STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105373	A. BUILDING _____ B. WING _____	**09/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNSET POINT	**1980 SUNSET POINT RD CLEARWATER, FL 33765**

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 0645 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation of the resident, interview with facility staff, and review of the medical record and facility policy the facility did not ensure that one resident (Resident #25) of 30 sampled residents, received a Level II PASRR evaluation prior to admission to the facility, as required since the resident had been identified on the Pre-Admission Screening and Resident Review (PASRR) as not being eligible for admission to a nursing home because of serious mental illness. Findings included: Resident #25 had multiple admissions to the facility based on a review of the electronic medical record and the Minimum Data Set (MDS) Assessments. The resident was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A transfer to the hospital, documented in the MDS assessments, was dated 8/13/2020 with a return to the facility on [DATE]. The resident was again transferred to the hospital on [DATE] and returned on 08/31/2020. The resident was again transferred to the hospital on [DATE] and returned on 09/11/2020. The resident was transferred to the hospital on [DATE] and returned on 09/16/2020. When the resident returned to the facility on [DATE], the hospital Social Worker completed a Pre-Admission Screening and Resident Review (PASRR) evaluation which identified the resident as having the following Mental Illnesses: [MEDICAL CONDITION] Disorder, [MEDICAL CONDITIONS], and Other: [MEDICAL CONDITION]. The resident was identified as currently receiving services for MI (Mental Illness). Section II of the Evaluation identified the resident as having had Psychiatric treatment more intensive than outpatient care. The individual was identified as exhibiting actions or behaviors that may make them a danger to themselves or others. The resident had not been diagnosed as having a primary [DIAGNOSES REDACTED]. This admission was not a Provisional Admission. Section IV of the PASRR determined that the Individual may not be admitted to a Nursing Facility due to the resident's Serious Mental Illness. The form was signed by the Hospital's MSW (Masters prepared Social Worker) on 08/30/2020, with the resident signing on 08/31/2020. According to page one of the evaluation, the Social Worker was requesting admission for the resident to this facility. On 09/17/20 in an interview that began at 1:13 p.m., the facility's social worker (SW) reported that she looks over new admissions' PASRR evaluations prior to their admission to the facility. The SW confirmed, Resident #25's PASRR dated 08/31/20 indicated the resident was not cleared for admission to a nursing home and a PASRR Level II should have been obtained prior to the transfer from the hospital. The SW confirmed that the MSW at the hospital should have stopped the transfer. The SW pointed to the facility's name listed on page 1 of the PASRR indicating the hospital was requesting admission to the facility. She reported that if there was a PASRR Level II in progress, it should be received prior to the resident's transfer to the facility. The SW confirmed that she had not attempted to obtain a Level II PASRR for Resident #25. Continued interview with the SW revealed that there was a facility policy related to the PASRR evaluations. The facility policy, Pre-admission Screening for Mental Disorder and/or Intellectual Disability Patients, included facility will assure that all patients with Mental Disorders and/or Intellectual Disability receive appropriate pre-admission screenings according to federal and/or state regulations. Under the section entitled Practice Standards, guidance was given: Social Services will coordinate and/or inform the appropriate agency to conduct the evaluation and obtain results if: 1.1 it is learned after Admission that the PASRR was not completed or is incorrect; 1.2 There is a significant change in status that results in new evidence of possible mental disorder, intellectual disability or a related condition. In a separate interview on 09/18/2020 beginning at 11:00 a.m., the Director of Nurses agreed that the facility should not have taken the resident back, according to the PASRR. In a phone interview on 09/18/2020 beginning at 12:33 p.m., the Medical Director reported that they had attempted to help Resident #25 by re-admitting him, but the resident seemed impossible to offer care to due to his behaviors. The Medical Director reported that he didn't think Resident #25 was appropriate for a nursing home due to his noncompliance. The Medical Director reported that the facility had no control over the admission process, as the Corporate Admissions Office directs admissions. On 09/17/20 at approximately 9:20 a.m., the resident was observed awake, eyes open, lying on his side in bed with his covers pulled up under his neck. He stared at the surveyor when greeted. The resident was asked several questions such as how he felt, how he slept and how his breakfast was. The resident did not answer but continued to stare at the surveyor, until the aide answered the question about the resident's breakfast. Later that morning, before lunch, the resident was observed sitting up in bed, with his sheet pulled over his head. Again, he did not respond when the surveyor spoke with him. The nurses' notes for the admission beginning 08/31/2020 revealed: On 09/01/2020 at 7:10 a.m., the nurse's note indicated the resident had had a change in condition and included symptoms: resident called 911 from office phone 09/01/2020 at night. At 10:30 a.m. on 09/01/2020 the nurse's note read resident noncompliant all shift. Resident propelling throughout facility freely. Declining to stay in room or wear mask. Resident states, If you try to stop me I'll say you hit me. Resident in dietitian's office, sitting in her chair, twice. resident stated, I'm comfortable here. Resident proceeded to call 911. On 09/01/2020 the resident refused his [MEDICATION NAME] and [MEDICATION NAME], per the nurse's note. On 09/02/2020 at 6:33 a.m., the nurse's note read, resident kept coming out of his room claiming he was going to find a phone to call 911 because we won't do anything for him here and that when the police come he will tell them that he is being abused so they will take him to the hospital. redirected multiple times back to his room and he was yelling vulgar words and stating he would punch anyone that came near him. I called his aunt at 9:30 p.m. and put the phone on speaker phone. she was able to calm him down a little and told him that she does not want him going back to the hospital anymore because of COVID. Around 3 a.m., he walked out of his room and went into another resident's room and took her wheelchair. Asked resident why he went into the room and he stated he wanted to use that bathroom but since we stopped him he just went in wheelchair instead. He finally calmed down at 4:30 a.m. and went to bed. On 09/02/2020 the resident refused [MEDICATION NAME] (ordered for extrapyramidal symptoms), [MEDICATION NAME] (for [MEDICAL CONDITION]), [MEDICATION NAME] (for depression) , and [MEDICATION NAME] (for [MEDICAL CONDITION]). On 09/02/2020 at 22:35 (10:35 p.m.) the nurse's note read: 8 pm was in another resident's room when she heard some female residents screaming get out, get out of here, when writer ran to room found this resident in room [ROOM NUMBER] at the foot of (resident's bed). he had closed the door and was hanging onto her bed. refused to let go. and walk back to room. swearing at staff to 'f off.' it took three staff members to get him out. sat on his bed. explained to patient that he can not go into a female's room or any other rooms. finally laid down. approximately 10 p resident was found standing in his doorway ready to come out. again two staff members had to help him back to bed. told patient not to get out of bed again. 10:45 p remains in his room. writer returned to room [ROOM NUMBER] to apologize for his actions. resident very upset, wanted her door closed. door closed, no further problems. On 09/03/2020 at 3:24 a.m., the nurse's note read, resident entering various resident's rooms attempting to take their wheelchairs. resident educated multiple times to wear a mask, stay in room. resident states F*ck that and F*ck you. I can go where I want. Touch me and I'll tell them you assaulted me. Writer and Aide assisted resident back to his room without difficulties. resident currently in bed. call light functioning and within easy reach. fluids at bedside. On 09/03/2020 the resident refused barrier cream to sacrum, [MEDICATION NAME] and [MEDICATION NAME]. From 09/04/20 until 09/07/2020, according to the nurse's notes, the resident did not have a documented behavior, but had refused medications. On 09/08/2020 at 4:11 a.m. the nurse documented that the resident had called 911 and they were awaiting their arrival. The resident was

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105373	A. BUILDING _____ B. WING _____	**09/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNSET POINT	**1980 SUNSET POINT RD CLEARWATER, FL 33765**

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 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) readmitted on [DATE]. On 09/12/2020 at 1:39 a.m., the nurse's note documented, resident is having behavior issues at this time, observed sitting on his pillow and scooting down the hallways looking for a phone, trying to go to other rooms to find a phone, very non-compliant, staff attempted to re-direct with no effect, he is cursing and yelling at staff. he is refusing to go back to his room. Later on 09/12/2020, at 18:00 (6 p.m.) the nurse's documented that the resident would not allow the aide to take his vitals. On 09/12/2020 at 23:35 (11:35 p.m.) the nurse documented, resident found in another female resident's room sitting on the bed. patient refused to get up. reminded patient that nurse would be calling 911. patient then said shut up B****. after ten minutes he returned to his room with assist. the hospice nurse was here to see patient. he wouldn't acknowledge her, kept his blanket over his head. 11 p.m. , patient remains in bed. patient also refused all his meds this shift. On 09/13/2020 at 23:45 (11:45 p.m.) the nurse documented, 5p, resident sitting on pillow in his doorway with no mask, writer educated resident about wearing his mask and having the door shut. writer educated resident about using call light system which is affixed to his bed. resident said, ' F*** you, B****'. resident remained on floor on a pillow. Later, resident observed sitting on a chair in hallway with no mask on. resident declined to leave chair. shortly afterwards staff heard screaming. said resident was in a female's room. female resident was propelling up the hallway crying, stating there was a man in her room. and now wants to leave facility and go home. DON (Director of Nurses) now on scene. instructed writer to call 911. 911 here, informed DON he needed a MD to sign off on Baker Act. Doctor arrived to speak to police and initiate paperwork. resident taken to local hospital. POA notified. A review of the Certificate of Professional Initiating Involuntary Examination form completed by the resident's physician and facility Medical Director on 09/13/2020, revealed the resident was exhibiting behaviors that included, refusing essential meds and care; intruding and threatening the safety of other residents. The physician documented that the resident was a threat to himself and others. On 09/15/2020 the resident was back in the facility and at 22:42 (10:42 p.m.), per the nurse's note, the resident was observed walking down the hall, writer and aide tried to get him back to his room. He was screaming, F*** you, get out of my way or I will hit you. Swung his arms multiple times at staff. He then went into another resident room and sat down on his bed. Multiple aides tried to help him but he continued to try to hit the staff. Officer was called and stated that he needed to go to the hospital so officer called EMT (Emergency Medical Transport). On 09/16/2020 at 16:01 p.m. (4 p.m.), the social services staff documented, called to the unit to assist with resident as he was being argumentative, swearing at staff, trying to walk down the hall to find a phone to call 911 so he can go to the hospital. nursing and this writer were able to talk to him to get him to sit in a chair. he threatened to hit staff numerous times but did allow the DON to clean and treat his face as he was complaining of pain in that area. He did allow the nurse to give him pain medication as well. Offered to give him a snack and he did accept two cookies. Did tell him that I spoke to his Aunt and we are all working to find him placement closer to the family. He did say he wanted to go now. Explained to him that as soon as placement can be found he will be able to be transferred. Resident did become agitated , swearing and threatening staff numerous times through out conversation. Later on 09/16/2020 , at 22:40 (10:40 p.m.) the nurse documented, resident has been out of control this whole shift, refusing meds and dinner. resident has a one to one tonight. while aide on break at 9:45 p.m., resident was able to walk into another resident's room, closed the door behind him. writer and other nurse entered room and found patient on the phone. resident took bottle of lotion and threw it at writer's head, just missing her face. 911 here and an officer. they spoke with the resident and informed him they weren't taking him to the hospital, so patient stated he was gonna kill himself. after a few minutes they spoke to his aunt who started yelling at the resident. 911 left and resident assisted back to his room by his aide. On 09/17/2020 at 4:12 p.m., the nurse documented that the resident was able to use the phone in another resident's room. The EMTs arrived but did not take him to the hospital as the POA (power of attorney) had been called and she requested he not be taken to the hospital. The resident had been followed monthly by a Medication Management team to ensure that the resident's medications related to his psychiatric history were appropriate. A note was reviewed that was written on 09/17/2020, after the resident had returned from the hospitalization for the involuntary admission. The APRN (Advanced Practice Registered Nurse) assessed the resident as continuing to have behaviors that were present before the psychiatric inpatient stay. patient expresses delusions of persecution and harm as well as occasional hallucinations that were not observed this visit. Patient can become agitated and physical with staff, he has not been compliant with pharmacological recommendations that would manage psychotic features. Goal of inpatient psychiatric stay was to establish MI (mental illness) schedule of antipsychotic dosing to prevent exacerbation of delusions and consequential medication refusals. patient appears to have been discharged with no changes to [MEDICAL CONDITION] following psychiatric admission. One of the APRN's recommendations was consider alternative placement tailored to psychiatric needs.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to implement and develop a resident centered care plan for three (#20, #22, #80) of thirty sampled residents related to continuous oxygen use for Resident #20, activities of daily living (ADL) for Resident #22, and the use of [MEDICAL CONDITION]-Embolic Deterrent (TED) hoses for Resident #80. Findings included: 1. On 9/15/20 at 10:15 a.m., Resident #20 was observed in her room watching television, and wearing an O2 (oxygen) Nasal Cannula (NC) connected to an oxygen concentrator. The oxygen concentrator was set to 2.5 Liters (L). An observation was conducted on 9/16/20 at 11:40 a.m. of Resident #20 self-propelling in a wheelchair to her room, wearing a Nasal Cannula facemask. The oxygen tubing was connected to an oxygen tank located behind the wheelchair. The dial on the oxygen tank was set to 1.5 (L). On 9/17/20 at 12:09 p.m., Resident #20 was observed in her room watching television and was receiving 2.5 liters of oxygen via NC. The resident stated, I always wear it, it is continuous, and I am supposed to be on 2.5 L of oxygen always. A record review for Resident #20 indicated she was admitted on [DATE] with multiple [DIAGNOSES REDACTED]. A review of physician orders [REDACTED]. A review of the quarterly Minimum Data Set ((MDS) dated [DATE], identified in Section C, that Resident #20's Brief Interview for Mental Status (BIMS) score was 10, indicating moderate cognitive impairment. On 9/18/20 at 11:25 a.m., an interview was conducted with the Care Plan Coordinator. She confirmed Resident #20's most recent care plan dated 7/7/20, did not have continuous oxygen on it. She further revealed that with [DIAGNOSES REDACTED]. An interview was conducted with the Director of Nursing (DON) on 09/17/20 at 4:30 p.m. He was informed of the concerns related to Resident #20's continuous oxygen usage. The DON confirmed that the resident's most recent care plan did not have a focus care area, goals, and interventions related to continuous oxygen use and that the care plan should be updated. The DON further revealed that the resident never had a physician order [REDACTED]. 2. On 9/15/20 at 11:50 a.m., Resident #22 was observed lying on his back in bed with the head of bed elevated and a bed side tray table in front of him. Resident # 22 stated that at times he has to wait for his call light to be answered and will start yelling for someone. He stated he likes to have his bed bath around 7:00 PM and was told that would be mentioned to the certified nursing assistants (CNA's). He reported that there have been times when the CNA's will tell him they do not have time to give him a bath. The resident stated that he feels staff avoid caring for him because of his weight. A review of the resident's record revealed [DIAGNOSES REDACTED]. Review of Resident #22's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident required extensive assistance with all care tasks, such as personal hygiene, dressing, and toileting. Review of the care plan completed on 7/14/20 revealed a focus care area documenting that Resident #22 required assistance for activities of daily living (ADL) care in bathing, grooming, personal hygiene, dressing, bed mobility, transfer, locomotion, and toileting related to: Chronic disease condition including chronic [MEDICAL CONDITION], resulting in activity intolerance, Limited mobility. The interventions included: Provide Resident #22 with assistance for bathing, dressing, grooming and toileting/catheter care. Review of the CNA's documentation form for July, August, and September 2020: ADL RECORD revealed the form was divided by care areas to include bed mobility, transfers, eating, toilet use, walk, locomotion, dressing, personal hygiene and bathing. Each of these tasks were then divided by day and shift (11 PM - 7 AM, 7 AM - 3 PM and 3 PM - 11 PM) Each day and care area had a box where the CNA's were to mark each task with the level of assistance the resident required and at the bottom there was a coordinating box for day and shift where the CNA was to initial. From 7/1/20-7/31/20 there were: 31 days of no CNA documented care on the 11 PM - 7 AM shift for all care areas. 29 days of no CNA documented care on 7 PM - 3 PM shift for all care areas. 29 days of no CNA documented care on the 3 PM - 11 PM shift for all care areas. From 8/1/20-8/9/20 there were: 8 days of no CNA documented care on 11 PM - 7 AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105373	A. BUILDING _____ B. WING _____	**09/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNSET POINT	**1980 SUNSET POINT RD CLEARWATER, FL 33765**

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) shift for all care areas. 8 days of no CNA documented care on 7 AM - 3 PM shift for all care areas. 8 days of no CNA documented care on the 3 PM - 11 PM shift for all care areas. From 8/14/20-8/31/20 there were: 10 days of no CNA documented care on 11 PM - 7 AM shift for all care areas. 6 days of no CNA documented care on 7 AM - 3 PM shift for all care areas. 14 days of no CNA documented care on the 3 PM -11 PM shift for all care areas. From 9/1/20-9/16/20 11 days of no CNA documented care on the 11 PM -7 AM shift for all care areas. 11 days on no CNA documented care on the 7 AM - 3 PM shift for all care areas. 10 days of no CNA documented care on the 3 PM - 11 PM shift for all care areas. On 9/17/20 at 10:40 AM, Staff C, CNA, assisted with explaining the CNA ADL RECORD form for Resident #22. Staff C reported that the form was supposed to be completed at the end of each shift. On 9/18/20 at 11:20 AM, the DON stated he expected the CNA's to complete the ADL RECORD form and nurses were to complete their documentation for each of their assigned residents by the end of each shift before they leave. The unit manager was to bring the forms/documentation to morning meetings for review. If the form was not completed the assigned staff member would be contacted and asked to come in and complete their documentation. 3. On 9/15/20 at 10:30 AM, Resident #80 was observed up in her wheelchair visiting with another resident. Resident # 80 was observed with slight redness and swollen bilateral lower extremities. During an observation of Resident #80 on 9/16/20 at 11:20 AM, she was up in her wheelchair seated in her room next to her bed. Resident #80 pointed out the folded clothes and towels on the foot of her bed and stated she was waiting for the CNA. Interview with Resident #80 revealed that she did not wear stockings and never has since she was a little girl. She stated she did not like them, she was in her 80's, and she wasn't going to change now. Resident #80 was not wearing any stockings or TED hoses at the time of interview and observation. Clinical record review revealed Resident #80 had [DIAGNOSES REDACTED]. A review of the Resident #80's quarterly MDS dated [DATE] revealed Resident # 80 required extensive assistance of one staff person with all ADL's. A review of the resident's current physician orders [REDACTED].#80's care plan completed on 9/3/20 revealed a focus area of: Resident #80 exhibits fluid volume excess as evidence by [MEDICAL CONDITION]. The intervention included to administer medication as ordered and monitor for side effects, report as indicated to physician, and notify physician if [MEDICAL CONDITION] continues or increases. A second focus area of: Resident # 80 requires assistance with ADL's was documented. The intervention stated: Assist in wearing TED hose as ordered-encourage as she refuses often. On 9/16/20 at 10:15 AM review of Resident #80's electronic treatment administration record (eTAR) revealed that from 7/1/20 through 7/31/20 there were 10 blanks for the 7-3 shift regarding physicians order to assist resident with putting on knee high TED hose in the AM. From 8/1/20 through 8/31/20 there were 3 blanks on the 7-3 shift regarding assisting the resident with putting on the TED hose and one blank for the 11-7 shift in regard to taking off the TED hose. There were also, 10 refusal's documented on the 7-3 shift. From 9/1/20 through 9/16/20 there was one blank on 7-3 regarding assisting the resident to put on TED hose. On 9/16/20 at 10:00 AM a review of Resident #80's progress notes revealed no refusals were documented from 9/1/20 through 9/16/20 and 10 refusals of putting on the knee-high TED hose from 8/1/20 through 8/31/20, and 1 refusal from 7/1/20 through 7/31/20. No progress notes were noted on contacting the physician or resident's representative related to the resident's refusals. Interview with Staff G on 9/16/20 at 11:50 AM revealed she did not work with Resident # 80 often but was familiar with her. She stated Resident #80 does not like to wear TED hose. Staff G stated if she was working with the resident and she attempted to assist with putting on the TED hose and the resident refused, she would attempt again later and notify the nurse of the resident's refusal. On 9/16/20 at 12:00 PM, Staff B revealed that if a resident refused to participate in a physician order [REDACTED]. When a nurse notified the physician, it was protocol for the nurse to make a note in the chart. On 09/17/20 at 09:58 AM, the Assistant Director of Nursing (ADON) stated that nursing was to monitor the resident's [MEDICAL CONDITION] to determine if treatment was effective. If the resident was refusing TED hose, the family was contacted, and staff would approach the resident again later in the day. Once the family and physician were notified and orders have been given, the care plan needs to be modified to reflect the physician's orders [REDACTED].# 80 had been refusing the TED hose for a period of time the physician should be contacted and an alternative treatment approach should have been ordered. The ADON stated the resident had an order for [REDACTED].#80 was seated in her wheelchair visiting with another resident. She did not have on TED hose at this time. During an interview with the DON on 09/17/20 at 10:50 AM, he stated if a resident refused he expected the CNA to report to the nurse, the nurse should re-attempt, and if they are unable to encourage the resident, the family should be contacted. If the resident had multiple days of refusing an order, the physician should be contacted and informed about the refusals and orders should be adjusted accordingly. A review of the policy and procedure titled Person-Centered Care Plan, effective date: 11/28/16, revision date: 7/1/19 revealed: POLICY: The center must develop and implement a baseline person-centered care plan within 48 hours for each patient that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality of care. PURPOSE: To promote positive communication between patient, resident representative, and team to obtain the patient's and resident representative's input into the plan of care, ensure effective communication and optimize clinical outcomes. PRACTICE STANDARDS: 7. Care plans will be: 7.2 Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals.
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and interview, the facility failed to ensure storage of respiratory equipment, of a facemask, in accordance with professional standards of practice for three residents (#4, #20 and #44) of 17 residents receiving respiratory treatments for four of four days observed. Findings included: 1. On 9/15/20 at 10:05 a.m., an observation was conducted of Resident #4's room; the resident was in the bathroom and it was observed that the respiratory (nebulizer) facemask was hanging on the side of the bedside nightstand, and not properly stored in the plastic treatment bag. (Photographic Evidence Obtained.) During observation and interview of Resident #4's on 9/16/20 at 9:00 a.m., the respiratory (nebulizer) facemask was observed to be hanging on the side of the bedside table. The resident was observed to be looking at the facemask and was asked if she had previously had a nebulizer treatment that morning. Resident #4 revealed that it was her fault that the facemask was not stored properly in the plastic treatment bag. She further indicated she did not want to get the nurses in trouble. An observation was conducted of Resident #4 on 09/18/20 at 8:15 a.m., lying in bed and watching television. During the observation it was noted that the nebulizer facemask was again hanging off the bedside nightstand but had liquid in the nebulizer cup below the nebulizer facemask piece. The resident was asked if she had been given her nebulizer treatment today, and she stated, Oh no, I was just going to put it on my face and do it. Resident #4 was further asked if the nurse had poured the nebulizer medication in the cup piece and left the room. The resident indicated that she did and left the room because she knows how to administer it herself. An immediate interview was conducted at 8:22 a.m., with the Director of Nursing (DON), who was informed of the observation and confirmed that Resident #4 did not have a physician order [REDACTED]. An interview was conducted with Staff F, Unit Manager, (UM) on 09/18/20 at 10:26 a.m., who earlier in the morning was seen administering medications on Resident #4's hallway. Staff F was informed of the prior observation made of Resident #4's nebulizer facemask, with nebulizer medication inside the cup. Staff F stated, I did not give the resident the nebulizer medication. It was from a previous shift, and I do confirm that the nurse needs to be in the room while administering the nebulizer treatment. The resident needs a self-medication order to administer her own nebulizer. Clinical record review of Resident #4's care plan revealed that she was re-admitted on [DATE] with multiple [DIAGNOSES REDACTED]. A further record review of physician orders [REDACTED]. During a random observation on 09/15/20 at 10: 39 a.m., Resident #20 was observed to be sitting in a wheelchair dressed and groomed. Respiratory equipment of a nebulizer facemask was observed, from the hallway, to be on the bedside nightstand and not stored appropriately in a plastic bag. A repeat observation of Resident #20's room was conducted on 09/15/20 at 11:41 a.m. The facemask was noted to be on the bedside nightstand not stored appropriately in a plastic bag , but this time next to a roll of toilet paper. (Photographic Evidence Obtained.) During a subsequent observation of Resident #20's room on 09/17/20 at 8:35 a.m., the nebulizer facemask was observed to be on the bedside nightstand again improperly stored. The resident was asked about the nebulizer treatment, and where it is usually stored. She stated Yes when it's completed it goes on the bedside nightstand, I put it there when it's done. Resident #20 further indicated that her nebulizer treatment was administered early in the morning and when it was completed it stays on the bedside nightstand until staff put it away in the plastic bag next to the nebulizer respiratory machine. On 9/18/20 at 8:00 a.m. an observation was conducted of Resident #20's room. During the observation, the nebulizer facemask was not stored in the plastic bag near the respiratory nebulizer machine. Staff F, Unit Manager (UM) for the North Hall, was outside the resident's room and confirmed the presence of the nebulizer mask on the nightstand bedside table. Clinical record review for Resident #20 indicated she was admitted on [DATE] with multiple

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105373	A. BUILDING _____ B. WING _____	**09/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNSET POINT	**1980 SUNSET POINT RD CLEARWATER, FL 33765**

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 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) [DIAGNOSES REDACTED]. Record review of a physician order [REDACTED].# 20 revealed [MEDICATION NAME] Nebulization Solution (2.5 Mg/3 ML (milligrams/milliters)) 0 0.083, 3ML inhale orally via nebulizer one time a day (06:30 a.m.) for [DIAGNOSES REDACTED]. 3. On 09/15/20 at 10:47 a.m. an observation was conducted of Resident #44 lying in bed sleeping. During the observation the resident's respiratory facemask was seen to be on top of the continuous positive airway pressure ([MEDICAL CONDITION]) machine, near a role of toilet paper, and not stored appropriately in the plastic bag. Subsequent observation was conducted at 12:00 p.m., of the [MEDICAL CONDITION] facemask still on top of the [MEDICAL CONDITION] machine located on the bedside nightstand, and not stored appropriately. (Photographic Evidence Obtained.) Clinical record review for Resident #44 indicated that he was re-admitted on [DATE] with multiple [DIAGNOSES REDACTED]. A record review of Resident #44's recent care-plan dated 8/12/20, indicated the resident was care-planned for risk of respiratory issues related to sleep-apnea- requiring [MEDICAL CONDITION] therapy at bedtime. On 9/17/20 at 4:30 p.m. an interview was conducted with the Director of Nursing (DON). The DON was informed of the observations made of the respiratory (nebulizer) facemask being left out on Resident #20's bedside nightstand. The DON was also shown two photographs of the nebulizer facemask near a toothbrush, magazines and next to a towel on the bedside nightstand. The DON stated, I will immediately have staff change out her nebulizer facemask and tubing for it, and I will make sure the staff put it in the bag when they do the nebulizer treatments. A second interview was conducted with the DON on 9/18/20 at 12:05 p.m. The DON was informed of the earlier 08:00 a.m. observation, and that Staff F confirmed its presence of being left out on the resident's bedside nightstand. The DON further revealed that Resident #20 does not have an order to self-administer medications, and that the nurse should have stayed in the room at 06:00 a.m., until the nebulizer treatment was complete and stored the respiratory (nebulizer) facemask appropriately. A review of facility policy titled, Nebulizer: Small Volume with a revision date of 11/01/19, read as follows: 20.1 Place in treatment bag labeled with patient name and date.
F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident must receive and the facility must provide necessary behavioral health care and services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation of the resident, review of the resident's medical record, and interview with facility staff, the facility did not ensure that one resident (#25) of 30 sampled residents, received mental health services appropriate for his assessed needs. Findings included: Resident #25 had multiple admissions to the facility based on a review of the electronic medical record and the Minimum Data Set (MDS) Assessments. The resident was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A transfer to the hospital, documented in the MDS assessments, was dated 8/13/2020 with a return to the facility on [DATE]. The resident was transferred to the hospital on [DATE] and returned on 08/31/2020. The resident was transferred to the hospital on [DATE] and returned on 09/11/2020. The resident was transferred to the hospital on [DATE] and returned on 09/16/2020. When the resident returned to the facility on [DATE], Admission paperwork included the Pre-Admission Screening and Resident Review (PASRR) evaluation which identified the resident as having the following Mental Illnesses: [MEDICAL CONDITION] Disorder, [MEDICAL CONDITIONS], and Other: [MEDICAL CONDITION]. The resident was identified as currently receiving services for MI (Mental Illness). Section II of the Evaluation identified the resident as having had Psychiatric treatment more intensive than outpatient care. The individual was identified as exhibiting actions or behaviors that may make them a danger to themselves or others. The resident had not been diagnosed as having a primary [DIAGNOSES REDACTED]. This admission was not a Provisional Admission. Section IV of the PASRR determined that the Individual may not be admitted to a Nursing Facility. due to the resident's Serious Mental Illness. The form was signed by the Hospital's MSW (Masters prepared Social Worker) on 08/30/2020, with the resident signing on 08/31/2020. According to page one of the evaluation, the Social Worker was requesting admission for the resident to this facility. A review of the Minimum Data Set Quarterly Assessment completed on 07/10/20 identified the resident as having moderately impaired cognition (Brief Interview for Mental Status score of 12). The resident answered yes to several Mood - related questions, indicating almost daily he had trouble sleeping, felt tired with little energy, had a poor appetite, felt badly about himself, and was fidgety and restless. According to the assessment the resident had behavioral symptoms, needed extensive assist by one staff member for Activities of Daily Living, and was always incontinent of bowel and bladder. The resident was 67 tall and weighed 108 lbs, which was 73% of his ideal body weight for his height. The MDS listed [DIAGNOSES REDACTED]. At the time of the MDS assessment, he was not taking any antipsychotic medications, but he was taking an antidepressant and a hypnotic. His care plan (initiated on 11/11/2019 with revision on 09/16/2020), included focus areas of being resistive to care, refusing to talk, refusing to take medication, hitting out and yelling at staff, calling 911, and urinating in the courtyard, which were identified as all being related to mood/psychiatric disorders. Interventions were to include allowing time for the resident to express his feelings; Staff were to provide empathy, encouragement and reassurance; the need for psych/behavioral health needs was to be evaluated; When the resident became resistive, care or activities were to be postponed to allow time for the resident to regain composure; Staff were to provide a calm quiet, well - lit environment and to explain all care including the procedure and the reason; and Social services was to provide support . The care plan (initiated on 07/12/20) also focused on the resident's risk for distressed or fluctuating mood symptoms related to verbalizing various mood issues and the [DIAGNOSES REDACTED]. Interventions were for psych intervention as needed; observing for signs or symptoms of worsening sadness or depression; existing psychiatric disorders or new psychiatric disorders; and the resident was to be encouraged to seek staff support for his distressed mood, to focus on the positive. The care plan (initiated on 12/03/2019) also focused on the resident's PASRR II level of determination secondary to his [DIAGNOSES REDACTED]. The intervention included arranging for a PASRR re-evaluation if there was a significant change in status that may result in new evidence of a possible mental disorder. review of the resident's medical record revealed [REDACTED]. The Level II evaluation, dated 12/03/2019, indicated the resident's nursing facility placement was recommended to continue and that he didn't require specialized services for serious mental illness. A new PASRR was completed on 08/30/2020 which determined that the resident had a Serious Mental Illness and that he shouldn't be admitted to a nursing facility. A level II evaluation was required prior to being admitted to a nursing facility. The resident was admitted to the nursing facility on 08/31/2020. The resident was followed monthly by a medical management Advanced Practice Registered Nurse (APRN) . Review of the note dated 08/25/2020, just after and also prior to a hospitalization , included the assessment, patient was seen for evaluation since return from inpatient stay. Patient continues to have paranoid delusions and has been calling 911. Patient was in his room with his blanket over his head, he becomes agitated with questioning and is minimally engaged. He asks why are you here? Patient appears to be paranoid as before when patient was off of [MEDICATION NAME]. Patient might benefit from an increase in [MEDICATION NAME] to manage psychotic features during acute phase. The APRN assessed the resident on 09/17/2020, after he had returned from the hospital admission due to an Involuntary Admission (Baker Act) and documented : patient continues to have behaviors that were present before psychiatric inpatient stay. patient expresses delusions of persecution and harm as well as occasional hallucinations that were not observed this visit. The APRN recommended consider alternative placement tailored to psychiatric needs if family honors patients refusals. In a phone interview on 09/18/2020 beginning at 12:33 p.m., the Medical Director reported that they had attempted to help the resident, by re-admitting him, but the resident seemed impossible to offer care to due to his behaviors. The Medical Director reported that he didn't think Resident # 25 was appropriate for a nursing home due to his noncompliance. The Medical Director reported that the facility had no control over the admission process, as the Corporate Admissions Office directs admissions. On 09/17/20 at approximately 9:20 a.m., the resident was observed awake, eyes open, lying on his side in bed with his covers pulled up under his neck. He stared at this Surveyor when greeted. He was given an explanation of this surveyor's purpose for visiting him, he was asked several questions such as how he felt, how he slept and how his breakfast was. The resident did not answer, but continued to stare at this Surveyor, until the aide answered the question about the resident's breakfast. Later that morning, before lunch, the resident was observed sitting up in bed, with his sheet pulled over his head. Again, he did not respond when this Surveyor spoke with him. The nurses' notes for the admission beginning 08/31/2020 were reviewed. On 09/01/2020 at 7:10 a.m., the note indicated a change in condition and included symptoms: resident called 911 from office phone 09/01/2020 at night. At 10:30 a.m. on 09/01/2020 the nurse's note read resident noncompliant all shift. Resident propelling throughout facility freely. Declining to stay in room or wear mask. Resident states, If you try to stop me I'll say you hit me. Resident in dietitian's office, sitting in her chair, twice. resident stated, I'm comfortable here. Resident proceeded to call 911. On 09/01/2020 the resident refused his [MEDICATION NAME] and [MEDICATION NAME]. On 09/02/2020 at 6:33 a.m., the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105373	A. BUILDING _____ B. WING _____	**09/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNSET POINT	**1980 SUNSET POINT RD CLEARWATER, FL 33765**

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 0740 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) nurse's note read, resident kept coming out of his room claiming he was going to find a phone to call 911 because we won't do anything for him here and that when the police come he will tell them that he is being abused so they will take him to the hospital. redirected multiple times back to his room and he was yelling vulgar words and stating he would punch anyone that came near him. I called his aunt at 9:30 p.m. and put the phone on speaker phone. she was able to calm him down a little and told him that she does not want him going back to the hospital anymore because of COVID. Around 3 a.m., he walked out of his room and went into another resident's room and took her wheelchair. Asked resident why he went into the room and he stated he wanted to use that bathroom but since we stopped him he just went in wheelchair instead. He finally calmed down at 4:30 a.m. and went to bed. On 09/02/2020 the resident refused his [MEDICATION NAME] (ordered for his Extrapyramidal symptoms) his [MEDICATION NAME] (for [MEDICAL CONDITION]), his [MEDICATION NAME] (for depression), and his [MEDICATION NAME] (for [MEDICAL CONDITION]). On 09/02/2020 at 22:35 (10:35 p.m.) the nurse's note read: 8 pm was in another resident's room when she heard some female residents screaming get out, get out of here, when writer ran to room found this resident in room [ROOM NUMBER] at the foot of (resident's bed). he had closed the door and was hanging onto her bed. refused to let go. and walk back to room. swearing at staff to f off. it took three staff members to get him out. sat on his bed. explained to patient that he can not go into a female's room or any other rooms. finally laid down. approximately 10 p resident was found standing in his doorway ready to come out. again two staff members had to help him back to bed. told patient not to get out of bed again. 10:45 p remains in his room. writer returned to room [ROOM NUMBER] to apologize for his actions. resident very upset, wanted her door closed. door closed, no further problems. On 09/03/2020 at 3:24 a.m., the nurse's note read, resident entering various resident's room attempting to take their wheelchairs. resident educated multiple times to wear a mask, stay in room. resident states F*ck that and F*ck you. I can go where I want. Touch me and I'll tell them you assaulted me. Writer and Aide assisted resident back to his room without difficulties. resident currently in bed. call light functioning and within easy reach. fluids at bedside. On 09/03/2020 the resident refused barrier cream to his sacrum, his [MEDICATION NAME], his [MEDICATION NAME], his [MEDICATION NAME], his [MEDICATION NAME] and his [MEDICATION NAME]. From 09/04/20 until 09/07/2020 the resident did not have a documented behavior, but had refused medications. On 09/08/2020 at 4:11 a.m. the nurse documented that the resident had call 911 and they were awaiting their arrival. The resident was readmitted on [DATE]. On 09/12/2020 at 1:39 a.m., the nurse's note documented, resident is having behavior issues at this time, observed sitting on his pillow and scooting down the hallways looking for a phone, trying to go to other rooms to find a phone, very non-compliant, staff attempted to re-direct with no effect, he is cursing and yelling at staff. he is refusing to go back to his room. Later on 09/12/2020, at 18:00 (6 p.m.) the nurse's documented that the resident would not allow the aide to take his vitals. On 09/12/2020 at 23:35 (11:35 p.m.) the nurse documented resident found in another female resident's room sitting on the bed. patient refused to get up. reminded patient that nurse would be calling 911. patient then said shut up B****. after ten minutes he returned to his room with assist. the hospice nurse was here to see patient. he wouldn't acknowledge her, kept his blanket over his head. 11 p.m. , patient remains in bed. patient also refused all his meds this shift. On 09/13/2020 at 23:45 (11:45 p.m.) the nurse documented, 5p, resident sitting on pillow in his doorway with no mask, writer educated resident about wearing his mask and having the door shut. writer educated resident about using call light system which is affixed to his bed. resident said, ' F*** you, B****' resident remained on floor on a pillow. Later, resident observed sitting on a chair in hallway with no mask on. resident declined to leave chair. shortly afterwards staff heard screaming. said resident was in a female's room. female resident was propelling up the hallway crying , stating there was a man in her room. and now wants to leave facility and go home. DON (Director of Nurses) now on scene. instructed writer to call 911. 911 here, informed DON he needed a MD to sign off on Baker Act. Doctor arrived to speak to police and initiate paperwork. resident taken to local hospital. POA notified. On 09/15/2020 the resident was back in the facility and at 22:42 (10:42 p.m.) the nurse documented, the resident was observed walking down the hall, writer and aide tried to get him back to his room. He was screaming, F*** you, get out of my way or I will hit you. Swung his arms multiple times at staff. He then went into another resident room and sat down on his bed. Multiple aides tried to help him but he continued to try to hit the staff. Officer was called and stated that he needed to go to the hospital so officer called EMT (Emergency Medical Transport). On 09/16/2020 at 16:01 p.m. (4 p.m.) the social services staff documented, called to the unit to assist with resident as he was being argumentative, swearing at staff, trying to walk down the hall to find a phone to call 911 so he can go to the hospital. nursing and this writer were able to talk to him to get him to sit in a chair. he threatened to hit staff numerous times but did allow the DON to clean and treat his face as he was complaining of pain in that area. He did allow the nurse to give him pain medication as well. Offered to give him a snack and he did accept two cookies. Did tell him that I spoke to his Aunt and we are all working to find him placement closer to the family. He did say he wanted to go now. Explained to him that as soon as placement can be found he will be able to be transferred. Resident did become agitated , swearing and threatening staff numerous times through out conversation. Later on 09/16/2020 , at 22:40 (10:40 p.m.) the nurse documented, resident has been out of control this whole shift, refusing meds and dinner. resident has a one to one tonight. while aide on break at 9:45 p.m., resident was able to walk into another resident's room, closed the door behind him. writer and other nurse entered room and found patient on the phone. resident took bottle of lotion and threw it at writer's head, just missing her face. 911 here and an officer. they spoke with the resident and informed him they weren't taking him to the hospital, so patient stated he was gonna kill himself. after a few minutes they spoke to his aunt who started yelling at the resident. 911 left and resident assisted back to his room by his aide. On 09/17/2020 at 4:12 p.m. the nurse documented that the resident was able to use the phone in another resident's room. The EMTs arrived but did not take him to the hospital as the POA (power of attorney) had been called and she requested he not be taken to the hospital.
F 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure a drug regimen review was conducted and communicated to report and correct irregularities for 3 out of 5 (Resident #30, Resident # 22, Resident # 17) residents sampled for unnecessary medications regarding lack of recommendations related to missing data on the Medication Administration Record [REDACTED]. Findings include: 1. Review of Resident #30's current physician orders [REDACTED]. -[MEDICATION NAME] 10 mg three times a day for Muscle Spasms, with a start date of 6/4/20. -[MEDICATION NAME]-Qulnldine Capsules 20-10 mg two times a day for PBA, with a start date of 9/7/18 -Duloxetine HCI Capsules DR Particles 30 mg 2 times a day for depression, with a start date of 9/7/18. -[MEDICATION NAME] 600 mg two tablets at bedtime for [MEDICAL CONDITION], with a start date of 9/13/19. -[MEDICATION NAME] Solution, Inject 80 units SQ two times a day for DM, with a start date of 5/16/20. -[MEDICATION NAME] R Solution Inject 5 units SQ before meals for DM, with a start date of 5/15/20. -[MEDICATION NAME] ER 12 hour abuse-deterrent 20 mg, one tablet two times a day for non-acute pain, with a start date of 7/31/20. Closer observations of the MAR indicated [REDACTED]. -[MEDICATION NAME] 10 mg three times a day-1 blank for the month of July. -[MEDICATION NAME]-Qulnldine Capsules 20-10 mg two times a day- 1 blank for the month of July; 2 blanks for the month of august; and 1 blank for the month of September. -Duloxetine HCI Capsules DR Particles 30 mg 2 times a day-1 blank for the month of July; 2 blanks for the month of August; and 1 blank for the month of September. -[MEDICATION NAME] 600 mg two tablets at bedtime -1 blank for the month of July; 2 blanks for the month of August; and 1 blank for the month of September. -[MEDICATION NAME] Solution, Inject 80 units SQ two times a day-2 blanks for the month of July. -[MEDICATION NAME] R Solution Inject 5 units SQ before meals-3 blanks for the month of July. -[MEDICATION NAME] ER 12 hour abuse-deterrent 20 mg, one tablet two times a day-2 blanks for the month of August. For a total of 22 blanks on the MAR for resident #30 from 7/1/20 to present (9/18/20). Interview on 9/17/20 at 11:40 AM with the DON revealed that the he was not aware if the consultant Pharmacist had reviewed the MARs for blanks. He reported that the Consultant Pharmacist reviews and recommendations are non-existent, that there are just piles of papers and that he has not been able to find any of them other that August 2020 since he took over the DON position. 2. Record review revealed Resident # 17 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of care plan completed on 7/6/20 revealed a focus area that Resident #17 is at risk for distressed/fluctuating mood symptoms. Review of Resident #17's current physician orders [REDACTED].(repeated recommendation from 6/10/20. Please respond promptly to assure facility compliance with federal regulations.) Resident #17 PRN Order(s) below have not been used within the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105373	A. BUILDING _____ B. WING _____	**09/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNSET POINT	**1980 SUNSET POINT RD CLEARWATER, FL 33765**

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 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) previous 60 days: 1. prn [MEDICATION NAME] DM 2. prn Questran) Please consider discontinuing due to lack of use. On 9/9/20 (repeated recommendation from 6/10/20. Please respond promptly to assure facility compliance with federal regulations.) (Resident #17 PRN Order(s) below have not been used within the previous 60 days: 1. prn [MEDICATION NAME] DM 2. prn Questran) Please consider discontinuing due to lack of use. Review of Resident # 17's current physician orders [REDACTED]. There is no documentation in the record that would indicate that the physician was made aware of the consultant pharmacist recommendations and there is no documentation that would indicate that the recommendations were acted upon. Continued review of Resident # 17's record revealed a MAR for the months of July 2020, August 2020, and September 2020. Closer review of the July, August and September 2020 MARs revealed a total of 33 blanks as follows: [MEDICATION NAME] Tablet 0.25 Mg, Give 1 tablet by mouth three times a day for anxiety, order date: 6/16/19, 15 blanks from July 1st to present Blood Glucose Test Strip (Glucose Blood), Inject 1 strip subcutaneously two times a day for Diabetes mellitus notify Doctor if BG >400 or <60, order date: 5/28/20 7 blanks from July 1st to present Carvedilol Tablet 3.125MG, Give 1 tablet by mouth two times a day for hr **HOLD for B/P less than 100/60 or pulse less than 60** order date: 6/12/20 6 blanks from July 1st to present Fiber Tablet, Give 1 tablet by mouth two times a day for ibs, order date: 12/27/19 2 blanks from July 1st to present [MEDICATION NAME] Capsule 100MG, Give 1 capsule by mouth three times a day for [MEDICAL CONDITION], order date: 5/29/19 11 blanks from July 1st to present [MEDICATION NAME] Tablet 5 MG, Give 1.5 tablet by mouth two times a day for diabetes Total 7.5mg, order date: 9/14/20 2 blanks from July 1st to present Is resident free from side effects of psychotherapeutic medications? (if no, document side effects in PN), every shift for depression, anxiety, order date 2/11/19 3 blanks from July 1st to present [MEDICATION NAME] HCI Tablet, Give 1000MG by mouth two times a day for Diabetes, order date: 9/14/20 1 blank from July 1st to present [MEDICATION NAME] Tablet Delayed release 20 MG, Give 20 mg by mouth one time a day [MEDICAL CONDITION]/24/19 3 blanks from July 1st to present [MEDICATION NAME] Tablet 75 MCG, Give 1 tablet by mouth one time a day [MEDICAL CONDITION], order date: 10/21/19 2 blanks from July 1st to present Review of the records revealed that there was no documentation that would indicate that the Consultant Pharmacist was reviewing the MARs and making recommendations to the facility related to ensuring that medications are given as ordered and appropriately documented as given. 2. A review of the Consultation Report on 9/18/20 at 1:00PM for Resident # 22 revealed recommendations were submitted from the pharmacist on 8/17/20, 9/9/20 and 9/9/20 on various medication changes and monitoring, however no follow through from physician was noted. 3. Review of Resident #22's current physician order [REDACTED]. Review of the consultation pharmacist recommendations revealed the following: On 8/17/20 Please clarify the following items on the Medication Administration Record [REDACTED]. [MEDICATION NAME] order needs a pulse prompt. 2. [MEDICATION NAME] order has parameters and needs a pulse and blood pressure prompt on the e[DATE]. Please change the times [MEDICATION NAME] to 630 am and 430 pm. On 9/9/20 Please clarify the following items on the Medication Administration Record [REDACTED]. [MEDICATION NAME] order needs a pulse prompt. 2. [MEDICATION NAME] order has parameters and needs a pulse and blood pressure prompt on the e[DATE]. Please change the times [MEDICATION NAME] to 630 am and 430 pm. Review of Resident # 22's current physician orders [REDACTED]. There is no documentation in the record that would indicate that the physician was made aware of the consultant pharmacist recommendations and there was no documentation that would indicate that the recommendations were acted upon. Continued review of Resident # 22's record revealed a MAR for the months of July 2020, August 2020, and September 2020 with a total of 33 blanks as follows: [MEDICATION NAME] Acid Tablet 500MG, Give 1 tablet by mouth two times a day for supplement, order date: 8/14/20 7 blanks from July 1st to present [MEDICATION NAME] Suspension 0.5 MG/2ML, 1 vial [MEDICAL CONDITION] times a day for sob, order date: 8/14/20 8 blanks from July 1st to present [MEDICATION NAME] HCI Tablet 10MG, Give 1 tablet by mouth one time a day for Allergy symptoms, order date: 8/14/20 3 blanks from July 1st through August 10th Insulin Regular Human Solution 100UNIT/ML, Inject as per sliding scale, order date: 8/14/20 9 blanks from July 1st to present [MEDICATION NAME] Tablet Delayed Release 20MG, Give 1 tablet by mouth two times a day for acid indigestion, order date: 8/14/20 7 blanks from July 1st to present [MEDICATION NAME] Tablet 10MG, Give 1 tablet by mouth one time a day for cholesterol control, order date 8/14/20 11 blanks from July 1st to present 3. During an interview with the DON on 9/18/20 at 11:04 AM it was learned that the DON was receiving medication reviews from the pharmacist through e-mails. The DON stated he has not had much time to follow through because he has been busy with staffing and working the nursing cart at times. A phone interview on 9/18/29 at 11:35 AM with the Consultant Pharmacist revealed that he started working at this facility in February 2020 and has only entered the facility one time due to COVID-19 restrictions. He reported that he has been completing his reviews via remote access to the facilities electronic records and that he e-mails his recommendations to the DON and puts them on an electronic e-mailing system. He stated he has not been receiving follow up to his recommendations. He has been communicating with the administrator and the DON. He stated that when he completes his reviews and if they are not acted upon he will repeat his recommendation the following month if he feels it is still appropriate. He reported that he would like a response to his recommendations with-in two weeks after his recommendation, but his expectation is that the facility acts on his recommendations at least before the next review date. He stated that he is unsure as to why the facility was not responding to his recommendations. He reported that he sends the physician a copy of the recommendations. The Consultant Pharmacist reported that he has not contacted the medical director regarding the lack of follow-up to the consultant pharmacy recommendations when he does not hear back from the administrator or DON. The Consultant Pharmacist reported that if he sees any blanks on the eMAR that are significant he will make recommendations to address that as well. Phone interview on 9/18/20 at 12:36 PM the Medical Director revealed that he had not been contacted directly about the medication reviews conducted by the Consultant Pharmacist. He reported that his expectation is that if the Consultant Pharmacist saw blanks in the eMAR that the pharmacist would make a recommendation to follow up. He reported that his expectation is that medications used to monitor resident behavior be monitored each shift by the staff and that if this is not done that recommendations from the Consultant Pharmacist are expected.

F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to assure 2 out of 5 (#30, #44) sampled residents were free from unnecessary medications related to Gradual Dose Reductions (GDR), lack of monitoring medications used to control behavior. Findings included: 1. Review of the Resident #30's medical record revealed his [DIAGNOSES REDACTED]. Review of the resident's current physician orders [REDACTED]. could locate Gradual Dose Reduction (GDR) information and said that the consultant pharmacist reviews and recommendations were non-existent. Interview on 9/17/20 at 1:35 PM with Staff B LPN/Unit Manager revealed that Resident #30 used to exhibit behaviors such as trying to hit staff and being non-compliant with taking his medication and receiving care. She reported that since the resident's change in condition he had a decline and had not exhibited any behaviors in months. Interview on 9/17/20 at 1:36 PM with Staff A, RN revealed that over the past several months Resident #30 has had a steady decline, is currently on hospice and does not exhibit behaviors anymore. Review of the medication management assessment dated [DATE] revealed that the resident has current [DIAGNOSES REDACTED]. The document revealed that the resident had current use of [MEDICATION NAME] 25 mg daily, [MEDICATION NAME] 30 mg bid and [MEDICATION NAME] 259 mg bid. The document indicated that Self abusive thoughts; suicidal thoughts; aggressive thoughts and homicidal thoughts were absent, No known of past attempts to harm self or others, and estimation of risk for violence was absent and that patient was currently not a danger to self or others. The assessment and recommendation section of this document indicated that The patient was seen for routine 7 week follow up, Patient has displayed no new behaviors or concerns. Stable at this time. Continued review of this document revealed that [MEDICATION NAME] was the only medication reviewed for GDR and that the determination was that GDR Contraindicated; Chronic mental Illness w/Relapse Risk, and a GDR Rationale #1 Patient past reduction failed; #2: patient use has persisted beyond 6 months without reduction trial. Review of the behavior monitoring found on the MAR for July, August, and September 2020 revealed that the resident did not exhibit any behaviors during these months. Review of the resident record revealed that there was no other documentation in the record that would indicate that Resident #30 had received a Gradual Dose Reduction in the past year. 2.During an interview with the DON on 9/18/20 at 11:04 AM the DON stated the pharmacist is sending medication recommendations in e-mail to DON. The DON stated he had been busy working on staffing and covering nursing carts. He also stated a GDR review is an IDT (Interdisciplinary Team) with the psychologist and they should be discussing behaviors and looking at dosage and see if can be reduced. He continued to state that the GDR meetings are not occurring; however, the psychologist is coming in and reviewing dosage, then it is being discussed in morning meeting. On 9/18/29 at 11:35 AM the Pharmacist stated he started working at this facility in February and has only entered the one time due to COVID. He has been completing his reviews on the electronic medical record and he e-mails his recommendations to the DON. He reported that he does have meetings every month with the psychologist and they discuss GDR, but these meetings are not a team meeting. He reported that he is unaware of previous attempts of GDR. During an interview on 9/18/20 at 12:36 PM the Physician stated he has not been contacted directly about the medication reviews by the pharmacist. He states the [MEDICAL CONDITION] medications review should be completed by the psychologist and they should consider nursing recommendations with behaviors to make the GDR recommendations accordingly. He reported that the psychologist will make the original recommendations for medication changes and the physician will follow up on any changes. 4. A record review for Resident #44 indicated he was re-admitted on [DATE] with multiple [DIAGNOSES REDACTED]. A review of physician orders [REDACTED]. A continued record review revealed no documentation of behavioral monitoring since the resident was admitted to the facility on [DATE]. Clinical record review of psychiatric progress notes indicated the resident has been taking [MEDICATION NAME] Solution, and managed by facility Psychiatrist and Advanced Practice registered nurse (APRN). The APRN writes on most recent progress notes Gradual Dose Reduction (GDR) remains clinically inadvisable at this time. A continued record review revealed target behavior documentation for behavior monitoring was not being conducted, based on observation of Electronic Medical Record (EMAR) for 7/1/2020 to 7/31/2020, 8/1/2020 to 8/31/2020, and 9/1/2020 to 9/16/2020. A review of care plan dated 08/12/2020 showed under interventions to complete behavior monitoring flow sheet, monitor for changes in mental status and functional level and report to the MD as indicated. Monitor for continued need for medication as related to behavior and mood. Monitor for side effects and consult physician and/or pharmacist as needed. The review of the quarterly Minimum Data Set ((MDS) dated [DATE], identified in Section C, that resident #44's Brief Interview For mental Status (BIMS) score was 06, (indicating severe cognitive impairment); and Section N indicated the resident was receiving antipsychotic therapy on a routine basis. On 09/18/20 08:03 a.m., an observation was conducted of Resident #44, lying in bed, sleeping, with the television volume on. During an interview with the Director of Nursing (DON) on 09/18/2020 at 11:04 a.m., he was informed that Resident # 44 had not had behavior monitoring conducted for the past three (3) months on the EMAR for the medication [MEDICATION NAME]. The DON confirmed that target behavior monitoring was not being conducted and revealed that his staff are not able to monitor Resident #44 appropriately if they do not know what they are specifically supposed to be looking for when assessing behavior monitoring. On 09/18/2020 at 12:08 AM a telephone interview was conducted with the pharmacy consultant for the facility. He was notified that the facility was not conducting anti-psychotic behavior and side effects monitoring for the medication [MEDICATION NAME]. He revealed that the facility must be monitoring psychotic medications with specific target behaviors and documenting them appropriately. A facility provided policy titled 3.8 [MEDICAL CONDITION] Medication Use, revision date 11/28/16 Page 1-3 reads: Procedure 1.1.3 Staff should become familiar with the cultural, medical, and psychological information about the resident to identify potential environmental and other triggers to prevent or reduce behavioral symptoms and/or distress, types and the consequences of behaviors exhibited by the resident and interventions that may be indicated for a specific behavior type. 7. All medications used to treat behaviors must have a clinical indication and be used in the lowest possible dose to achieve the desired therapeutic effect. All medications used to treat behaviors should be monitored for: 7.1 Efficacy 7.2 Risks 7.3 Benefits, and 7.4 Harm or adverse consequences 12. Facility staff should monitor the resident's behavior pursuant to Facility policy using a behavioral monitoring chart or behavioral assessment record for residents receiving [MEDICAL CONDITION] medication for organic mental syndrome with agitated or psychotic behavior(s). Facility staff should monitor triggers, episodes, and symptoms. Facility staff should document the number and/or intensity of symptoms and the resident's response to staff intervention.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105373	A. BUILDING _____ B. WING _____	**09/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNSET POINT	**1980 SUNSET POINT RD CLEARWATER, FL 33765**

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 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) Based on observation, interviews, and record review the facility failed to appropriately secure medications in three of four medication carts. Findings included: A review of the facility's Policy & Procedures Page 01-02, dated 12/1/07 and revised 10/31/16, titled 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles, read as follows: Applicability: Policy 5.3 sets for the procedures relating to the storage and expiration dates of medications, biologicals, syringes and needles. 3. General Storage Procedures: 3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. 10. Facility should ensure that all medications and biologicals for each resident are stored in containers in which they were originally received. On 09/17/20 at 12:40 p.m., an observation of medication cart #2, located on the South Hall included seven (7) loose tablets, and seven (7) loose half and quarter pieces of loose tablets. (Photographic Evidence Obtained.) Staff B, Licensed Practical Nurse, (LPN) confirmed the presence of the unsecured tablets. On 9/17/20 at 1:00 p.m., an observation was conducted on medication cart #1, located on the South Hall, which included ten (10) loose tablets and three (3) loose pieces of tablets. ((Photographic Evidence Obtained.) Staff D, (LPN) confirmed the presence of the unsecured tablets. On 9/17/20 at 1:15 p.m., an observation was conducted on North Hall medication Cart #1, which included many loose tablets that filled a clear medication cup up to the one-half marker or one (1) tablespoon (TBS). Staff E, (LPN) confirmed the presence of the unsecured tablets. An interview was conducted with the Director of Nursing (DON) on 09/18/20 at 1:30 p.m. During the interview the DON who was informed of the observation made of unsecured tablets in three (3) of four (4) medication carts. The DON stated, The
F 0908 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep all essential equipment working safely.** Based on observations, review of maintenance requests and proposals for work, an interview with the Director of Dietary, the Director of Maintenance and the Administrator, the facility failed to maintain equipment and the facility premises in safe operating condition as evidence by the facility: 1. failed to ensure that four ceiling tiles surrounding air vents in two of four resident halls were clean and free of dark stains and black spots; 2. failed to replace floor tiles and a loose wall board in the kitchen; and 3. failed to replace a freezer door that was identified as not fitting the door frame due to a build-up of ice. Findings included: 1. On 09/16/2020 at 8:49 a.m., three ceiling tiles surrounding outflow air vents on the 400 hall were noted to be stained with a brown color and the metal flanges on the ceiling vents were noted to be soiled with a black spotty substance. The three ceiling tiles (Photographic Evidence Obtained, photo # 5, 6, 7), were adjacent to rooms #402, #406, and #408. The fourth ceiling tile was observed outside of the storage room on the 300 hall. In an interview with the Director of Maintenance, on 09/18/2020 beginning at 2:45 p.m., the ceiling tiles were observed. The Director of Maintenance, while observing the ceiling tiles and outflow vents, reported that the brown staining on the ceiling tiles was only a buildup of dust that had been smeared into the surface of the tile. The Director of Maintenance reported that the black spots observed on the ceiling vent flanges were only dust, and they would disappear if the flanges were dusted. When it was suggested that the brown stains on the ceiling tiles resembled water stains, the Director of Maintenance disagreed, commenting that there had been no problem with water in the ceiling that would have stained the ceiling tiles. In an interview with the Administrator on 09/18/2020 beginning at 2:20 p.m., the Administrator confirmed that she had been made aware of the discolored ceiling tiles and the black spots on the vent flanges, but she had not observed them for herself. She reported that they would need to remove the tiles and see what was happening above. 2. On 09/15/2020 beginning at 9:30 a.m., an initial tour was made of the facility's main kitchen. Floor tiles in the dish machine room were noted to be cracked with some missing tile pieces allowing water to collect in the depressions. (Photographic evidence obtained - see photos 3 and 4.) In the dish machine room, at the exit door to the service hall, where meal tray carts entered the dish machine room, the last tile in the baseboard was noted to be standing away from the door frame. This tile was attached to the wall board, and when the tile was moved, the tile and wall board moved. The loose tile and the unsecured wall board provided an entry point for vermin. The request for maintenance of the broken floor tiles in the dish machine room was reviewed and noted to have been requested on 7/17/20 . The work needed was described as broken tiles are located in dish room area and by freezer door. The priority was marked as High. 3. On 09/15/2020 at 9:40 a.m., the door to the walk-in freezer was noted to be ill-fitting in the door frame. When the door was pulled opened, a wire rack just inside of the freezer and to the left, was noted to be storing boxed product which was frosted with ice. The door threshold of the freezer was noted to have a buildup of ice pushing up the metal threshold plate. The Dietary Manager reported at that time, that the freezer door needed to be replaced and this had been a problem as the ice buildup kept the door from shutting fully. On 09/18/20 at 10:30 a.m., the freezer door was noted to have a chunk of ice (approximately 4 inches high) at the juncture of the bottom of the door and floor. (Photographic evidence obtained - Photo # 1, 2). When the freezer door was pulled open, ice was noted to have built up under the threshold, pushing the threshold up. (See photo 2). Again, the Dietary Manager reported that the freezer door was a problem and there had been discussion about having to replace the entire walk-in freezer/refrigerator unit. He reported that the freezer door had been replaced in the past , but that didn't ensure the door fit well curtailing the ice buildup. The Director of Maintenance provided documents related to the replacement of the walk-in freezer. They were noted to date back to 10/30/2018 with the description of service: requested service for the walk- in freezer that is not properly working. There is ice buildup and the heating/cycle is off. Work completed onsite. Technician arrived on site and found the frames degraded. Recommend replacement of the unit. On 12/17/18 a second maintenance request was reviewed and noted with the description: requests service for the buildup of ice on their walk-in freezer. They think that air is entering from the door. Work completed onsite. Technician determined the walk-in freezer box needs to be replaced. This request included that a quote for the work was needed. A quote provided to the facility, dated 02/22/2019, was reviewed. The quote included the facility's address as the site where the work would be performed, but the project scope, replacement of existing walk in cooler/freezer combo unit with new walk in cooler/freezer unit, named a different facility. The quote was not signed by the facility. The quote included a photo of the freezer, which mirrored photo #2, obtained by the surveyor, which showed ice under the freezer floor at the threshold. The request for replacement of the walk-in units for the 2021 capital budget included the description, The walk-in walls are deteriorated and are causing major condensation issues in the freezer. The box itself has had the freezer door replaced in the past. The State wrote this up on their last visit. Some of the refrigeration components have already been replaced. Proposals for the replacement of this box were obtained last year as the walls of the box itself are splitting at the seams from being frozen and melting. The request for maintenance of the broken floor tiles in the dish machine room was reviewed and noted to have been requested on 7/17/20 . The work needed was described as broken tiles are located in dish room area and by freezer door. The priority was marked as High.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review the facility failed to ensure that the environment was maintained in a safe manner in three of eight resident rooms (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER]) located on one of four resident halls (200 hall) related to a wrapped call light string and holes in the walls. Findings included: Observations during the initial tour of the facility on 9/15/20 at 10:30 a.m. revealed the following: -room [ROOM NUMBER]- A hole was noted in the wall, located near the bathroom door, where an electrical outlet should be. -room [ROOM NUMBER]- A large gaping hole was noted in the wall behind the bed located closest to the window. -room [ROOM NUMBER]- The call light string was noted to be wrapped around the grab bar located in the bathroom. (Photographic Evidence Obtained) Observations on 9/17/20 at 2:30 p.m. of the resident rooms 203, 204, 206 with the Director of Maintenance present confirmed that there was a large hole behind the resident's bed in room [ROOM NUMBER], confirmed that an electrical outlet was hanging leaving an open hole in the wall in room [ROOM NUMBER], and confirmed that the call light string was wrapped around the grab bar in the bathroom of room [ROOM NUMBER]. Interview with the Director of Maintenance at this time revealed that staff are to report all maintenance concerns to him and then it would be reflected on the Building Management Software system. He reported that he has a helper and that they both would be responsible to fix these concerns. A request was made to provide from the Building Management Software system any type of documentation that would indicate that this concern was presented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105373	A. BUILDING _____ B. WING _____	**09/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNSET POINT	**1980 SUNSET POINT RD CLEARWATER, FL 33765**

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 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 7) to the maintenance department and to provide the facility policy on maintenance. This documentation was not provided. Review of the facility policy titled, Accommodation of Needs, with an effective date of 6/15/05 revealed: 1. The Center must provide: 1.1 A safe, clean, comfortable, and homelike environment, allowing the resident to use his/her personal belongings to the extent possible.