STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105749	A. BUILDING _____ B. WING _____	**10/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ABBEY REHABILITATION AND NURSING CENTER	**7101 DR MARTIN LUTHER KING JR ST N SAINT PETERSBURG, FL 33702**

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

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observations, interviews and record reviews the facility failed to ensure resident care areas were maintained in a clean, safe and sanitary manner as evidenced by the lack of housekeeping and laundry staff to maintain housekeeping and laundry services for a census of 112 residents, not ensuring the floors in the resident rooms and bathrooms and bedside tables in resident rooms were clean in 14 rooms (118, 116, 112, 111, 110, 107, 105, 102, 119, 123, 124, 125, 127 and 131) on one hall (100) of three halls, not ensuring resident linen and personal laundry were cleaned and stored in a sanitary manner, and returned to the residents in a timely manner for three halls (100, 200, 300) out of three halls. Findings included: During the initial tour of the facility on 10/13/20, beginning at 10:07 a.m. and ending with a tour of the laundry room at 12:45 p.m., there were no housekeeping staff observed cleaning resident rooms, resident care areas or in the halls cleaning high touch areas. During the initial tour of the facility and observation of resident rooms on the 100 hall (118, 116, 112, 111, 110, 107, 105, 102, 119, 123, 124, 125, 127 and 131) it was found the floors were covered with debris and were sticky when walked on. The tops of the bedside tables were sticky, and the bathroom floors were dirty with soiled areas, paper was on the floors and sticky brown areas in front of the sinks and in front of the toilets were observed. An interview was conducted on 10/13/2020 at 10:36 a.m., Resident #10 said, Look at this room. Look at my bathroom. Have you ever seen any place this filthy? Housekeeping might come in every couple of days and sweep and mop the high spots. An interview was conducted on 10/13/2020 at 11:08 a.m., Resident #10 said, Would you want to live in this room? It's filthy. They come in and pretend they are sweeping and mopping the rooms. They never wipe down anything. Touch this. Look how sticky the top of my table is. People can't live like this. An interview was conducted on 10/13/2020 at 10:21 a.m., Resident #20 said, They do not clean these rooms. Look at the floors. Can you get someone to clean our room and bathroom? An interview was conducted on 10/13/2020 at 10:47 a.m., Resident #18 said, The room is pretty dirty. Look at the dust on the floor under my bed. There is three of us in this room and that is hard enough, but to live in filth like this makes it harder. An interview was conducted on 10/13/2020 and the Nursing Home Administrator (NHA) said, I think we have three housekeepers here today. A review of the Housekeeping and Laundry Employee Roster with the NHA had names of staff working in the facility (10/13/2020) highlighted in yellow. The roster documented that only one housekeeper was working on the floors cleaning resident rooms. The NHA reviewed the list and said, Yes, she is the only one on the floors with a cart. The other two are floor techs. I had a housekeeper walk off the job last week. The census on 10/13/2020 was confirmed to be 112 residents. A tour of the 200 and 300 halls (located in a separate building from the 100's) was conducted on 10/13/2020 at 12:30 p.m., with the NHA. The elevator that connected the 2nd floor to the third floor was observed and the grate of the elevator had dark sticky debris, paper and crumbs. The NHA said, Oh, your right that does need to be cleaned. The tour continued on the 200 and 300 halls with the NHA and dirt and debris on the floors in the resident rooms and out in the hallways was observed. There was a resident on the secured unit (300 hall) stooped over in the hall across from the elevator picking up little pieces of paper and debris up off the floor. The NHA walked over to the resident and said, You don't have to do that. I will take that paper and put it in the trash. A tour of the laundry room was conducted on 10/13/2020 at 12:14 p.m., two rolling linen carts stacked to approximately six to seven feet high with resident clothing were observed. An interview was conducted with Staff C, Laundry Aide who said, I am (age) years old and had to come back to work. I am doing the best I can. It's mostly me back here. Sometimes I will have another person here for a few hours. Another person was supposed to be here today, but she did not show up. It will take four to five more people for us to get this caught up. Some of the residents are complaining that it takes over two weeks to get their clothes cleaned. We may even need to re-wash some of this because it has been sitting stacked up like that for days. In addition, a review of the Laundry Lint Trap Cleaning Log revealed no documentation of cleaning for 10/08/2020 through 10/12/2020. A review of the Housekeeping and Laundry Employee Roster, with names of staff working in the facility highlighted in yellow, documented both laundry aides as working. The second name on the highlighted list did not report to work. An interview was conducted on 10/13/2020 at 11:08 a.m., Resident #10 said, I have not had any clean clothes in over two weeks. They have had the laundry staff doing the housekeeping around here. Hard to tell right? I had to order more clothes today. I have complained and nothing ever happens. They listen, but they never get back with us. An interview was conducted on 10/13/2020 at 12:43 p.m., the NHA said, I was not aware of how dirty the resident rooms were. We are trying to get a new contract in place for our housekeeping services. We have not had a Director of Environment or Laundry for the past month.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and policy reviews the facility failed to ensure respiratory equipment was maintained in a sanitary manner in accordance with professional standards of practice for four residents (#1, #8, #9, #19) out of 22 residents receiving respiratory treatments. Findings included: A review of the facility policy titled, Disposable Equipment Change Schedule, with a date of May 2020 from the Respiratory Practice Manual, documented under Policy: The facility requires that respiratory supplies are routinely changed or cleaned in order to prevent nosocomial infections. The approved facility frequency is outlined below. Procedure: 1. O2 (oxygen) delivery devices (non-aerosol producing)-for example, (name brand) masks, nasal cannulas, oxygen supply tubings-weekly and PRN (as needed). u. Medication/ nebulizer storage bags-with nebulizer set-up changes. 2. Date all disposable supplies upon opening. An observation was conducted on 10/13/2020 at 10:08 a.m., in Resident #1's room the resident's nebulizer mask was sitting on the top of the nightstand next to the resident's bed. There was not a plastic storage bag for the respiratory equipment in the room. On the back of Resident #1's wheelchair was a small oxygen tank and the tubing and nasal cannula were lying across the seat of the wheelchair onto the floor. (Photographic Evidence Obtained) An interview was conducted on 10/13/2020 at 10:08 a.m. and Resident #1 said, Yes, that's my machine. They just forgot to put my oxygen tubing in a bag. No, I do not see a bag. Resident #1 confirmed the respiratory equipment observed had been there from the night before when they put him in bed and changed over from the E-tank to the concentrator. An interview was conducted on 10/13/2020 at 10:12 a.m., Staff D, Nurse said, Yes, all respiratory is supposed to be in a plastic bag when it is not in use. I will go take a look at (Resident #1). A review of the medical record for Resident #1 reflected a [DIAGNOSES REDACTED]. An observation was conducted on 10/13/2020 at 10:30 a.m., Resident #8's oxygen tubing was lying out uncovered across the top of the oxygen concentrator that was on the floor next to the resident's bed. There was not a plastic storage bag attached to the oxygen concentrator or to the nightside stand. An interview was conducted on 10/13/2020 at 10:31 a.m., Staff D, Nurse said, Yes, I see the oxygen tubing on the concentrator. I will take care of it. A review of the medical record for Resident #8 documents shortness of breath and a history of [MEDICAL CONDITION]. An observation was conducted on 10/13/2020 at 10:32 a.m., Resident # 9's nebulizer mask was

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 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) sitting on the top of the nightstand next to the resident's bed. There was not a plastic storage bag for the respiratory equipment in the room. A review of the medical record for Resident #9 reflected a current physician order for [REDACTED].#19's nebulizer mask was sitting on the top of the nightstand next to the resident's bed. There was not a plastic storage bag for the respiratory equipment in the room. Resident #19 confirmed the respiratory equipment observed had been there from the night before. An interview was conducted on 10/13/2020 at approximately 11:15 a.m., Staff E, Certified Nursing Assistant (CNA) said, Yes, when the patient finishes a treatment the nurse is supposed to clean it out and put it in the plastic bag. A review of the medical record for Resident #19 reflected a current [DIAGNOSES REDACTED]. An interview was conducted on 10/13/2020 at approximately 2:30 p.m., the photographic evidence was reviewed with the NHA and the DON who confirmed the findings. They stated that staff know when a resident completes a breathing treatment, the equipment is to be cleaned and dried and placed in the plastic bag at bedside.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation of the main kitchen, review of logs, and interviews with dietary staff, the facility failed to store, prepare, distribute and serve food in accordance with professional standars for food service safety that had the potential to affect 104 out of 112 residents. The facility failed to ensurie the kitchen and cooking equipment were maintained in a clean and sanitary manner related to: the dish washing machine not reaching the required temperatures, sanitization logs not being completed, soiled walls and floors throughout the kitchen and behind cooking equipment; soiled can opener; soiled range, soiled meal carts; chemical cleaners stored on food preparation tables, dirty vents and ceiling fan. The facility failed to label and date frozen foods items and the dietary staff failed to perform hand hygiene or wear gloves when touching meal trays and silverware. Findings included: During a tour of the main kitchen, conducted on 10/13/2020 beginning at 11:19 a.m. with the Dietary Manager and the Dietician the following was observed and confirmed: 1. Upon entering the walk-in freezer, which was located outside of the building, the plastic vinyl strip curtains were noted with a brown sticky substance. The floor had debris noted to include a dried shrimp shell as identified by the Dietary Manager who said, Someone must have carried that in on the bottom of their shoes. 2. A package of frozen green peas and frozen chopped carrots were in the walk-in freezer in a package that had been opened without a date. The Dietary Manager was observed with an opened an undated bag of chicken strips. The Dietary Manager confirmed there was no date and said, Yes, all of these bags should have a date on them. (Photographic Evidence Obtained). 3. An observation at 11:29 a.m. revealed the pot sink sanitization area with clean pots stored at the end on a rack. The pot sink sanitization record had not been filled out for the breakfast meal on 10/13/2020. (Photographic Evidence Obtained). 4. The Dietary Manager, at approximately 11:31 a.m. on 10/13/2020 stated the dish washing machine was a low temperature dish machine with a minimum wash and rinse temperature of 120 degrees Fahrenheit (F) and a required range of sanitizer between 50 and 100 ppm. The temperature log was reviewed and for 10/13/2020 a wash temperature of 120 and a rinse temperature of 128 was documented. There was no documentation of the required sanitization range. Staff A, Dietary Aide started a wash cycle and the temperature gauge showed a reading of 109 (F) and a rinse temperature of 118 (F). The Dietary Manager said, You have to run the low temperature dishwasher through at least two cycles and then the temperatures will be correct. Staff A, Dietary Aide, with the assistance of the Dietary Manager, ran a second cycle through the dish machine and the gauge registered for the wash cycle at 109 (F) and the rinse cycle was at 118 (F). The Dietary Manager said, Sometimes the gauge just sticks. This is the first time that I am aware of that, the dish machine has not reached the required temperatures. Staff A, Dietary Aide said, It has been broken before the Dietary Manger got here. The Dietary Manager was then asked to get a thermometer and to calibrate it so the wash and rinse temperatures could be checked. The Dietary Manager said, The thermometer needs to be calibrated to 32 degrees to gauge it. The Dietary Manager put the thermometer in ice water until the temperature on the thermometer registered approximately 32 degrees. The Dietary Manager placed the thermometer inside the dish machine and started the wash cycle. The thermometer for the wash cycle registered at 119 (F). The Dietary Manger checked the temperature of the rinse cycle and it registered at only109 (F). The Dietary Manager was not sure when the dish machine was last serviced and stated they would use disposable service items for the lunch service. 5. On 10/13/2020 beginning at 11:44 a.m., the lunch service line was observed, and temperatures were being checked by Staff B, Dietary Tech (DT). Staff B, DT was observed temping the foods on the lunch service line without gloves on. The Dietary Manager said, Yes, he should have on gloves. Staff B, DT then put on gloves without performing hand hygiene. Staff B, DT calibrated the digital thermometer and monitored the temperature of an 8-ounce carton of milk, that was in a large bin full of 8-ounce cartons of milk and ice cubes packed around the cartons. At that time, Staff B reported that the milk is kept in the refrigerator until the tray line begins, then ice is added to the bin to cover the milk and the cart with the milk is brought out to the tray line. The milk was noted to have a temperature of 46 degrees F and the second carton of milk tested was at 49 degrees F. 6. There was a small fan observed suspended from the ceiling near the stove and the food preparation and service line. It had large gray and black fluffy debris noted on the fan blades. The fan was noted to be in operation. (Photographic Evidence Obtained) 7. An observation above the range and food preparation table revealed a large bulging area in the ceiling with a vent with black residue on the louvers. 8. A large white drain next to the range was observed with several large pieces of dark debris and other unknown objects in the drain. (Photographic Evidence Obtained) 9. Behind the range, on the wall, were dried dark stains down to the floor baseboard and were sticky to the touch. 10. On the range, was a large brown crusty spill near one of the burners. There were crumbs and dark sticky debris splattered all over the burners on the range top. The Dietary Manager said, That must be from where she cooked eggs this morning. Yes, we have cooked lunch since then and it should have been cleaned after breakfast. 11. The pincer on the table mounted can opener was soiled with a black - brown sticky residue. The Dietary Manager said, I brought in a new one. I don't know why it has not been put on. 12. On the food preparation table, sitting next to the toaster, was a red bucket with dirty brown liquid and a white rag with brown stains submerged in the brown liquid. (Photographic Evidence Obtained) 13. A second red bucket of liquid with a brown stained white rag was observed sitting on the tray line near the pureed foods. The Dietary Manager said, That is cleaner in the red bucket. It should not be up on the prep tables like that. 14. Behind the food tray line a metal cart with several shelves on it that contained trays and hot plate covers was observed. On the top shelf, were eight three ring binders. (Photographic Evidence Obtained) 15. Behind the area where food trays were being prepped were three metal dietary carts that per the Dietary Manger would be loaded with resident meal trays and taken to the floor for lunch. The outside of the three metal carts had dried sticky residue and dried liquid run marks cascading down the sides of each cart as well as crumbs and a dried sticky substance on the bottom rim of the carts. The Dietary Manager said, The carts are to be cleaned after each meal. I will get them cleaned. (Photographic Evidence Obtained) 16. The ice maker in the kitchen when the lid was opened had a white dried substance on the lid, the side that closes up against the ice. The Dietary Manager at the end of the tour on 10/13/2020 said, We have our work cut out for us. An interview was conducted on 10/13/2020 at 1:18 p.m., the Nursing Home Administrator reviewed the photographic evidence and confirmed the findings. We know we have work to do in the kitchen. We will get it cleaned up.
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to make sure call lights were able to be within residents' reach in nine rooms (102A, 105A, 108B, 110B, 118B, 131C, 133 B, 301A and 301B) rooms out of 11 sampled rooms, and failed to ensure call lights were functioning correctly for residents in two rooms (134 and 208B) and one shower room on one hall (100) out of three halls. Findings included: A tour of the facility was conducted on 10/13/2020 at 10:07 a.m., the call lights in the following resident rooms revealed the pull strings/cords were to short and as a result the call lights could not be positioned within the residents' reach: Resident room [ROOM NUMBER] A Resident room [ROOM NUMBER] A Resident room [ROOM NUMBER] B Resident room [ROOM NUMBER] B Resident room [ROOM NUMBER] B Resident room [ROOM NUMBER]C Resident room [ROOM NUMBER] B Resident room [ROOM NUMBER] A Resident room [ROOM NUMBER] B An observation was conducted on 10/13/2020 at 10:24 a.m., Resident #5 was up sitting in his wheelchair by his bed. The call light was not within the

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F 0919 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) resident's reach. The red cord coming from the switch on the wall above the resident's bed was too short to even place within the resident's reach. An interview was conducted on 10/13/2020 at 10:26 a.m., Resident #6, pointed to the emergency switch on the wall with a red cord coming from it and said, Yes, that is what we use for our call lights. I guess they are the old kind. Half the time they don't work. An observation was conducted on 10/13/2020 at 10:30 a.m., Resident #8 was in bed and the red call light string connected to the wall unit was too short to position it where the resident could reach it. Random call light checks were conducted on 10/13/2020: The shared resident shower room between rooms [ROOM NUMBERS] was observed to have the call light cord in the bathroom too short to be pulled in case of an emergency. In resident rooms [ROOM NUMBERS]B, the call light pressure pad, when pressed, would not turn of the call light outside of the residents' room to alert nursing staff that the resident in the room needed assistance. In resident room [ROOM NUMBER] B the call push button would not turn on the call light outside of the resident's nurse to alert staff that the resident in the room needed assistance. An interview was conducted on 10/13/2020 at 1:10 p.m., with the Maintenance Director. The Maintenance Director said, We have the old school call light system. We are supposed to conduct random call light checks monthly. I will see if I have a copy of the last audit we did. The Maintenance Director confirmed there were no work orders received from the staff related to the cords being to short or call lights not functioning, The findings from the tour regarding the call lights were reviewed with the Maintenance Director. The Maintenance Director provided a copy of the call light system audit dated 10/13/2020 at 4:24 p.m., that confirmed the findings. The Nursing Home Administrator stated she was aware of the problems with the call lights and that the Maintenance Director is fixing them now. The NHA said, The Maintenance Director just hired someone to help him last week. A review of the facility policy provided by the Nursing Home Administrator titled, Resident Rights Education and Staff Acknowledgement, with a date of November 2013, documented under 2. To receive care, and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations. Each resident must receive all care and services described in the rules for that type of facility. This includes but is not limited to supervision and assistance in caring for basic personal needs, appropriate response in case of emergencies, medication management, adequate furnishings, and activities program, and assistance in arranging for health and mental health services.
F 0943 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.** Based on record review and interview the facility failed to ensure three direct care staff members (F, G and H) out of five direct care staff members had evidence of receiving training on abuse, neglect and exploitation upon hire or annually. Findings included: On 10/13/2020 a review of the employee files provided by the Human Resource Director revealed: Staff F, Certified Nursing Assistant (CNA), Date of Hire (DOH): 8/28/2019 - The employee file documented the last evidence of training on abuse, neglect, and misappropriation training was dated 6/18/2009. Staff G, CNA, DOH: 9/08/2019 - A review of the employee file revealed there was no evidence of training on abuse, neglect, and misappropriation, or proof of abuse training during orientation. Staff H, CNA DOH: 9/25/2020 - A review of the employee file revealed there was no evidence of training on abuse, neglect and misappropriation, or proof of abuse training during orientation. An interview was conducted on 10/13/2020 at 2:38 p.m., the Director of Human Resources said, I provided you with the documents that I had. A review of the facility policy titled, Abuse, Neglect and Misappropriation, with a revised date of March 2019, revealed: Procedure: The facility strives to reduce the risk of resident abuse, neglect and misappropriation. This applies to abuse/neglect/misappropriation whether penetrated by an employee, another resident, a family member or other visitor(s) . Procedure: Training: New employees are educated during orientation and, at a minimum, annually .