STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105390	A. BUILDING _____ B. WING _____	**06/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JACARANDA MANOR	**4250 66TH ST N SAINT PETERSBURG, FL 33709**

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews and facility policy and procedure review, the facility failed to ensure that an allegation of abuse was reported immediately, no later than 2 hours after the allegation was made, for 2 residents (#1 and #2) of 2 residents reviewed for abuse. Resident #1 was found disrobed in Resident #2's bedroom on 06/02/20 at approximately 10:35 p.m. and Resident #1 and Resident #2 were found disrobed in a bedroom on 06/03/20 at 3:30 a.m. and the facility did not report until the afternoon of 06/03/20. Findings include: A review of the facility Abuse Prevention Policy & Procedure, revised 10/01/2017, documented the Purpose: The purpose of this written Resident Abuse, Neglect and Misappropriation Prevention program (RANMP) is to outline the preventative steps taken by this facility to reduce the potential for the mistreatment, neglect and abuse of residents and misappropriation of resident property, and to review those practices and omissions, which if allowed to go unchecked, could lead to abuse 1. Policy Statement: .All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately to the Administrator and Director of nursing. All allegations involving abuse, neglect, exploitation or mistreatment, .are reported immediately to the state survey agency, adult protective services and to all other agencies as required, per state and federal guidelines. Immediately means as soon as possible, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury . 2. Definitions: .Alleged violation-a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property . Sexual Abuse: non-consensual sexual contact of any type with a resident. Neglect: The failure to fulfill a care-taking obligation to provide goods or services necessary to avoid physical harm, pain, mental anguish or emotional distress; . A review of Resident #1's clinical file, the Face Sheet, documented an admission of 11/2018. The Face Sheet listed a family member as the resident's responsible party. The [DIAGNOSES REDACTED]. An attempt to interview Resident #1 was conducted on 06/22/20 at 6:55 a.m. Resident #1 was observed sitting in her wheelchair, dressed appropriately for the season, sitting outside in the facility courtyard. Resident #1 declined to be interviewed. A review of Resident #2's clinical file, the Face Sheet, documented an admission of 10/2018. The Face Sheet listed a Guardian as the resident's responsible party. The [DIAGNOSES REDACTED]. An observation was conducted on 06/22/20 at approximately 10:00 a.m. of Resident #2, standing in his room, dressed appropriately for the season. At approximately 8:00 a.m. on 06/22/20, the surveyor had reviewed the electronic clinical record for Resident #1 and #2. Notes that were documented from the review of the clinical chart on 06/22/22, nurse progress notes for Resident #1: 06/03/20, 4:27 a.m.: Resident observed lying in peers' bed on another unit. 06/03/20, 1:18 p.m.: Resident on 15-minute checks. 06/03/20, 4:08 p.m.: 8:30 a.m. call to doctor; continue 15-minute checks 06/03/20, 7:34 p.m.: call to Responsible . For Resident #1, the nursing progress notes had no entry for an unusual occurrence that occurred on 06/02/20. Notes that were documented from the review of the clinical chart on 06/22/20, nurse progress notes for Resident #2: 06/02/20, 10:47 p.m., (referred to the incident on 6/2/2020) the nurse that made the entry was Staff A, Registered Nurse. The nursing progress notes were requested for the time period of 05/01/2020 thru 06/22/20 from the Director of Nursing on the date of survey. Subsequent phone calls to the facility on ,[DATE], 06/24 were conducted to request the nurse progress notes for a more thorough review. The facility did not provide the notes. On 06/22/20 at 9:00 a.m., an interview with Staff A, RN. She confirmed that she had documented an event on 06/02/20 that occurred with Resident #1 and Resident #2. She stated, I was at the nurse's station. The Certified Nursing Assistant (CNA), Staff J, she called me down to Resident #2's room. If I charted at 10:45 p.m., it happened around that time, 10:35 p.m., almost at the end of the shift. She (Resident #1) was sitting in the wheelchair with her top off. Did she have a bra on? No bra. I asked him if anything had happened. He did not say anything. He had his clothes on. Did you tell anyone about the event? I told the oncoming nurse, Staff K, RN. Did you complete an incident report? I did not write an incident report. Staff L, RN, told me I did not have to do one, because nothing happened. Did you call the doctor? No Did you call the family or representative? No If it were to happen again, would you do anything different? I should have called the supervisor; I should have completed an event report. On the date of survey, 06/22/20, the facility had no evidence of reporting an allegation of alleged sexual abuse to the appropriate State agencies within 2 hours for the event that occurred on 06/02/20 at approximately 10:35 p.m. On 06/22/20 at 9:30 a.m., an interview was conducted with the Director of Nursing (DON) and the Risk Manager (RM). The RM confirmed that she had 1 event report completed for Resident #1 and Resident #2 for an event that occurred on 06/03/20 at 3:30 a.m. What was the event? Resident #1 was lying in Resident #2's bed. Resident #2 was standing across the room behind his wheelchair. (The residents were) found by Staff M, a CNA. Was Resident #2 wearing clothes? No Was Resident #1 wearing clothes? No The RM stated that both residents resided on the 1st floor, 4-5 rooms apart. On 06/22/20 at approximately 9:15 a.m., an interview was conducted with DON and Assistant Director of Nursing (ADON), RN, 1st floor. He reported reviewing the progress notes at the standup meeting on 06/03, that he had found the event progress note (06/02) that had been documented for Resident #2, and also, the event progress notes (06/03) for the Resident #1 and Resident #2. They contacted the Risk Manager Assistant, and the allegation was called in on 06/03/20 in the afternoon (untimely reporting). A review of the facility Abuse log was conducted on 06/22/20 with the Risk Manager (RM) and the Director of Nursing (DON). The RM confirmed that that the log for June 2020, listed one event for Resident #1 and Resident #2, dated 06/03/2020, at 3:30 a.m. The RM confirmed that she also had a single event report on file for Resident #1 and Resident #2, that was for the event that occurred on 06/03/20 at 3:30 a.m. An interview conducted on 06/22/20 at 10:45 a.m. with the RM, she stated that she will have an event report completed for the 06/02/20 event with Resident #1 and Resident #2. She stated that she would call in an immediate report for the 06/02/20 event with Resident #1 and Resident #2.
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 record review, observation and interview, the facility failed to ensure that adequate supervision was provided to ensure the safety of residents that had been identified to have a disrobing event for 2 (#1 and #2) of 2 sampled residents. Resident #1 was found disrobed in Resident #2's room on 06/02/20 at approximately 10:35 p.m., subsequently, Resident #1 was

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) found in Resident #2's room on 06/03/20 at 4:27 a.m., both residents were disrobed. Findings include: A review of Resident #1's clinical file, the Face Sheet, documented an admission of 11/2018. The Face Sheet listed a family member as the resident's responsible party. The [DIAGNOSES REDACTED]. An attempt to interview Resident #1 was conducted on 06/22/20 at 6:55 a.m. Resident #1 was observed sitting in her wheelchair, dressed appropriately for the season, sitting outside in the facility courtyard. Resident #1 declined to be interviewed. A review of Resident #2's clinical file, the Face Sheet, documented an admission of 10/2018. The Face Sheet listed a Guardian as the resident's responsible party. The [DIAGNOSES REDACTED]. A review of Resident #1's Care plan: Focus area: Resident #1 has the following behavior problem(s): History of talking about giving birth to triplets, sextuplets, etc. Easily agitated, yells out; resists care; wanders; hears things; believes they are someone else; screaming outbursts. Related to [MEDICAL CONDITION] Disorder, [MEDICAL CONDITION] type, start date of 01/21/20. Further review of the focus areas and interventions reflected no behaviors of disrobing in another resident's (opposite sex) room. An observation was conducted on 06/22/20 at approximately 10:00 a.m. of Resident #2, standing in his room, dressed appropriately for the season. At approximately 8:00 a.m. on 06/22/20, the surveyor had reviewed the electronic clinical record for Residents #1 and #2. Notes that were documented from the review of the clinical chart on 06/20/22, nurse progress notes for Resident #1: 06/03/20, 4:27 a.m.: Resident observed lying in peers' bed on another unit. 06/03/20, 1:18 p.m.: Resident on 15-minute checks. 06/03/20, 4:08 p.m.: 8:30 a.m. call to doctor; continue 15-minute checks 06/03/20, 7:34 p.m.: call to Responsible . For Resident #1, the nursing progress notes had no entry for an unusual occurrence that occurred on 06/02/20. Notes that were documented from the review of the clinical chart on 06/22/20, nurse progress notes for Resident #2: 06/02/20, 10:47 p.m., there was a reference to the incident in an entry made by Staff A, Registered Nurse. A copy of the nursing progress notes were requested for the time period of 05/01/2020 thru 06/22/20 from the Director of Nursing on the date of survey. Subsequent phone calls to the facility on [DATE] and 06/24/20 were conducted to request the nurse progress notes. The notes were not provided. On 06/22/20 at 9:00 a.m., an interview with Staff A, RN. She confirmed that she had documented an event on 06/02/20 that occurred with Resident #1 and Resident #2. She stated, I was at the nurse's station. The Certified Nursing Assistant (CNA), Staff J, she called me down to Resident #2's room. If I charted at 10:45 p.m., it happened around that time, 10:35 p.m., almost at the end of the shift. She (Resident #1) was sitting in the wheelchair with her top off. Did she have a bra on? No bra. I asked him if anything had happened. He did not say anything. He had his clothes on. Did you tell anyone about the event? I told the oncoming nurse, Staff K, RN. Did you complete an incident report? I did not write an incident report. Staff L, RN, told me I did not have to do one, because nothing happened. Did you call the doctor? No Did you call the family or representative? No If it were to happen again, would you do anything different? I should have called the supervisor; I should have completed an event report. On 06/22/20 at 9:30 a.m., an interview was conducted with the Director of Nursing (DON) and the Risk Manager (RM). The RM confirmed that she had 1 event report completed for Resident #1 and Resident #2 for an event that occurred on 06/03/20 at 3:30 a.m. What was the event? Resident #1 was lying in Resident #2's bed. Resident #2 was standing across the room behind his wheelchair. (The residents were) found by Staff M, a CNA. Was Resident #2 wearing clothes? No Was Resident #1 wearing clothes? No The RM stated that both residents resided on the 1st floor, 4-5 rooms apart. At 9:45 a.m., the RM stated that Staff A was the nurse. She was suspended while we investigated. She was educated on timely reporting. The RM further stated that the Assistant Risk Manager was educated on reporting. During the interview, the DON stated that the event on 06/02 was an abuse allegation and it should have been reported. She stated that training was conducted with the nurses and the certified assistant nurses about timely reporting and communication to the supervisor. On 06/22/20, No event report was available for the 06/02 disrobing event of Resident #1 in Resident #2's room at approximately 10:35 p.m. On 06/22/20, No abuse report was available for an event that occurred on 06/02/20 at approximately 10:35 p.m. No documentation of increased supervision was provided by the facility for the protection and safety Resident #1 and #2 as of result of the event on 06/02/20 at approximately 10:35 p.m. A review of the facility Abuse log was conducted on 06/22/20 with the Risk Manager (RM) and the Director of Nursing (DON). The RM confirmed that that the log for June 2020, listed one event for Resident #1 and Resident #2, dated 06/03/2020, at 3:30 a.m. The RM confirmed that she also had a single event report on file for Resident #1 and Resident #2, that was for the event that occurred on 06/03/20 at 3:30 a.m. A review of the facility policy and procedure, Accidents and Incidents-Investigating and Reporting, revised 10/01/2017, documented a policy: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring at our facilities must be investigated and reported to the administrator. Purpose: To ensure the safety of all residents, employees, and visitors. Investigation into the cause of any incident will be tracked in order to improve care and to prevent future occurrences. General Guidelines: 1. Reporting of accidents/Incidents: a. Regardless of how minor an accident or incident may be, including injuries of an unknown origin, it must be reported to the department supervisor as soon as the accident/incident is discovered or when information of such accident/incident is learned. B. An Incident Report Form must be completed for all reported accident or incidents. C. An employee witnessing an accident or incident involving a resident, employee, visitor, etc., must report such occurrence to his or her immediate supervisor as soon as possible. Do not leave an accident victim unattended unless it is absolutely necessary to summon assistance; and d. The nurse supervisor/charge nurse must be immediately informed of accidents or incidents so that medical attention can be provided. E. Procedures governing the reporting and investigation of abuse, neglect, and/or misappropriation of resident property are located in the facility abuse prevention/event section of this manual Steps in the procedure .complete the assessment of the resident .notify the physician and document the name of the family member or responsible party who was contacted .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, policy review, and Centers for Disease Control and Prevention (CDC) guidelines the facility did not ensure appropriate infection control measures were implemented in regards to 1). Residents (15 out of a total census of 217) not [MEDICATION NAME] safe social distancing on first floor near dining room and exit to courtyard/smoking area; 2). Housekeeping staff not performing hand hygiene after touching soiled equipment and then re supplying clean linen to floor carts; and 3). Housekeeping staff not cleaning frequently touched areas in one (second floor) of two dining rooms. Findings included: 1. On 6/22/2020 at 5:45 a.m. the main hallway that connects the East 1 hall with the first floor main dining room, and the area that leads out to the courtyard/smoking area, was observed with fifteen residents huddled up near the exit door to the smoking area. It was evident that the residents were awaiting staff to let them out so they can smoke. However at the time of the observation, it was not scheduled smoking time, according to an interview with the East 1 Unit Manager. The area where the residents were huddled, revealed at least ten residents not wearing any type of face masks, and all were standing and sitting in such a way that was less than three feet apart from each other. None of the residents were observed to practice safe social distancing of six feet or more. Further, there were no staff observed in this area to redirect or educate the residents to be six feet apart from each other or to make sure they were wearing a face mask. Also, the entire floor area in the hallway between East1 and the first floor dining room was observed with black sticky substance on the floor. The entire area was observed soiled and sticky. Some residents were observed seated on the floor. In a later interview with the Smoking supervisor, she revealed that the residents will stand near the doors in the hallway for long periods of time because they want to go out and smoke. She was aware that they gather in large groups and she indicated that she tells the residents many times that they need to practice social distancing. She continued to say that its hard to keep redirecting them. The Smoking supervisor was not aware who was responsible to ensure the residents were separated when gathering in large groups prior to smoking times. 3. On 6/22/2020 at 8:42 a.m. the East 2 Unit main hallway was observed with staff and residents walking up and down it, and also with resident equipment positioned in different areas throughout this hallway. Further observations revealed a housekeeping staff member, Employee B. pushing a plastic bin down the hallway and stopped between resident rooms [ROOM NUMBERS]. He was observed to take clean linen from out of the bin and placed them into a clean linen cart that was placed up against the wall. It was determined that he was refilling the cart with clean linen. Employee B. was observed using his bare hands while refilling the clean linen cart. When he was finished with filling the cart with clean linen, he then started pushing his cart to the East2 Unit station. Prior to getting to the unit station, he was observed to push various resident equipment that was in the way, away with his bare hands, in order to get his bin through. He touched various things such as plastic shower chairs and resident wheelchairs. Once employee B. got to the East2 unit station, he then pushed the linen bin down another hallway and stopped between resident rooms [ROOM NUMBERS]. He was again observed to refill another clean linen cart with clean linen. He was refilling the linen with his bare hands. Through the observations starting from where he was first observed near rooms [ROOM NUMBERS], through to pushing the bin down the hall, through to where he was again

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) placing clean linen near rooms [ROOM NUMBERS], Employee B. never performed hand hygiene. It was determined after he had soiled hands after moving resident equipment out of the way with his bare hands and then placing clean linen in various clean linen carts. Employee B. was asked when he washed his hands. He said regularly. He was asked if he sanitized or washed his hands between placing linen in various clean linen carts and answered No. He confirmed that he has had hand hygiene training recently. 5. On 6/22/2020 during facility tour at 6:00 a.m., 8:00 a.m., 9:10 a.m., 11:30 a.m., and 1:15 p.m., the Second floor main dining room, located on East2, was observed with one door open and with the television on. The room had over ten tables with chairs. It had been revealed during an earlier interview with the Nursing Home Administrator and Director of Nursing that the main dining rooms are not used during meal times and that residents eat meals in their rooms only. However, observations in this dining room revealed various liquid pools stuck to the table tops and some with finely ground food crumbs. The floors were also observed with food crumbs. Interview with the Nursing Home Administrator and Director of Nursing both revealed that they do have food vending machines and residents go in the dining room and eat their snacks. They indicated that residents are educated on how to practice safe social distancing but sometimes do not follow those rules and have to be redirected. The Nursing Home Administrator and Director of Nursing revealed that there are cleaning schedules for housekeeping staff to clean the dining rooms but did not know exactly when they do that. An interview with the Housekeeping Director during the exit meeting conference revealed that his staff should be checking and cleaning the dining rooms regularly during day and did not know why the area was observed soiled for so long without being cleaned. A cleaning schedule was not provided for review. Review of the Centers for Disease Control and Prevention Key Strategies to Prepare for COVID-19 in Long-term Care Facilities (LTCF's) with a last review date 4/15/2020 revealed information in the following link: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html To prevent spread of COVID-19: Actions to take now: o Cancel all group activities and communal dining. o Enforce social distancing among residents. o Ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others, including whenever they leave the facility for essential medical appointments. Review of the facility's Coronavirus Disease (COVID-19) - Infection Prevention and Control Measures, with last revision date 5/20/2020, revealed that This facility follows recommended standard and transmission-based precautions, environmental cleaning and social distancing practices to prevent the transmission of COVID-19 within the facility. Policy states as follows: #2. While in the building, personnel are required to strictly adhere to established infection prevention and control practices, including: a. Hand hygiene f. Environmental cleaning with EPA- registered disinfectants approved for use against [DIAGNOSES REDACTED]-CoV-2; and g. Laundry practices #8. Group outings, group activities, and communal dining are canceled until further notice. #9. Social distancing is highly encouraged and enforced among residents as much as possible. Noncompliance will be documented on individual resident care plans. #16. Objects and environmental surfaces that are touched frequently and in close proximity to the resident (e.g., bed rails, over the bed table, bedside commode, lavatory surfaces in resident bathrooms) are cleaned and disinfected with an EPA- registered disinfectant for healthcare setting (effective against the organism identified if known) at least daily and when visibly soiled. Review of the facility's Handwashing/Hand Hygiene policy and procedure with last revised date 8/2019, revealed that This facility considers hand hygiene the primary means to prevent the spread of infection. The policy revealed under: #2. All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents and visitors. #7 (k.) After used dressing, contaminated equipment, etc. #7 (l.) After contact with objects (e.g. medical equipment) in the immediate vicinity of the resident