

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106033	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2024
NAME OF PROVIDER OR SUPPLIER  St Petersburg Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  521 69th Ave N Saint Petersburg, FL 33702	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015</b></p> <p>Based on record review, interview, and review of the facility's policy Abuse Investigation and Reporting the facility failed to immediately report an allegation of abuse, upon resident disclosure, for one resident (Resident #2) of three residents reviewed for abuse.</p> <p>Findings included:</p> <p>A review of the Admission Record showed Resident #2 was admitted to the facility on [DATE] with diagnoses that included but not limited to Acute kidney failure, insomnia, unspecified dementia, severity without behavioral disturbance, major depressive disorder, recurrent and anxiety disorder.</p> <p>Review of the Quarterly Minimum Date Set dated 01/24/24 showed Section C- Cognitive Patterns Resident #2 had a Brief Interview of Mental Status (BIMS) of 07 (cognitively impaired). Section I- Active Diagnoses showed Resident #2 had Non-Alzheimer's Dementia and Depression.</p> <p>Review of Resident #2's care plan showed:</p> <p>Focus</p> <ul style="list-style-type: none"> <li>- [Resident #2] has a potential for re-traumatization related to recent traumatic experience: being attacked by another resident.</li> </ul> <p>Goal:</p> <ul style="list-style-type: none"> <li>- Resident will remain free from episodes of re-traumatization AEB: (personalize) through the next review.</li> <li>- Resident will remain free from episodes of re-traumatization AEB no flashbacks or upsetting dreams through the next review.</li> </ul> <p>Interventions:</p> <ul style="list-style-type: none"> <li>- Establish a relationship of trust with the resident.</li> <li>- Encourage participation in activities of choice.</li> </ul> <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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Use a calm approach. Explain action during cares.</p> <p>- Observe changes in mood/behavior; update physician if noted.</p> <p>Review of a facility's reportable dated 12/16/23 revealed Resident #2 was observed being physically and verbally abused by Staff L Certified Nursing Assistant (CNA) on 12/16/23. Further review of the witness statements revealed:</p> <p>- A witness statement provided by Staff S, Registered Nurse (RN) who witnessed the abuse of resident #2 showed On 12/16/23 at approximately 1400 hours, I witnessed a [Staff L] CNA grab resident [Resident #2] by her arm and pull her close to him stating things about what she is going to do, specifically say what now bitch? CNA was previously upset because the resident came to me claiming he had grabbed her wrists and hurt her. I did not see any new markings. Resident is confused and an elopement risk, traveling about the unit speaking to multiple people. Photographic evidence obtained.</p> <p>- A witness statement provided by Staff T Registered Nurse (RN) Nurse Supervisor (NS) showed, [Staff S RN] reported to writer that she observed [Staff L CNA] approach 202B [Resident #2] and stated, What now Bitch while holding resident's arm. Writer then spoke with [Staff L CNA] about the matter. He stated that he knew who had reported the issue. He was then escorted from the facility.</p> <p>- A witness statement provided by Staff L Certified Nursing Assistant (CNA) dated 12/16/24 showed, I was up on the 2nd floor and [Resident #2] tried to escape out the back door and I had to keep her from going out the back and I tried to take her room nurse was missing and CNA's.</p> <p>During an interview on 05/29/24 at 12:21 p.m., Staff S RN stated Resident #2 had disclosed to her, the morning of 12/26/23, that Staff L CNA had grabbed Resident #2's arms and hurt her. Staff S RN stated that Resident #2 had dementia and was confused. Staff S RN stated she did complete a skin assessment on Resident #2 after the abuse allegation was disclosed but did not see any markings on Resident #2's arms. Staff S RN stated knowing Resident #2 had dementia and confusion and Staff L CNA, you wouldn't think it to be true however, when I saw [Staff L CNA] that afternoon on 12/16/24 grab Resident #2's wrist and say What now Bitch I thought this looks like the allegation could be true so I immediately reported abuse to [Staff T RN, Nurse Supervisor). Staff S RN stated that she had provided a written statement to the facility prior to leaving for the day on 12/16/23.</p> <p>During an interview on 05/29/24 at 3:30 p.m., the Director of Nursing (DON) stated the incident with Resident #2 and Staff L CNA occurred over a weekend. The DON stated that she did not investigate this allegation of abuse because at the time of the incident the previous Administrator was the Risk Manager. The DON reviewed the facility's reportable of the incident with the Team of Surveyors. The DON, after reviewing Staff S RN witness statement, stated that she would have expected Staff S RN to have reported Resident #2's allegation of abuse the morning of 12/16/23 at disclosure. The DON stated that it was not the facility's policy to wait to observe abuse before reporting abuse. The DON stated that Staff S RN should have reported the allegation of abuse that morning at which time Staff L CNA would have been suspended upon investigation.</p> <p>Review of the facility's policy Abuse Investigation and Reporting revised date July 2017 showed, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies and thoroughly investigated by the facility.</p>		