STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105959	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KR AT COLLEGE HARBOR	**4600 54TH AVE S SAINT PETERSBURG, FL 33711**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident record review and staff/resident interviews, the facility failed to honor/maintain residents in a respectful manner for 3 (#31, #19, and #99) related to: 1. Resident #31 observed four of four days (3/2/20 - 3/4/20) wearing a bright yellow wrist band that identified as Fall Risk; 2. Staff observed speaking to Resident #19 in a manner of non-caring and disinterest; 3. Staff observed referring to Resident #99 as Feeder during tray pass; 4. Staff not knocking/announcing prior to entering resident rooms four of four days observed (3/2/20 - 3/5/20); and 5. Staff not wearing name badges routinely in order to identify the staff member to residents providing care/services. Findings included: 1. On [DATE] at 10:00 a.m., 3/3/2020 at 7:45 a.m., 1:00 p.m., 3/4/2020 at 7:30 a.m., 8:30 a.m. Resident #31 was observed in different areas of the facility to include her room, the hallways, the dining room and activity room, seated in her wheelchair. Further observations revealed her left arm/wrist area was observed with a bright yellow plastic band that read in bold black letters, FALL RISK. On 3/4/2020 at 8:30 a.m., Resident #31 was asked about the band and she pointed at it and said she did not know, but stated, I have had since hospital. She was asked how long has that been. She replied, A long time ago. She was asked if the band is something she likes to wear, and she shook her head No, and made a frown face. On 3/5/2020 at 7:40 a.m., Resident #31 was observed seated in a wheelchair in the main dining room at a table with two other residents. She was dressed for the day and well groomed and awaiting her breakfast meal. She was still noted with a bright yellow plastic bracelet that read, FALL RISK. Review of Resident #31's medical record revealed she was admitted to the facility on [DATE] and readmitted from the hospital on [DATE]. Review of the most current MDS (Minimum Data Set) assessment (Annual) and dated 1/26/2020 revealed: (Cognition/BIMS Brief Interview Mental Status score 4 of 15, which is low cognition). On 3/5/2020 at 1:45 p.m., during an interview with the Social Service Director, the staff member could not provide a reason as to why Resident #31 was wearing a Fall Risk wrist band, and did not know if this was an intervention that the facility takes to identify a risk. On 3/5/2020 at 3:00 p.m. an interview with the Director of Nursing revealed she was not aware of why Resident #31 was wearing a bracelet on her Left wrist that identified Fall Risk. She further indicated that this was not an intervention the facility puts in place for residents who are at risk for falls. She further added that this wrist band came from the hospital and confirmed the resident has been back from the hospital for about six months. She confirmed that Resident #31 should not have a wrist band on with indicators of fall risk. 2. On [DATE] at 10:15 a.m. Resident #19, who was noted in his room, was overheard yelling aloud and stated I need a cup of coffee, hello, and I need my [MEDICAL CONDITION] bag changed, it smells. He said hello aloud several more times and with his call light on. At 10:16 a.m. an aide, Employee A., who had no identification badge on, was observed to walk down the hall to the room and walked directly in without first knocking and or announcing. She went into the room and was overheard telling the resident, I'm still busy, I will be back when I can. She did not turn off the call light. The aide then walked briskly out from the room. The call light was observed still on. At 10:21 a.m. he was yelling aloud, again, for someone to come in. The Director of Nursing was observed to answer the light at 10:23 a.m. and assisted resident. Then again at 10:50 a.m., Employee A walked into the room, again without first knocking and announcing, and was overheard telling the resident, Look, I told you I am busy and I will get to you when I get to you . got it? Employee A was observed to walk out from Resident #19's room and went down the hall. At 12:00 p.m. Resident #19 was interviewed and he was asked how staff treat him. He explained that staff were generally ok. This surveyor then asked him about Employee A and how she spoke with him earlier. He said he did not like it and he did not know her very well. He further indicated he had not reported her to staff yet. Review of Resident #19's medical record found he was admitted to the facility for rehab services on 12/16/2020 and was now long term. He was his own responsible party with family involvement. Review of the most current MDS assessment revealed (Cognition/BIMS Brief Interview Mental Status) score was 10 of 15, which indicated the resident was able to make his needs known. On 3/5/2020 at 2:00 p.m., an interview with the Director of Nursing and Nursing Home Administrator both indicated that staff should not be speaking to residents in that type of manner. It was explained that Employee A was agency staff, but still she should know better than speaking to residents so rudely. 3. On 3/4/2020 at 8:12 a.m. the hallway at the Main Dining room was observed with a meal tray cart and with staff gathered around the cart and conversing loudly with each other. They were all trying to figure out where each meal tray goes. Staff members Employee I, J, and K were all overheard each saying Resident #99 is a Feeder, and is a Feed. There were several residents within earshot of the area and all three staff members were overheard loudly saying She is a Feeder. The employees were overheard saying Feeder over four times between them. On 3/5/2020, review of Resident #99's medical record revealed she was admitted to the facility for rehab services on 3/3/2020. Review of the advance directives revealed the resident had a Power of Attorney in place. Resident #99 had had a previous admission and during that time the last MDS assessment completed 11/1/2019 (Discharge) revealed (Cognition/BIMS Brief Interview Mental Status score 3 of 15, low cognition function), (ADL - Eating supervision). Review of the admission evaluation/progress note dated 3/20/2020 21:35, revealed Resident not interviewable and family not available, dining preference in the dining room, eating assistance performed by staff. 4. a. On [DATE] at 10:15 a.m., Employee A walked into resident room [ROOM NUMBER] without first knocking or announcing. She walked into the room as the call light was on and told Resident #223, You know I'm busy right now, and then walked out of the room, leaving the call light on. b. On [DATE] at 10:25 a.m., Employee A walked into room [ROOM NUMBER], again, without first knocking or announcing. The resident was still in the room. c. On [DATE] at 11:34 a.m., Employee B was observed to walk into resident room [ROOM NUMBER] without first knocking or announcing. The resident was in the room at the time. d. On 3/3/2020 at 7:24 a.m., Employee C was observed to walk into resident room [ROOM NUMBER] without first knocking or announcing. The resident was in the room at the time. e. On 3/3/2020 at 7:30 a.m., Employee D was observed to walk into resident room [ROOM NUMBER] without first knocking or announcing. The resident was in the room at the time. f. On 3/3/2020 at 10:45 a.m., Employee D was observed to walk into resident room [ROOM NUMBER] without first knocking or announcing. The resident was in the room at the time. g. On 3/4/2020 at 7:58 a.m., housekeeping staff Employees E and F were observed to walk into room [ROOM NUMBER] without first knocking and or announcing. A resident was in the room at the time. h. On 3/4/2020 at 8:04 a.m., Employees E and F were observed to walk into room [ROOM NUMBER] without first knocking and/or announcing. The resident was in the room at the time. i. On 3/4/2020 at 8:06 a.m., Employees E and F were observed to walk into room [ROOM NUMBER] without first knocking or announcing. A resident was in the room at the time. j. On 3/4/2020 at 8:08 a.m., Employees E and F were observed to walk into room [ROOM NUMBER] without first knocking and/or announcing. A resident was in the room at the time. k. On 3/4/2020 at 8:10 a.m., Employee D was observed to walk into room [ROOM NUMBER] without first knocking and announcing prior to entering. Resident was observed in the room at the time. On [DATE] through 3/5/2020, over five random residents, who all wished to not be identified, revealed that staff always just walk into the room and rarely ever knock or announce.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105959	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KR AT COLLEGE HARBOR	4600 54TH AVE S SAINT PETERSBURG, FL 33711

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) They would like their privacy and would like to have staff knock. Some residents indicated that this has been brought up to administration and things get better, but always gets bad again. The residents indicated that they do not bother to complain anymore. On 3/5/2020 at 2:00 p.m. an interview with the Nursing Home Administrator and Director of Nursing both indicated that all staff, to include regular and agency, should honor resident respect and dignity and should either knock or announce prior to entering the room. The DON revealed they do not have a specific policy for knocking and or announcing. 5. a. On [DATE] at 10:15 a.m. an employee walked into resident room [ROOM NUMBER], and the resident had asked who she was. She did not answer and just told him that she will come back when she can. She was not wearing a name badge. It was later found out that Employee A, who is an agency aide, was the person who would not identify herself to the resident. b. On [DATE] at 10:25 a.m., the aide Employee A was observed to walk down the hallway with a linen cart and parked it just outside resident room [ROOM NUMBER]. She then walked inside and shut the door. She did not call out or knock prior to entering the room. The resident was still observed in the room. The aide could be overheard talking to the resident and said, Look, you know I'm busy and I will get to that when I get to it. She was not wearing her name badge. c. On 3/3/2020 at 7:15 a.m., Employee H was observed to walk into room [ROOM NUMBER] without first knocking and/or announcing. She went into the room and closed the door at 7:22 a.m. She came out from the room with a bag of soiled linen. She was noted not to be wearing a name badge. When asked her name, she replied with her name and then indicated she did not have her name badge on. d. On 3/3/2020 at 7:23 a.m., 10:00 a.m. and 11:10 a.m., Employee G was observed going in and out from resident rooms. She had not been wearing a name badge. When verifying staffing, it was determined that the employee was Staff G. When asked, she had no reason as to why she was not wearing her name badge. e. On 3/4/2020 at 7:45 a.m., 11:03 a.m. a nurse was observed walking the hallway, preparing and passing medications and assisting with residents. She was noted not to be wearing a name badge. She was later found out to be Employee N. She was asked by the surveyor what her name was and what her position title was. She gave no word as to why she did not wear a name badge. She did say she was a facility nurse and is PRN or as need. On 3/5/2020 at 2:00 p.m., an interview with the Nursing Home Administrator and Director of Nursing indicated that all staff should wear name badges in order for residents to identify who they are. They further indicated that agency staff are aware of this as well. They had no documentation on how they monitor staff wearing or not wearing name badges. Further, there was no Policy or Procedure related to wearing of name badges.
F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review of the Grievance Log, the facility failed to ensure that that a nursing/customer service concern was addressed in a timely manner for one (#98) out of thirty sampled residents. Findings Included: On 3/3/2020 at 12:40 p.m., a family interview was conducted with Resident #98's stepdaughter, as she spoke about the lack of care he had received at the facility. She stated call lights were not answered timely. And when a nurse came in the bedroom, she was told about a toileting concern. She shut the light off and said someone will return. Well, no one did. We had to put the call light back on. Another concern she spoke about was when her stepfather was given his medications. She said, I was there when she gave them to him. She stated the nurse gave him too many pills at a time. He began to cough and choke. The nurse never asked him his name to confirm it was him, nor did she tell him what the medications were. She was asked what the nurses name was she stated, I don't know; half of the staff don't wear name tags. She wasn't wearing one at that time. The stepdaughter spoke about his pain medications not being given when they were due. She said that On his last day at the facility, I went in to visit him and found him having severe pain to his leg. She said, That was when I requested him to be sent back out to the hospital. The stepdaughter was asked if she had told anyone at the facility of her concerns. She stated, I told the Minimum Data Set (MDS) guy. She said that no one had called her from the facility to follow up with her. Medical record review was conducted that revealed Resident #98 was admitted to the facility in early February 2020 for eight days before he was transferred back to the hospital for pain. History and Physical, dated on [DATE], reflected [MEDICAL CONDITION] with an unwitnessed ground level fall (GLF) at home. X-ray of the femur showed mildly displaced greater trochanter fracture. Computerized tomography (CT) of the pelvis confirmed presence of traumatic fracture with intact femoral head. The facility Grievance Tracking Log was reviewed that revealed Resident #98's name. It was dated on 2/27/2020. Listed on the log was a section that indicated the date resolved. The resolved section was blank. The log section summary was documented nursing/customer service. On 3/4/2020 at 12:00 p.m., an interview was conducted with the facility social worker (SW) as he was asked about Resident #98's unresolved grievance. He said that his daughter had told our MDSC about her concerns. He filled out a grievance form and brought it to our attention. The SW was asked what the concern had entailed. He stated, She said the nurse didn't give the medications on time. When the nurse gave him his medications, she did not explain what the medications were. The SW said that she spoke about the call lights being answered by the nurse, the nurse shutting off the light indicating someone would be coming back, and no one came back. The SW continued to read off the grievance form that An aide told her we don't give one on one care. The SW at that time stated, We do provide one on one care if it's needed. The SW was asked if the form contained any additional information; he said when she came to visit him, he was found sitting in stool. The SW said apparently, he had just been brought back to his room after therapy. The SW was asked what the investigation had revealed thus far. He did not respond at first, as he was then asked, Was Resident #98's medication given late? The SW said, The resident is no longer in the facility. You would need to ask the Assistant Director of Nursing about that. The SW picked up his phone at that time and called the ADON. He said that there would be a call light in-service, but one had not been conducted as of yet. At 12:54 p.m., the ADON was in her office, as she confirmed no call light in-service had been conducted. She said I guess I will have to do everyone for the call lights. I guess I misunderstood that. The ADON was asked about the nurse that was in the grievance. She stated, I have not talked to any nursing as of yet. She then stated, I believe it was . then stated, No, it was from the evening before. The SW was asked for a copy of the facility policy on grievances. He was asked about the timeliness on the resolution process. He stated, It's supposed to be done within five to seven days. The SW confirmed that today is was the sixth day. The facility provided a copy of their policy and procedure Grievance Program that had no date. Purpose: Right to file Grievances: the right also includes the right to prompt efforts by the facility to resolve residents grievances, including grievances with respect to the behavior of other residents. Definition: a grievance is a concern that cannot be resolved to the satiation of the person making the objection at the bedside and or immediately. All facility grievance investigations will be initiated as soon as possible after the grievance is filed. Completed and timely followed up will be conducted by the department supervisor, the Grievance Officer and/or the Administrator.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews, the facility failed to ensure the monitoring and safety for one of thirty sampled residents (#14), related to fall hazards. Resident #14 who was a Fall Risk, and had a history of [REDACTED]. Findings included: On [DATE] at 11:00 a.m., Resident #14 was observed in her room and lying in bed with her legs hanging off the left side of the bed. Most of her lower body was hanging off the side of the bed. There were no floor mats on the floor, and she was observed dangerously hanging off the side of the bed and at risk to fall down. She was again observed in the same position at 1:20 p.m. Various staff had been observed to go in the room to assist the roommate, and none attempted to reposition Resident #14 as her legs were hanging off the side of the bed. On 3/3/2020 at 7:30 a.m., a CNA (Certified Nursing Assistant), Employee D, was observed to walk to Resident #14's room and entered and closed the door. The resident was in the room at the time and it was determined that the aide was assisting with getting her dressed for the day. There were no odors coming from the room. Resident #14 was not overheard presenting with any behaviors, pain or discomfort. At 9:30 a.m., Resident #14 was noted in her room. The bed was not made and covers were observed disheveled. After the room was entered further, Resident #14 was observed lying at the head of the bed flat on back, with head on a pillow and with her legs hanging off the left side of the bed. She was observed with her eyes closed. The bed side table next to her legs appeared to have liquid spilled all over it. There was some liquid puddled on the floor under the table. At 10:43 a.m., Resident #14's room was approached, again, and she was still observed in the same position with her legs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105959	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KR AT COLLEGE HARBOR	**4600 54TH AVE S SAINT PETERSBURG, FL 33711**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) hanging off the left side of the bed and her eyes closed. At 10:45 a.m. an aide, Employee D, went into the room and walked in without knocking or announcing. She walked over to Resident #14's roommate's bed and changed the sheets. She pulled the privacy curtain and continued to make up the roommate's bed. Employee D did not first try and attempt to reposition Resident #14, while hanging dangerously off the side of the bed. At 10:46 a.m. a Nurse, Employee O, was observed to walk up to the room and asked the aide if she had seen another staff member. Employee O also did not attempt to observe or reposition the Resident #14 while her legs still hanging off the side of the left side of the bed. Resident #14 could be seen from this position at the doorway. Neither staff member attempted to address the positioning of the resident. At 10:50 a.m. the aide, Employee D, was finished making Resident #14's roommate's bed and then walked over to Resident #14 and awoke her and asked if she wanted to get back into bed. The resident awoke and Employee D lifted her legs gently back straight and into the bed. An interview with the aide, Employee D, indicated that both residents in the room were on her assignment today, but today was the first day she has had this assignment. She was unaware if Resident #14 has had falls in the past and was also unaware if Resident #14 was at risk for falls. Employee D was unaware if there were any fall risk interventions at this point as she has never worked with the resident before. She was asked if she noticed the resident in that previous position with her legs hanging off the side, and she said she had noticed earlier today but did not think anything of it. She was asked if she reported the positioning or behavior to the nurse and she said she had not. Employee D indicated that she would, though. Review of Resident #14's medical record revealed she was admitted to the facility for long term care on 12/21/2019. Review of the Advance Directives revealed resident had a Power of Attorney in place. Review of the cumulative [DIAGNOSES REDACTED]. The Fall scale assessment dated [DATE] revealed a score of 19, which was moderate risk. The Post Fall safety risk evaluation dated 12/25/2019 revealed a score of 12, which was moderate risk. The Post Fall safety risk evaluation dated [DATE] revealed a score of 14, which was moderate risk. The Post Fall safety risk evaluation dated 1/30/2020, revealed a score of 14, which was moderate risk. Review of the SBAR Change of condition dated [DATE], revealed Resident #14 had a Ground level fall, hitting her head and complaining of right leg pain The Fall screen evaluation, dated [DATE], revealed a score of 12, indicating low risk. Review of the following nurse progress notes, dated, revealed: - 12/22/2019 06:13 - Writer summoned to resident's room by CNA. Upon entering, resident observed in a sitting position by her bed. Writer asked what happened. Resident states, I fell stupid for not using the thing to call for help and Lost my balance when coming back to the bathroom. Resident denies hitting head and no apparent injury noted. Resident assisted back to bed and resident promised to use the call light from now on. Message left with emergency person. - [DATE] 19:26 - Resident noted kneeling on knees at bedside. Call light on. Resident tried to self transfer to get in w/c. No injuries noted. Denies having to use to the toilet. Denies hitting head. Will continue with plan of care. MD and rep notified. (IDT 1/6/2020 Reviewed resident found kneeling next to bed. On therapy caseload. RP and MD notified. Resident educated on using call light when needing help). - 1/23/2020 - 04:32 CNA noted resident sitting on floor by doorway in 230. - 1/29/2020 - 00:19 - Resident observed on floor outside of bathroom door in resident's room. Resident states she walked to the bathroom by herself and on her way back to bed, she became unsteady and fell on her buttocks. Educated resident on safety awareness. Resident to request help from staff with all transfers. - [DATE] - 22:47 - CNA approached writer and stated that resident was on the floor. Writer entered room and observed resident sitting on the floor next to bed, when writer asked what happened she stated she rolled out of bed and hit her head on the floor and was complaining of head pain and right lower extremity pain. Resident vitals taken. Call placed to MD. Orders to go to the hospital for treatment and eval. Call placed to daughter. - [DATE] 01:45 - Resident returned from Hospital. It was determined per review of the fall incident log/report, and nurse progress notes, Resident #14 had four incidents out of six since 12/22/2019 where she was found on floor next to her bed. Review of the current care plans with next review of 4/22/2020, revealed Resident #14 had problem areas to include Falls/Fall risk. The care plan had interventions in place but nothing related to bed safety positioning. It was determined only after the State surveyor identified several observations of resident being unsafe in bed, did they add new interventions related to bed safety, which was on 3/3/2020. The annual survey inspection was from [DATE] through to 3/5/2020. Review of the Nurse Aide Information sheet Kardex book, which is kept at the nurse station, revealed a section for Resident #14. The information sheet had various indicators of care for the resident. In the comments section, revealed, Fall Risk. There was no other information as to what interventions needed to be in place related to Fall Risk. On 3/4/2020 at 10:30 a.m., a second interview with the aide (Employee D) was obtained. The aide indicated that she should have read the Kardex yesterday (3/3/2020) with regards to resident #14. She indicated that she did not receive any information from other staff about her and her irregular positioning while in bed and she should have read the Kardex to identify if resident was a Fall Risk. The aide was asked if there was any information in the Kardex that specified what to do in relation to Fall Risk. Employee D did not have an answer as to what to do intervention wise. She was also unaware Resident #14 just had a recent fall on [DATE]. In an interview on 3/3/2020 at 1:00 p.m., the DON (Director of Nursing) explained that they do have many agency staff that work in the facility, and they and regular staff are to always look and review the resident Kardex to see what is needed, assistance wise, and that includes with falls. She explained that on Resident #14's Kardex, it only indicated Fall Risk. She was asked how staff identify or determine what to do when there is only indication of Fall Risk. The DON indicated that staff should know what to do. There was no written information to show what know what to do meant. The DON also confirmed that Employee D, though regular staff, was new to the assignment to care for Resident #14. The DON confirmed that Employee D and Nurse Employee O should have repositioned Resident #14 when they entered the room on [DATE] and 3/3/2020. The DON further confirmed that Resident #14 had a fall from her bed later in the evening on [DATE] and staff should have better monitored her and repositioned her on 3/3/2020, when she was hanging off the side of the bed. Review of the facility's Fall Prevention Program, dated 1/2019, revealed that Each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls. Under Policy Explanation and Compliance Guidelines section, #5 revealed, Low/Moderate Risk Protocols, (a) Implement universal environmental interventions that decrease the risk of resident falling, including but not limited to: (ii) Bed is locked and lowered to a level that allows the resident's feet to be flat on the floor when the resident is sitting on the edge of the bed. There were no details in the policy that included what the aides are responsible under Fall Risk precautions. Further, review of the Kardex only indicated resident was at Fall Risk, it did not indicate if resident was low, moderate, or high risk. It was determined that Employee D would not have known what type of risk Resident #14 was prior, during and after her fall.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and medical record review, the facility did not ensure that the medication error rate was below 5 % for one (# 43) of 4 sampled residents who were administered medications. This resulted in 4 errors from 25 medication administration opportunities, for a medication error rate of 16%. Findings Included: On [DATE] at 10:24 a.m., a medication administration was conducted with Licensed Practical Nurse Q (LPN Q). She stated, Today was the first day I have ever worked at the facility. The electronic medication administration (EMR) was red in color as LPN Q confirmed the medications were late. She was asked if any of the facility licensed staff had asked if she needed assistance; she looked at the surveyor and shook her head in the no gesture. LPN Q went on to say that she started the medication pass late. As she stated, The night nurse gave me a verbal report that was an hour in length. At 10:25 a.m., the unit manager on the 200 unit approached the medication cart and was observed looking at the EMR. She said that she would start getting vital signs from the residents for her. She then asked the LPN if she needed anything at that time. The LPN told her there had been a medication she could not find in the cart. The unit manager said she would get it from the storage room. LPN Q began preparing medications for Resident #43 that consisted of a total of ten medications. Resident #43 was given her medications at 11:00 a.m. The LPN had also indicated at that time Residents #5, 22 and 24 had not yet received their scheduled morning medications. Medication reconciliation was conducted for Resident #43 that revealed four of the ten Physician ordered medications were scheduled to be administered more than one time a day: [MEDICATION NAME] 25-100 mg 1 tablet by mouth every 4 hours for parkinsonism every 4 hours for 6 doses while awake that was dated on [DATE], a.m. [MED] tablet (apixaban) give 5 mg by mouth two times a day for A-fib dated on [DATE]. [MEDICATION NAME] HCL tablet 10 mg give 1 tablet By mouth two times a day [MEDICAL CONDITION] for SBP under 110, dated on [DATE], and [MED] tablet 10 mg give one tablet by mouth every 12 hours for dementia, dated on [DATE]. Nursing Progress notes for Resident #43 did not indicate that the Physician had been notified of the late administration of the medications until 3/5/2020. The facility provided a copy of their policy titled Medication Administration - General Guidelines that contained a revision dated on January 2018. Policy: Medications are administered as prescribed in accordance with good nursing principles and practices. The facility has sufficient staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105959	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KR AT COLLEGE HARBOR	**4600 54TH AVE S SAINT PETERSBURG, FL 33711**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) and medication disproportion system to ensure safe administration of medications without unnecessary interruptions. FIVE RIGHTS- right resident, right drug, right dose, right route mand right time are applied for each medication being administered.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, medical record review and contact precautions, the facility failed to ensure that contact precautions were utilized as posted for two (#40 & #29) of two residents who were on contact precautions. Findings Included: 1. On 03/02/20 09:51 a.m., Resident #40 was lying in his bed with his eyes closed. Home Health Aide (HHA M) was sitting in a chair at his bedside. HHA M was asked why she was wearing a gown and gloves. She said she was told she needed to wear them when she was in the room. The HHA spoke about being at the facility three days a week for twelve hours each day. She said the resident was confused and attempted to get out of bed unassisted. Outside of the doorway entrance, personal protective equipment (PPE) hung on the door, along with a posted sign that read Contact Precautions. Visitors must report to nursing station before entering. Wear gloves when entering room or cubicle, and when touching patients' intact skin, surfaces or articles in close proximity. Wear gown when entering room or cubicle and whenever anticipating that clothing will touch patient items or potentially contaminated environmental surfaces. Medical record review was conducted for Resident #40 that revealed Physician orders [REDACTED]. Contact precautions:[MEDICAL CONDITION]/wound gown/gloves when providing care every shift [MEDICAL CONDITION], until 3/8/2020, dated on 3/5/2020, and [MEDICATION NAME] HCL capsule 300 mg give 1 capsule by mouth two times a day [MEDICAL CONDITION] for 10 days, dated on 2/25/2020. On 03/03/20 at 12:51 p.m. a Home Health Aide L (HHA L) was in Resident #40's bedroom as he was observed sitting up in his wheelchair. She indicated that she cares for the resident during 12-hour shifts. HHA L was standing next to the resident on her personal cell phone. As she leaned toward him, her clothing came in contact with the over bedside table that was sitting in front of him. The HHA was not wearing a gown or gloves. She was asked about the sign that was posted on the bedroom door, along with the PPE that was present. She stated, one of the aides told me I only needed to wear it when I'm providing care to him. HHA L did not recall which of the aides had told her this. Resident #40's left lower extremity contained a white gauze dressing that was clean, dry and in place. Resident #40 was pleasantly confused as he tried to propel his wheelchair with the locks in place. He verbalized his name when asked as cognitive deficit was noted. Resident #40's roommate was noted, along with his wife, entering and exiting the bedroom throughout the day. No PPE was utilized by the family as they walked past Resident #40 each time they exited and entered the shared bedroom. At 3:15 p.m. the roommate of Resident #40's wife was overheard in the hallway asking for staff to lay her spouse in bed. Two staff members stood in front of the doorway entrance and were overheard talking if they needed to wear the PPE to cross the room with the mechanical lift. They decided not to as they both walked past the first bed, where Resident #40 laid, to his roommate. The curtain divider was noted moving after being contacted with the staff members frequently during the mechanical transfer. On 03/03/2020 at 3:45 pm an interview was conducted with the Assistant Director of Nursing (ADON). She was asked about staff and family's entering resident bedroom and not utilizing the PPE. As the sign that was posted indicated, the room was on contact precautions. The ADON stated the staff don't have to wear the PPE if they're not providing care. [MEDICAL CONDITION] is in his leg and that is wrapped. She was asked if his roommate was being also treated for [REDACTED]. She didn't respond. On 03/04/20 at 10:00 a.m. Resident #40's roommate was no longer in the bedroom, as all of his belongings were no longer present. At 11:00 a.m. Registered Nurse N stated that she was ready to perform Resident #40's dressing change to his left lower leg. As she stood outside of the resident bedroom door, she was unable to reach a gown that that hung off the door. She stated out loud, The bag is causing the door to stick and I don't want to cross the threshold of the room without a gown. After a gown and gloves were donned the room was entered as a different HHA was in the room, sitting in a chair on the resident's right side of the bed. The resident at that time was attempting to get out of the bed. As he did this, he utilized his left leg where the kerlix dressing was located. The dressing was noted to be moving in an upward motion, and not securely in place. The HHA at that time stood up from the chair and walked around the bed to the left side stating, You have to wait for your treatment before you can get up. The HHA was wearing a gown, gloves and a face mask. She was asked at that time about the PPE she was wearing. She said when she came in this morning, she asked a nurse after she saw the sign posted about contact precautions. She stated, The nurse just looked at me and did not answer. During the observation of the wound care treatment, the old dressing was observed. The old dressing was noted containing a moderate amount of yellow and red drainage. On 3/4/2020 at 10:41 a.m. an interview was conducted with the facility Vice President of Clinical Services. She was asked about the facility current contact precautions, as signs were no longer in place as they had been. She said that it would make sense to separate the residents, indicating both Residents #40 and Resident # 29, and reinforce precautions on both residents' beds. The vice present went on to say they need to relook at cohorting guidance. The DON indicated at that time there weren't open beds to put them in. She was informed that there were two rooms on that unit that were empty when the facility was entered. She said they had just discharged . On 03/05/20 at 1:33 p.m., Resident #40's bedroom door was noted without Contact Precautions. A different sign was in place, stating to see nurse prior to entry. HHA Was noted in the bedroom with no gown in place as she was sitting at the resident bedside on her phone. Based on the current evidence, the CDC continues to recommend the use of Contact Precautions [MEDICAL CONDITION]-colonized or infected patients. CDC will continue to evaluate the evidence on Contact Precautions as it becomes available. In addition, CDC continues to work with partners to identify and evaluate other measures to decrease transmission of MDROs in healthcare settings. JAN2020, https://www.cdc.gov/mrsa/healthcare/inpatient.html To [MEDICAL CONDITION] infections, doctors, nurses, and other healthcare providers: o Clean their hands with soap and water or an alcohol-based hand rub before and after caring for every patient. o Carefully clean hospital rooms and medical equipment. o Use Contact Precautions when caring for patients [MEDICAL CONDITION]. Contact Precautions mean: o Whenever possible, patients [MEDICAL CONDITION] will have a single room or will share a room only with someone else who also [MEDICAL CONDITION]. o Healthcare providers will put on gloves and wear a gown over their clothing while taking care of patients [MEDICAL CONDITION]. o Visitors may also be asked to wear a gown and gloves. o When leaving the room, hospital providers and visitors remove their gown and gloves and clean their hands. https://www.cdc.gov/mrsa/pdf/SHEA-mrsa_largertext.pdf Contact Precautions Ensure appropriate patient placement in a single patient space or room if available in acute care hospitals. In long-term and other residential settings, make room placement decisions balancing risks to other patients. In ambulatory settings, place patients requiring contact precautions in an exam room or cubicle as soon as possible. Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. https://www.cdc.gov/infectioncontrol/basics/transmission-based precautions. 2. On 03/02/20 at 2:11 p.m., the door to Resident #29's room was observed to have a caddy on the door that held personal protective equipment (PPE) and a sign that revealed contact precautions. The sign indicated to perform hand hygiene before entering and before leaving the room, wear gloves when entering room or cubicle, and when touching patient's intact skin, surfaces, or articles in close proximity, wear gown when entering room or cubicle and whenever anticipating that clothing will touch patients items or potentially contaminated environmental surfaces, and use patient dedicated or single use disposable shared equipment or clean and disinfect shared equipment (BP cuff, thermometers) between patients. This room was not on contact isolation earlier that day. Staff Q, Licensed Practical Nurse (LPN), was observed in the room near bed B and was not wearing PPE. On 03/02/20 at 2:12 p.m., Staff Q, LPN, exited the room and she stated she did not know who was on contact isolation because the PPE was not there this morning. Staff Q stated that she would find out. On 03/02/20 at 2:15 p.m., Staff Q stated that she guessed the PPE was for A bed. She stated that when she pulled up his name, an order for [REDACTED]. A progress note dated 03/02/20 revealed that a new order was received to start contact isolation for ESBL in urine. A review of the labs, dated 03/01/20, revealed that the resident had ESBL in the urine, but the order for contact isolation was not received until 03/02/20. On 03/03/20 at 1:45 p.m., the Director of Nursing (DON) reported that contact isolation was communicated to the staff through 24 hour report, nurse to nurse report, and huddles which was the report for all staff. The DON stated that she would verbally tell the nurses or leave them a copy of the telephone order. The DON stated that she was in the process of putting the orders in, therefore Staff Q was unaware of the contact isolation. On 03/03/20 at 2:02 p.m., the DON reported that staff wears PPE depending on the type of organism. If Bed A was on contact isolation and staff was not caring for Bed A, staff would not have to wear PPE.