STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105398	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tierra Pines Center	7380 Ulmerton Rd Largo, FL 33771

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure recommendations from the Preadmission Screening and Resident Review (PASRR) Level II were incorporated into the care plan for one Resident (#46) out of eight residents sampled. Findings included: Review of Resident # 46's admission Record showed she was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to included but not limited to major depressive disorder, recurrent, moderate, bipolar disorder, current episode manic without psychotic features, severe, other schizophrenia, unspecified psychosis not due to a substance or known physiological condition, generalized anxiety disorder. Review of the Florida Preadmission Screening and Resident Review (PASRR) Level II Determination Summary Report showed a level II determination dated 1/21/2020, with the following service recommendations to be added on the patient's Comprehensive Persons Centered Nursing Care plan - Psychiatric Medication Management, and Supportive Counselling. In addition, recommendations for staff to continue monitoring the patient closely for mood and behavioral issues, and to inform the licensed mental health professional of any changes or difficulties in managing Resident # 46 symptoms. Review of the Electronic Health Record (EHR) for Resident #46 under care plans showed there was no evidence of the PASRR Level II recommendations incorporated into the care plan. During an interview on 1/30/2025 at 12:35 pm with the Director of Nursing (DON), Social Service Director (SSD), and Social Service Assistant (SSA). They all stated they were not aware the recommendations from Resident # 46's Preadmission Screening and Resident Review (PASRR) Level II needed to be added to her care plan. The facility did not have a PASARR policy.

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	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of Resident # 7's admission record showed she was admitted to the facility originally on 9/15/23 and readmitted on [DATE] with diagnoses to include but not limited to bipolar disorder current episode mixed, unspecified, adjustment disorder with depressed mood, adjustment disorder with anxiety. Review of Resident #7 's Preadmission Screening and Resident Review (PASARR) Level I dated 9/13/23 showed in section A. Mental Illness (MI) or Suspected MI was blank. The review showed qualifying diagnoses were not checked. During an interview on 1/29/25 at 4:00 p.m. with the Director of Nursing (DON), she stated she was not aware Resident #7's Level I PASARR did not have her Mental illness (MI) diagnoses listed. She stated this was an oversight on their part and that it needed correction. 4. Review of Resident #86's admission Record showed an original admission date of 12/18/24 with a readmission date of 01/04/25. Resident #86 had the following diagnoses to include but not limited to depression unspecified, anxiety disorder unspecified and unspecified dementia mild without behavioral , psychotic, mood and anxiety disturbances. Review of Resident's #86's Preadmission Screening a Resident Review (PASARR) dated 12/11/24 showed in Section A- MI (Mental Illness) or suspected MI (check all that apply) did not have Depressive disorder checked as a mental illness. The review showed the Level I PASARR was incomplete. Review of Resident #266's admission record showed an original admit date of 9/11/24 with a readmission date of 01/23/25. Resident #266 had the following diagnoses to include by not limited to epilepsy unspecified not intractable without status epilepticus and depression unspecified. Review of Resident #266's PASARR dated 8/07/24 did not have depression checked in Section A nor epilepsy checked in Section B related conditions. The review showed the Level I PASARR was incomplete, and a level II was not submitted for consideration. Review of Resident #43's admission record showed an admission date of 11/18/24. Resident #43 had the following diagnoses to include but not limited to dementia in other diseases classified elsewhere unspecified severity with agitation, bipolar disorder current episode manic without psychotic features unspecified, insomnia unspecified, and anxiety disorder unspecified. Review of Resident #43's PASARR dated 11/12/24 did not have bipolar disorder, insomnia nor anxiety checked in Section A for mental illness or suspected mental illness. The review showed the Level I PASARR was incomplete. On 01/30/25 at 1:13 p.m., an interview was conducted with the DON. The DON acknowledged Resident #266's history of epilepsy and had stated the resident has had this since he was twenty-four years old. She stated the resident will require a Level 2 PASARR. The DON agreed Resident #43 had an incomplete PASARR and stated a Level 2 would be triggered once a properly identified Level I PASARR was completed. The DON acknowledged the lag in updated PASARRs and stated we have recognized the need to complete and update PASARRs. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A request was made for the facility's policy and procedures related to PASARRs. The facility did not have a policy. Based on record review and staff interview, the facility failed to complete/update the Pre-admission Screening and Resident Reviews (PASARRs) for residents with a mental disorder and individuals with intellectual disability following qualifying mental health diagnoses for eight (#81, #7, #10, #63, 86,#16, #266 and #43) of 12 residents reviewed for PASARRs. Findings included: 1. Review of the admission record showed Resident #81 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include dementia - 5/8/24, anxiety disorder - 5/8/24, major depressive disorder - 5/8/24 and Epilepsy - 5/8/24. Review of a level I PASARR for Resident #81 dated 5/8/24 revealed a blank PASARR and the qualifying diagnoses were not checked. The review showed the Level I PASARR was incomplete, and a level II was not submitted for consideration following qualifying diagnoses. An interview was conducted on 1/30/25 at 12:34 p.m. with the Director of Nursing (DON), Social Services Director (SSD), and the Social Services Assistant (SSA). After reviewing Resident #81's Level I PASARR, the DON said in November 2024 the facility identified the diagnoses needed to be corrected. The DON confirmed a level II had not been submitted for consideration. 3. Review of Resident #6's admission record revealed an original admission date of 5/9/22 and a readmission date of 1/14/25 with diagnoses to include major depressive disorder - 8/9/23, other schizophrenia - 10/12/23, generalized anxiety disorder - 8/9/23, bipolar disorder current episode mixed, severe, with psychotic features - 5/9/22. Review of the Level I PASARR, dated 08/26/2022, showed in Section I showed only Schizoaffective Disorder was marked. Other diagnoses of , generalized anxiety disorder, bipolar disorder, and current episode mixed, severe, with psychotic features were not checked. The resident had a Parkinson's diagnosis 5/14/24, which was not indicated under other neurological conditions. The review showed a level II evaluation which was submitted in 2022, prior to the newly acquired qualifying diagnosis. The review showed the Level I PASARR was incomplete, and a level II was not submitted for consideration following newly acquired diagnoses. Review of Resident #10's admission record revealed an admission date of 7/14/24. Resident #10 was admitted to the facility with diagnoses of major depressive disorder - 7/9/24, dementia unspecified Severity, with psychotic disturbance - 7/14/24, Dementia in other diseases classified elsewhere with mood disturbance - 7/14/24, unspecified psychosis - 7/9/24 and generalized anxiety disorder - 7/9/24. Review of the Level I PASARR, dated 6/14/2024, only depressive disorder diagnosis was checked. The review showed the Level I PASARR was incomplete, and a level II was not submitted for consideration following qualifying diagnoses. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #63's admission Record revealed an admission date of 11/30/24 with a primary diagnosis of Neurocognitive Disorder with Lewy Bodies - 11/30/24, and other diagnoses to include bipolar disorder - 11/30/24 and insomnia -11/30/24. Review of the Level I PASARR, dated 11/29/24, revealed the bipolar disorder was not checked and in section II, dementia was marked as primary. The review showed the Level I PASARR was incomplete, and a level II was not submitted for consideration related to the dementia diagnosis. During an interview on 1/30/25 at 12:34 p.m., with Director of Nursing (DON), Social Services Director (SSD), and the Social Services Assistant (SSA), The DON stated on admission, the SSA checks the PASARRs with the 3008. The SSA reviews the PASARRs at the morning meeting with the DON. They stated they compare the diagnoses in the residents' charts and the PASARRs and then follow up with the DON so she can update them. The DON stated Resident #6 did not have a diagnosis of dementia. The DON reviewed Resident #6's chart and did not see the diagnosis on any of her admission paperwork. The SSA stated Resident #63's and #10's PASARRs were identified in their audit for being blank and needed to be updated to match current diagnosis. The DON stated she was behind with updating PASARRs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation interview and record review, the facility failed to provide or assist with shaving facial hair for two residents (#72 and #78) of three reviewed for Activities of Daily Living (ADL) care. Findings Included: 1. During an interview and observation on 1/27/25 at 1:35 P.M. Resident #72 was lying in bed wearing a hospital gown, his facial hair on his neck and the sides of his face were approximately ½ inch in length and appeared unkept. Resident #72 said he would like the hair under his chin and neck to be shaved and staff have not offered to assist him. During an interview and observation on 1/28/25 at 11:15 A.M. Resident # 72 said he does not like the hair on his face and neck, when I get a shower it [facial hair] softens up. Resident #72's unkept facial hair remained unchanged on 1/29 and 1/30. During an interview on 1/30/25 a 2:34 P.M. the Director of Nursing (DON) said staff are expected to offer to shave residents during their shower task. Review of the admission Record showed #Resident # 72 was admitted to the facility on [DATE] with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of Resident #72's 5-day Minimum Data Set (MDS) dated [DATE], showed Section C - cognitive patterns, a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. Section GG - functional abilities showed Resident #72 required partial or moderate assistance with shower/bath. Review of the ADL care plan showed a focus for Resident #72 dated 1/4/25 , showing has a potential for Activities of Daily Living (ADL) self-care deficit related to chronic medical conditions, cerebrovascular accident (CVA), and limited mobility. The care plan's goal showed Resident #72 will improve ADL functioning through next review date. The interventions included ADL Care: may need limited to extensive by 1-2 staff members for ADL care. Review of the facility's 2nd floor shower schedule showed Resident #72 was scheduled for showers on Tuesdays and Fridays. Review of Resident #72's documentation survey report v2, dated January 2025 showed full bed bath was provided on 1/3, 1/7, 1/10, 1/14, 1/17, 1/28 and a shower on 1/24. There was no documented evidence Resident #72 received facial hair care. 2. During an interview and observation on 1/28/25 at 10:06 A.M. Resident #78 was lying in bed, wearing a hospital gown with unkept facial hair. He said he would like his facial hair shaved, he does not remember when he was last shaved, and staff has not offered to assist him. The hair on his cheeks and both sides of his neck is approximately 3/4 -1 inch long. The same observations was made on 1/29/25 and 1/30/25. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission Record showed Resident # 78's was admitted to the facility on [DATE] with a primary diagnosis of Parkinson's disease with Dyskinesia without mention of fluctuations. Review of Resident #78's admission 5-day MDS dated [DATE], showed in section C- cognitive patterns a BIMS score of 12 which indicated moderate cognitive impairment. Section GG, functional abilities showed Resident #78 is dependent (helper does all the effort) to shower/bathe self. Review of the ADL care plan dated 12/18/24 showed a focus for Resident #78, as follows has an ADL self-care deficit related to ADL needs and participation vary - Dx (diagnosis) Parkinsons. The care plan's goal was Resident #78 will improve ADL functioning through the next review date. The interventions included ADL Care: may need limited to extensive by 1-2 staff members for ADL care. Review of the facility's 2nd floor shower schedule showed Resident #78 was scheduled to shower on Mondays and Thursdays. Review of Resident #78's documentation survey report v2, dated January 2025 showed full bed bath was provided on 1/6, showers on 1/2 and 1/16 and he refused on 1/20. There was no documented evidence Resident #78 received facial hair care. During an interview on 1/28/25 at 10:50 A.M. with Staff E, Certified Nursing Assistant (CNA), He said residents are offered and assisted with shaving on their shower day. He said residents in A beds are showered during the 7:00 A.M.- 3:00 P.M. shift and B beds are showered during the 3:00 P.M. -11:00 P.M. shift. During an interview on 1/30/25 at 10:28 A.M Staff B, CNA said residents shaving is offered during showers . She provides showers for Resident #78, and he has never requested assistance with shaving. Staff B confirmed she had not offered Resident #78 assistance with facial care. During a tour on 1/30/25 at 10:40 A.M. an interview was conducted with staff, C, Licensed Practical Nurse (LPN), Unit Manager (UM) and Resident #78 and #72. Staff C said, Resident #78 stated he would like to be shaved and Staff C, LPN, UM said I will get his CNA to shave him. Resident #72 said he would like to be shaved and does not know what time. Staff C, LPN, UM said she will follow up later. Review of a facility policy standard and guidelines: Activities of Daily Living (ADL) Care and Services, revision date 1/2004 showed: residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. Under guideline - Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal, and oral hygiene. Procedure: 1. Residents will be provided with care, treatment, and services to ensure that their activities of daily living are met. 4. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a) Hygiene (bathing, dressing, grooming, nail care and oral care).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review, the facility failed to stop bleeding, protect wounds from infection, and promote healing for one resident (#73) of one reviewed for non-pressure related wound care and failed to follow physician orders related to wound care for one resident (#4) out of 6 residents sampled. Findings included: During an interview and observation on 1/27/25 at 10:15 A.M. Resident #73 was lying in bed wearing a hospital gown. Multiple areas with various shades of pink and purple bruising to both arms and hands were observed. On his arms and hands and right cheek there were many lines of crusted brown and black blood, and multiple areas of blood oozing onto his gown and sheet. There was dried blood caked under his nail and around his nailbeds. His linen and gown had numerous areas of moist and crusted blood. Resident # 73 said hi and was unable to provide additional information. Review of the admission record showed Resident #73's initial admission date to the facility was on 9/27/24 with diagnoses to include urinary tract infections, atrial fibrillation, congestive heart failure, dementia, anemia, peripheral vascular disease, neuromuscular dysfunction of the bladder, and diverticulum of the bladder. Review of Resident #73's order summary report dated 12/1/24 -1/31/25 showed the following orders: apply zinc skin protectant cream to buttocks and sacrum skin areas daily and as needed (PRN) every shift, observe for signs and symptoms of excessive bruising, hematuria, hemoptysis, or other bleeding, immediately report abnormalities to the physician. Weekly skin checks every Thursday morning, Aquaphor External ointment to both arms, chest and back every day and evening shift for xerosis (dry skin), Plavix 75mg daily for peripheral artery disease, order dated 1/28/25, cleanse bilateral arms with wound cleanser, apply Xeroform and ABD pad and wrap with kerlix every day shift and PRN (as needed). Review of Resident # 73's care plan, focus dated 1/24/25 showed: has a skin impairment related to picking at his skin causing scabs, mostly to BUE (bilateral upper extremities). The goal is Resident #73 will show signs and symptoms of healing/resolution without complications by next review date. The interventions included the following: apply lotion to dry skin after activities of daily living, monitor the resident's changes in skin condition, and pain levels. Report changes to the physician, monitor and observe skin while providing routine care, notify nurse of any area of concern as indicated, skin checks weekly and as indicated, report any signs or symptoms of breakdown to the physician or wound team as indicated, treatments as ordered/indicated and as tolerated by the resident, initiated 1/24/25. Review of Resident #73's care plan focus: has a rash of the xerosis on both arms, chest and back, Goal: rash will heal by review date, Interventions to include: administer medications as ordered, avoid scratching and keep hands and body parts from excessive moisture, monitor skin rashes for increased spread or signs of infection, seek medical attention if skin becomes bloody or infected, initiated 12/27/24. Review of Resident #73's Skin Check, dated 12/26/24, 1/2/25, 1/9/25,1/16/25, and 1/24/25 did not show there were new skin issues to his arms. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 1/27/25 at 1:15 P.M. Resident #73's Case Manager said, he picks at his skin and when she visits his sheets are often not clean. She stated she had discussed these concerns with the unit manager and social services. During an interview on 1/28/25 at 10:12 A.M. with Staff D, Registered Nurse (RN) said she was aware of the bleeding and [medicated moisturizer] is currently ordered for Resident # 73's arms and hands. During an observation on 1/28/25 at 10:12 A.M. Resident #73 was lying in bed with his eyes closed with scattered open wounds oozing blood on both arms and hands draining on his hospital gown and linen. During an interview on 1/28/25 at 10:12 A.M. with Staff E, Certified Nursing Assistant, said they are not able to treat the bleeding areas Resident #73's arms, it is continuous. During an interview on 1/28/25 at 4:06 P.M. Resident # 73's family member said prior to Resident #73's admission to the facility his arms were covered to prevent bleeding from scratching. The family member visits 3-4 times weekly and said during her visits she asks staff about the care for Resident #73's bleeding areas and they [the facility] do not do anything. During an interview on 1/29/25 at 7:40 A.M. Staff H, Licensed Practical Nurse (LPN), wound care nurse, said on 1/28/25 an order was received to place the following dressing on Resident # 73's arms apply collagenase ointment, cover with an absorbent dressing and wrap with a gauze roll. During a telephone interview on 1/30/25 at 11:29 A.M. Resident # 73's Physician Assistant (PA) said his skin condition was chronic, and she had just updated the orders following surveyor inquiry. The PA stated she would have expected the wounds to be covered. During an interview on 1/30/25 at 2:34 PM, the Director of Nursing (DON) said staff are expected to immediately notify the physician or wound care nurse, get orders and cover the wounds. Review of the facility's policy titled, Wound Care and Treatment, revised 1/2024 showed the following: Standard: The purpose of this procedure is to provide guidelines for the care of wounds and promote healing. 2. During an observation on 01/27/25 at 11:15 a.m. and on 01/28/25 at 10:15 a.m., an attempt was made to interview Resident #4, and she was not able to answer any questions regarding her care. Review of Resident #4's admission record revealed an admission date of 05/30/23 with diagnoses of unspecified protein-calorie malnutrition, adult Failure to thrive, age-related osteoporosis without current pathological fracture, major depressive disorder, recurrent, mild, vascular dementia, severe, with other behavioral disturbance, and muscle weakness (Generalized). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's quarterly Minimum Data Set (MDS) dated [DATE] revealed, Section M - skin conditions, formal assessment instrument/tool (e.g., [name of assessment tools], or other), Clinical assessment, risk of pressure ulcers/injuries, was marked Yes. Risk of Pressure Ulcers/Injuries: unhealed pressure ulcers/injuries was marked Yes. Number of Stage 3 pressure ulcers 1. Skin and Ulcer/Injury Treatments: pressure reducing device for chair, pressure reducing device for bed, nutrition or hydration intervention to manage skin problems, application of nonsurgical dressings (with or without topical medications) other than to feet, applications of ointments/medications other than to feet. Review of current physician orders for Resident #4 revealed: Order Start Date: 01/27/25 Enhance Barrier: Encourage and assist residents to maintain enhanced barrier precaution daily. every shift for Right hip wound. Order Start Date: 01/16/25 Right Hip- Clean with wound cleanser, Santyl, calcium alginate, cover with composite dressing, change daily and PRN. Every day shift for Wound Care. Order Start Date: 01/06/25 Amlactin Daily External Lotion 12 % (Lactic Acid (Ammonium Lactate)) Apply to BLE/feet topically two times a day for xerosis Order Start Date: 12/31/24 Right Hip- Clean with wound cleanser, apply collagen, cover with composite dressing, change every other day and PRN. Every day shift every Mon, Wed, Fri, Sun for Wound Care. Discontinued on 12/31/2024. Order Start Date: 12/25/24 Right Hip- Clean with wound cleanser, apply xeroform, cover with composite dressing, change every other day and PRN. Every day shift every Mon, Wed, Fri, Sun for Wound Care. Discontinued on 12/30/24. Order Start Date: 12/12/24 Right Hip- Clean with NS, apply Santyl, calcium alginate, cover with composite dressing, change daily and PRN. Discontinued on 12/12/24. Order Start Date: 12/05/24 Treatment: Right Hip- Cleanse with Normal Saline, Pat dry, apply Santyl with calcium alginate, skin prep to peri-area; cover foam silicone border ;(may substitute dry dressing if silicone not available) Daily and or if becomes dislodged or soiled. Discontinued on 12/05/24. Order Start Date: 11/10/24 Right Hip- Clean with NS, apply Santyl, calcium alginate, cover with composite dressing, change daily and PRN. Discontinued on 11/10/24. Review of the Treatment Administration Record (TAR) for Resident #4 for January 2025 revealed wound care was missed as follows: Right Hip- Clean with wound cleanser, Santyl, calcium alginate, cover with composite dressing, change daily and PRN. Every day shift for wound care order was not completed on 1/19/25, 1/25/25 and 1/26/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Amlactin Daily External Lotion 12 % (Lactic Acid (Ammonium Lactate) Apply to Bilateral (BLE) feet topically two times a day for xerosis order was not completed on 01/06/25 at 1700, 01/07/25 at 900 and 1700, 1/8/25 at 900, 01/11/25 at 900, 1/12/25 at 900 and 1700, 1/25/25 at 900, and 1/26/25 at 900. Review of Resident #4's Treatment Administration Record (TAR) for December 2024 revealed wound care was missed as follows: Right Hip- Clean with NS, apply Santyl, calcium alginate, cover with composite dressing, change daily and PRN. Every day shift for wound care order was not completed on 12/02/24 and 12/14/24. Right Hip- Clean with wound cleanser, apply xeroform, cover with composite dressing, change every other day and PRN. Every day shift every Mon, Wed, Fri, Sun for Wound Care was not completed on 12/29/24. During an interview on 01/30/25 at 8:44 a.m., Staff I, LPN, stated the nurses put in the orders from the physician. She stated once the order is put into their documentation software, it is added to the TAR. Once the order is on the TAR they then will document as needed. She stated if the order was for a wound, the wound nurse typically documents the treatment that is completed. She stated if anyone other than the wound nurse was doing rounds and a wound needed to be addressed for any reason, they would be the ones to treat and document. During an interview on 01/30/25 at 9:45 a.m., the Director or Nursing (DON), she stated it was the nurses' responsibility to follow an order. She said if it was a treatment, or something related to the wound they could talk to the wound care nurse to make sure they have what they needed. She stated she would expect the nurses to be documenting on the TAR. She reviewed Resident #4's TAR for January 2025 and December 2024 and identified there where holes where the nurse did not document if treatment was given for both months. Review of the facility policy dated 01/01/24, titled, Wound Care Treatment, revealed: the purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Under Documentation: The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time of the wound care was given. 3. The name and title of the individual performing wound care. 4. Any change in the resident's condition. 5. Any problems or complaints made by the resident related to the procedure. 6. If the resident refused the treatment and the reasons why. 7. The signature and title of the person recording the data. Review of the facility policy dated 1/20/24, titled, Physician Orders, revealed: Guideline: orders and administration of medications and treatments will be consistent with principles of safe and effective order writing. Procedure: 9. Physician order should be followed as prescribed, and if not followed, this should be recorded in the resident's medical record during that shift. The physician should be notified and the party responsible if indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105398	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tierra Pines Center	7380 Ulmerton Rd Largo, FL 33771

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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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation interview and record review, the facility failed to ensure proper monitoring of sanitation solution for the dish machine in 1 of 1 facility kitchens. Findings Included: During a kitchen tour on 01/27/2025 at 9:50 a.m., Staff F, Dietary Aide, stated the dish machine is a low temp machine. He stated he does not normally record the temps or the sanitizing parameters for the machine. He pointed at the Certified Dietary Manager (CDM) and stated he (CDM) fills out the log. Staff F, Dietary Aide, was not sure what the rinse cycle water temp needed to be at. Staff F, Dietary Aide started a wash cycle and checked the sanitation level. The test strip stayed white during the testing, showing there was no sanitation. The sanitation bucket which was located below the dish machine was noted empty. Review of the Dish Machine Temp Log revealed and entry for Breakfast on 01/27/2025. 120 Min Wash had a recording of 125 temperature, 120 Min Rinse and a recording of 123. Sanitaization level was recorded as 50 PPM (Parts Per Minute). During an interview on 01/27/2025 at 9:55 a.m., The CDM stated staff should be checking the sanitation levels daily and record them on the log. During an interview on 01/30/2025 at 9:15 a.m., The CDM stated the person who is doing the dirty side of the dishes is the one who was responsible for filling out the log, because that is the initial side of dishes. He said it should be checked before each meal service such as before breakfast and lunch. He stated he was not sure who filled out the log for Monday at breakfast. He stated he does check the logs, and it was part of his daily routine. He stated he could not remember if he checked the log that morning, and he had not seen that the sanitation was empty. He stated he did not have a set expectation for the sanitation to be checked, but he would not expect it to be changed if it is a quarter full. During an interview on 01/30/2025 at 10:58 a.m., the Nursing Home Administrator (NHA), stated the CDM should be following up on the log and making sure the dishes are being cleaned and sanitized and the machine was in good repair. (Photographic Evidence Obtained)