STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105117	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Heritage Health & Rehabilitation Center	718 Lakeview Ave S Saint Petersburg, FL 33705

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and review of the facility policy, the facility did not ensure a sanitary and home-like environment was provided in the main shower room and in two shared bathrooms (100/102 and 129/131) out of thirteen rooms with shared bathrooms.Findings included: On 10/15/25 at 9:43 a.m., an observation of the main shower room revealed clumps of hair and debris in the drain. Further observations of the main shower revealed a white shower chair, by the door, which had a clear cup with a green colored substance and multiple black particles on the left leg and arm handle. On 10/15/25 at 9:45 a.m., an observation of the shower area in room [ROOM NUMBER] and 102 revealed a bedpan on the shower chair with black debris and particles inside. Further observation of the floor revealed multiple strands of dark colored hair as well as multiple areas of black bio-growth. On 10/15/25 at 10:08 a.m., an observation of the shower area in room [ROOM NUMBER] and 131 revealed multiple areas of green and black colored bio-growth along the tiles and edges of the floor. On 10/15/25 at 10:11 a.m., an interview with Staff D, Housekeeping was conducted. He stated, I don't do anything in the showers. Staff D, Housekeeping said he only cleaned the toilet and mirrors and replaced the paper towels and toilet paper. He stated he was currently filling in the housekeeping position and was cleaning up from the previous night.On 10/15/25 at 10:22 a.m., an interview with Staff E, Housekeeping was conducted. He said cleaned the toilet and mirrors, sweeps and mops the floor, and replaced paper towels and soap. Staff E, Housekeeping said he cleaned the main shower room in the mornings, and the certified nursing assistants (CNAs) were responsible for cleaning after each resident. He said he would clean the main shower room throughout the day if staff brought it to his attention. He said there are two rooms, that he knows of in his assignment, with showers. Staff E, Housekeeping stated he kept the showers clean by picking up items off the floor but does not, Deep clean, because, Residents don't use them. He said there are housekeeping staff from 7:00 a.m. to 3:00 p.m. Staff E, Housekeeping said nursing staff are responsible for cleaning when housekeeping is not there. On 10/15/25 at 1:12 p.m., an interview was conducted with the housekeeping supervisor. He said some showers are not in use by residents. The housekeeping supervisor reviewed a facility map and counted 8 to 9 showers with water running into them. The housekeeping supervisor said he expected staff to clean the toilets and showers, as well as sweep up trash. He stated if there was bio-growth the housekeeping staff is expected to let him know and, Get something stronger to clean. He said the housekeeping staff are expected to use disinfectant to clean. The housekeeping supervisor confirmed the housekeeping staff should be cleaning the showers whether a resident uses it or not. He said for shower chairs, the housekeeping staff are supposed to clean them, including wiping them down. Photographic evidence was shown to the housekeeping supervisor of the main shower room and the showers in rooms 100/102 and 129/131. He confirmed the bio growth observed would not have happened overnight. The housekeeping supervisor said he thought the shower in room [ROOM NUMBER]/131 is going to be re-done and confirmed it should still be cleaned. A review of the facility's policy titled, Physical Environment, effective August 2024, revealed the following, A safe, clean, comfortable, and home-life environment is provided for each resident, allowing the use of personal belongings to the greatest extent possible. Sufficient space and equipment and dining, health services, recreation, and program areas are provided to enable staff to provide residents with needed services. 4. Assure resident care equipment is clean, properly stored, and identified.(Photographic Evidence Obtained).

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to to ensure the medication error rate was less than 5.00%. Twenty-two medication administration opportunities were observed, and fifteen errors were identified for two residents (#3 and #2) of two residents observed. These errors constituted a 68.18% medication error rate. Failure to ensure the accurate administration of medications has the potential to greatly affect the effectiveness of the medication and jeopardize the health and safety of the resident. Findings included:1.On 10/15/25 at 10:06 a.m., an observation of medication administration with Staff A, Licensed Practical Nurse (LPN), was conducted with Resident #3. The resident's medication profile was colored red, showing medications were late. The staff member removed an insulin pen and insulin syringe lying both on top of the medication cart then dispensed the following medications:- saccharomyces boulardii over-the-counter (otc) 500 milligram (mg) tablet- haloperidol 2 mg tablet- 4 gabapentin 100 mg capsules- fluoxetine 10 mg capsule- benztropine 2 mg tablet- aspirin 81 mg chewable otc tablet- meloxicam 15 mg tablet- metformin 1000 mg tablet- insulin degludec pen 24 unitsThe staff member uncapped and used an alcohol pad to wipe the rubber stopper of the insulin cartridge before inserting the needle from an insulin syringe into the pens cartridge, and drawing up 24 units. The staff member did not engage the safety sheath of the syringe leaving the needle exposed. Staff A laid the insulin syringe onto the mouse pad atop the medication cart to confirm the dispensation of 11 tablets. The staff member proceeded to pick up the syringe then laid it back down on an empty blister card of atorvastatin, picked up a cup of water, the syringe, and a glucometer with the syringe resting upon the glucometer. Staff A entered Resident #3's room, lying the insulin syringe with the exposed needle directly onto the resident's over bed table proceeding to open an alcohol pad package. The staff member was asked to stop the administration and return to the hallway. Staff A stated they were not to draw up insulin from the pen but when they order pen needles pharmacy does not send them. The infection control issues were discussed with Staff A and the staff member returned to the medication cart, discarding the insulin syringe. The staff member again used an insulin syringe to draw up insulin degludec from the pen, returned to the resident's room, injected the insulin, and obtained blood glucose level of 117 acknowledging the resident did not require short-acting insulin. Review of Resident #3s Medication Administration Record (MAR) revealed the following medications were to be dispensed and included the times in which the medications were scheduled to be administered:- acidophilus (lactobacillus) tablet - one time a day for prophylaxis otc. Medication provided by facility, pharmacy do not send.- haloperidol 2 mg oral tablet- give 2 mg by mouth two times a day for schizoaffective disorder bipolar type. The medication was scheduled for 9:00 a.m. and 5:00 p.m.- gabapentin 100 mg - give 400 mg by mouth three times a day for neuropathic pain, give 4 capsules of 100 mg. The medication was scheduled for 9:00 a.m., 1:00 p.m., and 5:00 p.m.- benztropine mesylate oral 2 mg tablet - give 2 mg by mouth two times a day for EPS (Extrapyramidal symptoms). The medication was scheduled for 9:00 a.m. and 5:00 p.m.- metformin 1000 mg - give 1000 mg by mouth two times a day related to type 2 diabetes mellitus without complications, give with breakfast and dinner. The medication was scheduled for 9:00 a.m. and 5:00 p.m.- insulin degludec subcutaneous solution pen-injector 100 unit/milliliter (mL) - inject 24 uit subcutaneously every morning and at bedtime for diabetes. The medication was scheduled for 8:00 a.m. and 9:00 p.m. Review of the administered medications and the MAR showed the resident received the probiotic yeast (fungus), saccharomyces boulardii instead of the ordered bacteria probiotic, acidophillus (lactobacillus acidophillus). Review of Resident #3s progress notes, conducted on 10/15/25 at 3:32 p.m. did not reveal the physician had been notified and instructions were received for the next dose(s) of the late medications of haloperidol, gabapentin, benztropine or metformin. Review of insulin degludec's manufacturers prescribing information (https://www.novo-pi.com/tresiba.pdf) included Dosage and Administration - Important Administration Instructions: DO NOT transfer (brand name) insulin degludec from insulin degludec FlexTouch pen into a syringe for administration (see Warnings and Precautions (5.4)). The warnings and precautions (5.4) instructed users To avoid dosing errors and potential overdose, never use a syringe to remove (brand name - insulin degludec) from the (insulin degludec) flex touch disposable insulin prefilled pen (see Dosage and administration (2.1) and Warnings and Precautions (5.3)). An interview was conducted with Staff A on 10/15/25 immediately following the medication administration observation. The staff member stated the facility has not had insulin pen needles since switching over from vials to pens. 2.An observation was made

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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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, record reviews, and interviews the facility failed to implement an effective infection control program related to ensuring one of one observed needle attached to an insulin syringe was appropriately sheathed, staff failed to provide a barrier between an insulin syringe and an over bed table, failed to clean hands in between residents and handling random resident equipment stored in hallway, failed to don gloves prior to the administration of eye drops for one (#2) of one resident receiving this type of medication, and failed to ensure two (B & C) of three direct care nurses fingernails had the ability to be cleaned thoroughly and adequately to prevent the transmission of microbes. Failure to not implement and educate staff regarding infection control measures could cause serious harm to residents by not ensuring cross contamination between environmental and residents. Findings included:On 10/15/25 at 10:06 a.m. Staff A was observed during Resident #3's administration of medications. The observation showed Staff B extract 24 units from an insulin degludec insulin pen with a safety sheath insulin syringe, after the extraction the staff member placed the syringe without sliding safety sheath onto the mouse pad lying on the medication cart before picking it back up. Staff A placed the uncapped/unsheathed syringe on an empty blister card of atorvastatin with the needle lying next to/on a blister to confirm the number of dispensed oral tablets. The staff member picked up a cup of water in one hand and with other picked up insulin syringe and glucometer with the unsheathed needle resting against the back of meter. The staff member entered Resident #2s room and placed water, glucometer, and syringe on the resident's over bed table without placing a barrier. The observation was stopped and the staff member was asked to exit the room. The infection control issues with the uncapped needle being unsheathed and eedle touching multiple surfaces were discussed and the staff member confirmed the observations. On 10/15/25 at 10:29 a.m. an observation revealed a medication cart parked in front of an unknown resident room. Staff B was observed exiting the room and move the medication cart to the other side of the hallway, moving a wheelchair out of the way. The staff member was observed with green square cut fingernails extending approximately a half inch (1/2) past fingertips. The staff member confirmed dispensing 10 oral tablets, inhaler, nasal spray, and (bottle) of eye drops. Staff B entered Resident #2s room, the resident squirted one spray of nasal spray into each nostril, swallowed oral medications refusing the guaifenesin, and administered one inhalation of the inhaler, gargling with water and spitting out. The staff member, without hand hygiene and gloving, administered one drop into the left eye then the right eye. Staff B left the resident room. Immediately following the observation, at the medication cart, the staff member stated I didn't put my hands on some sanitizer, thought I did and should have worn gloves when putting eye drops in. Staff B reported the fingernails were real. On 10/15/25 at 3:39 p. m. Staff C, Unit Manager, was observed with square cut fingernails painted pink with sparkles extending approximately 1/2 past end of fingertips. An interview on 10/15/25 at approximately 4:30 p.m. the Director of Nursing (DON) stated hand hygiene should almost every time, (during) casual touch, when you provide before and after putting on gloves, and supposed to do hand hygiene with hand sanitizer during medication administration. The DON stated she would have to check the handbook regarding fingernail length but normally says if you turn and look at palm should not see fingernails, would have to check. Review of the Facility Employee Handbook 2025 showed under Personnel Hygiene Fingernails should be kept neat, clean, and nails short so not to create safety or infection control issues. No artificial nails, appliques, or studs on nails may be worn at any time. Review of policy - Infection Prevention and Control Program, effective October 2021, showed The infection Prevention and Control Program is comprehensive program that addresses detection, prevention and control of infections and communicable disease among residents, visitors, volunteers, those individuals providing services under contractual agreement and personnel. The Infection Prevention and Control Program, in addition, will facilitate activities to imprvove antibiotic use to reduce adverse events, prevent emergence of antibiotic resistance, and promote better outcomes for residents. The goals of the Infection Prevention and Control Program are to: a. Provision of a safe sanitary, and comfortable environmentb. Decrease the risk of infection and communicable disease development and transmission to residents, volunteers, visitors, individuals providing services under a contractual arrangement and personnel.Review of the Centers of Disease Control and Prevention guidance, Clinical Safety: Hand Hygiene for Healthcare Workers, dated February 27, 2024, included the following: Protect yourself and your patients from deadly germs by cleaning your hands.All healthcare personnel should understand how to care for and clean their handThe CDC explained the importance of proper and adequate hand hygiene was:Hand