

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 07/24/2024
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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51023</p> <p>Based on observation, interview and record review, the facility failed to provide adequate supervision and a safe environment to prevent accidents for 1 of 1 resident reviewed for falls with injuries, out of 2 sampled residents, (#1).</p> <p>The facility's failure to ensure nursing staff were knowledgeable to utilize the required transfer sling and ensure proper positioning of the resident during transfers to prevent fall with injury and transfer to a higher level of care for treatment, resulted in isolated actual harm at F689, for resident #1.</p> <p>Findings:</p> <p>Resident #1 was admitted to the facility on [DATE], with diagnoses that included dysarthria following cerebral infarction, muscle weakness, bradycardia, hypertension (HTN), non-ST-elevation myocardial infarction (NSTEMI), type 2 diabetes, chronic obstructive pulmonary disease (COPD), dementia, abnormal posture, difficulty walking, atrial fibrillation (AFIB), polyosteoarthritis, and cognitive communication deficit.</p> <p>Review of the medical record revealed physician orders for a Hoyer lift for all transfers and Eliquis 2.5 milligrams (mg) twice a day for AFIB.</p> <p>Eliquis is a medication used to lower the risk of stroke or a blood clot in people with a heart rhythm disorder called atrial fibrillation. Eliquis can make it easier for you to bleed, even from a minor injury, (retrieved on 8/02/24 from www.drugs.com)</p> <p>Review of a Physical Therapy evaluation dated 1/12/2024 revealed resident #1 was dependent on staff for transfers and required the use of a Hoyer lift for bed to wheelchair transfers.</p> <p>Review of the admission care plan revealed resident #1 required 2 people to assist with transfers using the Hoyer lift.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a progress note dated 7/04/2024 at 5:20 PM, revealed the nurse was notified resident #1 had fallen while being transferred to bed from her wheelchair. Upon entering the room, the nurse noted the resident lying on the floor, on the right side of her bed with her feet pointed towards the door. The nurse noted a small amount of blood coming from the back of her head. The note indicated the resident was fully conscious and denied pain. The nurse noted a 2-centimeter-long laceration on the back of her head. She documented resident #1 was transferred to the emergency room (ER) for evaluation and treatment.</p> <p>Hospital paperwork from 7/04/24 revealed resident #1 presented to the ER with a small abrasion to her right occiput (back of scalp). A computerized tomography (CT) scan, labs and electrocardiogram performed in the emergency department were all negative for acute diagnoses and the resident returned to the facility 7/04/24 at 10:45 PM.</p> <p>A progress note dated 7/08/24 revealed an Interdisciplinary team meeting was held to discuss the fall from the mechanical lift. The note indicated: Two staff members utilized the mechanical lift to assist the resident to transfer from the wheelchair to the bed. The resident slipped through the opening in which her buttocks should be placed when transferring. She bumped her head when she landed on the floor. Neuro checks were initiated. She was sent to the ER and returned with no new orders. The mechanical lift sling has been changed, as the prior sling was too large for her and allowed room to slip out.</p> <p>In a witness statement dated 7/08/24 by Certified Nursing Assistant B (CNA B) and presented by the Director of Nursing (DON) on 7/24/24 at approximately 9:55 AM, he stated the resident slid out of the sling feet first and landed on her buttocks. In the statement she indicated CNA B admitted he didn't ensure the sling was the correct size for the resident nor did he know what the correct size was supposed to be.</p> <p>On 7/24/24 at approximately 10:00 AM, the DON stated on 7/08/24, she had interviewed CNA C who was assigned to resident #1 on the date of the fall. She stated the day shift CNA would have been the person to transfer the resident into the wheelchair in the morning. The DON described that CNA C stated she was assigned to the resident on the 7 AM to 3 PM shift but was unsure whether she used the Hoyer lift to get the resident up that day. She also didn't recall who assisted her with the transfer but said if she did get Resident #1 up that day she would have a sling under her and ready for the next CNA to put her back into bed. The DON explained the CNA would have gotten the sling out of the resident's room and if it wasn't there, she would have gotten one from laundry or central supply.</p> <p>CNA A's witness statement from 7/04/24 revealed at approximately 5:20 PM, she and CNA B transferred the resident from the chair to the bed with a mechanical lift. She detailed CNA B was in the front, and she was positioned in back to transfer her to the bed. Her statement described how she saw the resident sliding down, but said the wheelchair was locked and she couldn't move it quickly enough to catch resident #1 and she ended up on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/24/24 at 9:53 AM, the DON revealed that after she read the witness statements from the two CNAs involved on the fall on 7/04/24, she felt she needed to conduct follow up interviews with them to obtain more information about the incident. The DON stated that following her interview with CNA A on 7/05/2024, she asked her which type of sling they used at the time. CNA A confirmed they had used a sling referred to as a 'shower or toilet' sling which had a hole towards the bottom of the sling where a resident's buttocks should be. The DON explained this type of sling was designed so the resident could be transferred onto the toilet with their buttocks positioned through the hole so the resident could sit onto the toilet. The sling was designed so the resident was positioned in more of a sitting position to make it easier to transfer onto the toilet. CNA A told her they didn't notice the residents' buttocks weren't positioned over the hole until they had started to raise the arm of the mechanical lift. Instead, the resident's feet were positioned by the hole and when they lifted her up, she went feet first through the hole since the sling positioned the resident in a seated position. The DON said she concluded the CNAs had incorrectly used a shower/toilet sling when they should have used a regular sling. The DON also concluded the shower/toilet sling used was too large for the resident.</p> <p>On 7/23/24 at 3:00 PM, CNA A revealed CNA B was assigned to Resident #1, but she assisted her to transfer the resident on 7/04/24. She stated CNA B had asked for her help to transfer the resident from the wheelchair to her bed. CNA B explained the resident already had a sling under her from her transfer earlier in the day from her bed to the wheelchair. She stated when they lifted the resident out of the wheelchair with the mechanical lift, she fell and hit her head on the floor. CNA B recalled she then called a nurse to assess the resident who was sent out to the hospital. She stated the day after the incident she received one on one training on safe transfers with the Director of Rehabilitation.</p> <p>On 7/24/24 at 12:18 PM, CNA B revealed when he and CNA A transferred the resident from the wheelchair to the bed he made sure the colors on each strap lined up. He recalled the sling was too big for the resident. CNA B stated when they lifted the resident up, she slid out of the sling feet first thru the hole where the buttocks normally went in the shower sling. CNA B explained after the fall, the facility trained him on safe transfers and mechanical lifts. He explained after the training he realized he needed to check to make sure the resident had the correct type of sling and the correct size of sling before using the lift.</p> <p>In the facility's policy with most recent review dated 02/23, titled, 'Lifting machine, using a mechanical' it states that the purpose is to establish the general principles of safe lifting using a mechanical lifting device. Under the section Procedure Guide, one of the steps is to visually check the size of the sling to ensure it is not too large or too small.</p>		