STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105050	A. BUILDING _____ B. WING _____	**10/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHORE ACRES CARE CENTER	**4500 INDIANAPOLIS ST NE SAINT PETERSBURG, FL 33703**

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 observation, record review and interviews, the facility failed to ensure that it implemented a grievance process to receive, investigate and respond to grievances for 3 (#1, #2, #4) of 6 sampled residents. Findings include: On 10/16/20 at 5:30 p.m., an interview was conducted with Resident #2. Resident #2 was observed to be sitting in her wheelchair (w/c) outside of her room, a staff member was observed to be donning gown and gloves prior to taking the resident into her room. The resident agreed to be interviewed. The staff member left the room. Resident #2 stated that she had been at the facility since April. Resident #2 stated that she was a one-person transfer. When asked if she had been Abused or Neglected, she stated that there had been 1 Saturday, that an aid, Staff F, left me wet for 4-5 hours or longer. This aid was working from 7am-3pm. She stated that the 3-11 p.m. nurse changed me. A grievance was filed. The Social Worker was in contact with me. (He) said it would go thru the appropriate channels. This happened at the end of August. She stated that he had not gotten back with her about the outcome. Yes, the aid still works here. Yes, she still provides care to me. When Resident #2 was asked if staff responded timely to call bell lights, she stated, No, 2 hours or something. Is any time worse than others? Happens night and day, worse on the weekends. Last Saturday night, it took 2 hours and 20 minutes. Someone comes in and cuts off the light. It is not the 10 minutes that they say it should be. I told the nurse, she was Agency. Do not know her name. They should come when they should. I can't care for myself. An observation was conducted on 10/16/20 at 5:53 p.m. of Resident #1's room. An observation of a Hospice RN (Registered Nurse) in the room with Resident #1, who was sitting in a w/c having a conversation with Resident #1. At 5:55 p.m., an interview was conducted with a Hospice (RN). He stated that Resident #1 was alert and oriented. That the resident had physical decline, weight loss, difficulty swallowing, no ability to do his own ADLs. He stated that ., he had had recent decline. He stated that the resident could be interviewed, that his speech was slurred, but, able to communicate. At 6:16 p.m., an interview was conducted with Resident #1. He stated that he had been at the facility since June. For staff responding to the call light, he stated, it takes like 2 hours. He stated no aids are here during the weekend. At night it is not so good. To Bed? 1 time had to wait unit 2:30 a.m., I was in the room at 11:30 p.m., no aid came around. I like to go to bed around 12. They do not answer the call light. I feel like I cannot breathe. If you come here on the 3rd shift, you will not find anyone. They are always in the break room. One girl gave me the middle finger. I told her to leave the room (2 weeks ago). The Administrator knew. The floor nurse, Staff G knew. Do not know the aid's name. At 6:50 p.m., an interview was conducted with Resident #4. Resident #4 was observed to be self-propelling her w/c from the courtyard, up the ramp, and into the building. She agreed to be interviewed. When asked if she used her call light, she confirmed that she would. When asked if the staff if staff were timely to answer the call light, she stated, No, timely means within 30 minutes. It takes them 1 - 1.5 hours. I cannot get up by myself. I have to wait 1-2 hours. I have had 2 [MEDICAL CONDITION]. If I press the call light, someone should be here in 30 minutes. A review of the facility Grievance log for the period of 06/01/20 thru the date of survey, 10/16/20, reflected no listing for Resident #2's concern. For Resident #1, the facility had documented 1 concern regarding care, 10/05/20. On 10/16/20, at 9:54 p.m., an interview was conducted with the Social Service Director (SSD). Review of the grievance/concern report for Resident #1, documented date received, 10/05/20; Describe grievance/concern using factual terms: (Resident #1) states that nighttime CNAs (Certified Nursing Assistants) are not answering his call light in a timely manner. Resolution: Action taken to resolve educated 11-7 staff on answering call lights in a timely manner. The SSD was asked if he had performed the education/training for the staff. He stated, No. I told nursing and I wrote down what they said. The SSD was asked if he knew who was trained. He stated, I imagine they huddled the 11-7 CNAs. Do you have documentation of the training or the attendees? (no answer) During the interview, the SSD was asked if the facility had documentation of the training and who the attendees were for the training. No documentation of the latter was provided during the survey. At approximately 10:00 p.m., the SSD stated that he normally follows up with the residents on grievances. He stated that he did not see a grievance for Resident #2. He stated that he always logs a grievance. He stated that he did not recall her having a care and service concern. A review of the facility's policy and procedure, Grievances/Complaints, Filing, dated revision 05/2020, documented a Policy Statement: Residents and their representatives have the right to file grievances, either orally or in wring, to the facility staff or to the agency designated to hear grievances. The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative. Included in the Policy Interpretation and Implementation, section 5: Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint 8. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed verbally upon close of the investigation of the findings and the actions that will be taken to correct any identified problems. A written summary of the investigation will be provided to the resident/responsible party upon request.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on observation, record review and interviews, the facility failed to ensure that it submitted a timely (within 1 day of discovery of the incident) and allegation of abuse to the State Agency for 1 (#1) of 7 sampled residents. Findings include: A review of the Agency For Health Care Administration (AHCA) website, reviewed on 10/27/20, https://ahca.myflorida.com/MCHC/Field-Ops/CAU/Federal_Reporting.shtml, documented: Nursing Homes are required by the federal government specifically section483.12,CFR to report and investigate all allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source, and misappropriation of resident property to the State Agency. Nursing Homes must submit a 2-hour/Immediate Report and follow up Five-Day Report to the Agency for Health care Administration. The Immediate Report should be submitted as soon as possible, but no later than 24 hours of discovery of the incident. If the events that cause the allegation involve abuse or result in serious bodily injury, they must be reported within two hours after the allegation is made. An interview was conducted on 10/16/20 at approximately 11:00 p.m. with the Nursing Home Administrator (NHA), she confirmed that she was the Abuse Coordinator. She stated that she had gotten a call last night (10/15/20) from her corporate person that handled the facility compliance line and that she had stated that a resident, Resident #7, had contacted the compliance line. The NHA stated, yesterday evening, .I went home and then I got the call from corporate representative about the allegation that Resident #1 had been thrown into bed by an aid.

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Department of Children & Families was called on 10/15/20. On 10/17/20 at 12:06 a.m., the interview with the NHA was continued regarding Resident #1's abuse allegation. The NHA was asked what time the event happened with Resident #1. She reported that she did not know, that the Social Service Director (SSD) was conducting the investigation. She reported she did not know how the nurse was over the hall that Resident #1 was in. She reported that they were still investigating. She was asked if Staff C, CNA, reported the event to the nurse. The NHA stated, I do not have knowledge of that yet. The NHA provided a written statement from Staff C, CNA: A review of Staff C, CNA's witness statement, dated, 10/16/20, event: Wednesday night (10/14/20) as I was putting (Resident #1) to bed and I was putting him to bed and as we walked to the bed, my foot got caught up under the wheel chair while head to the bed and we both fell in the bed and I apologized several times but, (Resident #7) wasn't standing by the door and (roommate) was in the room as well when putting him to bed. The NHA was asked what time she had received Staff C's written statement. She stated that she got it around 4:30 p.m. (date of survey, 10/16/20). The NHA confirmed that the event was still under investigation, that other residents had to be interviewed and other staff members needed to be interviewed. On 10/25/20, the AHCA Complaint Administration Unit (CAU) was contacted and it was confirmed that the facility had not filed an Immediate Report for the allegation of abuse pertaining to Resident #1 that the Nursing Home Administrator became aware of on the night of 10/15/20.
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, record review and interviews, the facility failed to timely respond to an allegation of abuse and provide protection of the resident by not immediately removing a care giver (Staff C), Certified Nursing Assistant whom was alleged to have thrown a resident in bed, while the abuse investigation was in process for 1 (#1) of 7 sampled residents. Findings include: On 10/16/20 at 6:31 p.m., an interview and observation was conducted of Staff C, Certified Nursing Assistant (CNA). She stated that she was Agency, that she had worked at the facility about 5 times. She stated that she was working 3 p.m. - 11 p.m., that she worked various shifts., and she stated her assignment which was located in the hall where Resident #1 resided in. A review of the facility abuse log for the period of 06/01/20 thru the date of survey, 10/16/20, the October log reflected an entry for Resident #1, date of incident was documented to be 10/15/20. An interview was conducted on 10/16/20 at approximately 11:00 p.m. with the Nursing Home Administrator (NHA), she confirmed that she was the Abuse Coordinator. She stated that she had gotten a call last night (10/15/20) from her corporate person that handled the facility compliance line and that she had stated that a resident, Resident #7, had contacted the compliance line. The NHA stated, yesterday evening, .I went home and then I got the call from corporate representative about the allegation that Resident #1 had been thrown into bed by an aid. Department of Children & Families was called on 10/15/20. On 10/17/20 at 12:06 a.m., the interview with the NHA was continued regarding Resident #1's abuse allegation. The NHA was asked what time the event happened with Resident #1. She reported that she did not know, that the Social Service Director (SSD) was conducting the investigation. She reported she did not know how the nurse was over the hall that Resident #1 was in. She reported that they were still investigating. She was asked if Staff C, CNA, reported the event to the nurse. The NHA stated, I do not have knowledge of that yet. The NHA provided a written statement from Staff C, CNA. A review of Staff C, CNA's witness statement, dated, 10/16/20, event: Wednesday night (10/14/20) as I was putting (Resident #1) to bed and I was putting him to bed and as we walked to the bed, my foot got caught up under the wheel chair while head to the bed and we both fell in the bed and I apologized several times but, (Resident #7) wasn't standing by the door and (roommate) was in the room as well when putting him to bed. The NHA was asked what time she had received Staff C's written statement. She stated that she got it around 4:30 p.m. (date of survey, 10/16/20). The NHA confirmed that the event was still under investigation, that other residents had to be interviewed and other staff members needed to be interviewed. The NHA was asked, have you suspended anyone yet? I have not, no. Staff C is an Agency CNA. A review of the facility policy and procedure, Resident Mistreatment, Neglect and Abuse Prohibition Guidelines, RM/QAA manual 2019 Version 1.0-August 2018, documented the Purpose: The facility is committed to protecting the physical and emotional well-being and personal possessions of every resident. Each facility has systems, procedures and a program of employee training and supervision in place to foster dignified treatment, respect and [MEDICATION NAME] for residents. Any form of mistreatment of [REDACTED]. All allegations of abuse, neglect, injuries of unknown origin and misappropriation or mistreatment of [REDACTED]. In the Guidelines, the Protection: To protect residents and employees from harm or retribution during an investigation each facility should ensure that: Measures are promptly taken to remove any resident from immediate harm or danger as indicated; Staff member9s) believed to be involved may be suspended pending the outcome of an investigation . On 10/19/20 at 3:08 p.m., the NHA sent an e-mail which included the statement, the agency staff member has been suspended from the facility pending investigation and the agency has been informed.
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, record review and interviews, the facility failed to ensure that it provided support services of two + persons for transfer assistance to prevent accidents for 1 (#1) of 7 sampled residents. Findings include: A review of Resident #1's Minimum Data Set (MDS) documented an entry of 06/07/20, and discharge of 06/24/20. Further review of the MDS listed an entry (readmission) of 08/27/20, with no discharge date listed. The MDS assessment, Section G Functional Status - Functional Status, (B) Transfer-How resident moves between surfaces including to or from bed, chair, wheelchair, standing position (excludes to/from bath/toilet.) The resident was coded as a 3 for Support, which meant, Two Person Physical assist. An observation was conducted on 10/16/20 at 5:53 p.m. of Resident #1's room. An observation of a Hospice RN (Registered Nurse) in the room with Resident #1, who was sitting in a w/c having a conversation with Resident #1. At 5:55 p.m., an interview was conducted with a Hospice (RN). He stated that Resident #1 was alert and oriented. That the resident had physical decline, weight loss, difficulty swallowing, no ability to do his own ADLs. He stated that ., he had had recent decline. He stated that the resident could be interviewed, that his speech was slurred, but, able to communicate. A review of Resident #1's clinical chart, the Admission Record, documented initial admission of 06/07/20 with a readmission of 08/27/20. Resident #1's [DIAGNOSES REDACTED]. A review of Resident t#1's Care Plan, documented a Focus area: Resident #1 is at risk for falls and/or fall related injury r/t: DX (diagnosis) ALS, generalized weakness, impaired balance, unsteady gait, has poor safety awareness, receives [MEDICAL CONDITION] meds, initiated 06/23/20. The Goal of the plan: Resident #1 will minimize risk of falls with staff intervention thru the next review date. The interventions included: Supervise during transfers and ambulation for unsteady gait, impaired balance assist as needed, initiated 06/23/20. In addition, the interventions listed a revision, dated 10/16/20, which included: Mechanical lift for all transfers, by 2 staff. An interview was conducted on 10/16/20 at approximately 11:00 p.m. with the Nursing Home Administrator (NHA), she confirmed that she was the Abuse Coordinator. She stated that she had gotten a call last night (10/15/20) from her corporate person that handled the facility compliance line and that she had stated that a resident, Resident #7, had contacted the compliance line. The NHA stated, yesterday evening, .I went home and then I got the call from corporate representative about the allegation that Resident #1 had been thrown into bed by an aid. Department of Children & Families was called on 10/15/20. On 10/17/20 at 12:06 a.m., the interview with the NHA was continued regarding Resident #1's abuse allegation. The NHA was asked what time the event happened with Resident #1. She reported that she did not know, that the Social Service Director (SSD) was conducting the investigation. She reported she did not know how the nurse was over the hall that Resident #1 was in. She reported that they were still investigating. She was asked if Staff C, CNA, reported the event to the nurse. The NHA stated, I do not have knowledge of that yet. The NHA provided a written statement from Staff C, CNA: A review of Staff C, CNA's witness statement, dated, 10/16/20, event: Wednesday night(10/14/20) as I was putting (Resident #1) to bed and I was putting him to bed and as we walked to the bed, my foot got caught up under the wheel chair while head to the bed and we both fell in the bed and I apologized several times but, (Resident #7) wasn't standing by the door and (roommate) was in the room as well when putting him to bed. The NHA was asked what time she had received Staff C's written statement. She stated that she got it around 4:30 p.m. (date of survey, 10/16/20). The NHA confirmed that the event was still under investigation, that other residents had to be interviewed and other staff members needed to be interviewed. On 10/17/20 at 12:40 a.m., an interview conducted with the MDS Coordinator, a review of the MDS for Resident #1 and compared to the Care Plan. The MDS coordinator confirmed that the Mechanical lift intervention was initiated, 10/16/20. The MDS coordinator confirmed that the supervise during transfers and ambulation for

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) unsteady gait, impaired balance; assist as needed. was initiated on 06/23/20 for a care plan intervention with no update to the care plan until 10/16/20. The MDS coordinator reviewed the MDS information and confirmed that the resident was assessed as extensive 2 person assist in section G, as of 08/31/20. On 10/17/20 at 12:55 a.m., Staff D, Licensed Practical Nurse (LPN), was interviewed. She confirmed that she was familiar with Resident #1, that he had moved to the hall a couple weeks ago. She confirmed that she worked the 11 p.m. to 7 a.m. shift and that she was working the hall that Resident #1 resided on. She confirmed that she worked the night of Wednesday, 10/14/20. She was asked if Staff C, CNA, had reported to her that she (Staff C) had fell into the bed with Resident #1. She stated, no. Staff D, LPN, was asked if she expected the staff member to tell her. She said, she is supposed to. Why is she supposed to tell you? She stated, It is protocol, if someone has had an accident. Do you have access to the resident's care plan? No. Do you know how many persons are to transfer the resident? I do not know. On 10/17/20 at 1:00 a.m., Staff E, CNA, was interviewed, she confirmed that she was working 11 p.m.-7 a.m. and that she was assigned rooms that included Resident #1. When asked if she was familiar with Resident #1, she stated, (I) Have gotten to know him, talked to the other girls about him. He does not require much; mostly in bed during my shift. 11-7 always puts him to bed. Yes, (I) put him to bed. When you put him to bed, do you put him to bed by yourself? When I asked about him, they told me he could stand. And take a few steps. The first time I had him, his chair was far from the bed; I moved the chair closer to the bed, so that way it was pretty much a pivot; instead of trying to walk him. She confirmed that she transferred him by herself.