STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105274	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLEARWATER CENTER	**1270 TURNER ST CLEARWATER, FL 33756**

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 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record and policy review, the facility did not ensure grievance documentation, reporting, and resolution for one (Resident #100) of three residents sampled. Findings included: A record review of Resident #100's Facesheet revealed an admission to the facility on [DATE] with a [DIAGNOSES REDACTED]. The Minimum Data Set, dated dated [DATE], revealed: Section C: Cognitive Patterns: Cognitive Skills for Daily Decision Making of 3, which indicated Resident #100 had severely impaired cognitive function. An interview on 3/11/2020 at 10:41 a.m., with Resident #100's Power of Attorney (POA) revealed that during visits with Resident #100 on different days, the POA found the Resident wearing clothing that did not belong to them such as pants, and shirts. I talked to the social worker, the unit manager, and the head nurse. They told me they were going to take care of it. But after this, sometimes, I still see her wearing her own clothing and sometimes not. I live far so it would be very hard to do (Resident #100) laundry. I am coming in (to the facility) today and I will verify if she is wearing her own clothing. A record review of the Grievance/Concern Log for the months of September 2019, October 2019, November 2019, December 2019, January 2020, February 2020, and (NAME)2020 revealed that no grievance was filed related to lost items or property for Resident #100. During an interview and observation on 3/11/2020 at 3:00 p.m., Resident #100's POA said that Resident #100 was not wearing pants that the family purchased. They stated, The pants are not hers and they are too big on her. I spoke directly with the head nurse, Director of Nursing (DON), about a month ago regarding this issue because my mom's personal clothing keeps coming up missing. I see her wearing other people's clothing. The POA revealed that the DON said they would begin labeling Resident #100's clothing. The POA verified that the shirt Resident #100 was wearing had her name on the label, but the pants did not. The POA stated, This is really my only concern because otherwise the staff takes care of her. She is clean and everything, but we spend money on nice things for her, my siblings will send things, we want her wearing them. I brought her in a blanket a while ago that went missing and they (the facility) still doesn't know where it is. An interview was conducted on 3/11/2020 at 3:25 p.m., with Staff A, a Certified Nursing Assistant (CNA) stated, Each resident's clothing is organized to their side of the closet but sometimes housekeepers will put clothing on the wrong side. To prevent this, the facility will write the name of the resident on the inside of the clothing. Staff A revealed that new clothing is put into a bag with the resident's name and room number for housekeeping to label it. Staff A was asked if any family or residents' have complained about missing clothing, or residents' clothing that was not purchased for them. Staff A stated, Yes, people have complained about this. Like (Resident #100)'s (POA) has brought it to my attention once. Sometimes the clothing will be worn before it is labeled, and housekeeping takes it away when it is dirty. So, we will take them down to the laundry room, identify the clothing, and label it from there. An interview was conducted on 3/11/20 at 3:39 p.m., with the DON. The Assistant Director of Nursing (ADON), and the Regional Nursing Consultant were also present during this interview. The DON stated, I kind of remember this situation, it occurred around January but I'm not one-hundred percent sure. The (POA) had made a complaint that (Resident #100) was missing some clothing. I made a grievance related to the incident. The grievance would be on the log (Grievance/Concern Log). If somebody said that something is missing, we do make a grievance and then we go on to resolve it by asking them to provide a receipt and then we would reimburse them for it. The DON revealed that grievances are not kept in any other location besides the log. An interview and observation were conducted on 03/11/20 at 3:50 p.m., with the DON and the POA. The POA began separating the clothing from Resident #100's closet into two piles, one that belonged to Resident #100, and one that did not. The POA stated to the DON, Again, I am very pleasured with the care that you are giving her. But the laundry is just not doing their job. I buy (Resident #100) nice things, and pretty colors, so (Resident #100) can look nice but they aren't here. I don't even want to buy her anything else. Even the pants (Resident #100) is wearing are not hers. The POA showed various clothing items found ranging in sizes such as a 3XL sweatshirt and a 1XL t-shirt for Resident #100 who wears small to medium size clothing. The DON responded to the POA, I am very sorry that this happened, I don't even know what to say. We will remove the clothing that is not hers, go to the laundry and identify your mother's clothing. If we cannot find her items, then we will reimburse you. An interview was conducted on 3/11/20 at 4:30 p.m., with the Social Services Director (SSD). The SSD oversees all the facility's grievances. She stated I was not aware of any grievances related to this issue. Any grievances would be on the log. We do not have another location where grievances are kept. A review of the facility's policy titled Grievance/Concern Management, revised (NAME)2017, revealed, resident's/representative have the right to present concerns on behalf of themselves, and/or others to the staff and/or administrator of the facility, to government officials, or to any other person. The concern may be filed verbally or in writing, and the reporter may request to remain anonymous. Under section Procedure, number 5, The Social Services Representatives/Grievance Official in collaboration with the NHA will be responsible for assigning the concern to the appropriate department for investigation. Social Services will monitor and document resident/family satisfaction upon completion of the investigation and the summary of findings/conclusion. The facility leadership team will review and discuss concerns and the progress of an investigation(s) and resolution(s). On 03/11/20 04:39 P.M., the Administrator provided documentation related to laundering, grievances, and labeling. What people will do is go out and have to buy a new item, submit a receipt and then they are reimbursed from there. What people should do is drop off the clothing to have it labeled, but, sometimes with Spanish speakers there is a disconnect or they don't fully understand but that is not unique to us that is sometimes what occurs at most facilities. We also provide them with a letter that goes over the laundry services. Sometimes does housekeeping but clothing in the wrong location, yea, but that happens sometimes.
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 observations, records review, and interviews, the facility did not ensure that care plans were developed and implemented for 2 (Resident #94 and Resident #100) out of 33 residents sampled related to refusing to let staff weigh them, and for the application of an electronic wander bracelet for Resident #100. Findings included: 1. A record review of Resident #94's Facesheet indicated an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #94's Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, meaning high cognitive ability. A record review of Resident #94's Care Plan, revised on 11/14/2019, revealed the Resident is at risk for nutritional problems related to [DIAGNOSES REDACTED]. Resident #94 frequently refusing facility meals and

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) foods brought in by family. Interventions included providing ice cream for lunch and dinner, weights per facility policy, notify MD and RD of significant changes, allow adequate time to eat, and providing a regular diet. A record review of Resident #94's Progress Notes revealed on 11/27/2019 a weight warning was issued due to a significant weight loss. The family was notified and monitoring of the Resident will continue. On 12/5/2019, the Resident's family was notified of the resident refusal of weights with decreased appetite, monitoring of the Resident will continue. On [DATE], the Resident was noted to refuse a weight with a history of refusing labs, medications, and care. On 3/5/2020 a care meeting was held to discuss the meeting including medications, diet, and weight. The care plan was to be continued with weight monitoring as available. On 3/20/2020, the resident's last recorded weight was on 12/23/2019 at 99lbs; the resident chooses not to be weighted with a downward trend. A record review of Resident #94's weekly weights recorded on a Weight Recording Form, revealed that weights were not performed for months of February and (NAME)2020. Documentation showed the resident refused to be weighed on [DATE], [DATE], 1/15/2020. An interview was conducted on 3/12/2020 at 3:01 p.m., with the Dietitian. The Dietitian stated, Resident #94 refuses a lot of weights due to behaviors. We have been communicating with her sister. Resident #94 came to the facility at 107 and it seems like Resident #94 is staying at 99. Resident #94 is refusing supplements but likes ice cream, so we try to increase that, but the Resident does not talk to me. The Resident pulls her privacy curtain all the time. I try to reach out to the sister regarding her preferences. The Dietitian was asked how often weights are taken of residents to which they responded, Usually weekly or monthly. The Dietitian was asked if the 2/21/2020 Care Plan should reflect the Resident's weight refusals. I believe yes, it does show that she refuses care but that is related to the breast care. The Power of Attorney is aware of the refusal and weight loss. The MDS Coordinator should update the care plan at the meeting and would have more information on this situation. An interview was conducted on 3/12/2020 at 3:39 p.m., with the MDS coordinator related to Resident #94's nutritional care plan. She stated Yes, the resident always refuses care. The MDS coordinator was asked if the Care Plan reflected that the Resident refuses weights she stated I'm not seeing it on here that the resident refuses weights, but weights may be under dietary, and I'm not seeing it there. I honestly don't remember if we discussed refusing weights in the care plan meeting. Everyone comes together and nutrition would be the one to bring up if the resident was refusing weights. The care plan does not reflect that the Resident refuses weights. She also said that Nutrition would be the responsible party for weight monitoring and tracking so I would have to refer to them regarding this. 3. An observation was made of Resident #100 on 3/11/20 at 9:07 a.m. The Resident was walking up and down hallway with an electronic wander bracelet in place on her left ankle. The resident was observed walking into room [ROOM NUMBER] without knocking. The resident began touching the privacy curtains; no other residents were in the room. After exiting the room, the Resident walked into the dining room. At 9:20 a.m., the Resident left the dining room and walked down the hallway, entering room [ROOM NUMBER] without knocking. The Resident then exited the room. At 9:45 a.m., the Resident entered room [ROOM NUMBER] without knocking, walked into the bathroom, prior to exiting the room at 9:50 a.m. There were no facility staff members monitoring the Resident. An observation of Resident #100 was conducted on 3/12/2020 at 2:07 p.m. with Staff B confirmed who the presence of an electronic wander bracelet on the left ankle. A record review of Resident #100's Facesheet revealed she was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Resident #100's MDS, dated [DATE], revealed: Section C: Cognitive Patterns: Cognitive Skills for Daily Decision Making of 3, which indicated Resident #100 had severely impaired cognitive function. A record review of the Nursing Quarterly and PRN Data Collection dated, 2/21/2020, revealed: Section Q Mood and Behavior that the resident does exhibit wandering behaviors and was at risk for elopement. Subpart 7: Care Plan revealed that interventions included applying an electronic wander bracelet, verifying the wander bracelet during routine care, and checking the functioning. The MDS Section P: Restraints and Alarms revealed that no physical restraints or alarms are used for the Resident. An interview was conducted on 3/12/2020 at 2:35 p.m., with the Director of Nursing (DON), Assistant Director of Nursing (ADON), and another surveyor. The DON stated, Upon admission residents are screened for wandering behaviors such as if the resident states they want to leave, packing their bags, or moving towards the exit doors. Specifically, on the secured unit many of these residents are always going towards the doors, and shadowing staff to try and get out. The DON was also asked to clarify Resident #100's Care Plan related to the meaning of an audible alarm system. The DON stated, an audible alarm system is when the resident moves towards the doors and the bracelet sets off the door. The bracelet would be included in the plan. I don't see an elopement evaluation; this should have been done before a (an electronic wander bracelet) was placed on the Resident. The DON and the ADON confirmed Resident #100 did not have an order for [REDACTED]. The MDS Coordinator was asked if a resident should be care planned for an electronic wander bracelet. She stated, Yes, absolutely, that will be found under the elopement care plan.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record and facility policy review, the facility failed to follow their policy for supervision of elopement/wandering behaviors and an electronic wander bracelet for one (Resident #100) of six residents in the sample group. Findings included: An observation was conducted on [DATE] at 11:07 a.m. Resident #100 was observed walking up and down the hallway of the secured unit, repeatedly saying hi, hi, hi. Resident #100 attempted to follow the writer into another resident's room who was sitting on their bed reading a book. Resident #100 began speaking loudly in Spanish to the resident sitting on their bed who stated, get out of my room. Resident #100 approached the resident sitting on their bed, pointing their finger at the resident. The other resident stood up from the bed and stated, get her out of here or I'm going to hit her. She always does this. She always comes to my doorway and does this. I sit here trying to read and I don't bother anyone unless they bother me. The situation began to escalate. The writer called out to a staff member and Staff B, Certified Nursing Assistant (CNA) responded and entered the room. Resident #100's hand, which was still being pointed into the other resident's face, was slapped away by the other resident. The CNA removed Resident #100 from the room and said they were going to file an incident report. The writer, along with another surveyor, also directly reported the incident to the Administrator. A record review of Resident #100's Facesheet indicated an admission date of [DATE] with [DIAGNOSES REDACTED]. Review Resident #100's Minimum Data Set (MDS), dated [DATE], revealed: Section C: Cognitive Patterns: Cognitive Skills for Daily Decision Making of 3, which indicated Resident #100 had severely impaired cognitive function. A record review of the Nursing Quarterly and PRN Data Collection, dated [DATE], revealed: Section Q Mood and Behavior that the resident does exhibit wandering behaviors and is at risk for elopement. Subpart 7: Care Plan revealed that interventions include applying an electronic wander bracelet, verifying the wander bracelet during routine care, and checking the functioning. The MDS Section P: Restraints and Alarms revealed that no physical restraints or alarms are used for the Resident. A record review of Resident #100's Care Plan, dated [DATE], revealed a focus area created on [DATE] of an elopement risk. Interventions included: Resident #100 resides on a secured unit, educate resident/responsible part regarding the sign out procedures, photograph of resident to be maintained in facility, use verbal cues for direction to minimize exit-seeking behavior, use audio alarm system to alert staff to exit-seeking behavior, reassure resident who is displaying distress encourage participation in activities of choice, routine monitoring. An observation was conducted on [DATE] at 9:07 a.m. Resident #100 was walking up and down the hallway with an electronic wander bracelet in place on her left ankle. The resident was observed walking into room [ROOM NUMBER] without knocking. The resident began touching the privacy curtains; no other residents were in the room. After exiting the room, Resident #100 walked into the dining room. At 9:20 a.m., the Resident left the dining room and walked down the hallway, entering room [ROOM NUMBER], without knocking. The Resident then exited the room. At 9:45 a.m., Resident #100 entered room [ROOM NUMBER] without knocking, and walked into the bathroom. Resident #100 exited the room at 9:50 a.m. There were no facility staff members monitoring the resident. An interview was conducted on [DATE] at 10:37 a.m., with Resident #100's Power of Attorney (POA). The POA was asked how the staff handles the Resident's wandering behaviors around the unit. The POA stated, The staff just let her be. She walks back and forth in the aisles, she likes to be nice, she is always smiling. Yesterday, they called me and told me someone attacked her. I can't blame that resident because it isn't like they really understand what is going on. I understand that Resident #100, sometimes, can bother other people's privacy and space. Somebody even grabbed her hair at the beginning of the year. An observation was conducted on [DATE] at 10:30 a.m. Resident #100 was observed walking up and down the halls of the secured unit with an electronic wander bracelet on their left ankle. An observation was conducted on [DATE] at 12:08 p.m. Resident #100 was being assisted into the dining room by Staff C, CNA, with a large cut and raise lump on their

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) forehead. An interview with Staff C, CNA found that Resident #100 is always walking up and down the hallways to and from the exit doors. She stated, Around 11 a.m., Resident #100 walked into the metal pole section of the door frame resulting in the head trauma. I notified the nurse of the incident, the area was cleaned, and I plan on filing an incident report. An observation was conducted on [DATE] at 12:26 p.m. Resident #100 walked into room [ROOM NUMBER] without knocking and stood behind A bed's privacy curtain. During this time there were three facility aides standing in the hallway by the dining room entrance next to the meal tray cart; located within eyesight of room [ROOM NUMBER]. Resident #100 exited the room, walked down the hallway, and entered room [ROOM NUMBER] without knocking. The resident walked out of the room and at 12:35 p.m., walked into room [ROOM NUMBER] without knocking. Once Resident #100 exited the room at 12:36 p.m., a staff member escorted the resident to the dining hall for lunch. At 12:55 p.m. Resident #100 left the dining room after eating and walked into room [ROOM NUMBER] without knocking. The Resident stood beside B bed, which, at the time, was occupied by a sleeping resident behind a halfway pulled privacy curtain. When Resident #100 was standing beside the sleeping resident, an aide was across the hall removing a finished meal tray from room [ROOM NUMBER]. A record review of Resident #100's Order Summary Report revealed no order for an electronic wander bracelet , electronic wander bracelet placement, or function checks. Review of Resident #100's Medication Administration Report (MAR) and Treatment Administration Report (TAR) for February 2020 and (NAME)2020 revealed no placement or functional checks were conducted for an electronic wander bracelet. An interview was conducted on [DATE] at 1:47 p.m., with Staff D, both a Licensed Practical Nurse (LPN) and the Unit Manager. LPN said that the electronic wander bracelets are checked nightly using a transmitter tester. Periodically, guards are changed if they are either expired or defective. The LPN stated, for a resident to be wearing a (an electronic wander bracelet), an order must be in place which can be placed by a nurse if the resident is at risk for elopement. When asked how long Resident #100 has had an electronic wander bracelet, the LPN began to investigate the online medical record to verify the order placement; she was unable to find the order and began reviewing Resident #100's hard chart by the nursing station. After looking through the hard chart the LPN stated, I don't see it The LPN was asked if the electronic wander bracelet was being checked. She stated, If there isn't an order then it doesn't come up on the MAR indicated [REDACTED]. The LPN was asked if they knew how long Resident #100 had been wearing an electronic bracelet. The LPN took a long pause and stated, I'm not sure, but I don't think she has been checked out of the facility. An observation was conducted on [DATE] at 2:07 p.m. Staff B confirmed the presence of an electronic wander bracelet on the left ankle. An interview was conducted on [DATE] at 2:35 p.m., with the Director of Nursing (DON), the Assistant Director of Nursing (ADON), and nurse surveyor. The DON stated, Upon admission residents are screened for wandering behaviors such as if the resident states they want to leave, packing their bags, or moving towards the exit doors. Specifically, on the secured unit many of these residents are always going towards the doors, and shadowing staff to try and get out. When asked if everyone on the secured unit wears an electronic wander bracelet , the DON stated, No, there are just a few on the secured unit in terms of their ambulation that need one. We don't force a (electronic wander bracelet). We have daily monitoring of function and placement. The resident should have an order in place to have a (electronic wander bracelet). The DON was asked to verify if Resident #100 had an order in place for an electronic wander bracelet. The DON checked Resident #100's active and discontinued orders and stated, I don't see an order. The DON was asked to clarify Resident #100's Care Plan related to what an audible alarm system means. The DON stated, An audible alarm system is when the resident moves towards the doors and the bracelet sets off the door. The bracelet would be included in the plan. I don't see an elopement evaluation; this should have been done before a (electronic wander bracelet) was placed on Resident #100. Both the DON and the ADON confirmed there was no order or evaluation for an electronic wander bracelet. An interview was conducted on [DATE] at 2:55 p.m., with the MDS Coordinator and another surveyor. The MDS Coordinator was asked if a resident should be care planned for an electronic wander bracelet. She stated, Yes, absolutely, that will be found under the elopement care plan. The MDS Coordinator was asked to evaluate Resident #100's Care Plan. We just put one on Resident #100 recently. Oh, looks like she had an order put in today. I thought she had one before that. If I see a (electronic wander bracelet) on an order, I would make a Care Plan for that. The MDS Coordinator confirmed that Resident #100's Care Plan did not reflect an electronic wander bracelet. An interview was conducted on [DATE] at 8:40 a.m., with the DON. When asked if Resident #100 should be Care Planed for wandering into other Resident's rooms, the DON stated, We can put that behavior on the Care Plan, but it is not mandatory because each resident would react differently. Say if Resident #100 wandered into a resident room, some may say get out, some may be aggressive. The most important thing is staff monitoring, there is a specific amount of staff that we try to keep over there to watch the wandering. You can never really blame how another resident will react. The DON was asked what staff should be doing if a resident is wandering in and out of other resident's rooms. The DON stated, The staff should be redirecting the resident. Sometimes it is easier than other times because a resident can become belligerent. The staff should be cueing them and really doing anything that helps them. A policy review of Elopement-Facility Practices, revised February 2020, revealed maintain door alarms and wander control systems in proper working order. Validate, through observation, the resident/patient is wearing electronic device every shift as indicated and document on the TAR. Validate daily that the electronic device is properly functioning and document on the TAR. A policy review of Physician Orders, revised February 2020, revealed under number 12, confirm the accuracy of orders. Review orders daily in the Clinical meeting to confirm accuracy in transcription and identify errors of omission. Under subsection, End of Month Physicians' Order Change Over Process, Assigned nursing staff will complete a monthly review to ensure physicians orders are captured accurately on the monthly physician's orders [REDACTED]. This process should be completed 3 days before the end of the month. Reviewed to ensure scheduling of the medication, treatment, etc. entered correctly. A policy review of Care Plan-Interdisciplinary Plan of Care from Interim to Meeting, revised (NAME)2017, revealed, facility shall assess and address care issues that are relevant to individual residents, to include, but may not be limited to monitoring resident condition and responding with appropriate interventions. The comprehensive care plan is an interdisciplinary communication tool. It includes measurable objectives and time frames and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being The care plan is reviewed and revised periodically, and the services provides or arranged are consistent with each resident's written plan of care. Under number 2, Daily updates to care plans are added by a member of the IDT at the time the change is implemented, the intervention is needed, or other care plan revision is indicated. Accuracy of the care plan is validated by the IDT during daily clinical meeting.