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	05/16/2024

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

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223 Based on observation, interview, and record review, the facility failed to give the opportunity to choose urinal placement and length of the bed frame for one (Resident #104) of one resident sampled. An interview was conducted with Resident #104 on 5/13/2024 at 10:30 a.m. He stated he did not want the urinal on the over the bed table all of the time. He said he was able to smell the urine all the time, even when the urinal was empty. He said he had numerous conversations with personnel in the past. He stated there was not anywhere else for the urinal to be placed without having to call for assistance. He stated, They [the facility] doesn't have a place for the urinal and they don't listen, I have told them numerous times and continue to tell them, I don't like to eat with the urinal next to my tray. He stated he needed a longer bed due to his height, as his feet were always pressing on the footboard. He said the nurse told him nothing could be done and placed a pillow under his feet. On 5/13/2024 at 12:18 p.m. and 5/15/2024 at 8:30 a.m., Resident #104's urinal was on the over bed table with the meal tray and the resident's feet were pressed to the footboard. An interview was conducted with Staff L, Licensed Practical Nurse (LPN) on 5/13/2024 at 10:56 a.m. Staff L said nothing could be done with the length of the bed, [the nursing staff] just put a pillow underneath the feet to ensure no breakdown. An interview was conducted with Staff M, Certified Nursing Assistant (CNA) on 5/14/2024 at 1:25 p.m. She said she understood Resident #104 wanted the urinal placed on the over bed table, she was just not sure what the answer was. Staff M confirmed Resident #104's feet were on the footboard normally and again not sure what could be done. An interview was conducted with Staff J, CNA on 5/15/2024 at 2:32 p.m. Staff J confirmed Resident #104 had requested to have the urinal placed elsewhere although there was no other option, so we ended up leaving the urinal on the over bed table. Staff J, CNA stated the resident's bed was probably too short but did not know what to do about, as the nurse knew. An interview was conducted with Staff G, Registered Nurse (RN) on 5/15/2024 at 3:18 p.m. Staff G confirmed Resident #104's urinal on the over the bed tray and there was not really anywhere else to place it and the bed could be longer. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility grievance log revealed no grievances were filed for Resident #104, during the months of April and May 2024. An interview was conducted with the SSD (Social Service Director) on 5/15/2024 at 12:05 p.m. The SSD confirmed there were no grievances filed for Resident #104. The SSD stated the resident requests should be honored, if possible and care planned. An interview was conducted with the DON (Director of Nursing) on 5/16/2024 at 11:15 a.m. The DON stated she did not know the resident wanted a longer bed and urinal placement changed. The DON said she did not know why the resident's request was not facilitated. Review of Resident #104's Admission Record showed the resident was admitted on [DATE], with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, left foot drop, anxiety disorder, neuropathy unspecified, chronic kidney disease and other co-morbidities. Review of Minimum Data Set (MDS), Section C Cognitive Pattern, dated 4/20/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15/15, which meant the resident was cognitively intact. A policy for choices or accommodation of need was requested. No policies were produced at the time of the survey.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on record review, observation, and interview, the facility failed to ensure the comprehensive Minimum Data Set (MDS) assessment was accurately coded for two (Residents #24 and #17) of twenty-six sampled residents. Finding include: During an observation and interview on 05/13/24 at 10:45 a.m., Resident #24 was sitting up in his bed eating peanuts. He said his left hand was contracted. He said he wore a splint on his left hand, but staff had not assisted him with putting it on. He said sometimes he refused to put his splint on because it hurt his hand. Review of an Admission Record dated 05/15/2024 showed Resident # 24 was admitted to the facility on [DATE] with diagnoses to include but not limited to Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease Affecting Left Non- Dominant Side, Major Depressive Disorder, Recurrent, Unspecified, Bipolar Disorder, Unspecified. Review of the quarterly Minimum Data Set (MDS) dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. Further review of the MDS section GG for Functional Abilities and Goals showed section GG0115 coded to indicate Resident # 24 did not have any upper extremity impairment. During an interview on 05/16/2024 at 2:00 p.m. with Staff A, Registered Nurse/ Clinical Reimbursement Specialist, she stated the facility did not have a restorative therapy program at that time to assist with putting splints on residents with contractions. She said [Resident #24] had an upper extremity impairment due to left hemiparesis. Staff A stated, I should have identified this on his MDS assessment. This was a mistake on my part. During an interview on 05/16/2024 at 2:00 p.m. with the Director of Nurses (DON), she stated her expectations were that residents' MDS was coded accurately. Review of the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument, RAI showed If, the resident can perform all arm, hand, and leg motions on the right side, with smooth coordinated movements. They can perform grooming activities (e.g., brush their teeth, comb their hair) with their right upper extremity and are also able to pivot to their wheelchair with the assistance of one person. They are, however, unable to voluntarily move their left side (limited arm, hand, and leg motion), as they have a flaccid left hemiparesis from a prior stroke. Coding: GG0115A would be coded 1, upper-extremity impairment on one side. GG0115B would be coded 1, lower-extremity impairment on one side. Rationale: Impairment due to left hemiparesis affects both upper and lower extremities on one side. Even though this resident has limited ROM that impairs function on the left side, as indicated above, the resident can perform ROM fully on the right side. Even though there is impairment on one side, the facility should always attempt to provide the resident with assistive devices or physical assistance that allows the resident to be as independent as possible. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual On 5/13/2024 at 11:50 a.m., Resident #17 was observed in the north unit dining room with a bed sheet over the wheelchair. Resident #17 was sitting in the wheelchair, both legs bent and feet were resting on the seat cushion. Resident #17 did not respond to questions. An interview was conducted with Staff M, Certified Nursing Assistant (CNA) on 5/13/2024 at 11:54 a.m. Staff M stated Resident #17 sat like that all of the time. Staff M stated Resident #17 made it very clear if anything was needed. Resident #17 was originally admitted on [DATE] with a recent readmission of 6/7/2023 with diagnoses of Secondary Parkinsonism, psychosis, seizures, recurrent major depressive disorder, epilepsy, Bipolar disorder, Schizoaffective Disorder, Paranoid personality disorder, Hypertension and other co-morbidities. Review of Resident #17's chart showed a Pre-admission Screening and Resident Review (PASRR) Level II dated 6/4/2021. Review of Resident #17's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/9/2023 revealed Section A for PASRR not marked, indicating Resident #17 does not have a Level II PASRR, nor were Resident #17's conditions marked. Section E. Behavior revealed Resident #17 had no potential for psychosis (hallucinations, and delusions). During an interview on 5/16/2024 at 9:09 a.m. with Staff A, Registered Nurse/Clinical Reimbursement Director (CRD), She stated she was responsible for completing the MDS. Staff A verified the resident had a PASRR Level II and had one prior to the completion of the MDS and verified that the Level II PASRR section was inaccurately coded. During an interview on 5/16/2024 at 11:30 a.m. the Director of Nursing (DON) stated her expectation on accuracy of the MDS was important. Review of the facility Policy and Procedure titled: Resident Assessment Instrument: MDS Section Completion by Discipline, with an effective date of October 2023 revealed: Overview: The Interdisciplinary Team members participate in the Resident Assessment Instrument to assess each Resident's individual needs and strengths through an approach that assesses problems or conditions and collaboration on appropriate interventions to achieve a Resident's highest level of functioning possible and maintain their sense of individuality. Guidelines: 1. The resident assessment instrument will be coordinated by a registered nurse that signs and certifies the completion of the assessments. 2. Interdisciplinary Team members participating in the MDS completion process are responsible sign the MDS (physical signature or per electronic signature policy), designate their professional title and date the interview or MDS on date data was gathered on, enter the MDS data into the appropriate sections of the MDS software system and complete corresponding care plan updates, revisions, or reviews in a timely manner. 48223

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39866 Based on observation, interview, and record review, the facility failed to develop a care plan related to trauma informed care for one (Resident #103) out of 37 sampled residents. Findings included: Review of Resident #103's Admission Record revealed she was admitted to the facility on [DATE] from an acute care hospital. Her medical diagnoses included but were not limited to post traumatic stress disorder (PTSD), schizoaffective disorder, bipolar type, major depressive disorder, and adjustment disorder with anxiety. An interview was conducted on 05/13/24 at 3:40 p.m. with Resident #103. She confirmed she had PTSD but declined to give details about the PTSD. She gave permission to ask the staff and review her record related to the details. She said she saw psychiatry and psychology every week. She said they also gave her medication for it and she felt it helped. Review of Resident #103's physician orders showed an order with a start date of 4/5/24, without an end date, for Prazosin HCl Oral Capsule (Prazosin HCl). Give 3 mg by mouth at bedtime for PTSD related nightmares. Review of Resident #103's medical record did not show an assessment for PTSD. Review of Resident #103's Psychosocial History and assessment dated [DATE] showed .12. Trauma Informed Care 1. Has the resident ever been diagnosed with PTSD (Post Traumatic Stress Disorder), had a life altering event or life changing event? No. Review of Resident #103's Care plans did not reveal a care plan related to PTSD. Review of Resident #103's Psych note dated 5/10/2024 showed .She also acknowledges that a book that she likes to read has helped her understand her PTSD and other trauma. She denies any specific new appetite changes and agrees to maintain the current regimen and ongoing plan . An interview was conducted on 05/16/24 at 8:50 a.m. with the Director of Nursing (DON). She said she was not aware Resident #103 had PTSD until last night (5/15/24). She said there should be a care plan in place related to her PTSD. She said the resident did not come in with many diagnoses because she came from the streets. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 05/16/24 at 9:09 a.m. with Staff A, RN, Clinical Reimbursement Director. She said when the nurses did the admission assessment that triggered the baseline care plan, she confirmed the PTSD diagnosis was documented in Resident #103's chart. The Social Services Director completed a Psychosocial History and Assessment. PTSD should be identified in the assessment and from that assessment a trauma informed care plan should be developed to identify the resident's trigger. She said, it's a cumulative effort with social services, psych physician, and nursing but Resident #103 has been stable since she has been with us. She said, I have not spoken with the psych doctor about her PTSD. She reviewed Resident #103's care plans and confirmed she did not have a trauma informed care plan in place. Review of the facility's Trauma Informed Care, undated, revealed Policy: The facility will provide services for residents who have experienced mental or psychosocial adjustment difficulty, or who have a history of trauma or have diagnosis of post-traumatic stress disorder (PTSD). Purpose: To ensure that residents who are trauma survivors receive culturally sensitive, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223 Based on observation, interview, and record review, the facility failed to ensure the development, revision, and/or implementation of comprehensive care plans was completed for two (Resident #259 and #73) of six sampled residents. The findings include: Review of the Admission Record for Resident #73 revealed an admitted [DATE] and a recent admission of 3/16/2024 with diagnoses to include: end stage renal disease; heart failure; diabetes type 1; cachexia; hyperkalemia; protein-calorie malnutrition; muscle wasting and atrophy; and other co-morbidities. Review of the Minimum Data Set (MDS) from admitted d 3/18/2024, showed Resident #73 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated intact cognition. The MDS showed the resident had no identified moods or behaviors and was on hemodialysis. Review of Resident #73's Physician Order Summary dated 5/16/2024, showed an order for a 1500 cc Fluid Restriction Dietary to give 1200cc nursing to give up to 300cc/24hr 7-3 (120cc), 3-11 (120cc), 11-7 (60c) every shift Fluids to be given with medications, no water to be left at bedside order start date of 4/1/2024. Resident to have Dialysis on days: [Dialysis center name]: . catheter site: right chest: . bag meal/snack to go with resident to dialysis yes fluid restriction no order start date of 3/18/2024 and 3/24/2024. Review of Resident #73's Care Plan showed a focus area of: Elopement Risk: Resident is at risk for elopement dated 10/28/2022. Goals and interventions were also listed. Resident #73 had a focus are of: hemodialysis: The resident has renal failure and is on Hemodialysis Resident to have dialysis on days: [dialysis center name]: . catheter site: right chest: . bag meal/snack to go with resident to dialysis yes fluid restriction no date initiated 1/16/2024 and revised on 4/3/2024. Focus area of: Infection: Resident #73 has an infection Respiratory Infection Covid positive date initiated/revised 3/19/2024, with goals and interventions listed. An interview was conducted with Resident #73 on 5/14/2024 at 9:50 a.m Resident #73 stated he did receive a bag meal nor did have an elopement/wandering problem. Resident #73 continued to state he had not been on isolation for some time, he had been free of Covid for a long time. During an interview on 5/16/2024 at 11:35 a.m., Staff A, Registered Nurse (RN), Clinical Reimbursement Director (CRD) confirmed responsibility for updating and developing care plans along with the MDS for each resident. Staff A stated the care plan for Resident #73 should have been reviewed and revised at readmission, and it was not. Staff A, RN stated she would have to investigate the issue. On 5/14/2024 at 9:30 a.m., Resident #259 was observed lying in her bed with the covers over her waste. Resident #259's bed was in the high position, floor mats were not in place and the call light was not within reach. Resident #259 had an Enhanced Barrier Precaution Sign on the door to her room. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Admission Record for Resident #259 revealed an admitted [DATE] with diagnoses to include: history of falling; presence of right artificial hip joint; aftercare following joint replacement surgery; Schizophrenia; Anxiety Disorder; Other Genetic related Intellectual Disability; Malignant Neoplasm of Bladder; Methicillin Resistant Staphylococcus Aureus Infection (MRSA) and other co-morbidities. Review of the Medical Certification For Medicaid Long-Term Care Services and Patient Transfer Form - AHCA Form 5000-3008 dated 4/22/2024 signed by a physician revealed Resident #259 had MRSA, Candida auris (C. Auris), Extended Spectrum Beta-Lactamase (ESBL) in the urine, and a history of falls. Review of the Physician Progress note from the hospital dated 4/21/2024 revealed Resident #259 had recent right hip pain and fracture after a fall status post ORIF (open reduction and internal fixation) on 3/30/2024. Review of the MDS from Admission, dated 5/5/2024 revealed Resident #259 had a BIMS score of 9 out of 15, which indicated moderate cognitive impairment. Section J for Falls history showed: Resident #259 did not have any falls in the last 2-6 months prior to admission/entry or reentry and had not fallen with any fracture in the 6 months prior to admission/entry. Review of Resident #259's Treatment Administration Record dated April, 2024 showed a physician order for Contact Precautions for ESBL in the urine until 4/29/2024. Review of Resident #259's Order Summary Report with an active date of 5/16/2024 showed an order for Transmission Based Precautions Enhanced Barrier Precautions dated 4/23/2024. Review of Resident #259's Care Plan reveals a care plan with a focus of Fall: Resident #259 has had a fall because of: deconditioning, gait/balance problem. date initiated 5/7/2024. A focus of: Resident requires Enhanced Barrier Precautions related to: C. Auris date initiated: 5/5/2024. During an interview on 5/16/2024 at 11:35 a.m. Staff A stated the care plan for Resident #259 should have been developed on 4/24/2024 and revised as needed. Staff A, RN confirmed there was no fall care plan on admission nor was there an infection control care plan and there should have been. Review of the facility's policies and procedures with the Topic: Care Plan - Interdisciplinary (IDT) Plan of Care from Interim to Meeting dated effective February 2024. 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 resident condition, and responding with appropriate interventions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Procedure: . 2. Update to Care Plans: a. Ongoing updates to care plans are added by a member of the ID tea 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 completion of the admission, annual, significant change in assessment for other comprehensive assessment, and the associated care area assessments.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observation, record review, and interview, the facility failed to ensure Activities of Daily Living ADL grooming was provided for one (Resident # 101) out of eight residents sampled. Findings include: During observations made on 05/13/2024 at 10:30 a.m. and on 05/14/2024 at 3:00 p.m., Resident #101 was observed laying down in his bed with his call light within reach, dressed in his nightgown. He was observed with some missing teeth in his mouth and facial hair. The resident's room was observed well-lit and with a homelike environment. Review of Resident #101's Admission Record dated 05/16/2024 showed Resident #101 was admitted on [DATE] with diagnose to included but not limited to respiratory disorder in diseases classified elsewhere, other reduced mobility, and need for assistance with personal care. Review of a Minimum Data Set (MDS) dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 00 which indicated Resident 101 was unable to complete the interview. Review of a care plan focusing on Activity of Daily living (ADL) dated 2/27/24 and revised 5/16/24, showed Resident #101 had an ADL self-care Performance Deficit. Review of the care plan interventions showed no interventions related to the resident's hygiene. During an interview on 05/16/2024 at 12:00 p.m., with Staff J, Certified Nursing Assistant (CNA), Staff J said she did not shave Resident # 101 because he did not ask her to shave him. She stated she only provided the resident with shaving assistance when he asked her. During an interview on 05/16/2024 at 3:00 p.m., with the Director of Nursing (DON), she stated her expectation was that staff assisted their resident with personal hygiene care whether the resident asked for assistance or not, especially if the resident was not independent with care. If the resident was refusing care, the CNA should report the resident's refusal to their nurse so that the situation could be addressed. Review of the Certified Nursing Assistant (CNA) Job Description dated 07/01/2019 showed Essential Duties and Responsibilities (To be completed without harming or injuring the resident/patient, co-works, self, or others): Direct care responsibilities: Ensure resident's personal care needs are being met in accordance with the resident's/ patient's wishes. Shaves patients.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observation, record review, and interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice related to 1. transportation for coordination of care to their doctors' appointment for four (Residents # 209, #33, #7, and #58) out of 10 residents sampled and 2. application of a medication patch for one (Resident #81) of one sampled resident. Findings include: During an observation on 05/13/2024 at 10:00 a.m., Resident #209 was observed dressed in a nightgown, sitting in her wheelchair in her room. She was observed with soiled bandages on her right and left foot. Resident said she had been up since 9:00 a.m. this morning waiting to go to her appointment for her skin grafts on her feet. She said she had missed a couple of appointments already because transportation did not always show up to pick her up for her appointments. During an observation on 5/13/2024 at 1:00 p.m., Resident #209 was observed sitting in her room in her wheelchair, with signs of distress. She said she was very upset because she had been waiting for a long time to go to her doctor's appointment. She said she was told that transportation had not shown up again to transport her to her appointment. Resident # 209 began to cry as she explained that she felt like the facility was setting her back with her healing because she had not been able to go to her appointments because of transportation. Review of the admission record dated 05/16/2024, showed Resident #209 was admitted on [DATE] with diagnoses to include but not limited to encounter for other specified surgical aftercare, other abnormalities of gait and mobility, chronic kidney disease, unspecified, unspecified abdominal pain. Review of a Minimum Data Set, dated dated dated [DATE] showed a Brief Interview for Mental Status, (BIMS) score of 15 which indicated Resident #209 was cognitively intact. Review of the Medication Administration Record showed an order dated 5/13/2024 to follow-up with [name of physician] at 10:00 a.m. Further review showed the order was discontinued on 5/13/2024. Additional review of the medication record dated 5/13/2024 showed another order to follow up with [name of physician] at 1:15 p.m. During an interview on 05/13/2024 at 2:00 p.m. with Staff B, Unit Manager, he stated the resident's appointment was rescheduled because the transport did not pick Resident #209 up for her appointment. He said he would reschedule her doctor's appointment and transportation. Staff B said the resident's appointments and transportation were set up through her insurance company. (continued on next page)

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	05/16/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 9:26 a.m., in an interview with the Medical Records Manager, she stated Resident #209 missed her appointment on Monday, 5/13/2024, because she [Medical Records Manager] was unaware of the appointment and stated the appointment notification sheet was never handed to her. She looked through a binder titled Transportation 2023 to demonstrate no sheet was filled out for Resident #209 to go to her May 13th appointment. The Medical Records Manager was unaware of the new re-scheduled appointment for Resident #209 made for May 20th by Staff I, RN/UM. The Medical Records Manager stated Resident #209 would have missed her appointment for May 20th had this conversation not taken place, stating to arrange transportation efficiently, forty-eight-hour notice was needed. The Medical Records Manager stated the appointment notification sheet was never received for the May 20th appointment. During an interview on 05/16/2024 at 11:30 a.m. with the Nurse Practitioner, he stated Resident # 209 was admitted to the facility because of the wounds she had on her right and left foot. He said skin grafts were not always a guarantee for healing. If [Resident #209] did not make it to her appointments it could cause a delay in the healing of her wounds. On 5/14/24 at 12:00 p.m., an observation was made of Resident #33 being escorted past the nurses' station in her wheelchair by Staff F, Personal Care Attendant (PCA). Staff F stated to Staff G, Registered Nurse / Unit Manager (RN/UM) and Staff H, RN, Resident #33 did not get her CT (Computed Tomography) scan at the hospital because the facility did not provide the proper paperwork for Resident #33 to continue with the CT scan as ordered. Staff G, stated the paperwork was there but she would reschedule the CT scan appointment. On 5/15/24 at 9:26 a.m., an interview was conducted with the Medical Records Manager regarding arrangements for transportation. She stated she was responsible for setting up appointments and transportation for all the residents in the facility. The process for setting up appointments started with the nurses who placed the order(s) into the [electronic medical record software] and filled out the Appointment Notification Sheet [photographic evidence obtained] and either hand it to me or slid it under my office door if I am not in my office. The Medical Records Manager scheduled the appointment(s) and then called the resident's individual insurance company to arrange transportation. The Medical Records Manager stated transportation arrangements were not a major concern but if there was, a discussion would be made with the administration. She said, We will try to get insurance companies to cover the transport but sometimes we will have to rearrange appointments if transport is not covered. From there we will ask if the family can cover the cost, or as a last resort, whether the facility will cover the cost of transport. The Medical Records Manager was unaware of the reason Resident #33 missed her CT scan scheduled for yesterday, 5/14/2024, but stated the resident was rescheduled for this Thursday, 5/16/2024. The Medical Records Manager stated the resident missed her MRI (Magnetic Resonance Imaging) appointment scheduled for today, May 15, 2024, because she was unaware of this appointment and had not made any transportation arrangements. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medical Records Manager stated her process to communicate to the unit managers was as follows I complete the 'Appointment Notification Sheet' and make two copies, one for my binder and I place the second copy at the resident's nurses' station appointment binder. From there, the unit managers agree to look through the binder to see who had an appointment and review and send the copy of the 'Appointment Notification Sheet' with the resident and/or the resident accompanied by the PCA. I will also send an email and/or a text message to the Nursing Home Administrator, the Director of Nursing, the Unit Managers, staffing coordinator and the front desk of residents' appointments. The Medical Records Manager stated there was a morning meeting of the clinical team but she did not attend those meetings. On 5/15/24 at 10:14 a.m., an interview was conducted with the Director of Nursing (DON). She stated the current process for appointments and transportation started in January. The DON stated a sheet was filled out by the Medical Records Manager once an order was printed out for her by the unit managers. From there, the Medical Records Manager would arrange the appointment and transportation and document on the sheet or the actual printed order. The DON presented Resident #209's printed physician orders with notes made by the Medical Records Manager on the printed-out orders. When Resident #209 missed her appointment, calls were made to the transportation company listed on the printed physician orders. According to the DON, Staff I, RN/UM was unable to contact the transportation company from the number left on the printed physician order sheet. We could have easily paid for her way had we known she was in the process of missing her appointment. The DON stated she knew nothing of Resident #33 missing her MRI appointment today and her expectation was for her to be notified immediately to resolve the issue of a resident missing an appointment. The DON stated Staff I, RN/UM should have notified her of the situation but stated Staff I, RN/UM was used to doing things the old way in which the unit managers arranged the appointments. On 5/15/24 at 10:58 a.m., an interview was conducted with the Nursing Home Administrator (NHA) regarding appointments and transportation for the residents. The NHA stated had she known about the issues she would have arranged for another means of transport. She stated If they ask me, I would have paid for transportation, I'll get an Uber or taxi or we would use petty cash. The NHA stated the Medical Records Manager came to the morning meetings held every morning at 8:30 a.m. and informed the team of a resident's appointment(s) and/or we would get an email or text. If a resident missed an appointment, the expectation was the NHA and the physician were to be informed and a grievance should be submitted on behalf of the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 beginning at 11:37 a.m., an interview was conducted with Staff F, Personal Care Attendant (PCA) regarding transportation of residents for their appointments. Staff F stated she was informed of residents' appointments upon starting her shift. Staff F stated transportation was an issue getting to and from the residents' appointments. Staff F stated she was with Resident #33 yesterday when she could not continue with her CT appointment at a local hospital. Staff F stated she went with the resident and arrived at the appointment before 9:00 a.m. She said the hospital radiology department could not continue because they did not have the actual physician orders of what to scan and the reason for the scan. Staff F stated she attempted three times to call the facility unsuccessfully to have the physician orders faxed over to the hospital. The first call to the front desk went unanswered, the second call was answered by the front desk staff but went unanswered when transferred to the nurses' station. The third call went unanswered at the nurses' station. The hospital was willing to wait for the fax but transport arrangements were made by Staff F to return to the facility. Staff F stated, Transport can take hours and I thought I could time the planning for transport back to the facility and the resident could still get her scan without waiting all day. When transport showed up two hours later, we had to go without the scan getting done and the resident did not have anything to eat that day. Staff F continued with the interview and stated, Today, 5/15/2024, [Resident #7] missed his dental appointment because transportation did not show up. According to Staff F Resident #7 had a pick-up time between 9:10-9:40 a.m. and was waiting in the front lobby. At 10:00 a.m., Staff F stated she went to the nurses' station to inform the unit manager the resident had not been picked up. Staff F stated Staff G RN/UM stated, ok. Staff F stated when she followed up with the resident he wanted to wait in the lobby because he thought transportation was slow this morning. Staff F stated she returned to the nurses' station to inform Staff G the resident wanted to wait in the lobby but Staff G informed her transportation was not coming due to a flat tire. On 5/15/24 at 11:56 a.m., an interview was conducted with Staff G, RN/UM regarding transportation for residents to their appointments. Staff G stated orders were put into the [electronic medical record software] and I will make the appointments or really anyone can. I will print two copies of the order and pass one to the Medical Records Director to arrange transportation. I will create a task for the nursing staff to see so they will get the resident ready the day of the appointment. I will put the second copy into the appointment book and then [Medical Record Manager], will put the information for transport including the telephone contact, confirmation number and if an escort is needed. Staff G, RN/UM could not explain why Resident # 33 missed her CT scan yesterday stating, I got her an appointment for tomorrow for the CT and all the paperwork is there. Staff G stated she saw the order for the first time for the MRI yesterday and informed the Medical Record Manager. Staff G said she did not take the original order but the other unit manager did and stated, I did not know she had an appointment today. Staff G said the Assistant Director of Nursing (ADON) informed her of Resident #7 missing his dental appointment due to the transportation's flat tire and a rescheduled appointment was made for May 31, 2024. The resident was informed as well as his family. [photographic evidence obtained] On 5/15/24 at 2:00 p.m., an interview was conducted with Resident #58 who stated she will make her own transportation arrangements herself because she was tired of the long wait times and missing her appointments. She stated, I call my insurance company and make the arrangements and I never have a problem. Resident #58's roommate added she would arrange her own transportation as well because when the facility arranged for her appointment the transportation company refused to take her in her wheelchair with an extra oxygen tank. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures entitled, Transportation Services, effective date of February 2021 states the following statement: The facility will assist and/or provide resident/ patient transportation services when needed to ensure that each resident/ patient receives a complete continuum of services. 1. Enter outside appointments on a calendar 2. Obtain transportation preference as applicable from the resident patient, family, or legal representative. 3. Schedule transportation private or ambulance service as soon as the date and time of appointment is known. 4. Communicate date and time for which the transportation has been scheduled to the staff. 5. Assure resident /patient, family, or legal representative is notified of the appointment. 6. Assure resident /patient is up, dressed, and ready for the scheduled appointment. 2. Review of Resident #81's Admission Record revealed he was admitted to the facility on [DATE] from an acute care hospital. His medical diagnoses included but were not limited to respiratory disorders in disease classified elsewhere, lack of coordination, pneumonia, aphasia, dysphagia, and hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. An observation was conducted on 05/13/24 at 10:35 a.m. Resident #81 was observed in bed, his gastrostomy tube was connected to his enteral nutrition, the enteral nutrition pump was turned off, and his head of the bed was elevated. Resident #81 was observed to have a wet, weak cough. The resident said he did not know if his enteral nutrition pump should be on. An interview was conducted with the resident's family member, and he said he came often to visit. He said the resident had a build up of secretions and when he had his patch it brought the secretion's down by 80%. The family member looked at the patch and said the patch needed to be changed. The patch was observed not to be intact with the resident's skin on his neck and the patch was not labeled. The family member said the patch should be changed every 2 days and it should have a date on it. (Photographic evidence obtained) An observation was conducted on 05/13/24 at 3:06 p.m. Resident #81 was observed lying in bed, with his medication patch not intact and not labeled. The resident was alert, had a weak wet cough, and was not in any respiratory distress. An observation was conducted on 5/14/24 at 10:10 a.m. of Resident #81. He was observed in bed, alert, eyes open. There was a large basin with several paper towels on his bed next to him. He was observed to have a buildup of saliva in his mouth as he talked and said the basin was for all the secretion's he had in his mouth. His medication patch was observed not to be intact and was not labeled. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #81's physician orders revealed an order with a start date of 2/27/24 and no end date for Levsin Oral tablet 0.125 milligrams (MG), give 1 tablet via PEG-Tube every 8 hours for secretion's. Review of Resident #81's May medication administration record (MAR) revealed no documentation on 5/11/24 at 2:00 p. m. An order dated 4/11/24 with no end date revealed Scopolamine Patch 72 Hour Apply 1 patch transdermal every 72 hours for NAUSEA document the presence of the scopolamine Path every day and remove per schedule. Review of the MAR revealed no documentation on 5/11/24 that the patch was removed or applied as ordered and the last documented removal and applied date was signed off on 5/8/24. The May MAR also revealed Resident #81's patch placement was only documented on 5/2/24, 5/5/24, 5/8/24, and 5/14/24. There was no daily documentation on the presence of the Resident #81's patch. An observation was conducted on 05/15/24 at 8:56 a.m. of Resident #81. He was observed in bed, the head of the bed was elevated, and a basin was on his bed next to him. Staff B, South Unit Manager (UM) was observed in the room at the time of the observation. Staff B went out of Resident #81's room and reviewed Resident #81's MAR and Treatment Administration Record (TAR). He confirmed placement for a scopolamine patch had not come up for him and he was not sure if the resident had one on. He went into the residents room and confirmed the resident had the scopolamine patch on his right neck and it was dated 5/14/24. An interview was conducted on 05/16/24 at 8:53 a.m. with the Director of Nursing (DON). She said the staff called her around 8:0 a.m. to say the Internet was down on 5/11/24 but the staff should have documented medication administration on paper MAR's, but she needed to look into it. She confirmed medication patches should be intact, labeled, and monitored for placement every shift. No additional documentation related to Resident #81's scopolamine patch application was provided by the end of survey. Review of the facility's Transdermal Delivery System (Patches) Policy dated 05/16 revealed the following: Policy To administer medication through the skin by continuous absorption while the patch is in place and maintaining proper placement of the patch and care of the application site. .Procedures .9. Label patch with date and nurse's initials. 10. Apply new patch firmly against skin. Rotate sites in accordance with manufacturer's recommendations. Avoid extremities and hairy body areas. .13. Document placement site on MAR. For patches applied less frequently than daily, check placement and document that patch at least daily 48441 39866

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	105293	A. Building B. Wing	05/16/2024

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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** 39866 Based on observation, interview, and record review, the facility 1. failed to ensure a physician order was in place for the administration of oxygen for one (Resident #21) out of four residents reviewed for respiratory care, and 2. failed to ensure emergency tracheostomy supplies were readily available for one (Resident #97) out of one resident with a tracheostomy tube. Findings included: 1. An observation was conducted on 05/13/24 at 9:33 a.m. Resident #21 was observed in bed with her eyes closed, an oxygen concentrator was on and set to 1.5 liters per minute (LPM), the oxygen tubing observed to be behind the residents back and not on the resident. An observation was conducted on 05/13/24 at 3:30 p.m. Resident #21 was observed in bed with her eyes open, nasal cannula in her nose, an oxygen concentrator was on and set to 1.5 LPM. The resident said she wore oxygen for her chronic obstructive pulmonary disease (COPD) and she was supposed to be on 6 LPM. She said she had been asking since last week to get oxygen on her wheelchair. She said her wheelchair was in the bathroom. An observation was conducted of the wheelchair in the bathroom without an oxygen tank on her wheelchair. The resident said she was feeling good right now because she had been resting in the bed but when she got out of the bed, she got short of breath. Review of Resident #21's medical record on 05/13/24 at 2:46 p.m. did not reveal an order for oxygen. An interview was conducted on 5/13/24 at 3:32 p.m. with Staff D, Registered Nurse (RN) Supervisor. She confirmed Resident #21 used oxygen, and she thinks the resident was supposed to be on 2 LPM oxygen. She looked at the oxygen concentrator and confirmed the resident was on 1.5 LPM. She said she would have to look at the physician orders to find out how much oxygen the resident was ordered to have. She exited the room and did not review the physician orders. An interview was conducted on 05/13/24 at 4:10 p.m. with Staff D, RN Supervisor, she said she forgot to look up Resident #21's physician orders, but she told the nurse to look it up. The nurse in training assigned to Resident #21 said the resident was supposed to be on 2 LPM oxygen according to the report sheet. Review of the report sheet revealed a handwritten note O2 @ 2L. The note was not written under Resident #21. An observation was conducted on 05/14/24 at 10:14 a.m. Resident #21 was in bed and said someone came in and wanted me to sign paperwork but I was too short of breath. Resident #21's oxygen concentrator was set on 3 LPM via nasal cannula. Resident #21's breathing was observed to be rapid and shallow. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 5/14/24 at 10:15 a.m. with Staff E, Licensed Practical Nurse (LPN). She confirmed she was Resident #21's nurse and she said Resident #21 was usually on oxygen I think it's 2 liters but I would need to check. I have not experienced her being short of breath today. She normally is not up this early and I know she likes to be left alone when she's tired. Staff E, LPN reviewed Resident #21's physician orders and said, I don't see an order for oxygen, but she has been on oxygen since I started in January of 2024. I don't know what happened to the order. An interview was conducted on 5/14/24 at 10:17 a.m. with Staff B, South Unit Manager. He reviewed Resident #21's physician orders and confirmed he could not find an order for oxygen and said, she used to have oxygen orders for 2 liters PRN [as needed]. On 5/14/24 at 10:20 a.m., Staff E, LPN went into the Resident #21's room and confirmed the oxygen was set to 3 LPM and adjusted the concentrator to 2 LPM. The resident said, please help me I can't breathe Resident #21 was observed to still have shallow rapid breaths. Staff E said she was going to get the machine to check her oxygen and the resident said please hurry. Staff E left the room. Resident #21 was observed to be in the bed eyes closed, saying a healthy baby boy. On 5/14/24 at 10:24 a.m., Staff E entered Resident #21's room and placed the pulse oximeter machine on the resident and confirmed her oxygen saturation was 92%, adjusted her nasal cannula, and confirmed the resident's oxygen saturation went up to 93% and then back down to 92%. Staff E said. I'll call the doctor. She asked the resident if she was having any shortness of breath and the resident said yes. The nurse said are you having any pain? The resident said, yes in my chest. Review of Resident #21's care plan revised on 10/3/23 revealed The resident has Oxygen Therapy r/t [related to] Ineffective gas exchange. dx [diagnosis] with COPD. The goals revealed Will be able to participate in activites [sic] of choice. Will have no s/sx [signs and symptoms] of poor oxygen absorption through the review date. Will have no untreated s/s [signs and symptoms] of SOB [shortness of breath] through next review. The interventions were as follows: o Special Equipment: Oxygen o Administer Oxygen/Nebs as ordered. (Refer to current POS [physician order set]/MAR [medication administration record] for current order) o Give medications as ordered by physician. Monitor/document side effects and effectiveness. o Turn and Reposition resident to facilitate ventilation/perfusion matching: Use upright, high-Fowler's position whenever possible to allow for optimal diaphragm. o Promote lung expansion and improve air exchange by positioning with proper body alignment. o Monitor for changes in or development of signs & symptoms of breathing difficulty (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and report: SOB, cough (productive or nonproductive), fever, chills, difficulty speaking, bluish skin color, changes in cognition. o Report changes in respiratory status to physician. Change and date respiratory equipment tubing weekly & prn [as needed]. o Keep exterior of respiratory equipment clean. Review of Resident #21's progress note dated 5/14/24 at 3:50 p.m. revealed Resident complained of SOB [shortness of breath] and mild chest pain. Vitals assessed. MD [medical doctor] notified. orders received for STAT CXR [chest x-ray] and lab work. Resident received PRN [as needed] inhaler. Continued on 7-3 [7:00 a.m.-3:00 p.m.] shift without issue, no further complaints of pain or signs of distress. Family at bedside. Review of Resident #21's physician orders revealed an order with a start date of 5/14/24 Stat CXR PA [posterior anterior]and Lateral. An order with a start date of 5/15/24 and an end date of 5/22/24 revealed Zithromax Oral Tablet 500 MG (Azithromycin) Give 1 tablet by mouth one time a day for PNEUMONIA for 7 Days. Review of Resident #21's Chest X-ray 2 view radiology report dated 5/14/24 revealed Conclusion: Left lower lobe infiltrates suspicious for pneumonia. 46498 2. An observation and interview was conducted on 5/16/24 at 11:40 a.m. Staff K entered Resident # 97's room and said the resident had a [brand name] tracheostomy tube (6.0 XL) she searched the resident's room and confirmed there was not an extra or an emergency tracheostomy tube in the room. She confirmed there were extra trach (tracheostomy) ties, suction machine, suction kits, and a [brand name] tracheostomy tube (6.0 x I) inner cannula and ambu bags at the bedside. Review of Resident # 97's admission record dated 05/16/2024 showed he was admitted to the facility on [DATE] with diagnose to include but not limited to Acute Respiratory Failure with Hypoxia, Tracheostomy Status, Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris. Review of a Medication Administration Record for the mouth of May 2024 showed an order dated 03/28/2024 to maintain ambu bag at bedside and replacement trach of equal size and one size down maintained at bedside, every shift for preventative measures. Maintain suction set up at bedside on every shift. An interview was conducted on 5/16/24 at 11:43 a.m. with the Director of Nursing (DON). She said, [Resident # 97's] room was set up with extra trachs. She directed Staff K, LPN to get an extra trach and a size smaller trach to put in the resident's room. Staff K obtained a [brand name] tracheostomy tube (6.0 XL), and a [brand name] tracheostomy tube (5.0 XL), and put it in the resident's room. (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 the facility policy titled, Tracheostomy Care undated, showed 2) Gather the necessary equipment and proceed to the patient's room. Equipment should include. C. Emergency tracheotomy tube replacement, the same size and 1 size smaller.

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	05/16/2024

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

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223 Based on observation, interview, and record review, the facility failed to follow the comprehensive person-centered care plan and physician orders for one (Residents #73) of one sampled resident who required dialysis, which included providing dietary needs (breakfast/snacks). Findings included: During an interview on 5/14/2024 at 8:45 a.m., Resident #73 stated he did not receive breakfast or a snack to take to dialysis. If needed, he had the driver of the transport stop at the convenience store. Resident #73 stated it would be nice if breakfast was provided as I have to leave at 5:45 a.m. and am gone until lunch, that is a long time without food. Review of the Admission Record for Resident #73 showed an admitted [DATE] and a recent admission of 3/16/2024 with diagnoses to include: end stage renal disease; heart failure; diabetes type 1; cachexia; hyperkalemia; protein-calorie malnutrition; muscle wasting and atrophy; and other co-morbidities. Review of Resident #73's physician Order Summary dated 5/16/2024 revealed an order for Resident to have Dialysis on days: [Dialysis center name]: . catheter site: right chest: . bag meal/snack to go with resident to dialysis yes fluid restriction no, order start date of 3/18/2024 and 3/24/2024. Review of Resident #73's Care Plan revealed a focus area of: hemodialysis: The resident has renal failure and is on Hemodialysis Resident to have dialysis on days: [dialysis center name]: . catheter site: right chest: . bag meal/snack to go with resident to dialysis yes fluid restriction no date initiated 1/16/2024 and revised on 4/3/2024. Further review of the care plans showed the resident was at risk for impaired nutrition related to chronic kidney disease stage as of 8/1/2023. Interventions included but not limited to honor food requests and preferences as appropriate initiated 4/5/2023, diet as ordered (refer to POS for current order) initiated 10/4/2022, fluid restrictions 1500 cc/hr revised on 4/3/2024. During an interview on 5/16/2024 at 6:55 a.m. with Staff O, Certified Nursing Assistant (CNA), she said she provided care to Resident #73 on a regular basis. Staff O stated she had not been able to give a bag meal to Resident #73 for a while as the refrigerator was broken. The kitchen staff provided the bags (meals). An interview was conducted on 5/16/2024 at 7:15 a.m. with Staff N, Cook. She stated the kitchen did provide bag meals to residents who needed them. Staff N stated nursing gave dietary a list and they prepared the meals, and passed them out. Staff N stated she not made a bag meal in a long time, as nursing had not provided a list of anyone who was in need of one. An interview was conducted with the Staff G, Registered Nurse/Unit Manager on 5/16/2024 at 8:30 a.m. She stated Resident #73 received his lunch bag from the kitchen, nursing did not have anything to do with it. (continued on next page)

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	105293	A. Building B. Wing	05/16/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedure with the topic: Dialysis Management (Hemodialysis) dated October 2021 revealed: the facility will coordinate care and services for hemodialysis residents. The facility will coordinate routine transportation for the resident. Contractual agreement will include, but may not be limited to, the following: * medical and non-medical emergencies, * development and implementation of resident care plan, * interchange of information useful/necessary for the care of the resident. Guidelines: 1. Obtain a physician's order to include but not limited to: . 6. Manage special dietary regimen and dietary/fluid restrictions as ordered. 7. Verify that travel meal is provided in a thermal bag and has an ice pack . 11. Review and revise care plan/Kardex as needed.

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	105293	A. Building B. Wing	05/16/2024

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 48223 Based on observation and interview, the facility failed to post the nurse staffing data to ensure the information was readily accessible to all residents and visitors during two of four days of survey. Findings included: On 5/13/2024 at 9:52 a.m., an observation revealed the total number and actual hours worked per shift for licensed and unlicensed staff responsible for resident care was not posted. On 5/16/2024 at 8:52 a.m. an observation revealed the total number and actual hours worked per shift for licensed and unlicensed staff responsible for resident care was not posted. During an interview on 5/16/2024 at 11:15 a.m., Staff P, CNA staffing coordinator stated responsibility for posting the staffing numbers. Staff P stated posting the numbers for two days at a time to ensure the weekends are covered. Staff P, stated with the surveyors coming in on Monday the posting was delayed and the same must have happened this morning. Staff P stated posting the information today although it was later in the morning. Review of the facility policy and procedure with the topic: Staffing dated effective April 2015 revealed: policy: each nursing center has sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable, physical, mental, and psychosocial well-being of each resident, as required by the federal law, and sufficient staff to meet applicable state law requirements (including minimum staffing ratios). The projected staffing plans are reevaluated on an ongoing basis in response to changes in the facility, resident population, or other circumstances. Staffing is monitored on an ongoing basis through a combination of offsite and onsite facility reviews conducted by facility, consulting and compliance staff. The facility administrator and/or the director of nursing should evaluate staffing on a daily basis. Procedure: Other: 1. Post the daily staffing hours.

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	105293	A. Building B. Wing	05/16/2024

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223 Based on interview and record review, the facility did not ensure residents who entered arbitration agreements understood the contract contents for one (Resident #259) of three residents sampled. Findings included: During an interview on 5/14/2024 at 10:04 a.m., the Nursing Home Administrator (NHA) stated there was only one resident who had signed an arbitration agreement. The NHA stated all residents were presented the option to review and sign the arbitration agreements upon admission. The NHA stated the Admission Director (AD) was responsible for the arbitration agreements and expectation was that everyone understood what was being signed. Review of the Admission Record for Resident #259 showed an admitted [DATE], with diagnoses to include Schizophrenia; Anxiety Disorder; Other Genetic related Intellectual Disability; Malignant Neoplasm of Bladder; and other co-morbidities. The Responsible Party/Guarantor listed indicated it was not Resident #259. Review of the Arbitration Agreement - Resident Booklet, was signed by Resident #259 and the Admission Coordinator (AC) on 4/24/2024. Review of the Medical Certification For Medicaid Long-Term Care Services and Patient Transfer Form - AHCA Form 5000-3008 dated 4/22/2024 signed by a physician showed under section U. Mental/Cognitive Status at Transfer - Resident #259 alert, disoriented, but can follow simple instructions. Review of the hospital physician progress note dated 4/21/2024, showed resident was pleasantly confused. Review of the Occupational Therapy Plan of Care dated 4/25/24 revealed Resident #259's Cognition ** orientation person (x 1); Cognition **Memory profound (0-10% ability; dependent, coma/vegetative state, delirium, acute psychosis episode); Cognition **Safety-Judgment Moderately impaired (25-50% intact); Cognition **sequencing moderate (51-70 % ability; frequent direction required in occasional situations). Review of an Admission Minimum Data Set (MDS) for Resident #259, dated 4/28/2024, showed Resident #259 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated moderate cognitive impairment. (continued on next page)

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	105293	A. Building B. Wing	05/16/2024

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/2024 at 11:44 a.m., the AD stated the goal was to have residents signed in within 48-72 hours, herself, and the Admission Coordinator (AC) both completed sign ins. This included the Admission Agreement and Arbitration Agreement. The AC worked part-time at the facility and not at the facility today, 5/15/2024. The AD stated, We utilize the resident's 3008 [Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form - AHCA Form 5000-3008] and nurse to nurse to determine if a resident can sign themselves into the center. The AD provided a list of residents who had and had not signed the Arbitration Agreement. The AD continued to state the Arbitration Agreement was optional and the resident did not have to sign to be able to be admitted . The AD stated, I focus on the agreement being optional. The AD stated the AC completed R#259's Admission Agreement which included the Arbitration Agreement. The AD confirmed Resident #259 had signed the arbitration agreement with the AC as the facility representative on 4/24/2024. The AD stated R#259's signature was in the form of a line and lower-case cursive letters in the bottom right corner of the agreement. The AD stated the facility would sign the corner of the agreements if the residents were not able. An interview was conducted on 5/13/2024 at 3:57 p.m. Resident #259 's Resident Representative (RR). She said had not had communication with the facility with regards to admission paperwork or anything else. The RR stated there had been very little to almost no communication with the facility. The RR explained Resident #259 had been diagnosed with Intellectual Disability in school age years. The RR stated Resident #259 never was able to learn how to read or write. The RR stated Resident #259 usually would request for her to review documents. Policy and Procedure for Arbitration Agreements was requested on multiple days, one was not provided prior to the survey exit on 5/16/2024.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 48441 Based on observations, interviews, and record review, the facility 1) failed to initiate an Enhanced Barrier Precautions (EBP) isolation program for thirteen out of thirteen residents on EBP and, 2) failed to implement an effective infection control program related to facility failure to handle, store, process, and transport all linens and laundry in accordance with infection control practices to produce hygienically clean laundry for 105 out of 105 residents in the facility. Findings included: On 05/15/24 at 11:09 a.m., an interview was conducted with the Director of Nursing (DON) regarding infection control for isolation residents. The DON stated newly arrived residents are screened for any isolation precautions from the transferring facility. The placement of the newly admitted residents depends on their isolation needs and if they can cohabitate with another resident. The DON admitted knowledge of the Center for Disease Controls (CDC) new Enhanced Barrier Precautions (EBP) recommendations announced in February 2024, and stated thirteen residents have been identified in the facility requiring EBP. She stated the residents identified had a potential source of increased risk for infection due to tube feedings via percutaneous endoscopic gastrostomy tubes, wounds, medication via peripherally inserted central catheters, intravenous catheters, and indwelling urethral catheters. The DON stated the facility had not had the opportunity to initiate an Enhanced Barrier Precaution program but stated she will be putting bins out by resident's rooms for gloves and gowns, and proper (EBP) signage was ordered. The DON stated education would be starting in May but was unable to present calendar dates assigned for education for the month of May. The DON stated the Enhanced Barrier Precautions would be difficult to have staff and residents comply. She stated education would be deferred to the new Infection Control Preventionist. (continued on next page)

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	105293	A. Building B. Wing	05/16/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/16/24 at 10:30 a.m., a tour of the laundry area was conducted with the Housekeeping /Linen Manager (HM). The facility's entrance to the laundry room was located along an outside perimeter of an open courtyard. An observation was made of three laundry carts of clean folded linen. The cart covers were tattered, threadbare and torn, leaving the clean linen exposed to the elements. [Photographic evidence obtained]. Above the laundry carts on the opposite side of the walkway were five bird's nests with active birds flying overhead. Three large gray garbage bins were observed outside the laundry room in the courtyard. One bin was not labeled, the middle bin was labeled, Clean mops, and the third bin was labeled, Clean microfiber mops. [Photographic evidence obtained]. A wire basket cart on wheels was observed next to the garbage bins with a pile of mops heads and torn clothes. The HM stated the basket was how they dried the rags because the facility did not dry the items in the dryers due to the chemicals utilized. The HM proceeded to demonstrate how the rags were dried. The HM moved the wire basked into the center of the courtyard (so the basket would be in the direct sun). The HM stated the items in the wire basket were dry and moved the cart back to the side of the facility. The items were observed to be moist to the touch and had a musty smell to them. The HM stated the rags are then moved to one of the gray bins for the housekeepers use. The HM opened the unlabeled gray bin, and a strong, pungent musty odor was noted. Another gray bin with a lid on it and a washcloth on top, was between the doors to the clean and soiled rooms, no label was observed on the bin. The HM stated the bin was for clean linen. Behind the open door was another blue bin with the lid upside down and a white cloth hanging from the side, no label observed. The HM stated this bin was for soiled laundry. Directly touching this blue bin was a beige cover to another laundry cart that was holding clean donated clothing. The HM stated this clothing was for any staff member to come out and take to a resident. There was clothing observed on the ground and pushed against the facility at the base of the donated clothing rack. The beige cover did not close, leaving the clothing exposed to the elements, including birds' nests which were visualized to the immediate left of the cart. [Photographic evidence obtained]. The soiled laundry entrance was a receiving area. There were two large linen carts, each covered with a blue canvas, a large gray bin covered with a fitted sheet and a pile of clothes in the corner in between the two linen carts and behind the gray bin uncovered [Photographic evidence obtained]. The Housekeeping/Linen Manager stated clean linen was stored in these areas. Next to the linen cart, directly touching were two large bins of soiled laundry covered with a soiled sheet. The Housekeeping/Linen Manager stated there is no place to store clean laundry, that is why the clean is stored in the soiled room. Two washing machines were active with wastewater emptying behind the machines. The level of the wastewater was high. The HM stated sometimes the wastewater will overflow the basin and he has to take all the bins and carts out to squeegee the water out of the laundry room [Photographic evidence obtained]. Proceeding through plastic strips that represent a barrier to the clean laundry room, the plastic strips were observed to be soiled with an orange sticky substance and brown/black spots along the length of the plastic strips. The dryer/clean laundry area revealed two staff members folding clothes with a fan on the ground to keep the area cool. The staff stated the air conditioning (AC) unit works but will freeze up and drip water in the laundry area, then they must run the fan until the AC unit will work again. In the corner of the laundry area was a clean laundry cart sparsely full of clean linen. The Housekeeping/Linen Manager stated staff would come in and grab linen if they need it for emergencies at nighttime [Photographic evidence obtained]. A review of the facility's policy titled, Barrier Precautions, effective April 2024, revealed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Enhanced Barrier Precautions (EBP) states an infection control intervention designed to reduce transmission of multidrug resistant organisms (MDROs) that employ targeted gown and gloves used during high contact resident activities. EBP are used in conjunction with standard precautions and expand the use of PPE (Personal Protective Equipment) to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (multi drug resistant organisms) to staff hands and clothing. EBP is indicated for residents with any of the following: 1. Infection or colonization with CDC-targeted multi-drug resistant organism when Contact Precautions do not otherwise apply or, 2. Wounds and /or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Procedure 1. Start will be routinely trained in infection control practices to include when to use Standard Precaution, Contact Precautions, Enhanced Barrier Precautions, and Droplet Precautions. 2. A grid is provided (Appendix A) for staff reference which outlines the differences between Contact Precautions and Enhanced Barrier Precautions. 3. Director of Nursing/ Designee will track resident infections and ensure staff is notified of resident -specific precautions. 4. Signage is used, as appropriate. Appendix A [Photographic evidence obtained]. Review of the Infection Control Overview & Policy, undated, revealed the following: Policy Statement: [Vendor Name] promotes the health and safety of all employees, as well as that of the clients and residents we serve. Infections are a significant source of sickness and death for nursing home residents and account for up to half of all nursing home resident transfers to hospitals. Infections result in an estimated 150,000 to 200,000 hospital admissions per year at an estimated cost of up to $2 billion annually when a nursing home resident is hospitalized with a primary diagnosis of infection, the death rate can reach as high as 40%. The purpose of this infection control program for [vendor name] and its subsidiaries is to: 1. Investigate, control, and prevent infections in the facility; 2. Communicate the environmental and or dining services procedures that should be applied in the field; 3. To maintain a record of incidents and corrective actions taken related to infections by reporting incidents through the proper facility chain of command; (continued on next page)

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	105293	A. Building B. Wing	05/16/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	B. Transferring Soiled Linen It is very important to properly transport and store soiled linens to prevent the spread of infection period to do so, all soiled linen and clean linen must be covered during transportation and while being stored on the unit or floors. Additionally, no clean linen may touch floor during transport, if it does, the clean linen is then considered to be soiled. Soiled linen containers must be lined with an impervious (waterproof) liner. Do not allow soiled linens to simply be dropped into a container. At designated times, laundry workers are to collect soiled linens from each soiled linen room using a large bin with lid, marked For Soiled Linen Only. . 2. Sorting Soiled Linen the laundry room must have a process in place to effectively sort soiled linen without cross-contaminating clean linen. For example, soiled linen must never come in contact with clean linen. Soiled linens brought down manually must have a separate delivery entrance and must be placed into the soiled linen bins. 48223