STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106112	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tampa Lakes Health and Rehabilitation Center	750 Hayes Rd Lutz, FL 33549

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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 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** Based on record reviews and interviews, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR) Level II were completed to ensure recommended services were provided for residents with mental illness (MI) or suspected MI for four residents (Resident #49, Resident #111, Resident #131, and Resident #40) of sixty-seven sampled residents. Findings included: Review of Resident #49's admission Record showed Resident #49 was admitted to the facility on [DATE] with a primary diagnosis of senile degeneration of the brain. Other diagnoses include major depressive disorder, visual hallucinations, and delusional disorders. Review of Resident #49's Level I PASRR screen dated 09/07/2024 showed in Section II: Other Indications for PASRR Screen Decision-Making, under question 5: Does the individual have a primary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease)?: No, was marked. Section II also showed a Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease). The screen showed under Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required, was marked. Review of Resident #111's admission Record showed Resident #111 was admitted to the facility on [DATE] with a primary diagnosis of senile degeneration of the brain. Other diagnoses include major depressive disorder and post-traumatic stress disorder. Review of Resident #111's Level I PASRR screen dated 09/07/2024 showed in Section II: Other Indications for PASRR Screen Decision-Making, under question 5: Does the individual have a primary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease)?: Yes, was marked. The screen showed in Section II, under question 7: Does the individual have validating documentation to support the dementia or related neurocognitive disorder (including Alzheimer's disease)?: Yes, was marked. Section II also showed a Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease). The screen showed under Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required, was marked. (continued on next page)

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

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #131's admission Record revealed an original admission date of 6/14/2024, and a re-admission date of 10/30/24. Resident #131's admission Record revealed diagnoses including Alzheimer's disease, restlessness and agitation, unspecified dementia, unspecified severity, with other behavioral disturbance, panic disorder [episodic paroxysmal anxiety], major depressive disorder, recurrent, moderate, other specified persistent mood disorders, and generalized anxiety disorder. Review of Resident #131's Level I PASRR screen dated 01/06/2025 showed in Section II: Other Indications for PASRR Screen Decision-Making, under question 5: Does the individual have a primary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease)?: Yes, was marked. The screen showed in Section II, under question 7: Does the individual have validating documentation to support the dementia or related neurocognitive disorder (including Alzheimer's disease)?: Yes, was marked. Section II also showed a Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease). The screen showed under Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required, was marked. Review of Resident #40's admission Record revealed Resident #40 was admitted on [DATE]. Resident #40's admission Record revealed diagnoses including senile degeneration of the brain, major depressive disorder, bipolar disorder, dementia, and anxiety disorder. Review of Resident #40's Level I PASRR screen dated 10/24/2024 showed in Section II: Other Indications for PASRR Screen Decision-Making, under question 5: Does the individual have a primary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease)?: Yes, was marked. The screen showed in Section II, under question 7: Does the individual have validating documentation to support the dementia or related neurocognitive disorder (including Alzheimer's disease)?: Yes, was marked. Section II also showed a Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease). The screen showed under Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required, was marked. Review of the facility policy titled Admission/Social Services-Pre-admission Screening for Resident Review (PASRR), revised October 2015 revealed the following: Overview: The purpose of PASRR is to ensure individuals who are being considered for placement in a nursing facility are evaluated for serious mental illness and/ or intellectual disability and are offered the most integrated setting appropriate for their long-term care needs (including determining whether a nursing facility is appropriate). All persons, regardless of payer or age, needing admission to a nursing facility must first be screened for possible mental illness (MI) or the presence of an intellectual disability (ID) or both (Level I). If a mental illness (MI) or intellectual disability (ID) appears to exist, the person must be referred for further evaluation (Level II) before nursing facility admission The Level II PASRR screen must be done prior to admission for all persons seeking admission except when the following exemption applies for a provisional admission: (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Individuals who are discharged from a hospital into a nursing facility after receiving acute impatient care, and require NF services, for which they receive an inpatient hospital care, may be admitted to the nursing facility if a physician certifies on the AHCA 3008 form before admission that the individual is likely to require less than 30 days of NF services. Policy for PASRR: The Admissions Coordinator is responsible for ensuring that the Level I PASRR Screen and Level II PASRR evaluation and determination, if applicable, are completed prior to admission. Procedure: . 2. When applicable, our request for a Level II evaluation is made using the attached [State Survey Agency] Medserv I Form 004, Part B, November 2011. This request must be sent to the comprehensive assessment and review for long-term care services (CARES) unit. CARES will make the referral to the substance abuse and mental health (SAMH) and/ or agency for persons with disabilities (APD) and they should complete the evaluation within 7 to 9 days and forward it to the admitting nursing facility .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to monitor blood pressure before administering medication ordered for increased blood pressure for one resident (Resident #36) of six residents reviewed for medication regimens. Findings included: During an interview and observation on 1/6/25 at 11:51 A.M., Resident #36 was lying in bed and said he was outside and recently returned to his room. He also said he was feeling lightheaded. Resident #36 said the lightheaded occurs at least twice each week and he reported feeling lightheaded to the nurses several times. Review of admission Record showed Resident #36 was admitted to the facility on [DATE], with a diagnosis of essential hypertension. Review of Resident #36's quarterly Minimum Data Set (MDS) assessment dated [DATE] showed under Section C - Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 14, indicating cognition is intact. Review of Resident #36's Order Summary Report, active orders as of 1/1/25, showed an order dated 10/28/24 for Metoprolol Succinate ER (Extended Release) Oral Tablet 24 Hour 50 mg (milligrams) give 1 tablet by mouth in the morning for increase blood pressure. Review of the Medication Administration Report for December 2024 showed vital signs every evening shift and blood pressures ranged from 109/70 to 161/56. During an interview on 1/8/25 at 9:56 A.M., Staff O, Registered Nurse (RN), Unit Manager (UM) said the order for metoprolol for Resident #36 should have an order to check supplemental blood pressure, they should be checking it and there are no parameters ordered. Review of Resident #36's Order Summary Report, active orders as of 1/8/25, showed an order dated 1/8/24 with a start date of 1/9/24 for Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 mg give 1 tablet by mouth in the morning for HTN (high blood pressure) hold for systolic BP (blood pressure) less than 110 mmHg (millimeters of mercury) and/or heart rate less than 60. During an interview on 1/9/25 at 1:44 P.M., Staff P, Licensed Practical Nurse (LPN) said he always checks blood pressure before administering medications if they're ordered for increased blood pressure. During an Interview on 1/9/25 at 1:46 P.M., the Director of Nursing (DON) said her expectations for orders without listed parameters are for staff to verify parameters do not exist and notify the resident's physician. Review of Medline Plus article (https://medlineplus.gov/druginfo/meds/a682864.html#how) titled Metoprolol, last revised on 9/15/23, showed Side Effects may include dizziness or lightheadedness.

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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 observations, interviews, and record review, the facility failed to follow professional standards for food service safety in the facility kitchen, three of six dining areas, and two of six nourishment rooms. Findings included: On 1/6/25 at 9:23 a.m., a tour of the facility's kitchen was conducted with the Assistant Food Service Director. Observations revealed a white foam cup with a straw and lunchbox on the drying rack, where clean kitchenware and other items were stored. The Assistant Food Service Director stated the cup and lunchbox belonged to a staff member. She motioned to the staff member and stated, it's her breakfast. On 1/6/25 at 9:47 a.m., three staff members were observed in the dish machine area. Observations revealed one dietary aide was scraping and discarding food off of plates. A second staff member, Staff H, Dietary Aide, was observed rinsing off kitchenware and putting the items into the dish machine. Staff E, Dietary Aide was placing clean plates and other kitchenware on the rack to dry. Staff H, Dietary Aide was asked which type of dish machine it was, she responded it was a high temperature dish machine. The Assistant Food Service Director corrected her and stated it was a low temperature dish machine. A review of the sanitizing log for the dish machine was conducted with Staff E, Dietary Aide and the Assistant Food Service Director. Staff E, Dietary Aide stated he did not take or record the sanitizing temperatures. He stated if he were to do them, he would check what the sanitizing solution buckets indicated and record that information for the temperatures. Further observations of the sanitizing solution log for the dish machine, with the date of 1/6/25, revealed the initials written down were not his. The Assistant Food Service Director stated those initials were the day cooks. She confirmed Staff E, Dietary Aide should be taking and recording the sanitizing solution temperatures on the log. The Assistant Food Service Director was observed demonstrating and educating Staff E, Dietary Aide on how to test the sanitizing solution, what parts per million (ppm) they are looking for, and what she expected to be recorded on the log. On 1/6/25 at 9:29 a.m., observations and interviews regarding the holding freezer were conducted with the Assistant Food Service Director. The holding freezer contained two cases of food that were not labeled or dated and appeared to be opened. One of the boxes observed was frozen hamburger patties and the other box contained French fries. The Assistant Food Service Director confirmed they should have been labeled and dated when they were opened. At 9:35 a.m., observations of the walk-in cooler revealed a container of black olives had approximately three penny sized white spores in the liquid. The Assistant Food Service Director proceeded to throw away the container of olives. She stated the olives were not going to be used for resident meals as they were not on the menu today. At 9:36 a.m., further observations of the walk-in cooler revealed a box containing loose lettuce pieces stored in a plastic bag, open, and exposed to the air. Two fruit plates were observed on a mobile rack in the walk-in cooler, with a date of 1/5/25. The Assistant Food Service Director could not confirm if 1/5/25 was the use by date or the prepared date. She proceeded to remove the two fruit plates. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/6/25 at 12:21 p.m., observations of the nourishment room in the 100 unit were conducted. The refrigerator and freezer temperature log was observed to be filled out through 1/7/25. Observations of the refrigerator revealed one carton of Glucerna 1.5 with an expiration date of 1/1/25, one carton of Peptamen Intense Very High Protein (VHP) with a use by date of 11/19/24, and a cup of what appeared to be macaroni and cheese labeled 1/5/25. At the time of the observation, the cup of macaroni and cheese did not indicate a resident name or room number. (Photographic Evidence Obtained) On 1/6/25 at 12:23 p.m., observations revealed Staff E, Dietary Aide entered the 100-unit dining area with a meal cart and proceeded to put prepared food on the steam table. At 12:33 p.m., he was observed putting on gloves before starting to handle food. Throughout the dining observation, Staff E, Dietary Aide wore the same gloves while also touching and opening cupboards. At 12:47 p.m., he was observed wiping his gloved hands with a napkin as it appeared to have food particles on them, but did not take the gloves off. From approximately 12:33 p.m. to 12:55 p.m., Staff E, Dietary Aide, was not observed changing gloves while serving food and doing other tasks. On 1/6/25 at 12:29 p.m., observations of the 200-unit dining area revealed no food temperatures were taken or recorded by the dietary staff. At 12:38 p.m., observations revealed soup started to be served. Observations of a dietary aide revealed they were not wearing gloves while handling and serving the soup to residents. A few minutes after the initial observation, another staff member provided gloves to the dietary aide. An observation was conducted on 1/6/25 at 12:37 p.m. of a staff member serving food on the BB unit food line with a hairnet on with two braids pulled out of the hairnet on each side of her face, leaving her hair uncovered while scooping food onto resident plates. The food was observed being delivered to the food line from the kitchen until the end of service. During that time, no temperatures were taken, however, after service, the temperature log at the BB unit food line had food temperatures documented for that meal. On 1/6/25 at 12:55 p.m., an interview with Staff E, Dietary Aide revealed he does not take or record food temperatures on the tray line in the dining area. He confirmed he did not take or record food temperatures for the 1/6/25 lunch meal in the 100-unit dining area. On 1/6/25 at 4:08 p.m., observations of the nourishment room in the 200-unit were conducted. Observations of the refrigerator revealed resident food not dated to include a pie, broccoli salad, unknown item from [Vendor name], and a container of dessert dated 12/24/24. Further observations of the refrigerator revealed a lunch box containing food items and beverages with no date identified. A to-go container was observed with a date of, 1/6, but no resident name or room number was identified on the container. The refrigerator and freezer temperature log was observed to be filled out through 1/7/25. (Photographic Evidence Obtained) On 1/7/25 at 9:38 a.m., a review of the food temperature log for the 100-unit dining area was conducted. Observations of the log revealed food temperatures on 1/6/25 were completed for lunch. (Photographic Evidence Obtained) On 1/7/25 at 10:26 a.m., a review of the 100-unit nourishment room refrigerator revealed the same concerns identified on 1/6/25. (Photographic Evidence Obtained) (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/8/25 at 12:02 p.m., observations revealed Staff D, Dietary Aide entered the 100-unit dining area with a meal cart. At 12:05 p.m., Staff D, Dietary Aide was observed washing his hands and putting on gloves. At 12:08 p.m., he was observed putting food on the steam table and started serving soup at approximately 12:11 p.m. At 12:12 p.m., Staff D, Dietary Aide was observed touching various drawer handles to obtain placemats. He was observed putting placemats on the dining tables in front of seated residents, while wearing the same gloves he put on at the beginning of the meal service. From 12:05 p.m. to 12:32 p.m., Staff D, Dietary Aide wore the same gloves and there was no observation of him changing them. On 1/8/25 at 12:04 p.m., an observation revealed Staff R, Dietary Aide entered the 600-unit dining area with a meal cart. Observations revealed she opened the meal cart, removed the covered food trays, and placed them on the steam table. Staff R, Dietary Aide was observed removing aluminum foil covering a tray of lasagna with ungloved hands. She was not observed performing hand hygiene before removing the aluminum foil from the tray of lasagna. Further observations of Staff R, Dietary Aide revealed she discarded the aluminum foil in the garbage and put serving ware on top of the covered food trays on the steam table. After that task, she was observed putting on gloves and started to serve soup. Staff R, Dietary Aide was observed at the sink running water over a scoop and using a rag to wipe it off. Her hands were observed to be ungloved throughout this task. Another observation in the 600-unit dining area revealed, Staff S, Dietary Aide pulled down her hair band, touched her face, and left the dining area. Upon her return to the dining area, she was observed passing a bowl to another staff member with an ungloved hand. She was observed removing aluminum from a covered food tray and putting the tray on the steam table. Staff S, Dietary Aide did not have gloves on and was not observed performing hand hygiene when these tasks were conducted. On 1/9/25 at 10:44 a.m., an interview with the Assistant Food Service Director regarding the process for taking and recording the food temperatures revealed they are completed in the kitchen, before the meal carts go out to the units. She stated one of the reasons temperatures are not taken and recorded on the units is due to an audit. The Assistant Food Service Director stated there was an audit taking place, requested by the Nursing Home Administrator (NHA), from 1/5/25 - 1/7/25. She stated the NHA was asking for random checks of meal temperatures on the units. A review of the audit logs was conducted with the Assistant Food Service Director to reveal the 200, 300, and 400 units were included in the audits. On 1/9/25 at 10:47 a.m., a follow up interview with the Assistant Food Service Director revealed dietary staff are responsible for everything in the nourishment room, except for formula and, Med pass items. She stated dietary staff responsibilities included cleaning the refrigerator, stocking, dating, reviewing expiration dates, and rotating items. The Assistant Food Service Director stated every morning she completed rounds of the nourishment rooms, To make sure everything is up to par. She also stated her rounds included restocking if needed, review of refrigerator and freezer temperatures, and review of expiration dates and labeling of resident's personal food items. The Assistant Food Service Director confirmed during her rounds she checked if formula was expired. She stated if she saw expired formula she would discard them. A review of dish machine competencies/education provided by the Assistant Food Service Manager revealed a date of 1/2/2024. The staff members in the observation on 1/6/25 are not indicated on the attendance log. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/9/25 at 2:20 p.m., an interview with the Director of Nursing (DON) revealed food that belongs to the resident, brought to the facility by a family member, should be discarded after three days. A review of the facility policy titled Food Holding and Service, undated, revealed the following Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be held and served according to the Florida Food Code and HACCP (Hazard Analysis and Critical Control Points) guidelines. Further review of the policy revealed under Procedure, the facility will take and record the temperatures of all food prior to service. A review of the facility policy titled Food Storage, undated, revealed the following Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the Florida Food Code and HACCP guidelines. Further review of the policy revealed the following Procedure: . 2. Refrigerators . c. Date and label all refrigerated foods. d. Use all leftovers within 48 hours. Discard items that are over 48 hours old. A review of the facility policy titled Employee Sanitation, undated, revealed the following Policy: The kitchen employees of the facility will practice good sanitation practices in accordance with the Florida Food Code in order to minimize the risk of infection and food borne illness. Further review of the policy revealed the following, Procedure: . d. Employees will not eat or drink in food storage and preparation areas, or in areas containing exposed food or unwrapped utensils, or where utensils are cleaned or stored. 5. Hand washing a. Employees must wash their hands at designated hand washing facilities at the following times: i. After touching bare human body parts other than clean hands . v. During food preparation, as often as necessary to remove soil and contamination and prevent cross contamination when changing tasks. vii. After engaging in other activities that contaminate the hands . 6. Use of Gloves . c. Change gloves: i. Between each food preparation task. ii. After touching items, utensils or equipment not related to task. iii. After touching a source of contamination v. When damaged, soiled or when

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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. Based on observations and interviews, the facility did not ensure the privacy of resident information on three (AB, BB, and EB) of six units in the facility. Findings included: An observation was conducted during a facility tour on 1/6/25 at 10:15 a.m. of a list posted, facing the main hall, on the AB unit nurses' station with resident names, room numbers, and the type of therapy they are receiving. There was also a paper lying on the counter with a resident name and doctor's order, and another paper showing the resident census with medical information. The tour also revealed the document with resident names, room number, and type of therapy was posted, facing the main halls on the BB and EB units. The documents remained posted all on three units on 1/7/25 and 1/8/25. An observation was conducted on 1/7/25 at 9:37 a.m. of a computer screen on the wall on the BB unit, open, with a resident's medical record visible. No staff were in the vicinity at the time. An observation was conducted on 1/8/25 at 10:00 a.m. of a medication cart computer on the BB unit, open, with resident information on the screen. No staff were at the cart and a visitor was observed walking past the open screen. Staff J, Registered Nurse (RN) returned to the medication cart. She confirmed the screen should have been locked and said staff are educated to make sure the screen is closed. An interview was conducted on 1/8/25 at 4:22 p.m. with Staff M, Licensed Practical Nurse (LPN) and Staff F, Certified Nursing Assistant (CNA). They both stated computer screens should be locked, and papers should be turned over so resident information is not visible. Both staff members reviewed the posted document with resident names, room number and types of therapy being provided and agreed the document contained personal resident information and should not be posted. Staff M, LPN said the document is supposed to be in the nurses station, not facing the hall. An interview was conducted on 1/8/25 at 4:30 p.m. with the Director of Nursing (DON). She said staff should always lock their computers when they are not at them working and paperwork should not be left on the nurses' station counter where it could be seen by others. The DON also confirmed the document with resident, names, rooms, and therapy posted on the AB, BB, and EB nurses' stations should be in the nurses' station, not visible to residents or visitors. Review of a facility policy titled HIPAA [Health Insurance Portability and Accountability Act] Guidelines-Computer Terminals/Workstations, effective 11/1/2013, showed: Policy Computer terminals and workstations will be positioned/shielded to ensure that resident and facility information is protected from public view or unauthorized access. Interpretation and Implementation (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Insofar as practical/feasible, computer terminals/workstations will be positioned or shielded so that screens are not visible to the public or to unauthorized staff. Encryption of ePHI [Electronic Protected Health Information] will be implemented if reasonable and appropriate. 2. Only authorized users are granted access to resident and facility information. Such access is limited to specific, defined, documented and approved applications and level of access rights. 3. A user may not leave his/her workstation or terminal unattended for long periods of time (e.g., breaks, lunch, meetings, etc.) unless the terminal screen is cleared, and the user is logged off. Each user must log off at the end of his/her work shift. 4. A user must clear the terminal screen if the workstation or terminal is left briefly unattended. 5. All hard copy printed information must be positioned in such a manner that it cannot be viewed or read by the public or unauthorized staff. . Photographic Evidence Obtained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106112	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tampa Lakes Health and Rehabilitation Center	750 Hayes Rd Lutz, FL 33549

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not ensure proper infection control practices related to 1.) failing to ensure proper hand hygiene was conducted after exiting the room of one resident (Resident #578) of one resident on contact precautions for clostridium difficile (C. diff), 2.) failing to ensure proper storage of respiratory masks on one unit (AB/100 unit) of six units, and 3.) failing to ensure appropriate hand hygiene was performed by staff and offered to residents on two units (AB/100 unit and BB/200 unit) of six units during meal service. Findings included: 1. An observation was conducted on 1/6/25 at 12:23 p.m. of Resident #578's room, which had a contact precaution sign posted on the door. A staff member was observed donning personal protective equipment (PPE), removing it while exiting the room, then using alcohol-based hand rub (ABHR). The contact precaution sign showed everyone must: perform hand hygiene with alcohol-based hand rub (ABHR) or soap and water before entering and exiting. Review of Resident #578's January 2025 Order Listing Report showed the resident was on contact precautions for C. diff starting 12/27/24. Review of admission Records showed Resident #578 was admitted on [DATE] with diagnoses including acute respiratory failure, sepsis, and bacteremia. Review of Resident #578's Lab Results Report showed a positive result for C. diff antigen and C. diff toxins on 12/28/24. An interview was conducted on 1/8/25 at 3:30 p.m. with Staff F, Certified Nursing Assistant (CNA) and Staff L, CNA. They both confirmed Resident #578 was on contact precautions, but they did not know why. They said for contact precaution rooms, they wear a gown and gloves to enter the room and then either wash their hands or use alcohol-based hand rub when they exit. They both stated they followed the sign on the door for what to do with the precaution rooms. An interview was conducted on 1/9/25 at 12:15 p.m. with Staff J, Registered Nurse (RN). She said Resident #578 was on contact precautions for C. diff. She also said staff wore a gown and gloves to enter the room and can use hand sanitizer (ABHR) to clean their hands. Staff J, RN said they follow the sign on the door. 2. An observation was conducted on 1/6/25 at 10:29 a.m. in room [ROOM NUMBER] of a respiratory mask on the bedside table uncovered. An additional mask was in the top drawer, unbagged, with the end of the resident's oxygen tubing lying on the floor. The mask remained on the bedside table, unbagged, and uncovered on 1/8/25 and 1/9/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation was conducted on 1/6/25 at 12:21 p.m. in room [ROOM NUMBER] A of a respiratory mask on the bedside table uncovered. The mask remained unbagged and uncovered on the bedside table on 1/9/25. An interview was conducted on 1/9/25 at 11:26 a.m. with Staff Q, Licensed Practical Nurse (LPN). She said residents with respiratory masks should have a clear bag at their bedside and the masks should be stored in the bag when not in use. Staff Q, LPN also said if staff see the masks out they should place them in a bag. An interview was conducted on 1/9/25 at 11:44 a.m. with the facility's Respiratory Therapist (RT). She said all respiratory masks should be bagged when taken off the resident, which helps prevent them from getting dirty and/or falling on the floor. The RT said she had placed bags in all the rooms that needed them with the resident's name for staff to place the masks in. The RT also said she had just come from room [ROOM NUMBER] where she saw the respiratory mask uncovered on the bedside table. 3. An observation was conducted on 1/6/25 at 12:37 p.m. of lunch service on the BB/200 unit. Residents were observed being brought into the dining room for lunch. At no point were the residents offered hand hygiene wipes, alcohol-based hand rub, or hand washing prior to eating their lunch. There was a sink with soap available in the dining room. An additional observation was conducted on 1/8/25 at 12:35 p.m. of lunch service on the BB/200 unit. Residents were observed being brought into the dining room for lunch. No hand hygiene options were offered to residents before the meal. On 1/6/25 from 12:16 p.m. to 1:03 p.m., the AB/100 unit dining area was observed for lunch. Observations of the dining area revealed four dining tables with three to four residents at each table. Staff members were observed in the dining area included Staff G, CNA, Staff F, CNA, and Staff C, CNA. Residents were not observed being offered hand sanitizer or hand washing before eating. Staff were not observed performing hand hygiene prior to meal service or between passing of individual resident meals. At 12:46 p.m., Staff F, CNA was observed assisting Resident #718 with eating. Staff F, CNA did not perform hand hygiene before assisting this resident with eating her meal. Prior to assisting Resident #718, Staff F, CNA was observed assisting with passing of meal trays to the residents sitting in the AB/100 unit dining area. On 1/8/25 at 12:02 p.m., the AB/100 unit dining area was observed for lunch. The same concerns, observed on 1/6/25, related to hand hygiene not being offered to residents before eating or during the lunch meal service was observed. At 12:08 p.m., Staff B, RN was observed reviewing and writing on meal tickets, directly to the left of the steam table, as Staff D, Dietary Aide was serving food. From 12:08 p.m. to 12:32 p.m., Staff B, RN was observed touching plates with food and handing them to another staff member to provide to residents. Staff B, RN was not observed performing hand hygiene after handling the meal tickets and touching the plates with food being provided to residents. On 1/8/25 at 12:51 p.m., an interview with Resident #569 revealed staff don't offer or provide hand hygiene to her before meals. She stated she has wipes located in the bathroom she uses to clean her hands before eating. She confirmed she was not offered hand hygiene for breakfast or lunch that day. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/9/25 at 12:16 p.m., an interview with Staff C, CNA revealed hand hygiene is offered and performed in resident's rooms before they come to the dining area. She stated hand hygiene is also offered to residents who dine in their rooms. Staff C, CNA stated staff perform hand hygiene, All the time. On 1/9/25 at 12:23 p.m., an interview with Resident #19 revealed staff don't offer or provide hand hygiene to her before meals. She stated, I could do it myself, but it would be hard, and pointed to her right arm. Resident #19 stated, It would be nice if it was offered. On 1/9/25 at 12:28 p.m., an interview with Staff B, RN revealed the CNA's offered and perform hand hygiene for residents. She confirmed she sometimes helps with the dining meal service, including feeding residents who need assistance or passing trays. Staff B, RN stated when she assisted with the dining meal service the residents are already seated at the table, therefore, they had hand hygiene completed in their rooms. She stated when she passes meal trays to resident rooms she washes her hands, every three rooms. On 1/9/25 at 12:32 p.m., an interview with Staff A, Unit Manager (UM) for the AB/100 unit revealed hand hygiene should be offered to residents during morning care, before and after meals, if they touch their wheelchairs, and as needed. She stated her expectations for staff is to perform hand hygiene when they care for residents and remove personal protective equipment (PPE) in between passing trays and when they are working in the kitchen/dining areas. On 1/9/25 at 12:37 p.m., an interview with Resident #153 revealed staff don't offer or provide hand hygiene to her before meals. An interview was conducted on 1/9/25 at 12:24 p.m. with the facility's Infection Preventionist (IP). He said if a resident was on contact precautions for C. diff, staff should wear a gown and gloves, then wash their hands with soap and water. He confirmed Resident #578 tested positive for C. diff and staff should have been using soap and water to clean hands, not alcohol-based hand rub. He also confirmed the sign posted on the resident's door did say alcohol-based hand rub could have been used. He said they did not have a sign with enteric contact precautions. The IP said when he placed the sign, he told staff the resident was on precautions for C. diff, and they should have passed it along to the next shift so staff would know to use soap and water when exiting Resident #578's room. The IP confirmed all respiratory masks should be stored in a bag and not left uncovered on the bedside tables. He said if staff see a mask uncovered, they should place it in a bag. When asked about residents being offered hand hygiene before meals the IP said, that would be a great practice. He confirmed they did not offer residents hand hygiene options prior to eating. Review of a facility policy titled Clostridium Difficile, revised July 2014, showed the following: Policy Statement Preventative measures will be taken to prevent the occurrence of Clostridium difficile infections among residents and precautions will be taken while caring for residents with C. difficile (to prevent transmission of C. difficile to others). Policy Interpretation and Implementation (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. When caring for residents with diarrhea or fecal incontinence caused by C. difficile, staff will maintain vigilant hand hygiene. Hand washing with soap and water is superior to ABHR for the mechanical removal of C. difficile spores from hands 12. Glove use when caring for residents with C. difficile infection, washing hands with soap and water upon exiting the room of a resident with C. difficile infection and strict adherence to hand hygiene in general is considered best practice. Review of a facility policy titled Use of CPAP/BIPAP/APAP, undated, showed: Purpose: To provide guidance for use of CPAP (continuous positive airway pressure therapy) or BIPAP (bi-level positive airway pressure therapy) or APAP (auto-adjusting positive airway pressure therapy) for the treatment of obstructive sleep apnea (OSA). Care and Maintenance: - Store equipment when not in use. Photographic Evidence Obtained