STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105305	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairway Oaks Center	13806 N 46th St Tampa, FL 33613

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 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. Based on interview and record review the facility failed to ensure the resident representative was notified prior to the resident's transfer for one resident (#2) of three residents reviewed for discharge.Findings Included: Review of Resident #2's Minimum Data Set (MDS), with a target date of 7/23/25, Section C, Cognitive Patterns, showed a Brief Interview for Mental Status (BIMS) score of 00. This BIMS score indicated severe cognitive impairment. The resident's representative was a family member.On 11/20/2025 at 12:51 a.m., an interview was conducted with the Social Service Director (SSD). The SSD stated there is no discharge note or documentation notifying the representative. She said consent was not provided by the representative.On 11/20/2025 at 1:31 p.m., an interview was conducted with the NHA. He confirmed he does not have any paperwork showing the representative gave consent.Review of the Nursing Home Transfer and Discharge Notice with a notice date of 7/21/2025 and an effective date of 8/19/2025, revealed the form did not list the transfer location for the resident. The notice did not have the signature at the bottom of the page showing that the resident's representative signed before the resident was transferred to another facility.

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 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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide activities of daily living (ADLs) related to grooming and personal hygiene care for three dependent residents (#4, #6, and #7) out of three sampled residents. Findings included:Review of Resident #4 admission Record revealed an admission to the facility on [DATE] with medical diagnoses of bullous pemphigoid, dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, adult failure to thrive, muscle weakness and other reduced mobility.An interview was conducted on 11/20/2025 at 9:50 am via telephone with Resident #4's family member (fm). The fm stated having raised concerns and spoke with staff at the facility about Resident #4's overgrown fingernails and residents' nails not being cut down. A grievance was filed by Resident #4's family member 7/7/2025 with the facility regarding concerns with ADL care and Resident #4's nails. The facility noted in the grievance follow-up that nails and shower were done on 7/8/25.Review of Resident # 4's Quarterly Minimum Data Set (MDS) dated [DATE], section titled, Cognitive Patterns revealed resident was rarely understood. The assessment revealed Resident #4 was severely impaired. Resident #4 was dependent for toileting hygiene, and shower/bathe care.Review of Resident #4's care plan revealed no documentation for Resident #4 needing assistance with nail trimming/care. The care plan revealed Resident #4 was dependent on staff for bathing needs.On 11/20/2025, at 3:15 p.m., an interview was conducted with Staff B, Certified Nursing Assistant (CNA). Staff B stated they did not cut the residents' nails, but they cleaned them. Staff B stated CNAs are not allowed to trim resident's nails. Staff B stated that CNAs document showers and nail care on the specific resident's shower sheet. Staff B stated the residents are showered at least twice a week. Staff B stated if an unplanned event occurred and the resident requires a shower on a non-shower day, then the resident would be showered.2. During an observation and interview on 11/20/2025, at 10:40 a.m., Resident #6 was observed lying in bed on clean bed linen and wearing a clean gown, disheveled in appearance and overgrown fingernails. Resident #6 stated, concern about overgrown fingernails. Resident #6 stated preferring short fingernails. Resident #6 stated previously addressing this with staff but that no one had come to trim them down. Resident #6's fingernails were observed to be long, with dirt underneath the nails.Review of Resident #6's admission Record revealed resident was admitted to the facility on [DATE] with medical diagnoses of osteomyelitis of vertebra, lumbar region, muscle weakness, muscle wasting and atrophy, intraspinal abscess and granuloma, repeated falls.Review of Resident #6's Quarterly MDS dated [DATE], Section GG revealed Resident #6 is dependent for toileting hygiene and requires substantial/max assistance for shower/bathe care.Review of Resident #6's care plan did not reveal documentation of the resident needing assistance for nail care. An interview was conducted on 11/20/2025, at 2:50 p.m., with Staff C, CNA. Staff C stated they trim residents' nails once a week on bath days. Staff C stated they usually bathe residents two to three times a week at residents' request. She stated the nails are trimmed/cleaned during shower days.Review of Resident #6's shower sheets for the month of November 2025 revealed the following:On 11/6/25 Resident #6 did not receive a shower. There is no documentation of nails being trimmed/cleaned. Resident #6 received a bed bath. Under nails being trimmed/cleaned, it was documented the resident refused.On 11/13/25 Resident #6 did not receive a shower. There is no documentation of nails being trimmed/cleaned.3. During an observation and interview on 11/20/2025, at 11:07 a.m., Resident #7 was observed lying in bed, disheveled in appearance and overgrown fingernails. Resident #7 stated concerns about having overgrown fingernails and that preferred to have nails that are a lot shorter. The fingernails were observed to be long and with dirt underneath the nails. Resident #7 stated having previously addressing this with the facility staff, but no one had come to trim them. Resident #7 stated in the past there was someone who came regularly to conduct nail trimming but Resident #7 had not seen them in a very long time.Review of Resident #7's admission Record revealed the resident was initially admitted to the facility on [DATE] with medical diagnoses of unspecified atrial fibrillation, muscle weakness, muscle wasting and atrophy, and difficulty walking.Review of Resident #7's Quarterly MDS dated [DATE], revealed Resident #7 is dependent for toileting hygiene, and requires substantial/max assistance for shower/bathe care.Review of Resident #7's shower sheets for the month of October and November 2025 revealed the following:On 10/18/25, 10/23/25, 10/27/25, and 10/30/25, Resident #7 received a bed bath. There is no documentation of nails being trimmed/cleaned.On 11/3/25, 11/6/25, 11/11/25, 11/13/25, and 11/17/25 Resident #7 received a bed bath. There is no documentation of nails being trimmed/cleaned An

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews the facility failed to maintain complete clinical records for one resident (#5) of five sampled residents which were accurately documented, readily accessible, and systematically organized.Findings included:Review of Resident #5's admission Record showed the resident was admitted on [DATE]. The record included diagnoses not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, aphasia following cerebral infarction, unspecified systemic lupus erythematosus, not having achieved remission myeloid leukemia, and need for assistance with personal care. The record showed the resident's family member was an emergency contact proxy. Review of Resident #5's 5-day Minimum Data Set (MDS), dated [DATE], showed the resident scored 3 of 15 on a Brief Interview of Mental Status (BIMS) indicating a severe cognitive impairment.Review of the facility incident log showed Resident #5 had falls on 10/15/25 at 11:30 a.m. and 10/22/25 at 4:00 a.m.A record review of Resident #5 revealed the resident was discharged to the community with a family member on 11/3/25.Review of Resident #5's Situation, Background, Appearance, and Review/Notify (SBAR) summary effective 10/15/25 at 12:47 p.m. showed the resident had suffered a fall with no changes observed in mental status and functional status was fall. The nursing observations, evaluation, and recommendation were Patient was observed on the floor. The recommendation from the primary care provider was to Initiate Neuro Checks and monitor for further changes. The note did not reveal any further information on the resident's fall or if the family member had been notified of the incident.Review of Resident #5's progress notes for 10/15/25 included:- Advance Directive follow up note, effective 10/15/25 at 1:29 p.m. revealed pt was observed on the floor. no new injury noted will continue to monitor. No note did not contain any further documentation.- Fall Evaluation, effective 10/15/25 at 1:30 p.m. revealed the resident was re-oriented to the call light and the fall risk evaluation was reviewed, and education was provided with the resident. The outcome of the education provided was unsuccessful.- A late entry SBAR effective 10/15/25 at 5:31 p.m. revealed the resident had a fall and did not show either the primary care provider or family member was notified.- No progress note on 10/15/25 showed the emergency contact or proxy of Resident #5 had been notified of the fall.Review of Resident #5's electronic record did not include documentation of the neuro checks recommended by the physician after the resident's fall on 10/15/25.Review of an Interdisciplinary note (IDT), effective 10/16/25 at 9:45 a.m. showed Resident #5's fall was reviewed with the IDT. The facility-initiated use of a communication board due to expressive aphasia and slurred speech. The note did not contain any other information regarding where the resident fell, was the fall witnessed or unwitnessed, who found the resident, or how the resident was found.Review of Resident #5's change in condition progress note, effective 10/22/25, at 6:51 a.m. showed the change in condition was Falls. The blood pressure, pulse, respiration rate, temperature, and pulse oximetry was taken on 10/22/25, at 4:00 a.m. The nursing observations, evaluation, and recommendations were Patient able to communexpesionicate with body and facial expression. The note showed the physician was called with no answer and a message was left. The note did not show the emergency contact/proxy was notified of the fall.Review of Resident #5's SBAR evaluation showed a fall had occurred on 10/22/25 and the condition, symptom, or sign had not occurred before. The evaluation showed the physician was notified on 10/22/25, at 6:45 a.m. with other recommendations which did not describe other. The nursing note for additional information was blank and did not describe the resident's fall. The evaluation showed the emergency contact/proxy was notified 10/29/25, at 6:43 a.m. (7 days after the incident).Review of Resident #5's IDT note, 10/22/25 at 9:18 a.m. showed the resident's fall was reviewed and no injury was noted. The resident was to be assisted with toileting upon rising, before and after meals, and at bedtime. The note did not reveal any specific details on the resident's fall.Review of Resident #5's progress notes showed on 10/22/25 at 2:46 p.m. the nurse called the emergency contact regarding of a clinical situation. The notes showed on 10/22/25 at 1:47 p.m. a Certified Nursing Assistant (CNA) had called the nurse to the resident's room to alarm the nurse of a bruise on right hip and due to facial expression of minor distress x-ray of right hip was ordered.An interview was conducted with the Director of Nursing (DON) on 11/20/25 at 12:35 p.m. The DON stated the facility did not have hard (physical) charts, everything was uploaded unless the document was in Medical Records waiting to be uploaded. The interview was in response to the request for Resident #5's neuro check evaluations from 10/15/25.An interview and observation was conducted on 11/20/25, at 1:05 p.m. with the Nursing Home Administrator (NHA) of the