

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55202</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/26/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ALHAMBRA HEALTHCARE &amp; REHABILITATION CENT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7501 38TH AVE N SAINT PETERSBURG, FL 33710</b>
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N 000	<p><b>INITIAL COMMENTS</b></p> <p>A relicensure survey, in conjunction with a complaint survey for complaint numbers 2024011838, 2025003326, 2024012200, and 2024015945, was conducted at Alhambra Healthcare and Rehabilitation Center from to . Deficiencies were identified at the time of the survey.</p> <p>Complaint numbers 2024011838, 2025003326, 2024012200, and 2024015945 had no deficiencies cited.</p>	N 000		
N 066 SS=F	<p>400.23(3)(b)4, FS Posting Staff</p> <p>Each nursing home facility must document compliance with staffing standards as required under this paragraph and post daily the names of licensed nurses and certified nursing assistants on duty for the benefit of facility residents and the public. Facilities must maintain the records documenting compliance with minimum staffing standards for a period of 5 years and must report staffing in accordance with 42 C.F.R. s. 483.70(q).</p> <p>This Statute or Rule is not met as evidenced by: Based on observation and record review, the facility failed to ensure nurse staffing information was posted in a way to benefit residents and the public on one (East Wing) of two facility units.</p> <p>Findings included:</p> <p>Review of the facility's policy and procedure dated . . . . . titled Nursing Services - Nurse Staffing Information showed:</p>	N 066	<p>Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the accuracy of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted to comply with the requirements set forth under state and federal laws and agencies.</p>	

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
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Electronically Signed /25

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N 066	<p>Continued From page 1</p> <p>INTENT: It is the policy of the facility to make staffing information readily available in a readable format to residents and visitors at any given time. POLICY:</p> <ol style="list-style-type: none"> <li>1. The facility will post the following information on a daily basis:             <ol style="list-style-type: none"> <li>a. Facility name.</li> <li>b. The current date.</li> <li>c. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:                 <ol style="list-style-type: none"> <li>i. Registered nurses.</li> <li>ii. Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>iii. Certified nurse aides.</li> <li>d. Resident census.</li> </ol> </li> </ol> </li> <li>2. The facility will post the nurse staffing data on a daily basis at the beginning of each shift.</li> <li>3. Data must be posted as follows:             <ol style="list-style-type: none"> <li>a. Clear and readable format.</li> <li>b. In a prominent place readily accessible to residents and visitors.</li> </ol> </li> <li>4. The facility will, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</li> <li>5. The facility will maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</li> </ol> <p>On _____ at 10:12 AM, the East Wing staffing board was observed with the date _____ with two nursing staff names and three Certified Nursing Assistant staff names for the 7 AM to 3 PM shift.</p> <p>On _____ at 5:45 PM, the East Wing staffing board was observed unchanged from the earlier observation. No room numbers or shift data was</p>	N 066	<ol style="list-style-type: none"> <li>1. Re-education provided to East wing nurse from 7am-3pm and East wing nurse from 3pm-11pm by NHA on _____ on the requirement to post nurse staffing information in a way to benefit the residents and public.</li> <li>2. No other areas or residents were affected by deficient practice.</li> <li>3. Reeducation was provided to nursing staff by DON or designee by _____ on requirement for posting up-to-date staffing information daily.</li> <li>4. The Director of Nursing or designee will complete quality assurance check weekly 5X a week for 6 weeks then 3X a week for an additional 6 weeks to ensure up-to-date staffing information is posted daily. All results of the quality assurance checks/audits will be monitored and reviewed by the QA&amp;A committee monthly until substantial compliance is assured.</li> </ol>	

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N 066	Continued From page 2 posted.  Class III	N 066		
N 110 SS=D	<p>400.141(1)(h) FS; 59A-4.122(1) FAC Physical Environment - Safe, Clean, Homelike</p> <p>400.141(1)(h) FS Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner.</p> <p>59A-4.122(1) FAC The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible</p> <p>This Statute or Rule is not met as evidenced by: Based on observations, interviews, and policy review, the facility did not ensure a safe, clean, and homelike environment in two resident rooms (#201 and #214) of 32 rooms in the facility.</p> <p>Findings included:</p> <p>During an observation and interview on _____ at 10:45 AM and _____ at 12:15 PM, in _____, the resident stated the dark brown armoire's drawer is broken and will not open. The resident who resided in the room stated the furniture has not worked for a while and would like to be able to use the space. The _____ of the top drawer of the dark brown armoire was observed separated from the rest of the drawer on the left side facing the drawer.</p>	N 110	<ol style="list-style-type: none"> <li>The armoire's drawer in _____ was repaired on _____ by the maintenance director. The toilet base in _____ was secured to the floor on _____ by the maintenance director.</li> <li>Quality assurance check of all residents' armoires and toilets was completed on _____ by maintenance director. No additional findings were noted.</li> <li>Quality staff received education on utilizing the TELS system for work orders by NHA or designee by _____.</li> <li>Quality assurance checks on armoires and toilets will be completed by IDT members 3x a week for 6 weeks then 1x a week for an additional 6 weeks. All results of the quality assurance checks</li> </ol>	

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N 110	<p>Continued From page 3</p> <p>During an observation and interview on _____ at 11:00 AM and _____/205 at 9:00 AM, in _____, the toilet base was not secured to the floor. Both residents of the room stated they utilized the toilet.</p> <p>During an interview on _____ at 10:45 AM, Staff D, Certified Nursing Assistant (CNA), stated both residents in _____ utilized the bathroom with assistance. If the staff noticed anything in need of repair a work order should be placed in the facility electronic work order system.</p> <p>During an observation and interview on _____ at 9:15 AM, the Housekeeping Director (HD) stated housekeeping cleans the bathrooms daily. If the housekeeping staff notices anything in need of repair, the housekeeping staff would let them know, as the housekeeping staff do not have access to the facility electronic work order system. The HD stated being responsible for relaying the information to the Maintenance Director (MD) of the area of concern. The HD observed the toilet in _____ and stated, "oh yeah, that needs to be fixed."</p> <p>During an observation and interview at _____ at 9:30 AM, the MD confirmed not having a work order for _____. Upon entering the bathroom of _____, the MD stated the toilet is not affixed to the floor and would need to be corrected.</p> <p>During an observation and interview at _____ at 12:26 PM, the MD confirmed not having any work orders for _____. Upon observation of the armoire in _____, the MD confirmed it was in need of repair.</p> <p>A facility policy for Building/Equipment Maintenance was requested on _____ and _____</p>	N 110	will be monitored and reviewed by the QA&A committee monthly until substantial compliance is assured.	



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

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F 000	INITIAL COMMENTS  A recertification survey, in conjunction with a complaint survey for complaint numbers 2024011838, 2025003326, 2024012200, and 2024015945, was conducted at Alhambra Healthcare and Rehabilitation Center from to . The facility was not in compliance with 42 CFR, Part 483, Requirements for Long Term Care Facilities.  Complaint numbers 2024011838, 2025003326, 2024012200, and 2024015945 had no deficiencies cited.	F 000			
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)  §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safety.  The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.  §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584			

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 584	<p>Continued From page 1</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)( );</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and policy review, the facility did not ensure a safe, clean, and homelike environment in two resident rooms (#201 and #214) of 32 rooms in the facility.</p> <p>Findings included:</p> <p>During an observation and interview on _____ at 10:45 AM and _____ at 12:15 PM, in _____, the resident stated the dark brown armoire's drawer is broken and will not open. The resident who resided in the room stated the furniture has not worked for a while and would like to be able to use the space. The _____ of the top drawer of the dark brown armoire was observed separated from the rest of the drawer on the left side facing the drawer.</p> <p>During an observation and interview on _____ at 11:00 AM and _____ /205 at 9:00 AM, in _____,</p>	F 584	<p>Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the accuracy of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted to comply with the requirements set forth under state and federal laws and agencies.</p> <p>1. The armoire's drawer in _____ was repaired on _____ by the maintenance director. The toilet base in _____ was secured to the floor on _____ by the maintenance director.</p> <p>2. Quality assurance check of all residents' armoires and toilets was completed on _____ by maintenance director. No additional findings were noted.</p>	

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F 584	<p>Continued From page 2</p> <p>the toilet base was not secured to the floor. Both residents of the room stated they utilized the toilet.</p> <p>During an interview on _____ at 10:45 AM, Staff D, Certified Nursing Assistant (CNA), stated both residents in _____ utilized the bathroom with assistance. If the staff noticed anything in need of repair a work order should be placed in the facility electronic work order system.</p> <p>During an observation and interview on _____ at 9:15 AM, the Housekeeping Director (HD) stated housekeeping cleans the bathrooms daily. If the housekeeping staff notices anything in need of repair, the housekeeping staff would let them know, as the housekeeping staff do not have access to the facility electronic work order system. The HD stated being responsible for relaying the information to the Maintenance Director (MD) of the area of concern. The HD observed the toilet in _____ and stated, "oh yeah, that needs to be fixed."</p> <p>During an observation and interview at _____ at 9:30 AM, the MD confirmed not having a work order for _____. Upon entering the bathroom of _____, the MD stated the toilet is not affixed to the floor and would need to be corrected.</p> <p>During an observation and interview at _____ at 12:26 PM, the MD confirmed not having any work orders for _____. Upon observation of the armoire in _____, the MD confirmed it was in need of repair.</p> <p>A facility policy for Building/Equipment Maintenance was requested on _____ and _____, but no policy was provided by the facility.</p>	F 584	<p>3. Facility staff received education on utilizing the TELS system for work orders by NHA or designee by _____.</p> <p>4. Quality assurance checks on armoires and toilets will be completed by IDT members 3x a week for 6 weeks then 1x a week for an additional 6 weeks.</p> <p>All results of the quality assurance checks will be monitored and reviewed by the QA&amp;A committee monthly until substantial compliance is assured.</p>		

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F 584	Continued From page 3	F 584			
F 645 SS=E	<p>Photographic Evidence Obtained</p> <p>PASARR Screening for MD &amp; ID</p> <p>CFR(s): 483.20(k)(1)-(3)</p> <p>§483.20(k) Preadmission Screening for individuals with a mental and individuals with intellectual</p> <p>§483.20(k)(1) A nursing facility must not admit, on or after , any new residents with:</p> <p>(i) Mental as defined in paragraph (k)(3) (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services; or</p> <p>(ii) Intellectual , as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual or authority has determined prior to admission-</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual</p> <p>§483.20(k)(2) Exceptions. For purposes of this section-</p>	F 645			

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F 645	<p>Continued From page 4</p> <p>(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.</p> <p>(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-</p> <p>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,</p> <p>(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and</p> <p>(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.</p> <p>§483.20(k)(3) Definition. For purposes of this section-</p> <p>(i) An individual is considered to have a mental if the individual has a serious mental defined in 483.102(b)(1).</p> <p>(ii) An individual is considered to have an intellectual , if the individual has an intellectual , as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, review of policy and procedures, and interviews, the facility failed to ensure a Level II Pre-Admission Screening and Resident Review (PASRR) screening was completed for five residents (#48, #29, #6, #13, and #2) of 15 residents sampled.</p>	F 645	<p>1. Social services director submitted a Level II PASRR request for resident #48 on , resident #29 on , resident #6 on #13 on and #2 on .</p> <p>2. The Social services director will audit</p>	

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F 645	<p>Continued From page 5</p> <p>Findings included:</p> <p>1.</p> <p>A review of Resident #48's Admission Record showed an admit date of _____ with diagnoses of Post- _____ Stress ( _____ ), unspecified _____ and _____. The diagnosis of major _____ was added on _____.</p> <p>A review of Resident #48's Level I PASRR screen completed on _____ showed in Section A. Mental Illness ( _____ ) or suspected _____, and _____ were checked. Section II showed, Question #5: Does the individual have a primary diagnosis of _____? The response was checked "Yes". Section II: Other Indications for PASRR Screen Decision-Making also showed, A Level II PASRR evaluation must be completed if the individual has a primary diagnosis of _____ or related _____, and a suspicion or diagnosis of a Serious Mental Illness, Intellectual _____, or both. A Level II PASRR may only be terminated by the Level II PASRR evaluator. The facility did not complete a Level II PASRR screen for Resident #48.</p> <p>2.</p> <p>A review of Resident #29's Admission Record showed an admit date of _____ with diagnoses of _____, _____, unspecified _____ not due to a substance or known physiological condition, and _____. A diagnosis of major _____ was added on _____.</p>	F 645	<p>residents who have a diagnosis of SMI, ID, and/or _____ or related _____ in the facility and if warranted, will submit for level 2 PASRR screen by _____</p> <p>3. Reeducation was provided to the IDT team on the Level II PASRR screen process by NHA or designee on Ongoing, new admissions to the facility with diagnosis of SMI, ID, and _____ or related _____ will be audited by social services director or designee within 72 hours of admission for presence of level 2 PASRR screen and submit if warranted. IDT will conduct quality assurance check weekly for 12 weeks on _____, _____, provider documentation to identify any additional diagnoses requiring a level 2 PASRR screen to be initiated.</p> <p>4. All results of the quality assurance checks/audits will be monitored and reviewed by the QA&amp;A committee monthly until substantial compliance is assured.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2025  
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>105712</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/26/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALHAMBRA HEALTHCARE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7501 38TH AVE N</b> <b>SAINT PETERSBURG, FL 33710</b>		
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F 645	<p>Continued From page 6</p> <p>A review of Resident #29's Level I PASRR screen completed on _____ showed in Section A. Mental Illness ( ) or suspected _____, and unspecified _____, not due to a substance or known physiological condition and _____, checked.</p> <p>A review of Resident #29's most recent _____ progress note with a service date of _____ showed the rationale behind diagnoses for _____ as, "the history of this patient shows that the patient has _____ inconsistent _____ . These symptoms cause significant distress and functional _____ to the patient. The patient has had a history of _____ for more than one month, causing emotional and behavioral disturbance for six months or more."</p> <p>A Level II PASRR screen was not completed for Resident #29 for his severe _____ serious mental illness of _____</p> <p>3.</p> <p>Review of Resident #6's Admission Record showed an admit date of _____ with a diagnosis of _____ . Diagnoses of _____ identity _____ and _____ were added on _____ and a diagnosis of major _____ was added on _____</p> <p>Review of Resident #6's Level I PASRR screen completed on _____ showed in Section II: Other Indications for PASRR Screen Decision-Making, question 2. C. Adaption to change: The individual has serious difficulty in adapting to typical changes in circumstances</p>	F 645			

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F 645	<p>Continued From page 7</p> <p>associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system, was checked "no".</p> <p>Review of Resident #6's . . . . . Subsequent Note dated . . . . . revealed under Assessments and Plan, Resident #6 had a treatment objective to learn to adjust to living in the facility by building resiliency skills and engaging in enjoyable activities.</p> <p>Review of Resident #6's record did not reveal a Level II PASRR screen.</p> <p>4.</p> <p>Review of Resident #13's Admission Record showed an admit date of . . . . . Diagnoses included . . . . . and major . . . . ., added . . . . .; and . . . . ., added . . . . .</p> <p>Review of Resident #13's Level I PASRR screen completed on . . . . . showed in Section A. Mental Illness ( ) or suspected . . . . ., . . . . ., and unspecified . . . . ., unspecified severity, were checked. Section II showed, Question #5: Does the individual have a primary diagnosis of . . . . . ? The response was checked "Yes", Section II: Other Indications for PASRR Screen Decision-Making also showed, A Level II PASRR evaluation must be completed if the individual has a primary diagnosis of . . . . . or related . . . . ., and a suspicion or diagnosis of a Serious Mental Illness, Intellectual</p>	F 645			

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F 645	<p>Continued From page 8</p> <p>, or both. A Level II PASRR may only be terminated by the Level II PASRR evaluator. The facility did not complete a Level II PASRR screen for Resident #13.</p> <p>5.</p> <p>Review of Resident #2's Admission Record showed an admit date of . Diagnoses included , added ; major , added ; and , added</p> <p>Review of Resident #2's Level I PASRR screen completed on showed in Section II: Other Indications for PASRR Screen Decision-Making, question 2. C. Adaption to change: The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system, was checked "no".</p> <p>Review of Resident #6's . Subsequent Note dated revealed Resident #2 has been being seen for major with a follow up scheduled for the following week due to the resident not feeling well.</p> <p>Review of Resident #2's record did not reveal a Level II PASRR screen.</p> <p>During an interview on at 1:14 PM, the Social Services Director (SSD) and the Director of Nursing (DON) confirmed being responsible for completing the PASRR screens. The SSD and</p>	F 645		

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F 645	<p>Continued From page 9</p> <p>DON confirmed according to the directions on the Decision-Making Screen, a Level II PASRR evaluation is needed if the resident has a primary or secondary diagnosis of _____ or related _____, and a suspicion or diagnosis of a Serious Mental Illness, Intellectual _____, or both. The SSD and DON continued to state they have never really thought of the questions being indicated for them to complete, and confirmed, in reading the questions in Section II, they should be completing the questions if the residents are being treated or have the characteristics on a continuing or intermittent basis. The SSD and DON confirmed in the examples above the sections should have been marked "yes" and then a Level II evaluation would have been indicated.</p> <p>Review of the facility's policy and procedures titled Preadmission Screening and Resident Review (PASRR) with a revision date of _____ showed:</p> <p>Policy Statement: It is the policy of the facility to assure that all residents admitted to the facility receive a Pre-Admission Screening and Resident Review, in accordance with State and Federal Regulations.</p> <p>Policy Interpretation and Implementation:</p> <p>1. All new admissions and readmissions are screened for mental _____ (MD), _____ (ID) or related _____ (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process.</p> <p>a. The hospital or facility conducts a Level I PASRR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD.</p> <p>b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or</p>	F 645		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 645	Continued From page 10 she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. (1) The social worker or designee is responsible for making referrals to the appropriate state designated authority. c. Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or men I condition, what specialized or rehabilitative services he or she needs, and whether placement in facility is appropriate. d. The state PASARR representative provides a copy of the report to the facility. e. The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential resident that are outlined in the evaluation. f. Once a decision is made, the state PASARR representative, the potential resident and his or her representative are notified.	F 645		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	<p>Continued From page 11</p> <p>the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review, and interviews, the facility failed to develop an individualized plan of care to include goals and interventions for two residents (#11 and #9) of forty two residents sampled.</p> <p>Findings included:</p> <p>1.</p> <p>On _____ at 11:09 a.m., Resident #11 was observed reading a book while sitting in a wheelchair. An interview was attempted, however, she did not respond and continued to read her book. Her roommate stated Resident #11 is, "Always reading, hard of hearing, and doesn't wear her _____."</p> <p>A review of Resident #11's Admission Record revealed an original admission date of _____ and a re-admission date of _____. Further review of the admission record revealed the following diagnoses to include: unspecified _____, unspecified severity, without behavioral _____</p>	F 657	<p>1. The care plan for resident #11 was updated to include interventions related to approach and determining her preference for care by MDS director on _____ Care plan for resident #9 was updated to include information regarding what _____ center the resident goes to for _____ by MDS director on _____</p> <p>2. MDS director or designee will complete quality assurance checks on resident care plans to ensure they include individualized goals and interventions by _____</p> <p>3. Reeducation was provided to the IDT team that resident care plans must be individualized with goals and interventions.</p> <p>4. Quality assurance checks will be conducted of four random residents' care plans by the MDS director or designee 3 times a week for 6 weeks then weekly for an additional 6 weeks to ensure they are individualized with interventions and goals.</p> <p>All results of the quality assurance _____</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 12 disturbance, , disturbance, disturbance, and , major , generalized , , and post- stress  A review of Resident #11's , notes, dated , and , revealed the following, " ... History of Present Illness: This is a patient with a past , history of and ( ); The history suggests that this patient suffered from significant resulting into nightmares, flashbacks, and hypervigilance in the past. These symptoms have caused significant distress and functional to the patient. The symptoms have lasted for more than one months and have occurred without any or organic Care Plan for diagnosis: : history of from father (Both physical and ) as a child. ... " Further review of , notes, dated , revealed the following, " ... Section: , mistreated by family (provided by facility) No triggers noted. ... Due to associated with the patient is unable to elaborate on current symptoms or provide detailed history. However, staff and caregivers report no observable symptoms, such as nightmares, hypervigilance, flashbacks, or avoidance behaviors. ... Care Plan for diagnosis: : history of from father (Both physical and ) as a child. Triggers: Approach ... Corrected/Confirmed Diagnosis: Added dx [diagnosis] and care plan in the chart: As , [patient] has active symptoms of such as flashbacks, nightmares, hypervigilance, causing distress, I added dx. The is	F 657	checks/audits will be monitored and reviewed by the QA&A committee monthly until substantial compliance is assured.	

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F 657	<p>Continued From page 13</p> <p>mistreated by family (provided by facility). The current triggers are not reported. ..."</p> <p>A review of Resident #11's care plan, revised on _____, revealed the following: "[Resident name] has risk or actual diagnosis of _____ and has potential for re-_____ R/T [related to] Childhood _____: _____, felt unloved by family." A review of goals revealed the following, "Resident will remain free from episodes of re-_____ AEB [as evidenced by]: (personalize) through the next review. Revision on: _____ Target Date: _____ Resident will remain free from episodes of re-_____ AEB no flashbacks or upsetting dreams through the next review Target Date: _____, Resident will have minimal triggers of re-_____ thru the next review. Target Date: _____, Resident will have minimal negative changes in thinking and _____ through the next review Target Date: _____" " A review of interventions include the following. " ... Establish a relationship of trust with the resident, Date Initiated: _____, Created on: _____, ... Provide calming and reassuring environment, Date Initiated: _____, Created on: _____, ... Use calm approach. Explain action during cares. Date Initiated: _____, Created on: _____, ... Avoid positioning yourself between the resident and the door Date Initiated: _____, Created on: _____, ... Provide female caregivers ONLY to assist with cares per resident/responsible party preference. Date Initiated: _____, Created on: _____ Provide male caregivers ONLY to assist with cares per resident/responsible party preference. Date Initiated: _____, Created on: _____</p>	F 657			

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F 657	Continued From page 14  On _____ at 9:18 a.m., an interview was conducted with Staff C, Certified Nursing Assistant (CNA) who stated she looked at the care card to view a resident's diagnoses. Staff C, CNA stated she would go into the resident's electronic medical record or speak with the nurse to determine what their needs are. She stated she's not sure where to view in their chart how to approach a resident related to triggers for someone diagnosed with _____. She stated she thinks the care card or Kardex would have that. She stated, "The care card tells you everything about the resident." Staff C, CNA confirmed she hasn't had training or education related to _____. Regarding Resident #11, she stated she worked with the resident often. Staff C, CNA stated she didn't know the resident had _____ and could not identify her triggers.  On _____ at 9:56 a.m., an interview was conducted with the Social Services Director (SSD). He stated for residents with _____ they, "Determine the root cause and psych follows them." He stated for the diagnosis of _____, there is a care plan in place. The SSD stated the care plan included how to approach the person, their environment, avoid putting yourself in front of them and between the door, medication management as needed, observing for changes in behaviors, and _____ (psych) services as needed. He stated for _____ or assault they determine if the resident feels comfortable with a male or female staff. The SSD stated the care plan, "Has prefilled boxes to check off," however, they could be filled in. He stated he hasn't had to put individualized triggers for any _____ care plans. Regarding Resident #11, the SSD stated he knows the resident has _____	F 657			

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F 657	<p>Continued From page 15</p> <p>. He stated the resident told him her stemmed from the loss of her , and she felt her family didn't love her. He stated he reviewed Resident #11's psych notes and confirmed the psych provider attended monthly interdisciplinary team meetings. The SSD stated he printed and looked at every psych note. He confirmed he had not seen the psych notes which included documentation related to physical and . The SSD confirmed Resident #11's care plan should include interventions related to approach and determining her preferences for care.</p> <p>2.</p> <p>Review of the Admission Record for Resident #9 revealed an admission date of and a readmission on with diagnoses to include hypertensive with stage 5 or ( ); and dependence on .</p> <p>Review of the Minimum Data Set (MDS) from Admission dated revealed Resident #9 was on .</p> <p>Review of Resident #9's Order Summary Report dated revealed the following orders:</p> <ul style="list-style-type: none"> <li>- : Check access site for signs of (warmth, redness, tenderness or ) when performing routine care at regular intervals every shift</li> <li>- : center to maintain changes to access site.</li> <li>- : If there is major from the access site, apply pressure to insertion site, contact emergency services and center</li> </ul>	F 657			

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F 657	<p>Continued From page 16</p> <p>period verify any clamps are closed on lumens if not an . This is a medical emergency. Do not leave the resident alone until (Emergency Medical Services) arrives. As needed for major</p> <p>- : Mild , from the access site (post ) can't be expected. For mild reinforce pressure . Contact the center or physician for further instructions. As needed for mild</p> <p>- : Remove pressure after return from (enter days Monday Wednesday and Friday) per orders. In the evening every Monday, Wednesday, Friday.</p> <p>- : access site: (Left Upper Arm). Type of Access: every shift</p> <p>- : Monday, Wednesday, Fridays; Pick up time: 11:30 am Center Address [listed address, phone, transportation company] every day shift every Monday, Wednesday, Friday.</p> <p>- : Do not use the access site arm to take sample, administer ( ) fluids, or give injections. Left arm, every shift.</p> <p>- : Palpate the access site to feel the " " use stethoscope to hear the " " of flow through the access site. Left upper arm, every shift for monitoring left upper arm.</p> <p>Review of Resident #9's care plan revealed a Focus area, Resident has potential for complications related to for treatment of site is located: (Specify location), Receives on: (Mon., Wed., Fri), Receives at: (insert center name, address, phone number), Date Initiated: , Revision on:</p> <p>Goal showed: Resident will remain free from</p>	F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>105712</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/26/2025</b>
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F 657	<p>Continued From page 17</p> <p>avoidable complications related to thru the next review date. Target Date:</p> <p>.....</p> <p>During an interview on _____ at 11:45 a.m. the Minimum Data Set (MDS) Coordinator confirmed being responsible for updating and completing the care plans. The MDS Coordinator reviewed Resident #9's care plan for _____ and stated "I must have missed updating the information. The information should be updated and individualized as needed."</p> <p>During an interview on _____ at 9:28 a.m., the Director of Nursing (DON) stated in general staff are educated to, "Look for behaviors" and report behaviors to the nurse, the nurse reports to the doctor, and CNAs are educated on a, "Need to know basis" and it wouldn't be appropriate for them to go through diagnoses for each resident. The DON stated she was unaware of Resident 11's triggers but knew Resident #11 had _____</p> <p>The DON confirmed _____ triggers should be on the care plan and knowing the resident's and their triggers would assist the staff in knowing how to approach individuals. The DON confirmed care plans should be individualized and updated as needed.</p> <p>Review of the facility's policies and procedures dated revised _____ and titled Care Plans, Comprehensive Person-Centered revealed the following:</p> <p>Policy Statement: A comprehensive, _____ person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, _____ and functional needs is developed and implemented for each</p>	F 657			

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F 657	Continued From page 18 resident. Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. ... 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. ... 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and ... well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASARR recommendations; and (3) which professional services are responsible for each element of care; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas/conditions. 8. Services provided for or arranged by the facility and outlined in the comprehensive care plan are: a. provided by qualified persons; b. culturally competent; and c. -informed. 9. Care plan interventions are chosen only after	F 657			

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F 657	Continued From page 19 data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 10. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 11. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment.	F 657			
F 699 SS=D	Informed Care CFR(s): 483.25(m)  §483.25(m) -informed care The facility must ensure that residents who are survivors receive culturally competent, -informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re- of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to identify specific triggers related to , ( ) and develop an individualized plan of care to prevent re- for one resident (#11) of one residents reviewed for  Findings included:	F 699	1. The care plan for resident #11 was updated to include specific triggers related to , to prevent re- by the MDS director on . 2. MDS director or designee will complete quality assurance checks on resident care plans to ensure they have an		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 699	<p>Continued From page 20</p> <p>On at 11:09 a.m., Resident #11 was observed reading a book while sitting in a wheelchair. An interview was attempted, however, she did not respond and continued to read her book. Her roommate stated Resident #11 is, "Always reading, hard of hearing, and doesn't wear her _____."</p> <p>A review of Resident #11's Admission Record revealed an original admission date of _____ and a re-admission date of _____. Further review of the admission record revealed the following diagnoses to include: unspecified _____, unspecified severity, without behavioral disturbance, _____ disturbance, _____ disturbance, and _____, major _____, generalized _____, and post-stress _____.</p> <p>A review of Resident #11's care plan, revised on _____, revealed the following: "[Resident name] has risk or actual diagnosis of _____ and has potential for re-_____/T [related to] Childhood _____; _____ felt unloved by family." A review of goals revealed the following, "Resident will remain free from episodes of re-_____ AEB [as evidenced by]: (personalize) through the next review. Revision on: _____ Target Date: _____ Resident will remain free from episodes of re-_____ AEB no flashbacks or upsetting dreams through the next review Target Date: _____, Resident will have minimal triggers of re-_____ thru the next review. Target Date: _____, Resident will have minimal negative changes in thinking and _____ through the next review Target Date: _____." A review of interventions include the</p>	F 699	<p>individualized plan to prevent re-_____ by _____</p> <p>3. Reeducation was provided to the IDT team that resident _____ care plans must be individualized and include specific triggers related to _____ to prevent re-_____ by NHA or designee on _____</p> <p>4. Quality assurance checks will be conducted of four random residents' care plans by the MDS director or designee 3 times a week for 6 weeks then weekly for an additional 6 weeks to ensure they are individualized with specific triggers related to _____ to prevent re-_____. All results of the quality assurance checks/audits will be monitored and reviewed by the QA&amp;A committee monthly until substantial compliance is assured.</p>	

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F 699	Continued From page 21 following. " ... Establish a relationship of trust with the resident. Date Initiated: _____, Created on: _____, ... Provide calming and reassuring environment. Date Initiated: _____, Created on: _____, ... Use calm approach. Explain action during cares. Date Initiated: _____, Created on: _____, ... Avoid positioning yourself between the resident and the door Date Initiated: _____, Created on: _____, ... Provide female caregivers ONLY to assist with cares per resident/responsible party preference. Date Initiated: _____, Created on: _____, Provide male caregivers ONLY to assist with cares per resident/responsible party preference. Date Initiated: _____, Created on: _____ ..."  On _____ at 9:18 a.m., an interview was conducted with Staff C, Certified Nursing Assistant (CNA) who stated she looked at the care card to view a resident's diagnoses. Staff C, CNA stated she would go into the resident's electronic medical record or speak with the nurse to determine what their needs are. She stated she's not sure where to view in their chart how to approach a resident related to triggers for someone diagnosed with _____. She stated she thinks the care card or Kardex would have that. She stated, "The care card tells you everything about the resident." Staff C, CNA confirmed she hasn't had training or education related to _____. Regarding Resident #11, she stated she worked with the resident often. Staff C, CNA stated she didn't know the resident had _____ and could not identify her triggers.  On _____ at 9:28 a.m., an interview with the Director of Nursing (DON) revealed staff are	F 699			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 699	<p>Continued From page 22</p> <p>educated, "To look for behaviors." She stated she expected CNAs to report behaviors to the nurse, then the nurse would report to the provider. She stated CNAs are educated on a, "Need to know basis." The DON stated it wouldn't be appropriate to specify diagnoses to staff for each resident. She stated if a resident was displaying behaviors, she'd tell staff to, "Watch for certain behaviors and keep them on enhanced monitoring." The DON stated she doesn't know about Resident #11's triggers. She stated she knows the resident has . The DON stated she knows Resident #11's comes from, "Military." The DON confirmed triggers should be on the care plan as she expected nurses to look there. She stated staff, "Learn the residents and their triggers to identify how to approach." She stated Resident #11 doesn't have behaviors or outbursts, "Only if she had a [ ]" The DON stated staff are provided general education about behaviors and behaviors being charted.</p> <p>On at 9:56 a.m., an interview was conducted with the Social Services Director (SSD). He stated for residents with they, "Determine the root cause and psych follows them." He stated for the diagnosis of , there is a care plan in place. The SSD stated the care plan included how to approach the person, their environment, avoid putting yourself in front of them and between the door, medication management as needed, observing for changes in behaviors, and , /, , (psych) services as needed. He stated for or assault they determine if the resident feels comfortable with a male or female staff. The SSD stated the care plan, "Has prefilled boxes to check off," however, they could be filled in. He</p>	F 699			

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F 699	<p>Continued From page 23</p> <p>stated he hasn't had to put individualized triggers for any care plans. Regarding Resident #11, the SSD stated he knows the resident has . He stated the resident told him her stemmed from the loss of her , and she felt her family didn't love her. He stated he reviewed Resident #11's psych notes and confirmed the psych provider attended monthly interdisciplinary team meetings. The SSD stated he printed and looked at every psych note. He confirmed he had not seen the psych notes which included documentation related to physical and . The SSD confirmed Resident #11's care plan should include interventions related to approach and determining her preferences for care.</p> <p>A review of the facility's policy titled Informed Care revised revealed the following: Purpose: To guide staff in appropriate and compassionate care specific to individuals who have experienced</p> <p>Preparation: 1. All staff are provided in-service training about , its impact on health, and post-stress in the context of the healthcare setting ... General Guidelines: ... 2. -informed care is culturally sensitive and person-centered. ... 3. Caregivers are taught strategies to help eliminate, mitigate, or sensitively address a resident's triggers ...</p> <p>F 732 SS=F Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)</p>	F 699			
F 732 SS=F	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732			

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F 732	<p>Continued From page 24</p> <p>§483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:</p> <p>(i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. ( ) Resident census.</p> <p>§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:</p>	F 732			

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F 732	<p>Continued From page 25</p> <p>Based on observation and record review, the facility did not ensure up-to-date staffing information was posted on one day ( ) of three days observed.</p> <p>Findings included:</p> <p>Upon entering the facility on at 9:00 AM, an observation was made of a posting titled, "Daily Staffing Projection", dated with census of 60.</p> <p>On at 10:12 AM, the staffing posting was still not updated.</p> <p>Review of the facility's policy and procedure dated titled Nursing Services - Nurse Staffing Information showed: INTENT: it is the policy of the facility to make staffing information readily available in a readable format to residents and visitors at any given time. POLICY:</p> <ol style="list-style-type: none"> <li>1. The facility will post the following information on a daily basis:             <ol style="list-style-type: none"> <li>a. Facility name.</li> <li>b. The current date.</li> <li>c. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:                 <ol style="list-style-type: none"> <li>i. Registered nurses.</li> <li>ii. Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>iii. Certified nurse aides.</li> <li>d. Resident census.</li> </ol> </li> </ol> </li> <li>2. The facility will post the nurse staffing data on a daily basis at the beginning of each shift.</li> <li>3. Data must be posted as follows:             <ol style="list-style-type: none"> <li>a. Clear and readable format.</li> </ol> </li> </ol>	F 732	<ol style="list-style-type: none"> <li>1. Re-education provided to staffing coordinator by NHA on requirement to post nurse staffing information daily on .</li> <li>2. No other areas or residents were affected by deficient practice.</li> <li>3. Reeducation by NHA on was provided to IDT team on requirement for posting up-to-date staffing information daily.</li> <li>4. The administrator or designee will complete quality assurance check weekly 5X a week for 6 weeks then 3X a week for an additional 6 weeks to ensure up-to-date staffing information is posted daily.</li> </ol> <p>All results of the quality assurance checks/audits will be monitored and reviewed by the QA&amp;A committee monthly until substantial compliance is assured</p>		

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F 732	Continued From page 26 b. In a prominent place readily accessible to residents and visitors. 4. The facility will, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. 5. The facility will maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 732			
F 812 SS=F	Photographic Evidence Obtained Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)  §483.60(i) Food safety requirements. The facility must -  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.  §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility did not follow professional standards for food service safety as evidenced by food not	F 812	1. On _____ the following was completed by kitchen manager: The pliers with a red handle on the		

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NAME OF PROVIDER OR SUPPLIER  <b>ALHAMBRA HEALTHCARE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7501 38TH AVE N SAINT PETERSBURG, FL 33710</b>		
(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) COMPLETION DATE
F 812	<p>Continued From page 27</p> <p>maintained for safe consumption and improper labeling and dating of food items in the main kitchen and dining room.</p> <p>Findings included:</p> <p>On at 9:56 a.m., an initial tour of the facility's kitchen was conducted with the facility's Certified Dietary Manager (CDM). An observation of the dish machine area, that was in use by Staff E, Cook, revealed pliers with a red handle on the machine's base. Further observations on the top area of the dish machine revealed light brown colored crumbs and other food particles. An observation of the dish machine hood revealed multiple dark brown and black spots along the top and sides. The multiple spots observed appeared to be signs of rust.</p> <p>On at 10:03 a.m., an observation of the walk-in cooler, conducted with the CDM, revealed strips of bacon in a clear storage bag with an open date of . . . , but no use by date. The CDM identified the food as, "Vegan bacon," and stated the staff should have kept the original package label to determine the expiration date. She proceeded to remove the vegan bacon strips. Observations of the right side of the walk-in cooler revealed a box of two large lettuce heads with leaves that were separated. The separated leaves had areas that were yellow, brown, and black in color. She proceeded to remove the separated lettuce leaves, while the other two lettuce heads were left in the box. Further observations of the right side of the walk-in cooler revealed a box of potatoes had multiple blue, gray, and white spores/bio growth. The CDM proceeded to remove the box of potatoes. At 10:11 a.m., an interview with the</p>	F 812	<p>machines base in the dish machine area were removed.</p> <p>The top area of the dish machine was cleaned.</p> <p>The dish machine hood was cleaned.</p> <p>The bacon strips in clear storage bag were discarded.</p> <p>The lettuce was discarded.</p> <p>The potatoes were discarded.</p> <p>In refrigerator #2 the lemon and limes and stick of butter were discarded.</p> <p>All items that did not belong to residents with name and date were discarded from dining room refrigerator.</p> <p>2. Regional dietary manager conducted sanitation and quality audit of facility kitchen on . No other findings were identified.</p> <p>3. Re-education was provided by Regional Dietary Manager by to Kitchen Manager and dietary staff on storage, labeling and dating of food as well as kitchen sanitation. Reeducation was provided to maintenance staff on ensuring tools/equipment are removed from any area if not being actively worked on.</p> <p>Quality assurance checks for sanitation and for proper food storage, labeling and dating will be completed by the Kitchen Manager or designee weekly 3X for 12 weeks.</p> <p>4. All results of the quality assurance checks/audits will be monitored and reviewed by the QA&amp;A committee monthly until substantial compliance is assured</p>		

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F 812	<p>Continued From page 28</p> <p>CDM revealed the Kitchen Manager should be reviewing the walk-in cooler for proper storage of food and beverage items, to include labeling and dating.</p> <p>On at 10:11 a.m., an observation of the reach-in refrigerator, identified as #2, was conducted with the CDM. Observations of reach-in #2 revealed a shallow pan containing lemons and limes that had multiple gray and black spots. The CDM was observed removing the pan with the lemons and limes. Further observations of reach-in #2 revealed a stick of butter was not properly sealed and the top part was exposed to the air.</p> <p>On at 10:32 a.m., an observation of the refrigerator/freezer in the dining room area was conducted with the facility's Director of Nursing (DON). She stated the refrigerator/freezer was for resident's food. An observation of the refrigerator revealed a food item with a resident's name, but no date or other labeling. The DON could not confirm how long the food had been there. An observation of the freezer revealed two individual ice cream packages. The DON confirmed the ice cream was not provided by the facility. The DON confirmed the two ice cream items did not have a resident's name.</p> <p>On at 12:48 p.m., an interview was conducted with the facility's Kitchen Manager. The Kitchen Manager stated the pliers observed on on the dish machine base were potentially there since last week. He stated the dish machine pipe was being fixed by maintenance last week and the maintenance staff member was using those pliers. Regarding observations of the top part of the dish machine,</p>	F 812			

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F 812	<p>Continued From page 29</p> <p>he stated it's part of the cleaning schedule. He stated the staff member that used the dish machine is responsible for cleaning that area and, "It should have been cleaned." Regarding the dish machine hood, the Kitchen Manager stated he's not sure when it's been cleaned as it's not part of the cleaning schedule. He stated, "It's been overlooked."</p> <p>On _____ at 1:06 p.m., interviews were conducted with the Kitchen Manager and CDM. The Kitchen Manager stated all staff are responsible for proper storage, labeling, and dating and he conducted daily monitoring of storage, labeling, and dating. He stated the dietary staff's monthly meeting, conducted on _____ and _____, included topics such as labeling/dating and expectations for personal items. A review of the sign-in sheet revealed all staff attended. He stated he talked about storage, labeling, and dating every month. The Kitchen Manager stated reviews of the refrigerator/freezer in the dining room is on the cleaning list for dietary staff. He stated Certified Nursing Assistants (CNA's) are expected to label and date food/beverage items. The CDM stated items should be discarded if it's in there for more than 3 days or if items are not labeled or dated. She stated dietary staff are expected to review the refrigerator/freezer in the dining room at least once a day, as they have to put beverages in there. The Kitchen Manager stated he reviewed the refrigerator/freezer in the dining room once a day.</p> <p>A review of the facility's policy titled Labeling and Dating dated _____ revealed the following, "Leftovers and opened foods shall be clearly labeled with date food item is to be discarded.</p>	F 812		

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F 812	<p>Continued From page 30</p> <p>Food items to be labeled and dated include items prepared in house and food items that are opened and stored for later use. (i.e. salad , pickles, etc.)." Further review of the policy, under Procedure, revealed the following, " 1. 7 day shelf life including date of preparation -label includes: a. Name of food item, b. Discard date (to be discarded at end of 7th day) ... 2. 30 day shelf life, usually applies to items that are shelf stable until opened - label includes: a. Name of food item if not clearly identified on container b. Discard date (i.e. opened , discard )..."</p> <p>A review of the facility's policy titled Food Storage revealed the following. "All food stock and food products are stored in a safe and sanitary manner. All food stock is dated and used on a first in, first out basis."</p> <p>A review of the facility's policy titled FIFO (First In First Out) revealed the following under Procedure, "1. Date all food items upon receipt. (If item has vendor delivery date label, further dating is not required unless individual cans, boxes, etc. are removed from the dated packaging) ... 5. Food products are used by the expiration date, if not, food items are discarded."</p> <p>Photographic Evidence Obtained</p>	F 812			