STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105725	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HOME ASSOCIATION, THE	**1203 E 22ND AVE TAMPA, FL 33605**

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 0554 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow residents to self-administer drugs if determined clinically appropriate.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure residents were assessed and had orders to self-administer respiratory medications for 1 (#17) resident out of 4 residents receiving respiratory treatments. Findings included: An observation was conducted on 8/26/2020 at 10:14 a.m., in Resident #17's room sitting out on the nightstand beside his bed was an uncapped small hand held container of [MEDICATION NAME], a inhalation medication. (photographic evidence was obtained). A review of the facility resident information sheet for Resident #17 reflected an original admission date of [DATE] with a recent re-admission date of [DATE] with pertinent [DIAGNOSES REDACTED]. A review of the Medication Administration Record [REDACTED]. There was not a physician order for [REDACTED].#17 revealed there was not a self assessment for Resident #17 to self -administer any of his medication. An interview was conducted on 8/26/2020 at 3:00 p.m., with the DON, Director of Nurses who reviewed the photographic evidence obtained of the inhaled medication of Resident #17's on his nightstand. No, it should not be left out in the open like that. A resident has to be assessed and there needs to be a physician order to self-administer any medication. An interview was conducted on 8/26/2020 at 4:28 p.m., the pharmacy consultant said, The facility must complete an assessment to see if a resident is able to safely administer their medications. There also needs to be a physician order that the resident is to self-administer a medication. A review of the facility policy titled Self-Administration of Medications revised April 2013 revealed under Policy Statement: Residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so. Policy Interpretation and Implementation: 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications. 5 The staff and practitioner will document their findings and the choices of residents who are potentially capable of self-administering medications. 8. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. 9. Staff shall identify and give to the Charge Nurse and medications found at the bedside that are not authorized for bedside storage, for return to the family or responsible party.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure medications were labeled per pharmacy guidelines and that the drugs were labeled per facility policy for 2 (#11, #22) residents out of 5 residents receiving tube feedings. Findings included: An observation was conducted on 8/26/2020 at 10:16 a.m., Resident #11 was in his room in bed. A peg tube feeding of [MEDICATION NAME] was running at 75 cc/hour with a bag of water flush to infuse 150 cc of flush every 8 hours. The bag of water flush did not have the resident's name, the date the bag was hung, or the time. (photographic evidence was obtained). An observation was conducted on 8/26/2020 at 11:05 a.m., Resident #22 was in her room in bed. A peg tube feeding of [MEDICATION NAME] Kangaroo bag was at the bed side not infusing at the time that was not dated, did not have the residents name, the time it was hung or the amount to be infused. The bag of water flush did not have the resident's name, the date the bag was hung, or the time. (photographic evidence was obtained). An interview was conducted on 8/26/2020 at 11:15 a.m., the Unit Manger said, The feeding bags and flushes should have all of that patient identifying information on it. I am not sure why it is not on there. An interview was conducted on 8/26/2020 at 3:00 p.m., the Director of Nursing reviewed the photographic evidence obtained and said, I can see in the picture that the feeding and the flush for the 3 residents is not labeled correctly. An interview was conducted on 8/26/2020 at 4:28 p.m., the pharmacy consultant said, All of the information that pertains to an order should be on the label before it is administered. A review of the facility policy titled Labeling of Medication Containers with a revised date of April 2007 revealed under Policy Statement: All medications maintained in the facility shall be properly labeled in accordance with current state and federal guidelines. Policy Interpretation and Implementation: 3. Labels for individual drug containers shall include all necessary information, such as: a. The resident's name; b. The prescribing physician name; c. The name, address, and telephone number of the issuing pharmacy; d. The name, strength, and quantity of the drug; e. The prescription number if applicable; father date the medication was dispensed; g. Appropriate accessory and cautionary statements; h. The expiration date when applicable; and i. Directions for use. A review of the facility policy titled Enteral Tube Feeding via Gravity Bag with an origination date of 8/25/2015 and last revised on 2/22/2016. Purpose: The purpose of this procedure is to provide nourishment to the resident who is unable to obtain nourishment orally, General Guidelines: 3. Check the Enteral nutrition label against the order before administration. Check the following information: a. Resident name, ID and room number; b. Type of formula; c. Date and time formula was prepared; d. Route of delivery; e. Access site; f. Method (pump, gravity, syringe); and g. Rate of administration (ML/hour). Initiate the feeding: 4. On the formula label document [DIAGNOSES REDACTED]ils, date and time the formula was hung, administered, and initial the label was checked against the order. The facility did not have a specific policy for Enteral feeds via pump.
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	Based on observation, staff interview and review of the facility communication plan dated 3/23/2020 the facility failed to communicate to their residents and resident representatives positive testing status results for COVID-19 for nine (#2,#3,#4,#5,#6,#7,#8,#9 and #18) residents and thirteen staff members with positive COVID-19 results in the required time frame. Findings included: On 8/26/2020 at 3:00 p.m. the Director of Nursing (DON) provided a copy of the facility completed Centers for Disease Control (CDC) assessment signed and dated by the DON as being completed on 3/23/2020. The CDC assessment tool is titled: Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long Term Care Facilities. A review of the facility toll indicates on page 4: A person has been assigned responsibility for communications with staff, residents and families regarding the status and impact of COVID-19 in the facility. The DON was interviewed and asked which staff member was responsible for the communication to residents/families and staff who test positive for COVID-19, she confirmed it was the Social Service Director and that communication notes would be found in each of the residents medical records. The DON was asked for their policy on communicating this information on a timely manner as required; she confirmed that they do not have a written policy, they follow the regulation and the CDC guidelines. On 8/26/2002 at 3:15 P.M. an interview was conducted in the conference room with the Director of Social Services (SSD) and the Social Service Assistant. During the interview the SSD revealed that her department is responsible for the communication to residents/representatives and staff of positive COVID-19 cases in the facility. The SSD reported that communication to family is conducted on a weekly basis by social service department based on the weekly testing results. The SSD was asked if they followed the regulation timeframe of notification must occur by 5:00 p.m. the next calendar day after any positive

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 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) COVID-19 result. The SSD confirmed that she has not contacted family representatives according to the CDC guidelines or the regulation. She added We failed to document our weekly calls as well. During the medical record review for residents and staff interviews with the Nursing Home Administrator and the DON on 8/26/2020 at 2:45 a.m. revealed that there were nine residents that tested positive for COVID-19 on the following dates with no communication to residents/representatives: Resident #2 tested positive for COVID-19 on 8/10/2020, #3 tested positive for COVID-19 on 8/19/2020, #4 tested positive for COVID-19 on 8/19/2020, #5 tested positive for COVID-19 on 8/18/2020, #6 tested positive for COVID-19 on 8/18/2020, #7 tested positive for COVID-19 on 8/18/2020, #8 tested positive for COVID-19 on 8/19/2020, #9 tested positive for COVID-19 on 8/19/2020 and #18 on 8/22/2020. Additionally, (13) staff members had tested positive on the following dates with no documented evidence of timely communication to residents or family/representatives: Staff members: I.- tested positive for COVID-19 on 8/07/2020, J. tested positive for COVID-19 on 8/07/2020 K. tested positive for COVID-19 on 8/07/2020 L. tested positive for COVID-19 on 8/07/2020 M. tested positive for COVID-19 on 8/22/2020 N. tested positive for COVID-19 on 8/14/2020 O. tested positive for COVID-19 on 8/11/2020 P. tested positive for COVID-19 on 8/07/2020 Q. tested positive for COVID-19 on 8/14/2020 R. tested positive for COVID-19 on 8/17/2020 S. tested positive for COVID-19 on 8/14/2020 T.-tested positive for COVID-19 on 8/11/2020 U. tested positive for COVID-19 on 8/19/2020
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public in regards to 1) unclean air vents in 6 resident rooms (151, 152, 154, 156 159, 163), on the first floor out of 40 window units and 9 resident rooms (202, 204, 206, 208, 210, 212, 214 235 and 239) on the second floor out of 54 window units, and 2) the facility failed to ensure a resident sink was maintained to prevent leaks in 1 (room [ROOM NUMBER]) out of 1 room observed. Findings included: 1) An observation was conducted during the initial tour of the facility on 8/26/2020 starting at 10:04 a.m., and ended at 11:14 a.m., the resident rooms 151, 152, 154, 156 159, 163 on the first floor and rooms 202, 204, 206, 208, 210, 212, 214 235 and 239 AC (air conditioning) unit filters were full of gray debris that was so thick that it would fall off as the AC filter was lifted from the front of the AC units for inspection. (photographic evidence was obtained). An interview was conducted on 8/26/2020 at Staff O, Certified Nurse's Aide in room [ROOM NUMBER] looked at the A/C vent and said, Oh my goodness! That is filthy. An interview was conducted on 8/26/2020 at 11:48 a.m., the Maintenance Director said, Housekeeping is responsible for cleaning the AC units in the resident rooms. A second interview was conducted on 8/26/2020 at 12:02 p.m., the Maintenance Director provided a copy of the Monthly Quality Assurance Committee agenda for the month of May 2020 and June 2020. For the month of June 2020 under the column for other revealed, Ceiling Fans, A/C filters and under Committee Discussion it is documented, Has been Cleaned. The Maintenance Director said, I am not sure what was cleaned or what rooms. A review of the Monthly Quality Assurance Committee agenda for May 2020, under the column for other revealed, Ceiling fans and A/C Filters, and under Committee Discussion it is documented, Entire building was cleansed A/C filters entire building was cleaned. The Maintenance Director said, I am not sure what exactly cleaned or what rooms they cleaned. I don't know what they cleaned. Monthly Quality Assurance Committee agenda for the month of July documents under the column, Other: Veiling fans and A/C filters. Documented under Committee Discussion: Hallways, Resident rooms completed. The Maintenance Director said, I do not know where or which rooms. 2) An observation was conducted on 8/26/2020 at 10:43 a.m., in room [ROOM NUMBER] of the sink and mirror in the bedroom part of the room. Underneath the sink on the floor was a pink basin half full of brown water with sediment noted in the bottom of the basin. (photographic evidence was obtained). An interview was conducted on 8/26/2020 at 10:44 a.m., Staff O, Certified Nurses Aide (CNA), who was sitting in room and confirmed the water in the basin was because, The pipes underneath the sink drip. It has been that way for a while. A review of the work order book maintained at the nurse's station for the main hall on the second floor revealed no documentation of a work order to repair room [ROOM NUMBER]. An interview was conducted on 8/26/2020 at 11:48 a.m., the Maintenance Director who presented a copy of the Maintenance Service Request log with an entry dated 8/26/2020 with a time of 7:30 a.m., with documentation, Leaking sink for 238. The maintenance Director said, They just handed this to me. It was explained to the Maintenance Director that the work order was not in the book when checked and that it is room [ROOM NUMBER] with a basin full of water underneath the sink not room [ROOM NUMBER]. Oh, I will get it fixed right away.