

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105140	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER The Bristol Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 E Fletcher Ave Tampa, FL 33612	

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)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453</p> <p>Based on interviews and record review, the facility failed to act upon a resident's concerns and grievances for one (#102) of four residents reviewed.</p> <p>Findings included:</p> <p>During a facility tour on 01/27/25 at 10:11 a.m., Resident #102 stated she was missing some clothes. The resident said she had a closet full of clothes and was missing a couple pairs of pants and undershirts. Resident #102 said, They are gone. I told the laundry lady. The resident stated it had been a while ago, may be three weeks or so. 01/28/25 at 2:23 p.m., Resident #102 stated her clothes were still missing. She stated the family had brought them in.</p> <p>Review of the admission record showed Resident #102 was admitted to the facility on [DATE] with a primary diagnosis of unspecified fracture of right femur.</p> <p>Review of a quarterly Minimum Data Set (MDS) dated [DATE], showed Resident #102 had a Brief Interview for Mental Status (BIMS) Score of 11, which indicated moderate impairment.</p> <p>On 01/29/25 at 4:30 p.m., an interview was conducted with the Social Services Director (SSD). She stated she had not received any grievances from this resident or from any staff filing on her behalf. She confirmed the grievance log did not show any entries for this resident.</p> <p>An interview was conducted on 01/30/25 at 9:47 a.m. with the Housekeeping and Laundry Supervisor and her Assistant. The laundry supervisor stated if a resident's laundry was missing, they reviewed the inventory sheet and then checked the Lost and Found . She stated she asked the resident how long the clothing had been missing. She stated if they could not find the items, they initiated a grievance for the resident. The laundry supervisor stated the expectation was to return to the resident with a response within three days.</p> <p>On 01/30/25 at 9:54 a.m., an interview was conducted with the assistant laundry supervisor. The assistant confirmed this resident had told her she was missing her clothes. The assistant supervisor said, She was saying that someone brought her some clothes maybe a week ago or so. I can't remember specifically. She stated the resident reported family had brought the clothes, some pants and shirts. The assistant laundry supervisor said, I could not find her specific clothes. I gave her some other clothes from the donations pile. I should have initiated a grievance.</p> <p>(continued on next page)</p>

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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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/30/25 at 10:22 a.m., an interview was conducted with the Director of Nursing who stated if the resident had reported to staff her laundry was missing, she would have expected a grievance to be initiated.</p> <p>Review of a facility policy titled, Grievances/Complaints, Filing revised April 2017 showed Residents, and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances (e.g., the State Ombudsman).The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999</p> <p>Based on observations, review of reported incidents, and interviews, the facility failed to ensure a thorough investigation was conducted for one (#188) of four allegations of abuse related to a staff member allegedly slapping the resident.</p> <p>Findings included:</p> <p>On 1/27/25 at 9:48 a.m. Resident #188 was observed lying in bed, on a long-term care unit, with a blanket over her head and body, one foot was observed outside of the blanket.</p> <p>On 1/27/25 at 1:59 p.m., Resident #188 was observed and interviewed in her room with her significant other at the bedside and roommate lying in the next bed. The resident voiced nobody had hit or talked bad to her. The resident's significant other left room and the resident covered her head with a blanket, allowing for the interview to continue. The resident reported no concerns with care as the significant other returned.</p> <p>Review of a facility reported incident (Nursing Home Federal Report Form v1.0), showed on 12/2/24 at 3:52 p.m. Resident #72 (the roommate of Resident #188) informed the Social Service Director (SSD) of an incident that had occurred between Resident #188 and Staff I, Registered Nurse (RN) on 12/2/24 at 6 a.m. The roommate stated Staff I was doing med pass with Resident #188 and the nurse did not have water so the resident pushed the staff member away resulting in the nurse slapping the resident on the hand. The roommate did not witness the slap but saw the nurse leaving the room. The report showed Staff I had been suspended, a skin evaluation had been completed on Resident #188 without any new impairments, and the physician was notified. A psychologist consult was placed and widespread abuse, neglect, and misappropriation in-service initiated with staff. The report revealed Resident #188 was admitted to the facility on [DATE] and the latest Brief Interview of Mental Status (BIMS) score was 15, which indicated intact cognition. The residents' diagnoses included congestive heart failure, major depressive disorder, bipolar disorder, generalized anxiety disorder, and morbid obesity. The roommate's (Resident #72) latest BIMS score was 15. A facility-conducted interview with Resident #188 revealed over the weekend of the second (12/2/24), Staff I had attempted to give medications by putting them in the resident's mouth and the resident pushed the nurse's hand away. The resident stated, the Nurse popped [Resident #188] in the hand lightly and said to [Resident #188], we don't do that. The facility conducted an interview with Staff I. Staff I alleged the resident was awoken to take requested as needed medications and the resident slapped Staff I's hand. Staff I attempted to block the resident's hit as she was trained to do. Staff I reported not slapping or hitting the resident in retaliation. Staff I reported the slap Resident #72, the roommate, heard was Resident #188 hitting the nurse. Staff I immediately exited the room to separate herself from the situation. The report showed Staff J, Assistant Administrator (AA) interviewed Resident #72 on 12/9/24. The resident stated Staff I tried to force [Resident #188's] medications in her mouth when she was not ready for them. Resident #72 acknowledged not witnessing the slap but heard a slap and noted the nurse leaving the room.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with Staff J on 1/29/25 at 12:44 p.m. Staff J stated Resident #72 had informed the SSD that Staff I was doing med pass with Resident #188 and Resident #188 pushed the nurse's hand away so the nurse slapped the resident's hand. Staff J reported Resident #188 had informed the roommate, Resident #72, [Staff I] had slapped her hand. The facility suspended Staff I pending the investigation and reported the incident to officials on 12/2/24 following the report by the SSD. Staff J reported statements were obtained from Resident #188 and #72 and Staff I. Staff J reported the slap heard (by Resident #72) was probably from Resident #188 hitting Staff I. Staff J stated only the 3 people involved (the residents' and Staff I) were interviewed and written statements had been obtained on 12/5 and 12/6 from the three Certified Nursing Assistants (CNA) on the unit at the time, who did not witness the incident.</p> <p>An interview was conducted with Staff J on 1/29/25 at 2:52 p.m. The staff member stated no other residents on the unit had been interviewed. A continued interview was conducted with Staff J on 12/29/25 at 3:14 p.m. The staff member stated the 7 days between the incident and Resident #188 and #72's interviews were within the 5-day window but did not know why it took 7 days to get their statements, normally does them right away but sometimes things come up.</p> <p>Review of undated - Abuse Investigation Guidelines revealed:</p> <ol style="list-style-type: none"> 1. The individual conducting the investigation will, as a minimum: <ol style="list-style-type: none"> h. Interview other residents to whom the accused employee provides care or services; and i. Review all events leading up to the alleged incident. <p>Review of the policy - Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, revised April 2021, revealed Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The interpretation and implementation of the policy revealed the resident abuse, neglect and exploitation prevention program consists of a facility wide commitment and resource allocation to support the following objectives:</p> <ol style="list-style-type: none"> 1. protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to facility staff: <ol style="list-style-type: none"> a. facility staff; b. other residents; c. consultants; d. volunteers; e. staff from other agencies; f. family members; <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure two dependent residents (#123 and #283) of four sampled for Activities of Daily Living received showers per plan of care and choice.</p> <p>Findings included:</p> <p>1. On 1/27/25 at 10:24 a.m., Resident #123 was observed lying in bed. The resident reported wanting a shower, as bed baths don't get it. The resident stated his last shower was before transferring to his current room and he stopped asking why he could not have a shower.</p> <p>Review of Resident #123's Admission Record showed the resident was admitted on [DATE]. The record included diagnoses not limited to hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, unspecified rheumatoid arthritis, and unspecified osteoarthritis unspecified site.</p> <p>Review of Resident #123's quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 15 of 15, which indicated intact cognition. The functional ability of the resident showed the resident had range of movement impairment to one upper extremity and to bilateral lower extremities. The assessment revealed the resident was dependent upon staff for oral, toileting, and personal hygiene, shower/bathing, and dressing.</p> <p>Review of Resident #123's annual MDS, dated [DATE] revealed the resident's preference to choose between a tub bath, shower, bed bath, or sponge bath was very important.</p> <p>Review of Resident #123's Certified Nursing Assistant (CNA) Kardex revealed the resident was to receive showers every Tuesday and Friday during the 3:00 p.m. - 11:00 p.m. shift.</p> <p>Review of the shower schedule for the unit where Resident #123 resided revealed the resident was assigned to receive a shower during the 3:00 p.m. - 11:00 p.m. shift on Tuesday and Fridays.</p> <p>Review of Resident #123's Skin Monitoring Comprehensive CNA Shower Review instructed staff to Perform a visual assessment of a resident's skin when giving the resident a shower. The facility provided 3 of these forms, dated 1/7, 1/10, and 1/24 for the last 30 days. The forms did not reveal the type of bathing the resident had received.</p> <p>Review of Resident #123's CNA Task documentation for January 2025 showed CNA's had documented the resident had received a shower on Friday 1/3 at 2:15 p.m., Tuesday 1/7 at 2:21 p.m., Tuesday 1/14 at 2:39 p.m., Friday 1/17 at 2:25 p.m., Tuesday 1/21 at 2:59 p.m., Friday 1/24 at 2:59 p.m., and Tuesday 1/28 at 2:18 p.m. and at 10:49 p.m. The documentation did not reveal the type of bathing the resident had received and the resident had not received a shower on Friday 1/10/25. The task revealed staff had bathed the resident within the last hour of the 7:00 a.m. - 3:00 p.m. shift and had received an unknown type of bath one time in January during the assigned shift of 3:00 p.m. - 11:00 p.m. The review of CNA documentation did not reveal if the resident received a shower per voiced preference.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #123's Comprehensive CNA Shower Review and the CNA documentation revealed staff had not completed Comprehensive Shower reviews for the documented bathing on 1/3, 1/14, 1/17, 1/21, and 1/28/25.</p> <p>An interview was conducted on 1/29/25 at 11:06 a.m. with Staff K, CNA. The staff member reported she always gave showers and documented the level of assistance and if the resident did not receive a shower documented NA, not applicable.</p> <p>An interview was conducted on 1/29/25 at 11:30 a.m. with Staff Q, CNA. The staff member reported not normally working the Northeast Hall. The staff member reported filling out a shower form on paper and also in the computer. Staff Q reported documenting how much assistance a resident needed (with bathing) and if a shower was given, documentation was done in two places.</p> <p>An interview was conducted on 1/29/25 at 12:30 p.m. with Staff M, CNA. Staff M stated staff completed a shower sheet on paper when a bath was given. Staff M reviewed the computer and stated Section GG (MDS) showed how much assistance the resident needed. Staff M reviewed the CNA electronic documentation and showed a tab that allowed staff to document if the resident received either a shower or a bed bath. Staff M she said she would chart on this to indicate what type of bathing occurred.</p> <p>An interview was conducted on 1/30/25 at 8:08 a.m. with Staff L, CNA. Staff L stated Resident #123 got out of bed sometimes if asked. Staff L reported documenting on shower sheets, amount of assistance required with the task, if not the resident's shower day, documented NA. The staff member stated there were three places staff documented bathing: paper (Comprehensive Shower Review), electronically Section GG - assistance needed, and type of shower (resident received).</p> <p>2. Review of Resident #283's Admission Record showed the resident was admitted on [DATE] and 9/17/23. The record included diagnoses not limited to unspecified hypotension, Non-ST elevation (NSTEMI) myocardial infarction, unspecified neuromuscular dysfunction of bladder, and need for assistance with personal care.</p> <p>Review of Resident #283's Discharge Minimum Data Set (MDS) dated [DATE] showed at the time of discharge the resident was dependent on staff for showering/bathing, sit to standing, chair/bed to chair transfer, and tub/shower transfer.</p> <p>Review of Resident #283's Annual MDS dated [DATE] revealed it was somewhat important to choose between a tub bath, shower, bed bath, or sponge bath.</p> <p>Review of a grievance filed on 6/27/24 by Resident #283's family member showed the resident had been lying in bed for 3 weeks. The facility response was to implement a get-up schedule for the resident.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/28/25 on 2:03 p.m., the Director of Nursing (DON) reviewed Resident #283's CNA documentation of the section GG - functional ability for shower/bathe self. The documentation revealed Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower. The documentation revealed staff were to document every shift (7:00 a.m. - 3:00 p.m., 3:00 p.m. - 11:00 p.m., and 11:00 p.m. - 7:00 a.m.) the resident's ability to shower/bathe self. The CNA's documentation revealed the resident was dependent on staff for bathing 40 times, required substantial/maximum assistance 14 times, partial/moderate assist twice, assistance was not applicable 13 times, and no documentation seven times out of 69 opportunities. The task did not reveal the type of bathing the resident had received. The DON confirmed the task did not reveal if the resident received a shower or bath. She said if staff documented the resident was dependent with bathing it meant the resident had received bathing on that day and yes if the staff documented three times a day the resident received bathing three times a day. She said if staff documented NA it meant the resident did not receive a bath/shower. The DON reported only keeping the paper shower forms for 30 days.</p> <p>Review of Resident #283's clinical record revealed on 7/26/24 at 5:44 a.m., the resident had a change of condition and at 6:11 a.m. was transported to an acute care facility.</p> <p>Review of Resident #283's CNA documentation of section GG: shower/bathe self (ability) revealed per the DON interview the resident had received a type of bathing on 7/26/24 at 4:52 p.m. (approximately 10.5 hours after being transferred to the acute care facility), and on 7/29/24 at 4:30 p.m., 82.25 hours after transferring from the facility and sequentially being discharged without returning.</p> <p>The facility did not provide Resident #283's documentation showing the resident did receive bathing services and the type received during the month of July 2024 prior to discharge.</p> <p>Review of the policy - Supporting Activities of Daily Living (ADLs), undated, revealed 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 in oral hygiene.</p> <p>1. Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADL's are unavoidable.</p> <p>a. Unavoidable decline may occur if he or she:</p> <p>(1) has a debilitating disease with known functional decline;</p> <p>(2) has suffered the onset [NAME] acute episode that caused physical or mental disability and is receiving care to restore or maintain functional ability; and/ or</p> <p>(3) refuses care and treatment to restore or maintain functional abilities and:</p> <p>a) the resident representative has been informed of risk and benefits of the proposed care of treatment; and</p> <p>(continued on next page)</p>		

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