STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105149	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Healthcare and Rehabilitation Center	1301 16th St N Saint Petersburg, FL 33705

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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 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** Based on observations, interviews, and record reviews the facility did not ensure one resident (#7) was assisted out of bed daily and splints were placed for one resident (#27) out of thirteen sampled residents.Findings included: An observation was conducted on 9/3/25 at 9:25 a.m. of Resident #7. The resident was observed to be lying in bed flat on his/her back with a neck support pillow. The resident remained in this position throughout the day. An observation was conducted on 9/4/25 at 10:09 a.m. and 12:00 p.m. of Resident #7 lying flat in the bed with a neck support pillow in place. Review of Resident #7’s “admission Record” showed Resident #7 was admitted on [DATE] with diagnoses of unspecified fall, dementia, cerebral infarction, muscle weakness, difficulty in walking, and need for assistance with personal care. Review of Resident #7’s quarterly Minimum Data Set (MDS), dated , 6/8/25, Section C, cognitive patterns, showed a score of 99, indicating the resident was unable to complete the interview. Review of Resident #7’s care plan, dated 8/21/24, showed a focus area of extensive assistance to total care for most activities of daily living (ADL) completion due to weakness, cognitive condition and poor safety awareness. Interventions included extensive assistance needed to get in and out of bed to a chair/wheelchair and returning to bed. An interview was conducted on 9/3/25 at 1:08 p.m. with Resident #7’s Resident Representative (RR). The RR said they don’t understand why the resident is never out of bed. The RR said Resident #7 is only out of bed when they request staff to get him/her up. The RR said they wanted the resident to have a good quality of life for what life he/she had left and did not want the resident to sit in bed all the time. The RR said they want Resident #7 up and in the common areas and being able to see other people. An interview was conducted on 9/4/25 at 1:25 p.m. with Staff A, Certified Nursing Assistant (CNA). Staff A said Resident #7 was typically out of bed on Tuesdays when the RR visited. Staff A said there was a staff member that got the resident up on Mondays. Staff A said he/she got the resident up on the weekends they worked. When asked about Resident #7 being out of bed the other days of the week, Staff A only responded by saying “I will probably get [Resident #7] up this weekend.” Staff A confirmed Resident #7 had not been out of bed on 9/3/25 or 9/4/25. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 9/4/25 at 3:22 p.m. with Staff B, Licensed Practical Nurse (LPN). Staff B said Resident #7 used to be out of bed more and didn’t know why the resident didn’t get out of bed now. Staff A said maybe it was the family’s request, but they didn’t know. An interview was conducted on 9/4/25 at 4:51 p.m. with the Director of Nursing (DON). The DON said Resident #7 did get out of bed and they wanted him up at least three days a week. She did say that it is not written anywhere or documented. The DON said Resident #7’s RR had spoken to her not long ago about getting the resident out of bed more. The DON said she told the RR she would work on it but honestly hadn’t done much to make sure it happened and had not put anything in the medical record. The DON agreed it was not ok for Resident #7 to lay in bed all day and not be up. She said the resident even had a new wheelchair. Review of a facility policy titled “Activities of Daily Living (ADLs), Supporting, undated, showed: Policy Statement 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. Policy Interpretation and Implementation 2. Appropriate care and services will be provided 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: b. mobility (transfer and ambulation, including walking) 2. An observation was conducted on 9/3/25 at 11:00 a.m. of Resident #27. The resident was observed lying in bed, and the resident’s right hand was visible. Resident #27’s right hand appeared contracted (fingers bent into the palm of the hand). Resident #27 stated he/she had a splint for the right hand, but staff don’t offer to put the splint on. The resident’s right hand remained in this position throughout the day without a splint on. During an interview on 9/4/25 at 9:49 a.m. Resident #27 stated the splint is dirty and needs to be cleaned, the staff do not offer to wash it. Resident #27 stated the staff did not offer to put the splint on today. Review of Resident #27’s admission Records showed Resident #27 was admitted on [DATE] with diagnoses of Parkinson’s Disease, epilepsy, cerebral infarction, and other co-morbidities. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #27’s quarterly MDS dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating the resident was cognitively intact. The quarterly MDS also revealed Resident #27 had range of motion (ROM) impairment on one side of Resident #27’s upper and lower extremities. Review of Resident #27’s care plan with a revision date of 10/25/21 showed Resident #27 had a self-care deficit with dressing, grooming, bathing related to: generalized weakness and Parkinson’s Disease. The goal revealed Resident #27 will continue to improve toward previous baseline ADL functioning throughout this review period. The interventions showed: resting hand splint to right hand seven times week. Apply following a.m. care, remove prior to p.m. care. Monitor skin integrity when applying and removing. Review of Resident #27’s “Visual/Bedside Kardex [a care document showing a specific resident’s care needs]” dated as of 9/3/25 showed ADLs: put on palm pillow to right hand in a. m. (morning) up to 8 hours… to prevent further contractures. May remove for ADL care; put on palm pillow to right hand seven times week. Apply following a.m. care, remove prior to p.m. (evening) care. Monitor skin integrity when applying and removing; and resting hand splint to right hand seven times week. Apply following a.m. care, remove prior to p.m. care. Monitor skin integrity when applying and removing. Review of Resident #27’s physician order summary revealed an order dated 8/20/24 occupational therapy clarification: DON (put on) palm pillow to right hand in a.m. and doff (take off) in p.m. as tolerated. Remove every shift to ensure skin integrity. May remove PRN (as needed) for ADL care. During an interview on 9/4/25 at 10:06 a.m. Staff N, CNA stated the Kardex is how we know what each resident is cared for. Staff N, CNA stated being familiar with Resident #27 and not sure if Resident #27 needs hand splints. During an interview on 9/4/25 at 10:10 a.m. Staff B, LPN stated CNAs are responsible for putting on residents’ splints or other personal care items if residents have them. Staff B, LPN stated being responsible for Resident #27 and not being sure if hand splints are required. During an interview on 9/4/25 at 10:24 a.m. the Director of Nursing (DON) stated splints should be donned and doffed according to the physician orders. The CNAs usually don and doff the splints, although any member of the nursing or therapy team are able. The DON stated not being aware the staff have not been placing Resident #27’s hand splint on and off. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility’s policy and procedure titled Splints, not dated, revealed: Policy: When a patient is on rehab for contracture management and splinting, the Therapy Department will monitor the splints and the wearing schedule. In preparation for discharge from therapy, Nursing, and Nursing Assistants will be trained in proper donning/doffing of equipment and proper skin evaluation. Procedure: 1. The therapist will write a T.O. (telephone order) with the proper instructions. The therapist will implement tasks on Kardex and MDS will follow up with placing in Care plan. 2. The resident's splint will be placed in the dresser or in the closet. The splint will have the resident's name on it. 3. CNA/nursing will be responsible for the proper donning/doffing of splints at the appropriate times. 4. Therapy will conduct random audits to determine if the splints are being properly donned/doffed. 5. Upon removing a splint and prior to donning, the resident should receive proper range of motion as tolerated and the skin should be checked for any reddened areas. Skin should be clean, dry, but moisturized (not wet) upon donning a splint. 6. Splints may be removed for ADLS, and prn (as needed) per patient tolerance. 7. Any areas that are reddened indicate areas of pressure. Pale or blanched areas may indicate severe pressure. In both cases, nursing is to be notified immediately, and the splint shall be returned to the DON who will then communicate with therapy. 8. Splints should be returned to therapy for proper cleaning.

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	105149	A. Building B. Wing	09/05/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 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, interviews, and record reviews the facility did not ensure chemicals were secured and the smoking policy was followed for two residents (#32 and #50) out of seven residents that smoke. Finding included: An observation was conducted on 9/3/25 at 9:29 a.m. of Residents #32 and #50. Both residents were on the smoking patio with no staff present or in sight of the residents and no smoking aprons on or available. It was also observed that a shed on the patio was unlocked. The shed had a CAUTION HAZARDOUS CHEMICALS. AUTHORIZED PERSONNEL ONLY sign on the door and inside the shed were multiple bottles of chemicals observed.An observation was conducted on 9/3/25 at 1:18 p.m. of Resident #32 on the smoking patio with no staff present or within sight and no smoking apron on or available. Resident #32 was sitting in his/her wheelchair slumped over asleep. The resident woke up when his/her name was called. Upon waking up it was observed Resident #32 had a lit cigarette in their right hand. The shed containing chemicals remained unlocked.An observation was conducted on 9/4/25 at 1:20 p.m. of Resident #32 along with three other residents on the smoking patio. Staff C, Certified nursing Assistant (CNA) was present. Resident #32 did not have a smoking apron in place. The shed containing chemicals remained unlocked. Review of admission Records showed Resident #32 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), polyneuropathy, muscle weakness, and tobacco use. Review of Resident #32's Brief Interview for Mental Status (BIMS), dated 7/28/25, showed a score of 15 out of 15, indicating intact cognition. Review of Resident #32's care plan, revised on 9/3/25, showed a focus area of a desire to smoke. Resident #32 has been assessed as able to smoke with a smoking apron. Interventions included, accompany resident to designated smoking area as needed and provide supervision while smoking in resident-designated smoking area, monitoring for signs of unsafe smoking practices, apply/remove smoking apron. Prior to the 9/3/25 smoking care plan revision Resident #32 was care planned from 4/25/24 through 9/3/25 to be assessed as able to smoke independently. Review of Resident #32's progress notes showed a nurse's note dated 8/31/25, Nursing attempted to give resident am [morning] medications. He is currently sitting on the patio asleep. He has burned a hole in his pants, and the cigarette is on the ground still lit with fire. Resident states he wasn't asleep.Review of Resident #32's Nursing Smoking Evaluation, dated 9/2/25 revealed Resident #32 does not remain alert during the course of smoking. The resident safely lights a cigarette, safely holds a cigarette, disposes ashes and butts properly, the resident is free of visible upper extremity tremors, is free from upper extremity contractures, is free from loss of mobility, reduced movement, weakness, or paralysis of the dominant upper extremity. And the resident is free from visual issues that impair their ability to smoke. the total score of the smoking assessment was a 1 if the total number is 1 or more, they are considered and unsafe smoker and must use a smoking apron until a screening is completed by occupational therapy. The resident/resident representative/resident family have been informed of the smoking policy/procedures. can plan has been reviewed and updated. On 9/3/25 the Occupation Therapist documented on the smoking assessment During observation by this therapist several time[sic] during the day, patient demonstrated good safety while lighting, holding, smoking and extinguishing cigarette. Patient shows good fine motor coordination and dexterity needed to smoke a cigarette. Review of Resident #50's admission Records showed Resident #50 was admitted on [DATE] with diagnoses of acute kidney failure, fall on same level, and tobacco use. Review of Resident #50's BIMS score, dated 8/29/25, showed a score of 14 out of 15, indicating intact cognition. Review of Resident #50's care plan, dated 9/4/25, showed a focus area of Resident desires to smoke. Resident has been assessed as able to smoke with supervision. Interventions included, accompany resident to designated smoking area as needed and provide supervision while smoking in resident-designated smoking are, monitor for signs of unsafe smoking practices, and accompany resident to designated smoking area to provide supervision. An observation and interview were conducted on 9/4/25 at 1:30 p.m. with the Nursing Home Administrator (NHA). The NHA was observed walking on to the smoking patio and going to the shed containing chemicals. The NHA confirmed the shed was unlocked and it contained chemicals from the housekeeping department. The NHA said the shed should always be locked and agreed it was a potential hazard to residents. The NHA confirmed residents are able to come and go from the courtyard. An interview was conducted on 9/4/25 at 2:48 p.m. with Staff C, CNA. Staff C confirmed he was the staff member on the smoking patio on 9/4/25 at 1:20 p.m. He said Resident #32 did not have a smoking apron on while smoking. A follow up interview was conducted

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	105149	A. Building B. Wing	09/05/2025

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. (continued on next page)

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	105149	A. Building B. Wing	09/05/2025

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on record review and interviews, the facility failed to have eight consecutive Registered Nurse (RN) hours seven days a week for seventeen of ninety-one days in the third quarter of Fiscal Year (FY) 2025. Findings included: Review of Payroll Based Journal (PBJ) Data (FY) Quarter 3 2025 (April 1-June 30) revealed no RN Hours were Triggered on 10/05/2024; 10/12/2024; 10/13/2024; 4/5/2025; 4/6/2025; 4/12/2025; 4/13/2025; 4/19/2025; 4/20/2025; 4/26/2025; 4/27/2025; 5/11/2025; 5/25/2025; 5/26/2025; 5/31/2025; 6/1/2025 and 6/21/2025.During an interview on 9/4/25 at 09:50 a.m., with Staff H, Staffing Coordinator, employed for one year, stated, It is my responsible to staff the building and when I staff the building, I make sure that I have enough Licensed Practical Nurses (LPN) and RNs to meet the needs of the residents. For instance, if I have 38 residents, .when it comes to nurses, I try to always have two to three RN's and LPN's, which we're required to have an RN on staff eight hours a day. If I do not have an RN working on the floor for med [medication] pass, I use the Assistant Director of Nursing [ADON] or the Director of Nursing [DON] as substitutes for RNs on the floor during med pass. The ADON or DON will fill in and no temp [contracted staff] services are used in the facility. Not having temps has not caused us an issue. We have not run into an instance where we weren't able to cover RN hours. Looking at the scheduling, it appears we didn't have RN's assigned during 10/05/2024; 10/12/2024; 10/13/2024; 4/5/2025; 4/6/2025; 4/12/2025; 4/13/2025; 4/19/2025; 4/20/2025; 4/26/2025; 4/27/2025; 5/11/2025; 5/25/2025; 5/26/2025; 5/31/2025; 6/1/2025 and 6/21/2025. My order for acquiring an RN for staff is to call the current staff, then go to the ADON, then the DON. The staff that is on call that weekend is given a company phone to answer to come to staff that weekend. While reviewing the dates with no RN hours reported, the Staffing Coordinator stated, The days you're referring to, we did not have RN's available to fill in per my schedule.During an interview on 9/4/25 at 10:39 with the NHA and DON. The DON stated, we generally always have a minimum of two LPN'S and RN'S on staff 24/7 [twenty-four hours a day, seven days a week]. Just to ensure if someone calls out an emergency to cover them, we use a master schedule if someone calls out, then we have a call in policy. We ensure there is coverage, either from the DON or the ADON makes the call and provides coverage. We have a work phone for the call down list to ensure that someone answers. The DON and ADON will be called in to staff if we can't get anyone else to staff the floor, specifically Registered Nurse's. We alternate weekends with the DON/ADON for on-call staff. The NHA said, the data was sent was miscoded by the contracted human resources department to the payroll-based journal reporting system. The companies that we used to report to payroll data and to the Centers for Medicaid Services (CMS) were contracted and unfortunately, based on past payroll policy we don't have data to show RN hours for the covered periods identified. Due to a policy with the old payroll and reporting company who reported the hours, I learned I miscoded the data and will get help with staffing and coding going forward to fix the reporting issue. Review of facility's staffing coordinator job description dated January 2015. The primary purpose of your position is to ensure adequate and appropriate staffing of the facility's nursing department to meet the needs of the residents based on budget, census and as may be directed by Facility administration. Delegation of AuthorityAs Staffing Coordinator you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties.Work with Human Resource Delegate and DON when scheduling modified work duty employees, in accordance with work restrictions and Facility policy. Complete monthly nursing schedule coordinating requests to ensure appropriate coverage of units.Consult with nursing department staff and supervisors concerning the staffing and scheduling needs: to assist in elimination and correction of problem areas, and/or improvement of services. Review of the facility's policy Staffing revised on October 2017 revealed, Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment.1. Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care and services.4. Direct care staffing information per day (including agency and contract staff) is submitted to the CMS payroll-based journal system on the schedule specified by CMS, but no less than once a quarter.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility did not ensure infection control practices were followed related to: 1) food handling; 2) a non-cleanable surface and storage of a respiratory mask in two out of two resident rooms. Findings included: 1. On 9/3/25 at 10:31 a.m., an observation of Resident #2 revealed he was sitting in the wheelchair using a yellow gait belt to maneuver between the bed and the window. He lifted up the mattress and revealed a flattened cardboard box on top of the bed frame. He said facility staff put the cardboard box there because the bar in the middle of the bed was hurting his back. Further observations of the top of the cardboard box revealed particles of food and other small debris. A review of Resident #2’s admission record revealed an initial admission date of 11/7/22 and a re-admission date of 3/29/23. Further review of the admission record revealed diagnoses to include hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, muscle weakness (generalized), other muscle spasm, and other lower back pain. On 9/4/25 at 10:29 a.m., an interview was conducted with Staff D, Licensed Practical Nurse (LPN). She said Resident #2 has told her his mattress is not comfortable and the bar presses into his back. She said that is why the cardboard box is under the mattress. Staff D, LPN said the mattress had been switched a few times, but the resident continued to say it is not comfortable. On 9/4/25 at 4:32 p.m., an interview was conducted with the Housekeeping Supervisor. She said she was not aware Resident #2 had cardboard under the mattress and between the bed frame. The Housekeeping Supervisor said it could be nursing or maintenance staff who put it there. An observation of the flattened cardboard box with the Housekeeping Supervisor, and Resident #2 present, revealed it was put there to prevent the mattress from slipping. The Housekeeping Supervisor said the cardboard box is cleanable. She said it could be sprayed with chemicals and wiped down. Observations of the cardboard box revealed it had the same food particles and debris seen on 9/3/25. On 9/4/25 at 4:47 p.m., a follow-up interview was conducted with the Housekeeping Supervisor. She said the previous Director of Maintenance (DOM) put the cardboard box under Resident #2’s mattress because he expressed his back was hurting. She said this information was provided to her from the resident. On 9/4/25 at 4:49 p.m., an interview was conducted with the Nursing Home Administrator (NHA). She stated Resident #2’s, “Mattress has always been an issue.” She said the previous DOM put the cardboard box under the mattress. The NHA stated, “The resident asked for it because there’s a pole there.” She stated staff sprayed liquid on the cardboard and, “Sounds like they are letting the liquid sit.” The NHA said she didn’t consider that it was not a cleanable surface. (continued on next page)

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	105149	A. Building B. Wing	09/05/2025

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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 - Some	2. On 9/4/25 at 11:17 a.m., an observation of Staff E, dietary staff revealed he was handling food with gloved hands, walked away to cough, and came back to resume the task without changing gloves/performing hand hygiene. Staff E, dietary staff wiped his face on his sleeve multiple times during the observation with the same gloves and did not perform hand hygiene. He was observed touching his pants and shirt while wearing gloves and handling food. At 11:24 a.m., the Kitchen Manager removed the gloves he had on while completing tasks and put those gloves on a meal tray that was to be used by a resident. On 9/4/25 at 2:58 p.m., an interview was conducted with the Kitchen Manager. He said staff should be completing hand hygiene when they are in the middle of a task, then leave the area to complete another task, and come back. The Kitchen Manager stated when staff, “Move away from tasks,” they should wash their hands. He stated, “You should take your gloves off, wash your hands, put gloves on again, then do the next task.” The Kitchen Manager said if staff touched their clothes while handling food, they should take their gloves off and wash their hands. He said he's responsible for educating the dietary staff on hand hygiene. He said the last education the dietary staff received on hand hygiene was about two weeks ago. 3. An observation was conducted on 9/3/25 at 10:50 a.m. of a nebulizer mask sitting on the bedside table with stuffed animals, unbagged in room [ROOM NUMBER]. The nebulizer machine was sitting on a carboard box on the floor beside the table. An observation was made on 9/5/25 at 10:00 a.m. of the respiratory mask was again observed to be unbagged in room [ROOM NUMBER] and hanging off the side of the table behind a balloon. An interview was conducted on 9/5/25 at 10:10 a.m. with Staff D, Licensed Practical Nurse (LPN). Staff D said respiratory masks in resident rooms should be in a bag at the bedside. An interview was conducted on 9/5/25 10:45 a.m. with the facility’s Infection Preventionist (IP). The IP said carboard is not a cleanable surface. She said she was not aware of the carboard on the bed in room [ROOM NUMBER] until 9/4/25. The IP said the carboard should not have been on the bed and a new bed had been ordered for the room. As for infection control practices of the kitchen staff, she said the CDM would have educated them. The IP said the kitchen staff did participate in “all staff” trainings that are held and they did participate the skills fair in the spring that include infection control. The IP said she had not done infection control audits of kitchen staff but she would expect them to do hand hygiene after coughing and between touching other items such as clothes or hair then touching food items. Regarding respiratory masks, the IP said the masks in resident rooms should be in plastic bags at the bedside when they are not in use. The IP said she saw the respiratory mask in room [ROOM NUMBER] unbagged on 9/4/25 and she went and got a bag for it. She said the nebulizer must have been administered and then not put back in a bag. The IP said she also saw the nebulizer machine sitting on the cardboard box on the floor and staff had done that to keep the machine off the floor. The IP said the machine needs to be on the table. Review of a facility policy titled “Infection Prevention and Control Program,” revised October 2018, showed: Policy Statement: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105149	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Healthcare and Rehabilitation Center	1301 16th St N Saint Petersburg, FL 33705

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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 - Some	An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Review of a facility policy titled “Handwashing/Hand Hygiene,” revised August 2019, showed: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The facility did not have a policy related to nebulizer mask storage.