STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105616	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrington Place of St Pete	10501 Roosevelt Blvd N Saint Petersburg, FL 33716

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure surgical wounds were assessed and measured for three residents (#2, #6, #7) out of three sampled residents. Findings included: 1. Review of the admission Record showed Resident #2 was admitted on [DATE] with diagnoses included but not limited to rhabdomyolysis, open wound right hip, paroxysmal atrial fibrillation, congestive heart failure, hypertension, anemia, dementia, chronic kidney disease, generalized muscle weakness, history of falls, intervertebral disc degeneration, lumbar region with discogenic back pain only. Review of the admission, Minimum Data Set (MDS) dated [DATE] showed in Section C, Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). Section M, Skin Conditions showed surgical wound. On 06/16/2025 at 11:35 a.m. Resident #2 was observed sitting in his wheelchair at bedside. The resident was dressed and groomed for the day. The resident stated he was told the wound vac was supposed to be discontinued yesterday (Sunday). Review of physician orders showed wound care every Tuesday, have resident up and dressed before 8:00 a. m. for pick up. Apply wound vac 125mmhg/change Monday, Wednesday, Friday, apply black foam and as needed if dislodged as of 06/03/2025. Wound MD/NP (Medical Doctor / Nurse Practitioner) may evaluate and treat as indicated. Review of the progress notes dated 05/17/2025 showed skin warm and dry, skin color within normal limits, and turgor is normal. Review of the internal wound physician's progress note dated 05/20/2025 showed post-surgical wound size 6 x 6 x 0.5 cm (centimeters); moderate serous exudate; 100% granulation. Review of the Wound-Weekly Observation Tool dated 05/21/2025 showed right trochanter hip surgical wound, size 6 x 6 x 0.5. No odor. Serous drainage. Well-approximated edges. Review of the Skin only progress note dated 05/21/2025 showed skin warm and dry. Resident has current skin issues. Skin issue: surgical wound. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105616	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrington Place of St Pete	10501 Roosevelt Blvd N Saint Petersburg, FL 33716

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Skin only progress note dated 05/28/2025 showed skin warm and dry. No current skin issues noted at this time. Skin note: There are no skin impairments or treatment orders in place at the time of this assessment. Review of the external wound physician's progress note dated 06/03/2025 showed right trochanter wound size 5.5 cm x 6.6 cm x 1.6 cm. Review of the Wound-Weekly Observation Tool dated 06/05/2025 showed right trochanter surgical incision. No measurements. Overall impression is wound improving. Granulation tissue present. 20% necrosis/and or slough in the wound bed. Moderate amount of serous drainage. No odor. Well approximated wound edges. Wound progress improved. Review of the Skin only progress note dated 06/10/2025 showed skin warm and dry. Resident has current skin issues. Skin Issue: Open lesion (other than ulcers, rashes and cuts). Skin issue location: right hip. Skin note: treatment in place for right hip. Review of the Wound-Weekly Observation Tool dated 06/14/2025 showed right trochanter surgical incision. No measurements. Wound/vac continuous. Overall impression is improving. Granulation tissue present. Moderate serous drainage. No odor. Well approximated edges. Review of the care plans the resident has potential/actual impairment to skin integrity related to fragile skin, use/side effects of medication, incontinence of bladder, admitted with wounds to right hip/hematoma. Resident non-compliant with wound vac, will remove at times. date Initiated: 05/16/2025 and revised on 06/16/2025. Interventions included but not limited to weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations as of 06/05/2025. Monitor / document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to MD (Medical Doctor) as of 06/05/2025. During an interview on 06/16/2025 at 11:41 a.m. Staff A, Licensed Practical Nurse wound care nurse, wound certified stated Resident #2 laid on the floor for 4 days at his home per the family member. The resident laid on his right side / hip and caused necrosis in that area. They did an incision and drainage of the right hip at the hospital. Staff A stated the facility's wound care doctor saw him once. Staff A stated the facility's wound doctor classified the wound as a surgical wound. Staff A stated the facility's wound care doctor discharged him to the external surgeon. Staff A stated the resident was being followed by his surgeon on the outside. Staff A stated the resident had been seen by the surgeon once or twice. Staff A stated either him or Staff B, Registered Nurse (RN) sees the residents weekly. Staff A, LPN stated the wound care sizes are performed by the doctor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105616	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrington Place of St Pete	10501 Roosevelt Blvd N Saint Petersburg, FL 33716

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/16/2025 at 12:11 p.m. the Director of Nursing (DON) stated they (hospital) put a graph patch on the wound during surgery. The DON verified the 05/21/2025 Wound-Weekly Observation Tool note showed wound sizes. The DON reviewed the medical record, and the DON stated there were gaps in the wound assessment and measurement documentation. The DON verified the 06/05/2025 and 06/14/2025 Wound-Weekly Observation Tool lacked documentation regarding the wound measurements and assessment. The DON stated there was documentation of the wound size from the outside wound care doctor / surgeon on 06/03/2025 showed the measurements were 5.5 x 6.6 x 1.6, with undermining at 3-6 and of 1.8 centimeter (cm). The DON stated this documentation should have been in the medical record. The DON verified there were no wound sizes since 06/03/2025 when the resident went to the outside doctor/surgeon. The DON stated either Staff A, LPN or Staff B, RN can do wound sizes. The DON stated they have four staff members in the building that attended the wound certification class. The DON stated they should be doing surgical measurements and notes. The DON stated without this documentation they cannot see if the wound was better or not. The DON stated, Staff A, LPN should be driving the boat, he is responsible. Staff B, RN just fills in on weekends. The DON agreed the care plan showed to measure the wounds each week. 2. Resident #7 was admitted on [DATE]. Review of the admission Record showed diagnoses included but not limited to unspecified organism sepsis, cellulitis of left lower limb, diabetic foot ulcer, hypertension, peripheral vascular disease, Review of the physician orders showed to cleanse surgical incision of the left foot with normal saline, pat dry, apply calcium alginate with silver and wrap with gauze roll every day for surgical incision. Review of the Skin Only Evaluation dated 6/14/25, written by Staff B, RN, showed an open area to the left planter foot. Measurements and description were left blank. Surgical incision to left planter foot, treatment in place. Bruising to the right upper arm near IV site. Review of the Nursing admission Screening/History dated 06/13/2025 showed SKIN. Treatment ordered or required, yes. Resident has a diabetic foot ulcer to the right foot. No description or measurements documented. Review of the progress notes showed an admission summary dated [DATE] showed resident arrived at approximately 6 p.m. Resident's admitting diagnoses was septic diabetic foot ulcer to right foot. Resident also has MRSA (Methicillin Resistant Staphylococcus Aureus) in blood and was a type 2 diabetic. Isolation precautions in place. Review of the Skin Only progress note dated 06/14/2025 showed skin warm and dry. Resident has current skin issues. Surgical wound. Skin issue location: open area to the left planter foot. No wound odor. Tunnelling: yes. No undermining. Review of the baseline Care Plan dated 06/13/2025 and closed on 06/16/2025 (during survey) showed H. Safety Risks 4. Skin risk 4a. current skin integrity issues. 4a1. Specify skin integrity issue: left foot. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105616	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrington Place of St Pete	10501 Roosevelt Blvd N Saint Petersburg, FL 33716

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/16/2025 at 1:25 p.m. the DON stated the Skin Only Eval was the form the floor nurses do. The DON stated the Skin Only form filled out by Staff B, RN on 06/14/2025 would have been for Staff B doing the wounds. The DON stated the misconception that both Staff A, LPN and Staff B, RN had was that we do not size surgical wounds. The DON stated that Resident #7's wound would have been draining due to the use of calcium alginate. The DON stated that surgical wounds still have to be sized. The DON stated there was no description of the wound found. The DON stated, I did not see what I need to see. The DON stated she should have seen an observation on this wound from the weekend. The DON stated they need sizes to show smaller or larger (of the wound). The DON stated a baseline care plan had not been done, it was not in the assessment section of the medical record. 3. Resident #6 was admitted on [DATE]. Review of the admission Record showed diagnoses included but not limited to unspecified organism sepsis, cutaneous abscess of groin, Methicillin Resistant Staphylococcus Aureus infection (MRSA), cellulitis of abdominal wall, extended spectrum [NAME] lactamase (ESBL) resistance, acute bronchitis, diabetes, chronic obstructive pulmonary disease (COPD), hypertension. Review of the physician's orders showed abdominal permanent suture: cleanse and cover every other day; cleanse right inguinal area with Dakin's solution apply 3 ABD (abdominal) pads and secure with tape daily. Do not pack the wound with dressings. Review of the Nursing admission Screening / History dated 06/11/2025 showed SKIN abdomen surgical incision, groin surgical incision, right lower leg (rear) surgical incision. Treatment as ordered. No description or measurements noted. Review of the Skin Only Evaluation dated 06/11/2025 showed skin issue #1, location of groin and right abdomen. No wound sizes or wound description documented. Skin issue #2, abdomen no wound sizes or description documented. Skin issue #3, RLE (right lower extremity) no wound measurements or description. Skin note showed resident has open areas on right inguinal area, right abdomen, right lower leg. Treatments in place. dry, clean dressing on old previous surgical area middle of abdomen. Review of the baseline care plan dated 06/11/2025 showed H. Safety Risks 4. Skin Risk 4a. current skin integrity issues. 4a1. Specify skin integrity issue: wound. During an interview on 06/16/2025 at 1:25 p.m. the DON stated the wound evaluation should have been on the Wound Weekly Observation Tool. The DON stated the resident had been there since 06/11/2025. The DON reviewed the progress notes also and stated there was not a description or measurements of these wounds. The DON verified Resident #6 also did not have a Baseline Care Plan in his medical record. During an interview on 06/16/2025 at approximately 2:00 p.m. the DON stated the staff closed the Baseline Care Plans for both Resident #6 and Resident #7. The DON stated they had not been closed which was why they were not showing up in the medical record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105616	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrington Place of St Pete	10501 Roosevelt Blvd N Saint Petersburg, FL 33716

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy, Pressure Ulcers / Skin Breakdown, revised September 2017 showed 2. The staff and practitioner will examine the skin of newly admitted residents/patients for evidence of existing pressure ulcers and other skin conditions. Monitoring: 11. During the resident/patient visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or poorly healing wounds. This should be based on looking at the wound periodically and on reviewing pertinent information about the patient. Review of the facility's policy, Charting and Documentation, revised July 2017 showed all services provided to the resident, progress toward the care plan goals, or any changes in their resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation 2. The following information is to be documented at the resident medical record: a. Objective observations; c. Treatments or services performed; d. Changes in the resident's condition; f. Progress toward or changes in the care plan goals and objectives. 7. Documentation procedures and treatments will include care specific details, including: a. the date and time the procedure / treatment was provided; b. The name and title of the individual who provided the care; c. The assessment data and / or any unusual findings obtained during the procedure last treatment; g. The signature and title of the individual documenting. Review of the facility's policy, Care Plans-Baseline, revised January 2020 showed a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. Policy and Interpretatoin and Implementation: 1. To assure that the resident's' immediate care needs are met and maintained, a baseline care plan will be developed within 48 hours of the resident's admission. 2. The interdisciplinary team will review the health care practitioner's orders and implement a baseline care plan to meet the resident's immediate care needs including but not limited to: B. Physician orders. 3. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan.