STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105891	A. BUILDING _____ B. WING _____	**10/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
YBOR CITY CENTER FOR REHABILITATION AND HEALING	**1709 TALIAFERRO AVE TAMPA, FL 33602**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0561 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and medical record review, the facility failed to honor the choice and desire for showers for four (Residents # 22, 36, 7, and 41) of five residents sampled for activities of daily living (ADLs) out of a total sample of 29 residents. Findings included: 1. Record review revealed Resident #22 was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE], showed a Brief Interview of Mental Status (BIMS) score of 13 (indicating cognitively intact). Review of Section E: Behavior: revealed that Resident #22 did not exhibit physical or verbal behavioral symptoms or rejection of care. Section F: Interview for Daily Preferences: was coded with the numeral 1, which indicated it was very important to the resident to choose between a tub bath, shower, bed bath or sponge bath. Section G: Functional Status: indicated the resident needed one person physical help with part of the bathing activity. During an observation of Resident #22 on 9/29/20 at 10:30 a.m., the resident was lying in bed with the bedside table over his bed. He stated Well, I've been a resident here for about 8 years. They do come and offer sponge baths, but I've been asking for a shower. I haven't had a shower in over 2 months. The aides told me that I couldn't have a shower because of [MEDICAL CONDITION]. But it would feel good to be under some running water. Those sponge baths really don't do much. Review of Resident #22's physician's orders [REDACTED]. His care plan, initiated on 8/12/2020, revealed that Resident #22 had a self-care deficit requiring daily extensive to total assistance with ADLs and more specifically, that he needed extensive assistance with showers. Nursing progress notes from August through September 2020 were reviewed and revealed that the resident was alert and oriented and able to make his needs known. Nursing progress notes revealed that total care was rendered for the resident. No progress notes indicated refusal of care, and the notes did not indicate that any showers were given. Review of the CNA Flow Sheet for August 2020 revealed that Resident #22 received 2 showers in the month of August; a shower on 8/24/2020 (day shift) and on 8/29/2020 (evening shift). There was no CNA flow sheet for the month of September 2020 in the ADL logbook, and the facility was unable to provide one. The September 2020 shower list sheet for Resident #22's hall revealed that the resident did not receive a shower in September. 2. Record review revealed Resident #36 was readmitted to the facility in March of 2020 with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE], showed a Brief Interview of Mental Status (BIMS) score of 11 (indicating moderate cognitive impairment). Review of Section E: Behavior: revealed that Resident #36 did not exhibit physical or verbal behavioral symptoms or rejection of care. Section F: Interview for Daily Preferences: was coded with the numeral 1, which indicated it was very important to the resident to choose between a tub bath, shower, bed bath or sponge bath. Section G: Functional Status: indicated the resident needed one person total assistance with bathing. During an observation of Resident #36 on 10/01/20 at 11:30 a.m., the resident was sitting in his wheelchair next to his bed. His responses were slow. He was asked if he had a shower recently. He shook his head no. He said, no showers. When asked if he could remember when his last shower was given, he shook his head indicating no and said, long time ago. When asked if he liked showers or bed baths, Resident #36 said showers. Review of Resident #36's physician's orders [REDACTED]. His care plan, initiated on 3/03/2020, revealed that Resident #36 had a self-care deficit requiring daily extensive to total assistance with ADLs including bathing. His care plan also included interventions for verbal aggression/behaviors, but these were related to the resident wanting to be helped out of bed at his preferred times. Nursing progress notes from August through September 2020 were reviewed and revealed that the resident was alert and oriented and able to make his needs known. No progress notes indicated refusal of care, and they did not indicate that any showers were given. Review of the CNA Flow Sheet for September 2020 and the September 2020 shower list sheet for Resident #36's revealed that Resident #36 only received 1 shower for the whole month; otherwise only bed baths and sponge baths were given. The facility did not provide the CNA flow sheet for the month of August 2020. 3. Record review revealed Resident #7 was readmitted to the facility in mid August 2020 with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE], showed a Brief Interview of Mental Status (BIMS) score of 15 (indicating cognitively intact). Review of Section E: Behavior: revealed that Resident # 7 did not exhibit physical or verbal behavioral symptoms or rejection of care. Section F: Interview for Daily Preferences: was coded with the numeral 1, which indicated it was very important to the resident to choose between a tub bath, shower, bed bath or sponge bath. Section G: Functional Status: indicated the resident needed one person total assistance with bathing. During an observation of Resident #7 on 9/29/20 at 10 a.m., the resident was sitting up in her bariatric bed. She was asked if she had a shower recently. Resident #7 stated Well, no. I haven't had a shower in about 2 months, only sponge baths. I was told by the staff that I could only have a sponge bath due to [MEDICAL CONDITION]. I asked them for a shower several times. I hope I will be able to take a shower soon. You know, a sponge bath is not the same as having a shower. I don't feel clean. Review of Resident #7's physician's orders [REDACTED]. Her care plan, initiated on 2/18/2020, revealed that Resident #7 had a self-care deficit requiring daily total assistance with ADLs including bathing. Nursing progress notes from August through September 2020 were reviewed and revealed that the resident was alert and oriented and able to make her needs known. Progress notes did not indicate there was refusal of care, and they did not indicate that any showers were given. Review of the CNA Flow Sheet for September 2020 revealed that Resident #7 did not receive a shower for the whole month; only bed baths and sponge baths were given. The facility did not provide the CNA flow sheet for the month of August 2020. Review of the August and September 2020 shower list sheet for Resident #7's hall revealed that no showers were given to this resident. 4. Record review revealed Resident #41 was admitted to the facility in September of 2019 with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE], showed a Brief Interview of Mental Status (BIMS) score of 12 (indicating moderate cognitive impairment). Review of Section E: Behavior: revealed that Resident #41 did not exhibit physical or verbal behavioral symptoms or rejection of care. Section F: Interview for Daily Preferences: was coded with the numeral 1, which indicated it was very important to the resident to choose between a tub bath, shower, bed bath or sponge bath. Section G: Functional Status: indicated the resident needed one person total assistance with bathing. During an observation of Resident #41 on 9/29/20 at 11:00 a.m., the resident was sitting in her wheelchair next to her bed. She was looking for something in one of the drawers of her nightstand. She was asked about bathing. Resident #41 said I used to get showers. I haven't had a shower in a very long time. They just bring me a wet washcloth and I clean the important areas. I was told that no one could have a shower because of the illness, you know, [MEDICAL CONDITION]. I told them I prefer showers. Review of Resident #41's physician's orders [REDACTED]. Her care plan, initiated on 9/19/2020, revealed that Resident #41 had a self-care deficit requiring daily extensive to total assistance with ADLs including total assistance with showers per schedule. Nursing progress notes from August through September 2020 were reviewed and revealed that the resident was alert and oriented and able to make her needs known. Progress notes did not indicate refusal of care, and they did not indicate that any showers were given. Review of the CNA Flow Sheet for September 2020 revealed that Resident #41

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 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) did not receive a shower for the whole month; only bed baths and sponge baths were given. The facility did not provide the CNA flow sheet for the month of August 2020. Review of the August and September 2020 shower list sheet for Resident #7's hall revealed that the resident did not receive a shower during these months. Review of the Shower List Sheet for the hall of Resident #22, #6, #7, and #41 revealed the following instructions on the bottom of the sheet: CNA's are to do showers as scheduled. Make sure to sign after each shower is given. Please notify the nurse immediately if the resident refuses. Nurses, these are to be turned in daily to the DON. Each sheet was dated at the top. Review of these shower sheets for 13 days (8/2/20, 8/5, 8/21, 9/3, 9/7, 9/11, 9/14, 9/18, 9/25, 9/28 and 9/29/20) revealed that only a very small percentage of residents received a shower in the months of August and September 2020. An interview was conducted on 10/1/20 at 10:45 a.m. with Staff F, a Certified Nursing Assistant (CNA). Staff F stated There was a period over the last few months that we couldn't give the residents showers. I was told during CNA report that because of the COVID 19 virus, we couldn't take residents to the shower rooms in the main hall by the entrance (300 hall). That was where most residents were taken for showers. So, we were giving the residents bed baths/sponge baths instead. When asked if residents in the 400 hall had showers in their own rooms, Staff F said Yes, most do, but those showers are in a tight space, and the toilet sticks out and makes it difficult to transfer residents from the wheelchair into the shower chair. So, we were taking them to the main hall showers. There is only one room on the 400 hall, room [ROOM NUMBER], which has a wider space to accommodate the wheelchairs, but they are all male residents in that room, and we can't take female residents in there to take showers. When asked if the administration was aware of this issue with showers, Staff F nodded yes. An interview was conducted on 10/1/20 at 1:40 p.m. with Staff E, a Licensed Practical Nurse (LPN) on the 400 Hall. He confirmed that the CNA documents the showers or baths on the CNA flow sheet and on the shower list sheets. He confirmed that he turned in the shower sheets daily to the DON. He was asked what he knew about showers not being given to the residents on the 400 hall. Staff E stated If you heard that showers were not given on this hall due to the [MEDICAL CONDITION], then that is what happened. There were a lot of residents being transferred back and forth from the COVID hall to this hall. So, it was hard to keep up with their shower schedules. There was a risk of transferring these residents to the other hall because of the isolation for COVID. An interview regarding showers was conducted on 10/1/20 at 4:45 p.m. with Staff G (an LPN), and Staff H (a CNA), from the evening shift. Staff G confirmed that the shower sheets are given to the DON. Staff G stated I can only speak for the 3-11 p.m. shift. I never heard that residents couldn't have showers because of the [MEDICAL CONDITION]. That doesn't make any sense. I do agree that the showers in most of these rooms on the 400 hall are set up in such small spaces, that it is difficult to maneuver with the wheelchair around the toilet. Staff H said Yes, but it can be done. We just use the sit to stand lift and manipulate the lift to get them into the shower chair that's in the shower. I wasn't told that showers can't be given because of COVID-19. All my people get taken care of, that's all I can say. If the residents refuse, we tell the nurse and they document it. A interview was conducted with the Assistant Director of Nursing (ADON/Infection Preventionist) on 10/1/20 at 5 p.m. She was asked if there had been a restriction on showers. The ADON shook her head no, and the surveyor disclosed that a few staff had mentioned that showers were restricted due to [MEDICAL CONDITION]. The ADON then stated, Yes, we did stop showers because we were being cautious, and we didn't want the COVID to spread. An interview was conducted regarding showers with the Director of Nursing (DON) and the ADON on 10/2/20 at 1 p.m. Two surveyors were present. The DON stated At the end of July, we had a huge outbreak and about 13 residents were positive for COVID 19 and at least 6 staff were positive. We did tell staff not to give showers for the months of August and September because of the safety issues. We weren't sure of how it spread, if it was airborne or not. We didn't want them being transferred from the 400 hall to the main hall for showers. The DON was asked if there were any showers in the rooms on the 400 hall. The DON stated No. After the surveyor disclosed that she had observed showers in at least 2 rooms on the 400 hall, the DON said Oh yes, I'm sorry, I forgot. Some rooms do have their own showers on the 400 hall. When asked why residents were not given showers in their own rooms or in the 400 hall, the DON stated, We thought the showers in the rooms were small spaces and we didn't want [MEDICAL CONDITION] to spread rapidly in these small spaces. The DON was asked how shower schedules were determined. The DON stated when the resident gets admitted , we ask them about their preferences, like on what 3 days they want to be showered and on what shift. That is put on the Shower list sheet. The CNA must sign that and the CNA flow sheet in the ADL logbook. If the resident refuses a shower, the CNA must tell the nurse, and the nurse must go and encourage the resident to comply. The nurse is expected to document this in the progress notes and document the outcome. On the Shower List sheet or the CNA flow sheet, they are supposed to mark R for refused. I do get a copy of the shower list sheet with signatures at the end of each shift, submitted by the nurse. The DON was asked for a policy regarding completion of ADL tasks or honoring resident preferences regarding daily activities/tasks. The facility was unable to provide a policy regarding these issues.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review and review of facility policy and procedures, the facility failed to ensure alleged violations involving potential abuse were thoroughly investigated, reported, and had action taken to prevent further potential abuse or mistreatment for one (#104) of 29 sampled residents. Findings included: A review of the facility's policy titled Abuse, Neglect, Exploitation & Misappropriation with an effective date of Feb. 2006 and a revision date of December 2016 revealed: It is the policy of this facility to take appropriate steps to prevent abuse (be it verbal, sexual, physical, or mental), neglect, exploitation and misappropriation and the occurrence of an injury of an unknown source, and to ensure that all alleged violations of Federal and/or State laws are reported immediately to the Administrator, Risk Manager, the Social Service Director, and the Director of Nursing . The facility shall take the following steps to prevent, detect, and report suspected maltreatment: Prevention - the facility encourages residents and families, and requires staff to report concerns, incidents and grievances without fear of retribution and is provided feedback, when possible, on these reports. The facility identifies, corrects, an intervenes in situations of alleged abuse, neglect, and exploitation and focuses on the following areas for prevention: . e. Maintenance of an open system of communication and encouraging the submission of complaints; f. A commitment to follow through on all complaints and provide feedback to those involved, when possible. Protection: 2) If the suspected perpetrator is an employee, the Administrator or designee shall place the employee on immediate suspension, pending the outcome of the investigation . Reporting: All staff members are required to report suspected maltreatment. They may report to the abuse hotline .; however, they are also obligated to report to a supervisor or department manager in the facility so that the resident may immediately be protected from further maltreatment. The Administrator, Risk Manager, Social Service Director, and Director of Nursing are to be informed of the situation immediately. The DON/designee shall notify the physician and the resident's representative concerning the suspected maltreatment and the findings of the assessment. The DON/designee shall reassure the resident's representative that an investigation has been initiated, that the resident is being protected and that appropriate action has been taken. All verbal contact with the representative shall be documented accordingly. Upon initial investigation, where there is suspicion that ANE may have occurred, the Abuse Coordinator/designee shall immediately report the alleged violation to the State Agency (for the Federal report), Adult Protective Services, and local law enforcement when appropriate. The Risk Manager/designee will file the Immediate Federal report with the State Agency, and then submit the summary and findings of the investigation with the 5-Day Federal Report. Investigation: A thorough investigation will be conducted. The Abuse Coordinator/designee will initiate procedures for conducting the investigation. The investigation will include: a. The type of allegation. b. What occurred, when, where and to whom? By whom? . c. Describe the injury and any treatment. d. Interview witnesses separately; interview caregivers, roommates; get statements; observe/document demeanor; include names, addresses, and phone numbers of actual witnesses. e. Document cognitive status of victim, resident witnesses; document if credible/believable. F. Obtain signed statement from alleged perpetrator, if possible. g. Review alleged perpetrators past performance and reputation. h. Describe action taken to protect resident. i. Note any bias between alleged perpetrator and witness. j. If agency personnel, obtain info from agency n. Review schedules and assignments. o. Review any meds that may cause resident to bruise easily or be r/t nature of the injury. p. Review facility policies and procedures for unsafe technique used by staff. q. Review nurse's notes and other records for information about the incidents. Upon completion of the investigation, the facility should prepare a summary report of the findings and conclusions, including any actions taken by the facility. Corrective Action: The facility shall make all reasonable efforts to determine the cause of the suspected maltreatment and take corrective action consistent with the investigation findings to eliminate any ongoing danger to the resident or other residents. Observations of Resident #104 on 9/30/20 at 10:15 AM revealed that this resident was lying in bed watching television. Interview with the resident at this time revealed the

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) resident was alert and oriented and familiar with her surroundings. The resident complained that different staff members are nasty to her and that she had made complaints to administration but nothing had been done about it. Review of Resident #104's medical record revealed that her previous admitted was 11/13/19 with a re-admission date of [DATE]. The resident had [DIAGNOSES REDACTED]. Continued review of Resident #104's record revealed no documentation related to the resident's allegation of being treated poorly by staff. Review of the facility's Immediate and 5 Day Reporting Log from January 2020 to October 2020 revealed no entries related to Resident #104's complaint about staff treating her poorly. Review of the facility's grievances from 4/1/20 to current revealed a grievance dated 4/6/20 at 4:30 PM which indicated Staff D, Certified Nursing Assistant (CNA) was treating Resident #104 like (expletive). She has been nasty as hell since the incident with another resident; Staff C, Licensed Practical Nurse (LPN), yelled because she had to get the O2 (oxygen) tank; Staff not answering call lights for up to one hour; Resident afraid to ask for coffee because she could get yelled at. Review of the facility's grievances from 4/1/20 to present revealed that there was a grievance filed on 4/8/20 by Resident #104 at 4:30 PM, which included the following concerns: (1) not having an inhaler at BS (bedside); (2) 2 days with zero O2 for w/c (wheelchair); (3) Wants list of meds; (4) Request cup of ice; (5) Not getting snacks; (6) Wants shower no later than 6 PM; (7) gets woken up at 10 PM for meds; (8) feels like she is being treated like dirt. Based on the grievance form, the facility did follow-up on all concerns except for the concern related to the allegation that Resident #104 felt that she was being treated like dirt. Review of the facility's grievances from 4/1/20 to present revealed that there was a grievance filed by Resident #104 on 6/26/20 at 8:30 AM. This grievance had four different areas of concern which included a statement that Staff D, CNA, is rude to her. Review of the facility's documented grievances revealed that Resident #104 complained about the treatment by Staff D on both the 4/6/20 and the 6/26/20 grievances. There was no documentation that would indicate that the facility had protected the resident from staff treating her inappropriately, no documentation that would indicate that the facility had prevented the staff persons involved continued access to Resident #104, no interviews with the staff persons involved, and no interviews or statements from other staff persons or other residents who may have knowledge of the incidents/events. The facility did not provide any training to staff related to abuse in order to prevent further incidents and did not make appropriate notifications. On 10/02/20 at 9:36 AM, the Social Service Director revealed that the incidents on 4/6/20, 4/8/20, and 6/26/20 where the resident expressed concerns about staff treatment were all reviewed by Social Service as grievances. She reported that the concerns in April were addressed in a care plan meeting with the resident and that the resident had a history of [REDACTED]. She confirmed that these grievances were not investigated as allegations of abuse, no statements were obtained from staff or other residents, no staff training occurred, and no removal of staff occurred in order to protect the resident from potential harm. Interview on 10/02/20 at 9:43 AM with the Risk Manager/LPN, revealed there was no investigation for the identified grievances indicating an allegation of verbal abuse as the concerns were addressed in a care plan meeting. She reported that the resident changed her story several times. She reported that there was no staff training conducted, no notifications of appropriate agencies and persons, no statements from any staff or other residents, and that the staff persons identified in each incident were not removed from having access to the resident. She reported that, now looking back, there should have been an investigation.