

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Boca Ciega Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223</p> <p>Based on observations, interviews, and record review, the facility failed to accommodate the needs for one resident (#85) related to placing the call light within the resident's reach out of six residents sampled for environmental concerns.</p> <p>Findings included:</p> <p>On 4/29/2024 at 9:58 AM Resident #85 was observed in the bed, facing the ceiling, arms crossed at the waist. The call light was around the bed rail on the left side near the head of the bed. Resident #85 was on an air mattress with a perimeter cover, in front of the bed rail. Resident #85 was not able to reach the call light when requested.</p> <p>An interview was conducted with Staff S, Licensed Practical Nurse (LPN) on 4/29/2024 at 10:00 AM. Staff S, LPN confirmed Resident #85 uses the call light and call lights should be within the resident's reach. Staff S, LPN confirmed Resident #85's call light was not within reach. Staff S, LPN assisted resident and placed the call light within the resident's reach.</p> <p>On 4/29/2024 at 3:15 PM Resident #85 was observed in the bed facing the door, arms crossed at the waist. The call light was underneath Resident #85's left shoulder. Resident #85 was not able to reach the call light when requested.</p> <p>An interview was conducted with Staff R, CNA on 4/29/2024 at 3:17 PM. Staff R, CNA confirmed Resident #85 uses the call light and call lights should always be within the resident's reach. Staff R, CNA observed the call light and stated, [Resident #85] would not be able to utilize the call in that position. Staff R, CNA moved the call light into the resident's reach.</p> <p>On 4/30/2024 at 9:15 AM Resident #85 was observed in the bed, facing the ceiling, arms crossed at the waist. The call light was underneath Resident #85's left shoulder. Resident #85 was not able to reach the call light when requested. Resident #85 stated, Happens all of the time.</p> <p>On 4/30/2024 at 10:00 AM Resident #85 was calling out for assistance. Resident #85 was observed lying in bed, facing the ceiling, arms crossed at the waist. The call light was underneath Resident #85's left shoulder. Resident #85 was not able to reach the call light when requested. Staff S, LPN was informed Resident #85 was calling out for assistance. Staff S, LPN confirmed the call light was not within Resident #85's reach.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #85's Admission Record revealed she was readmitted to the facility on [DATE] from an acute care hospital. Her medical diagnoses encephalopathy, abnormalities of gait and mobility, lack of coordination, reduced mobility, and muscle wasting and atrophy.</p> <p>During an interview on 5/1/2024 at 3:40 PM the Director of Nursing (DON) stated Resident #85 was able to use her call light, and residents should be able to access the call light when needed.</p> <p>During an interview on 5/1/2024 at 4:00 PM the Nursing Home Administrator (NHA) stated the facility does not have a policy and procedure for call lights.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223</p> <p>Based on observations, interviews, and record review, the facility failed to ensure a safe, clean, and homelike environment for resident rooms and bathrooms, during four days (4/29, 4/30, 5/01, and 5/02/24) of four days observed, in three of four hallways observed.</p> <p>Findings included:</p> <p>1) On 4/29/2024 at 9:53 AM the nightstand of the occupied room [ROOM NUMBER] B was observed to have three drawers. The front of the middle drawer was not attached to the base on the right side, leaving the drawer lopsided and resting on the bottom drawer. (Photographic Evidence Obtained).</p> <p>On 4/29/2024 at 10:00 AM the door to the bathroom in the occupied room [ROOM NUMBER] was observed with a cylindrical metal piece protruding from where the doorknob should be. No doorknob was found. (Photographic Evidence Obtained).</p> <p>On 4/29/2024 at 10:08 AM the wall behind the occupied bed of 415 A was observed with a deep gouge in the drywall, leaving a hole in the wall behind the bed. The head of the bed was resting on the wall and floor, not attached to the bed. (Photographic Evidence Obtained).</p> <p>On 4/29/2024 at 10:11 AM the nightstand of the occupied room [ROOM NUMBER] B was observed to have three drawers. The front of the top drawer was not attached to the base on the right side, leaving the drawer lopsided and resting on the middle drawer. (Photographic Evidence Obtained).</p> <p>On 4/29/2024 at 10:12 AM the wall behind the occupied bed of 415 C was observed with a gouge in the drywall, behind the bed. (Photographic Evidence Obtained).</p> <p>On 4/30/2024 at 10:11 AM and 10:13 AM the sinks in the occupied resident rooms of 415 and 413 respectively, were observed with cracks in the base of the sinks around the drains. The cracks traveled up the sink base to approximately the middle of the bowl. The cracks were visible with brownish/black substance in the cracks. (Photographic Evidence Obtained).</p> <p>An interview was conducted with the Maintenance Director on 5/2/2024 at 3:52 PM. The Maintenance Director observed the vent cover in room [ROOM NUMBER] and stated, Oh Goodness, that is not acceptable, the vent absolutely needs to be cleaned. The Maintenance Director continued to tour the facility and confirmed the areas were not acceptable and needed repair and painting. The Maintenance Director stated, The entire building needs to be audited and repaired.</p> <p>An interview was conducted with the Nursing Home Administrator (NHA) on 5/2/2024 at 3:50 PM. The NHA reviewed the photographic evidence and confirmed the environment needs repair/replacement/cleaning.</p> <p>37999</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2) On 4/29/24 at 11:11 a.m., an observation was made of the bathroom in room [ROOM NUMBER]. The bathroom did have a shower in the room which had eleven tile transition tiles missing, the floor of the shower and the shower wall grout was discolored black, the shower floor tiles were discolored with a black substance, the caulking around the toilet base was discolored black, and the white shower curtain had black spots of biogrowth.</p> <p>(Photographic evidence was obtained).</p> <p>On 4/30/24 at 8:54 a.m., an observation was made of the bathroom in room [ROOM NUMBER]. The shower curtain in the bathroom was discolored with an unknown black substance and along the bottom edge was tan-colored. The observation revealed the vinyl cove base was pulled away from the wall leaving a gap between the base and tile of a few inches.</p> <p>(Photographic evidence was obtained).</p> <p>On 5/2/24 at 8:47 a.m., an observation of room [ROOM NUMBER]'s bathroom revealed the shower curtain had black spots of unknown substance attached to it and the vinyl cove base was pulled away from the tiled wall next to the toilet.</p> <p>On 5/2/24 at 8:50 a.m., an observation of room [ROOM NUMBER]'s bathroom revealed the shower curtain had black spots of an unknown substance, the showers wall grout and floor tile was discolored with a black unknown substance, and the two safety handles beside and behind the toilet was rusty, therefore uncleanable.</p> <p>On 5/2/24 at 10:20 a.m., observations of room [ROOM NUMBER] and 206's bathrooms were conducted with the Housekeeping Manager and the Environmental District Manager (EDM). The EDM stated they could take money out of petty cash to replace the shower curtain in room [ROOM NUMBER] and the resident reported seeing palmetto bugs/roaches coming out of the cove base about every other day. The EDM stated the floor in room [ROOM NUMBER]'s shower could be cleaned and the shower curtain should have been changed. The EDM stated the handrails were not cleanable and the Housekeeping manager stated the safety handles are cleaned then a hour later the rust was back.</p> <p>46498</p> <p>3) During an observation made on 04/29/2024 at 12:00 p.m., rooms [ROOM NUMBERS] had paint missing off the doors. room [ROOM NUMBER]'s sink inside the room was observed with a black like substance stuck inside the sink. room [ROOM NUMBER] was observed with a dirty privacy curtain hanging up in the room. (Photographic evidence obtained).</p> <p>Review of the facility policy titled, Physical Environment, Effective date January 1, 2020, revealed the following:</p> <p>Policy: A safe, clean, comfortable, and home -life environment is provided for each resident/patient, allowing the use of personal belongings to the greatest extent possible. All essential mechanical, electrical, and resident/patient care equipment is maintained in safe operating condition throughout the facility's Preventative Maintenance Program.</p> <p>4. Assure resident/patient care equipment is clean, properly stored, and identified.</p> <p>(continued on next page)</p>		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Assure an applicable working system is in place and within reach for the resident/patient to summon assistance, including, but not limited to: Typical call light with cord, Manual call bell, Specialty call bell as needed.		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999</p> <p>Based on observations, record reviews, and interviews, the facility 1) failed to revise and review one resident (#60) care plan with the appropriate staff/professionals and resident out of forty-one sampled residents, 2) failed to review and revise the care plan for four residents (#55, #1, #47, and #85) related to psychotropic medications, falls, activities of daily living (ADL), and range of motion (ROM) out of forty-one sampled residents.</p> <p>Findings included:</p> <p>1.</p> <p>Review of Resident #60's Admission Record revealed the resident was initially admitted on [DATE] and readmitted on [DATE]. The record included diagnoses not limited to Type 2 Diabetes Mellitus, unspecified peripheral vascular disease, and unspecified sequelae of cerebral infarction.</p> <p>During an interview on 4/30/24 at 9:46 a.m., Resident #60 reported no participation in care planning meetings and stated, They're supposed to do all that?, then began chuckling and clapping hands.</p> <p>Review of Resident #60's Quarterly Minimum Data Set (MDS), dated [DATE], showed the resident's Brief Interview of Mental Status (BIMS) score was 13 out of 15, indicating an intact cognition.</p> <p>Review of Resident #60's care plan revealed the goals for the resident's focuses had been revised on 1/15/24 with a target date of 6/20/24. A focus regarding the resident being a smoker had been initiated 4/11/24.</p> <p>Review of Resident #60's progress notes revealed there was no progress note on 4/11/24 regarding a care plan meeting. Review of the resident's progress notes from 12/30/23 to 1/29/24 did not reveal a care plan meeting had been held.</p> <p>An interview was conducted on 5/1/24 at 9:29 a.m. with Staff G, Registered Nurse/Unit Manager (RN/UM). The staff member reported being unaware of the location of Resident #60's care plan.</p> <p>An interview was conducted on 5/1/24 at 9:45 a.m., with Staff L, Senior Clinical Reimbursement Director. The staff member stated the CRD was in charge of scheduling and notifying residents and representatives of care plan meetings. The staff member reported doing an electronic progress note and at minimum the note contained what was discussed. Staff L reported the invitation (to resident) was used to record the attendees at the time of the care plan meeting.</p> <p>An interview was conducted on 5/1/24 at 11:11 a.m., with Staff L, the staff member reported finding one progress note for Resident #60 regarding a care plan meeting, dated 4/14/23, revealing a meeting was scheduled for 1 p.m. on 4/19/23. The staff member confirmed there was no note revealing what was discussed and being unable to locate a care plan invitation for the period between December 2023 and January 2024. Staff L confirmed the invitation for the care plan meeting on 4/11/24 at 1:45 p.m. for Resident #60 was blank.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on 5/2/24 at 9:58 a.m. with the Social Service Director (SSD), the SSD stated the attendees at the care plan meetings were a Certified Nursing Assistant, Activities, the Unit Manager or nurse or the MDS Coordinator has already spoken with the nurse regarding meds, (and/or) therapy.</p> <p>Review of Resident #60's care plan meeting invitations for 7/12/23 and 9/21/23 revealed the attendees were the resident, the CRD and the SSD.</p> <p>2.</p> <p>On 4/30/24 at 8:16 a.m., Resident #55 was observed sitting in wheelchair, appropriately dressed, and the resident's bed was made. On 5/1/24 at 12:48 p.m., Resident #55 was observed lying in bed, eyes closed, with audible rhythmic breathing.</p> <p>Review of Resident #55's Admission Record showed an admitted [DATE] and diagnoses including but not limited to other encephalopathy, unspecified depression, and unspecified severity unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>Review of Resident #55's care plan revealed Psychotropic Med: The resident uses psychotropic medications related to (r/t) antidepressant to manage: depression, initiated and revised 4/4/23. The goals initiated 4/4/23, revealed Resident will be at the lowest dose required to reduce symptoms while minimizing adverse effects to ensure maximum functional ability both mentally and physically through the next review and Will have no side effects of psychotropic medications. The goals were initiated on 4/4/23, revised on 4/22/24, and had a target date of 7/6/24.</p> <p>Review of Resident #55's active physician orders did not reveal the resident was to receive either a scheduled or as needed psychotropic medication.</p> <p>Review of Resident #55's current and discontinued medications revealed the resident did not have a current order for any psychotropic medication and the discontinued medications showed the last psychotropic order was Trazodone 50 milligram - Give 1 tablet via gastrostomy (G-tube) at bedtime for insomnia. The resident's order for Trazodone was started on 4/3/23 and discontinued on 10/30/23.</p> <p>An interview was conducted with Staff L, Clinical Reimbursement Director (CRD) on 5/2/24 at 3:44 p.m., the CRD reviewed Resident #55's care plan and confirmed it revealed the resident was receiving antidepressant medications. The CRD reviewed the current and discontinued medications, revealing the resident had not been receiving any psychotropic medications since Trazodone, confirming the care plan should have been resolved when the resident's antidepressant, Trazodone had been discontinued in October 2023.</p> <p>The facility did not provide any other discontinued psychotropic orders from the time frame of October 2023 to May 2, 2024.</p> <p>48223</p> <p>2.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/29/2024 at 10:08 AM Resident #1 was observed sitting on the edge of the bed, feet on the floor, bed in the low position. Resident #1 was observed leaning forward reaching for the floor, then sitting up and laying back on the bed, rolling back and forth.</p> <p>On 4/29/2024 at 11:30 AM Resident #1 was observed on the floor outside of room [ROOM NUMBER], wheelchair nearby, and staff attending. Resident #1 was returned to the wheelchair by the staff.</p> <p>Review of Resident #1's Admission Record showed a readmitted [DATE] and original admitted [DATE] with diagnoses including but not limited to: cerebral infarction, abnormalities of gait and mobility, reduced mobility, muscle wasting and atrophy, spinal stenosis, lack of coordination, pulmonary edema, heart failure, anxiety disorder, and schizophrenia.</p> <p>Review of Resident #1's care plan revealed the following:</p> <p>Focus: Fall: Resident #1 is at risk for falls or fall related injury related to unsteady gait, history of falls, decreased safety awareness secondary to impaired cognition and psychotropic and narcotic medication use. Resident #1 is very impulsive, difficult to redirect, also very independent minded, no awareness of abilities or lack thereof - date initiated: 6/28/2021, revision date on 4/15/2024.</p> <p>Goal: Will minimize the risk of injury - date initiated: 1/26/2023, revised on 3/8/2024. Will have no untreated fall related injury - date initiated 3/8/2024.</p> <p>Interventions/tasks: Encourage and try to assist resident with toileting before meals and at bedtime - date initiated 9/20/2023. 4/23 prompted toileting, before and after meals, and at bedtime -date initiated 4/30/2024.</p> <p>Focus: Incontinence: Resident #1 is incontinent of bladder/bowel related to severely impaired cognition with impaired awareness of need to void an unpredictable pattern - date Initiated: 7/16/2021, revised on 10/6/2023.</p> <p>Goal: Will maintain dignity - date initiated 7/16/2021 revised on 10/11/2023. Will minimize the risk of infection - date initiated 7/16/2021 revised on 10/11/2023. Will minimize the risk of skin breakdown - date initiated 7/16/2021 revised on 10/11/2023.</p> <p>Interventions/Tasks: check for incontinence frequently and provide incontinence care is indicated - date initiated 7/16/2021, revised on 1/26/2023. Provide perineal care and apply barrier cream after incontinent episodes as needed - date initiated 7/16/2021. Utilizing continent products as needed to provide dignity - date initiated 7/16/2021. Observe condition of skin with each incontinent episode - date initiated 1/26/2023. Observe for foul smelling, cloudy urine, change in urinary output, mental status change, changes in bowel pattern and report as needed - date initiated 1/26/2023.</p> <p>An interview was conducted with Staff L, CRD on 5/1/24 at 3:18 PM. Staff L, CRD reviewed Resident #1's care plan and confirmed the care plan interventions under the Fall Care Plan were redundant in regards to the encourage toileting. Staff L, CRD stated the resident's entire care plan should have been reviewed and an intervention placed after the root cause for the fall ascertained. Staff L, CRD continued to state the toileting intervention was not appropriate if the Incontinence Care Plan was accurate.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/29/2024 at 10:13 AM Resident #47 was observed sitting upright in bed. Resident #47 had an enteral tube feeding hanging on a pole next to the bed. The enteral feeding was dated 4/28/2024 not timed and half of the bottle was gone. The pump was not on and the tubing was not connected to Resident #47.</p> <p>On 4/30/2024 at 9:11 AM Resident #47 was observed sitting upright in bed, an over the bed table next to the bed with a carton of milk.</p> <p>Review of Resident #47's Admission Record showed a readmitted [DATE] and original admitted [DATE] with diagnoses including but not limited to: encephalopathy, vascular dementia, abnormalities of gait and mobility, dysphagia, acute kidney failure, a transient cerebral schematic attack (TIA), depressive disorder, hypertensive heart disease, and anxiety.</p> <p>Review of Resident #47's Physician Order Summary Report showed:</p> <p>Regular Diet Mechanical soft/soft and bite sized SB6 texture, Regular (Thin) consistency for diet, with an order date of 4/23/2024.</p> <p>Urinary Catheter for obstructive uropathy with urinary catheter size #16FR with 10cc balloon. Observe every shift with an order start date of 3/29/2024.</p> <p>Review of Resident #47's care plan revealed:</p> <p>Focus: Nutritional: the resident has a nutritional problem or potential nutritional problem related to advanced age, depression, hypertension, Benign prostatic hyperplasia (BPH), anxiety, Depression, hyperlipidemia, dementia and muscle wasting . date initiated: 10/11/23 and revised on 11/29/2023.</p> <p>Goal: Maintain nutritional and hydration status via by mouth (PO) intake to avoid significant weight changes, while honoring resident's food preferences - date initiated 10/11/23 and revised on 10/24/23.</p> <p>Interventions/Tasks: Resident is nothing by mouth (NPO)- do not provide food or fluids by mouth. See nurse. - date initiated: 3/1/2024.</p> <p>Focus: activities of daily living (ADL): the resident has an ADL self-care performance deficit related to recent hospitalization , dementia, history of TIA. date initiated: 1/5/2024 and revised on 3/20/2024.</p> <p>Interventions/Tasks: Resolved: Eating: Independent - resolved 3/1/2024. Eat nothing by mouth - date initiated 3/1/2024. Bladder: Incontinent - date initiated 3/1/2024.</p> <p>Focus: Behavioral: the resident is noted with the following behaviors: urinating on the floor - date initiated 11/17/2023.</p> <p>Goal: risk for complications related to behavior will be minimized through review date - date initiated 11/28/2023.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interventions/Tasks: administer psychotropic medications as ordered. Report missed or refused medications to physician - date initiated: 11/28/2023. Medications as ordered, report missed or refused meds to physician, discuss possible alternatives with MD and resident - date initiated 11/28/2023. Praise the resident will behavior is appropriate - date initiated 11/28/2023. Observe for changes in behavior and report to physician for example insomnia, nervousness, loss of interest, decreased ability to concentrate, repetitive movements etc. - date initiated 11/28/2023. Do not Corner if agitated. Provides space, remove other residents, remain calm and call for assistance - date initiated 11/28/2023. Psychiatry services as needed - date initiated 11/28/2023. Psychological services as needed - date initiated 11/28/2023.</p> <p>During an interview on 5/2/2024 at 9:15 AM Staff L, CRD reviewed Resident #47's care plan with focus areas of Nutritional, Tube Feeding and ADLs. Staff L, CRD stated Resident #47's care plan is not updated. Staff L, CRD stated when the order was received for the catheter the behavior and ADL care plan should have been updated to reflect resident's current status. Staff L, CRD continued to state, The same should have been done with the diet order. If the Care Plan is not updated the CNAs, Kardex does not get updated. The Kardex is what tells the CNAs what care to provide for the residents.</p> <p>On 4/29/2024 at 9:58 AM and 4/30/2024 at 9:15 AM Resident #85 was observed in bed, with arms crossed at the waste and hands bent with fingers touching both palms. Resident #85 was not able to open fingers or extend either arm out from the elbow.</p> <p>Review of Resident #85's Admission Record showed a readmitted [DATE] and original admitted [DATE] with diagnoses including but not limited to: encephalopathy, abnormalities of gait and mobility, dysphagia, depressive disorder, hypertensive, anxiety, and paranoid schizophrenia.</p> <p>Review of Resident #85's care plan revealed the ADL care plan had been resolved on 3/25/2024.</p> <p>During an interview on 5/2/2024 at 10:15 AM Staff L, CRD reviewed Resident #85's care plan and stated an ADL care plan should be in place.</p> <p>During an interview on 05/2/2024 at 12:40 PM the Director of Nursing (DON) stated the expectation is to update the residents care plans as changes occur.</p> <p>Review of the facility's policy and procedure topic, Care Plan - Interdisciplinary (IDT) Plan of Care from Interim to Meeting, dated effective February 2024 showed:</p> <p>Policy The facility shall support that each resident must receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The facility shall assess and address care issues that are relevant to individual residents, to include, but may not be limited to, monitoring residents condition, and responding with appropriate interventions.</p> <p>The comprehensive care plan is an interdisciplinary communication tool. It includes measurable objectives and time frames and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan is reviewed and revised periodically, and the services provided or arranged are consistent with each resident's written plan of care.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The overall care plan should be oriented towards: 1. Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence (e.g., palliative approaches in end-of-life situations, coordination with Hospice plan of care). Managing risk factors to the extent possible or indicating the limits of such interventions. a. Addressing ways to try to preserve and build upon a residence's strengths, needs, personal, and cultural preferences. b. Applying current standards of practice in the care planning process. c. Evaluating treatment of measurable objectives, timetables, and outcomes of care. d. Respecting the residents right to choose to decline treatment, request treatment, or discontinue treatment. e. Offering alternative treatments, as applicable. 2. Using appropriate interdisciplinary approach to care plan development to improve the resident's functional abilities. a. Involving the resident to have a role in care planning even if a judged incompetent, and the resident's family and/or other resident representatives as appropriate to participate in the development and implementation of his or her person-centered plan of care. b. Assessing and planning for care to meet the residents medical, nursing, mental, and psychosocial needs. c. Involving the direct care staff with the care planning process relating to the resident's expected outcomes. d. Addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procedure 2. Update to Care Plans - a. Ongoing updates to care plans are added by a member of the IDT, as needed. 3. Dates and Documentation on the Care Plan a. New, revised, or discontinued problems, goals, or interventions are dated for the date the documentation was made. b. Problems and goals have IDT approaches and interventions to assist the resident in their goal attainment. 5. Comprehensive Plan of Care a. The comprehensive care plan is developed by members of the IDT and the resident, resident's family, or representative, as appropriate, in conjunction with the completion of the Admission, Annual, Significant Change in Assessment or other comprehensive assessment, and associated Care Area Assessments. b. The comprehensive care plan describes or includes: i. The services that are to be furnished and goals that reflect the resident's wishes, choices, and exercise of rights. ii. Any services that would normally be provided but are not provided due to the residents exercise of rights, include the right to refuse treatment, or any alternative means or options to address the problem. iii. The needs, strengths, and preferences identified in the comprehensive resident assessment. iv. Prevention of avoidable declines in functioning or functional levels v. Standards of current professional practice vi. Adequate information provided to make informed choices regarding treatment. c. The comprehensive care plan is completed within regulated time frames. 6. Quarterly Update of the Plan of Care a. The comprehensive care plan is reviewed and revised by members of the IDT and the resident, resident's family, or representative, as appropriate, in consultation with completion of the Quarterly Assessment. b. The IDT members make a quarterly care plan review note within the designated discipline's progress notes which include: i. If goals are met or unmet ii. If care plan will remain in effect for resident 7. Care Plan Meeting Invitation a. The facility assists residents or their representatives to participate in and understand the assessment and care planning process, when feasible, holding care planning meetings at the time of day when a resident is functioning best, planning enough time for information exchange and decision making; Encouraging a residence representative to attend (e.g., family member, friend), if desired by the resident, and/or Hospice representative. b. The clinical reimbursement director (CRD) and/or clinical reimbursement specialist (CRS) facilitate the care plan schedules and letters to be delivered to the resident or their representative prior to the care plan meeting. i. A copy of the letter is retained by the facility and is filled into the medical record upon completion of the care plan meeting. ii. When feasible, CRD, CRS, or designee calls or visits resident or their representative prior to meeting if no response has been received for confirmation of attendance. Call or visit is recorded on copy of letter. 8. Care Plan Meeting a. All team members are to report promptly at time indicated on weekly schedule. b. Care plan meetings are held in an uncluttered, confidential setting with all team members able to sit as well as resident and/or representative. c. All care plan updates, revisions, and evaluations are completed prior to the meeting. d. IDT Meats regardless of resident and/or resident representative ability to attend. e. Care plans are discussed allowed, to include discussion goals, interventions, and evaluations. f. CRD, CRS, unit manager (UM) or other designee in absence of, facilitates and explains the purpose and length of the meeting: i. Purpose: to communicate the medical, psychosocial, recreational and nutritional condition and discuss the approaches being taken to attain goals. ii. Time time allotted for meeting: 15 minutes per resident or private meeting after with appropriate department team members. iii. Introduction to team members and their titles. g. Nursing i. Review current diagnosis, tests, or procedures, treatments (wounds, rashes, etc.), discuss current interventions and risk of further breakdown, if applicable, recent, or pending referrals, physician consults, restorative, medications, pain management plan, behavioral management plan, special needs, risks of falls and current interventions, and recent falls or other issues (informed consents, isolation, etc.) ii. Clinical representative will be UM we're charged nurse familiar with the care of the resident. Assigned CNA also attends or provides input to IDT regarding care provided and resident response. Absence of UM or charge nurse should be by exception. h. Dietary/nutritional status i. Current weight, loss or gain, appetite, supplements, food likes/dislikes, and confirm history of allergies. i. Social Services i. Review any changes needed to face sheet information, advanced directive status, review code status to include do not resuscitate (DNR) and presence of state required documents. Discuss living will, ethical concerns, competency/capacity (surrogate, DPOA, guardian status), ancillary, services/pending referrals - dental, Podiatry, vision, hearing, mental health, recent changes in cognition, behaviors, and socialization and approaches, any discharge planning or any needed assistance with Medicaid application process or grievances that may need to be addressed. i. Recreation i. Update on customers participation in</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** 46498</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure two dependent residents (#81 and #13), were provided with Activity of Daily Living(ADL) assistance related to hair and fingernail care out of forty one sampled residents.</p> <p>Finding Included:</p> <p>1. During an observation on 04/29/2024 at 11:00 a.m., Resident # 81 was observed laying down in bed dressed in his nightgown with his call light within reach. Resident # 81 fingernails were observed long and dirty and he had thick facial hair. Resident # 81 stated he has asked staff to cut his hair and his fingernails, but they will not assist him.</p> <p>During an observation on 04/30 /24 at 02:24 PM Resident #81 was observed laying down in bed with his call light in reach, dressed in his nightgown. Resident # 81 said he has asked his aide to cut his facial hair and his fingernail, but she did not assist him with his care.</p> <p>Review of an Admission Record, dated 05/02/2024, showed Resident #81 was admitted initially on 06/17/2023 and readmitted on [DATE] with diagnoses to include but not limited to non-Pressure chronic ulcer of unspecified part of left lower leg with unspecified severity, adjustment disorder with anxiety, and Pressure Ulcer of Sacral Region, Stage 4.</p> <p>Review of a Minimum Data Set (MDS), dated [DATE], showed a Brief Interview for Mental Status, (BIMS) score of 14 to indicated Resident #81 was cognitively intact. Further review of the MDS showed in section GG, for Functional Abilities and Goals, Resident #81 was dependent for his personal hygiene.</p> <p>Review of a care plan focusing on ADL's showed:</p> <p>Resident #81 has an ADL self-care performance deficit related to paraplegia status post Motor Vehicle Accident. Date initiated: 01/03/2024 and revised on 01/03/2024.</p> <p>Interventions: Dependent for personal hygiene. Date initiated 09/06/2023 and revised on 01/03/2024.</p> <p>During an interview on 05/01/2024 at 12:00 p.m., with Staff Q, a Certified Nursing Assistant, CNA, she stated she provides all of Resident #81's ADL care because he is a total dependent resident. She said the first thing she does is empty his colostomy and catheter bag in the morning. She said Resident #81 asked her to shave him yesterday, but she was not able to do it because she was too busy.</p> <p>During an interview on 05/01/2024 at 12:15 p.m., with Staff E, a Registered Nurse, RN, He said his expectation is if staff are having problems with completing their ADL task, they should report it to him and document the reason why they could not complete the task. For example, if resident refuses care the aide needs to report the situation to their nurse and document the concern. His expectation are staff should follow out the residents ADL's according to the resident's plan of care.</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>During an interview on 05/01/2024 at 1:00 p.m., with the Director of Nurses, DON, the DON said her expectation was that every resident should be provided with ADL care. If for some reason they are not able to complete the task, then they should report the issue to their nurse and they should follow up with documentation regarding the resident's refusal of care.</p> <p>50434</p> <p>2. During an observation on 04/29/2024 at 10:30 a.m. Resident #13 was observed lying in bed dressed in a gown. Resident #13 was observed to be disheveled in appearance with her hair knotted and overgrown fingernails.</p> <p>During an observation on 04/30/24 10:00 a.m. Resident #13 was observed lying in bed dressed in a gown. Resident #13 was observed to be disheveled in appearance with her hair knotted and overgrown fingernails. During the observation she was yelling out. Resident was not observed to be engaged in any activities throughout the observation.</p> <p>During an observation on 05/01/2024 at 11:00 a.m. Resident #13 was observed lying in bed dressed in a pink sweater. Resident #13 was observed hair was noted to have been brushed and resident was clean looking in appearance. Resident was happy in demeanor. Resident was not observed to be engaged in any activities throughout the observation.</p> <p>During an observation on 05/02/2024 at 9:45 a.m. Resident #13 was observed lying in bed dressed in a pink sweater. Resident #13 was observed to be disheveled in appearance with her hair knotted. Resident was not observed to be engaged in any activities throughout the observation.</p> <p>Review of Resident #13's Admission Record revealed she was admitted to the facility on [DATE] with medical diagnoses of reduced mobility, need for assistance with personal care, other chronic pancreatitis, adjustment disorders with anxiety, major depressive disorder, and anxiety disorder.</p> <p>Review of Resident #13's Quarterly Minimum Data Set (MDS), dated [DATE], Section C, Cognitive Patterns revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15. Section GG revealed Resident #13 was dependent for Toileting hygiene, and Shower/bathe care. Resident requires substantial/maximal assistance for Oral hygiene, upper body dressing and lower body dressing.</p> <p>During an interview on 05/01/2024 at 10:30 a.m. with Staff N, Certified Nursing Assistant (CNA), she stated she is typically assigned to another part of the building and used to be on this hall. She stated Resident #13 is a fully dependent resident who requires full assistance with all of her care. She stated she helps with oral care, dressing for the day, bathing and with meals daily. She stated Resident #13 prefers to have a bath over a shower so she is sure to give her a bed bath daily. She stated Activities of Daily Life (ADL) care are supposed to be completed every shift and she cannot speak for other shifts or staff but when she is working, she ensures the Resident #13 gets her ADL care. She repositions the resident every 2 hours and uses a pillow to keep her comfortable, since the resident prefers to stay in bed most of the time. She stated the resident prefers to do activities in her room and she had brought her an audio book to listen to during the day before and she really enjoyed it.</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>During an interview on 05/02/2024 at 10:30 a.m. with Staff O, CNA she stated she is supposed to provide ADL care to the residents daily. ADL care consists of oral care, daily bathing, and dressing for the day. She also assists the residents out of bed if they wish. Staff O, CNA stated Resident #13 prefers to stay in bed most days and often refuses her help with ADL care. She stated she does not force the resident to let her help them with care or out of bed. If the resident refuses, she takes no as the answer and does not encourage the resident any longer. She stated she does not provide any activities for the residents to do in their rooms because the facility has an activities director who goes to residents rooms and offers them things to do like coloring or a word search puzzle. Staff O, CNA stated she does not document when residents refuse showers, or not wanting to get out of bed or the behavior of the residents because she does not have access to do so. Staff O, CNA stated she reports to the nurse on duty when residents do not want to get out of bed or refuse their showers.</p> <p>During an interview on 05/02/2024 at 11:15 a.m. with the DON she stated they have residents who refuse care and when residents continue to refuse care, they update the care plan. CNA's do not have access to documents when residents refuse care. DON reviewed Resident #13's care plan, dated 03/03/2024, and noted the resident was not care planned to refuse ADL care. Her expectation for activities for residents who are dependent is for the activities director to visit the rooms of those residents and provide them with activities.</p> <p>The facility was asked to provide a policy regarding their ADL care and stated they do not have a Policy for ADL Care.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498</p> <p>Based on observations, record reviews, and interviews the failed to ensure two residents (# 68, 13) residing on the same hall were provided with activities out of eight residents sampled.</p> <p>Finding Include:</p> <p>1. During an observation made on 04/29/2024 at 10:00 a.m., 11:30 a.m., and again at 3:00p.m., Resident# 68 was observed in bed, leaning off the side of her bed. Resident # 68 was dressed in her nightgown, with her call light out of her reach.</p> <p>During an observation made on 04/30/24 at 9:00 a.m. and 11:30 a.m., Resident # 68 was observed in bed, dressed in a nightgown with her call light out of reach. Resident # 68 was observed leaning to the side.</p> <p>Review of an Admission Record dated 05/02/2024 showed Resident # 68 was admitted on [DATE] with diagnoses to include but not limited to Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety, Cognitive Communication Deficit, Need for assistance with Personal Care</p> <p>Review of a Minimum Data Set, MDS dated [DATE] showed a Brief Interview for Mental Status, BIMS showed a score of 05 to indicated Resident # 68 is severely impaired.</p> <p>Review of a care plan focusing on Activities showed Resident # 68 requires staff assistance with involvement of activities related to cognitive deficits. Date initiated 04/04/2023. Further review of the care plan interventions showed to encourage Resident # 68 to participate with activities of choice. Date initiated: 04/04/2023.</p> <p>During an interview on 05/02/2024 at 2: 00 p.m., with Staff P, the Activities Director. She stated she conducts room visits for dependent residents. She asked the residents in their rooms if they would like to do a word search, or color. She said she even does nail care as an activity for some residents in their rooms. She was not able to conduct activities this week for the dependent residents residing on the 100 halls because she was too busy.</p> <p>During an interview on 05/02/2024 at 2:30 p.m., with the Director of Nursing. She stated her expectation is that residents have activities according to their plan of care.</p> <p>50434</p> <p>2.</p> <p>During an observation on 04/29/2024 at 10:30a resident #13 was observed lying in bed dressed in a gown. Resident #13 was observed to be disheveled in appearance with her hair knotted and overgrown fingernails.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 04/30/24 10:00 AM resident #13 was observed lying in bed dressed in a gown. Resident #13 was observed to be disheveled in appearance with her hair knotted and overgrown fingernails. During the observation she was yelling out. Resident was not observed to be engaged in any activities throughout the observation.</p> <p>During an observation on 05/01/2024 at 11:00 am resident #13 was observed lying in bed dressed in a pink sweater. Resident #13 was observed hair was noted to have been brushed and resident was clean looking in appearance. Resident was happy in demeanor. Resident was not observed to be engaged in any activities throughout the observation.</p> <p>During an observation on 05/02/2024 at 9:45 am resident #13 was observed lying in bed dressed in a pink sweater. Resident #13 was observed to be disheveled in appearance with her hair knotted. Resident was not observed to be engaged in any activities throughout the observation.</p> <p>Review of Resident #13's Admission Record revealed she was admitted to the facility on [DATE] with medical diagnoses of reduced mobility, need for assistance with personal care, other chronic pancreatitis, adjustment disorders with anxiety, major depressive disorder, and anxiety disorder.</p> <p>Review of Resident #13's Quarterly Minimum Data Set (MDS) dated [DATE] Section C, Cognitive Patterns revealed a brief interview for mental status (BIMS) score of 10 out of 15. Section GG revealed Resident #13 is dependent for Toileting hygiene, and Shower/bathe care. Resident requires substantial/maximal assistance for Oral hygiene, upper body dressing and lower body dressing. According to the Self-Care Coding dependent means helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. Substantial/maximal means helper does more than half the effort. The helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>During an interview on 05/01/2024 at 10:30a with Staff N, Certified Nursing Assistant (CNA), she stated she is typically assigned to another part of the building and used to be on this hall. She stated resident #13 is a fully dependent resident who requires full assistance with all of her care. She stated that she helps with oral care, dressing for the day, bathing and with meals daily. She stated resident #13 prefers to have a bath over a shower so she is sure to give her a bed bath daily. She stated ADL care is supposed to be completed every shift and she cannot speak for other shifts or staff but when she is working, she ensures the resident #13 gets her ADL care. She repositions the resident every 2 hours and uses a pillow to keep her comfortable, since the resident prefers to stay in bed most of the time. She stated the resident prefers to do activities in her room and that she has brought her an audio book to listen to during the day before and she really enjoyed it.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/02/2024 at 10:30 am with Staff O, CNA she stated that she is supposed to provide ADL care to the residents daily. ADL care consists of oral care, daily bathing, and dressing for the day. She also assists the residents out of bed if they wish. Staff O, CNA stated that resident #13 prefers to stay in bed most days and often refuses her help with ADL care. She stated that she does not force the resident to let her help them with care or out of bed. If the resident refuses, she takes no as the answer and does not encourage the resident any longer. She stated that she does not provide any activities for the residents to do in their rooms because the facility has an activities director who goes to residents rooms and offers them things to do like coloring or a word search puzzle. Staff O, CNA stated that she does not document when residents refuse showers, or not wanting to get out of bed or the behavior of the residents because she does not have access to do so. Staff O, CNA stated she reports to the nurse on duty when residents do not want to get out of bed or refuse their showers.</p> <p>During an interview on 05/02/2024 at 11:15 am, with the DON she stated they have residents who refuse care and when residents continue to refuse care, they update the care plan. CNA's do not have access to documents when residents refuse care. DON reviewed resident #13's care plan dated 03/03/2024 and noted that the resident was not care planned to refuse ADL care. Her expectation for activities for residents who are dependent is for the activities director to visit the rooms of those residents and provide them with activities.</p> <p>During an interview on 05/02/2024 at 11:30 am, with Staff P, Activities director, she stated she is responsible for activities for the entire resident population. She visits residents who are dependent on Mondays, Wednesdays, and Fridays. She offers the residents word searches, coloring pages, and sits with the resident to provide companionship. She stated that she has not been able to visit the dependent residents recently because she has been busy with her other tasks. She stated this is a frequent occurrence because of everything she does with in the facility she is not able to do her one on one with all the residents because she is the only one who does activities.</p> <p>The facility was asked to provide their activities policy and the facility did not provide this policy.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</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 assess and obtain physician orders for the wounds of two (#60 and #45) out of three residents sampled for skin conditions.</p> <p>Findings included:</p> <p>1.</p> <p>On 4/30/24 at 9:51 a.m., Resident #60 was observed lying in bed and a tan-colored foam dressing was observed covering the left below the knee amputation (LBKA), the dressing was dated 4/28 11-7 and initialed, EC, with a pencil eraser-sized discoloration. Photographic evidence was obtained.</p> <p>On 5/1/24 at 2:22 p.m., Resident #60 was observed sitting in wheelchair and stated the dressing (to LBKA) had not been changed. The resident reported yesterday's nurse stated the 11 p.m. - 7 a.m. (11-7) shift nurse was going to change it. The dressing was observed and continued to be dated 4/28 11-7 EC with a pencil eraser-sized discoloration. Photographic evidence was obtained.</p> <p>Review of Resident #60's evaluations did not show a Change of Condition or Wound evaluation had been completed on 4/28 in regards to the skin condition covered by the dressing covering the LBKA.</p> <p>Review of Resident #60's April Medication and Treatment Administration Records (MAR/TAR), printed on 5/2/24 at 3:50 p.m., did not reveal a physician order for the dressing applied to the resident's LBKA, which was dated 4/28.</p> <p>Review of the facility provided list of wounds revealed Resident #60 was included with others with pressure, surgical, venous, arterial, diabetic, and moisture-associated skin damaged condition.</p> <p>An interview was conducted with Staff G, Registered Nurse/Unit Manager (RN/UM) on 5/1/24 at 2:26 p.m., the staff member reported the resident had redness to the perineal area, reviewed Resident #60's record, and confirmed there was no order for a LBKA dressing. An unsuccessful attempt was made with Staff G to observe the resident's dressing. The photo evidence of the resident's LBKA dressing was reviewed with the staff member, who stated oh no and confirmed there should have been a change in condition and assessment done for the area. The staff member asked writer if knowing what was under the dressing. On 5/1/24 at 2:47 p.m., the Director of Nursing (DON) was informed by the staff member of Resident #60's unassessed and unordered dressing.</p> <p>Review of Resident #60's care plan revealed the following:</p> <p>- Wound Risk: The resident is at risk of developing a wound related to (r/t)decreased mobility and multiple co-morbidities. The interventions instructed staff to observe for any new areas of skin breakdown: Redness, Blisters, Bruises, discoloration noted during bath or daily care; report to nurse if noted, Nurse will report to MD if noted.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Preference/Choice: Resident has indicated the following preferences and/or has made the following choice regarding their health care: Resident chooses to decline recommended or ordered health care interventions of: Resident may decline to be weighed at times; to attend scheduled medical appointments. The interventions should staff were to encourage resident involvement in plan of care.</p> <p>- Behavioral: The resident is noted with the following behaviors: intermittently confabulates information regarding staff and/or other residents; occasionally buys sodas or snacks for other residents (without them requesting such) and will later charge them for the soda and/or snack; will, at times, ask assistance from another resident and/or staff member to look for something she is missing and then report the item missing or taken.</p> <p>2.</p> <p>On 4/30/24 at 5:17 p.m., an observation was made with Staff J, Registered Nurse (RN) of Resident #45's bilateral lower extremities. The observation revealed no open areas to the resident's lower extremities. The staff member stated the area heals then reoccurs, and right now the staff are just putting cream on it.</p> <p>On 5/1/24 at 12:49 p.m., an observation was made of Resident #45 raising the head of bed as a meal tray was on the over-bed table in front of the resident.</p> <p>Review of Resident #45's Admission Record revealed an admitted [DATE] and diagnoses not limited to not elsewhere classified senile degeneration of brain, contracture of left knee, contracture of left ankle, and muscle wasting and atrophy not elsewhere classified unspecified site.</p> <p>Review of Resident #45's Skin Check Weekly and as needed (PRN), dated 1/26/24 revealed No New Areas of Skin Impairment. The document revealed staff also had New Areas of Skin Impairment Found, See Skin Grid (paper version or PCC Skin & Wound Module), See Skin/wound Note, Care Plan Reviewed & Current, and Resident Refused Skin Evaluation available to document any findings.</p> <p>Review of Resident #45's Skin Check Weekly and PRN, dated 2/2/24, revealed No New Areas Of Skin Improvements.</p> <p>Review of Resident #45's progress notes, dated 12/31/23 to 1/30/24, did not reveal the staff had documented any skin condition or change in condition for the resident.</p> <p>Review of Resident #45's progress notes revealed a note, dated 2/5/24, Resident noted with skin impairment to anterior bilateral lower extremities. MD notified with orders and Healthcare Proxy (HCP) called.</p> <p>Review of Resident #45's progress notes revealed the resident was seen by the facility wound care provider on 2/6/24 and an order for a vascular consult was obtained with the primary physician and Power of Attorney updated.</p> <p>Review of Resident #45's Infection Note, dated 2/7/24 showed the resident continued on oral antibiotic for cellulitis. The note on 2/15/24 revealed the resident continued on doxycycline for cellulitis to bilateral lower extremities.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #45's January Medication and Treatment Records (MAR/TAR) did not reveal any order for a dressing change or an order for an antibiotic related to any infection.</p> <p>Review of Resident #45's February MAR/TAR's revealed the resident was ordered:</p> <ul style="list-style-type: none"> - Doxycycline Hyclate Oral Tablet 100 milligram (mg) - Give 1 tablet by mouth two times a day for cellulitis to right (rt) leg for 10 days. The MAR showed the antibiotic was administered on 2/5-2/10, evening shift on 2/13, both times on 2/14 and not administered on morning shift of 2/15/24. - Cleanse area to left anterior lower leg with normal saline (NS), skin prep wound edges, apply Xeroform, and cover with dry dressing daily and PRN every day shift, ordered 2/6 and discontinued on 2/13/24. - Cleanse area to right posterior knee with NS, skin prep wound edges, apply Xeroform, and cover with dry dressing daily and PRN every day shift, ordered 2/6 and discontinued 2/13/24. - Cleanse area to right upper shin with NS, skin prep wound edges, apply Xeroform and cover with dry dressing, and daily and PRN every day shift, ordered 2/6 and discontinued 2/13/24. <p>An interview was conducted on 5/1/24 at 5:31 p.m., the Nursing Home Administrator (NHA) and the Director of Nursing (DON) regarding an incident of a CNA reporting a 7-day old dressing that the facility reported to the state agency. The NHA reported a Certified Nursing Assistant (CNA) had reported on 2/5/24 at 8:15 a.m. of observing a dressing to Resident #45's right lower extremity dated 1/27/24. The DON reported the resident has skin alterations of dry and crusty patches and one of the flakes had probably popped off. The NHA reported the investigation into the issue revealed a Registered Nurse (RN) had applied a dressing to the anterior right leg on 1/27/24 however did not follow wound protocol - did not put order in and did not document if an assessment had been done on the wound. The NHA stated the CNA had informed the nurse on 2/5/24 (different than the one on 1/27/24) and the nurse had not looked for a physician order but had just put the same type of dressing (dated 1/27/24) on the wound. The NHA reported Doppler studies were done on the lower extremity of Resident #45 and showed significant stenosis of the right popliteal artery. The wound provider diagnoses the resident with venous insufficiency and cellulitis and the antibiotic Doxycycline was started. At the time of the incident on 2/5/24, the DON assessed the wound and reported it hadn't changed in status and reported currently the resident had crusty scaly areas on legs. The NHA stated on 2/5/24 a physician order was obtained, a dressing was applied and the NHA started a Quality Assurance Performance Improvement plan. The NHA reported the roster of nurses who care from Resident #45 during the period of time were interviewed. The DON stated there was a piece of scale that was there, hadn't come off but did have some drainage. The NHA stated the root cause of the incident was that the nurse on 1/27/24 did not follow the facility's wound protocol. The NHA reported the incident was not substantiated because the wound had not worsened. The NHA stated the facility had completed audits of wound care dressings and labeling and the facility was no longer auditing due to the issue was resolved. The DON confirmed Resident #45's dressing (1/27-2/5/24) had been in place for 7 days, stating some dressings could be left on for 7 days. The facility education on 2/5/24 presented by the previous Assistant Director of Nursing (ADON) instructed staff when a new skin issue was found, a risk management assessment needs to be completed, a change of condition completed, report to the physician, get treatment orders, and notify the responsible party and DON.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #45's care plan revealed the resident was at risk for developing a wound related to (r/t) decreased mobility and incontinent of bowel and bladder and multiple co-morbidities. The goal was to minimize wounds from developing. The interventions included Observe for any new areas of skin breakdown: Redness, Blisters, Bruises, discoloration noted during bath or daily care; report to nurse if noted, Nurse will report to MD if noted.</p> <p>The facility failed to provide any skin/wound notes for January 2023, any evaluation for 1/26, 1/27, and 1/28/23.</p> <p>Review of the facility policy - Wound Prevention & Treatment Overview, effective October 2021, revealed The facility strives to ensure that a Resident/Patient entering the facility without Ulcers does not develop them unless the individual's clinical condition demonstrates they were unavoidable. A resident with ulcers will receive continued preventative interventions & necessary treatment & services to promote healing & prevent infection. Wound characteristics will be documented by measuring length, width & depth in centimeters. Additional documentation shall also include:</p> <ul style="list-style-type: none"> - Color of drainage - Wound Bed Color - Odor - Amount of Drainage - Wound Bed Tissue Type - Tunneling/undermining with depth if applicable. <p>Review skin integrity on a weekly basis as a proactive approach enabling the facility staff to identify possible changes in skin integrity/condition.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441</p> <p>Based on record review, observations and interviews the facility failed to provide restorative therapy related to applying splints for Resident #30 and did not prevent the further decrease in range of motion for Resident #85 out of twelve residents.</p> <p>Findings included:</p> <p>On 04/29/24 at 10:25 a.m., an observation was made of Resident #30 in his room with his eyes closed. Resident #30 had a blanket covering his body from chest to feet with his arms on top of the blanket. Resident #30's hands were in a curled loose fist bilaterally on top of his chest.</p> <p>Record review of Resident #30's Admission Record had an original admitted [DATE] with a readmitted [DATE]. Resident #30 has a primary diagnosis of Multiple Sclerosis (MS) with secondary diagnoses to include but not limited to aphasia and dysphagia following nontraumatic subarachnoid hemorrhage, major depression, and contracture of muscle multiple sites.</p> <p>A record review of Resident #30 physician orders shows orders for Physical/Occupational and Speech Therapy to evaluate and treat as needed and Restorative Nursing as needed with a revision date of 4/15/2024.</p> <p>A review of Resident #30 care plan has a focus area of Range of Motion (ROM) actual limitations in range of motion, and remains at risk related to diagnosis of MS as evidence by contracture bilateral lower extremities initiated on 02/16/2023 and revised 02/11/2024. The goal for this focus area will be to maintain range of motion and remain free of injuries or complications related to limitations of range of motion with a target date of 05/17/2024. Interventions for this focus area include: to encourage/assist the resident to change position for comfort and to observe and report decline in range of motion.</p> <p>On 5/01/24 at 12:10 p.m., an interview was conducted with the Program Manager for the therapy department. The facility's restorative therapy program is formally called Functional Maintenance program and it is nurse driven. The therapy department will determine if a resident is appropriate for the Functional Maintenance program after the initial acute therapy regimen is completed or if the resident has reached their goals and /or not progressing. The therapy department will design the program which includes but not limited to donning and doffing splints, active and/or passive range of motion, and eating assistance or devices for eating. The therapy department will train the nursing staff to the designed therapy specifically made for a resident in this program. The Program Manager will hand a paper form to the unit managers for each hallway which consists of the therapy designed for the resident, actual pictures of the splint and how it looks on a resident and an education sign in sheet of the staff in-service. The Program Manager stated the nursing staff will have to place this into the electronic medical records as well so it will show up as a task for the certified nursing assistants (CNAs) to implement. The Program Manager was unaware of a new order for Resident #30 for PT/OT/Speech therapy to evaluate and treat dated 4/15/24.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/01/24 at 12:35 p.m., an interview was conducted with the facility's two-unit managers (UM), Staff A, Registered Nurse and Staff G, Registered Nurse (RN). Both agreed there is a notebook which contains the information for restorative therapy but where not sure of its location.</p> <p>On 5/01/24 at 1:05 p.m., the Program Manager was observed in Resident #30's room doffing isolation personal protective equipment (PPE) stating the evaluation was completed.</p> <p>On 5/01/24 at 1:15 p.m., an interview was conducted with Staff C, CNA and Staff D, CNA. Both staff members stated they are familiar with Resident #30 and they have seen him in splints but stated they do not see any splints in his room currently. Both staff members agreed the restorative therapy is done by the smoking aid CNA when she comes in at 11:00 a.m., in between the smoking periods, she will take care of the residents in the program. Both staff members, added Staff B, CNA will assist with the restorative therapy program as well. Neither staff member knew of the formal name for the restorative therapy as the Functional Maintenance program.</p> <p>On 5/01/24 at 1:38 p.m., incontinence care was observed for Resident #30 with Staff C, CNA and Staff D, CNA. Resident #30 had bilateral feet and toes in a stiff pointing position. Both staff members stated he has splints for his feet and hands but were unable to locate in the resident's drawers or closet.</p> <p>On 5/01/24 at 1:44 p.m., an interview was conducted with Staff B, CNA regarding her role in the restorative therapy program. Staff B, CNA stated she oversaw all the residents assigned to restorative therapy and stated most of her job duties included donning and sometimes doffing of splints, range of motion either Active or Passive. She would get the instructions from the physical therapy team but the nurses would put the plan into the electronic chart so the tasks could be viewed and charted by the CNAs. She would also assist in the dining area for residents in need of assistance or for queuing and/or observation while eating and assist with weighing residents as ordered. Ever since Covid she no longer oversees the restorative program and stated, I miss it quite a lot. Staff B, CNA recalled Resident #30 wearing splints at some point in the past but is rarely assigned to his area. Currently, Staff B, CNA did not know anything about the smoking CNA assisting in restorative therapy.</p> <p>On 5/01/24 at 2:20 p.m., the Program Manager showed the process of a current resident getting ready to complete her acute therapy program and transition to the Functional Maintenance program (restorative therapy). In the packet was the written plan of therapy, pictures of the splint to be placed in various stages of donning and a blank sign in sheet for the CNAs to sign once they have been educated.</p> <p>On 5/01/24 at 3:30 p.m., two unlabeled notebooks were provided of the current residents for their Functional Maintenance program (Restorative Therapy). Upon review, Resident #30 had programs in both notebooks {photographic evidence}. A list of residents for splints/braces was provided by the facility for a total of four residents. Upon further investigation of these two notebooks, other residents were listed as well as residents no longer in the facility.</p> <p>On 5/02/24 at 11:20 a.m., an interview was conducted with Staff C, CNA, Staff N, CNA and Staff R, CNA. All three agreed to not be part of the restorative therapy program. All three stated they do not place splints/braces on residents and the smoking aid/CNA oversees the splints/braces when she arrives at 11:00 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/02/24 at 11:50 a.m., an interview was conducted with Staff I, CNA. Staff I, CNA stated if she sees on her task list a resident for splints, she will follow the task and place it on the resident and complete it in her task. Staff I, CNA stated physical therapy is good for educating the nursing staff but if she had a question, she knows therapy would assist her with her concerns.</p> <p>A review of Resident #30's Task Description for CNAs has under Nursing Rehab: Assistance with splint bilateral lower ankle foot orthotics (AFOs) for up to six hours as tolerated , may remove to check skin integrity and for hygiene care.</p> <p>On 5/02/24 at 12:29 p.m., an interview was conducted with the Assistant Director of Nursing (ADON). The newly hired ADON stated she is aware of the lack of ownership for the restorative therapy program and stated this will be addressed from the bottom up stating this is a nursing issue and all need to take responsibility for this project. The ADON was not aware of the smoking CNA responsible for the restorative therapy and stated it was inappropriate.</p> <p>On 5/02/24 at 12:29 p.m., an interview was conducted with Staff T, CNA. Staff T, CNA was feeding a resident in his room. Staff T, CNA stated she will do the restorative therapy in between smoking times, feeding residents, answering the phone in the front when the receptionist takes a break and whatever activities I need to do, I just go where they tell me.</p> <p>48223</p> <p>On 4/29/2024 at 9:58 AM and 4/30/2024 at 9:15 AM Resident #85 was observed in bed, with arms crossed at the waste and hands bent with fingers touching both palms. Resident #85 was not able to open fingers or extend either arm out from the elbow.</p> <p>Review of Resident #85's Admission Record showed a readmitted [DATE] and original admitted [DATE] with diagnoses including but not limited to: encephalopathy, abnormalities of gait and mobility, dysphagia, depressive disorder, hypertensive, anxiety, and paranoid schizophrenia.</p> <p>Review of Resident #85's Minimum Data Set (MDS) dated [DATE] revealed Section GG - Functional Abilities and Goals no upper or lower extremity impairments.</p> <p>Review of Resident #85's care plan revealed the Activity of Daily Living (ADL) care plan had been resolved on 3/25/2024.</p> <p>During an interview on 5/2/2024 at 10:15 AM Staff L, Clinical Reimbursement Director (CRD) reviewed Resident #85's care plan and stated an ADL care plan should be in place.</p> <p>An interview was conducted with Staff D, Certified Nursing Assistant (CNA) on 4/30/2024 at 10:01 AM stated I only provide care, not Range of Motion (ROM). ROM is provided by someone else but I don't know who. Staff D, CNA continued to state noticing some tightness in the Resident's upper and lower extremities when trying to dress Resident #85.</p> <p>An interview was conducted with Staff S, Licensed Practical Nurse (LPN) on 4/30/2024 at 10:05 AM. Staff S, LPN stated she was unaware of who provided ROM to the residents. Staff S, LPN continued to state noticing Resident #85's fingers and elbows beginning to tighten, but did not think much of it.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted with the Director of Rehabilitation (DOR) on 5/2/2024 at 10:56 AM. The DOR stated residents are screened based on referrals from nursing and the therapist are knowledgeable of the residents. The DOR went on to say screens might also be completed on a resident when readmitted from the hospital or if the resident has a functional decline.</p> <p>On 5/2/2024 at 11:05 AM an observation and interview were conducted with Resident #85 and the DOR. Resident #85 was lying face up in bed, arms were crossed at the waist and fingers were touching the palms. Resident #85 was not able to open her fingers on either hand when requested by the DOR. Nor was she able to extend her arms. The DOR asked Resident #85 if she could massage her hands. Resident #85 granted permission. The DOR massaged the Resident's hands for a few minutes then tried to open the palm of the hand (one hand at a time) the Resident grimaced and pulled away, bilaterally. The DOR stated the resident is in need of an evaluation and would request an order from the physician.</p> <p>During an interview on 05/2/2024 at 12:40 PM the Director of Nursing (DON) stated the expectation is for all CNAs to complete ROM and a referral to therapy be made if a staff member notices a decrease in any flexibility of a resident.</p> <p>Review of the facility's Restorative Nursing Programs dated revision October 2017 showed: Topic Restorative Nursing Programs and Guidelines Overview The facility provides Restorative Nursing Programs that involve interventions to improve or maintain the optimal physical, mental and psychological functioning. The interdisciplinary team (IDT), resident and, or family identify the needs of the resident, and collaboratively determines appropriate Restorative Nursing Programs to achieve the resident's goals. The programs include: *Contracture Management and Prevention- This program includes the provision of active and/ or passive range of motion exercises/movements to maintain or improve joint flexibility as well as strength. This program also involves splint/brace assistance to protect joint and skin integrity. * Mobility- This program improves or maintains self-performance in bed mobility, transfers, wheelchair mobility and walking. * Activities of daily Living-This program involves improvement or maintenance of the resident's self-performance in dressing (including prosthetic care), grooming and bathing. * Bowel and Bladder Continence- This program involves facilitating a resident in regaining or preserving continence to their maximal functional potential. * Restorative Dining- This program improves or maintains the resident's self-performance and self-feeding which may involve compensatory/adaptive strategies, positioning, and assistance/cues. * Communication- This program involves activities to improve or maintain the resident's self-performance and expressive and receptive communication. This may involve adaptive techniques, compensatory strategies, and adaptive devices. These programs can be combined based on the person-centered goals of each resident. The varied combinations can promote the highest functional level of each resident as well as enhance the restorative process. Refer to the following potential combinations that may be beneficial to the resident's needs. Combinations to consider that may enhance the restorative nursing process: *Passive Range of Motion (PROM) + Splint/Brace Assist *PROM/AROM (Active Range of Motion) + Splint/Brace Assist *AROM plus dressing/grooming *Bed Mobility + Transfer *Eating/Swallowing + Splint/Brace Assist *Bed Mobility/Walking + Transfer *Amputation/Prosthesis Care + Dressing/Grooming *Transfer + Amputation/Prosthesis Care *Transfer + Walking + Bowel/Bladder *Transfer + Walking *Communication + Dining + Walking *Communication + ADL (grooming/dressing) + Transfers</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441</p> <p>Based on observations, interviews and record review, the facility failed to provide dialysis care and services to meet the needs of one resident (#53) out of eight residents related to timely assessment and vital signs post dialysis.</p> <p>Findings included:</p> <p>A record review of Resident #53's Admission Record has an original admitted [DATE] with a readmitted [DATE]. Resident #53 has a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. Secondary diagnoses include but are not limited to end stage renal disease requiring dialysis, Type 1 diabetes mellitus with diabetic autoimmune polyneuropathy and personal history of other venous thrombosis and embolism.</p> <p>A review of physician orders for Resident #53 include resident to have dialysis on days: Monday, Wednesday, Friday dialysis center, document vital signs upon resident returning from dialysis every Monday, Wednesday and Friday, monitor for signs and symptoms of bleeding, notify MD (physician) of bleeding, monitor for bruit and thrill AV (Arteriovenous) shunt located at left lower extremity (upper leg) and may remove compression dressing post dialysis per MD orders instructions one time a day every Monday, Wednesday and Friday for treatment follow physician instructions when to remove dressing.</p> <p>On 4/30/24 at 11:00 a.m., a review of Resident #53's dialysis communication binder had one day of communication between the facility and the dialysis center, dated 4/29/24. Post vital signs and assessment of AV fistula were not entered from the facility upon return to the facility post dialysis. There was no post dialysis report from the dialysis center either on the communication sheet or on a separate report.</p> <p>An interview was conducted with Staff A, Registered Nurse/Unit Manager (RN/UM) who stated the reports may be faxed over later today but if there was a concern the facility would notify us via telephone conversation. A request was made for Resident #53's dialysis communication tools for the month of April 2024.</p> <p>Later that afternoon on 4/30/24, the facility provided copies of the resident's dialysis communication tools for the month of April with the following dates: 4/05, 4/09,4/10, 4/12, 4/13, 4/15, 4/17, 4/19, 4/22, 4/24, and 4/26. Upon further review, three of the communication tools had vital signs and post assessment of the AV fistula documented. All the communication tools for the month of April lacked timely communication from the dialysis center either in writing or fax.</p> <p>On 5/01/24 at 08:30 a.m., an interview was conducted with Resident #53. Resident #53 was in the main lobby sitting in his wheelchair waiting for transport to take him to his dialysis center. Resident had a binder in the back of his wheelchair with his name on it and the word dialysis. A packed lunch was made for the resident and packed in an insulated lunch bag. Resident #53 confirmed the location of his AV fistula was in his left upper thigh, stating he has had AV fistulas before in his arms but they did not do well due to small vessels.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/01/24 at 5:43 p.m., an observation and interview were conducted with Resident #53 post dialysis. In the 300 hallways at the nurse's station, Staff A, RN/UM confirmed Resident #53 was back from dialysis. Resident #53 was in his wheelchair in his room. Resident #53 stated he got back about forty-five minutes ago. He stated he had issues today at the dialysis center when they removed his needle from his AV fistula. Resident #53 stated he bled more than usual from his fistula and required longer direct pressure time to stop the bleeding at the dialysis center. The resident stated blood was all over the place and seeped into his shorts. Resident #53 stated the nursing staff have not come into his room to take vital signs or assess his AV fistula site, stating, they never come and check on it. He stated he did not eat his lunch today because he did not feel good. A request was made for Resident #53's dialysis communication binder from Staff A, RN/UM. Staff A, RN/UM stated she did not have the communication binder and sent a certified nurse assistant to locate the binder. Resident #53's dialysis communication binder was with the resident behind his wheelchair. The CNA gave the binder to a nurse staff member in the process of medication administration. Staff A, RN/UM stated no changes in dialysis were reported to her from the dialysis center.</p> <p>Review of the facility's policy entitled, Dialysis Management (Hemodialysis) dated October 2021</p> <p>With the following guidelines:</p> <p>1. Obtain A physician's order to include but not limited to:</p> <p>Name and address of the dialysis center</p> <p>Scheduled days and times of dialysis treatment</p> <p>Fluid management /restrictions -fluids will be coordinated and provided by nursing and dietary</p> <p>Lab values</p> <p>Medication administration terms on dialysis days</p> <p>Blood pressure or blood draw in arm with the shunt or access (error)</p> <p>Site signs and symptoms to monitor such as pain infection or bleeding period</p> <p>.</p> <p>8. Complete the dialysis communication tool before and after dialysis and following up on any special instructions from the dialysis center.</p> <p>.</p> <p>10. Evaluate for and manage post dialysis complication which may include, but are not limited to, the following:</p> <p>confusion</p> <p>fever</p> <p>(continued on next page)</p>		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pruritus anaphylaxis seizures hypertension muscle cramps cardiac arrhythmia restlessness air embolus insomnia hemorrhage

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</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 obtain blood pressures for one (#60) out of 5 residents sampled for unnecessary medications related to the physician ordered vasodilator, Hydralazine.</p> <p>Findings included:</p> <p>On 05/1/24 at 8:06 AM, Resident #60 was observed lying in bed with eyes closed.</p> <p>Review of Resident #60's Admission Record revealed the resident was admitted on [DATE] and readmitted on [DATE]. The record included diagnoses not limited to essential (primary) hypertension and unspecified sequelae of cerebral infarction.</p> <p>Review of Resident #60's March Medication Administration Record (MAR) revealed the following physician orders related to the resident's diagnosis of hypertension:</p> <ul style="list-style-type: none"> - Hydralazine hydrochloride (HCL) 25 milligram (mg) - Give 25 mg by mouth every 8 hours as needed for Hypertension (HTN) related to essential (primary) hypertension, for systolic blood pressure (SBP) greater than 160. Ordered 8/31/23. - BP and pulse weekly every evening shift every Sunday (Sun) for preventative measure. - Hydrochlorothiazide 25 mg - give one tablet by mouth one time a day for HTN. - Metoprolol Tartrate 25 mg - Give 1 tablet by mouth two times a day for HTN. <p>Review of Resident #60's March MAR revealed the staff had obtained a blood pressure and pulse one time a week, on Sunday. The MAR did not reveal a blood pressure had been taken every 8 hours to ensure the resident's ordered Hydralazine was not required. The MAR showed a blood pressure was not ordered to be obtained prior to administering the resident's Hydrochlorothiazide and Metoprolol.</p> <p>Review of Resident #60's Blood Pressure Summary report revealed documented blood pressures on 3/3, 3/10 (twice), 3/17, 3/24, and 3/31/24.</p> <p>Review of Resident #60's April MAR revealed the following physician orders related to the resident's diagnosis of hypertension:</p> <ul style="list-style-type: none"> - Hydralazine hydrochloride (HCL) 25 milligram (mg) - Give 25 mg by mouth every 8 hours as needed for Hypertension (HTN) related to essential (primary) hypertension, for systolic blood pressure (SBP) greater than 160. Ordered 8/31/23. - BP and pulse weekly every evening shift every Sunday (Sun) for preventative measure. - Hydrochlorothiazide 25 mg - give 1 tablet by mouth one time a day for HTN. <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Metoprolol Tartrate 25 mg - Give 1 tablet by mouth two times a day for HTN.</p> <p>Review of Resident #60's April MAR revealed the staff had obtained a blood pressure and pulse one time a week, on Sunday. The MAR did not reveal a blood pressure had been taken every 8 hours to ensure the resident's ordered Hydralazine was not required. The MAR showed a blood pressure was not ordered to be obtained prior to administering the resident's Hydrochlorothiazide and Metoprolol.</p> <p>Review of Resident #60's Blood Pressure Summary report revealed documented blood pressures one time daily on 4/7, 4/14, 4/21, and 4/28/24.</p> <p>Review of Resident #60's care plan showed the resident had a cardiovascular problem related to (r/t) hypertension (HTN), A-fib, (and) history (hx) of cardiovascular accident (CVA). The goal was for the resident to be free from complications of cardiac problems through the review date. The interventions r/t this focus included Vital signs ordered and Administer medications as ordered.</p> <p>An interview was conducted with Staff G, Registered Nurse/Unit Manager (RN/UM), on 5/1/24 at 2:47 p.m., the staff member stated if the resident (#60) had an as needed (PRN) blood pressure medication with parameters and scheduled for every 8 hours (PRN), (the resident) should have blood pressures taken every 8 hours. The staff member reviewed Resident #60's Hydralazine order and stated yes staff should be taking blood pressures every 8 hours.</p> <p>Review of Resident #60's May MAR revealed the following order:</p> <p>- Hydralazine hydrochloride (HCL) 25 milligram (mg) - Give 25 mg by mouth every 8 hours as needed for Hypertension (HTN) related to essential (primary) hypertension, for systolic blood pressure (SBP) greater than 160. Ordered 8/31/23 and discontinued on 5/1/24 at 4:01 p.m.</p> <p>Review of the policy - Physician Orders, effective October 2021, revealed At the time each resident is admitted , the facility will have physician orders for their immediate care. physician orders will be dated and signed at next physician visit. The policy instructed staff to Confirm the accuracy of orders. Review orders daily in the Clinical meeting to confirm accuracy in transcription and identify errors of omission.</p> <p>The Regional Nurse Consultant reported the facility did not have a policy related to nursing documentation.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>37999</p> <p>Based on observations, record reviews, and interviews the facility failed to ensure medications were stored in a safe and secure manner and failed to ensure medications were discarded after manufacturer expiration date and failed to label medications with shortened shelf lives with open dates.</p> <p>Findings included:</p> <p>On 4/29/24 at 11:45 a.m., Resident #29 was observed with a bottle of eye drops, for the relief of redness of the eye due to minor eye irritant, on the over-bed table next to the resident's bed and on the bedside dresser was a bottle of nasal spray with a large green top. The resident stated the nasal spray did not work.</p> <p>Review of Resident #29's physician orders revealed an order for Fluticasone Propionate Nasal Suspension 50 microgram (mcg/act) - 1 spray in both nostrils one time a day for allergic rhinitis. The review did not reveal an order for any eye drops.</p> <p>Photographic evidence was obtained.</p> <p>On 4/30/24 at 9:51 a.m., Resident #60 was observed and interviewed in the resident room. The observation revealed on top of the bedside dresser was a large jar of 1% Silver Sulfadiazine cream with a medication on top of it containing a white cream. The Silver Sulfadiazine was labeled Prescription (RX) only. The resident reported not being able to say if (they) put the cream on rash by self.</p> <p>Review of Resident #60's April Medication Administration Record (MAR) revealed an order for Silvadene External Cream 1% - Apply to perineal area topically every shift for rash until resolved, ordered 4/6/24 and discontinued 4/26/24. Review of Resident #60's April Treatment Administration Record (TAR) revealed an order for Silvadene External Cream 1% - Apply to bilateral buttocks topically every shift for redness bilateral buttocks, ordered 12/12/22. The TAR showed Silvadene was applied to the resident's buttocks three times a day during April.</p> <p>On 5/2/24 at 10:02 a.m., the 200-hall medication cart was observed with Staff G, Registered Nurse/Unit Manager. The observation revealed the following:</p> <ul style="list-style-type: none"> - One round white tablet and one round pink tablet lying on the bottom of a drawer with boxes of eye drops. - Bottle of undated Latanoprost (Xalatan) 0.005% eye drops. The bottle has label to document open date. (According to https://medlineplus.gov/druginfo/meds/a697003.html#storage-conditions, accessed on 5/7/24 at 8:01 p.m., once opened Xalatan can be kept at room temperature for 6 weeks). - A container of disinfecting wipes stored in the same compartment of the bottom drawer as a bottle of Sodium Bicarbonate tablets which was sitting on top of a box of topical pain patches. <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- A Insulin Lispro Kwikpen labeled with no open date.</p> <p>- Novolog insulin pen labeled with no open date.</p> <p>- Levemir vial, not labeled with an open date. Pharmacy label showed the vial should be discarded in 42 days.</p> <p>Staff G observed the findings.</p> <p>On 5/2/24 at 10:38 a.m., the 400-hall medication cart was observed with Staff K, Licensed Practical Nurse. The observation revealed the following:</p> <p>- An undated open bottle of Liquid Protein. The label showed the bottle was to be discarded 3 months after opening.</p> <p>- A vial of Novolog insulin, opened on 3/16/24. The pharmacy label instructed Discard after 28 days. Review of calendar revealed the vial should have been discarded 4/13/24, 19 days prior to the observation.</p> <p>- A vial of Insulin Glargine, opened on 3/21/24. The pharmacy label instructed Discard after 28 days. Review of calendar revealed the vial should have been discarded 4/18/24, 14 days prior to the observation.</p> <p>- An undated open vial of Lantus insulin. The pharmacy label instructed Discard after 28 days.</p> <p>Staff K confirmed the findings.</p> <p>Photographic evidence was obtained of the medication carts and resident findings.</p> <p>The policy - Medication Storage, effective 09/18, revealed Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.</p> <p>4. Internally administered medications are stored separately from medications used externally such as lotions, creams, ointments, and suppositories.</p> <p>12. Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used. The opened insulin file may be stored in refrigerator or at room temperature. Opened insulin pens must be stored at room temperature. Do not freeze insulin. If insulin has been frozen, do not use.</p> <p>14. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to two procedures for medication disposal and reordered from the pharmacy, if a current order exists.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>16. Medication storage conditions are monitored on a regular basis as a random quality assurance (QA) check. As problems are identified, recommendations are made for corrective action to be taken.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46498</p> <p>Based on observations, interviews and policy review the facility failed to ensure a clean and sanitary kitchen on three of three observations regarding areas that were not clean or were in disrepair.</p> <p>Finding included</p> <p>During an observation on 4/29/2024 at 11:00 a.m. showed on an initial tour in the kitchen a dirty trash can next to the hand washing station. Food trays were observed piled up on kitchen sink, next to the hand washing station during meal preparation. Dirt and food particles were observed on the walk-in refrigerator floor.</p> <p>During a follow-up kitchen visit on 04/31/2024 at 11:00 a.m., showed the kitchen stove dirty with grease stuck on the side of the stove and missing stove knobs covers. An open garbage can was observed next to cooked food on the stove. The kitchen floor was observed dirty multiple times throughout the survey.</p> <p>During an interview on 5/3/2024 at 2:00 p.m., with the Certified Dietary Manager, CDM. She stated that there are areas in the kitchen that need to be cleaned up. She has tried to clean the walk-in refrigerator floor, but it is very hard to clean that type of floor. She agrees that the stove should be cleaner than what it looks like right now.</p> <p>During an interview on 5/3/2024 at 2:00 p.m., with the Nursing Home Administrator. She stated she has spoken with CDM multiple times about the cleanliness of the kitchen. The way the kitchen was presented is not acceptable and her expectations are that her kitchen remains clean.</p> <p>Review of the facility policy titled, Cleaning and Sanitation Effective date September 2012, showed the facility promotes a clean and sanitary environment for its employees, residents, and visitors. The entire Food and Nutrition Service team maintains clean and sanitary kitchen facilities and equipment walls, floors, ceiling, equipment, and utensils are clean, sanitized and in good working order.</p> <p>7. Follow appropriate procedures for washing and sanitizing kitchen equipment.</p> <p>12. Cover trash cans with lids while in the kitchen and/or when taken out to dumpster.</p> <p>Photographic evidence obtained.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441</p> <p>Based on observations, interviews and record review the facility failed to ensure medication was administered in a clean manner, ensure staff doffed PPE (personal protective equipment) appropriately, and residents were offered hand hygiene prior to meals.</p> <p>Findings included:</p> <p>On 4/30/24 at 11:00 a.m., an observation was made of the main dining area prior to lunch service of residents self-propelling with their arms to dining tables. Staff were present waiting for lunch tray delivery and/or bringing residents to the dining area.</p> <p>Residents were not offered hand hygiene prior to the delivery of lunch.</p> <p>The Activities Director was witnessed washing a resident's hands with a wet paper towel and then sitting next to this resident to assist with feeding.</p> <p>On 5/01/23 at 1:38 p.m., an observation was made during incontinence care of two Certified Nursing Assistants (CNAs) and a resident on Enhanced Precaution Isolation. Both CNAs were wearing appropriate personal protective equipment (PPE) during the care provided to the resident. The resident was turned to his left side with the assistance of Staff C, CNA while Staff D, CNA was in the process of cleaning the resident and changing the linen. Staff D, CNA with the same PPE still on rummaged through the resident's closet stating she was looking for a sheet. Unable to locate what she was looking for, Staff D, CNA walked out of the room with the same gloves and gown used while providing care and walked across the hallway to the locked linen closet pressing numbers on the code box to obtain access into the closet. Numerous attempts were made at accessing the linen closet via the locked keypad system. Unable to access the closet, Staff D, CNA returned to the resident's room. Staff C, CNA rolled the resident to his back, removed the PPE appropriately and gathered the sheet in the linen closet. Staff C, CNA donned new PPE and returned to assist Staff D, CNA to complete the care provided to the resident. Staff D, CNA removed the PPE she was wearing and left the room with dirty linen in a bag. Staff A, Registered Nurse/Unit Manager was notified of the incident and stated, She knows better than that, I will talk to her. Staff A, RN/UM was seen cleaning the keypad to the linen closet.</p> <p>On 5/01/24 at 9:30 a.m., an observation was made of Staff E, RN during medication administration. Staff E, RN was observed pulling medication administration cards for the resident but did not punch the tablet into a medicine cup but instead popped the medication in his hand to then dropped the pill into the cup. When questioned regarding the cleanliness of this process, Staff E, RN stated he uses the alcohol based hand rub (ABHR) in between each medication. This process was not witnessed consistently and Staff E, RN was witnessed opening and closing medication drawers as well as touching medication cards.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/02/24 at 8:18 a.m., an observation was made of Staff F, RN during medication administration. Staff F, RN was observed dropping a pill onto the medication cart and placed it back into the medicine cup. During medication administration of a resident, Staff F, RN attempted to give all eleven pills at once to a resident. Resident was unable to take all at once and pills were witnessed dropping down the side to the resident onto her side by her hip in the bed. Staff F, RN rummaged through the bed, picked up loose pills with his ungloved hand and placed them in the resident's mouth to complete the medication administration for this resident.</p> <p>On 5/02/24 at 10:30 a.m., the Director of Nursing was aware of the infection control during medication administration.</p> <p>A review of the facility's policy titled: Medication Administration General Guidelines, Section 7.1 dated 09/18 shows their policy as: Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medications.</p> <p>.</p> <p>11. Hands are washed with soap and water and gloves applied before administration of topical, ophthalmic, optic, parenteral, enteral, rectal, and vaginal medications. Hands are washed with soap and water again after administration and with any resident contact. Antimicrobial sanitizer may be used in place of soap and water as allowed per state nursing regulations and facility policy. Note: soap and water should always be used after contact with residents with Clostridium difficile (C. Diff) as antimicrobial sanitizer does not kill the spores produced by C. Diff., which may result in the spread of the infection.</p> <p>37999</p> <p>An observation was conducted of meal service on 5/1/24 at 8:12 a.m., with Staff H and Staff I, Certified Nursing Assistant's (CNAs). The observation revealed the breakfast meal cart was delivered on 5/1/24 at 8:16 a.m. to hallway. The following was observed:</p> <ul style="list-style-type: none"> - 8:16 a.m., the breakfast cart arrived to the unit. - Staff H delivered a tray to room [ROOM NUMBER] A-bed without offering hand hygiene; - Staff H delivered a tray to room [ROOM NUMBER] A-bed, leaving the room without offering hand hygiene; - 8:22 a.m., Staff I delivered tray to Resident #60, who opened eyes and stretched, the staff member encouraged the resident to open eyes and not close eyes, leaving the room without offering hand hygiene. <p>During an interview with Resident #60 on 4/30/24 at 9:47 a.m., the resident stated the facility did not ask residents to wash hands before meals. Resident #60 was observed during the survey period eating meals in room and in the main Dining Room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Boca Ciega Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's policy and procedure titled with the Topic Hand Hygiene dated Effective February 2021 showed: Policy The facility considers hand hygiene the primary means to prevent the spread of infections Procedure: . 2. Personal shall follow the handwashing/hand hygiene guidelines to help prevent the spread of infections to other personnel, residents, and visitors. 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies.</p> <p>No other policy and procedure were received from the facility in regards to resident hand hygiene.</p>		