Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55222	A. BUILDING: _____ B. WING _____	C 03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLFVIEW NURSING CENTER	3636 10TH AVE N SAINT PETERSBURG, FL 33713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	INITIAL COMMENTS An unannounced complaint survey for complaint numbers 2024016462 and 2025003110 was conducted on at Golfview Nursing Center LLC. Deficiencies were found at the time of survey. Complaint number 2025003110 had a deficiency cited at N917.	N 000		
N 917 SS=D	400.147(8), FS Report , Neglect, & , (8) , neglect, or , must be reported to the agency as required by 42 C.F.R. s. 483.13(c) and to the department as required by chapters 39 and 415. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an allegation of was reported within the two-hour time frame requirement, for one resident (#1) of three residents reviewed for . Findings included: Review of the facility's policy "Prevention of Resident , Neglect, Mistreatment or Misappropriation of Property" dated showed "Reporting/Documentation Requirements: If the event that causes the allegation involve or results in serious bodily injury, the event must be reported immediately, but no later than 2 hours after the allegation is made. Upon suspecting , neglect or , of a resident, the following procedure is to be followed: 1. Immediately notify:	N 917	1. The allegation related to Resident#1 was reported promptly upon notification to Administrator/ Coordinator and within 2-hour timeframe. CNA was suspended immediately upon notification of allegation by Director of Nursing. Resident #1 received appropriate interventions, including emotional support and follow-up assessments. Resident #1 remained at her behavioral baseline, in no mental anguish, and participating in her normal activities. 2. Administrator/Designee interviewed all alert and oriented residents on Staff D CNA's assignment were interviewed on and all not alert and oriented residents had skin assessments completed to observe for any possible signs of . No other residents were affected. Administrator/Designee conducted staff interviews on to	

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N 917	Continued From page 1 a. Administrator b. Director of Nursing c. FL Only- Florida Hotline 1-800-96- d. Center Risk Manager." Review of a Psych note for Resident #1 dated showed Resident #1 disclosed "the CNA [Certified Nursing Assistant] grabbed my arm (pointing to her left) and wouldn't let go. [Resident #1] then points at the on her on her left . There is a third on her left , and when asked her if that was related to the incident, she first says no and then quickly said yes." Review of a Change of Condition dated showed " Situation: 1. Sustained x 3 (left x 2 and left x 1)- combative with CNA - hitting and calling her names. This started on: ." Under A 2. Resident/Patient Evaluation on Behavior Evaluation, 7. Physical aggression was check marked. An interview was conducted on at 10:20 a.m. with Staff D, Certified Nursing Assistant (CNA). Staff D, CNA stated she recalled the incident between herself and Resident #1 which occurred on . Staff D, CNA stated Resident #1 had her call light on, so she stopped in Resident #1's room, during which she asked for her wheelchair to be moved away from in front of her television. Staff D, CNA said, "I informed Resident #1 that I would be in to assist her with her morning ADL (activities of daily living) care next, after I finished assisting another resident whose care was already in progress." Staff D, CNA stated when she went to Resident #1 and started to assist with her morning ADL, "Resident #1 reached out and grabbed a handful	N 917	identify any possible concerns. No concerns identified. A comprehensive review of all incidents over the last 90 days was completed by Director of Nursing/Designee to identify any potential un-reported allegations. No new findings were identified. 3. Administrator/Designee educated all staff on , Neglect, and Misappropriation Reporting Policies and Procedures and completed Post-Test. All education and post-tests were completed by or prior to their next scheduled shift. Administrator/Designee to educate all new hires on Policies and Procedures and post-test completed during new-hire orientation. DON/Designee completed written coaching with Staff F, Weekend Supervisor and Staff H, RN to ensure moving forward reporting process is followed. Administrator implemented random interviews with residents, staff, and families to be conducted by different members of the Interdisciplinary Team weekly x 3 months to ensure no events go un-reported. Administrator/Designee will review completed interviews daily to determine if any concerns need to be reported. 4. Administrator/Designee will complete daily audits of all incident reports x4 weeks then 3x a week audits for 3 months or until substantial compliance is achieved. Non-compliance in the reporting process will result in corrective training and disciplinary actions. Results of audits will be taken to monthly QAPI x3 months or until substantial compliance is achieved.	

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N 917	Continued From page 2 of my shirt with the left and was hitting me with her right ." Staff D, CNA stated that she "immediately began screaming for help" and asked her "to stop hitting me." Staff D, CNA stated, she grabbed her arm to her from hitting her, as she tried to pull herself from her grasp. Staff D, CNA stated Staff B, CNA, was the first person who came in to help, but by that time she had gotten away and moved herself away from the resident's reach. Staff D, CNA said, "the second person who came in to help was Staff F, Registered Nurse (RN) and observed Resident #1 who was calling me a "Nigger Bitch" and shaking her fist at me stating, "I am going to kill them." Staff D, CNA stated she got suspended during the investigation. Staff D, CNA stated when there is an allegation of staff are required to report it immediately. Review of the Admission Record showed Resident #1 was admitted to the facility on with diagnoses that included due to occlusion or of small communication in other classified elsewhere, adult and . Review of Resident #1's care plan revised on , showed, "Focus- The resident has self-neglect behaviors related to refusing care. Refusing ADL care. The goal showed, "The resident will have no evidence of behavioral concerns (Racist Comments) by review date." Interventions included: " , and meet the residents' needs, explain all procedures to the resident before starting and allow the resident (X minutes) to adjust to change, If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident."	N 917		

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N 917	Continued From page 3 Review of the facility's Incident Log showed an entry for Resident #1 under skin , incidents dated at 10:30 a.m. Review of the Reportable dated with the Nursing Home Administrator (NHA) showed the facility reported an allegation of between Resident #1 and Staff D CNA on at 4:30 p.m. The reportable showed the time the staff became aware of the allegation of was 10:30 a.m. An interview was attempted with Resident #1 on at 10:30 a.m. Resident #1 stated she could not recall any incidents that occurred on . An interview was conducted on at 10:42 a.m. with Resident #1's roommate who stated there was an incident that occurred between Resident #1 and Staff D, CNA, but she did not see anything because the curtain was pulled. This resident stated she was in the room at the time of the incident, and heard Staff D, CNA yelling for help and telling Resident #1, "don't hit me." During an interview on at 10:26 a.m. Staff B, CNA confirmed she was present during the day of the incident and heard Staff D, CNA screaming out for help. Staff B, CNA stated she ran down the hall to find where the yelling was coming from. She stated by the time she discovered where the yelling was coming from, she opened Resident #1's door and saw Staff D, CNA, standing at the of Resident #1's bed. During an interview on at 3:02 p.m. Staff F, Registered Nurse (RN) stated on ,	N 917		

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N 917	Continued From page 4 Staff D, CNA came to her about 10:30 a.m. and stated Resident #1 was combative and had grabbed her and hit her. Staff F, RN stated she went directly to Resident #1 and completed assessments, notified the doctor and the family immediately. Staff F, RN stated she advised Staff D, CNA to write out a witness statement. Staff F, RN stated she notified the weekend nurse supervisor, Staff H LPN about the incident. During an interview on at 3:20 p.m. Staff H License Practical Nurse (LPN) Weekend Nursing Supervisor (WNS) stated she was notified by Staff F, RN Resident #1 had received a during care the morning of . Staff H, LPN stated sometimes do happen with care and didn't think anything of it. Staff H, LPN, stated later in the afternoon she interviewed Resident #1 and staff about how Resident #1 got the . Staff H, LPN, stated Resident #1 stated Staff D, CNA had "grabbed my tightly during care and caused the ". Staff H, LPN stated Resident #1 had two on her and then third on her . Staff H, LPN stated once Resident #1 alleged , she started the reporting process. Staff H, LPN stated the allegation was not reported immediately because she was not told details of the allegation and had not investigated herself. During an interview on at 3:30 p.m. the Director of Nursing (DON) stated she received a call on around 2:30 p.m. and was informed Resident #1 had on her and arm. The DON stated she immediately called Staff H, LPN and told her to go interview Resident #1 and get witness statements. The DON stated that she would have been expected to have been	N 917		

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N 917	Continued From page 5 notified about the incident when it occurred around 10:30 a.m. on and not four hours later. An interview was conducted on at 1:30 p.m. with the NHA. The NHA stated the DON reported the incident to her around 2:30 p.m. on , stating Resident #1 had and that a CNA had reported Resident #1 was combative with the staff. The NHA stated Staff H, LPN assessed the resident and found Resident #1 had on her . She stated Staff D, CNA was suspended pending investigation and the police and DCF (Department of Children and Services) were notified. The NHA stated Staff D, CNA's witness statement showed Resident #1 had grabbed the CNA and was hitting her. The NHA stated her findings did not find where Staff D, CNA intentionally set out to hurt Resident #1 as she was trying to get away from Resident #1 who was hitting her. The NHA stated the incident occurred on at 10:30 a.m. and was not reported until at 4:30 p.m. because she was not informed of the allegation until a little after 2:00 p.m. The NHA stated Staff should have notified the DON and her earlier when the incident occurred. The NHA confirmed the allegation of was reported 4 hours after the incident. Review of the facility's education and in-service training showed the following in-service dated , Presenter: The Director of Nursing (DON) , "Topic: , Neglect and , /Theft - It is the policy of the center that each resident has the right to be free from verbal, , physical and mental ; corporal punishment; involuntary ; mistreatment of any kind, , and misappropriation of property. In addition, each	N 917		

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N 917	Continued From page 6 resident will also be protected from those practices and omissions, which left unchecked, could lead to . Further, each resident will be always treated with respect and dignity. The Center will foster an environment that recognizes the worth and uniqueness of all individuals with regards to person-centered care and to promote respect and set standards of care, Residents will not be subject to by anyone, including but not limited to Center staff, other residents, consultants, volunteer staff, contract staff, family members, friends and others." 1: Definitions of 2: Types of 3: If witnessed or expressed report to coordinator immediately. 4: Facility has a 2 our window to report the allegation 5: If is reported all staff must complete a witness statement 6: Resident to Resident altercation also under guidelines 7: Ensure that the affected and all surroundings' residents are safe 8: Theft- definition 9: Misappropriation- definition 10: For any risk, please contact DON. Class III.	N 917		

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F 000	INITIAL COMMENTS An unannounced complaint survey for complaint numbers 2024016462 and 2025003110 was conducted on at Golfview Nursing Center LLC. The facility was not in compliance with Code for Federal Regulations (CFR), Part 483, Requirements for Long-Term care Facilities. Complaint number 2024016462 had a deficiency cited at F626 and F624 Complaint number 2025003110 had a deficiency cited at F609.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of , neglect, , , or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving , neglect, , or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/2025

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.

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F 609	Continued From page 1 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure an allegation of was reported within the two-hour time frame requirement, for one resident (#1) of three residents reviewed for . Findings included: Review of a Psych note for Resident #1 dated showed Resident #1 disclosed "the CNA [Certified Nursing Assistant] grabbed my arm (pointing to her left) and wouldn't let go. [Resident #1] then points at the on her on her left . There is a third on her left , and when asked her if that was related to the incident, she first says no and then quickly said yes." Review of a Change of Condition dated showed " Situation: 1. Sustained x 3 (left x 2 and left x 1)- combative with CNA - hitting and calling her names. This started on: ." Under A 2. Resident/Patient Evaluation on Behavior Evaluation, 7. Physical aggression was check marked. An interview was conducted on at 10:20 a.m. with Staff D, Certified Nursing Assistant (CNA). Staff D, CNA stated she recalled the incident between herself and Resident #1 which occurred on . Staff D, CNA stated	F 609	1. The allegation related to Resident#1 was reported promptly upon notification to Administrator/ Coordinator and within 2-hour timeframe. CNA was suspended immediately upon notification of allegation by Director of Nursing. Resident #1 received appropriate interventions, including emotional support and follow-up assessments. Resident #1 remained at her behavioral baseline, in no mental anguish, and participating in her normal activities. 2. Administrator/Designee interviewed all alert and oriented residents on Staff D CNA's assignment were interviewed on and all not alert and oriented residents had skin assessments completed to observe for any possible signs of . No other residents were affected. Administrator/Designee conducted staff interviews on to identify any possible concerns. No concerns identified. A comprehensive review of all incidents over the last 90 days was completed by Director of Nursing/Designee to identify any potential un-reported allegations. No new findings were identified. 3. Administrator/Designee educated all staff on , Neglect, and Misappropriation Reporting Policies and Procedures and completed	

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F 609	Continued From page 2 Resident #1 had her call light on, so she stopped in Resident #1's room, during which she asked for her wheelchair to be moved away from in front of her television. Staff D, CNA said, "I informed Resident #1 that I would be in to assist her with her morning ADL (activities of daily living) care next, after I finished assisting another resident whose care was already in progress." Staff D, CNA stated when she went to Resident #1 and started to assist with her morning ADL, "Resident #1 reached out and grabbed a handful of my shirt with the left and was hitting me with her right ." Staff D, CNA stated that she "immediately began screaming for help" and asked her "to stop hitting me." Staff D, CNA stated, she grabbed her arm to her from hitting her, as she tried to pull herself from her grasp. Staff D, CNA stated Staff B, CNA, was the first person who came in to help, but by that time she had gotten away and moved herself away from the resident's reach. Staff D, CNA said, the second person who came in to help was Staff F, Registered Nurse (RN) and observed Resident #1 who was "calling me a [racial expletive] and shaking her fist at me stating, I am going to kill them." Staff D, CNA stated she got suspended during the investigation. Staff D, CNA stated when there is an allegation of staff are required to report it immediately. Review of the Admission Record showed Resident #1 was admitted to the facility on with diagnoses that included due to occlusion or of small communication , in other classified elsewhere, adult and , . Review of Resident #1's care plan revised on	F 609	Post-Test. All education and post-tests were completed by or prior to their next scheduled shift. Administrator/Designee to educate all new hires on Policies and Procedures and post-test completed during new-hire orientation. DON/Designee completed written coaching with Staff F, Weekend Supervisor and Staff H, RN to ensure moving forward reporting process is followed. Administrator implemented random interviews with residents, staff, and families to be conducted by different members of the Interdisciplinary Team weekly x 3 months to ensure no events go un-reported. Administrator/Designee will review completed interviews daily to determine if any concerns need to be reported. 4. Administrator/Designee will complete daily audits of all incident reports x4 weeks then 3x a week audits for 3 months or until substantial compliance is achieved. Non-compliance in the reporting process will result in corrective training and disciplinary actions. Results of audits will be taken to monthly QAPI x3 months or until substantial compliance is achieved.	

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F 609	Continued From page 3	F 609		

, showed, "Focus- The resident has self-neglect behaviors related to refusing care. Refusing ADL care. The goal showed, "The resident will have no evidence of behavioral concerns (Racist Comments) by review date." Interventions included: " , and meet the residents' needs, explain all procedures to the resident before starting and allow the resident (X minutes) to adjust to change, If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident."

Review of the reportable log with the Nursing Home Administrator (NHA) dated showed the facility reported an allegation of between Resident #1 and Staff D, CNA on at 4:30 p.m. The reportable showed the date and time the staff became aware of the allegation of was on at 10:30 a.m.

An interview was attempted with Resident #1 on at 10:30 a.m. Resident #1 stated she could not recall any incidents that occurred on .

An interview was conducted on at 10:42 a.m. with Resident #1's roommate who stated there was an incident that occurred between Resident #1 and Staff D, CNA, but she did not see anything because the curtain was pulled. This resident stated she was in the room at the time of the incident, and heard Staff D, CNA yelling for help and telling Resident #1, "don't hit me."

During an interview on at 10:26 a.m. Staff B, CNA confirmed she was present during

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F 609	Continued From page 4	F 609		

the day of the incident and heard Staff D, CNA screaming out for help. Staff B, CNA stated she ran down the hall to find where the yelling was coming from. She stated by the time she discovered where the yelling was coming from, she opened Resident #1's door and saw Staff D, CNA, standing at the of Resident #1's bed.

During an interview on at 3:02 p.m. Staff F, Registered Nurse (RN) stated on , Staff D, CNA came to her about 10:30 a.m. and stated Resident #1 was combative and had grabbed her and hit her. Staff F, RN stated she went directly to Resident #1 and completed assessments, notified the doctor and the family immediately. Staff F, RN stated she advised Staff D, CNA to write out a witness statement. Staff F, RN stated she notified the weekend nurse supervisor, Staff H, LPN about the incident.

During an interview on at 3:20 p.m. Staff H, License Practical Nurse (LPN)/Weekend Nursing Supervisor (WNS) stated she was notified by Staff F, RN Resident #1 had received a during care the morning of . Staff H, LPN stated sometimes do happen with care and didn't think anything of it. Staff H, LPN, stated later in the afternoon she interviewed Resident #1 and staff about how Resident #1 got the . Staff H, LPN, stated Resident #1 stated Staff D, CNA had "grabbed my tightly during care and caused the ". Staff H, LPN stated Resident #1 had two on her and then third on her . Staff H, LPN stated once Resident #1 alleged , she started the reporting process. Staff H, LPN stated the allegation was not reported immediately because she was not told details of

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F 609	Continued From page 5	F 609		

the allegation and had not investigated herself.

During an interview on at 3:30 p.m. the Director of Nursing (DON) stated she received a call on around 2:30 p.m. and was informed Resident #1 had on her and arm. The DON stated she immediately called Staff H, LPN and told her to go interview Resident #1 and get witness statements. The DON stated that she would have been expected to have been notified about the incident when it occurred around 10:30 a.m. on and not four hours later.

An interview was conducted on at 1:30 p.m. with the NHA. The NHA stated the DON reported the incident to her around 2:30 p.m. on , stating Resident #1 had and that a CNA had reported Resident #1 was combative with the staff. The NHA stated Staff H, LPN assessed the resident and found Resident #1 had on her . She stated Staff D, CNA was suspended pending investigation and the police and DCF (Department of Children and Services) were notified. The NHA stated Staff D, CNA's witness statement showed Resident #1 had grabbed the CNA and was hitting her. The NHA stated her findings did not find where Staff D, CNA intentionally set out to hurt Resident #1 as she was trying to get away from Resident #1 who was hitting her. The NHA stated the incident occurred on at 10:30 a.m. and was not reported until at 4:30 p.m. because she was not informed of the allegation until a little after 2:00 p.m. The NHA stated Staff should have notified the DON and her earlier when the incident occurred. The NHA confirmed the allegation of was reported 4

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F 609	Continued From page 6 hours after the incident. Review of the facility's education and in-service training showed the following in-service dated , Presenter: The Director of Nursing (DON) , "Topic: , Neglect and , /Theft - It is the policy of the center that each resident has the right to be free from verbal, , physical and mental ; corporal punishment; involuntary ; mistreatment of any kind, , and misappropriation of property. In addition, each resident will also be protected from those practices and omissions, which left unchecked, could lead to . Further, each resident will be always treated with respect and dignity. The Center will foster an environment that recognizes the worth and uniqueness of all individuals with regards to person-centered care and to promote respect and set standards of care, Residents will not be subject to by anyone, including but not limited to Center staff, other residents, consultants, volunteer staff, contract staff, family members, friends and others." 1: Definitions of 2: Types of 3: If witnessed or expressed report to coordinator immediately. 4: Facility has a 2 our window to report the allegation 5: If is reported all staff must complete a witness statement 6: Resident to Resident altercation also under guidelines 7: Ensure that the affected and all surroundings' residents are safe 8: Theft- definition 9: Misappropriation- definition 10: For any risk, please contact DON.	F 609		

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F 609	Continued From page 7 Review of the facility's policy "Prevention of Resident , Neglect, Mistreatment or Misappropriation of Property" dated showed "Reporting/Documentation Requirements: If the event that causes the allegation involve or results in serious bodily injury, the event must be reported immediately, but no later than 2 hours after the allegation is made. Upon suspecting , neglect or , of a resident, the following procedure is to be followed: 1. Immediately notify: a. Administrator b. Director of Nursing c. FL Only- Florida Hotline 1-800-96- d. Center Risk Manager"	F 609		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a safe and orderly discharge from the facility for one resident (#2) of two residents reviewed for transfer and discharge rights. Findings included:	F 624	1. Resident #2 was discharged to the hospital under a due to endangering herself or others on . Resident #2 did not return to the facility. 2. Administrator/designee reviewed all discharges in the last 3 months to ensure	

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F 624	Continued From page 8 Review of Resident #2's Admission Care Plan dated showed the following focus and intervention areas, Resident #2, "wishes to return into the community when medically cleared." The goal showed, "The resident will be able to verbalize/communicate required assistance post-discharge and services required to meet the needs before discharge." Interventions included to establish a pre-discharge plan with the resident/resident's representative/caregivers and evaluate progress and revise the plan frequently, and to evaluate the resident's motivation to return to the community. Review of Resident #2's medical record revealed the resident's discharge plan was not evaluated and her wish to return to the community when medically cleared was not honored. Resident #2's involuntary hospital transfer was rescinded on and the facility did not document any attempts to ensure a safe and orderly transfer. Resident #2 remained in the hospital awaiting an appropriate discharge location for an additional 17 days. Review of record showed Resident #2's bed hold agreement was not honored and there was no documentation related to the cause. Review of a social services progress note dated showed, "Spoke with the patient's [family member] regarding discharge planning. The family member stated the patient will discharge home with [them]. The family member was also educated on safe discharges, all questions and concerns were answered." Review of Resident #2's Admission Record showed an admission date of with diagnoses included but not limited to, Post	F 624	discharge preferences were followed, bed hold agreements were completed, and Nursing Home Transfer and DC Notice forms were completed. 3. Administrator/Designee educated licensed nurses and Social Services Director to ensure Discharge policies and procedures are followed. Administrator/Designee will conduct daily audits to ensure residents Discharge Care Plan was followed, bed hold and Nursing Home Transfer & DC Forms are completed accurately x4 weeks and then 3x weekly for 3 months or until substantial compliance is achieved. 4. Administrator/Designee to report all audit findings to monthly QAPI meetings x 3 months or until substantial compliance is achieved.	

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F 624	Continued From page 9 Stress ( ), Conversion (a mental health condition where distress manifests aa physical symptoms that cannot be explained by a medical condition) with or , unspecified, to left and periocular area and Encounter for general examination requested by authority. Review of a Bed-Hold Agreement for Resident #2 dated showed, "I [family member name], the representative of [Resident #2] hereby request that the facility hold his/her bed space while he/she is absent from the facility. I understand that I will be responsible for payment of the basic per diem rate. I understand the basic per diem rate is $261 per day, for maximum number of 8 days. The agreement signed by Staff F, RN showed "wants bed hold per [family member]. Further review of Resident #2's record did not show documentation rescinding the agreement. Review of the Nursing Home Transfer and Discharge Notice for Resident #2 dated revealed an incomplete document without signatures from the resident, resident representative and physician. The only signature was for Staff F, RN, signing on behalf of the NHA/designee, revealing "Your needs cannot be met at this facility." The brief explanation showed , "[involuntary hospitalization]". Review of Resident #2's Preadmission Screening and Resident Review (PASRR) Level II Determination Summary Report dated initiated at a local hospital showed	F 624		

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Resident #2 had a , , evaluation completed on after status post an involuntary hospitalization for worsening agitation and behavioral outbursts. The review showed on , Resident was deemed not necessary for the need for acute inpatient , , care and recommendations were made for rehabilitative services of a lesser intensity than specialized services added to the patient's Comprehensive Person-Centered Nursing Care Plan to include: , , . . medication management, individual , , if cognition permits and supportive counseling.

Review of Resident #2's physician order review report dated showed orders for , , , and , , , services as needed, effective .

Review of a minimum data set (MDS) for Resident #2 dated showed the resident was unable to complete a . . . . . ( ) assessment. The mental assessment revealed the resident had a memory problem and was moderately , . . - decisions poor, cues and supervision required.

Review of an , , , evaluation and plan of treatment note, certified period - showed, transition/discharge plan was for "patient to return to ALF (Assisted Living Facility). Under reason for , , , the assessment summary showed a goal to, " ... facilitate independence with ADLs (activities of daily living) in order to facilitate ability to live in an environment with least amount of supervision and assistance, be able to return to prior level of living, facilitate follow- through with techniques and strategies and facilitate safe transition to next

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level of care." Under , , barriers likely to impact discharge to next level showed, "None noted".

Review of Resident #2's evaluation note dated showed the following: "Patient is a female with history of type, , and being seen by for initial evaluation. She was recently admitted to the hospital for with change in behavior, throwing herself on the floor and banging her with aggressive behavior. She was placed under an involuntary hospitalization. She was treated for acute and once stabilized was admitted to [name of facility] nursing center on for continuance of care. During evaluation, patient was pleasant and throughout the interview. ...She denies any current or , plan, or intent ... Patient's nurse reports that she has been compliant with her medications this morning thus far and staff has not observed her with any features including , self-dialogue, and paranoia."

Review of Resident #2's Medication Administration Record (MAR) for the month of showed the resident was compliant with her medication with no entries for the resident refusing her medications.

On at 2:05 p.m., a telephone interview was conducted with Staff L, Case Manager at the local hospital where Resident #2 was admitted. Staff L stated Resident #2 was admitted on through the emergency department

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secondary to an involuntary hospitalization initiated by the facility. Staff L read from the resident's medical record and stated, "the resident was seen by the emergency department physician and noted with no behaviors." Staff L stated the resident was seen by , , , services via telehealth on at 9:46 a.m. and deemed okay to return to the facility. Staff L stated the involuntary hospitalization was rescinded. Staff L stated while in the emergency department, the resident was noted with no behavior issues. Staff L stated, according to the resident's hospital medical record, a call was placed to the facility's administrator on at 10:00 a.m. informing her the involuntary hospitalization was rescinded, and the resident was good to discharge to her facility. Staff L reading the medical records stated, the NHA stated the resident was not welcomed after assaulting her nurse and throwing furniture. Staff L stated there were numerous attempts to contact the facility but return calls were never received. Staff L stated Resident #2 was eventually discharged to another local long term nursing home facility on .

On at 5:20 p.m., an interview was conducted with Staff E, RN. Staff E, RN stated she had a resident currently with aggressive behaviors and was assigned 1:1 supervision. Staff E, RN stated this other resident was aggressive towards staff and would into other residents' rooms. Staff E confirmed the facility had other residents with aggressive behaviors, including refusing injections and were not placed under involuntary hospitalizations. Staff E stated residents with such behaviors are placed on 1:1 supervision and are followed closely by psych.

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Review of Resident #2's , , evaluation note dated showed the following, "[Resident #2 said "I feel and , I do not know why. I want to get out of here and live with my [family member]" .... Under patients strengths, the assessment showed, can benefit from structured care.

Review of Resident #2's , , evaluation note dated signed at 8:48 a.m. by the , , provider showed a treatment plan with recommendations as follows:
5. Nursing staff is to monitor patient for changes in and behavior and contact , , , if patient begins to exhibit any signs of , , , , or behaviors. Nursing staff was advised to continue to document behaviors appropriately.
6. Case was discussed today with nursing staff who will assist with implementing the plan of care.
7. Goals of treatment include: remission of , , , symptoms and behavioral disturbances using lowest effective dose of medication, minimizing SE (side effects) and promptly detecting and any , , medication complications.
8. Gradual dose reduction is not recommended at this time as patient's baseline behavior is still being determined and she is noted with agitation and breakthrough symptoms. Gradual dose reduction is likely to cause a decompensation in patient's mental status.
9. Follow -up in 1 to 2 weeks or sooner if needed.

On at 1:28 p.m., an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated in general the AHCA (Agency for Health Care Administration) transfer form is provided to a resident or the family/POA

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F 624	Continued From page 14 (power of attorney). She stated if they are not present, they obtain consent via phone. She stated if they were to discharge a resident, a 30 - day discharge notice is issued. The NHA stated, we have all parties sign discharge paperwork usually for those that are getting discharged, including transfer to hospital. The NHA stated if a bed was available they would return to whatever bed is available. She stated they try to pack up their belongings and try to keep in touch with the hospital and hopefully the resident can go to the same bed upon returning. Review of an undated facility policy and procedure titled, "Admission, Transfer and Discharge - Notice requirements before Transfer/Discharge" showed an intent statement: It is the policy of the facility to notify the resident and or their legal guardian of the transfer and or discharge before the transfer or discharge occurs in accordance with state and Federal regulations. The procedure showed: 2. The facility will provide sufficient preparation and orientation to residents to ensure safe and orderly transfer and or discharge from the facility. 3. If the information in the notice changes prior to effecting the transfer or discharge, the facility will update the recipients of the notice as soon as practicable once the updated information becomes available.	F 624		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the	F 626		

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F 626	Continued From page 15 following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the , location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to permit readmission from the hospital for one resident (#2) of two residents reviewed for transfer and discharge rights. Findings included:	F 626	1. Resident #2 was discharged to the hospital on due to being a danger to herself and others. NHA spoke to hospital on and requested additional testing and a true , , evaluation be completed and then did not hear from the hospital after. Resident #2 was admitted to another	

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F 626	Continued From page 16 Review of the facility's policy and procedure titled, "Admission, Transfer and Discharge- Transfer and Discharge Requirements" showed an intent statement: It is the policy of the facility to ensure residents are treated equally regarding transfer, discharge, and the provision of services, regardless of their payment source in accordance with state and federal regulations. On at 2:05 p.m., a telephone interview was conducted with Staff L, Case Manager at the local hospital where Resident #2 was admitted. Staff L stated Resident #2 was admitted on through the emergency department secondary to an involuntary hospitalization initiated by the facility. Staff L read from the resident's medical record and stated, "the resident was seen by the emergency department physician and noted with no behaviors." Staff L stated the resident was seen by , , services via telehealth on at 9:46 a.m. and deemed okay to return to the facility. Staff L stated the involuntary hospitalization was rescinded. Staff L stated while in the emergency department, the resident was noted with no behavior issues. Staff L stated, according to the resident's hospital medical record, a call was placed to the facility's administrator on at 10:00 a.m. informing her the involuntary hospitalization was rescinded, and the resident was good to discharge to her facility. Staff L reading the medical records stated, the NHA stated the resident was not welcomed after assaulting her nurse and throwing furniture. Staff L stated there were numerous attempts to contact the facility but return calls were never received. Staff L stated Resident #2 was eventually discharged to another local long term nursing home facility on .	F 626	Skilled Nursing Facility in the area. 2. Administrator/Designee reviewed all transfers to the hospital for the last 3 months. No other residents identified as not being permitted to return. 3. Administrator/Designee educated all licensed nurses and Social Services Director on Discharge Policies and Procedures. Administrator/Designee to conduct daily audits on all facility transfers x4 weeks and then 3 x weekly or until substantial compliance is achieved to ensure resident preferences to return to the facility are upheld. 4. Administrator/Designee to bring all audits to monthly QAPI meetings x 3 months or until substantial compliance is achieved.	

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F 626	Continued From page 17 Review of Resident #2's Admission Record showed an admission date of with diagnoses included but not limited to, ( ), Conversion (a mental health condition where distress manifests as physical symptoms that cannot be explained by a medical condition) with or unspecified, to left and periocular area and Encounter for general examination requested by authority. Review of Resident #2's Preadmission Screening and Resident Review (PASRR) Level II Determination Summary Report dated initiated at a local hospital showed Resident #2 had a evaluation completed on after status post an involuntary hospitalization for worsening agitation and behavioral outbursts. The review showed on , Resident was deemed not necessary for the need for acute inpatient care and recommendations were made for rehabilitative services of a lesser intensity than specialized services added to the patient's Comprehensive Person-Centered Nursing Care Plan to include: medication management, individual if cognition permits and supportive counseling. Review of Resident #2's physician order review report dated showed orders for and services as needed, effective Review of a minimum data set (MDS) for	F 626		

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	105409	A. BUILDING _____ B. WING _____	C 03/17/2025

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Resident #2 dated showed the resident was unable to complete a ( ) assessment. The mental assessment revealed the resident had a memory problem and was moderately , - decisions poor, cues and supervision required.

Review of Resident #2's Admission Care Plan dated showed the following focus and intervention areas, Resident #2 is placed under an involuntary hospitalization. Interventions included allowing the resident to make decisions about treatment regime, to provide a sense of control, educate the resident to voice out feelings of harming self and others/ and encourage as much participation/interaction by the resident as possible during care activities. A second focus in the same care plan showed Resident #2, "wishes to return into the community when medically cleared." The goal showed, "The resident will be able to verbalize/communicate required assistance post-discharge and services required to meet the needs before discharge." Interventions included to establish a pre-discharge plan with the resident/resident's representative/caregivers and evaluate progress and revise the plan frequently, and to evaluate the resident's motivation to return to the community.

Review of Resident #2's , evaluation note dated showed the following: "Patient is a , female with history of , type, , , , and being seen by , for initial , evaluation. She was recently admitted to the hospital for with change in behavior, throwing herself on the floor and

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banging her with aggressive behavior. She was placed under an involuntary hospitalization. She was treated for acute , , and once stabilized was admitted to [name of facility] nursing center on for continuance of care. During evaluation, patient was pleasant and , throughout the interview. ...She denies any current or , plan, or intent ... Patient's nurse reports that she has been compliant with her medications this morning thus far and staff has not observed her with any , features including , self-dialogue, and paranoia."

Review of Resident #2's Medication Administration Record (MAR) for the month of showed the resident was compliant with her medication with no entries for the resident refusing her medications.

Review of Resident #2's progress note dated at 12:47 p.m. by Staff F, Registered Nurse (RN) showed, Resident is physically aggressive towards nursing staff, hit nurse in the despite giving as needed , which was given at 11:45 a.m. due to resident yelling, "I want to get out of here" and being agitated and knocked over table on smoking patio, punching walls, and threw a remote control, was not redirectable and is likely to further injure staff and other residents. The involuntary hospitalization was initiated by the , provider after speaking with the resident on phone/video. Police and emergency medical transport were called, and the resident was taken to a local hospital. "Family member agreed to hold bed."

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Review of the Nursing Home Transfer and Discharge Notice for Resident #2 dated revealed an incomplete document without signatures from the resident, resident representative and physician. The only signature was for Staff F, RN, signing on behalf of the NHA/designee, revealing "Your needs cannot be met in this facility." The brief expanation showed, "[involuntary hospitalization]".

Review of a Bed-Hold Agreement for Resident #2 dated showed, "I [family member name], the representative of [Resident #2] hereby request that the facility hold his/her bed space while he/she is absent from the facility. I understand that I will be responsible for payment of the basic per diem rate. I understand the basic per diem rate is $261 per day, for maximum number of 8 days. The agreement signed by Staff F, RN showed "wants bed hold per [family member]. Further review of Resident #2's record did not show documentation rescinding the agreement.

On at 5:20 p.m., an interview was conducted with Staff E, RN. Staff E, RN stated she had a resident currently with aggressive behaviors and was assigned 1:1 supervision. Staff E, RN stated this other resident was aggressive towards staff and would into other residents' rooms. Staff E confirmed the facility had other residents with aggressive behaviors, including refusing injections and were not placed under involuntary hospitalizations. Staff E stated residents with such behaviors are placed on 1:1 supervision and are followed closely by psych.

On at 1:28 p.m., an interview was

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conducted with the Nursing Home Administrator (NHA). The NHA stated Resident #2 was placed under an involuntary hospitalization on for escalating behavior both physically and verbally towards the staff. The NHA stated she received a phone call on the morning of from the local hospital stating the resident's involuntary hospitalization had been rescinded and could return to their facility. The NHA stated she had tried to communicate her concern for the resident's short stay at the hospital and wondered how the resident could be better in less than twenty-four hours. The NHA stated she spoke to a case manager but could not recall who she spoke to but stated it was someone in the emergency department because the resident was still in the emergency department. The NHA stated she did not receive any further calls from the hospital, and she assumed Resident #2 went with her family member. The NHA stated she could not confirm if she had reached out to the resident's family member. The NHA stated she had asked the hospital for evidence to prove the resident was safe to return and as far as she could recall, the hospital never called her .