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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105528 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/31/2024 |
| NAME OF PROVIDER OR SUPPLIER Terrace of St Cloud, The | | STREET ADDRESS, CITY, STATE, ZIP CODE 3855 Old Canoe Creek Road Saint Cloud, FL 34769 | |

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) |
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| <p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35199</p> <p>Based on interview, and record review, the facility failed to implement their abuse policy to fully investigate and provide education for injury of unknown origin for 1 of 2 residents, of a total sample of 4 residents, (#2).</p> <p>Findings:</p> <p>Resident #2 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus, heart failure, stroke, dementia, and left-hand contracture. The resident received hospice services.</p> <p>Review of resident #2's medical record revealed a nurse's Progress note dated 9/17/23 at 4:51 AM, which indicated a purple discoloration was noted to the top of the resident's right hand, but no swelling or redness was noted. A few hours later another Progress note indicated the nurse was notified by the Certified Nursing Assistant (CNA) that the resident's right arm was swollen with a faint yellowish discoloration, and he complained of pain. The nurse noted the medical provider and resident Power of Attorney were contacted and a STAT radiograph of the right arm was ordered.</p> <p>On 9/17/23 an Immediate Investigation report was submitted by the facility for an injury of unknown origin to resident #2. The report described an X-ray report from 9/17/23 which indicated an acute spiral fracture of the right proximal humerus (upper arm bone). The document revealed an investigation was initiated by the facility.</p> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>In interviews on 5/30/24 at 2:11 PM, and on 5/31/24 at 6:02 PM, the Director of Nursing (DON) revealed the facility obtained statements and performed record review as part of their investigation. Review of the facility investigation with the DON revealed conflicting information regarding how and when resident #2's injuries occurred. A witness statement from Licensed Practical Nurse (LPN) B indicated resident #2 complained of pain to his right arm when CNA A provided incontinence care on 9/16/23. Various other staff statements and a statement from resident #2's daughter indicated he had bruising, swelling and complained of pain to his right arm and hand before 9/16/23. The DON explained any abuse or neglect allegation should be reported immediately and if after investigation it was found to be an adverse event that should be reported as well. She stated individuals involved in the incident should receive education immediately, and then all other staff to ensure no one else made the same mistakes. The DON stated the facility was unable to provide a Root Cause Analysis of the event, nor could they provide a timeline completed during the investigation. The DON said the expectation was after the facility learned of an alleged incident, the Administrator would write up the report and they would do an in-service for all staff regarding the injury or incident. The DON confirmed for this incident not all facility staff received in-service. The DON said she could not find any written evidence the steps were completed.</p> | | |