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 _____	**03/09/2020**

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 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, resident representative interview, staff schedule review, resident record review and resident council minutes review the facility failed to provide sufficient staff to meet the needs of the residents on the 11:00 p.m. to 7:00 a.m. shift for 8 out of 16 days reviewed. Findings included: Review of the Facility Assessment Tool dated 12/19/19 revealed Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies . nursing services . Licensed nurses providing direct care 1.0 (Follow State minimum mandated guidelines) Nurses aides 2.5 (Follow State minimum mandated guidelines) . individual staff assignment: Facility follows Federal staffing guidelines (please refer to the facility's staffing form.) 1. Review of the facilities Calculating Staffing for Long Term Care Facilities Form that was provided by the Staffing Coordinator was dated 2/23/2020-3/7/2020 and 1/19/2020-2/1/2020 revealed the facility met the state required minimums for certified nurse assistants (CNA) and Licensed nurses. On [DATE]20 at 2:16 p.m. an interview was conducted with the Staffing Coordinator and the Director of Payroll/ Human Resources. The Director of Payroll/Human Resources said I am the one who does the 2 week staffing hours calculations form. My process is after morning meeting me and the staffing coordinator sit down and she gives me the staffing schedule that had the corrections for each day, for example if we have a nurse working a CNA shift I put that as 8 hours for CNA hours not 8 hours for nursing hours. The Staffing Coordinator and myself worked on the staffing schedules that we gave you. What we gave you is how we came up with our numbers to put on the 2 weeks staffing calculations form. The Staffing Coordinator was in the room at the time of the survey and nodded her head in agreement. An interview was conducted on 3/8/2020 at 6:10 a.m. with Staff A, Registered Nurse (RN) and Staff B, RN together. They stated they are both nurses who typically work the 11:00 p.m. 7:00 a.m. shift. They stated right now we are both working as CNA's on the Bluewater Bay unit because they didn't have CNA's to work this shift on this unit. They both stated the facility definitely needs more help when it comes to CNA's. An interview was conducted on 3/8/2020 at 6:32 a.m. with Staff C, RN who was working on the Cabana Bay unit as a CNA. She stated I am an RN but I help them out when they are short staffed on CNA's. RN's doing the CNA jobs have been going on for about a month or so now. An interview was conducted with Staff D, RN nighttime Supervisor on 3/8/2020 at 6:57 a.m. she stated I have never worked at a place where they are paying RN's to do a CNA's job. Staffing is a huge issue here. Most of the RN's that are working did not know they were working as CNA's today. 2. An interview was conducted on 3/8/2020 at 8:43 a.m. with Resident #5 who lives on the Emerald Bay unit. He said I have to wait about an hour at night to have my call light answered. I push it when I have to be changed. I'd like my call light to be answered within 10-15 minutes. Record review was conducted for Resident #5 and the Admission Record revealed he had a [DIAGNOSES REDACTED]. Review of his Brief Interview of Mental Status dated [DATE] revealed a BI[CONDITION] score of 15/15 which indicated no cognitive impairment. Review of Resident #5's functional status dated [DATE] revealed he is an extensive assist for toileting, dressing, and personal hygiene. Review of the bowel and bladder status of the Minimum data sheet ((MDS) dated [DATE] revealed he is incontinent of bowel and bladder. Review of Resident #5's care plan revised on 7/24/2019 revealed he is incontinent of bowel and bladder with interventions to assist in incontinence care as needed and staff to assist to the extent necessary to meet daily incontinence needs. 3. An interview was conducted with the Resident Council President on 3/8/2020 9:33 a.m. she said every meeting we talk about how we are short staffed because people don't get their meals on time for all meals. Once and a while the administration will tell me they are searching out for people, but they just come and go, no one stays. Review of the Resident Council minutes from December 2019 to March 2020 revealed On 12/9/19 resident council concerns: Resident stated call light concern of 11:00p.m. -7:00a.m. shift. Resident council concern addressed: Call light audits are in place of all shifts. On 1/7/2020 resident council concerns: Call lights and staffing Resident council concern addressed: Informed residents call light audits are in place of all shifts and informed residents we are in the process of hiring more staff. On 2/5/2020 Resident council concerns: Staffing Resident council concern addressed: Informed residents we are in the process of hiring more staff. On [DATE] Resident council concerns: Staffing Resident council concern addressed: Informed residents we are in the process of hiring more staff. An interview was conducted with the Staffing Coordinator on [DATE]20 at 11:26 a.m. she said I create the schedules and I make sure everyone's schedule is correct and keep the building staffed. The CNA's cannot have more than 20 residents and a nurse cannot have more than 30 residents. She reviewed the staffing scheduled provided for the 11:00 p.m. - 7:00 a.m. shift, she confirmed there should be more nurses on and more CNA's on for the 11-7 shift. An interview with the Nursing Home Administrator on [DATE]20 at 11:45 a.m. she stated We would at least follow the state guidelines for staffing so CNA's should have up to 20 residents and nurses up to 40 residents. She reviewed the staffing schedules from [DATE]2-[DATE] and stated let me look into it. When she was asked why the facility uses licensed nurses to work in the CNA role on the 11-7 shift? She stated, we have a budget that can allow for that. 4- During an early morning visit to the facility, on [DATE]20 beginning at 6:15 a.m., the memory unit called Florida Bay was toured. Staff were posted for the 11p to 7a shift for 29 residents and included Aide X, Registered Nurse Y working as an Aide, and Registered Nurse Z, passing medication to the residents. Five residents were noted to be sitting at a large table in the common area of the unit with three sitting at the table adjacent. All residents were dressed for the day, the lights were low, and there was nothing to engage the residents, including having the television on or a radio playing. Of the eight residents, who were all female, five either had their heads down and eyes closed or their heads remained up with their eyes closed. Staff Z, who was passing medications to residents in their rooms reported, at 6:20 a.m. that the night had been quiet, but they could have used a third aide. She reported that most of the residents on the unit are two person assist and required total care. She reported that there were many residents who were identified as needing to be gotten up early, as they would try to get out of bed otherwise. She reported that both aides have to work together to get these residents up, cleaned up and dressed, and then brought out to the front, where they would sit unsupervised. Staff Z reported that many of the residents are at risk for falls and they do try to get up out of their chairs, but there is no one available to catch them or remind them to sit back down. At 6:40 a.m. another staff member was interviewed and she identified herself as usually working the unit as the nurse as she was a Registered Nurse. Staff Y reported that there are not enough aides, so the nurses get pulled all of the time. She reported that there are many residents on this unit that need to be gotten up early, and they have to start early as there are so many. She reported that the residents are all total care so you have to work with the other aide. She reported that all the residents require two aides or the mechanical lift (which requires two aides) to transfer and once they are up, they are brought out front and there is no one to supervise them. At 6:55 a.m., Staff X was interviewed and she confirmed that working just two aides on the shift is tough.

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 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) She reported that all of the residents are dependent with many residents needing to be gotten up early. She reported that the residents move about all night long, with none of them using the call bell to alert staff that they need assistance. She reported that there are no bed alarms either, so you have to round continuously and listen for any movement to alert you to a resident moving around. She reported that she works double shifts and had been on the job since 3 pm the day before. She said she is always asked to stay or come back early to help cover the next shift. At 6:30 a.m. an aide was observed on the floor who identified herself as having come in early for her 7am to 3 pm shift. She was observed looking in resident rooms for the night staff. At 8:15 a.m. breakfast had begun to be served with residents who were able to assist themselves having been served juice and oatmeal. Residents were seated at most of the tables in the room, with some being assisted and others with their heads down with glasses of juice in front of them. Slowly other staff entered the dining area and sat with residents to assist them with their breakfast. At 9:20 a.m., Staff Nurse U was observed at the medication cart. She reported that she only works weekends. She reported that she had been full time, either evenings or nights, but had gotten burnt out. She reported she was usually the only nurse and had asked for a break from this high acuity unit, but she was continually assigned to this unit. She reported that on this unit most residents are totally dependent, requiring the two assigned aides to work with each resident together. At 11:00 a.m. a second visit was made to the memory unit and eight residents were observed at the two tables in the common area. Two of the eight residents were observed to be coloring. The other residents were awake and looking around, with nothing to engage them. At that time two other residents were observed to have been positioned with the backs of their wheelchairs up against the edge of the nursing station. One resident, Resident #4, was leaning over in her wheelchair, with her nose resting on the arm of the wheelchair, dozing. At 12:05 p.m., staff were beginning to set up the dining room for lunch, with Resident #4 observed in the same position in front of the nursing station. At 12:25 p.m. Resident #4 was observed in the dining room being assisted with her lunch. An interview was conducted with the Activities Aide, (Staff S) on 03/09/2020 beginning at 9:00 a.m. She confirmed that she works every other weekend and identified another activities aide as having worked on [DATE]20. Staff S reviewed the posted activities calendar in the activities room and noted that there were two musical activities planned for the day. She reported that the activities calendar lists all planned activities for all units and residents can go to any unit for any planned event. She confirmed that there were no planned activities for early risers, but there were [MEDICATION NAME] and paper that aides can put out for the residents to use. In an interview with the weekend activities aide, (Staff R), on 03/09/2020 beginning at 11:40 a.m. , it was confirmed that she had worked over the weekend. She reported that she had held activities on [DATE]20 on the Dolphin unit, and confirmed she had not provided any activities for the residents on the Florida Bay unit. She reported that there are activities available and the aides just have to let her know that they need something for the residents to do. 5- On [DATE]20 at 11:15 a.m., Resident # 3 was observed in her room with a visitor combing her hair. The visitor introduced herself as a private aide that the resident's son had hired. The visitor reported that she was a certified nursing aide and had been given permission by the son to provide any care to the resident that she needed - showers, bathing, peri care, dressing, activities including walks outside, and assisting with meals and snacks that she brought in. The visitor reported that the resident spoke with her, loved music and would dance with her and sing. The visitor reported that she liked to massage the resident's legs and provide range of motion exercises to her legs and arms. The visitor reported that she was in the building a few times a week for various lengths of time. During an interview with the Resident's son, on [DATE]20 beginning at 5:05 p.m., the son confirmed that he had hired a private aide as he had visited many times to find his mother with wet clothing, needing a change; or in front of a plate of food that no one was assisting her with. He confirmed that the aide was a nursing aide who had his permission to provide any care that his mother needed. He allowed the aide to bathe his mother also as he had found her needing a bath when he would visit.