STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105202	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apollo Healthcare & Rehabilitation Center	1000 24th St N Saint Petersburg, FL 33713

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49227 Based on interview and record review, the facility failed to file a grievance on behalf of one resident (#44) of one resident reviewed for grievances. Findings included: Review of Resident #44's Admission Record showed admission to the facility on [DATE], with diagnoses to include metabolic encephalopathy, cognitive communication deficit, and dementia. An interview was conducted on 6/26/24 at 9:33 a.m. with Resident #44's family member. She said she reported to the facility concerns and had not received a response. The family member said one of the concerns was related to the death of Resident #44's roommate. In the presence of the family member, a member of the therapy team opened the roommate's curtain and said, oh she is dead and closed the curtain. The family member said this was immediately reported to the facility's leadership. The family member provided a written copy of concerns she discussed with the Director of Nursing (DON) earlier in the day. (Photographic Evidence Obtained.) An interview was conducted with the DON, Staff B, Licensed Practical Nurse (LPN), Unit Manager (UM), and Staff C, Social Services Director (SSD) on 6/27/24 at 11:36 a.m. Staff C said there had been two grievances filed for Resident #44 from the time of admission to the facility. Review of the facility's Receipt of Grievance/Concern for Resident #44, received on 6/20/24, initiated by a family member. The grievance description showed [Resident #44] does not use call light, recommend bell, [family member] approved. In the resolution section, the grievance was assigned to maintenance on 6/21/24 and the action taken to resolve the grievance showed provided bell on 6/26/24. The grievance was resolved on 6/26/24. The follow-up section of the form showed on 6/24/24 the family member was contacted and was satisfied with the resolution. The review section, the administrator signature section is unsigned and undated. Review of the facility's Receipt of Grievance/Concern for Resident #44, received on 6/20/24 initiated by a family member. The grievance description showed stated therapist was inconsiderate of resident's feelings when roommate passed away The resolution section showed the grievance was assigned to rehabilitation and nursing staff on 6/21/24. The action taken showed Psych will see resident for psychosocial wellbeing. Sensitivity education will be completed. The date resolved section was not completed. The follow-up section and review sections were not complete. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview was conducted on 6/28/24 at 12:33 p.m. with Staff C, SSD. She said the facility's goal was to resolve grievances within 5 days. An interview was conducted on 6/28/24 at 12:40 p.m. with the Nursing Home Administrator (NHA). She said, grievances are not always documented. Review of the facility's policy titled, Grievance/Complaint, Filing, revised 5/2020 revealed: Policy Statement Resident and their representatives have a right to grievances, either orally or in writing, to the facility .The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative. 1. Residents, family and resident representative have the right to voice or file grievances without discrimination or reprisal of any kind . .4. The administrator has delegated the responsibility of grievance and/or complaint investigation to the Grievance Officer who is the [Social Services Director.] 5. Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings to the administrator within 5 working days of receiving the grievance and or complaint. .8. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed verbally upon close of the investigation of the findings and the actions that will be taken to correct any identified problems. A written summary of the investigation will be provided to the resident/responsible party upon request.

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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** 39866 Based on interview and record review, the facility failed to ensure advanced directive care plans were accurate or developed for three residents (#31, #4, #36) out of 41 sampled residents. Findings included: 1. Review of Resident #31's Admission Record revealed she was admitted to the facility on [DATE], she received hospice services, and had medical diagnoses not limited to type 2 diabetes, major depressive disorder, and protein-calorie malnutrition. Review of Resident #31's physician order with a start date of 5/1/24 and no end date revealed DNR [do not resuscitate]. Review of Resident #31's [name of state] Do Not Resuscitate Order revealed Resident #31's power of attorney (POA) signed the document on 4/10/24 and Resident #31's physician signed the document on 4/11/24. Review of Resident #31's care plan with a revision date of 2/16/24 revealed [Resident #31] has expressed the following wishes regarding code status and has the following advanced directives in place: is Full Code, DPOA [durable power of attorney] for health care and finances. The goal revealed Resident's wishes regarding code status and advanced directives will be followed by staff. The intervention revealed Discuss Advanced Directives with resident and/or appointed health care representative. An interview was conducted with Staff C, Social Services Director (SSD), on 06/26/24 at 1:20 p.m. She said she was responsible for developing and revising advanced directive care plans. She said the care plan should be reflective of the resident's physician ordered code status. She said she had been in the SSD position since December 2024, and she had not created or revised any advance directive care plans. She reviewed Resident #31's physician orders and confirmed she had a physician's order for a DNR. Staff C, SSD reviewed Resident #31's care plans and confirmed she was care planned to be a full code. An interview was conducted on 06/26/24 at 2:03 p.m. with the Director of Nursing (DON). She said social service was responsible for the development and revision of advanced directive care plans and the care plan should be reflective of the physician's order. She reviewed Resident #31's physician orders and confirmed Resident #31 had orders in place for a DNR. She reviewed Resident #31's care plans and confirmed Resident #31 was care planned to be a full code before the advanced directive care plan was revised on 6/26/24. 2. Review of Resident #4's Admission Record revealed she was initially admitted to the facility on [DATE] and readmitted back to the facility from an acute care hospital on 6/23/24 with medical diagnoses, not limited to, specified injuries of right elbow, seizures, unsteadiness on feet, major depressive disorder, mild intellectual disability, generalized anxiety disorder, and schizoaffective disorder, depressive type. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's physician orders revealed an order with a start date of 6/23/24 and no end date for FULL CODE. Review of Resident #4's care plans on 06/25/24 at 2:45 p.m. revealed no advanced directive care plan was in place. Review of Resident #4's care plans on 06/26/24 at 12:56 p.m. revealed no advanced directive care plan was in place. Review of Resident #4's census revealed she was initially admitted to the facility on [DATE] discharged to the hospital on 6/19/24 and returned to the facility on [DATE]. An interview was conducted with Staff C, Social Services Director (SSD), on 06/26/24 at 1:20 p.m. She reviewed Resident #4's medical record and confirmed the resident had a physician order in place for full code. Staff C, SSD reviewed Resident #4's care plans and confirmed she did not have an advanced directive care plan in place. An interview was conducted on 06/26/24 at 1:45 p.m. with the Nursing Home Administrator (NHA) and Staff L, Regional Nurse Consultant (RNC). They said social services and nursing were responsible for the development and revision of advanced directive care plans. They said advanced directive care plans should be reflective of the physician ordered code status. An interview was conducted on 06/26/24 at 2:03 p.m. with the Director of Nursing (DON). The DON reviewed Resident #4's physician orders and confirmed she was ordered to be a full code. She reviewed Resident #4's care plans and confirmed her advanced directive care plan as created on 6/26/24. 3. A review of Resident #36's Admission Record revealed an original admitted [DATE] and an admitted [DATE]. A review of Resident #36's Active Orders revealed a Do Not Resuscitate (DNR) with an order date of 4/3/24. A review of Resident #36's miscellaneous documents, under the category of Advanced Directives, revealed a [name of state] DNR order form signed by the resident and the physician. The [name of state] DNR order for Resident #36 showed a date of 1/9/24. On 6/26/24, a review of Resident #36's current care plan revealed a focus to include, [Resident #36] has expressed the following wishes regarding code status and has the following advanced directives in place: is Full Code, with an initiated date on 11/25/22 and created on 11/25/22. On 6/27/24 at 2:44 p.m., an interview with the Director of Nursing (DON) revealed advanced directive orders would be found under orders, the grey ribbon under the resident's picture, and a document scanned in the resident's electronic medical record. She stated she would expect the care plan to have the same information as the orders, the grey ribbon area and the scanned document. On 6/27/24, the Administrator provided the resident's current care plan which revealed a focus to include, [Resident #36] has expressed the following wishes regarding code status and has the following advanced directives in place: is DNR, with an initiated date of 11/15/22 and revised on 6/26/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Advanced Directives, revised 9/2022, reflected the following under Policy Interpretation and Implementation: .2. Resident advance directive choices documented in electronic medical record. A review of the facility's policy titled, Care Planning - Interdisciplinary Team, revised 3/2022, reflected the following under Policy Interpretation and Implementation: .4. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. Surveyor: [NAME], Allegra 50570

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223 Based on observation, interview, and record review, the facility failed to ensure the notification and invitation to participate in the comprehensive care plan for two residents (#43 and #44) of two sampled residents. The findings include: Review of the Admission Record for Resident #43 revealed an admitted [DATE] with diagnoses to include: dementia; major depressive disorder, moderate protein-calorie malnutrition, hypertension; and other co-morbidities. An interview was conducted with Resident #43's representative on 6/25/2024 at 2:11 p.m. Resident #43's representative stated, I did not know they had care plan meetings, I have not received any information about any meetings. Review of the Admission Record for Resident #44 revealed an admitted [DATE], with diagnoses to include metabolic encephalopathy, cognitive communication deficit, dementia and other co-morbidities. An interview was conducted with Resident #44's representative on 6/26/2024 at 9:33 a.m. Resident #44's representative stated they have not received an invitation to attend care plan meetings. During an interview on 6/28/2024 at 10:34 a.m., Staff C, Social Services Director (SSD) stated the receptionist was responsible for completing the care plan meeting invitations. During an interview on 6/28/2024 at 10:40 a.m., Staff A, Receptionist said she had assisted with completing care plan meeting invitations in the past. Staff A stated this was no longer part of her responsibilities, the Minimum Data Set (MDS) nurse did this now. During an interview on 6/28/2024 at 11:10 a.m., Staff J, Licensed Practical Nurse (LPN), Minimum Data Set (MDS) Consultant stated the process for care plan meetings was as follows: the MDS nurse created a calendar 6-8 weeks out, the receptionist or SSD created and mailed the invitations to families/representatives. A copy of the invitation was scanned into the resident charts. The process was broken here, as this was not happening. Staff J stated not knowing why the process was not occurring as it was the expectation that the resident and resident representative be invited and encouraged to participate in the process. During an interview on 6/28/2024 at 12:30 p.m., the Director of Nursing (DON) stated the expectation was families and residents were invited to care plan meetings. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policies and procedures titled Care Planning - Interdisciplinary Team (IDT), not dated revealed: Policy Statement: The interdisciplinary team is responsible for the development of resident care plans. Policy interpretation and implementation: . 3. The IDT includes but is not limited to: . e. To the extent practicable, the resident and/or the resident's representative; and . 4. Resident, the resident's family and/or resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. 5. Care plan meetings are scheduled at the best time of the day for the resident and family when possible. 6. If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223 Based on observation, interview, and record review, the facility failed to ensure splints were applied to prevent the decrease of range of motion for one resident (#35) of five sampled residents . Findings included: On 6/25/2024 at 10:57 a.m. Resident #35 was observed and interviewed. Resident #35 stated she was not able to utilize her left hand due to a stroke. Resident # 35's left hand was observed laying across the resident's abdomen in a fist. Resident #35 was unable to move her fingers and stated, it would be nice to have something keep my hand open, as it (hand) becomes 'smelly'. On 6/26/2024 at 11:17 a.m. Resident #35 was observed lying in bed with no splint on her left hand. Review of Resident #35's Admission Record revealed an admitted [DATE] with diagnoses: flaccid hemiplegia affecting left nondominant side, cerebral infarction, and other co-morbidities. Review of Minimum Data Set (MDS) assessment, dated 5/16/2024, Section GG Functional Status revealed Resident #35 was dependent on staff with mobility and activities of daily living (ADL) performance and had functional limitations in range of motion on one side for upper extremity (shoulder, elbow, wrist, hand). Review of the Order Summary Report with active physician orders as of 6/28/2024 for Resident #35 revealed the following: Apply splint to left wrist after AM care. Doff before PM or as tolerated. Skin check to be done before/after application, order start date of 2/23/2024. The care plan for Resident #35 revealed a focus area for potential for complications related to contractures of: left (L) wrist; Date Initiated: 05/16/2024. Interventions revealed: Apply/remove splint/brace for joint protection as ordered Date Initiated: 05/16/2024 An interview was conducted with Staff K, Certified Nursing Assistant (CNA) on 6/25/2024 at 1:16 p.m. Staff K, CNA confirmed being assigned to Resident #35. Staff K, CNA stated Resident #35 did not wear splints. An interview was conducted with Staff G, Certified Nursing Assistant (CNA) on 6/26/2024 at 1:40 p.m. Staff G, CNA confirmed being assigned to Resident #35. Staff K, CNA stated Resident #35 did not wear splints. An interview was conducted with Staff H, Licensed Practical Nurse (LPN) on 6/27/2024 at 12:14 p.m. Staff H, LPN stated Resident #35 did not have splints. An interview was conducted with the Director of Rehabilitation (DOR) on 6/27/2024 at 12:20 p.m. The DOR stated Resident #35 was last on case load on 12/27/2023, at that time, Occupational Therapy recommended a left-hand splint. Resident #35 was able to tolerate and wear the splint. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 6/27/2024 at 12:44 p.m. The DON stated Resident #35 had a physician order for a left hand splint and her expectation was that Resident #35's left hand splint was on as ordered. Review of the facility's policy and procedures titled Resident Mobility and Range of Motion with a revised date of July 2017 revealed: Policy Statement: 1. Residents will not experience an avoidable reduction in range of motion (ROM). 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. 3. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility and less reduction in mobility is unavoidable. Policy interpretations and implementation: . 5. The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food by professional standards for food service safety. Findings included: A tour of the main kitchen conducted on 6/25/2024 at 9:15 a.m. and accompanied by the Dietary Manager (DM) showed the following: 1. A rag was noted on the main production counter that was not in any buckets or solutions, the solution bucket was sitting on the counter. A personal jacket was on the second shelf of the counter, sitting on top of the lids, and bowls. (Photographic Evidence Obtained). 2. A garbage can with no lid was at the entrance, another trash receptacle with no lid was next to the sink near the tray line. The DM stated the garbage should have lids on when not in use. (Photographic Evidence Obtained). 3. The second shelf of the tray line had a container of bleach sitting out next to a basket with crackers and open boxes of hot chocolate mix. The DM stated the chemicals should not be stored there. (Photographic Evidence Obtained). 4. The cooks prep cooler had chopped green fruit and pulled pork in containers, covered. A sticker on the containers had red ineligible writing with no date on the fruit and no date on the pork. A bin of sandwiches (meat/cheese) was dated but the plastic wrap was not sealed. A white bag tied shut with a sticker titled [Name] Food dated 6/24. The DM stated the items should be dated and sealed, and the bag was one of the staff's food and that it was okay to have personal items in the cooking prep fridge. (Photographic Evidence Obtained). 5. The dry storage area had 2 boxes of chemicals and a bottle of a chemical stored at the entrance. The dietary manager immediately removed them and stated they should not be there. An open bottle of Teriyaki Marinade and Sauce dated 5/24/24, the label on the bottle stated Refrigerate after opening. The dietary manager was unaware the sauce needed to be refrigerated after opening. (Photographic Evidence Obtained). 6. The walk-in freezer had a build up of ice on the entire floor as soon as the door was open. Condensation was noted on the freezer ceiling, and the fans had ice build-up on them. Two bags of ice were open with the ice exposed. The DM stated the freezer had been doing this on a regular basis since he started. The DM said the Maintenance Director looked at the freezer but had not fixed it. (Photographic Evidence Obtained). 7. The can opener had a significant build-up of a black sticky substance and brown color running down the length tool. The DM stated the opener needed to be soaked and cleaned. (Photographic Evidence Obtained). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. The pipe next to the stove had a build-up of grease and dust that was visible, the stove had a brown sticky substance running down the front, the oven doors had a brown sticky build-up on the outside and a black substance on the bottom corner. The cook stated the items needed to be cleaned. (Photographic Evidence Obtained). 9. Items stacked on shelves for drying were not open to air and were wet. (Photographic Evidence Obtained). During an interview on 6/25/2024 at 10:25 a.m. the DM stated the kitchen had come a long way and still had a way to go. The DM stated they did not have a cleaning schedule and one needed to be made. During an interview on 6/28/2024 at 11:00 a.m., the Nursing Home Administrator (NHA) was made aware of the findings. Review of the facility's policy and procedure titled Food Storage: Cold dated October 2019 revealed: Policy Statement: it is the centers policy to ensure all time/temperature control for safety (TCS), frozen and refrigerated food items common will be appropriately stored in accordance with guidelines of the FDA food code. Action steps: 1. The dining service director is responsible for storing all items 6 inches above the floor and 18 inches from the sprinkler unit. 5. The dining services director/cook ensures that all food items are stored properly in covered containers, labeled and dated and arranged in a manner to prevent cross contamination. Review of the facility's policy and procedures titled Food Storage-Dry Goods dated October 2019 revealed: Policy Statement: it is the centers policy to ensure all dry goods will be appropriately stored in accordance with guidelines of the FDA food code. Action steps: Dry Storage: 1. The dining services director or designee is responsible to store all items 6 inches above the floor on shelves. 6. The dining services director or designee ensures that the storage will be neat, arranged for easy identification, and date marked appropriate. 7. The dining services director will ensure that toxic materials are not stored with food. The facility's policy and procedures titled Environment dated October 2019 revealed: Policy: it is the center's policy that all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. Action steps: 1. The dining services director will ensure that the physical plant is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. 2. The dining services director will ensure that all employees are knowledgeable of the proper procedures for cleaning all food services equipment and services. 3. The dining services director will ensure that all food contact surfaces are cleaned and sanitized after each use. 4. The dining service director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces. 5. The dining services director will ensure that all dining areas are cleaned and sanitized after each use, including table surfaces, chairs, and floors. 6. The dining service director will ensure that all trash is contained in covered leak proof containers that prevent cross contamination. 7. The dining services director will ensure that all trash is properly disposed, and external receptacles dumpsters and that the area is free of debris.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 48223 Based on observations and interview, the facility failed to dispose of garbage appropriately for two of two dumpsters outside of the kitchen. Findings included: On 6/25/2024 at 9:50 a.m., during the initial tour of the kitchen, with the dietary manager, an inspection of the dumpster area was conducted, and the following was noted. -Two dumpsters were noted in the rear parking area near the kitchen door. An extreme odor was present. The walls of both dumpsters were soiled with brown/black substance surrounding most of the dumpsters. The walls of the dumpster's appeared to be black although at the top of the dumpster's were yellow in color. The top of one dumpster lid was fully open and the other closed. The side door of both dumpster's was open and exposing the garbage inside, additionally there were multiple trash bags, crates and significant amounts of debris noted to be stored on the side and back of the dumpster's. The debris consisted of used incontinent products, plastic utensils, gloves, empty pill wrappers, plastic cups, lids, straws, and numerous garbage bags. (Photographic evidence obtained). During an interview on 6/25/2024 at 9:55 a.m., the dietary manager stated the lids of the dumpster's should be closed, even the ones on the side. The dietary manager continued to state the area around the dumpster's should be clean and debris free. The dietary manager stated the debris was discussed everyday in morning meeting, although nothing changes, and no one cleans up the debris. Review of the facility's policy and procedure titled Food-Related Garbage and Refuse Disposal dated October 2017 revealed: Policy Statement: Food-related garbage and refuse are disposed of in accordance with current state laws. Policy Interpretation and Implementation: 1. All food waste shall be kept in containers. 2. All garbage and refuse containers are provided with tight fitting lids or covers and must be kept covered when stored or not in continuous use. 3. Housekeeping personnel will empty garbage and refuse containers daily and will clean the containers at least daily on the outside and at least weekly on the inside, taking care not to contaminate food, equipment, utensils, or food preparation areas while cleaning. 4. Brushes used for washing garbage and refuse containers will not be used for any other purposes. Wastewater from such cleaning operations will be disposed of properly to prevent any contamination. 5. Garbage and refuse containing food waste will be stored in a manner that is inaccessible to pests. 6. Storage areas will be kept clean at all times and shall not constitute a nuisance. 7. Outside dumpster's provided by garbage pickup surfaces will be kept closed and free of surrounding litter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105202	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apollo Healthcare & Rehabilitation Center	1000 24th St N Saint Petersburg, FL 33713

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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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223 Based on observation, interview, and record review,, the facility failed to implement and maintain an infection prevention and control program to mitigate and prevent the spread of infection related to: 1) not ensuring staff were donning appropriate Personal Protective Equipment (PPE) when entering a resident room under contact isolation precautions for one (#23) of one sampled resident observed for contact isolation precautions, 2) not ensuring resident medical equipment had a cleanable surface for one resident (#43) of five sampled residents, and 3) not ensuring linen was transported and stored in a way to prevent contamination with seven of seven carts observed. Findings included: An observation was conducted on 6/25/2024 at 10:03 a.m. during the initial tour of the facility. Resident #23's room door had a blue 8 1/2 by 11 (letter size) laminated paper sign that showed; Enhanced Barrier Precautions. The sign was hung on the door with mesh caddy with multiple pockets. The pockets contained gloves, isolation gowns, masks, and disinfecting wipes. (Photographic Evidence Obtained). On 6/26/2024 at 1:29 p.m., Staff G, Certified Nursing Assistant (CNA) was observed entering Resident #23's room. Staff G, CNA donned gloves prior to entering. Staff G, CNA stated Resident #23 needed to be assisted with incontinence care, Staff G, CNA provided privacy and closed the room door. Review of Resident #23's Admission Record revealed a re-admitted [DATE] with diagnoses: pressure ulcer left hip, local infection of the skin and subcutaneous tissue, Methicillin Resistant Staphylococcus Aureus infection (MRSA) and other co-morbidities. Review of the Order Summary Report with active physician orders as of 6/28/2024 for Resident #23 revealed the following: Keflex 500 milligram every 8 hours for wound infection for 10 days, with an order date of 6/21/2024. Culture right hip wound due to drainage/infection ordered dated 6/21/2024. Contact isolation - MRSA infection dated 4/11/2024. During an interview on 6/26/2024 at 1:40 p.m., Staff G, CNA stated Resident #23 was on enhanced barrier precautions. Staff G did not know why Resident #23 was on precautions but said, she could find out. Staff G said she did not wear a gown while providing incontinent care to Resident #23 and with enhanced barrier precautions a gown should have been worn with direct care being provided. During an interview on 6/26/2024 at 4:50 p.m., Staff I, CNA stated resident #23 was on enhanced barrier precautions and only needed to have personal protective equipment worn when providing direct resident care. During an interview on 6/26/2024 at 1:55 p.m., Staff H, Licensed Practical Nurse (LPN) stated being responsible for Resident #23. Staff H stated Resident #23 had a wound and that was why the resident was on enhanced barrier precautions. These precautions only required gowns when providing direct resident care. Resident #23 had no signs or symptoms of an infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Director of Nursing (DON) on 6/28/2024 at 11:07 a.m. She confirmed she was the infection preventionist and said residents with a Methicillin-resistant Staphylococcus aureus (MRSA) infection in the wound should be on contact precautions for the duration of the antibiotics plus three extra days. She confirmed Resident # 23 had an infection in the wound, was on intravenous antibiotics for the infection and was getting an X-ray of the wound. During an observation on 6/25/2024 at 10:41 a.m., Resident #43 was observed lying in bed, in a fetal position with bilateral side rails in the upright position. The siderails had colored [Brand name] padding (i.e., pool noodle) surrounding the bed rail attached with silver tape. The [Brand name] padding was textured with numerous pores throughout. (Photographic Evidence Obtained). During an interview with the DON on 6/28/2024 at 11:07 a.m., she confirmed she was also the infection preventionist and confirmed Resident # 43 had pool noodles on her bed rails and said We just wipe them down with the 3-minute dry time wipe. I would have to ask environmental services what they use to clean them. During an interview with the Environmental Service Supervisor (EVS) on 6/28/2024 at 12:07 p.m., he stated the bed rails were just wiped down nothing special was used. On 6/25/2024 to 6/28/2024 at various times of the day the facility linen carts were noted to be torn, thread-bare, and hanging open. (Photographic Evidence Obtained). During an interview with the DON on 6/28/2024 at 11:18 a.m., she confirmed the linen carts needed to be replaced but they would be able to be wiped off, if needed. An interview on 6/28/2024 at 12:07 p.m. with the EVS revealed he did not have an issue with the linen carts. He stated he had not seen any holes or rips lately in the covers of the linen carts. The EVS stated he reviewed the linen carts once or twice a week. He stated he reviewed the linen carts when the staff went to the linen room to pick up items. He stated if the cart was broken, he would expect maintenance to make repairs. The EVS stated the linen carts were cleaned once or twice, every other week. He stated one of his staff or himself cleaned the linen carts. He stated none of the housekeeping staff have reported issues to him. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedures titled Isolation - Categories of Transmission-Based Precautions dated September 2022 revealed: Policy Statement: Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; Arrives for admission with symptoms of infection; Or has a laboratory confirmed infection; And is at risk of transmitting the infections to other residents. Policy Interpretation and Implementation: . 2. Transmission based precautions are additional measures that protect staff, visitors and other residents from becoming infected. These measures are determined by the specific pathogen and how it is spread from person to person. The three types of transmission-based precautions are contact, droplet and airborne. 3. The Centers for Disease control and prevention (CDC) maintains a list of diseases, modes of transmission and recommendation precautions. 4. The facility makes every effort to use the least restrictive approach to managing individuals with potentially communicable infections. Transmission based precautions are used only when the spread of infection cannot be reasonably prevented by less restrictive measures. 5. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. a. Sign it informs the staff of the type of CDC precautions, instructions for use of PPE, and/or instructions to see a nurse before entering the room. b. Signs and notification comply with the resident's rights to confidentially or privacy. Contact precautions: 1. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by contact with the resident or indirect contact with environmental surfaces or resident care items in the residence environment. 2. Contact precautions are also used in situations when a resident is experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest an increased potential for extensive environmental contamination and risk of transmission of a pathogen, even before a specific Organism has been identified. 3. Contact precautions are used for residents infected or colonized with MDRO's in the following situations: a. When a resident has wounds, secretions, or excretions that are unable to be covered or contained and b. On units or in facilities where, despite attempts to control the spread of the MDRO, ongoing transmission is occurring. 7. Staff and visitors wear gloves (clean, non-sterile) when entering the room. 8. Staff and visitors wear a disposable gown upon entering room and remove before leaving the room and avoid touching potentially contaminated surface this with clothing after gown is removed.