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
	55215	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR	321 13TH AVE N SAINT PETERSBURG, FL 33701

(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 A complaint survey for complaint number 2025004290 was conducted on and at Manor, in conjunction with a revisit to a complaint survey for complaint number 2025001975 (UBR912). New deficiencies were identified at the time of survey. The facility has been out of compliance since . Complaint #2025004290 had a deficiency cited at F204.	N 000		
N 204 SS=G	400.022(1)(o), FS Right to be Free from , , etc 400.022, F. S. (1)(o) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following: (o) The right to be free from mental and , , , neglect, , , corporal punishment, extended involuntary , and , , corporal punishment, extended involuntary , and physical and chemical , except those authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of , and, in the case of use of a chemical , a physician shall be consulted immediately thereafter. may not be used in lieu of staff supervision or merely for staff	N 204		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/25

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N 204	Continued From page 1 convenience, for punishment, or for reasons other than resident protection or safety. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility neglected to provide the number of staff needed to ensure safety during bed mobility consistent with the assessed and care planned needs for one (#1) of two residents sampled for and neglect. Resident #1 sustained a from the bed resulting in a transfer to a higher level of care, and injury. Findings included: Review of a facility policy titled, Prevention Program, reviewed showed the facility has designated and implemented processes, which strive to reduce the risk of , neglect, , , mistreatment, and misappropriation of resident's property. These policies guide the identification, management, and reporting of suspected, or alleged, , neglect, mistreatment, and , . It is expected that these policies will assist the facility with reducing the risk of , neglect, , , and misappropriation of resident's property through education of staff and residents, as well as early identification of staff bum out, or resident behavior which may increase the likelihood of such events. Definitions: Neglect - Failure of the facility, its employees or service providers to provide good and services to a resident that are necessary to avoid physical harm, , , mental anguish or emotional distress. Procedure: The facility has implemented the following processes in an effort to provide	N 204	This plan of correction is submitted as required under state and federal laws. The submission of this plan of correction does not constitute an admission on the part of the skilled nursing facility as to the accuracy of the surveyor's findings or the conclusion drawn there from. The plan of correction does not constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. Any changes to facility policy and procedures should be considered remedial measures as that concept is employed in rule 407 of the federal rules of evidence and should be inadmissible in any proceeding on that basis. The facility submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the facility or any employee, agent, officer, director, or shareholders of the facility. The facility has not waived any of its rights to contest any of these allegations or any allegation or action. F-600 Free From and Neglect Element #1. Resident #1 was assessed to ensure no further injuries, and that , was at a level that was acceptable to the resdient. No additonal findings noted upon assessment and , level at acceptable level for resident. Resident	

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N 204	Continued From page 2 residents, visitors and staff with a safe and comfortable environment. - The Administrator is responsible for designating an Coordinator. - The designated shift supervisor is identified as responsible for immediate initiation of the reporting process. - The Administrator, DON and/or designated individual are responsible for the investigation and reporting of suspected, or alleged, , neglect, and , and misappropriation. - The Administrator, DON and/or designated individual are also ultimately responsible for the following: Implementation, Ongoing monitoring, Investigation, Reporting and Tracking and Trending. Review of a facility policy titled, Care Plan - Interdisciplinary Plan of Care from Interim to Meeting, effective , showed the facility shall support that "each resident must receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and , , well-being, in accordance with the comprehensive assessment and plan of care". The facility shall assess and address care issues that are relevant to individual residents, to include, but may not be limited to, monitoring resident condition, and responding with appropriate interventions. The comprehensive care plan is an interdisciplinary communication tool. It includes measurable objectives, and time frames and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and , , well-being. The care plan is reviewed and revised periodically, and the services provided or arranged are consistent with	N 204	#1's care plan was reviewed and updated as indicated. Nursing Home Administrator (NHA) and/or Director of Nursing (DON) conducted an audit of resident grievances and/or incidents to ensure that there were no concerns identified related to insufficient staffing levels. No new concerns were identified. Element #2. A review of facility staffing levels was completed to ensure adequate staffing levels in place to meet the needs of the residents. No additonal opportunities identied. An evaluation of current residents was conducted by the Director of Nursing (DON) and/or designee to ensure that no additional residents were , by the alleged deficient practice. No other opportunities were identified. Element #3. Current licensed nursing staff were in-serviced on the facility's Policy and Procedure and , Neglect, and , Policy as it relates to providing necessary assistance with activities of daily living, prevention, and potential for resident harm. Nursing Home Administrator (NHA) and Director of Nursing (DON) were in-serviced by Regional Nurse Consultant and/or Regional Director of Operations Consultant regarding the requirement that a daily staffing meeting/review is completed to ensure that daily mimnum staffing levels are met and maintinaed. A	

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N 204	Continued From page 3 each resident's written plan of care. Procedure: 1. Update to Care Plans (a.) Ongoing updates to care plans are added by a member of the IDT, as needed. 2. Dates and documentation on the care plan when (a.). New, revised, or discontinued Problems, Goals, or Interventions are dated for the date the documentation was made. (b.) Problems and Goals have IDT approaches and Interventions to assist the resident in their goal attainment. Review of a facility policy titled, and Injury Reduction Policy effective showed the facility has designated and implemented processes, which strive to reduce the risk for and injuries. This policy guides the identification, implementation of appropriate interventions, and management. It is expected that this policy will assist the facility with reducing the likelihood of a or injury while maintaining or maximizing dignity and independence through education of staff and residents, early identification of risk factors by collecting data, identifying resident behavior which may increase the likelihood of such occurrence. On at 11:29 a.m., Resident #1 was observed laying in bed. The resident's right arm was resting on his and was . Resident #1 was non-verbal but nodded yes or no to questions. He nodded "yes" to remembering a incident. He nodded "yes" to being in , . He shrugged his when asked if he was injured. Staff B, Licensed Practical Nurse (LPN) was present during Resident #1's observation and interview. Staff B, LPN reported she was assigned to Resident #1, and the resident suffered a bump during a . Staff B, LPN reached over the resident's and touched the right side of the resident's forehead to reveal a	N 204	plan was developed and implemented to enhance the hiring of registered, licensed, and certified nursing staff as required to assist with maintaining ddaily minumum staffing levels. Recruitment efforts continue. Element #4. The Director of nursing (DON) and/or designee will audit staffing levels three times a week for the next 60 days to ensure that staffing levels are appropriate to meet the needs of the residents. Findings will be brought by he Nursing Homes Administrator (NHA) and/or designee to the Quality Assessment and Assurance Committee monthly meeting for three months for further comments and/or recommendations. Element #5. Facility's Allegation of Compliance Date is , 20225.	

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N 204	Continued From page 4 remaining raised bump. Staff B, LPN stated the ␣ had gone down, but a small bump still remained. Staff B, LPN stated it was hard to know the impact due to the resident's other diagnoses. Staff B, LPN stated the resident had , does not speak, and does not always express , . Staff B, LPN said, "You have to know him and pay close attention to know when things are off." Review of a hospital visit summary for Resident #1 dated at 3:22 a.m. showed Resident #1 was seen due to a with diagnoses of , initial encounter, resulting in a injury. Review of the imaging results revealed, "skin/ soft tissue, small right frontal , hematoma." The CT (Computed ␣ , ,) scan revealed, indication " from bed" Findings "straightening of , most consistent with paraspinous , [meaning involuntary or cramping of the along the , , causing , , stiffness, and difficulty moving] and/or positioning." On at 11:42 a.m., Staff A, Certified Nursing Assistant (CNA) revealed she was assigned to Resident #1 the day he on She stated she had worked 3 p.m. - 11 p.m., and Resident #1 was the last resident she cared for. She said, "I was changing the bed when he started to off the bed. I tried to catch him to save the , but I could not." She stated, "As I wrote in my statement, I lowered the bed and was trying to lower it some more as I was holding on to him. I was alone in the room. I knew he needed two people. He cannot do anything for himself." Staff A stated Resident #1 could not hold on to the side rail/enabler because his right was . She said, "I know I should have	N 204		

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N 204	Continued From page 5 asked for help. It was my fault. I take responsibility for not asking for help." The CNA stated they were understaffed that day because someone called off and there was no replacement. She stated this happened many times, and the administration allowed the staff to continue working without a replacement. She stated that night, there was one nurse working and 2 CNAs in the entire building. She stated there would normally be staff. She stated the facility ended her employment because the resident was a two-person assist, and she cared for him alone. Staff A said, "I usually get help, but no one was available when I went into the room." She stated when the resident started to , she yelled out for help and the nurse (Staff C) came. The CNA stated she had worked with this resident many times before and knew he was dependent and needed staff to do everything for him. She stated prior to the incident, she had not received any education but only when she was hired two years earlier. She stated she could have reviewed the CNA task list to see this resident's care status. Staff A stated, "I knew he was dependent for all care. I take full responsibility." Staff A stated the resident was injured, he suffered a bump on his and was sent to the hospital. She stated the resident was non-verbal and could not express , . She stated looking at his , he looked like he was in some , . She stated she and the nurse assisted the resident to bed. Staff A stated she was suspended on . She stated not much was said to her at the time, and she was not asked to give a statement at the time. She stated she was contacted on and asked to come in and give a statement on . Review of the admission Record for Resident #1 revealed he was originally admitted to the facility	N 204		

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N 204	Continued From page 6 in 2013 and readmitted on with diagnoses to include wasting and atrophy, due to unspecified occlusion, wasting, unspecified, and , unspecified and of right and . Review of a SBAR (Situation, Background, Assessment, and Recommendation) form revealed a change in condition dated at 11:39 PM. Situation: The Change In Condition/s reported on this Evaluation are/were: , with New Testing Orders:- Send to ER (Emergency Room). Review of physician orders for Resident #1 showed an order dated at 11:24 PM to send to ER to evaluate and treat. Review of a progress note dated at 11:32 PM signed by Staff C, Registered Nurse (RN) showed: "This PM, . [patient] rolled out of bed during , care. was assisted into bed by this nurse and CNA. . assessed for injury and noted to have to R [Right] side of forehead. on . denies , at this time, pupils PERRLA [PERRLA - an acronym for Pupils are Equal, Round and Reactive to Light and Accommodation] bed in lowest position during incident. VS WNL [Vital signs within normal limits] and no deviation from baseline noted. This nurse notified MD [Medical Doctor] of clinical situation and received order to send to ER. DON [Director of Nursing] notified, and . is his own RP [Responsible Party]." Review of a Hospital transfer evaluation summary dated revealed an assessment was conducted - location and description: Top of	N 204		

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N 204	Continued From page 7 , - ˬ top of right forehead. Under , level assessment, the entry defaulted a "numerical" response with none noted. Review of a progress note dated showed... Patient s/p (Status Post) . Patient denies any , . . Review of a progress note dated . . . showed... "Patient's Right arm is ,, Patient has a knot to forehead..." Review of weekly skin checks for Resident #1 revealed four skin checks had been completed in a period of four months (, through ,), most recently on showing the resident had a knot on forehead, top of , , and on showing the resident has a knot on forehead, . Review of a Minimum Data Set (MDS) dated , showed in section C: . . . . . ( ) score of 00, showing he was unable to complete the interview and indicated severe ˬ , . Section GG - showed the resident had functional limitation in range of motion , on one side to the upper extremity and , on both sides to the lower extremities. The resident was dependent for toileting hygiene requiring the assistance of 2 or more helpers to complete the activity. The resident was dependent for the ability to roll from lying on to left and right side and return to lying on on the bed. Resident #1 required the assistance of 2 or more helpers for this activity. The resident was dependent for sitting on side of bed to lying flat on the bed and dependent from lying on his to sitting on the side of the bed with no support.	N 204		

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N 204	Continued From page 8 Review of Resident #1's Kardex (a document used by staff with instructions specific to a resident's care needs) dated showed the resident was dependent on staff, requiring assist of two for transferring, personal hygiene, and . For bed mobility, the task list showed: Dependent assist of 2 to turn and/or reposition. For locomotion the resident was non-ambulatory, uses a wheel chair and was dependent on staff. Review of a care plan for Resident #1 initiated on showed a focus - Resident #1 has an ADL (activities of daily living) self -care performance as evidenced by: , limited mobility, history of ( ). The goal showed the resident will maintain current level of self-performance with ADLs through next review date. Interventions initiated on included: Resident was totally dependent upon staff for ADLs. Encourage resident to participate at highest functional ability. Bed Mobility: dependent assist of 2 to turn and/or reposition date initiated: . Transfer: total to chair of 2; sling size: L date initiated: . Toilet use, dependent assist of 2 for care date initiated: . Review of a focus in the same care plan initiated on showed Resident #1 was at risk for or related injury because of: gait/balance problems, right sided , poor safety awareness, impulsiveness, history of , and medication use. The goal showed - Resident will minimize the risk of through review date target date: . Interventions included to: Lock brakes on bed, chair etc. before transferring date initiated: . (, , / (, ,) referral for screen and	N 204		

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N 204	Continued From page 9 treatment as needed. date initiated: . Report to physician and responsible party revised on . , and meet the resident's needs. Revised on . Provide environmental adaptations: adequate glare free lighting, area free of clutter date revised on . On at 11:19 a.m., an interview was conducted with Staff B, LPN. She stated she heard that Staff A, CNA rolled the resident away from her, he hit his , and had to be sent out. She stated he had a bump that had been slowly going down. Staff B, LPN confirmed Resident #1 required 2 staff assistance during all care. She stated to confirm transfer status, staff are expected to review the resident's care plan, review the CNA task list, or check with , , on status. She stated the problem that night was that they did not have enough staff. She said, "I believe 2 CNAs called off and they were not replaced. She stated this happened quite often." On at 11:30 a.m., an interview was conducted with Staff E, CNA and Staff D, CNA. Staff D stated a CNA had dropped Resident #1. She stated he had a bump on his for days. She said, "I think it is still there." Staff E stated this resident had always been dependent on staff for all care. She stated the problem that night was, "They did not have enough staff. There is no one to help. How can you run this place with only 2 CNAs when all these residents need total care?" Staff E stated she reviews the computer information to see the resident's care status. Staff E stated many times the residents are not changed, and it was passed on to the next shift because they did not have enough staff. She stated it was a set-up, what happened to Staff A, CNA was wrong. She was left without a choice.	N 204		

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N 204	Continued From page 10 Staff E and D stated the administration does not care." On at 1:15 p.m., an interview was conducted with the Director of Nursing (DON) and the Nursing Home Administrator (NHA). The DON stated the incident happened on Saturday, . He said, "I was on PTO {Paid Time Off]. I became aware on Wednesday, the 26th. I put the on the incident log and corporate called to get information on the 27th. They said because he was transferred to a higher level of care, we needed to report. The DON stated he called Staff A, CNA to come in for an interview. He stated on he interviewed Staff A, and reading her statement he said, "She was positioned on the right side of the resident's bed, resident was on his , bed in low position, when attempting to change his sheet, she rolled him to the right, his side, the momentum caused him to continue to roll. She immediately grabbed the lower body of the resident, which enabled her to maintain the position of the lower body on the bed while the right and forehead came into contact with the floor. She was lowering the bed lower while calling for help. The DON stated he interviewed the nurse. Reading Staff C's statement, he said, "On CNA approached this nurse and informed her the resident out of bed during patient care. The patient was assessed for injury and noted to have the right side of the forehead. Patient is on , , . Patient denies , at this time, no deviation noted. CNA stated the bed was in low position when incident occurred and patient rolled, the nurse and CNA assisted the patient to bed. Nurse notified the MD on the 22nd . MD gave orders to send patient to ER." The DON confirmed Resident #1 had a forehead after the . He stated he thought prior	N 204		

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N 204	Continued From page 11 to the incident, Resident #1 was a one person assist. He stated after the the care plan was updated to two person assist for all care. The DON said, "He should have been a two-person all along." An interview was conducted with the NHA on at 1:26 p.m. She stated she could not answer to why staff did not call her that weekend. She stated she thought they had notified the DON. She revealed she was notified by corporate on the 27th that she needed to file the report. She stated corporate said to obtain interviews and have the DON start education. The NHA said, "I did not do a timeline. The incident was reported to AHCA [Agency for Health Care Administration] on . It was late." She stated she became aware of the incident on Monday, , but it had occurred on . When asked why it took two days to be notified, the NHA stated it was the weekend and the DON and Director of Rehab were on leave. The NHA stated when she became aware she notified corporate on and suspended the CNA pending investigation. She stated she did not start her investigation. She stated she did not interview any other residents and did not interview the staff at the time. The NHA stated their process was to wait until corporate gave the go-ahead before contacting state agencies. The NHA stated this process affects her reporting and investigation timeline. She said, "That is why the reporting was late." The NHA stated she did a root cause analysis and determined there was a staffing concern. She said, "We had call-offs that we could not cover. I tried to call other staff, I offered a bonus, and no one picked up." She stated they did not meet staffing for that day. She stated one CNA called out and one was a no-show. The NHA stated the CNA should have asked for help. She stated she	N 204		

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N 204	Continued From page 12 should have known the resident needed two staff for care. The NHA stated they suspended the CNA pending investigation and initiated their investigation. She stated the DON had been educating staff. An interview was conducted with the Regional Risk Manager on at 2:11 p.m. She stated in their analysis, they discovered there was another problem. She stated the care plan was not active at the time. It had been resolved, meaning it would not have shown if it was a one or two staff assist. The staff would not have known the transfer status at the time. She stated they initiated a whole house audit. The Regional Risk Manager stated the CNAs are to notify the nurse or Minimum Data Set (MDS) Coordinator if the care plan was not showing. The Risk Manager said, "They did not have access to [name of a document used by staff with instructions specific to a resident's care needs]. The Risk Manager did not know how many people were affected by the resolved care plans. During an interview on at 2:29 p.m. an interview with the Traveling MDS Coordinator revealed she visits this facility once or twice a week. She stated the issue of the care plan resolving and the interventions not being visible was resolved for Resident #1. She stated she did not know why it was happening that way. She stated if a care plan intervention expired, The MDS nurse received a notification. The Traveling MDS Coordinator said, "The problem is there is not an MDS nurse here all the time. The person is shared between this facility and the sister facility. If the previous MDS Coordinator received the notification, I would not know." She stated their goal was to continue auditing. She stated they realized the problem was also duplicated care	N 204		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55215	A. BUILDING: _____ B. WING _____	C 04/23/2025

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N 204	Continued From page 13 plans with readmission from the hospital. The staff should not have started a new care plan. They should re-instate the old one. The MDS Coordinator said, "Our investigation included review of his history, he was a 2-person. Staff were historically using 2 staff for all care. Today, if I were to assess him, he would definitely be a 2-person assist." The Traveling MDS Coordinator stated she was currently auditing other care plans to see if any other interventions had resolved. A follow-up interview was conducted with the Regional Risk Manager and the NHA on at 2:53 p.m. The Risk Manager stated she would have expected staff to call the administration. She stated the should have been brought up in the morning meeting. The Risk Manager stated the , , Director, and the DON were off and that was why they missed the notification of the and hospital transfer. The NHA confirmed the IDT (Interdisciplinary Team) did not know. Class II	N 204		

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F 000	INITIAL COMMENTS A complaint survey for complaint number 2025004290 was conducted on and at Manor, in conjunction with a revisit to a complaint survey for complaint number 2025001975 (UBR912). The facility was not in compliance with 42 CFR, Part 483, Requirements for Long Term Care Facilities. The facility has been out of compliance since Complaint #2025004290 had deficiencies cited at F600, F609, F610, and F842.	F 000		
F 600 SS=G	Free from and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from , Neglect, and , The resident has the right to be free from , neglect, misappropriation of resident property, and , as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary and any physical or chemical not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, , or , , , corporal punishment, or involuntary ; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility neglected to provide the number of staff needed to ensure safety during bed mobility consistent with the assessed and	F 600	This plan of correction is submitted as required under state and federal laws. The submission of this plan of correction does not constitute an admission on the	

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 600	Continued From page 1	F 600		

care planned needs for one (#1) of two residents sampled for and neglect. Resident #1 sustained a from the bed resulting in a transfer to a higher level of care, and injury.

Findings included:

On at 11:29 a.m., Resident #1 was observed laying in bed. The resident's right arm was resting on his and was . Resident #1 was non-verbal but nodded yes or no to questions. He nodded "yes" to remembering a incident. He nodded "yes" to being in , . He shrugged his when asked if he was injured. Staff B, Licensed Practical Nurse (LPN) was present during Resident #1's observation and interview. Staff B, LPN reported she was assigned to Resident #1, and the resident suffered a bump during a . Staff B, LPN reached over the resident's and touched the right side of the resident's forehead to reveal a remaining raised bump. Staff B, LPN stated the had gone down, but a small bump still remained. Staff B, LPN stated it was hard to know the impact due to the resident's other diagnoses. Staff B, LPN stated the resident had , does not speak, and does not always express , . Staff B, LPN said, "You have to know him and pay close attention to know when things are off."

Review of a hospital visit summary for Resident #1 dated at 3:22 a.m. showed Resident #1 was seen due to a with diagnoses of , initial encounter, resulting in a injury. Review of the imaging results revealed, "skin/ soft tissue, small right frontal , hematoma." The CT (Computed , ,) scan revealed, indication " from

part of the skilled nursing facility as to the accuracy of the surveyor's findings or the conclusion drawn there from. The plan of correction does not constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. Any changes to facility policy and procedures should be considered remedial measures as that concept is employed in rule 407 of the federal rules of evidence and should be inadmissible in any proceeding on that basis. The facility submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the facility or any employee, agent, officer, director, or shareholders of the facility. The facility has not waived any of its rights to contest any of these allegations or any allegation or action.

F-600 Free From and Neglect

Element #1. Resident #1 was assessed to ensure no further injuries, and that , was at a level that was acceptable to the resident. No additonal findings noted upon assessment and , level at acceptable level for resident. Resident #1's care plan was reviewed and updated as indicated.

Nursing Home Administrator (NHA) and/or Director of Nursing (DON) conducted an audit of resident grievances and/or incidents to ensure that there were no concerns identified related to insufficient staffing levels. No new concerns were

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F 600	Continued From page 2 bed" Findings "straightening of , most consistent with paraspinous , [meaning involuntary or cramping of the along the , , causing , , stiffness, and difficulty moving] and/or positioning." On at 11:42 a.m., Staff A, Certified Nursing Assistant (CNA) revealed she was assigned to Resident #1 the day he on . She stated she had worked 3 p.m. - 11 p.m., and Resident #1 was the last resident she cared for. She said, "I was changing the bed when he started to off the bed. I tried to catch him to save the , but I could not." She stated, "As I wrote in my statement, I lowered the bed and was trying to lower it some more as I was holding on to him. I was alone in the room. I knew he needed two people. He cannot do anything for himself." Staff A stated Resident #1 could not hold on to the side rail/enabler because his right was . She said, "I know I should have asked for help. It was my fault. I take responsibility for not asking for help." The CNA stated they were understaffed that day because someone called off and there was no replacement. She stated this happened many times, and the administration allowed the staff to continue working without a replacement. She stated that night, there was one nurse working and 2 CNAs in the entire building. She stated there would normally be staff. She stated the facility ended her employment because the resident was a two-person assist, and she cared for him alone. Staff A said, "I usually get help, but no one was available when I went into the room." She stated when the resident started to , she yelled out for help and the nurse (Staff C) came. The CNA stated she had worked with this	F 600	identified. Element #2. A review of facility staffing levels was completed to ensure adequate staffing levels in place to meet the needs of the residents. No additonal opportunities identied. An evaluation of current residents was conducted by the Director of Nursing (DON) and/or designee to ensure that no additional residents were , by the alleged deficient practice. No other opportunities were identified. Element #3. Current licensed nursing staff were in-serviced on the facility's Policy and Procedure and , Neglect, and , Policy as it relates to providing necessary assistance with activities of daily living, prevention, and potential for resident harm. Nursing Home Administrator (NHA) and Director of Nursing (DON) were in-serviced by Regional Nurse Consultant and/or Regional Director of Operations Consultant regarding the requirement that a daily staffing meeting/review is completed to ensure that daily mimnum staffing levels are met and maintinaed. A plan was developed and implemented to enhance the hiring of registered, licensed, and certified nursing staff as required to assist with maintaining ddaily minumum staffing levels. Recruitment efforts continue. Element #4. The Director of nursing	

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F 600	Continued From page 3 resident many times before and knew he was dependent and needed staff to do everything for him. She stated prior to the incident, she had not received any education but only when she was hired two years earlier. She stated she could have reviewed the CNA task list to see this resident's care status. Staff A stated, "I knew he was dependent for all care. I take full responsibility." Staff A stated the resident was injured, he suffered a bump on his and was sent to the hospital. She stated the resident was non-verbal and could not express . She stated looking at his , he looked like he was in some . She stated she and the nurse assisted the resident to bed. Staff A stated she was suspended on . She stated not much was said to her at the time, and she was not asked to give a statement at the time. She stated she was contacted on and asked to come in and give a statement on . Review of the admission Record for Resident #1 revealed he was originally admitted to the facility in 2013 and readmitted on with diagnoses to include wasting and atrophy, due to unspecified occlusion, wasting, unspecified, and , unspecified and of right and . Review of a SBAR (Situation, Background, Assessment, and Recommendation) form revealed a change in condition dated at 11:39 PM. Situation: The Change In Condition/s reported on this Evaluation are/were: , with New Testing Orders:- Send to ER (Emergency Room).	F 600	(DON) and/or designee will audit staffing levels three times a week for the next 60 days to ensure that staffing levels are appropriate to meet the needs of the residents. Findings will be brought by he Nursing Homes Administrator (NHA) and/or designee to the Quality Assessment and Assurance Committee monthly meeting for three months for further comments and/or recommendations. Element #5. Facility's Allegation of Compliance Date is , 20225.	

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Review of physician orders for Resident #1 showed an order dated at 11:24 PM to send to ER to evaluate and treat.

Review of a progress note dated at 11:32 PM signed by Staff C, Registered Nurse (RN) showed: "This PM, , . [patient] rolled out of bed during , . care. , was assisted into bed by this nurse and CNA. . assessed for injury and noted to have to R [Right] side of forehead. . on , , . denies , at this time, pupils PEERLA [PERRLA - an acronym for Pupils are Equal, Round and Reactive to Light and Accommodation] bed in lowest position during incident. VS WNL [Vital signs within normal limits] and no deviation from baseline noted. This nurse notified MD [Medical Doctor] of clinical situation and received order to send to ER. DON [Director of Nursing] notified, and , . is his own RP [Responsible Party]."

Review of a Hospital transfer evaluation summary dated revealed an assessment was conducted - location and description: Top of , - top of right forehead. Under , level assessment, the entry defaulted a "numerical" response with none noted.

Review of a progress note dated showed... Patient s/p (Status Post) . Patient denies any , .

Review of a progress note dated showed... "Patient's Right arm is ,. Patient has a knot to forehead..."

Review of weekly skin checks for Resident #1 revealed four skin checks had been completed in a period of four months (through

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F 600	Continued From page 5 ,), most recently on showing the resident had a knot on forehead, top of , , and on showing the resident has a knot on forehead, . Review of a Minimum Data Set (MDS) dated , showed in section C: ( ) score of 00, showing he was unable to complete the interview and indicated severe , . Section GG - showed the resident had functional limitation in range of motion , on one side to the upper extremity and , on both sides to the lower extremities. The resident was dependent for toileting hygiene requiring the assistance of 2 or more helpers to complete the activity. The resident was dependent for the ability to roll from lying on to left and right side and return to lying on on the bed. Resident #1 required the assistance of 2 or more helpers for this activity. The resident was dependent for sitting on side of bed to lying flat on the bed and dependent from lying on his to sitting on the side of the bed with no support. Review of Resident #1's Kardex (a document used by staff with instructions specific to a resident's care needs) dated showed the resident was dependent on staff, requiring assist of two for transferring, personal hygiene, and . For bed mobility, the task list showed: Dependent assist of 2 to turn and/or reposition. For locomotion the resident was non-ambulatory, uses a wheel chair and was dependent on staff. Review of a care plan for Resident #1 initiated on showed a focus - Resident #1 has an	F 600		

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F 600	Continued From page 6 ADL (activities of daily living) self -care performance as evidenced by: , limited mobility, history of ( ). The goal showed the resident will maintain current level of self-performance with ADLs through next review date. Interventions initiated on included: Resident was totally dependent upon staff for ADLs. Encourage resident to participate at highest functional ability. Bed Mobility: dependent assist of 2 to turn and/or reposition date initiated: . Transfer: total to chair of 2; sling size: L date initiated: . Toilet use, dependent assist of 2 for care date initiated: . Review of a focus in the same care plan initiated on showed Resident #1 was at risk for or related injury because of: gait/balance problems, right sided , poor safety awareness, impulsiveness, history of , and medication use. The goal showed - Resident will minimize the risk of through review date target date: . Interventions included to: Lock brakes on bed, chair etc. before transferring date initiated: . (, . , / (, , ,) referral for screen and treatment as needed. date initiated: . Report to physician and responsible party revised on , and meet the resident's needs. Revised on . Provide environmental adaptations: adequate glare free lighting, area free of clutter date revised on . On at 11:19 a.m., an interview was conducted with Staff B, LPN. She stated she heard that Staff A, CNA rolled the resident away from her, he hit his , and had to be sent out. She stated he had a bump that had been slowly	F 600		

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F 600	Continued From page 7	F 600		

going down. Staff B, LPN confirmed Resident #1 required 2 staff assistance during all care. She stated to confirm transfer status, staff are expected to review the resident's care plan, review the CNA task list, or check with , , on status. She stated the problem that night was that they did not have enough staff. She said, "I believe 2 CNAs called off and they were not replaced. She stated this happened quite often."

On at 11:30 a.m., an interview was conducted with Staff E, CNA and Staff D, CNA. Staff D stated a CNA had dropped Resident #1. She stated he had a bump on his for days. She said, "I think it is still there." Staff E stated this resident had always been dependent on staff for all care. She stated the problem that night was, "They did not have enough staff. There is no one to help. How can you run this place with only 2 CNAs when all these residents need total care?" Staff E stated she reviews the computer information to see the resident's care status. Staff E stated many times the residents are not changed, and it was passed on to the next shift because they did not have enough staff. She stated it was a set-up, what happened to Staff A, CNA was wrong. She was left without a choice. Staff E and D stated the administration does not care."

On at 1:15 p.m., an interview was conducted with the Director of Nursing (DON) and the Nursing Home Administrator (NHA). The DON stated the incident happened on Saturday, . He said, "I was on PTO {Paid Time Off]. I became aware on Wednesday, the 26th. I put the on the incident log and corporate called to get information on the 27th. They said because he was transferred to a higher level of care, we

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needed to report. The DON stated he called Staff A, CNA to come in for an interview. He stated on he interviewed Staff A, and reading her statement he said, "She was positioned on the right side of the resident's bed, resident was on his , bed in low position, when attempting to change his sheet, she rolled him to the right, his side, the momentum caused him to continue to roll. She immediately grabbed the lower body of the resident, which enabled her to maintain the position of the lower body on the bed while the right and forehead came into contact with the floor. She was lowering the bed lower while calling for help. The DON stated he interviewed the nurse. Reading Staff C's statement, he said, "On CNA approached this nurse and informed her the resident out of bed during patient care. The patient was assessed for injury and noted to have the right side of the forehead. Patient is on , , . Patient denies , at this time, no deviation noted. CNA stated the bed was in low position when incident occurred and patient rolled, the nurse and CNA assisted the patient to bed. Nurse notified the MD on the 22nd . MD gave orders to send patient to ER." The DON confirmed Resident #1 had a forehead after the . He stated he thought prior to the incident, Resident #1 was a one person assist. He stated after the the care plan was updated to two person assist for all care. The DON said, "He should have been a two-person all along."

An interview was conducted with the NHA on at 1:26 p.m. She stated she could not answer to why staff did not call her that weekend. She stated she thought they had notified the DON. She revealed she was notified by corporate

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on the 27th that she needed to file the report. She stated corporate said to obtain interviews and have the DON start education. The NHA said, "I did not do a timeline. The incident was reported to AHCA [Agency for Health Care Administration] on . It was late." She stated she became aware of the incident on Monday, , but it had occurred on . When asked why it took two days to be notified, the NHA stated it was the weekend and the DON and Director of Rehab were on leave. The NHA stated when she became aware she notified corporate on and suspended the CNA pending investigation. She stated she did not start her investigation. She stated she did not interview any other residents and did not interview the staff at the time. The NHA stated their process was to wait until corporate gave the go-ahead before contacting state agencies. The NHA stated this process affects her reporting and investigation timeline. She said, "That is why the reporting was late." The NHA stated she did a root cause analysis and determined there was a staffing concern. She said, "We had call-offs that we could not cover. I tried to call other staff, I offered a bonus, and no one picked up." She stated they did not meet staffing for that day. She stated one CNA called out and one was a no-show. The NHA stated the CNA should have asked for help. She stated she should have known the resident needed two staff for care. The NHA stated they suspended the CNA pending investigation and initiated their investigation. She stated the DON had been educating staff.

An interview was conducted with the Regional Risk Manager on at 2:11 p.m. She stated in their analysis, they discovered there was another problem. She stated the care plan was

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F 600	Continued From page 10	F 600		

not active at the time. It had been resolved, meaning it would not have shown if it was a one or two staff assist. The staff would not have known the transfer status at the time. She stated they initiated a whole house audit. The Regional Risk Manager stated the CNAs are to notify the nurse or Minimum Data Set (MDS) Coordinator if the care plan was not showing. The Risk Manager said, "They did not have access to [name of a document used by staff with instructions specific to a resident's care needs]. The Risk Manager did not know how many people were affected by the resolved care plans.

During an interview on at 2:29 p.m. an interview with the Traveling MDS Coordinator revealed she visits this facility once or twice a week. She stated the issue of the care plan resolving and the interventions not being visible was resolved for Resident #1. She stated she did not know why it was happening that way. She stated if a care plan intervention expired, The MDS nurse received a notification. The Traveling MDS Coordinator said, "The problem is there is not an MDS nurse here all the time. The person is shared between this facility and the sister facility. If the previous MDS Coordinator received the notification, I would not know." She stated their goal was to continue auditing. She stated they realized the problem was also duplicated care plans with readmission from the hospital. The staff should not have started a new care plan. They should re-instate the old one. The MDS Coordinator said, "Our investigation included review of his history, he was a 2-person. Staff were historically using 2 staff for all care. Today, if I were to assess him, he would definitely be a 2-person assist." The Traveling MDS Coordinator stated she was currently auditing other care plans

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to see if any other interventions had resolved.

A follow-up interview was conducted with the Regional Risk Manager and the NHA on at 2:53 p.m. The Risk Manager stated she would have expected staff to call the administration. She stated the should have been brought up in the morning meeting. The Risk Manager stated the , , Director, and the DON were off and that was why they missed the notification of the and hospital transfer. The NHA confirmed the IDT (Interdisciplinary Team) did not know.

Review of a facility policy titled, Care Plan - Interdisciplinary Plan of Care from Interim to Meeting, effective , showed the facility shall support that "each resident must receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and , , well-being, in accordance with the comprehensive assessment and plan of care". The facility shall assess and address care issues that are relevant to individual residents, to include, but may not be limited to, monitoring resident condition, and responding with appropriate interventions. The comprehensive care plan is an interdisciplinary communication tool. It includes measurable objectives, and time frames and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and , , well-being. The care plan is reviewed and revised periodically, and the services provided or arranged are consistent with each resident's written plan of care.
Procedure: 1. Update to Care Plans (a.) Ongoing updates to care plans are added by a member of the IDT, as needed. 2. Dates and documentation

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on the care plan when (a.). New, revised, or discontinued Problems, Goals, or Interventions are dated for the date the documentation was made. (b.) Problems and Goals have IDT approaches and Interventions to assist the resident in their goal attainment.

Review of a facility policy titled, and Injury Reduction Policy effective showed the facility has designated and implemented processes, which strive to reduce the risk for and injuries. This policy guides the identification, implementation of appropriate interventions, and management. It is expected that this policy will assist the facility with reducing the likelihood of a or injury while maintaining or maximizing dignity and independence through education of staff and residents, early identification of risk factors by collecting data, identifying resident behavior which may increase the likelihood of such occurrence.

Review of a facility policy titled, Prevention Program, reviewed showed the facility has designated and implemented processes, which strive to reduce the risk of , neglect, , , mistreatment, and misappropriation of resident's property. These policies guide the identification, management, and reporting of suspected, or alleged, , neglect, mistreatment, and , . It is expected that these policies will assist the facility with reducing the risk of , neglect, , , and misappropriation of resident's property through education of staff and residents, as well as early identification of staff burn out, or resident behavior which may increase the likelihood of such events.
Definitions: Neglect - Failure of the facility, its

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F 600	Continued From page 13 employees or service providers to provide good and services to a resident that are necessary to avoid physical harm, , , mental anguish or emotional distress. Procedure: The facility has implemented the following processes in an effort to provide residents, visitors and staff with a safe and comfortable environment. - The Administrator is responsible for designating an Coordinator. - The designated shift supervisor is identified as responsible for immediate initiation of the reporting process. - The Administrator, DON and/or designated individual are responsible for the investigation and reporting of suspected, or alleged, , neglect, and , and misappropriation. - The Administrator, DON and/or designated individual are also ultimately responsible for the following: Implementation, Ongoing monitoring, Investigation, Reporting and Tracking and Trending.	F 600		
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	F 609		

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F 609	Continued From page 14 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 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 interviews and record review, the facility failed to report allegations of in a timely manner for two (#1 and #3) of two residents sampled for and neglect. (Cross reference F600 and F610) Findings included: 1. Review of a hospital visit summary for Resident #1 dated at 3:22 a.m. showed Resident #1 was seen due to a with diagnoses of , initial encounter, resulting in a injury. Review of the admission Record for Resident #1 revealed he was admitted to the facility on and readmitted on with diagnoses to include wasting and atrophy, due to unspecified occlusion, wasting, unspecified,	F 609	This plan of correction is submitted as required under state and federal laws. The submission of this plan of correction does not constitute an admission on the part of the skilled nursing facility as to the accuracy of the surveyor's findings or the conclusion drawn there from. The plan of correction does not constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. Any changes to facility policy and procedures should be considered remedial measures as that concept is employed in rule 407 of the federal rules of evidence and should be inadmissible in any proceeding on that basis. The facility submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the facility or any employee, agent, officer, director, or shareholders of	

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F 609	Continued From page 15 and , , aphasia and unspecified . An interview was conducted with the Nursing Home Administrator (NHA) on at 1:26 p.m. revealed she did not initiate the investigation for the incident on until . She stated she could not answer to why staff did not call her that weekend when the incident occurred. She stated she thought they had notified the Director of Nursing (DON). She revealed she was notified by corporate on the 27th [of] that she needed to file a report. She stated corporate said to obtain interviews and have the DON start education. The NHA said, "I did not do a timeline. The incident was reported to AHCA [Agency for Health Care Administration] on . It was late." She stated she became aware of the incident on Monday, , but it had occurred on . When asked why it took two days to be notified, the NHA stated it was the weekend, and the DON, and the Director of Rehab were on leave. The NHA stated when she became aware, she notified corporate on and suspended the Certified Nursing Assistant (CNA) pending investigation. She stated she did not start her investigation then. She stated she did not interview any other residents and did not interview the staff at the time. The NHA stated their process was to wait until corporate gave her the go-ahead before contacting state agencies. The NHA stated this process affects her reporting and investigation timeline. She said, "That is why the reporting was late." 2. On at 11:35 a.m. an interview was conducted with Resident #3. She stated she had reported some staff member for being rough and	F 609	the facility. The facility has not waived any of its rights to contest any of these allegations or any allegation or action. F-609, Reporting Alleged Violations Element #1. Resident's #1 and #3 were assessed to ensure there were no negative outcome from the alleged deficient practice. No negative findings identified. Element #2. The Nursing Home Administrator (NHA) and/or designee conducted an audit to identify any other allegations that were reported late within the past 30 days. Residents with previous reports were reassessed for ongoing safety and care concerns. No addiontal concerns identified. Element #3. Current facility staff will be in-serviced by the Nursing Home Administrator (NHA) and/or designee on timeliness of reporting allegations of , neglect, and , as well as the timeframes in which to report allegations to ensure they undestand when and how to submit allegations in a timely manner. The Nursing Home Administrator (NHA) and Director of Nursing (DON) were in-serviced by the Regional Vice President and/or Regional Nurse Consultant on timeliness of reporting allegations of , neglect, and , as welll as the timeframes in which to report allegations to ensure they understand	

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F 609	Continued From page 16 loud with her. She said, "They can't talk to me just anyhow." She stated she did not know if the issue was resolved. She stated she did not know what they did about it, but she had filed a grievance. Review of Resident #3's admission record showed she was originally admitted on with diagnoses to include , , , wasting and atrophy, and (severe) . A MDS (Minimum Data Set) assessment dated showed the resident had a ( ) score of 15 out of 15, indicating intact mental cognition. An interview on at 12:30 p.m. with the NHA revealed on Resident #3 stated the CNA (Staff F) was rough with her when providing care, and she did not like the CNA's approach. The NHA stated the resident was receiving care on and the NHA was notified on sometime in the afternoon. She stated she reported the allegation on at 3:50 p.m. She stated it was a day late. The NHA stated she reviewed the grievance form. She stated she did not ask the , to write a statement. She did not ask the CNA what "rough with her" meant. She stated she did not speak to any other staff about it. She said, "I see. I could have asked more questions." The NHA stated she did not report this allegation of . On at 3:02 p.m. an interview was conducted with the NHA regarding a second incident for Resident #3 that occurred on . The NHA stated the state agency for adult protective investigations had come to the facility to investigate an allegation of . She stated a family member had contacted the state	F 609	when and how to submit allegations in a tiemly manner. Element #4. The Nursing Home Administrator (NHA) and/or designee will audit new reportables once a week for the next 60 days to ensure timeliness of reporting. Findings will be brought by the Nursing Home Administrator (NHA) and/or designee to the Quality Assessment and Assurance Committee monthly meeting for three months for further comments and/or recommendations. Element #5. Facility's Allegation of Compliance Date is .	

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F 609	Continued From page 17 agency to report that the , (Staff G, Occupational , -) physically shakes and yells at the resident to wake her up when he is in her room. The NHA stated the state agency interviewed the resident and did not substantiate the allegation. The NHA stated state agency did not interview Staff G. The NHA stated she did not obtain a statement from Staff G, . She stated she interviewed one CNA who generally works the area. She stated the CNA (Staff H) stated on a few occasions (Resident #3) said she does not want to get up because she does not like them (referring to , ,). The CNA stated she yells, "get out, don't touch me" and , , staff leave and come later. The NHA stated she did not follow-up on these statements. She stated she did not interview any other staff on the day Resident #3 alleged from Staff G, . An interview on at 3:33 p.m. with the Regional Risk Manager revealed Resident #3's incident with Staff G, was reported to the facility by the state agency on . The Risk Manager stated the incident happened on . The Risk Manager stated this was not reported timely. She stated, "I need to ask why. It does not make sense." An interview was conducted with the NHA on at 3:49 p.m. The NHA stated regarding the incident with Staff F, CNA, they did not substantiate it. She stated we resolved it the same day. We did not report. The NHA stated, an allegation is an allegation. We should have reported. She stated corporate has to review incidents prior to reporting them, which affects their reporting timeline.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation	F 610		

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F 610	Continued From page 18 CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of , neglect, , , or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential , neglect, , , or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her 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 interviews and record review, the facility failed to investigate thoroughly and timely allegations of for two (#1 and #3) of two residents sampled for and neglect. (Cross reference F600 and F609) Findings included: 1. Review of a hospital visit summary for Resident #1 dated at 3:22 a.m. showed Resident #1 was seen due to a with diagnoses of , initial encounter, resulting in a injury. Review of the admission Record for Resident #1 revealed he was originally admitted to the facility in 2013 and readmitted on with	F 610	This plan of correction is submitted as required under state and federal laws. The submission of this plan of correction does not constitute an admission on the part of the skilled nursing facility as to the accuracy of the surveyor's findings or the conclusion drawn there from. The plan of correction does not constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. Any changes to facility policy and procedures should be considered remedial measures as that concept is employed in rule 407 of the federal rules of evidence and should be inadmissible in any proceeding on that basis. The facility submits this plan of correction with the	

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F 610	Continued From page 19 diagnoses to include wasting and atrophy, due to unspecified occlusion, wasting, unspecified, and , aphasia and unspecified On at 11:42 a.m., an interview was conducted with Staff A, Certified Nursing Assistant (CNA) assigned to Resident #1 the day the resident on . She stated she had worked 3 p.m. - 11 p.m. and Resident #1 was her last resident to provide care for. She said, "I was changing the bed when he started to off the bed. I tried to catch him to save the , but I could not." She stated, "As I wrote in my statement, I lowered the bed and was trying to lower it some more as I was holding on to him. I was alone in the room. I knew he needed two people. He cannot do anything for himself." Staff A stated Resident #1 could not hold on to the side rail/enabler because his right was . She said, "I know I should have asked for help. It was my fault. I take responsibility for not asking for help." The CNA stated they were understaffed that day because someone called off and there was no replacement. Staff A stated she was suspended on . She stated not much was said to her at the time, and she was not asked to give a statement at the time. She stated she was contacted on and asked to come in and give a statement on . An interview was conducted with the Nursing Home Administrator (NHA) on at 1:26 p.m. revealed she did not initiate the investigation for the incident on until . She stated she could not answer to why staff did not	F 610	intention that it be inadmissible by any third party in any civil or criminal action against the facility or any employee, agent, officer, director, or shareholders of the facility. The facility has not waived any of its rights to contest any of these allegations or any allegation or action. F-610, Investigate/Prevent/Correct Alleged Violations Element #1. Resident #1 was assessed to ensure no further injuries, and that was at a level that was acceptable to the resident. Resident #1's care plan was updated as indicated. Resident #3 was assessed and her grievance regarding care and customer service was reviewed. The Nursing Home Admnisitrator (NHA) and/or designee reinterviewed staff and residents and collected witness statements. The Nursing Home Administrator (NHA) and/or designee contacted the appropriate reporting agenicies, the resident's primary care physican, and resident's families/responsible parties. Element #2. The Nursing Home Administator (NHA) and/or designee conducted an audit to identify any other grievances pending completion or incomplete investiagtions occurring within the past 30 days. Opportunities that were identified during the audit were corrected as indicated. An evaluation of current residents was conducted by the Director of Nursing	

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F 610	Continued From page 20 call her that weekend. She stated she thought they had notified the Director of Nursing (DON). She revealed she was notified by corporate on that she needed to file a report. She stated corporate said to obtain interviews and have the DON start education. The NHA said, "I did not do a timeline. The incident was reported to AHCA [Agency for Health Care Administration] on . It was late." She stated she became aware of the incident on Monday, , but it had occurred on . When asked why it took two days to be notified, The NHA stated it was the weekend, and the DON, and the Director of Rehab were on leave. The NHA stated when she became aware she notified corporate on and suspended the CNA pending investigation. She stated she did not start her investigation then. She stated she did not interview any other residents and did not interview the staff at the time. The NHA stated their process was to wait until corporate gave her the go-ahead before contacting AHCA or DCF (Department of Children and Families). The NHA stated this process affects her reporting and investigation timeline. On at 11:35 a.m. an interview was conducted with Resident #3. She stated she had reported some staff member for being rough and loud with her. She said, "They can't talk to me just anyhow." She stated she did not know if the issue was resolved. She stated she did not know what they did about it, but she had filed a grievance. 2. Review of Resident #3's admission record revealed an original admission on with diagnoses to include , , , wasting and atrophy, and (severe) . An MDS (Minimum Data Set)	F 610	(DON) and/or designee to ensure that no residents were , by allegated deficient practices. No opportunities were identified. Element #3. The Nursing Home Administrator (NHA) and director of Nursing (DON) were in-serviced by the Regional Vice Presdient and/or the Reginal Nurse COnsultant on the Reportable Investigation, and the timeliness of reporting to state authorities to enusre they understand the process of conducting a complete investigation. Element #4. The Nursing Home Administrator and/or designee will audit new grievances and reportables once a week for the next 60 days for accurate and thorough investigations. Findings will be brought by the Nursing Home Administrator (NHA) and/or designee to the Quality Assessment and Assurance Committee monthly meeting for three months for furhter comments and/or recommendations. Element #5. Facility's Allegation of Compliance Date is	

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F 610	Continued From page 21 assessment dated showed the resident had a ( ) score of 15 out of 15, indicating intact mental cognition. Review of a grievance concern report for Resident #3 showed on the Social Serviced Director (SSD) had received a grievance showing, "Resident did not like the CNA's approach. Under action taken, the form showed the SSD, "Spoke to the CNA [Staff F], he said he came in and provided care to the resident and there were no issues." Under resolution, it showed the NHA reported the incident as a reportable, CNA was suspended, and the grievance was marked resolved the same day. The SSD stated the incident had happened the previous day. He did not know why it was not reported until . An interview on at 12:30 p.m. with the NHA revealed on Resident #3 stated the CNA (Staff F) was rough with her when providing care and she did not like the CNA's approach. The NHA stated the resident was receiving care on , and the NHA was notified on sometime in the afternoon. She stated she reported the allegation on at 3:50 p.m. She stated it was a day late. The NHA stated she reviewed the grievance form. She stated she did not ask the , , to write a statement. She did not ask the CNA what "rough with her" meant. She stated she did not speak to any other staff about it. She said, "I see. I could have asked more questions." The NHA stated she did not report this allegation of . On at 12:56 p.m., Staff F, CNA said I had her that Friday night. Staff F stated he found	F 610		

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out the following Monday there was a problem. He said, "I was told not to go to that room, they said she was making comments against me and to protect myself, I should stay away. He stated the resident had made allegation about another male employee before. He said, "I did not take it seriously." Staff F stated he did not write a statement. He stated no one said anything about a statement. He stated that week he did not go to the room. He said, "I was suspended 8 days. When I returned, I made sure to avoid her. I still do if I am scheduled to care for her, I switch out." Staff F stated he did not receive education regarding this incident. He said, " I just resumed my normal life. I just avoid her."

A follow-up interview with the NHA on at 1:04 p.m. revealed she did not have statements from other staff or residents regarding the allegation of for Resident #3. She stated she was unable to find them at this moment. She said, "I do not have them right now." The NHA confirmed she had not conducted an investigation to the allegation of . She confirmed they did not educate staff regarding the incident.

On at 3:02 p.m., an interview with the NHA regarding a second incident for Resident #3 that occurred on was conducted. The NHA stated DCF had came to the facility to investigate an allegation of . She stated a family member had contacted DCF to report that the , (Staff G, Occupational , -) physically shakes and yells at the resident to wake her up when he is in her room. The NHA stated DCF interviewed the resident and did not substantiate the allegation. The NHA stated DCF did not interview Staff G. The NHA stated she did not obtain a statement from Staff G, . She

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stated she interviewed one CNA who generally worked in the area where Resident #3 resided. She stated the CNA (Staff H) stated on a few occasions (Resident #3) said she does not want to get up because she does not like them (referring to , ,). The CNA stated she yells, "get out, don't touch me" and , , staff leaves and comes later. The NHA stated she did not follow-up on these statements. She stated she did not interview any other staff on the day Resident #3 alleged from Staff G, .

On at 3:20 p.m. an interview was conducted with Staff G, . He said, "I was accused of raising my voice with her [Resident #3]." He stated he spoke with the NHA briefly but did not provide a statement to the NHA or DCF. He stated neither of them interviewed him. He stated he was suspended for 5 days and when he returned, he was told everything was not founded. He stated he did not receive any education.

On at 3:23 p.m. an interview with the Regional Risk Manager revealed they should have asked the , , (Staff F, CNA and Staff G,) to provide statements. She stated they should have spoken to other staff.

During an interview on at 3:28 p.m., the NHA confirmed she should have obtained statements and educated all staff.

Review of a facility policy titled, Prevention Program, reviewed showed the facility has designated and implemented processes, which strive to reduce the risk of , neglect, , mistreatment, and misappropriation of resident's property. These policies guide the identification, management,

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F 610	Continued From page 24 and reporting of suspected, or alleged, , neglect, mistreatment, and , . It is expected that these policies will assist the facility with reducing the risk of , neglect, , , and misappropriation of resident's property through education of staff and residents, as well as early identification of staff bum out, or resident behavior which may increase the likelihood of such events. Investigation: An Event Report is initiated. NHA or designee is notified and will initiate and conclude a complete and thorough investigation within the specified timeframe. Investigation may include, but may not be limited to: - Resident statements/interviews. - Employee statements/interviews. - Visitor statements/interviews. - Observation of resident(s), staff, environment. - Document review i.e., chart reviews, policy review, education programs, appropriate resource review (such as medical literature); and - Re-enactment of event.	F 610		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted	F 842		

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F 842	Continued From page 25 professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and ( ) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; ( ) For public health activities, reporting of , neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842		

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F 842	Continued From page 26 §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; ( ) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to maintain medical records in accordance with professional standards and policy for weekly skin evaluations and assessments for one (#1) of two residents sampled. Findings included: Review of a facility policy titled, Prevention and Treatment Overview, effective showed - The facility strives to ensure that a Resident/Patient entering the facility without does not develop them unless the individual's clinical condition demonstrates they were unavoidable. The facility implements the following interventions to prevent the development of , : - Identify Residents/Patients at risk & the specific factors placing them at risk then implement an individualized Plan of Care based on the identified factors. - Reduce occurrence of pressure over bony	F 842	This plan of correction is submitted as required under state and federal laws. The submission of this plan of correction does not constitute an admission on the part of the skilled nursing facility as to the accuracy of the surveyor's findings or the conclusion drawn there from. The plan of correction does not constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. Any changes to facility policy and procedures should be considered remedial measures as that concept is employed in rule 407 of the federal rules of evidence and should be inadmissible in any proceeding on that basis. The facility submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the facility or any employee, agent, officer, director, or shareholders of the facility. The facility has not waived any of its rights to contest any of these allegations or any allegation or action.	

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F 842	Continued From page 27 prominences to minimize injury. - Protect against the adverse effects of external mechanical forces (pressure, friction, shear). - Increase the awareness of prevention through educational programs. The facility also recognizes the most vigilant nursing care may not prevent the development &/or worsening of in high-risk categories. In those cases, efforts will be directed at the following: Managing risk factors. Providing therapeutic intervention. Providing treatment. Procedure: Review skin integrity on a weekly basis as a proactive approach enabling the facility staff to identify possible changes in skin integrity/condition. Review of weekly skin checks for Resident #1 revealed four skin checks had been completed in a period of four months (through ,), most recently on showing the resident had a knot on forehead, top of , , and on showing the resident has a knot on forehead, . Review of the admission record for Resident #1 revealed he was admitted to the facility in 2013 and readmitted on with diagnoses to include wasting and atrophy, due to unspecified occlusion, , , , unspecified, , and , aphasia, unspecified and of right and . On at 3:40 p.m. an interview was conducted with the Director of Nursing (DON). The DON stated Resident #1's skin checks should be completed weekly as scheduled. The DON reviewed Resident #1's electronic record for	F 842	F-842, Resident Records-Identifiable Information Element #1. Skin check for Resident #1 was completed and documented in the electronic medical record. No new areas of concern were identified. element #2. Director of Nursing (DON) and/or desingee conducted a full-house skin sweep on current residents to identify any new areas of skin , . No new areas of concern were identiifed. Element #3. The Director of Nursing (DON) and/or designee will educate current licensed clinical staff on perfoming weekly skin checks on active residents and documenting findings in the electronic medical record timely and efficiently. Physicians and families will be notified of any newly identified skin , and any new orders will be transcribed into the electronic medical record as indicated. Element #4. Director of Nursing (DON) and/or designee will audit the weekly skin checks for active residents in the electronic medical record every week for eight (8) weeks to ensure that the weekly skin checks are being performed timely. Results of the audits will be brought by the Nursing Home Administator (NHA) or Director fo Nursing (DON) and discussed at monthly Quality Assurance Perfomance Improvmeent meetings for review and recommendation for three months.	

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F 842	Continued From page 28 the months of , through , and stated there were only four skin assessments documented on , , and . The DON said, "There should be more than that. They should be documented weekly. I see they are not done. I don't know what to tell you. We missed it." The DON stated they should have assessed and documented skin checks for Resident #1 on a weekly basis per their facility policy.	F 842	Element #5. Facility's Allegation of Compliance Date is , ,20205.	