STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105293	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Egret Cove Center	550 62nd St S Saint Petersburg, FL 33707

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 22481 Based on observation, record review, and interview, the facility failed to have evidence of the provision of a summary of the baseline care plan to the resident and their representative for one (#12) of fourteen sampled residents. Findings included: On 10/17/2024 at 10:30 a.m., Resident #12 was observed in his bed with his eyes closed. An interview was conducted at this time with his spouse. Resident #12's spouse said she had not been able to receive communication about what the plan was for her husband, how long he was going to be at the facility, or what services they were going to provide to him. At approximately 10:40 a.m., Resident #12 was observed to be awake. He stated he wanted to understand the services that were to be provided to him during his stay and why he needed to be at the facility. A review of Resident #12's Admission Record reflected an admission of 10/11/2024. Resident #12's diagnosis list included Urinary Tract infection, Nontoxic Multinodular goiter, and occlusion and stenosis of unspecified carotid artery. On 10/18/2024 at approximately 8:45 a.m., the Nursing Home Administrator was requested to provide a copy of Resident #12's Baseline Care Plan. On 10/18/2024 at approximately 10:45 a.m., the Director of Nursing was requested to provide a copy of the Baseline Care Plan for Resident #12 with evidence of the provision of the baseline care plan to the resident and resident's representative. On 10/18/2024 at approximately 11:12 a.m., the Traveling Minimum Data Set (MDS) Coordinator was requested to provide a copy of Resident #12's Baseline Care Plan and the parties who signed the plan. No evidence was provided during the survey to support Resident #12 and his representative had received a summary of the Baseline Care Plan.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 22481

Based on observation, record review, and interview, the facility failed to develop and/or implement a comprehensive person-centered care plan for four (#7, #8, #9, and #11) of fourteen sampled residents.

Findings included:

1. On 10/17/2024 at 9:35 a.m., Resident #7 was observed in bed. He was observed curled in a fetal like position, his arm was wrapped in his leg, watching the television. He was observed to have severe contractures, and dry lips.

When asked if staff put moisture product on his lips, he shook his head. When asked if he was provided pleasure foods by mouth, he stated sometimes. When asked if he was allowed to have water by mouth, he said, sometimes. He stated he would like water. He said his arm was stuck.

When asked if he could use his call bell light. the resident did not answer but turned his head towards the feeding tube pole. An observation was conducted of Resident #7's call bell light laying on the floor at the bottom of the tube feeding pole. Resident #7's breakfast meal tray, untouched, was observed to be positioned on the sink counter. Photographic evidence obtained.

A review of Resident #7's Admission Record documented an original admission in 08/2023, and a re-admission on 09/18/2024. A review of Resident #7's diagnosis information included, but not limited to: Muscle wasting and atrophy, muscle weakness, Dysphagia, and Spinal Stenosis.

A review of Resident #7's Care Plan on 10/18/2024 reflected no plan of care for contractures.

A review of Resident #7's Care Plan reflected a focus: Nutritional: [Resident #7] has a nutritional problem or potential nutritional problem r/t needed for TF (tube feeding) support to assist with wound healing and meeting ntr (nutritional) needs, initiated on 10/17/2024.

Interventions included:

Provide [Resident #7] with TF using Jevity at 80 ml (milliliter)/h (hour) over 10 h infusion .Also with PO (by mouth) intake during waking hours along with supplement using Medpass 240 ml BID (two times a day) to assist in meeting nutritional needs, initiated 10/17/2024.

Resident is NPO (nothing by mouth)-Do not provide food or fluids by mouth. See nurse, initiated 09/19/2024.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 10/18/2024 at 11:02 a.m. with the Rehabilitation Director, PTA (Physical Therapist Assistant). Regarding Resident#7, he stated the resident was a recent admission, the resident was on case load. When asked if the aids did anything for the resident's contractures, he stated, Not right now. He is super sensitive, and we want to keep his care with us for a while. When asked how the aids provided the resident incontinence care, he stated, Unroll him, the aids have been able to provide him incontinence care; it is work in progress. An interview was conducted on 10/18/2024 at 11:12 a.m. with the Traveling Minimum Data Set (MDS) Coordinator. When asked if Resident #7 had contractures, she stated, I would have to look. She confirmed Resident #7 did not have a Care Plan Focus area for contractures. When asked about Resident #7's feeding status, she stated, He was NPO when he readmitted on [DATE]. The order was discontinued on 09/30/2024. At that point a regular puree diet came into play on 09/30/2024. For meals, he would get the normal 3 meals per day. He would continue to get the peg tube feeding also. She confirmed the Nutrition Care Plan interventions were not current. An observation of Resident #7 was conducted on 10/18/2024 at 11:35 a.m. with the Traveling MDS Coordinator. She confirmed the resident had contractures. Resident was observed to have beads of sweat on his shoulders. Resident#7's call bell light was observed on top of the tube feeding machine. Resident was observed to be unclothed, on a specialized mattress. He said he was hot, burning up. During the observation at 11:37 a.m., Staff A, Personal Care Attendant (PCA) was observed to come in the room with a cup of water. She stated she was going to provide water to the resident. Staff A was asked if Resident #7 could use the push button call bell light. Staff A stated the resident could. She was observed to remove the call light from the top of the tube feeding machine and put it close to the resident's hand. She said the nurse had just put the cord up there a minute ago. For meal assistance: On 10/18/2024 at approximately 8:45 a.m., the NHA was requested to provide a printout of Resident #7's meal consumption for the last 30 days. On 10/18/2024, the list was provided. A review of Resident #7's meal intake documentation from 09/19/2024 thru 10/17/2024, documented from 09/19/2024 through 09/28/2024, the resident was NPO, or Tube fed. The following entries were documented or not documented by staff after 09/28/2024. 09/29 8:00 a.m., Resident consumed 76-100%. 09/29 11:00 a.m., Resident consumed 76-100%. 09/29 evening, No documentation. 09/30 No documentation. 10/01 morning, No documentation. 10/01 noon, No documentation. 10/01 18:03 (6:03 p.m.), Resident consumed 0-25% (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/02 8:00 a.m., Resident consumed 76-100% 10/02 11:30 a.m., Resident consumed 76-100%. 10/02 evening, No documentation. 10/03 morning, No documentation. 10/03 14:20 (2:20 p.m.), Resident consumed 76-100%. 10/03 22:38 (10:38 p.m.), Resident consumed 76-100%. 10/04 morning, No documentation. 10/04 14:35 (2:35 p.m.) Resident consumed 0-25% 10/05 9:35 a.m., Resident consumed 76-100%. 10/05 noon, No documentation. 10/05 evening, No documentation. 10/06 8:00 a.m., Resident consumed 76-100%. 10/06 11:30 a.m., Resident consumed 76-100%. 10/06 18:40. (6:40 p.m.), Resident consumed 76-100%. 10/07 8:00 a.m., Resident consumed 76-100%. 10/07 11:30 a.m., Resident consumed 0-25%. 10/07 22:08 (10:08 p.m.), Resident consumed 0-25%. 10/08, morning and noon, No documentation. 10/08 22:26 (10:26 p.m.). Resident consumed 76-100%. 10/09 morning and noon, No documentation. 10/09 21:40 (9:40 p.m.) resident refused. 10/10 through 10/14, No documentation. 10/15 8:00 a.m. and 11:30 a.m., resident refused. 10/15 20:12 (8:12 p.m.), Resident consumed 0-25%. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/16 10:28, Resident consumed 0-25%. 10/16 13:32 (1:32 p.m.), Resident consumed 76-100% 10/16 19:28 (7:28 p.m.), Resident consumed 76-100% 10/17 morning, No documentation. 10/17 12:24, Resident consumed 51-75% 10/17 12:27, Resident consumed 26-50% 10/17 evening, No documentation. Days reviewed, 09/29 through 10/17=19 days. Meal opportunities=19 x 3 = 57 meals 23 meals were documented to be offered. 34 meals had no documentation of being offered. A tour of the facility was initiated on 10/17/2024 at 9:32 a.m. The following observations were conducted during the tour. 2. On 10/17/2024 at 10:06 a.m., an observation was conducted of Resident #8, laying in her bed. She confirmed she could use the call bell light, but she could not reach it. Her call bell light cord was observed looped over the bed's right-side rail with the call light button hanging down to the bottom of the side rail. The bed was observed to have padding on the side rail which would prevent access to the call bell light cord. A review of Resident #8's clinical record, the Admission Record, reflected a re-admission of 06/10/2024. Her diagnosis list included but not limited to: Cerebral Infarction due to embolism of other cerebral artery, chronic obstructive pulmonary disease, and Dysphagia. A review of Resident #8's Care Plan, listed a focus area, Fall: [Resident #8] has had a fall because of history of falls . Interventions included: Provide environmental adaptions: Call light, frequently used items within reach . initiated 12/11/2022, updated 01/08/2023. 3. In the same room, Resident #9, was observed laying in her bed, eyes open, greeted the surveyor. The call light cord and button were observed on the floor. A review of Resident #9's clinical record, the Admission Record, reflected an admission in 06/2023. Her diagnosis list included but not limited to: Hemiplegia and Hemiparesis following cerebral infarction affecting left non dominant side and need for assistance with personal care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #9's Care Plan, listed a focus area, Fall: [Resident #9] had a fall injury because of: Deconditioning, Gait/balance problems, medications, initiated 06/23/2023. Interventions included: Provide environmental adaptions: Call light within reach, initiated 06/29/2023. 4. On 10/17/2024 at 10:24 a.m., Resident #11 was observed in bed with his eyes closed. His call bell light cord and button were observed to be laying on the floor. A review of Resident #11's clinical record, the Admission Record, reflected a re-admission of 06/19/2023. Her diagnosis list included but not limited to: Unspecified Dementia, and muscle wasting. A review of Resident #11's Care Plan, listed a focus area, Fall: [Resident #11] is at risk for falls or fall related injuries d/t (due to) her dx (diagnosis) of dementia . Interventions included: Provide environmental adaptions: Call light within reach, initiated 01/04/2021. An interview was conducted on 10/18/2024 at approximately 10:45 a.m. with the Director of Nursing. She confirmed it was her expectation that the call bell light should be placed within reach of the resident, for every resident. She confirmed for a cognitively impaired resident it was important to be within reach. If they need help, they can call for help. Photographic evidence obtained. A review of the facility's Care Plan-Interdisciplinary Plan of Care from Interim to Meeting policy & procedure, effective February 2024, documented the 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 not limited to, monitoring resident condition, and responding with appropriate interventions. 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Based on interview and record review, the facility failed to provide a timely respiratory assessment and care in accordance with professional standards of practice for one (#2) of three sampled residents related to an assessment of a resident in distress. Findings included: Resident #2 was admitted on [DATE] and discharged on [DATE]. Review of the Admissions Record showed the diagnoses included but not limited to Chronic Obstructive Pulmonary Disease (COPD), acute and chronic respiratory failure with hypercapnia, dependent on oxygen, pleural effusion, pulmonary hypertension, Hypertension, and Asthma. Review of the admission Minimum Data Set (MDS) dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 15 or cognitively intact. Review of Section GG, Functional Abilities and Goals showed substantial to maximum assistance for bathing. Section O, Special Treatments, Procedures, and Programs showed C1. oxygen therapy. G1. Non-invasive mechanical ventilator was blank (BIPAP/ Bi-level positive airway pressure and CPAP/ Continuous positive airway pressure). Review of the Hospital Records 08/21/2024 to 08/27/2024 showed a progress note dated 08/27/2024 that the patient has had recurrent admissions for this. There is poor compliance at home. Reports no CPAP use with naps and minimal at night as she only wears for short periods as she stated does not sleep well at night. Wean oxygen to keep sats 89 or above and use BIPAP nightly which we will order here. Continue BIPAP at night. Would benefit at home. Discussed importance of home CPAP compliance with sleeping at night and daytime with naps. Review of the physician orders and August and September Medication Administration Record (MAR) and Treatment Administration Record (TAR) showed Resident #2's scheduled 09/15/2024 9:00 a.m. medications were given at 10:01 a.m. per the September MAR by Staff B, RN (Registered Nurse) Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML every 6 hours as needed was given on 09/15/2024 at 10:30 a.m. per the September MAR by Staff B, RN No physician orders for a CPAP machine were found in the physician orders or in the August or September TAR. Review of the nursing progress notes showed On 09/14/2024 at 5:40 p.m., Resident presented with shortness of breath (SOB) and elevated B/P (blood pressure). Physician's office was called to report patient's change in condition and new orders given for Clonidine 0.5mg (milligram) stat by mouth and routine daily and hold for Systolic blood pressure under 140. Blood pressure showed 171/98. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/15/2024, at 10:30 a.m., Ipratropium-Albuterol Solution 0.5-2.5 (3) MG (milligrams)/3ML (milliliter) give 1 inhalation by mouth every 6 hours as needed for SOB. On 09/15/2024 at 11:21 a.m., Hospital Transfer Evaluation Summary showed: BP 175/89 - 9/15/2024 10:19 a.m. Position: Lying right arm; Pulse 78 - 9/15/2024 10:30 a.m. Pulse Type: Regular; Respirations 32.0 - 9/15/2024 10:30 a.m.; O2 99.0 % - 9/15/2024 01:53 a.m. Method: Oxygen via Nasal Cannula; Report completed by Staff B, LPN and Report called in by Staff B, LPN; Report called in to: 911. On 09/15/2024, at 11:28 a.m., Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML give 1 inhalation by mouth every 6 hours as needed for SOB was ineffective, resident was sent to hospital, MD (Medical Doctor) notified. On 09/15/2024 at 1:25 p.m. Resident presented with high blood pressure, 175/89 and SOB. Resident was given blood pressure medication and PRN Albuterol solution via nebulizer, and inhaler that was scheduled by mouth. At this time resident was available to take medication by mouth, during the morning. Writer noticed that no medication was successful, that she needed medical attention, and resident was being sent to the hospital for further evaluation and treatment. Spouse was called with no answer back. MD from ER (emergency room) called to verify resident's spouse telephone number. Dr. does not have at this time a communication with spouse. No answer to MD telephone calls. On 09/15/2024 at 2:04 p.m. Resident MD was notified that resident was sent to the hospital. Review of the Weights and Vitals Summary showed Blood pressure On 09/09/2024 at 11:51 a.m. was 132/76 On 09/14/2024 at 5:40 p.m. was 171/98 On 09/14/2024 at 6:32 p.m. was 171/98 On 09/15/2024 at 10:19 a.m. was 175/89 Respirations On 09/15/2024 at 1:53 a.m. was 18 On 09/15/2024 at 10:30 a.m. was 32 On 09/15/2024 at 10:40 a.m. was 34 O2 saturation On 09/15/2024 at 1:53 a.m. was 99% On 09/15/2024 at 10:40 a.m. was 95% (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of care plans showed Resident #2 was on oxygen therapy related to COPD, pulmonary hypertension, pleural effusion, asthma revised on 09/09/2024. Interventions included but not limited to administer oxygen as ordered, report changes in respiratory status to physician. Resident #2 had an emphysema/COPD care plan revised on 09/09/2024. Interventions included but not limited to give aerosol or bronchodilators as ordered; Monitor/document any side effects and effectiveness. Give oxygen therapy as ordered by the physician; Monitor for difficulty breathing (dyspnea) on exertion.; monitor for signs and symptoms of respiratory insufficiency: anxiety, confusion, restlessness, SOB at rest, cyanosis, somnolence; monitor/document/report to MD prn any signs / symptoms of respiratory infection. During an interview on 10/17/2024 at 12:10 p.m. Staff A, PCA (Patient Care Assistant) stated, I was passing [Resident #2] her breakfast tray, it was around 7 [a.m.] something. She did not look her usual. Something was off. Staff A stated she walked in the room, she was breathing funny to me. Staff A stated she went to the supervisor, (Staff C, LPN / Weekend supervisor) and told her Resident #2 looked like something was wrong. Staff A stated Staff C brushed me off. Staff C told Staff A, the resident has a UTI. Staff A stated to Staff C, She looks funny can you come check on her? She (Staff C) brushed me off. Staff A stated she finished passing the trays. Staff A went back to check on the resident and she was still the same. Staff A stated it was about 20 minutes later that she checked on Resident #2. Staff A stated, She was still breathing funny, not too good. Her oxygen was on. She was gasping. Staff A stated she went back to Staff C and told her again. Staff A asked Staff C, Can you please check on her, I think something is wrong. She told me, you need to worry about your residents. She is not yours. Worry about your hallway, do what you need to do. Staff A stated, Once that happen, I went and got Staff B, RN (Registered Nurse), she was the nurse that was on my hallway, 200 hallway. Staff A asked Staff B, Can you go check on 18? I told her the same story, something is off. Gasping for air. Staff B went in and told Staff C something was wrong. Staff C had been sitting at the nursing station the whole time. She was still sitting there. Staff A stated, Staff B took charge of the resident. Staff A stated that Staff B told her that the resident needed to be sent out. Staff A, stated, Staff C did not budge until the family got here. Staff A, PCA stated Staff C, LPN made up a story to the family and told them that she had told the other nurse (Staff B) the resident needed to go out. Staff A stated that Staff C did not do anything, she did not leave the desk. Staff B took charge, from another hallway. Staff B told Staff A she would take care of it. Staff A stated she saw the EMS and family in the room. The DON asked Staff A, PCT about what happened the next day and I told them the same thing I told you. Staff A stated, I believe Staff B, RN told the DON. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/18/2024 at 9:57 a.m. with Staff B, Registered Nurse (RN), she stated she was the nurse caring for Resident #2 on 09/15/2024. She stated she performed rounds around 7 a.m. Resident #2 was alert and responding at that time. Staff B stated the resident took her morning medications that morning, but she did not remember the exact time. Staff B stated Resident #2's vital signs were normal. The resident's family was not there when she took the resident's medications in. Staff B stated the family was there when she went back to check on the resident and give her a nebulizer treatment. Staff B stated she was waiting for a change (after the nebulizer treatment), but no change occurred, so she sent the resident to the hospital. Staff B stated the resident was not doing well on her second round. Staff B stated an aide told her the resident was not doing well. Staff B stated she did not remember who the aide was that day. Staff B stated that the resident, was not really gasping for air, not really. Staff B stated the resident needed the nebulizer and then she called the doctor. The doctor said to send the resident to the hospital. Staff B stated the resident was on her oxygen. Staff B stated she assessed the resident the first time (she made rounds), took her vital signs at the time she gave the resident her regular medications (10:01 a.m. based on MAR). Staff B stated before the medications were given, she checked the vitals. Staff B stated the resident was breathing okay when she gave her the medications. Staff B stated the aide told her the resident was not feeling well and Staff B stated she, went back again. Staff B stated, when I made the decision to send to hospital, send her to hospital. Staff B stated that Staff C, LPN (Licensed Practical Nurse / Weekend Supervisor) was sitting at the nursing station when she reported she was sending Resident #2 to the hospital. Staff B stated that Staff C was not at the reception desk (out front). Staff B stated she does not know if the aide spoke with Staff C, LPN or not. Staff B stated Staff A, PCA came and got her. Staff B stated the DON (Director of Nursing) did not talk to her about the incident. Staff B stated we gave a report to the DON that day, we do when we send someone to the hospital. Staff B stated she did not remember the resident's vital signs. Staff B stated the resident was her normal color and not gasping. Staff B stated the resident had COPD or asthma. Staff B stated the resident's family member came in after her morning medications were given. Staff B stated when she went back to give the nebulizer, the family member was there. Staff B stated during the nebulizer treatment two other family members came in. The second family members asked if I was going to send the resident to the hospital, and I said, Yes, going to call 911. Staff B stated she notified the doctor that she was sending the resident to the hospital. Staff B stated she went in to see the resident around 7:30 a.m. and she was in bed. Staff B stated, Do not recall what she looked like, had her a couple of time before, not really changed from prior. Staff B stated when giving the resident her meds, she was ok, gave them in pudding, ok. Staff B stated, She was declined that morning. She had a couple of words, yes or no. Staff B stated, at 7:30 a.m. she was fine, At approximately 9 a.m. I noticed she was in a little distressed, a family member was feeding her, gave her a breathing treatment. Staff B stated, I am a nurse. I know when my resident has a change in condition. She had an increased respiration rate, no sounds. Breathing not well. Staff B stated an aide [Staff A] came and told her So and so does not look good, I went back and gave her a nebulizer. Staff B stated she did not remember if the resident was on the aide's assignment or not. Staff B stated, I made my first rounds and gave the 9 a.m. meds. The aide came and got me and assessed her and she needed a nebulizer treatment. Staff B stated, I don't remember or know if the aide talked to Staff C LPN about the resident, only what I did. Staff B stated Staff C helped with the paperwork. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER: Egret Cove Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 550 62nd St S, Saint Petersburg, FL 33707	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 4:28 p.m., Staff C LPN / Weekend Supervisor stated she had never been Resident #2's nurse. Staff C stated, The nurse, cannot remember who it was, reported to me if they are going to send someone out. She was not looking good. Her O2 sats were low. She (Staff B) did not tell me the number. I said, fine, it was a nurse judgment. We started the paperwork; I usually print the paperwork off and help them out. Staff C, stated, I then reported to the DON, we sent her out. When I went to the nursing station, the nurse was already in the process. I don't know who it was, just who had her that day as the nurse. Staff C, stated, I was sitting up front in the reception area; we don't have a receptionist on the weekend. I do know earlier the family came in. I cannot even tell you the time frame. Activities usually comes in about 11 and it was before then. Staff C stated, If the nurse asks me to come in (the room), I will. I cannot recall if I went into the (resident's) room. The nurse came to the reception area and told me she needed to send her out. Only thing I remember is the family came to the reception and said they wanted to send her out. The family met me in the hallway, they were irate. Staff C stated, the family stated, We want her to go out, out now. It went very fast. I jumped up and assisted my nurse, it went so fast. Assisted the nurse by getting the paperwork. The nurse did tell me she was sending her out because she was having problem breathing. EMS came in, I did not let EMS in. Staff C stated she was at the south hall nursing station. Staff C stated, If someone is having problems with breathing or doesn't look right. Normally take the vital, O2 sats. Staff C stated if the resident was in distress, and had no oxygen on, would apply, call the MD and let them know. If the resident had COPD, the protocol would be to give a breathing treatment, if needed. Staff C stated, If having distress, give immediate care. Make sure they are breathing, airway is open. Staff C stated her expectation was for an assessment to be done and documented and if they report to her as the manager. Staff C stated, My nurse should have done an assessment, especially that nurse. She is not a brand-new nurse. If she reports to me not looking good, I assume she has already done the protocol of vitals, oxygen, call MD, pulse ox. I am the last call; I help to send resident out to hospital. Staff C, LPN stated, I don't recall. (anyone asking her about the incident). Staff C stated, When I called the DON, she asks me why. I told her. The next day, I don't remember writing a statement about the day. During an interview on 10/17/2024 at 2:00 p.m. the DON verified that Staff B, RN was assigned to Resident #2 on 09/15/2024. She also verified Staff C, LPN weekend supervisor was the charge nurse that day. During an interview on 10/17/2024 at 3:45 p.m. the DON stated they were unable to locate the admitting chart (chart with the hospital admission paperwork). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/18/2024 at 10:30 a.m. the DON stated Staff C, LPN / weekend supervisor calls when someone goes out on the weekend. The DON stated they had to send the resident out. The DON stated that Staff C told her The aide came and got me and said she (Resident #2) does not look good. The DON stated that Staff C told her, She [Staff C] assessed the resident and went and got Staff B, RN and they went in and assessed the resident together and agreed the resident needed to go out. The DON stated she did not know the time of the incident. The DON stated, I spoke with Staff B the next time she worked, Staff B told me 'When the aide got me, as soon as she got to the room, she knew she was in distress'. The DON stated Staff B got vitals; she did tell me her O2. The DON stated she did not remember what it was. The O2 was low, and they decided to get her out. The DON stated during the first conversation with Staff C, she explained that the family was in the room at the time. Staff C informed me Staff B and her [Staff C] both assessed the resident. DON stated, I don't know if Staff C went in first and then Staff B or what, I know they both assessed the resident. The DON stated she did not speak with the aide. The DON stated she knew now who the aide was, but not then. The DON stated, That is all I know; the resident was in distress and sent her out 911. Good call on the CNA. The DON stated, They review the chart on hospitalization s in the clinical meetings. When someone is transferred out, we have a clinical meeting the next day. If it was Saturday, it would have been discussed on Monday. Neither of the nurses involved were involved in the discussions. The weekly Unit Manager was involved. I remember when we reviewed the chart, they tried to call the husband at the time of the event, but was unable to get a hold of him, per the chart. The DON stated that an event was not documented. The DON stated, I did speak with Staff C and Staff B but did not write it down. The DON stated the family did not complain to her. The DON stated, Staff B and Staff C did not say they (the family) complained to them about her (the resident). The DON stated she had a spouse which came to the care planning meetings and another family member. The DON stated they found during an informal investigation they did the right thing. Her vitals were irregular. The DON stated, Just went by what Staff C and Staff B said, not the aide. The DON stated she would have to go see if they had orders for the CPAP machine and if it had been ordered. The DON stated, she can only go by what was told to her. During an interview on 10/18/2024 at 11:45 a.m. Staff E, Traveling MDS stated that Non-invasive Mechanical Ventilator under section O included BPAP and CPAP machines on this MDS due to the type of payor source. If the resident was Medicare, it would be more specific and include BPAP and / or CPAP. If ordered would be in the physician's orders and signed off on the TAR as performed. Staff E stated you would see on the TAR and check it off that way. Staff E reviewed TAR and verified she did not see an order for a BIPAP or CPAP for August and September 2024. During an interview on 10/18/2024 at 11:00 a.m. the DON stated on 10/18/2024 at 11:00 a.m. the facility had to call the hospital for the medication discharge report for the 08/27/2024 admission. They were unable to locate them in the facility. During an interview on 10/18/2024 at 11:52 a.m. the DON stated a CPAP was ordered on 08/29/2024. The DON stated Resident #2 was the only one admitted around that time, so it must be hers. The spreads sheet did not show it was specifically for that resident. The DON stated she had not looked to see if there was an order written for the CPAP. The DON stated she did not go into the resident's room to see if the equipment arrived. The DON stated it must have been sent back. During an interview on 10/18/2024 at 1:05 p.m. the DON verified the MAR showed the 09/15/2024 meds were given at 10:01 a.m. by the nurse (Staff B) and the nebulizer was given at 10:30 a.m. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/18/2024 at 2:00 p.m. the DON stated, Her expectation was for the nurse to assess the resident, get the resident out 911. The DON stated when we call 911, the nurse available gave EMS report. They send the face sheet, order summary, Do Not Resuscitate order, and transfer orders (with the resident). They follow-up with the hospital afterwards to get the admitting diagnosis. The DON stated someone did the paperwork, someone called the doctor, and someone would take care of the resident. Vital signs and a head-to-toe assessment were done. The nurses called the DON if she was not here. She stated all shifts called her. The next day they did the clinical meeting. Review of the facility's policy, Physician Orders, dated October 2021 showed 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. 16. The night shift nurses will verify orders received within the last 24 hours have been transcribed into the electronic record. The nurse will review each hard chart for new orders and compare to the electronic order listing report to ensure each written order has been entered into the electronic medical record. Review of the facility's policy, Care Plan - Interdisciplinary Plan of Care from Interim to Meeting, dated February 2024 showed 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 resident condition, and responding with appropriate interventions. 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 revised periodically, and the services provided or arranged are consistent with each resident's written plan of care. 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. Managing risk factors to the extent possible or indicating the limits of such interventions.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 22481 Based on observation, record review, and interview, the facility failed to ensure the clinical record contained documentation of the services provided for meal consumption for one (#7) of fourteen sampled residents. Findings included: 1. On 10/17/2024 at 9:35 a.m., Resident #7 was observed in bed. He was observed to have severe contractions, curled in a fetal like position. Resident #7 was able to answer questions. When asked if he was provided pleasure foods by mouth, he stated sometimes. When asked if he was allowed to have water by mouth, he said, sometimes. He stated he would like water. Resident #7's breakfast meal tray was observed to be positioned on the sink counter. The meal tray was observed to be untouched. A review of Resident #7's Admission Record documented an original admission in 08/2023, and a re-admission on 09/18/2024. Resident #7's diagnosis information included, but not limited to: Muscle wasting and atrophy, muscle weakness, Dysphagia, and Spinal Stenosis. A review of Resident #7's Care Plan reflected a focus: Nutritional: [Resident #7] has a nutritional problem or potential nutritional problem r/t needed for TF (tube feeding) support to assist with wound healing and meeting ntr (nutritional) needs, initiated on 10/17/2024. Interventions included: Provide (Resident #7 with TF using Jevity at 80 ml (milliliter)/h (hour) over 10 h infusion .Also with PO (by mouth) intake during waking hours along with supplement using Medpass 240 ml BID (two times a day) to assist in meeting nutritional needs, initiated 10/17/2024. Resident is NPO (nothing by mouth)-Do not provide food or fluids by mouth. See nurse, initiated 09/19/2024. On 10/18/2024 at approximately 8:45 a.m., the NHA was requested to provide a printout of Resident #7's meal consumption for the last 30 days. A review of Resident #7's meal intake documentation from 09/19/2024 thru 10/17/2024, documented from 09/19/2024 through 09/28/2024, the resident was NPO, or Tube fed. The following meal consumptions were not documented by staff after 09/28/2024. 09/29, evening, No documentation. 09/30, No documentation. 10/01, morning, No documentation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/01, noon, No documentation. 10/02, evening, No documentation. 10/03, morning, No documentation. 10/04, morning, No documentation. 10/05, noon, No documentation. 10/05, evening, No documentation. 10/08, morning and noon, No documentation. 10/09, morning and noon, No documentation. 10/10 through 10/14, No documentation. 10/17, morning, No documentation. 10/17, evening, No documentation. Days reviewed, 09/29 through 10/17=19 days. Meal opportunities=19 x 3 = 57 meals. 34 meals had no documentation of being offered. On 10/18/2024 at approximately 10:45 a.m. an interview was conducted with the Director of Nursing (DON). She stated for Resident #7 we were doing eat and tube feed. She confirmed the aides could feed Resident #7. Yes, the staff are supposed to document what the resident eats for the meal. She confirmed the aides should document a refusal of the meal also. A review of Resident #7's meal documentation was conducted with the DON. She confirmed the documentation for the last 30 days did not consistently document the offering of three meals a day for Resident #7. 34768

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 22481 Based on observation, and interview, the facility failed to ensure adequate placement of call assistance equipment to call for staff assistance for six (#7, #8, #9, #10, #11, and #13) of fourteen sampled residents. Findings include: A tour of the facility was initiated on 10/17/2024 at 9:32 a.m. The following observations were conducted during the tour. During an observation on 10/17/2024 at 9:35 a.m., Resident #7 was seen in bed with severe contractures of his arms and legs, curled in a fetal like position, and with his arm wrapped in his leg. He was observed watching television. Resident #7 was able to answer questions. When asked if he could use his call bell light. the resident did not answer but turned his head towards the feeding tube pole. An observation was conducted of Resident #7's call bell light laying on the floor at the bottom of the tube feeding pole. Photographic evidence obtained. Resident's call bell light was observed to be a push button type call bell that would require dexterity of the hand to hold and depress the button. On 10/17/2024 at 10:06 a.m., an observation was conducted of Resident #8, laying in her bed. She confirmed she could use the call bell light, but she could not reach it. Her call bell light cord was observed looped over the bed's right-side rail with the call light button hanging down to the bottom of the side rail. The bed was observed to have padding on the side rail which would prevent access to the call bell light cord. In the same room, Resident #9, was observed laying in her bed with her eyes open. She greeted the surveyor. The call light cord and button were observed on the floor. On 10/17/2024 at 10:15 a.m., an observation was conducted of Resident #10, in bed with his hand on his chest. He stated his chest hurt. His call bell light was observed wrapped around the bottom leg of his bed. On 10/17/2024 at approximately 10:17 a.m., an interview was conducted with Staff D, Licensed Practical Nurse (LPN). She was observed working at a medication cart outside of Resident #10's bedroom. She stated she had just provided Resident #10 with Tylenol. On 10/17/2024 at 10:24 a.m., Resident #11 was observed in bed with his eyes closed. His call bell light cord and button were observed to be laying on the floor. On 10/17/2024 at 10:45 a.m., Resident #13 was observed in bed, eyes closed. Observed his call bell light cord and button on the floor under a plastic hygiene bowl, at the foot of the tube feeding pole. An interview was conducted on 10/18/2024 at approximately 10:45 a.m. with the Director of Nursing. She confirmed it was her expectation that the call bell light should be placed within reach of the resident, for every resident. She confirmed for a cognitively impaired resident it was important to be within reach. If they need help, they can call for help.