STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105926	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Suncoast	1095 Pinellas Point Dr S Saint Petersburg, FL 33705

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39866 Based on interviews and record review, the facility failed to ensure an accurate care plan was in place related to Advanced Directives for one resident (#101) out of 40 sampled residents. Findings included: Review of Resident #101's Admission Record revealed he was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] from an acute care hospital. His diagnoses included dysphagia following unspecified cerebrovascular disease, muscle weakness, abnormalities of gait and mobility, repeated falls, and speech/language deficits following a cerebrovascular disease. A review of Resident #101's physician orders revealed an order, dated 4/21/24, for Do Not Resuscitate (DNR). Review of Resident #101's medical record revealed a State of Florida's Do Not Resuscitate Order, dated 3/29/24, completed by Resident #101's Durable Power of Attorney (POA) and signed by the physician on 3/30/24. Review of Resident #101's care plan, dated 4/5/24, revealed the following: Residents Advanced Directives have been reviewed and include: Full Code. The goal revealed, Resident's wishes will be honored. The interventions revealed: Assist resident/family as needed for completion of Advanced Directive documents where applicable. Educate resident/family regarding Advanced Directives. Make resident's wishes known through care continuum. Notify physician if any change in condition. Review resident's advanced directives quarterly. An interview was conducted on 04/23/24 at 09:10 AM with Staff F, Assistant Social Worker. She said upon admission Advanced Directives are obtained by the social services department and after hours the nurses obtain the Advanced Directives, then the social services department follows up. She stated the social services department develops Advanced Directive care plans and the care plans should be accurate and reflective of the information obtained. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 4/24/24 at 1:20 p.m. with the Director of Nursing (DON) and the Nursing Home Administrator (NHA). The DON and the NHA confirmed Advanced Directive care plans should be reflective of the physician order. The NHA said staff are to go to the physician order in the electronic medical record and in the hard chart to obtain the physician ordered code status. The care plan is not where the staff go to determine code status. Review of the facility's Comprehensive Care Plans policy, revised date 7/23, revealed the following: Policy: It is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. .Policy Explanation and Compliance Guidelines: .3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39866 Based on observations, interviews, and record review, the facility failed to ensure pressure relieving boots were applied to prevent the worsening of a pressure wound for one resident (#101) out of one resident sampled for pressure wounds. Findings included: Review of Resident #101's Admission Record revealed he was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] from an acute care hospital. His diagnoses included dysphagia following unspecified cerebrovascular disease, muscle weakness, abnormalities of gait and mobility, repeated falls, speech and language deficits following a cerebrovascular disease. An observation was conducted on 04/22/24 at 10:16 AM. Resident #101 was observed to be in bed eyes closed, feet resting on the mattress, with his green air boots on the chair next to his bed, not in use. An observation was conducted on 4/23/24 at 10:41 AM. Resident #101 was observed to be lying on his right side, in bed, with the sides of both feet resting on the air mattress, with his eyes closed, with his green air boots in the chair next to his bed, not in use. Review of Resident #101's physician orders revealed a start date of 4/21/24 with no end date for Air boots to heels while in bed. every shift for Wound/Prevention. A physician's order with a start date of 3/20/24 and no end date to float heels while in bed every shift for Pprevention [sic]. Review of Resident #101's Treatment Administration Record (TAR) revealed on 4/22/24 the day, evening, and night shift nurses signed off as administered on Resident #101's physician order for Air boots to heels while in bed. every shift for Wound/Prevention. On 4/23/24 the day and evening documented the air boots were administered. Review of Resident #101's April Medication Administration Treatment (MAR) and TAR did not reveal documentation related to float heels while in bed every shift for Pprevention [sic]. Review of Resident #101's Wound Assessment Report, dated 4/22/24, revealed the following: Location: left lateral heel: measurements: Length:1.07cm width: 1.00 cm LxW: 1.07cm2 Depth: 0.00cm (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Etiology: Pressure stage/severity: unstageable acquired in house: No date wound acquired 3/30/24 wound status: stable .Periwound: Fragile, Denuded, Macerated Exudate Amount: Moderate Exudate Description: Serosanguineous Odor Post Cleansing: None Treatment Dressing Change Frequency: Daily, and PRN [as needed] Clean Wound With: Cleanse with normal saline Primary Treatment: Betadine Other Dressings: float heels, Bordered foam, LAL [low air loss]/Heel Boots . Review of Resident #101's care plan, revised on 4/5/24, revealed the following: [Resident #101] has Coccyx and left lateral heel pressure related areas requires assist with bed mobility & repositioning, nutritional risk continues, and he continues to be at risk for further breakdown. The goals included Will not have further breakdown on coccyx. Will not develop additional skin breakdown/pressure injuries. The interventions included: air boots to heels while in bed with a creation date of 4/22/24. apply house lotion to dry skin PRN assist resident as needed with bed mobility & repositioning on rounds during cares & PRN check Braden scale encourage good nutritional intake (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	float heels while in bed OLO air loss alternating pressure air mattress observe resident's skin condition during routine care every shift and report any findings to nurse ooh cushion in wheelchair treatments as ordered weekly skin checks An interview was conducted on 4/24/24 at 1:18 p.m. with the Director of Nursing (DON) and the Nursing Home Administrator (NHA). The DON said the facility does not have a restorative nursing program. It is the responsibility of the staff to put on pressure-relieving boots. She said staff is either the nurse, Certified Nursing Assistant (CNA), or therapy. An interview was conducted on 4/24/24 at 1:45 p.m. with Staff G, CNA. She said the CNA's are responsible for putting on air boots and they are trained by therapy on how to do it. Review of the facility's Assistive Devices policy, revised on 7/23, revealed the following: Policy: The Purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function and/or dignity. Policy Explanation and Compliance Guidelines: .2. The use of assistive devices will be based on the resident's comprehensive assessment, in accordance with the resident's plan of care. 3. The facility will provide assistive devices for residents who need them. Nursing, dietary, social services, and therapy departments will work together to ensure availability of devices, such as for ordering and/or replacement. .5. Direct care staff will be trained on the use of the devices as needed to carry out there roles and responsibilities regarding the devices. Training will also include when to refer to other departments for changes in condition or problems with the device. 6. A nurse with responsibility for the resident will monitor for the consistent use of the device and safety in the use of the device. Refusals of use, or problems with the device, will be documented in the medical record. Modifications to the plan of care will be made as needed .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39866 Based on observations, interviews, and record review the facility failed to ensure identification and monitoring of a BIPAP (Biphasic positive airway pressure) machine was in place for one resident (#6) out of one resident sampled. Findings included: A review of Resident #6's Admission Record revealed he was initially admitted to the facility on [DATE] and readmitted from an acute care hospital on 4/18/24. His medical diagnoses included encounter for surgical aftercare following surgery on the digestive system, muscle weakness, abnormalities of gait and mobility, repeated falls, heart failure, and Type 2 Diabetes Mellitus without complications. An interview and observation was conducted on 04/22/24 at 10:10 AM. Resident #6 was observed to be lying in bed with his BIPAP mask on. He said he brought the BIPAP machine from home and he puts it on himself. He was observed to remove the BIPAP from his face and place it on his over bed table. Review of Resident #6's medical record on 4/22/24 at 11:15 p.m. did not reveal any orders related to a BIPAP machine. Review of Resident #6's care plan, with a revision date of 3/21/24, revealed the following: BIPAP therapy Obstructive Sleep Apnea. The goal included Resident Will Adhere to CPAP (Continuous Positive Airway Pressure) / BiPAP Regime. The interventions included BIPAP cleaning as scheduled and Encourage Resident's use of CPAP / BiPAP. An interview was conducted with the Director of Nursing (DON) on 4/24/24 at 12:58 PM. She said, We should have an order for the setting for the BIPAP and we would have the Respiratory Therapists come here weekly as well for the resident, and we should confirm the setting with home use or hospital use. Review of the facility's Noninvasive Ventilation (CPAP, BIPAP) policy, with a revision date of 7/23, revealed the following: Policy: It is the policy of this facility to provide noninvasive ventilation as per physician orders and current standards of practice. Definitions: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.BiPAP, or bi-level positive airway pressure, is a similar respiratory therapy interventions that delivers an inhale pressure and an exhale pressure to provide a patent airway. It requires a machine that generates the separate pressures through a tube into a mask that fits over the nose or mouth. Policy Explanation and Compliance Guidelines: .2. The facility will obtain an order for the use of a CPAP, BiPAP, device and settings from the practitioner. 3. The CPAP, BiPAP, device must be set up and maintained by_____(specify). 4. Pay personal CPAP/BiPAP device may/may not be brought into the facility for the resident's use. If brought in, the nurse/respiratory therapist will verify the settings on the machine prior to use. 5. The facility will follow the manufacturer's instruction for use of the machine. .7. Document use of the machine, resident's tolerance, any skin, respiratory or other changes and response(s). 8. Follow manufacturer instructions for the frequency of cleaning/replacing filters and servicing the machine. Only the supplier may service the machine .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49227 Based on record review and interviews, the facility failed to ensure ongoing assessment and monitoring of the dialysis fistula (dialysis access port) before and after dialysis treatments for one resident (#37) out of three residents sampled. Findings included: On 4/22/24 at 12:19 p.m., during an observation and interview, Resident #37 was sitting in a wheelchair in her room after her dialysis appointment. She said the dialysis access port was recently changed due to bleeding from the left thigh to the right thigh. Review of Resident #37's admission record revealed an admitted [DATE] with diagnoses including End Stage Renal Disease and dependence on renal dialysis, and complication of surgical fistula (dialysis access port), onset date 3/27/24. Review of a physician orders, dated 4/19/24, revealed the following: -Resident #37 was scheduled for 1) dialysis services at a dialysis center on Mondays, Wednesdays, and Fridays; -Completion of the dialysis communication form before the resident leaves the facility for dialysis and on return to the facility after dialysis. A review of Resident #37's care plan, initiated on 7/25/22 and revised on 3/28/24, revealed the following: Focus: Hemodialysis due to renal failure. The goal: Will have immediate intervention should any signs or symptoms of complications from dialysis occur. The intervention listed include: 1) complete the dialysis communication form as ordered; 2) receives dialysis on Monday, Wednesday, and Friday; 3) monitor dialysis catheter site for signs and symptoms of infection; 4) monitor vital signs and notify the medical doctor of significant abnormalities; 5) monitor, document and report as needed any signs or symptoms of infection to access site for example, redness, swelling, warmth or drainage; 6) monitor, document and report as needed signs and symptoms of bleeding, hemorrhage, Bacteremia and septic shock. A review of the Dialysis Communication Inter-Change form dated, 4/3/24, revealed the thrill and bruit assessments, signs of bleeding and or infection, and the nurses' signature were not recorded before leaving the facility for dialysis. The thrill and bruit assessments and signs of bleeding and or infection were not recorded after returning to the facility from dialysis. A review of a physician note, dated 4/3/24, revealed intermittent swelling in the left leg and staff to notify the physician if symptoms become more pronounced. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Dialysis Communication Inter-Change form dated, 4/5/24, revealed the thrill and bruit assessments, signs of bleeding and or infection and the nurses' signature were not recorded before leaving the facility. The thrill and bruit assessments and signs of bleeding and/ or infection was not recorded on return to the facility. A review of the progress note dated, 4/5/24, revealed the thrill and bruit assessments, signs of bleeding and or infection were not recorded. A review of the Dialysis Communication Inter-Change form dated, 4/8/24, revealed pre dialysis thrill and bruit assessments, signs of bleeding and/or infection and the nurses' signature were not recorded on the form for Resident #37 A review of a progress note, dated 4/8/24, revealed Resident #37 was admitted to the hospital from the dialysis center. A review of a hospital consultation report dated, 4/8/24 at 2:12 p.m., revealed a clot was removed from the left thigh dialysis fistula. A review of a progress note, dated 4/10/24 at 11:17 p.m., revealed Resident #37 arrived at the facility by ambulance. An assessment of the fistula was not recorded. A review of progress notes, dated 4/11/24 at 7:20 a.m., revealed Staff C, RN, ADON entered the residents room and observed copious amounts of [NAME] red blood and clots from the left dialysis fistula. A review of the Medical Certification for Medicaid Long-term Care Services and Patient Transfer form, (3008), dated 4/19/24, revealed a primary diagnosis of hemorrhage of hemodialysis fistula of left thigh. A review of the Dialysis Communication form dated, 4/22/24, revealed pre dialysis vital signs, thrill and Bruit assessment, signs of bleeding and or infection and the nurses' signature were not recorded. The post dialysis thrill and bruit assessments, signs of bleeding and or infection and the nurses' signature were not recorded for Resident #37 A review of the progress notes, dated 4/22/24, revealed the dialysis fistula assessment was not recorded. A review of the Dialysis Communication form dated, 4/24/24, revealed pre dialysis vital signs, thrill and Bruit assessment, signs of bleeding/ infection, and nurses' signature were not recorded. The post dialysis, thrill (feel fistula vibrations) and bruit (listen to the fistula with a stethoscope) assessments and signs of bleeding and/ or infection were not recorded for Resident #37 A review of the progress notes, dated 4/24/24, revealed assessment of the dialysis fistula was not recorded for Resident #37. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/25 at 3:23 p.m. an interview was conducted with the DON and, Staff C, RN, ADON. Staff C, RN, ADON said the facility expects staff to complete fistula thrill and bruit assessments every shift and document in the progress notes. She stated the thrill and bruit assessments should be documented on the dialysis communication form before a resident leaves the facility for dialysis and after returning to the facility from the dialysis center. Staff C, RN, ADON said care plans, medication lists, and a completed dialysis communication form are sent with each dialysis center appointment. She said the nursing staff are expected to complete a dialysis communication form before and after each dialysis treatment. She stated all information should be documented on the form as follows: -Prior to leaving the facility: Resident's name, date and time, name of the dialysis facility, blood pressure, temperature and pulse, bruit and thrill assessment, signs of infection or bleeding, and the nurses' signature. -On return to the facility: time returned, blood pressure, temperature and pulse, bruit and thrill assessment, signs of infection or bleeding, and the nurses' signature. On 4/25/24 at 9:08 a.m. an interview was completed with the DON and Staff C, RN, ADON. The DON said after Resident #37 returned from the hospital on 4/10/24, a dialysis fistula assessment was not recorded before she was transported to the hospital by ambulance. On 4/25/24 10:04 a.m. an interview was conducted with Staff D, Certified Nursing Assistant (CNA). She said some dialysis education has been provided, not a lot. Staff D, CNA, said if bleeding was noted or the bandage was wet the nurse would be notified. On 4/25/24 at 10:07 a.m. an interview was conducted with Staff E, Staff E, LPN said the education the facility provides is primarily web based. She said the dialysis fistula should be monitored every shift and documented in the progress note. Staff E said on 4/11/24 shortly after her shift started, she heard Resident #37 call out help, help. When she entered the resident's room she observed blood around the fistula area. Staff E immediately called the Director of Nursing (DON) and Staff C, Registered Nurse (RN), Assistant Director of Nursing (ADON) to the bedside. EMS was called to transport Resident #37 to the hospital. On 4/25/24 at 2:00 p.m. during an interview Resident #37 said, On 4/11/24 she awoke, felt her left thigh and there was blood on her hand, and her bed sheet and cover were soaked with blood. Review of Nursing education, dated 2023, titled Dialysis revealed the following steps must be completed on dialysis days for every dialysis resident. -Dialysis communication filled out completely pre and post dialysis -Dialysis communication sheet sent with resident to dialysis -Pre and post vital signs taken and recorded in the Electronic Health Record (EHR) and dialysis communication sheet. -Pre and post weights taken and recorded in the EHR and dialysis communication sheet. -Document Pre and post Thrill and Bruit in the EHR and dialysis communication sheet. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Post dialysis ensure the communication sheet is filled out completely. If not, do so now. Call the dialysis center if needed. -Make sure a nurse's note is written when the resident leaves and returns. -Skin assessment completed pre and post dialysis transportation and documented in PCC. -Care Plan and dialysis order is up to date and includes: --Transportation, Center name, location, phone number; times and days of dialysis; fistula dressing is in place, clean and intact; check thrill and bruit; vital signs pre and post; dialysis emergency procedures if bleeding is present (apply pressure).

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observations, interviews, and record review, the facility failed to ensure one resident (#72)with Post Traumatic Stress Disorder (PTSD) was assessed to identify triggers which may re-traumatize the resident out of 40 residents sampled. Findings Included: On 04/25/2024 at 2:00 and 3:00 p.m., Resident #72 was observed sitting with a group of residents attending an activity. Review of the Admission Record for Resident #72 showed she was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, Type 2 Diabetes Mellitus without complications, and post-traumatic stress disorder, unspecified. Review of a Minimum Data Set assessment, dated 03/1/2024, showed a Brief Interview for Mental Status (BIMS) score of 09 indicating Resident #72 was moderately cognitively impaired. Review of Resident #72's care plan showed the following: Focus: The resident has a history of Trauma related to a traumatic event as a child related to verbal and physical abuse, requires ongoing intervention to maintain psychosocial well-being. Resident # 72 is followed by Huntington Behavioral Services as needed. Dated initiated 02/13/2024, revised dated 02/13/2024. Interventions: Administer medications as ordered arrange for Licensed Mental Health Providers/ Psych services as indicated, encourage resident to expression of feelings and concerns in a safe space, encourage involvement in care planning decisions, encourage supportive relationships with family and friends, keep informed about changes to care, life at the facility, etc., observe for possible signs and symptoms of depression, anxiety, sleep disturbance substance abuse. Date initiated 02/13/2024. The care plan did not identify triggers specific for the resident which could potentially re-traumatize the resident. During an interview on 04/25/2024 at 3:30 p.m., with the Social Services Director, SSD, she stated Trauma Screening is part of the resident's admission assessment. She stated the resident or their representative are asked questions to determine if the resident has a history of trauma. Based on the assessment a Trauma care plan is created and then the resident is referred to psychiatric services. She stated they can identify what the resident triggers are when they ask the resident or their representatives to provide the resident trauma background information. She stated the resident triggers are then documented so staff would know how to properly assist the resident with their care needs. She stated Resident # 72 was verbally abused by a family member, but we did not ask her or her daughter if the resident had any triggers. The SSD stated she would have to reassess the resident to find out what triggers the resident. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/25/2024 at 3:45 p.m., with the Director of Nursing., she stated the Social Services Director reports to her, and she did not know much about Trauma Informed Care. She stated If we need any information about Trauma Informed Care, she would have to refer to her Social Services Director. She stated her expectations are residents with Post Trauma Stress Disorder triggers should be identified during their initial assessment so staff can be informed and provide better care for their residents. During an interview on 04/25/2024 at 3: 45 p.m., with the Nursing Home Administrator, he stated he will have the Social Services Director reassess all their residents who have Post Traumatic Stress Disorder, PTSD. He stated they will update the resident care plans and provide education to their staff related to trauma informed care. Review of facility policy titled, Trauma Informed Care, revised 6/2023, showed the following: Policy: It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and /or re-traumatization. 6. The facility will identify triggers which may re-traumatize residents with a history of trauma. Triggers-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identity ways to mitigate or decrease the effort of the trigger on the resident and will be added to the resident care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105926	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Suncoast	1095 Pinellas Point Dr S Saint Petersburg, FL 33705

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39866 Based on observations, interviews, and record review, the facility failed to ensure a paid caregiver for one resident (#205) out of 40 sampled residents had specific competencies and skill sets necessary to care for the resident's care needs. Finding included: Resident #205 was admitted to the facility on [DATE] with diagnoses of Hemiplegia and Hemiparesis following a cerebrovascular disease affecting the right dominant side, abnormalities of gait and mobility, and muscle weakness. An interview was conducted on 04/22/24 at 10:54 AM with Resident #205's private caregiver. The private caregiver was observed to have gloves on and said she had just taken the resident to the bathroom. She said the resident arrived at the facility last Thursday after having a stroke and went to the hospital. She said the resident had weakness on her right upper and lower extremities. The private caregiver said she had been transferring the resident to the bathroom, giving the resident showers, and helping get her dressed because when she put the call light on it would take 20-30 minutes for anyone to answer the light and when she would ask the staff if they can take the resident to the bathroom or give her a shower the staff told her the other private caregivers were doing the care so she could provide the care too. She asked the staff if they needed to see her transfer the resident and they said no they didn't need to see her do it. The private caregiver said she is a home health aide who works for a private agency and has not had any formal training as a Certified Nursing Assistant (CNA) or nurse. An interview/observation was conducted on 04/23/24 at 10:50 AM with Resident #205 and her private caregiver. The private caregiver was observed to have gloves on and said the resident was in the bathroom. The private caregiver said this morning when she arrived, she got the resident up, cleaned her up, dressed her and brought her to bathroom. The private caregiver said she arrives in the morning and leaves at 4:00 p. m. then the family comes. The private caregiver said yesterday (4/22/24) she provided all the activities of daily living (ADL) care the resident required without help from the staff until she left at 4:00 p.m. An interview was conducted on 04/23/24 at 10:50 AM with Staff H, CNA. He said this is his first time working with Resident #205. He said the resident has a private person in the room who comes after breakfast and gets the resident up, dressed, cleaned up and takes the resident to bathroom. He said he was not sure how many people the resident requires to transfer but he Would assume one person. An interview was conducted on 4/24/24 at 12:55 p.m. with the Director of Nursing (DON). She said our staff should be providing the residents care but the residents do have the opportunity to have a private caregiver. The DON said she was not aware Resident #205 had a private caregiver and she would have to follow up to find out if the private caregiver has had any training on how to perform care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105926	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Suncoast	1095 Pinellas Point Dr S Saint Petersburg, FL 33705

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 4/24/24 at 1:05 p.m. with the Nursing Home Administrator (NHA) who said he was aware Resident #205 had a private caregiver, but he did not know if the private caregiver had any formal training to provide ADL care. He said the facility staff should be performing ADL care. An interview was conducted on 4/24/24 at 1:45 p.m. with Staff G, CNA. She said Resident #205 has a private aide and the private aide provides the resident with all the ADL care, so she doesn't have to. A phone interview was conducted on 4/25/24 at 3:30 p.m. with Resident #205's family member. He said Resident #205 has had four strokes and the most recent one was a month ago which lead her to the facility after a hospital stay. He said since the stroke Resident #205 had become very weak and was unable to get up. He said he has a private caregiver come for seven hours during the day and four hours at night. He said the number one reason for the private caregivers is to provide hygiene to Resident #205. He said his only concern with the facility is the staff are supposed to provide the care to Resident #205, but the private aides are providing the ADL care when the facility staff do not provide the care. An interview was conducted on 4/25/24 at 3:33 p.m. with the NHA. He said he spoke to the private caregiver and asked if she had been pushing the call light, she said she had not been using the call light since the first day when it took a long time for the staff to come. He said he also found out she had been working out of her scope and our staff should be providing care. He said, so the private caregiver was educated that she is essentially a companion, and our staff should be providing all the care. The NHA interpreted the facility's policy titled Home health services CCRC's guidelines on limitations of service dated 02/05and said Resident #205 caregiver would be considered a Non-certified Personal Assistant (3) and her duties are limited to Provides domestic services such as: light housework, assistance with grooming, letter writing, companionship and assistance with transportation.