Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 12/04/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105271	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boca Ciega Center	1414 59th St S Gulfport, FL 33707

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441 Based on interview, observation, and record review, the facility did not ensure timely Activities of Daily Living (ADL) related to incontinence care for two (#1 and #2) of three residents. Findings include: On 8/08/2024 at 10:30 a.m., an interview and observation were conducted with Resident #2 in his room. Resident #2 was in his bed and when asked when was the last time his incontinence needs were addressed, he stated last night and agreed no one had come in this morning to change him. Resident #2 agreed he needed incontinence care now. On 8/08/2024 at 11:00 a.m., an interview and observation were conducted with Resident #1 in her room. She stated the last time she had her incontinence care addressed was 3:30 a.m. and currently was waiting for her morning needs to be met. Resident #1 agreed she was wet and in need of incontinence care stating, they will get around to it eventually, they are so busy. Resident #1 agreed she felt uncomfortable in her briefs but stated, there is nothing I can do about it. On 8/08/2024 at 11:15 a.m., an interview was conducted with Staff E, Certified Nursing Assistant (CNA). Staff E was unable to give a number of residents assigned to her but stated she had four residents requiring total care. Staff F, CNA refused to be interviewed. At some point, Staff F was replaced by Staff I, CNA after two days of orientation stating this was day three of her orientation. Staff E stated she would be assisting Staff I but was unable to give a number of the newly assigned residents requiring total care, stating, Some days I am able to get my work done and sometimes depending on who you work with it's a struggle. On 8/08/2024 at 11:50 a.m., an interview was conducted with Staff C, CNA and Staff D, CNA. Staff C stated she had eleven residents and of those eleven residents, five were dependent for total care. Staff D stated she had ten residents but could not state how many were total dependent but stated she had 4 more residents to take care of. A record review of Resident #1's Admission Record showed an admitted [DATE] with a primary diagnosis of Type 2 Diabetes Mellitus with hyperglycemia. Secondary diagnoses included but were not limited to adult failure to thrive, muscle wasting and atrophy not elsewhere specified, need for assistance with personal care, other reduced mobility, and history of falling. (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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NAME OF PROVIDER OR SUPPLIER Boca Ciega Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1414 59th St S Gulfport, FL 33707	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #1's Minimum Data Set (MDS) dated [DATE], for Section C-Cognitive Patterns showed Resident #1 did not require further mental status assessment based on the resident was able to complete Brief Interview for Mental Status. Section GG GG0130 self -care-Functional Abilities and Goals showed Resident #1 as Dependent for toileting /hygiene, showering/bathe self, lower body dressing, putting on/taking off footwear and substantial/maximal assistance with upper body dressing, and personal hygiene. Section GG0170- Functional Abilities and Goals showed Resident #1 as Dependent for roll left to right, the ability to roll from lying on back to left and right side and return to lying on back on the bed. In Section H-Bladder and Bowel, H0300 and H0400 urinary incontinence and bowel continence showed Resident #1 as always incontinent of bladder and bowel. A review of Resident #1's care plan revised on 3/14/2024 showed a focus area of incontinence of bladder/bowel related to immobility, involuntary or unpredictable bladder and bowel elimination, intolerance of using toilet, bedside commode or urinal, refusal or resistance to participation in any kind of programs. The goal for this focus area included maintain dignity, minimize the risk of infection, and minimize the risk of skin breakdown. The Interventions/Tasks for this focus area included but were not limited to check for incontinence frequently and provide incontinence care as indicated, provide perineal care and apply barrier cream after incontinent episodes and as needed, and observe condition of skin with each incontinent episode. A focus area of ADL Self-Care performance deficit cannot complete ADL tasks independently related to impaired mobility, resident declines to get out of bed routinely. The goal for this focus area included maintaining current level of self-performance with ADLs through the next review. The interventions/Tasks for this focus area included but were not limited to two person staff when providing care, bladder and bowel incontinent and assist of one for bathing in bed. A review of the daily tasks documented by the CNAs shows on 8/08/2024 Resident #1 received toileting care at 1:10 a.m. and no further entries were documented [photographic evidence obtained]. A record review of Resident #2's Admission Record showed an admitted [DATE] with a readmitted [DATE] with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Secondary diagnoses included but were not limited to dysphagia following cerebral infarction, muscle wasting and atrophy not elsewhere classified left lower leg, and need for assistance with personal care. A review of Resident #2's Minimum Data Set (MDS) dated [DATE], for Section C-Cognitive Patterns showed Resident #2 had a Brief Interview for Mental Status of four which indicated severe cognitive impairment. Section GG GG0130 self-care Functional Abilities and Goals showed Resident #2 as substantial maximal assistance for toileting /hygiene, showering/bathe self, lower body dressing, putting on/taking off footwear, eating, oral hygiene, upper body dressing and personal hygiene. Section GG0170- Functional Abilities and Goals showed Resident #2 was Dependent for toilet transfer, tub shower transfer, sit to stand, chair/bed-to-chair transfer, and Substantial/maximal assistance for roll left and right, sit to lying, and lying to sitting on side of bed. In Section H-Bladder and Bowel, H0300 and H0400 urinary incontinence and bowel continence showed Resident #2 as always incontinent of bladder and bowel. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #2's care plan revised on 5/28/2024 showed a focus area for incontinence of bladder/bowel and was not a candidate for a toileting program related to involuntary or unpredictable bladder and bowel elimination, decreased cognition. The goal for this focus area was to maintain dignity through next review, minimize the risk for infection and the risk for skin breakdown. Interventions included but were not limited to check for incontinence frequently and provide care as indicated and observe for foul smelling, cloudy urine, change in urinary output, mental status change, changes in bowel pattern and report as needed. The care plan showed a focus area of ADL Self-Care performance deficit related to impaired mobility related to cerebral vascular accident with left-sided weakness and decreased cognitive status. The goal for this focus area would be to maintain current level of self -performance with ADLs through next review. Interventions included but were not limited to personal hygiene, bladder (incontinent) and bowel (incontinent), eating, bed mobility with assist of one. A review of the daily tasks documented by the CNAs shows on 8/08/2024 Resident #2 received toileting care on 8/07/2024 at 7:13 p.m. and 8/08/2024 at 2:59 p.m. and 4:36 p.m. [photographic evidence obtained]. On 8/08/2024 at 5:10 p.m., an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). The DON stated staffing was based on the census, and we go above and beyond our numbers, we have an expectation of every two hours to check on residents and to document incontinence care. On 8/08/2024 at 10:40 a.m., an interview was conducted with Staff A, CNA and Staff B, CNA. Staff A stated her current assignment was twelve residents and of those twelve, nine were dependent for total care. Staff B stated her assignment was twelve and of those twelve, nine were dependent for total care. Both CNAs stated the night shift did not get residents up before they started their shift but stated they were fine with this because they both knew they did a good job in ensuring their residents were properly cleaned and groomed. Staff A stated, I have to rotate my residents when I get them up because it is too much, I try to get my residents up at least twice a week by a rotation process. Staff A and Staff B both agreed they worked well together but still had more residents to attend to and stated it's just too much. Staff A stated, I have to prioritize my morning but I am always in and out of my residents' rooms checking in on them. On 8/08/2024 at 11:30 a.m., an interview was conducted with Staff G, CNA and Staff H, CNA. Staff G stated she had fourteen residents and of those fourteen, eight were dependent for total care. Staff H stated she had thirteen residents and of those thirteen, nine required total care. Both stated they were still trying to complete their assignments for their residents. Both CNAs stated they worked well together but one sick call could mess up the whole day. On 8/08/2024 at 12:30 p.m., a third tour was conducted. Staff G, CNA stated a CNA was pulled from each hallway to assist in the main dining area. When the CNA returned to their assigned hallway, the remainder of trays that were served to residents in their room was completed and then the CNAs would assist those residents that required assistance. Staff G stated she had one more resident to attend to for ADL care. Staff H, CNA returned to her assigned hallway and stated she was able to complete her care of dependent residents right before she had to go to the main dining. Both CNAs stated it put a lot of stress on the CNAs to have one taken away from the hallway to assist in the main dining. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/08/2024 at 12: 50 p.m., Staff A, CNA and Staff B, CNA stated having a CNA pulled to the main dining area during mealtime placed a great deal of stress on the CNA left in the hallways. Staff C and Staff D stated there were two residents that required assistance with feeding in their hallway and when a CNA was pulled to the main dining there was a delay in feeding those residents. On 8/08/2024 at 4:45 p.m., an interview was conducted with the Staff J, CNA /Staffing Coordinator and Central Supply in her office. Staff J stated staffing assignments were based on the census but acuity was considered as well. Staff J stated sick calls were covered by their own staff and the facility did not use agency nurses. Staff J stated telephone calls were made or group texts were posted for coverage requests. Staff J stated Staff C was just suspended a few hours ago as well as Staff F from this morning. Staff J stated Staff C's CNA assignment was covered by Staff I, CNA. Staff J stated this was Staff I's third day of orientation but I was watching and assisting her all day. Staff J stated the Activities Director, Medical Records Director and herself were CNAs. They would cover assignments if there was a last-minute sick call until they could be replaced to then return to their job duties. Staff J stated she was currently covering a CNA who had overslept but would be in later today. A request for policies were requested for ADL care and/or incontinence care but the facility did not have such policies.