STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106112	A. BUILDING _____ B. WING _____	**08/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TAMPA LAKES HEALTH AND REHABILITATION CENTER	**750 HAYES RD LUTZ, FL 33549**

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview with staff members, the facility failed to provide two person assistance as directed by the resident assessment and care plan for one (#1) of three sampled residents resulting in a fall and lacerations to the right side of the head and front of the scalp. Findings included: A review of the Admission Record revealed that Resident #1 was a long term care resident and had resided in the facility for approximately 3 years. The resident had a primary [DIAGNOSES REDACTED]. A review of the Order Summary Report with active physician orders [REDACTED]. Per the CNA, the resident fell off the bed while changing her. Vitals were normal. 911, Risk Management, and Power of Attorney (POA) were called. The Medical Doctor (MD) was paged. A nursing note dated 07/25/2020 at 20:30 (8:30 PM) revealed that hospice was notified of the resident's fall and transfer to the hospital. A nursing note dated 07/25/2020 at 23:00 (11:00 PM) revealed that the resident returned to the facility. New orders: Remove sutures on the right side of forehead in 5 days. New skin issues noted. Bruise in middle of forehead. Laceration with sutures on forehead on the right side. A review of the most recent Minimum Data Set (MDS) assessment completed on 06/24/2020 for a significant change revealed Resident #1 was rarely/never understood, had memory problems, and had severe cognitive impairment. Section G indicated the following: Bed mobility- extensive assistance with two plus persons physical assist Dressing- extensive assistance with two plus persons physical assist Eating- total dependence with one-person physical assist Toilet use- total dependence with two plus persons physical assist Personal hygiene- extensive assistance with two plus persons physical assist Resident #1 had a care plan in place for Activities of Daily Living (ADLs). The care plan indicated that the resident needed total assist from staff members for ADL tasks due to poor mobility and weakness with a revision date of 04/14/2020. The interventions included but were not limited to the following: Bed mobility: The resident was totally dependent on two staff for repositioning and turning in bed as necessary revised on 04/14/2020 Personal hygiene/oral care: The resident was totally dependent on staff for personal hygiene and oral care revised on 04/14/2020. A review of the facility's computerized POC (plan of care) Response History revealed that prior to the incident and after the incident bed mobility was conducted for Resident #1 with one-person physical assistance on the following dates and times: 07/05/2020: 00:37, 18:09, 23:59 07/06/2020: 09:39 07/07/2020: 01:31, 13:55 07/08/2020: 03:32, 17:30 07/09/2020: 05:46, 17:34 07/10/2020: 03:36, 11:01, 20:26 07/11/2020: 04:07, 13:23 07/12/2020: 01:51, 07:29, 19:36 07/14/2020: 03:35, 10:01, 20:10 07/15/2020: 03:52 07/16/2020: 02:44, 09:49, 20:53 07/17/2020: 04:23, 21:03 07/18/2020: 02:37, 08:18, 17:01 07/19/2020: 03:36, 20:46 07/20/2020: 11:36 07/21/2020: 03:29, 13:27 07/22/2020: 03:46, 17:37 07/23/2020: 04:03, 15:50 07/24/2020: 03:53 07/25/2020: 03:33, 11:03 07/26/2020: 14:59 07/27/2020: 14:59 07/29/2020: 04:39, 13:37 07/30/2020: 21:09 07/31/2020: 22:13 08/01/2020: 00:12 A review of the POC Response History revealed on multiple occasions prior to the incident and after the incident dressing was conducted for Resident #1 with one-person physical assistance on the following dates and times: 07/04/2020: 16:54 07/05/2020: 00:36, 18:09, 23:59 07/06/2020: 09:39, 18:31 07/07/2020: 13:55 07/08/2020: 03:32, 14:59, 17:30 07/09/2020: 05:46, 17:34 07/10/2020: 11:01, 20:26 07/12/2020: 07:29, 19:36 07/13/2020: 00:09 07/14/2020: 10:02, 20:10 07/15/2020: 11:52, 21:39 07/16/2020: 09:48, 20:53 07/17/2020: 09:44, 21:03 07/18/2020: 08:18, 17:01 07/19/2020: 20:46 07/20/2020: 11:35, 21:22 07/21/2020: 13:27, 21:03 07/22/2020: 12:36, 17:37 07/23/2020: 15:50 07/24/2020: 13:31, 19:00 07/25/2020: 11:03 07/26/2020: 14:59 07/27/2020: 14:59 07/28/2020: 06:59 07/29/2020: 13:37, 21:31 07/30/2020: 21:09 07/31/2020: 01:35, 07:51, 22:13 08/01/2020: 00:12, 07:51, 18:54 Telephone interview with Staff A, CNA, on 08/04/20 at 5:27 p.m. revealed the incident happened after 1:00 p.m. on 7/25/20. She went in the room to check on the resident. Resident #1 had bed pillows on each side of her in the bed. Staff A stated that she pulled the cover back and removed each pillow. Resident #1 had formula from the tube feeding on her gown and soaker pad. Staff A stated she looked and said, oh I have to change this. The resident was positioned down on the air mattress and the sheet was crumpled up on her back. Staff A stated she grabbed a new sheet and soaker pad, went on the side by the window to get herself positioned, and pulled the resident closer to her. Staff A stated she thought she pulled the resident too close to her. She went to tuck the clean linen under the dirty linen, peeked into the resident's brief and found that the resident was dry. She stepped back getting ready to tuck things under and went to grab the resident, but her strength wouldn't let her, and the resident went down. Staff A reported that the resident did not hit the dresser. She came down to where the knobs on the dresser were sticking out. Staff A backed up and hollered for help. No one came. Staff A stated that she lost it. It happened so quick. The resident slid like she was coming off a hill. When she came down, down she went stated Staff A. Her original intention was to go get help after she repositioned the resident in bed. Staff A stated that she can only learn from it and that she knows it was a strike against her. Staff A was asked what she would do differently when caring for the resident. She stated that she would wait even if she was the only one on the floor. In her mind, she was thinking she could get the resident situated and then she could put the call light on to get someone to come help her. Staff A stated that she was not Resident #1's regular CNA and that she does restorative. She stated that she floats on different floors. Staff A stated that she does not usually work on that unit, but she knows the resident. Staff A again reported that she thought she moved the resident too close to her when trying to change the linen. She stated that she was getting the dirty stuff off the bed to put the clean linen and pad on. Staff A stated she initially only went in to change the resident's gown. The resident's daughter likes her situated and likes to facetime (video chat) with the resident so she wanted to get her cleaned up. Staff A reported that her understanding was that the resident required two people for care. She stated that she was thinking she could change the sheet and soaker pad and get the gown changed to get her freshened up and then call for someone to help pull the resident up after she was done. On 08/02/20 at 3:19 p.m., the Risk Manager reported that Staff A, CNA, had given Resident #1 incontinence care. The CNA was reaching for linen and stated at that time, the resident started to slide off the side of the bed. Staff A was unable to stop the resident before she fell to the floor. The Risk Manager reported that Resident #1 was a two person assist and then stated that she thought the resident was total assist. The Risk Manager reported that the two-person assist was for bed mobility and that the resident was not two person assist for toileting. The Risk Manager reported that Staff A was changing Resident #1 on the bed when the incident happened. She followed the plan of care and it was an accident stated the Risk Manager. The Risk Manager reported that Staff A was not moving the resident, she was moving linen. The linen was on the bed and she was not maneuvering the resident. It was not bed mobility stated the Risk Manager. On 08/02/2020 at 6:05 p.m., Staff B, CNA, reported that she had previously provided care to Resident #1. Staff B reported that she used two people because you have to turn Resident #1 with ADL care. Staff B reported that the Kardex for the resident would tell you if the resident was one or two persons assist. On 08/02/2020 at 6:17 p.m., Staff C, Registered Nurse (RN), was Resident #1's assigned nurse during the survey. He reported that Resident #1 was a two person assist for ADL care. Staff C reported that the resident had a change in behaviors when changing her position. He reported that he repositioned the resident and

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

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.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) always used 2 people. Staff C reported that since he's been employed in the facility, Resident #1 a was two persons assist. On 08/02/2020 at 6:31 p.m., Staff D, CNA, who was the resident's assigned CNA during the survey, reported that you need two people to provide care to the resident. You have to check the Kardex and it would tell you whether to transfer with one or two people. Staff D reported that she always used another person when caring for the resident. A telephone interview on 08/04/20 at 5:43 p.m. with the Director of Nursing (DON) revealed that Staff A was doing incontinence care on the day of the incident. The DON stated that Resident #1 was not a two person assist. She was only one person assist for incontinence care. The DON stated that it was an accident. The DON reported that she was not in front of the computer so she could not tell me specifics about Resident #1's ADL care. On 08/04/20 at 6:07 p.m., the DON reported that if what Staff A stated to the surveyor was true, she should have used two people to care for Resident #1. The DON stated that Staff A did not mention what she told the surveyor in her statement. A policy for ADL care was requested on 08/04/2020 at 5:56 p.m. The policy provided did not reflect the procedure to follow when caring for dependent residents.