

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105636	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/24/2024
NAME OF PROVIDER OR SUPPLIER Belleair Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1150 Ponce DE Leon Blvd Clearwater, FL 33756	
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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 22481 Based on observation, record review, and interview, the facility failed to demonstrate an effective response to grievances pertaining to care and life in the facility voiced by Resident Council. In addition, four (#6, #7, #8, and #5) of eleven sampled residents reported call bell light untimeliness response by staff. Findings included: A review of Resident Council meeting minutes for 05/2024, 06/2024, 07/22024, 08/2024, and 09/2024 was conducted on 09/23/2024. Review of the meeting minutes dated 05/16/2024, reflected Old Business concerns showed two room numbers beds not being made, 11-7 talking loud in hallway, not getting ice water 3-11. Further review of the meeting minutes reflected no response from the facility pertaining to the concerns. Review of the meeting minutes dated 06/11/2024, reflected no documentation of Old Business concerns. New Business concerns for nursing were listed, 400 hall call lights 11-7. Review of the meeting minutes dated 07/02/2024, reflected an Old Business concern, call lights 11-7. The meeting notes documented New Business concerns: call light response time/ beds not being made at times/ noise in hallway at evening shift change/ shower time accurisy (sic). Further review of the meeting minutes reflected no response from the facility pertaining to the concerns. Review of meeting minutes dated 08/05/2024 reflected Old Business concerns: water refills are slow/ call light times. New Business concerns: Loud TVs (televisions) at night/ good nursing/ loud at shift change/ water refills are slow/ beds sometimes not being made. Further review of the meeting minutes reflected no response from the facility pertaining to the concerns. Review of meeting minutes dated 09/05/2024 reflected Old Business concerns: Loud TVs at night/ Loud at shift change/ slow water refills/ beds sometimes not being made. New Business concerns included: Slow call light response times. (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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/23/2024 at approximately 2:52 p.m., an interview was conducted with the Director of Nursing (DON) regarding Resident Council meetings. She stated, she had attended the last meeting, which had been conducted on 09/05/2024. She stated the problems voiced by the Council were: Ice water, slow water refills, the concern the residents had was they had to ask for it and it could take a while for the water to get to the room. TVs were loud at night, also staff at night could be loud. Beds were not being made. She stated she did not know the particulars of this. She stated Activities would bring the concerns to her, it was not a standard, but it could go to the nurses. Education was started. She stated if the grievance was patient care, there should be a grievance. When asked if she or staff had conducted any call bell light audits within the last four months, she stated, no. On 09/23/2024 at 4:10 pm, the DON was re-interviewed, she stated, No audits have been conducted for call bell light services. When asked how she determined if the education she provided staff was effective, she said, Answering a call bell light expectation, is 7-10 minutes. What we do, we have our managers do guardian angel rounds. That is where we go in and check on the residents, ask them if they have any comments or concerns. If they, the residents, happen to say anything at that time to the guardian angel, that is how we ensure that the education has been heard. If they have issues with the call light they will say. When asked about a resident who could not tell her, she stated, That is a good question; the process involves observations. I talk to families all the time, typically when they call me. A couple have told me the call bell light is an issue. An exorbitant amount of time is 20-30 minutes, then it would be on the grievance. An interview was conducted on 09/24/2024 at 10:45 a.m. with Resident #6. She stated she was the Resident Council President. When asked about the call bell light response, she stated, sometimes we have to wait 1/2 hour to an hour and sometimes they will come in and turn it off. She stated she had verbalized the concerns at the meetings. She stated, we have received no feedback from Administration. When we state our grievance at the meetings, we never know one way or the other. It would be nice to know whether or not and for what reason. She stated, for example, we put in a request for the cleaning of wheelchairs. They said it was maintenance's job, and he was busy. Another example is I asked about them cleaning the windows. Did not hear back on that. For the water, I have had to chase them down. I do drink a lot of water. For the beds, there were 2 weeks where the beds did not get made. No bed making improvement. No water delivery improvement. No call bell light improvement. An interview was conducted on 09/24/2024 at 10:50 a.m. with Resident #7. She was observed sitting in her wheelchair (w/c) dressed in seasonally appropriate clothing. She stated for the call bell light it can take up to an hour. She said, they made our beds today because you were here. An interview was conducted on 09/24/2024 at 10:53 a.m. with Resident #8. He was observed lying in bed, he had a book at his bedside, he agreed to an interview. He was observed in his hospital gown. When asked if he had been abused or neglected, he stated, neglect, it can take half hour to forty-five minutes for them to answer the call bell light. They do not come. Yes, I have complained to the care person and the supervisor. An observation was conducted on 09/23/2024 at 10:21 a.m. of Resident #5, sitting on the front porch area, reading a book, dressed in seasonally appropriate clothing. She agreed to an interview. She stated, sometimes the call light takes 1 hour or more. I have asked them to put an extra chuck under me because sometimes I cannot wait so long. It used to bother me, but I do not worry about it now.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 22481 Based on observation, record review, and interview, the facility failed to ensure a functioning grievance process for two (#3 and #5) of three sampled residents related to missing items. Findings included: 1. A review of Resident #3's clinical chart, the face sheet reflected an admission of 10/22/2023 and a subsequent discharge of 11/03/2023 to another skilled nursing facility. On 09/23/2024 at 1:43 p.m., Resident #3's family member was interviewed by phone. He stated he had filed the grievance in October 2023 about a missing hearing aid. He said he was told by the nurse to fill it out. They were supposed to set up an appointment with the audiologist and they never followed up. I called the administrator several times. I left e-mails. We wanted to see if the audiologist would come to her new facility for the appointment. Four months later, we had no results. They never followed up with an appointment. We tried the grievance process. It did not work for us. We ended up buying her a new pair after waiting so long, she could not hear without them. We would like to be reimbursed. A review of a Grievance/ complaint report, dated 10/24/2023, received by the Social Service Director (SSD), from Resident #3's (family member), documented a grievance of a missing hearing aid. The grievance documented the family member suspected the hearing aid had gone to the laundry. For Actions taken: SSD & nursing looked in resident's room for missing hearing aid and could not find it. SSD informed the kitchen supervisor and housekeeping director of missing hearing aid, and it has not been found or turned in. It is very small with clear wiring. 10/26, Audiology to see, for follow (sic) hearing aid. 11/05, Call placed to son and voice mail left. Results of actions taken: Replacement authorized. The form documented the resident or the person acting on resident's behalf was satisfied with the grievance resolution with a comment, yes, will follow up with facility. The form was signed off as completed on 10/31/2023. Review of clinical record progress notes for Resident #3 reflected no documentation regarding an audiologist appointment, lost hearing aid, or replacement of hearing aid. A review of Resident #5's clinical chart, the face sheet reflected an admission in 02/2023. (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was conducted on 09/23/2024 at 10:21 a.m. of Resident #5, sitting on the front porch area, reading a book. She was dressed in seasonally appropriate clothing and agreed to an interview. She stated, I have a missing hearing aid. The company I got them through has a program for replacement. I am waiting on an audiologist appointment. Have not heard from anyone when it might be. I have a hard time hearing without it. A review of a grievance dated 08/23/2024 for Resident #5. Hearing lost. c/o (complained of) roommate had them, was looking at them, then they got lost. Actions taken: Obtained the name of the place she got the hearing aids from. Informed social services for replacement. Educated resident (roommate). Calls placed 08/23 and 08/26, awaiting call back, still have not received call back from provider. Facility agreed to have resident seen in house and will provide replacement. Signed off a completed 08/23/2024. An interview was conducted on 09/23/2024 at 1:20 p.m. with the Social Services Director (SSD). When asked how often the Audiologist came to the building, she stated they were supposed to come in one time per month. She stated the last two times they had come in was 07/09/2024 and 09/19/2024. For Resident #5, she stated she found out about the missing hearing aid in August (2024). Yes, there was a grievance for it. She stated, Resident #5 was supposed to be seen on 09/19/2024. She did not know if the resident was seen or not and was trying to call the audiologist company to find out. The SSD explained, Resident #5 was out of the facility for medical appointments 3 times a week. We were trying to coordinate. When the SSD was asked if she had documented any information about the audiologist, missing hearing aid, in Resident #5's clinical chart, she shook her head, no. During the interview, the Regional [NAME] President (RVP), stated, we are having it go through our grievance process. He provided the Audiologist Provider #1 visit notification for September 19th, and stated, we are trying to coordinate for the provider to see the resident. A review of the Audiology (Provider #1) Visit Notification for scheduled visit for 09/19/2024 listed sixteen residents' names printed with Resident #5's name handwritten with add-on per administrator. Record review of Resident #5's clinical chart reflected no documentation regarding the missing hearing aid, her audiology company (Audiologist Provider #2) who she had originally received the hearing aid from, nor any arrangements for hearing aid services through the facility audiology provider (Audiologist Provider #1). A phone interview was conducted on 09/23/2024 at 3:36 p.m. with Audiologist Provider #1, Representative #A. She stated the provider visited the facility once every 75-90 days: once per quarter. She explained how the Audiologist provider worked. She said, the resident had to be on the hearing policy. The residents had to sign up. They could ask the SSD, and the SSD would provide the face sheet to the provider for the resident. The enrollment team would contact the Business Office Manager (BOM) to review the resident's patient liability. Once the resident was enrolled in the program, an initial comprehensive examination was scheduled. She stated for Resident #5, it looked like the resident's face sheet was sent over to on 09/17/2024. It was then forwarded to the enrollment team. She stated for Resident #3, there was no documentation of receiving a request to see this resident. (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 09/24/2024 at 10:14 a.m. with Staff B, Licensed Practical Nurse (LPN) Unit Manager. She confirmed she was aware of Resident #5's missing hearing aid. She stated, Resident #5] came to me, told me about her roommate. Her roommate has a little confusion. I did the grievance. [Resident #5] gave me the number to [Audiologist Provider #2], that was where she got the hearing aids from. She gave me the number. I tried to call one time. I gave the number to social services. Social services tried to call. Staff B She said, [Resident #5] wanted to go to [Audiologist Provider #2] because it was where she had gotten her hearing aids originally and she gets some kind of percentage off. An interview was conducted on 09/24/2024 at 11:01 a.m. with Staff B, LPN. She confirmed she did not document her effort with calling the audiologist for Resident #5. On 09/24/2024 at 12:03 p.m., the SSD was re-interviewed. She stated she had been able to contact [Audiologist Provider #2] yesterday, 09/23/2024. She stated she had spoken with the provider with the resident present, and they were going to e-mail a form for the resident to sign and then they would send an invoice for the hearing aid, \$500.00. The hearing aid was under warranty and that would be the cost for the new set. She stated the facility would cover the cost. A review of the facility's Grievance/ Complaint Report policy and procedure, copyright 2008, documented the Purpose: To document receipt of a grievance or complaint, the facility actions and resolution. A grievance is defined as a concern or complaint that is unable to be immediately resolved and requires further investigation and action by facility leadership to achieve resolution. Procedure included: Responsible Person: Maybe initiated by any staff member upon identification of grievance or complaint. Follow up conducted by Grievance Official, Administrator or the director of Social Services or designee. When: Upon identification of grievance/ complaint Follow up done as soon as possible after identification . .Assignment of Actions: 8. Identify and document the individual(s) designated to take action on the concern. 9. Enter the date assigned and the date to be resolved by. 10. Note: Initial investigation and report will occur within three (3) working days, of receipt of the grievance. 11. Describe any other action taken to resolve the concern and the results of the action.		