STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105697	A. Building B. Wing	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Bay Rehabilitation Center	4470 E Bay Dr Clearwater, FL 33764

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49227 Based on observations, interviews, and record review, the facility failed to implement interventions in the comprehensive care plan one resident (#90) of three resident sampled. Findings included: A review of the admission record showed Resident #90 was admitted to the facility on [DATE] with diagnoses including disorder of the skin and subcutaneous tissue, adult failure to thrive, cachexia (unintentional weight loss), and abnormal weight loss. A review of the active orders, as of February 2024, showed the following: -Bilateral heel elevation boots when in bed every shift. Remove for skin checks, hygiene and all cares as needed. Start date 4/5/23. A review of Resident #90's quarterly Minimum Data Set (MDS), dated [DATE], revealed the following: -Section C-Cognitive Patterns: Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. -Section M M1200-Skin Conditions: requires pressure relieving devices while in bed and requires substantial/ maximal assistance (helper does more than half the effort) to roll from left to right in bed. A review of Resident #90's care plan, initiated 10/26/22 and revised on 1/23/24, showed Resident #90 had actual impairment to skin integrity of the right lateral foot. Interventions included bilateral heel elevation boots when in bed every shift; may remove for skin checks, hygiene and all cares as needed. A review of Resident #90's Treatment Administration Record (TAR), for February 2024, revealed a nursing treatment for bilateral heel elevation boots when in bed every shift. May remove for skin checks, hygiene and all cares as needed. Every shift for impaired skin integrity. Start date 4/5/2023. The nursing documentation revealed the treatment was administered by each shift from 2/1/2024 through 2/14/24. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/24 at 10:15 a.m. Resident #90 was observed lying in bed without heel elevation boots in place as ordered. On 2/13/24 at 9:40 a.m. Resident #90 was observed lying in bed without heel elevation boots in place as ordered. On 2/14/24 at 7:40 a.m. Resident #90 was observed lying in bed. The resident stated she slept well. Staff F, Certified Nurse Assistant (CNA) was present in the room and removed the covers to expose Resident 90's legs and feet. The resident was not wearing heel elevation boots as ordered. On 2/14/24 at 2:45 p.m. an interview was conducted with Staff L, Licensed Practical Nurse (LPN). Staff L stated, Resident #90 Should have heel elevation boots on, unless they are in the laundry. On 2/14/24 at 2:52 p.m. an interview was conducted with Staff I, RN, Assistant Director of Nursing (ADON). She said residents usually have two pairs of heel protector boots, and it Does not take long for the elevation boots to be returned from the laundry. She was unable to state what the turnaround time was for laundering the boots.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observations, interviews, and record review, the facility failed to ensure one resident (#98), who was dependent on staff for eating assistance, received eating assistance in a manor to promote a safe and comfortable eating experience out of forty-seven sampled residents during one observed meal (12/12/2024) of one meal observed. Findings included: On 2/12/2024 at 11:55 a.m. an observation in the main dining room during the lunch meal was conducted. There were two sections of the dining room. A large section with ten tables where residents who dine and eat without eating assistance, and a smaller section with six tables where residents were assisted with their meals. Residents who dine in the small assistive dining room, require forms of assistance to include cueing, supervision or assistance with eating activities. Resident #158 was observed seated in a wheelchair at a table along with Resident #98, who was lying back in a reclined Geri chair. Resident #98 was observed with sheets covering her entire body, and a pillow on the right side of the head rest. Resident #98 was overheard calling out and moaning out loudly. Staff intervened and comforted her twice. Every time staff left Resident #98 began to moan aloud again. At 12:00 p.m. Residents #158 and #98 were still seated at the same table together. Resident #158 received his meal tray at 12:18 p.m. At 12:23 p.m. Resident #158 received a family member visit who sat down at the table with him. Staff B, Speech Therapy was observed to enter the room and seat herself at the table next to Resident #158 and across the table from Resident #98. Staff B evaluated and assisted Resident #158 with the meal. Resident #98 continued to sit reclined in her Geri chair and did not have her meal yet. At 12:27 p. m. all residents seated in the restorative/assistive dining room had all been served, set-up, and were being assisted with their meals. Resident #98 was still at the table and had not been served the meal. At 12:32 p. m. a Staff A, Certified Nursing Assistant (CNA), was observed bringing an uncovered plate of food into the assistive section of the dining room and placed it on the table next to Resident #98. Staff A left the area, leaving Resident #98 seated next to her food. The plate of food was uncovered exposing all the food items to the air element. Staff B, Speech Therapy continued to assist and evaluate Resident #158 while talking with his family member. At 12:42 p.m., Staff A, CNA walked into the room. At 12:44 p.m. Staff A sat down next to Resident #98 and tried to give her a spoonful of food while she was still in a reclined position with her head tilted on the right side on a pillow. Staff A got up and adjusted the head portion of the Geri chair to a 30 - 40 degree position. Staff A tried to give the resident a spoonful of food while her head was still tilted on the side on the pillow. Resident #98 opened her mouth but was not able to properly take food in and swallow. The resident had a puree textured diet, and was not able to accept bites appropriately due to head positioning. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:45 p.m. an interview was conducted with Staff A, CNA. Staff A, stated she assists Resident #98 with eating almost daily and she was fully dependent on staff for eating assistance. Staff A stated she brought in the meal for Resident #98 and had to leave to assist with the rest of the tray pass in the dining room. At 12:46 p.m. an interview with Staff B, Speech Therapy was conducted. Staff B stated Resident #98 was on her case load and she would be working with the resident, but positioning would be something for Occupational Therapy would address. She stated she was not aware if Occupational Therapy had Resident #98 on their case load. Staff B stated Resident #98 would not be comfortable eating in the position she was in. A review of Resident #98's medical record revealed she was admitted to the facility on [DATE], with a diagnoses to include sepsis, dehydration, protein calorie malnutrition, acute kidney failure, dysphagia, adult failure to thrive, and dementia. A review of the advance directives revealed Resident #98 had a Power of Attorney in place to make her medical decisions. A review of the admission Minimum Data Set (MDS), dated [DATE], revealed the following: -Section C-Cognition: Brief Interview Mental Status score 7 of 15, which indicated severe cognitive impairment. Section GG-Activities of Daily Living (ADL): utilizes a manual wheelchair, chair/bed-to-chair transfer = substantial assistance from staff. A review of the Physician's Order Sheet, dated 2/2024, revealed an order to include: Comfort Measures Only No weights, no labs, No tube feeding or artificial Hydration. Order date was 1/31/2024. A review of the CNA ADL flow sheet and kardex, for February 2024, revealed staff are to monitor and complete the following: 1. ADL - Eating 1. IF NPO/tube feed indicate here, 2. Requires (1 or 2) person is (independent, set up/supervision, limited, extensive, or total) 3. May indicate if participating in restorative dining here. 2. ADL - Locomotion on Unit 1. Requires (1 or 2) person & is (independent, set up/supervision, limited, extensive, or total) assist., 2. Uses (walker, cane, w/c, electric w/c, ambulatory, Geri/Broda chair, &/or specify specific device). 3. ADL - Locomotion off Unit1. Requires (1 or 2) person & is (independent, set up/supervision, limited, extensive, or total) assist.2. Uses (walker, cane, w/c, electric w/c, ambulatory, Geri/Broda chair, &/or specify specific device) A review of the Occupational Therapy Evaluation and Plan of Treatment, with a certification period of 1/31/2024 - 3/15/2024 and with a start of care date of 1/31/2024, revealed the following; Treatment approaches to include: Therapeutic exercises, Manual therapy exercises, Occupational Therapy (OT) evaluation moderate complexity, Self care management training for five days a week and with a duration period of 45 days. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Occupational Therapy Treatment Encounter note, dated 2/9/2024, revealed a summary of daily skilled services to include: Wheelchair management and analysis of patient's body alignment and functional skills in a new or existing wheelchair and assessment of current seating system for appropriate modifications as patient is heavy left side lean even after neck light stretch and pillow for additional support. The skilled services also included; Patient was transferred max a to Geri chair which fully reclined and has the support of body as she needs for comfort and limited leaning head rest with half moon cut out. Patient requires light repositioning of neck i.e. gentle stretching and realignment, leans heavy to the right and fatigues easy, positioning with some mild yelling out. A review of the care plan, with next review date 4/30/2024, revealed the following: - The resident has an ADL self-care performance deficit r/t generalized weakness, impaired mobility, failure to thrive, with interventions in place, to include but not limited to: TRANSFER: extensive x 1. - The resident has impaired cognitive function or impaired thought processes r/t dementia, with interventions in place to include but not limited to: : Cue, reorient and supervise as needed. - The resident has a swallowing problem and is on a mechanically altered diet with thickened liquids, refer to physician's order for current diet orders, with interventions in place to include: Encourage resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly, Keep head of bed elevated 45 degrees during meal and thirty minutes afterwards, Monitor/document/report PRN any signs and symptoms of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat. On 2/14/2024 at 11:15 a.m. an interview was conducted with Staff C, Occupational Therapist (OT). Staff C stated she was familiar with Resident #98 and did have her on OT case load. Staff C stated Resident #98 had been declining and was on comfort measures only for a few weeks. Staff C revealed she had seen Resident #98 for positioning while in Geri chair and had to try different interventions to include more padding, in order for her to be correctly positioned. She further revealed Resident #98's head would routinely tilt to the side on her right side and off onto the side of the head of the Geri chair. She revealed an intervention to include an extra pillow on her right side helped some, but her head would still tilt off to the side. Staff C revealed she tried various interventions with her head positioning in order to decrease mouth drooling. She stated the resident would only keep her head in an upright position for so long and then her head would just tilt back to the side again. She stated there was routine staff intervention with the head repositioning and intervening when the resident would moan aloud. Staff C stated Resident #98 should not have been assisted with eating while her head was lowered and tilted to the side. She stated staff should have made sure she was positioned correctly while being assisted with her meal. A review of the policy titled Activities of Daily Living (ADL), Supporting, dated 01/2022, reveled the following: Policy: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). 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. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure: 1. Residents will be provide with care, treatment and services to ensue that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. 2. Appropriate care and services will be provide 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, to include: Mobility (transfers and ambulation, including walking), Dining (meals and snacks).

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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** 39866 Based on observations, interviews, and record review, the facility failed to provide quality care and services related to wound care for one resident (#88) out of 5 sampled residents. Findings included: Review of Resident #88's Admission Record revealed he was admitted to the facility on [DATE] from an acute care hospital. His diagnoses included weakness, altered mental status, need for assistance with personal care, cognitive communication deficit, muscle weakness, and a history of falling. An observation was conducted on 02/12/24 at 10:02 AM. Resident #88 was observed to have a bandage on his right shin which was not dated and was soiled with brownish yellowish drainage. Resident #88 said the bandage had been changed a few days ago. He said he can't remember how he got the wound. (Photographic evidence obtained) An interview was conducted on 02/12/24 at 12:28 PM with Resident #88's family member. The family said Resident #88 gets skin tears very easily. The family member said he was at the facility on Wednesday (2/7/24) and the resident did not have the bandage on his right shin at that time. The family member said the bandage was not dated and he was not sure when it happened or how. An observation was conducted on 02/12/24 at 01:51 PM. Resident #88 was observed to be sitting in his chair with the same unlabeled, soiled dressing on his right shin. An observation was conducted on 02/13/24 at 9:40 AM. Resident #88 was observed to be putting on his jacket with the same unlabeled, soiled dressing on his right shin. Review of Resident #88's medical record did not reveal a progress note about the right shin wound, there was no physician order to change or monitor the right shin wound, there was no change of condition related to the right shin wound, and there was no documented family or physician notification about the right shin wound. Review of Resident #88's Weekly skin observation tool, dated 2/6/24, revealed the following: Prior to skin check does the resident have any of the preexisting areas identified. 1. Check all areas that apply: 1. skin tears .4. bruises 3. Are there any new areas of skin irregularities notes for this skin check. No. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 2/14/24 at 10:55 AM with the Director of Nursing (DON). He reviewed the photographic evidence of Resident #88's right shin dressing and confirmed it should be labeled, a change in condition should be documented, and notification to the family and physician should be documented. He said there should be physician orders to change the wound bandage. An interview was conducted on 2/14/23 at 12:58 PM with the DON. He said per the family, the resident hit his leg on the bed frame on Sunday (2/11/24) and the nurse put a bandage on it. The DON confirmed there was no physician order, the bandage should have been dated, and it should not have been soiled. Review of the facility's Skin Integrity policy, dated 09/2017, revealed the following: Purpose To Provide consistent assessment and evaluation, monitoring, documentation, and implementation of therapeutic interventions to heal and maintain skin integrity . .Assessment/Evaluation: .3. The resident will be placed on a weekly skin check by the Licensed Nurse, If new skin areas/areas are identified. A Change in Condition Evaluation will be completed. If indicated, with notifications of Physician and Resident/POA [Power of Attorney] or Resident Representative. Treatment orders will be implemented per Physician's orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49227 Based on observations, interviews, and record review the facility failed to ensure 1) Medication pill splitters were maintained in a clean and sanitary manner in two of four medication carts, and 2) discontinued resident medications were disposed of within thirty days in two of two medication rooms. Findings included: On [DATE] beginning at 8:10 a.m. the Medication Storage facility task was conducted with Staff J, LPN Unit Manager, (LPM, UM). The following observations were noted: -In two of the facility's two medication storage rooms resident medications were stores in cardboard boxes labeled personal (Photographic Evidence Obtained). The boxes contained medication containers without a resident's name or the contents. -A clear amber pill bottle without a resident's name and the word Pepcid written on the lid, contained three different pill shapes and sizes (a capsule, a white round tablet, a white oblong tablet). (Photographic Evidence Obtained). - A three-section amber pill organizer was also in the box. (Photographic Evidence Obtained). -Staff J LPN, UM, said the pills are stored when residents are admitted and do not want the pills to be discarded. She stated she did not know which resident the pills belonged to or how long the pills had been stored in the medication room. -The medications belonged to residents who were discharged from the facility on [DATE] and [DATE]. -A heating pad, hearing aid containers, batteries, and hairbrush were stored in the medication box. (Photographic Evidence Obtained) -A bag with Intravenous (IV) antibiotic labeled Do Not Use after [DATE] was in the medication storage refrigerator. (Photographic Evidence Obtained). -Staff J LPN, UM said expired medication should be placed in the return to pharmacy bin. -A DNA test kit that contained a test tube labeled collect saliva by [DATE] was stored in a drawer with medical supplies including syringes. -Staff J LPN, UM, said she did not know why the test kit was stored in the drawer. (Photographic Evidence Obtained). -Two of the facility's medication carts were observed with pill cutters that contained rust and scattered white powder. (Photographic evidence obtained). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled IC12: Medications brought to the Facility by a Resident or responsible party, undated, revealed the following: -Policy: Medications brought into the facility by a resident or responsible party are used only upon written order by the resident's attending physician, after the contents are verified, and if the packaging meets the facility's guidelines. Unauthorized medications are not accepted by the facility. -Procedures: C. Medications not ordered by the resident's physician are unacceptable for other reasons, are returned to the responsible party or designated agent. If unclaimed within 30 days, the medications are disposed of in accordance with facility medication destruction / disposal procedures. Review of the facility's Temperature log for vaccines revealed the following instruction, place an x in the box that corresponds with the temperature. The hatched represent unacceptable temperatures ranges. Review of facility policy, undated, titled Equipment and Supplies for Administering Medications. -Policy: the facility maintains equipment and supplies necessary for the preparation and administration of medications to the residence. -Procedures: -the following equipment and supplies are acquired and maintained by the facility for the proper storage preparation and administration of medications 6) devices for crushing and splitting pills -the charge nurse on duty ensures that equipment and supplies relating to medication administration or clean and orderly -the charge nurse is notified if supplies are inadequate, or equipment failed to work properly. The charge nurse reports equipment and supply deficiencies to the director of nurses,

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 20536 Based on observations, interviews, and record review, the facility failed to ensure a clean, sanitary and maintained kitchen space to include: 1. Broken/missing trash receptacles at two of two hand washing stations; 2. A walk in freezer unit observed with heavy frosting crystallization on food items, shelving, and boxes of food items; 3. Overhead ceiling vents and ceiling tiles located above food prep and food service stations with dust and debris, 4. Various rusted areas near washed/sanitized cups and eating ware; and 5. Staff not wearing hair/beard covers appropriately while at food preparation and food service stations during three of four days observed, (2/12/2024, 2/13/2024, 2/14/2024). Findings included: 1. On 2/12/2024 at 9:07 a.m., the facility's kitchen was entered and toured with the Certified Dietary Manager (CDM). The hand washing sink was in a room next to the dish washing machine. The CDM stated he had only been back at the facility for two weeks, but has been employed at the facility about four years. A foot pedal operated trash receptacle was positioned at the right of the hand washing sink. The lid would not open when the foot pedal was depressed to dispose of paper towels used for hand hygiene. The only way to get the used paper towels in the receptacle was to lift the soiled lid. The lid to the receptacle was observed with various hardened food debris and dried colored liquid. The CDM stated he had been meaning to get a new trash receptacle. He confirmed due to the hand washing sink trash receptacle being in disrepair, staff would have to lift the lid with their bare hands to discard paper towels and other refuse. The CDM pointed out another hand washing sink in the kitchen, which was near a food preparation station. No trash receptacle was at or near the hand washing sink. There were no trash receptacles within eyesight of this hand washing station. The CDM again stated he was meaning to get a trash receptacle for this area. He stated when staff use this hand washing station, they would have to walk to another section of the kitchen and lift a lid to a trash receptacle and then discard their refuse. He stated the staff should not have to lift soiled trash receptacle lids with their clean/sanitized bare hands. (Photographic evidence was taken). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On 2/12/2024 at 9:30 a.m., and 2/14/2024 at 12:55 p.m. the kitchen's walk in refrigerator unit was entered. While inside and at the back of the unit, the back wall was observed with a cooling motor with a plastic covering/housing. The plastic housing for the main fan was observed with many areas with black biogrowth/debris. The inside of the refrigerator unit was observed full with packaged food items as well as boxes of unpackaged and uncovered vegetables and fruits. The boxes of vegetables and fruits were noted placed on shelves directly under the motor fan housing. The walk in freezer unit door was opened and there were about seven to ten plastic slats utilized as an air resistance curtain. All the plastic slats were observed with heavy built up icing. The CDM stated the unit has had recent repairs and everything was corrected during that repair. He could not remember exactly how long the repair was, but revealed the temperatures within the unit were at and below 32 degrees F. Upon entering the inside of this unit, there were shelves on either side as well as at the back of the unit. Observation revealed heavy icing and frosting at and near the motor housing; heavy icing on two of three shelves on the right side of the unit; heavy icing on three boxes of packaged food; heavy icing and frosting on an open box of food that contained plastic a large plastic wrapped roast, bags of opened vegetables, and other items within this box. Some of the items that had icing and frosting on them, could not be identified as the icing/frosting covered the entire food item. (Photographic evidence was taken). The CDM stated the iced and frosted food items should have been already thrown away, but he along with his staff must have missed those boxes of food items. He stated the unit appeared to be frosting/icing on one side of the unit and would need to put in a work order to get it fixed. He was not sure how long the inside of the freezer unit had been building up with ice and frost crystallization. 3. On 2/12/2024 at 9:30 a.m. and 2/14/2024 at 12:55 p.m. the main food service and food preparation area/station was observed with two ceiling vents directly above the food preparation table and the steam table where food is served from. The ceiling vents and surrounding ceiling tiles were observed with heavy dust/debris build up. The CDM stated the Maintenance Department is responsible for the cleaning and maintenance of the kitchen's ceiling and ceiling vents. He believed maintenance comes in about one a month or so. The CDM was not exactly sure how often maintenance has come in to clean the ceiling, but did confirm that he along with his staff should have seen all that dust/debris and should have put in a work order for maintenance to clean. 4. On 2/12/2024 at 9:30 a.m. and 2/14/2024 at 12:55 p.m. during kitchen tour, the back section of the room, where there was a food preparation table, and with staff preparing food items for resident consumption; revealed a long stainless steel shelf hanging on the wall directly above the table. Further observations revealed heavy rusting on the undercarriage of the shelf. The rusted areas were observed chipping and peeling away, which caused a risk for the debris to fall on exposed food items. Interview with the dietary staff in the room and the CDM revealed they were unaware of the rusted shelf. The area near the dish washing machine was observed with a large plastic and metal bug zapper device. The metal grating on this device was observed rusted and with paint chipping away. Directly below this device were crates of cleaned and sanitized cups and glasses. The rusted grating revealed chipped sections of paint and caused risk for the debris to fall on the already cleaned eating/drinking ware. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105697	A. Building B. Wing	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Bay Rehabilitation Center	4470 E Bay Dr Clearwater, FL 33764

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/14/2024 at 12:55 p.m. during the kitchen tour, the back room where a food preparation station was at, and also near the hand washing sink was observed with a long metal food preparation table. The metal table with an under shelf, was observed with a large gray round soiled trash can lid placed on the lower table shelf and leaning up against four various cleaned colored plastic cutting boards. Another section of under the metal table was observed with two full and used red and green sanitizer buckets with rags inside them. The buckets were observed placed directly next to a large clear plastic container of dry food product. The CDM stated the trash can lid and sanitizer bucket should not be in this area and certainly should not be leaning up against clean equipment. He stated the container of food should not have been in the same area as the sanitizer buckets and soiled trash lid. (Photographic evidence was taken). 5. On 02/14/24 at 1:31 p.m. during the kitchen tour Staff D, cook was observed with exposed facial hair from the chin up to his lower lip. On 02/14/24 at 1:34 p.m. an during an interview CDM, said staff should not have exposed hair while on duty. The CDM revealed he oversees the kitchen cleaning process and had listed duties each day, and a dedicated staff member has to complete and initial each task. He revealed there is a weekly cleaning scheduled for most areas and equipment in the kitchen. However, in between meal services, staff are expected to clean the floors, cooking equipment, eating ware, and as need areas. The CDM revealed during the cleaning process, he and his staff should have caught the above listed areas and either cleaned the areas or notified the maintenance department to repair equipment. A review of facility policy titled, Dietary Guidelines Manual, undated, Subject Person Hygiene revealed the following: Purpose: Staff involved in handling food follows proper hygiene practices to prevent contamination of food. -4) wear a hairnet at all times. -- caps are acceptable -- cover all hair including beards and mustaches. A review of the policy titled Dietary Guideline Manual related to Cleaning Freezers, dated 2015, revealed the following: Policy: The Freezers will be defrosted as needed (when frost is 1/4 inch thick, the freezer should be defrosted), or per the manufacturer's instruction. Procedures: Remove all food from the freezer. Sort out and throw away all that is not unusable. Store good food in another freezer, refrigerator or cooler until the freezer is cleaned. A specific policy with relation to kitchen and kitchen equipment sanitation was not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105697	A. Building B. Wing	02/15/2024

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49227 Based observations, interviews, and record review, the facility failed to follow infection control guidelines related to hand hygiene during two of six medication administration observations. Findings Included: On 2/13 /2024 at 8:30 a.m. Staff M, Registered Nurse (RN) was observed during medication administration for Resident #37. Staff M did not perform hand hygiene before beginning the procedure. Staff M, RN prepared seven medications for the resident and administered them as ordered. An interview was conducted with Staff M and she stated she did not perform hand hygiene prior to her medication administration. Staff M stated she did not follow the hand hygiene policy. On 2/13/2024 at 8:50 a.m. Staff N, RN was observed during medication administration for Resident #358. Staff N, RN did not perform hand hygiene before beginning the procedure. Staff N, RN prepared twelve medications for the resident and administered them as ordered. An interview was conducted with Staff N and she stated she did not perform hand hygiene prior to her medication administration. Staff N stated she did not follow the hand hygiene policy. A review of the facility policy titled Medication Administration-General Guidelines revealed the following: Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by the persons legally authorized to do so personnel authorized to administer medications do so only after they have been properly oriented to the facilities medication distribution system, procurement, storage, handle in and administration. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. -Procedures 2) Hand washing and hand sanitation: the person administered medication at the ears to good hand hygiene, which includes washing hands thoroughly -before beginning a medication passed, -prior to handling medications