brace and pillow. Staff B removed the privacy bag from the urinary drainage bag and observed the urine and replaced the privacy bag. Staff B removed her gloves, touched her clothes and hand sanitized. Staff B threw the resident's tissue away. Staff B removed the plate/barrier with the nasal sprays on it and exited the room. Staff B opened the medication cart, wiped the nasal sprays with disinfectant wipes with no gloves on. Staff B replaced the nasal sprays into the medication cart. Staff B placed the plate/barrier into the trash and inputted into the computer. At the beginning of medication administration it was noted the medication cart did not have Simethoane 80 mg (milligrams) which the resident was prescribed. Another staff member brought the medication to the medication cart. Without hand sanitizing, Staff B poured the medication into a medication cup and re-entered Resident #31's room to administer the medication. Staff B exited the room and without hand sanitizing started the administration process for the next resident. During an observation on 06/24/2025 at 11:07 a.m. Staff F, Licensed Practical Nurse (LPN) was administering medications to Resident #219. Staff F hand sanitized. She placed the blood glucose monitoring machine, two lancets, two alcohol wipes and a container of strips on a plate/barrier. She entered the room and placed the plate/barrier onto the overbed table. Staff F applied her gloves and wiped the left pointer finger off with alcohol. Staff F then used the lancet. She placed the blood glucose monitoring machine with the strip in place on the drop of blood. The glucose results were 134. She placed a tissue on the resident's finger. Staff F placed the blood glucose monitoring machine on the plate/barrier. Staff F removed her gloves and reapplied gloves with hand sanitizing. Staff F took the plate/barrier to the medication cart. Staff F removed disinfectant wipes from the medication cart and wiped the blood glucose monitoring machine and placed it covered with a wipe into a cup on the medication cart. Staff F removed her gloves and did not hand sanitize. She threw away the lancet. She placed the bottle of strips, which had not been cleaned back into a baggie. Staff F then hand sanitized. Staff F stated she was supposed to leave the blood glucose monitoring machine in the wipe for 30 seconds to 1 minute. Staff F applied one glove onto her left hand and wiped the blood glucose monitoring machine. She then removed the wipe and placed the blood glucose monitoring machine on a clean plate/barrier to dry. Staff F removed the left glove with no hand sanitizing and replaced the blood glucose monitoring machine into a baggie with the bottle of strips that had not been cleaned. Staff F placed the baggie into the medication cart drawer. Staff F went to the nursing station desk to see if there were paper Medication Administration Records (MARS) due to the internet being down. Staff F also checked the nursing station desk to see if that computer was working. The internet came back up and Staff F reviewed the insulin order for Resident #219. Staff F stated Resident #219 will receive Apidra 3 units as ordered before meals but none for the sliding scale. Staff F returned to the medication cart and put on gloves with no hand sanitizing. Staff F primed the Apidra insulin pen with 2 units and then loaded the 3 units. Staff F entered Resident #219's room and injected the insulin into her right upper extremity. Staff F removed her gloves and exited the room. Staff F removed the needle from the insulin pen, replaced the insulin pen into the baggie and replaced the baggie into the medication cart. Staff F then hand sanitized. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/2025 at 12:46 p.m. the Director of Nursing (DON) stated her expectation was for the staff to hand sanitize before and after care, between residents, between glove changes, when moving from one resident room to another, before and after medication administration. The DON stated the blood glucose monitoring machine was to stay wet from 1 to 3 minutes. The DON stated the nurse should have gloves on while cleaning with wipes. Review of the facility's policy, Hand Hygiene, accessed May 2025 showed all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility. Policy and Explanation and Compliance Guidelines showed: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. Hand Hygiene Table showed: Between resident contacts Before performing invasive procedures Before applying and after removing personal protective equipment (PPE), including gloves Before preparing or handling medication Before performing resident care procedures After handling items potentially contaminated with blood, body fluids, secretions, or excretions 6. Additional considerations: a. the use of gloves does not replace hand hygiene if you task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Review of the facility's policy, Administrating Medications, reviewed March 2023 showed 19. Staff follows established facility infection control procedures (e.g., hand washing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. Review of the facility's policy, Glucometer Disinfection, April 2025 showed the purpose of this procedure is to provide guidelines for the disinfection of capillary-blood glucose sampling devices to prevent transmission of blood borne diseases to residents and employees. Policy Explanation and Compliance Guidelines. 1. The facility will ensure blood glucometers will be cleaned and disinfected after each use. 2. The glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant. 3. Glucometers will be cleaned and disinfected after each use and according to the disinfectant manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use. 4. Procedure: b. wash hands. E. put on gloves. i. using first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer j. after cleaning, use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturer's instructions. Allow the glucometer to dry. L. perform hand hygiene.

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	105140	A. Building B. Wing	06/26/2025

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews and record review, the facility failed to ensure patient care equipment to include mechanical lifts were maintained in a safe operating condition for one resident (#142) of 65 sampled. Findings included: On 6/23/25 at 3:52 p.m., an interview was conducted with Resident #142. She was observed sitting up in bed, watching television. She stated she had an incident about a month and a half ago. Resident #142 said she fell from the Hoyer lift. She stated, The Hoyer locked, and the certified nursing assistant (CNA) didn't realize it. She said she went to hospital as a result of the fall as she was in a lot of pain. Resident #142 confirmed the Director of Nursing (DON) said the Hoyer needed to be removed, but it was not. She said the same Hoyer that was used during the incident was being used currently. She said the CNAs complained to her about that Hoyer lift. Resident #142 stated, It's happened where it's locked, they have to kick the wheel to align it. It [Hoyer lift] has jerked before, but this was a hard jerk. A review of Resident #142's admission record revealed an initial admission date of 3/18/24 and re-admission date of 5/24/25. Further review of the admission record revealed diagnoses to include unspecified fracture of left patella subsequent encounter for closed fracture with routine healing (onset date of 5/4/25), unspecified fracture of left femur, subsequent encounter for closed fracture with routine healing (onset date 3/18/24), pain in left hip, other specified disorders of bone density and structure, multiple sites, quadriplegia, unspecified, periprosthetic fracture around internal prosthetic left hip joint, subsequent encounter, other fracture of lower end of right femur subsequent encounter for closed fracture with routine healing (onset date of 3/18/24), pain in unspecified knee, and chronic pain syndrome. A review of Resident #142's quarterly Minimum Data Set (MDS), Section C - Cognitive Patterns, dated 5/20/25, revealed a Brief Interview for Mental Status (BIMS) of 15, which means cognitively intact. On 6/23/25 at 4:33 p.m., an interview was conducted with Staff M, Risk Manager (RM)/ Assistant Director of Nursing (ADON) and the Director of Nursing (DON) regarding Resident #142's fall on 4/28/25. Staff M, RM/ADON stated Resident #142 was, Assisted to the ground, she didn't fall. Staff M, RM/ADON said two CNAs had assisted Resident #142 using a Hoyer lift. She said one CNA was in the front while the other staff member was guiding the sling and pushing the lift. Staff M, RM/ADON said the Hoyer was hard to push, the resident shifted in the sling then slid, and both CNA's grabbed the resident underneath her arms while assisting her to the floor. The DON confirmed as part of the investigation, the staff completed a return demonstration. The DON said she was told by the staff the legs of the Hoyer were initially open when the CNA went to push the lift. She stated, They were pushing with the legs straight to put her in bed. The Hoyer was stuck, jerked, and she ended up repositioning. The DON said the Hoyer and sling was removed from the unit. The DON said the maintenance staff cleaned out debris from the wheels because they thought the wheel got stuck during the transfer. On 6/24/25 at 3:33 p.m., a phone interview was conducted with Staff P, CNA regarding the fall incident that occurred on 4/28/25 involving Resident #142. Staff P, CNA said she was at the bottom steering the lift and Staff O, CNA, was at the top. She said the lift was facing the sink initially and Staff O, CNAs back was towards the A bed. She said the feet of the lift were starting to go under Resident #142's bed with the legs closed. Staff P, CNA said when turning the Hoyer to the bed, it became stiff and hard to maneuver. She stated, I can't understand what happened. She said they couldn't prevent Resident #142 from falling, therefore, they held her under her arms to make her fall, Slower. She said the nurse and Staff M, RM/ADON came shortly after the incident where they demonstrated what happened. She said the lift was removed and she's not sure if it's currently in use. She stated she thinks the lift is the issue. She said, It worked fine putting her in the shower chair. She said she always tells the nurse to put the issue with the lift in the work order system. She stated, The CNAs biggest problem is the lift. During an interview on 6/24/25 at 4:26 p.m., Staff J, CNA said the Hoyer lifts don't frequently work. She said sometimes it's a battery issue, that they aren't charged, but sometimes the lifts are hard to push. On 6/24/25 at 4:39 p.m., an interview with Staff H, CNA was conducted. She stated, The lifts make the job very difficult, we have to search sometimes when we cannot find one, then they are hard to handle.On 6/24/25 at 4:42 p.m., an interview was conducted with Staff S, CNA. She said sometimes the legs of the Hoyer lift get stiff. She said she had to use a lot of strength to turn the lift. She stated, It's not good for us and the residents. On 6/25/25 at 8:55 a.m., an interview was conducted with Staff T, Maintenance Assistant. He said he checked the Hoyer lifts monthly. He said his inspection included checking the wheels to see if they are dirty, if the remote is functioning, if the batteries held a charge, and if the lift needed to be re-serviced. Staff T, Maintenance Assistant said they are not