STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105636	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belleair Health Care Center	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 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. Based on observations, interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for one resident (#93) of two residents sampled for nutrition. Findings include: On 08/12/25 at 2:25 PM an observation was made of Resident #93. The resident was observed with a pink NPO (nothing by mouth) wrist band to right wrist and was noted to be drinking from a cup at the bedside. Resident #93 said family had provided the cup, and he was aware he was not supposed to be drinking from it, but he was thirsty.Review of Resident #93's medical record revealed a physician's order dated 07/27/25 and no end date for NPO diet, NPO texture, NPO consistency.Review of Resident #93's care plan with a revision date of 07/15/25 revealed [Resident #93] has a swallowing problem r/t [related to] oral cancer, and dysphagia [difficulty swallowing]. The goal revealed [Resident #93] will not have injury related to aspiration through the review date. The interventions revealed, Diet to be followed as prescribed. Encourage resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly. On 08/13/25 at 2:45 PM an interview was conducted with the Care Plan Coordinator who said Resident #93 is NPO and confirmed the intervention of encouraging the resident to eat in an upright position, and to chew each bite thoroughly would not be appropriate for this resident. The Care Plan Coordinator said the care plan would not be considered a person-centered care plan for Resident #93.On 08/13/25 at 2:55 PM an interview was conducted with the Director of Nursing (DON). The DON said Resident #93's care plan interventions were not appropriate for the resident and confirmed the care plan should be patient centered.

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 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. Based on observations, interviews, and record review the facility failed to provide appropriate wound care by not following professional standards of care for one resident (#87) of three residents sampled for non-pressure related skin conditions.Findings included: On 08/12/25 at 1:45 PM an interview was conducted with Resident #87, who said he was here at the facility due to a wound on the right foot that became infected prior to admission to the facility. Observation of the resident's right foot revealed the right foot was covered in a gauze dressing and dated 08/12/25. Resident #87 said the dressing had been changed earlier today.An observation was conducted on 08/13/25 at 12:00 PM of Resident #87's right foot covered in a gauze dressing dated 08/13/25. Review of Resident #87's electronic medical record revealed a wound care physician order dated 07/29/25 for wound care-right hallux/plantar-apply collagen then apply calcium alginate-wrap with (gauze) and then (self-adherent bandage) daily and as needed. The physician order for the right heel dated 07/30/25 revealed wound care-right heel-cleanse with normal-saline pat dry-apply collagen-then apply calcium alginate-cover with dry dressing every day and as needed. Review of the physician order dated 07/06/25 for Resident #87's right foot revealed Medi honey wound/burn dressing external gel apply to open area right foot. On 08/14/25 at approximately 2:30 PM an observation of wound care for Resident #87's right foot was conducted provided by Nurse F, a Licensed Practical Nurse. Nurse F was observed to perform hand hygiene and don a gown and gloves prior to removing the soiled dressing from Resident #87's right foot. Nurse F then removed gloves and did not perform hand hygiene before donning new gloves and proceeded to clean the right plantar wound. Nurse F then cleaned the wound to the resident's right heel without changing gloves or performing hand hygiene. Nurse F was then observed to apply collagen and dry dressing to the right heel and then applied Medi honey and collagen to the right plantar wound without changing gloves or performing hand hygiene and covered both wounds with (gauze) dressing and secured with tape. Nurse F then removed the gloves and gown and performed hand hygiene. On 08/14/25 at 2:40 PM an interview was conducted with Nurse F who confirmed hand hygiene was not performed after removing the soiled dressing and applying clean gloves, and further confirmed gloves were not changed and hand hygiene was not performed between the two different wounds on Resident #87's right foot and that would be considered an infection control issue. After reviewing the physician orders for wound care for Resident #87 with Nurse F, Nurse F indicated the treatment order was not followed because the calcium alginate was not applied to either wound nor was the wound covered with (self-adherent bandage). On 08/14/25 at approximately 2:50 PM an interview was conducted with the Director of Nursing (DON) who said the expectation was that the nurse follows the physician orders for treatments and use good infection control practices and hand hygiene in between each step of the wound care process and in between each wound as well.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review the facility failed to ensure splints were applied according to physician orders for one resident (#14) out of one resident reviewed for splints.Findings included: An observation was conducted on 08/12/2025 at 1:52 PM. Resident #14 was lying in bed asleep with covers up to neck with both hands exposed. Resident #14 was observed to have a right-hand contracture with no splint in place. An observation was conducted on 08/14/2025 at 9:43 AM. Resident #14 was in bed watching television. The right hand was contracted with no splint or washcloth in place. Review of Resident #14's physician orders revealed an order dated 08/13/25 Restorative Nursing for splinting. Pt [patient] to tolerate R [right] palm guard with finger separators and rolled towel placed in elbow crease on 24 hours with removal for skin checks and hygiene.Review of Resident #14's Therapy Comprehensive Screen with an effective date of 8/11/25 revealed Resident #14 had current orders for adaptive equipment/device/splint/brace. The type of adaptive equipment /device/splint/brace was R [right] Hand palm guard with finger sep. [separators]. Review of Resident #14's OT [Occupational Therapy] Discharge summary with dates of service being 03/13/225-05/05/2025 revealed a goal of patient to improve tolerance for hand positioning with palm guard to four hours daily. The goal was met on 04/03/2025. Therapist to develop and train patient/restorative aid in range of motion (ROM) and splinting program to decrease risk of worsening contracture. On 05/05/25 restorative aide trained, and restorative program implemented. On 08/14/2025 at 11:23AM an interview was conducted with Staff E, Licensed Practical Nurse (LPN). Staff E, LPN said Resident#14 does have a splint for the right hand. Staff E, LPN was observed to assess Resident #14's right hand by opening the hand. Staff E, LPN did not put Resident #14's splint on the right hand after the assessment. On 08/14/25 at 1:35PM, an interview was conducted with the Director of Nursing (DON). The DON stated therapy puts orders in the system and therapy puts the splints on the resident and the floor staff monitor for skin and cleaning checks. On 08/14/25 at 1:45PM, an interview was conducted with the Rehabilitation Director (RD). The RD stated therapy ended for Resident #14 on 05/05/25 with the restorative program to continue therapy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews the facility failed to provide proper storage of medications for two residents (#93 and #11) of 38 sampled residents. Findings included: On 8/12/25 at 2:33 PM an observation was made of a bottle of “Dakin's Solution quarter strength” (a pharmacy grade bleach solution to treat wounds) was noted on Resident #93's dresser in his room. On 08/13/25 at 1:13 PM an observation was made of Resident's #93's dresser and revealed the bottle of “Dakin's Solution” was still present in the resident's room. On 08/13/25 at 1:14 PM an interview was conducted with Nurse F, a Licensed Practical Nurse who confirmed that the bottle of “Dakin's Solution” should not be kept on the resident's dresser in the room but should be stored on the treatment cart. Nurse F then removed the bottle from the resident's room. On 08/13/25 at 1:15 PM an interview was conducted with the Director of Nursing (DON). The DON said it was her expectation treatment supplies and medications were to be stored on the treatment cart and secured. 2. On 08/12/25 at 9:02 AM a container of Desitin cream (a cream used to prevent rash and provide skin protection) was observed on a shelf next to Resident #11’s bedside. Resident #11 was not inside the room. On 08/12/2025 at 12:04 PM, an interview was conducted with Resident #11 and said her family ordered the Desitin cream because she did not have it for four weeks and her perineal went raw. Resident #11 said there was a physician order to apply another cream, but that cream was too thick and Desitin worked better. Resident #11 said staff applied the Desitin cream every time she had an incontinent episode. On 08/13/2025 at 12:27 PM the Desitin cream was observed at bedside inside Resident #11’s room. On 08/13/2025 at 2:46 PM, the Desitin cream was observed on a shelf, inside Resident #11’s room. Photographic evidence was obtained. A review of Resident #11 medical record was conducted and there were no physician’s orders for Desitin cream. On 08/14/2025 at 2:25 PM, an interview was conducted with Staff A, a Certified Nurse Assistant (CNA). She stated she assisted Resident #11 with incontinence care, and she would apply Desitin cream every time during perineal care. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/14/2025 at 3:45 PM, an interview was conducted with Staff B, a Licensed Practical Nurse (LPN). She stated she was not aware, until yesterday, that Resident #11 kept Desitin inside her room. She reviewed Resident #11's medical record and verified Resident #11 did not have a physician order for the cream. On 08/14/2025 at 3:35 PM, an interview was conducted with Staff C, Unit Manager (UM). Staff C, UM stated he was not aware the CNA’s were applying Desitin cream to Resident #11 and he was not aware visitors were bringing it into the facility. Review of the facility policy titled Storage of Medications revised January 2018 revealed: Policy: Medication and biologicals are stored safely, securely, and properly, following manufacture's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and record review the facility failed to maintain proper infection control practice during wound care for one resident (#87) of three residents sampled for non-pressure related skin conditions.Findings included:On 08/12/25 at 1:45 PM an interview was conducted with Resident #87, who said he was here at the facility due to a wound on the right foot that became infected prior to admission to the facility. Observation of the resident's right foot revealed the right foot was covered in a gauze dressing and dated 08/12/25. Resident #87 said the dressing had been changed earlier today.An observation was conducted on 08/13/25 at 12:00 PM of Resident #87's right foot covered in a gauze dressing dated 08/13/25. Review of Resident #87's electronic medical record revealed a physician order dated 07/29/25 for wound care-right hallux/plantar-apply collagen then apply calcium alginate-wrap with (gauze) and then (self-adherent bandage) daily and as needed. The physician order for the right heel dated 07/30/25 revealed wound care-right heel-cleanse with normal-saline pat dry-apply collagen-then apply calcium alginate-cover with dry dressing every day and as needed. Review of the physician order dated 07/06/25 for Resident #87's right foot revealed Medi honey wound/burn dressing external gel apply to open area right foot. On 08/14/25 at approximately 2:30 PM an observation of wound care for Resident #87's right foot was conducted provided by Nurse F, a Licensed Practical Nurse. Nurse F was observed to perform hand hygiene and don a gown and gloves prior to removing the soiled dressing from Resident #87's right foot. Nurse F then removed gloves and did not perform hand hygiene before donning new gloves and proceeded to clean the right plantar wound. Nurse F then cleaned the wound to the resident's right heel without changing gloves or performing hand hygiene. Nurse F was then observed to apply collagen and dry dressing to the right heel and then applied Medi honey and collagen to the right plantar wound without changing gloves or performing hand hygiene and covered both wounds with (gauze) dressing and secured with tape. Nurse F then removed the gloves and gown and performed hand hygiene. On 08/14/25 at 2:40 PM an interview was conducted with Nurse F who confirmed hand hygiene was not performed after removing the soiled dressing and applying clean gloves, and further confirmed gloves were not changed and hand hygiene was not performed between the two different wounds on Resident #87's right foot and that would be considered an infection control issue. After reviewing the physician orders for wound care for Resident #87 with Nurse F, Nurse F indicated the treatment order was not followed because the calcium alginate was not applied to either wound nor was the wound covered with (self-adherent bandage).On 08/14/25 at approximately 2:50 PM an interview was conducted with the Director of Nursing (DON) who said the expectation was that the nurse follows the physician orders for treatments and use good infection control practices and hand hygiene in between each step of the wound care process and in between each wound as well.