STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105438	A. BUILDING _____ B. WING _____	**09/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ORCHARD RIDGE	**4927 VOORHEES RD NEW PORT RICHEY, FL 34653**

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 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with residents and facility staff, and review of the residents' medical record and facility documents, the facility failed to ensure a request for frequent showers was accommodated for two residents (#1, #7) of 18 sampled residents. Findings included: An interview was conducted on 9/16/2020 at 10:48 a.m., Resident #7 said, They just started giving me and my roommate (Resident #1) our showers a couple of weeks ago. We have not had a shower in over three months. They told us they could not give us a shower. But, I have this place on my butt that will open up if I am not clean there. My shower days are Tuesday and Fridays. When I got my shower on 9/08/2020 they told me that place on my butt was open again. A request for shower sheets for the past two months for Resident #7 was requested. Shower sheets were provided for 9/04/2020, 9/08/2020 and 9/15/2020 only. An interview was conducted on 9/16/2020 at 10:50 a.m., Resident #1 said, How clean would your hair get if you sat on the commode and they poured water over your head? Why would they not give us a shower. A request for shower sheets for the past two months for Resident #1 was requested. Shower sheets were provided for 9/08/2020, 9/14/2020 only. An interview was conducted on 9/17/2020 at 9:00 a.m. with a family member for Resident #1. The family member said, They just stopped giving the residents there a shower. How clean do you think you would feel if you did not get a shower? I heard they started giving the showers again around the first of September. It has been more than three months that Resident #1 did not get a shower. They may have told Resident #1 why they were not giving showers, but no one told me. If she wanted a shower they should have given her one. An interview was conducted on 9/16/2020 and Staff F, Certified Nursing Assistant (CNA) said, We give our residents showers twice a week. Yes, we did stop showering the residents for over a month. We started them back up the first of this month. We were told it was because they did not want to spread [MEDICAL CONDITION]. The residents in the private rooms, if their showers were working, got their showers. An interview was conducted on 9/16/2020 at 12:39 p.m., when asked for shower sheets for the past two months for Resident's #1 and #7 the Nursing Home Administrator said, We were not using the communal shower rooms for several months. The residents got bed baths instead. We just went back to giving showers three times a week. I was told by our corporate office to stop the showers. Corporate said that each communal shower would have had to be bleached after every resident use. They were just not willing to take the risk of that not being done and having [MEDICAL CONDITION] spread.
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 observation, resident interviews, staff interviews and facility policy review, the facility failed to ensure that a grievance by one resident (# 1) was addressed with a prompt resolution and notification of patient/representative grievance/concern for missing items of a total sample of three residents. Findings included: On 9/16/2020 a facility policy was reviewed titled, OPS204 Grievance/Concern, with a review date of 8/18/2020, which indicated that all residents and/or their representatives may voice grievances/concerns and recommendations for changes. Center leadership will investigate, document and follow up on all formal concerns and grievances registered by any resident or resident's representative. Social Services personnel will serve as patient advocates in the grievance/concern process. The Center Executive Director (CED) will serve as the Grievance Officer who is responsible for overseeing the grievance process, including Civil Rights grievances/concerns, receiving and tracking grievances through their conclusion, leading any necessary investigations by the facility, maintaining confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident, and coordinating with state and federal agencies . Under the heading Purpose To assure prompt receipt and resolution of patient/representative grievance/concern. The department manager will: 6.1 Contact the person filing the grievance to acknowledge receipt; 6.2 Investigate the grievance; 6.3 Take corrective actions, as needed; 6.4 Engage the support of the Ombudsman, if warranted; and 6.5 Notify the person filing the grievance within 72 hours. A medical record review was conducted for the Resident#1 which revealed that she had been admitted to the facility on [DATE]. Review of the MDS (minimum data set) quarterly review dated 8/18/2020 indicated the resident was coded for cognition as (08) indicating moderately impaired. The Nursing Home Administrator (NHA) provided the grievance log on 9/16/2020 at 11:30 a.m. for review. Review of the grievance log revealed that the daughter of Resident#1 filed a grievance/concern dated 9/8/2020 regarding missing laundry/items. The log indicated under the heading disposition: continuing to search, items not on inventory- no date of resolution as of today 9/16/2020. A review of the findings documented by the Social Service Director (SSD) are as follows: On 9/8/2020 the daughter of the resident filed a grievance of missing items including Theme Park T-Shirts, sleeping T-shirts, shorts, non-skid blue slippers, white sneakers, blue and grey wind breaker, hair brush, barbells, hand weights, 1 lb. (pound) wrist weights, memory foam pillow, family and pet photos; states all clothing was labeled; however, could not say when items arrived or when they were noticed missing. Under the heading Resolution of Grievance/Concern- The SSD wrote on 9/8/2020- Will call daughter to discuss replacement, labeling and inventory of items. Several clothing items in closet but resident refuses to allow staff to look at them or in drawers. The date of communication to family for follow up was left blank. There was no documented evidence that the SSD followed the facility grievance/procedure on notifying the complainant within 72 hours for any updates or resolutions. An interview at 11:50 a.m. was held with Resident#1 in her room. Resident #1 granted permission to check her closet for missing items. Resident#1 confirmed that her sleep shirts were hanging along with a pair of blue non-skid socks, a pair of shorts, and the memory foam pillow was at the side of her bed labeled with the resident's name. The white sneakers, a blue grey windbreaker, and no family or pet photos were observed. At this time the resident in bed (A) added to the conversation that when the subject was admitted to the facility, she only came with a hospital gown on, clothes have been brought in , but does not know if they belong to Resident #1. The resident in the A bed stated, Laundry is always losing our clothes. Resident #1 was alert and confused regarding exact items missing and unable to clearly recall the details of the missing items. The list that was generated on the grievance form was reviewed with Resident #1 and she was asked if staff had attempted to locate items for her. Resident #1 acknowledged that only today, just prior to the interview, someone looked in her closet and asked her about her missing clothing. She reported that she told this staff member that she always has clothing missing. An interview at 12:15 p.m. was conducted with the SSD in her office regarding the grievance for Resident#1 dated 9/09/2020. She reported that on 9/08/2020 she received a grievance regarding missing items/clothing. On this date she spoke with a nurse to look in the resident's room. The SSD pulled the inventory sheet and it was blank. Neither the facility nor the resident had completed the

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.

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F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) inventory form. The SSD further stated that she spoke with the nurse and CNA (certified nursing assistant) on the floor and none have seen items. The report was that the resident prefers to stay in bed, does not dress and has been seen discarding clothing in the room stating, That is not mine. Met with resident she declines room search. A copy of the grievance was given to laundry on 9/8/2020. On 9/11/2020 the SSD reported no information from laundry and nursing reports related to items not found. On 9/14/2020, no items were returned by laundry. Today, 9/16/2020, (no time provided) SSD met with the resident and reports that the resident agreed again for a room search but became upset when the closet door was opened and reported that she is missing a Fuchsia color blanket very silky soft, not labeled with name. The SSD was asked why she had not contacted the daughter with the findings or some type of notification to the grievance that she had filed on 9/8/2020. The SSD stated that she had not been here, but when it was brought to her attention that she had notes dated 9/11/2020, 9/14/2020 and even one for today 9/16/2020, she acknowledged that she should have contacted Resident#1's daughter with an update. The SSD was asked if she had followed the facility protocol to contact in 72 hours and she stated that she had not.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** Based on observations, interviews and record review the facility failed to ensure personal care for grooming related to nail care was provided for 7 (#1, #8, #9, #11, #12, #13, #14) dependent residents out of a sample of 18. Findings included: A review of the facility policy titled, NSG200 Activities of Daily Living (ADL's), with an effective date of 6/01/1996 and a revision date of 11/01/2019, revealed: Practice Standards: The Center must ensure that: 1.1 A patient is given the appropriate treatment and services to maintain or improve his/her ability to carry out ADLs; 1.2 A patient who is unable to carry out ADLs receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident #8 was observed on 9/16/2020 at 10:38 a.m. sitting up in her bed with her hands on top of a white sheet. Resident #8's nails were over an inch long with dark debris under her fingernails on both hands. An interview was conducted on 9/16/2020 at 10:38 a.m., Staff F, Certified Nursing Assistant (CNA) confirmed the findings of long dirty nails on Resident #8. Staff F said, I cut their nails whenever I see they need to be cut. Resident #12 was observed on 9/16/2020 at 10:40 a.m. lying in her bed with the head of her bed elevated, and Resident #12's nails were observed to be long and there was about 1/4 inch of dark debris under her fingernails on both hands. An interview was conducted on 9/16/2020 at 10:40 a.m., Resident #12 said, Yes, my nails are filthy. They need to be cut. An interview was conducted on 9/16/2020 at 10:41 a.m., Staff H, Licensed Practical Nurse (LPN) said, Yes, some of the residents need their nails cut. The aides do that. Resident #14 was observed on 9/16/2020 at 10:46 a.m The resident's nails were over an inch long and there was thick dark debris under her fingernails on both hands. Resident #14 said, My nails are dirty. They do not take care of me. Resident #1 on 9/16/2020 at 10:48 a.m., was observed lying in her bed and her nails were long, with chipped red nail polish on them. Many of the nails were uneven. When asked, Resident #1 turned her hands over and you could see dark debris underneath her nails. Resident #9 was observed on 9/16/2020 at 11:15 a.m. sitting up in his wheelchair. Both hands were visible and Resident #9's nails were over an inch long and there was approximately 1/4 inch of dark debris under his fingernails on both hands. Resident #13 on 9/16/2020 at 11:18 a.m., was observed and held up both of her hands and Resident #13's nails were more than an inch long. Resident #13's nails had thick dark debris under her fingernails on both hands. Resident #11, on 9/16/2020 at 11:20 a.m. was observed sitting up in his wheelchair in his room. Resident #11 had a removable lap tray and when asked, he put both of his hands on top of his lap tray. Resident #11's nails were over an inch long and there was about 1/4 inch of dark debris under her fingernails on both hands. An interview was conducted on 9/16/2020 at 11:20 a.m., Resident #11 said, Yes, please can you get someone to cut my nails before I stab someone with them. An interview was conducted on 9/16/2020 at 3:00 p.m., The Nursing Home Administrator said, I heard about the nails and we are getting them cut now. The aides are responsible for cutting and cleaning their fingernails. They should do it on shower days if needed.