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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRIN	TED:	07/28/2014	
FC	DRM	APPROVED	
OMB	NO.	0938-0391	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		105772	B. WING _		R 03/20/2014
	ROVIDER OR SUPPLIER	PETE		STREET ADDRESS, CITY, STATE, ZIP COI 435 42ND AVE S SAINT PETERSBURG, FL 33705	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLÉTION DATE
{F 000}	INITIAL COMMENTS	3	{F 0	00}	
	SKILLED NURSING	FACILITY			
	March 17 - March 20), 2014			
		Immediate Jeopardy were /S: J AND F520 S/S: J.			
		dentified at the Annual QIS substantial compliance:			
	A partial extended st 3/20/14.	urvey was completed on			
		as informed of the on-going on 3/20/14 at 6: 55 p.m.			
	in compliance with 4	enter of St. Petersburg is not 2 CFR Part 483 ong Term Care Facilities.			
	The facility has not be compliance since 2/	10/2014.			4/40/44
F 278 SS=D		SSMENT DINATION/CERTIFIED	F	DEFENDAN	4/19/14
	The assessment muresident's status.	ist accurately reflect the		EXHIBIT	
	A registered nurse neach assessment w			898	
LABORATORY	DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIVE'S SIGNATU	RE	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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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		105772	B. WING				? 20/2014
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIF 435 42ND AVE S SAINT PETERSBURG, FL 337		03/	20/2014
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIA		(X5) COMPLETION DATE
F 278	Continued From pa	age 1	F:	278			
	A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.						
	willfully and knowin false statement in a subject to a civil mo \$1,000 for each as willfully and knowin to certify a material resident assessme	and Medicaid, an individual who agly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who agly causes another individual and false statement in a nt is subject to a civil money e than \$5,000 for each					
	Clinical disagreeme material and false s	ent does not constitute a statement.					
	by: Based on observa interview, the facilit assessment inform habits were accura resident's to reflec evidenced by 3 trai during 01/14 and 0 shortness of breath Findings include: A review of Reside documented an originate	NT is not met as evidenced tion, record review and by failed to ensure that current ation regarding smoking te for 1 (#20) of 9 sampled t a decline in health as asfers to a higher level of care 2/14 regarding concerns of and COPD. Int #20's clinical record ginal date of admission of d female with diagnoses that					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
		105772	B. WING _			R 03/20/2014
	ROVIDER OR SUPPLIER	PETE		STREET ADDRESS, CITY, STATE, ZIP O 435 42ND AVE S SAINT PETERSBURG, FL 33708		00/20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIAT	
F 278	and foot, personal his pneumonia/recurrent failure, depressive dibehavioral disturbance diabetes, insomnia, chypertension, unspecesophageal reflux. A review of Resident revealed a transfer for was confirmed with E9:26 a.m., 03/20/14). 11 p.m. to 7 a.m. number of the factor of the facility was conflored in the facility was conflored i	walking, pain in joint, ankle story of anemia, congestive heart sorder, dementia with bees, polyneuropathy in chronic airway obstruction, bified psychosis and #20 's clinical chart form, dated 02/23/14. (Date Director of Nursing (DON) at The form was signed by the se, the current Medical transfer): SOB (Shortness of an telephone order, dated for an telephone order, dated for an elephone order, dated for a hospital) to evaluate diagnosis shortness of the spital history and physical, and for a hospital admission of leasant 56 year oldwho of from her skilled nursing worsening shortness of does have a longstanding PD with ongoing tobacco.	F 2	278		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1		INSTRUCTION	(X3) DATE COMP	SURVEY
						l r	R
		105772	B. WING			03/	20/2014
	ROVIDER OR SUPPLIER TATION CENTER OF ST	PETE		435 4	EET ADDRESS, CITY, STATE, ZIP CODE B2ND AVE S NT PETERSBURG, FL 33705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F 278	A review of the 01/22 (MDS) Quarterly Review Section J300 that ask of "Current Tobacco blank. A review of the 02/10 for Resident #20, sequestion of the status found this area was large and the status found this area was large and particular for the status found this area was large and proceed facility. The smoking southwest side of the observation, no staff Resident #20 was obpatio in possession of lighter. The resident cigarette and proceed A Review of a facility Awareness" form, da Activity Director, reversident #20 was to attendant for safety. The resident #20 was to attendant for safety revealed no docume resident's current diatthat could have a beduring the smoking a reviewed and found services provided by by nursing staff in su supervision by nursing staff in su supervision by nursing staff.	the outside smoking patio. 2/14 Minimum Data Set view for Resident #20, ked the question of the status Use" found this area was 2/14 MDS Discharge Data set ction J300 that asked the sof "Current Tobacco Use" blank. 2/14 MDS Discharge Data set ction J300 that asked the sof "Current Tobacco Use" blank. 2/14 MDS Discharge Data set ction J300 that asked the sof "Current Tobacco Use" blank. 2/15 Conducted on 03/17/14 at on the smoking patio of the gratio was located on the ebuilding. During the were present on the patio. Discrived to be present on the patio of a pack of cigarettes and a sewas observed to light a did to smoke. 2/15 Conducted on 03/17/14 at on the smoking patio of the patio was located on the ebuilding. During the were present on the patio. Discrived to be present on the patio. Discription of the eagled that the level of the pation of the pation. The form was further to have higher levels of a staff, such as "Supervised prevised group and 1:1	F	278			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		DNSTRUCTION	(X3) DATE COMP	SURVEY
		105772	B. WING _			1	R 2 0/2014
	ROVIDER OR SUPPLIER	PETE		435	EET ADDRESS, CITY, STATE, ZIP CODE 42ND AVE S NT PETERSBURG, FL 33705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	times to smoke 03/08/14 at 22:41 p.m oriented. Remained a from time to time. Pai 03/07/14 at 14:17 p.m has been referred for 03/04/14 at 14:09: WI B/L lungs receives ne hoursPRN oxycodo 03/04/14 at 2:47 a.m. throughout facility and 03/03/14 at 2:16 a.m. abt in progress for pn 02/16/14 at 2:31 a.m. downstairs to patio to During an interview of 10:58 a.m. with Staff p.m. shift nurse, she facility 3-4 days a wer #20 is a heavy smoke facility independently. CNA's will go down whout, that the resident smoking patio on her An interview conducted with the DON, she stafacility in 6/13 and has since that time. In recompletes the "Smole She further stated that the stated that th	g entries: a.: down to patio several a.:Patient alert and ambulatory. Goes to smoke in pill administered earlier. a.: Vision Care: Resident vision services. heezing noted throughout. be treatments prn every 4 one for pain control :Patient ambulates d smoke area at will. : down to patio to smoke, reumonia : up ambulating about unit, o smoke, back on unit." onducted on 03/20/14 at member E, the 11 p.m. to 3 stated that she works at the ek. She stated that Resident er who can ambulate thru the . She stated that she or the vith the resident on occasion; has gone down to the own. ed on 03/20/14 at 9:46 a.m. ated that she came to the s been in the DON position	F	278			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION NG	((X3) DATE COMP	SURVEY LETED
		105772	B. WING _				R 20/2014
	ROVIDER OR SUPPLIER	PETE		STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705			20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	DED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		OULD BE		(X5) COMPLETION DATE
	identified as a smoke nurses do complete a stated that the prior e assessment that wou nursing staff, and the Point click care electr assessment was received. The DON was asked Smoking assessment #20; she reviewed the resident at 9:51 a.m. there was not a nursing resident in the system was not in the electron the chart. The smoking provided was the 10/0 "Smoker Safety Awar completed by the Activaditional assessment agreed that the form a medical conditions of COPD and the shorten been experiencing. 483.60(b), (d), (e) DR LABEL/STORE DRUGOTHE DRUGOTHE DRUGOTHE CONTROLLE	nt is a smoker. They are r. She also indicated that the a smoking assessment. (She lectronic system had an ld be completed by the n the facility changed to a conic system the smoking ently added.) to provide the Nursing completed for Resident e electronic record for the con 03/20/14 and stated that ng assessment for the n; she stated that since it nic system, it should be in ng assessment that was 07/13 assessment, the eness" form that had been vities Director. No nt was provided. The DON did not capture the current the resident regarding the ness of breath that she had eUG RECORDS, GS & BIOLOGICALS loy or obtain the services of t who establishes a system	F 2	31}			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY
		105772	B. WING			1	R 20/2014
	ROVIDER OR SUPPLIER	PETE		STREET ADDRESS, CITY, STATE, ZIP C 435 42ND AVE S SAINT PETERSBURG, FL 33705		1 00/	20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		FION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
{F 431}	professional principle appropriate accessor instructions, and the applicable. In accordance with S facility must store all locked compartments controls, and permit chave access to the key to be acc	e with currently accepted es, and include the ry and cautionary expiration date when tate and Federal laws, the drugs and biologicals in sunder proper temperature only authorized personnel to	{F 4	31}			
	by: Based on observation review, the facility fail pharmaceutical integration biological's and medious medication Storage Floor) and 3 of 6 Mes Second Floor South, Finding Include: 1. On 3/17/2014 at 1 medication storage revealed 1 bottle of #Zinc expiration date of the second floor south, finding Include:	rity of time sensitive cations in two of three Rooms (First and Third dication Carts (First Floor 1, Third Floor North). 2:20 p.m. observation of com First floor unit 1 60 tablet of Advance Stress					

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		105772	B. WING				R 20/2014
	ROVIDER OR SUPPLIER TATION CENTER OF ST	L		4	STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705	1 03/	20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 431}	medication. 2. On 3/17/2014 at 1 medication storage rerevealed Novolog 100 per pharmacy label to opening. Two Insulin indicated on label of pStaff Interview with that 12:40 p.m. confirm syringe and stated shonce week on every \$\frac{1}{3}\$. On 3/18/14 at 10:4 medication cart on the Staff member C and Undated medications medications and resident # 72 1) Leopen date not indicate unit open date not indicate unit open date not indicated unit opening". Resident # 2 1) Hum date not indicated and "Discard after 28 day Resident # 20 1) Nov date not indicated and "Discard after 28 day 100 unit vial open date from pharmacy reads opening". Resident # 13 1) Nov date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No date not indicated and "Discard after 28 day Resident # 127 1) No	2:40 p.m. observation of the com of the Third floor of unit vial opened 1/19/2014 of discard 28 days after Flex-pens open date not open. e Unit manager on 3/17/14 ed expired medication and e checks the storage room whonday. 0 a.m. observation of a 3rd Floor North Team with Unit Manager revealed for the following dents. Evemir Insulin 100 unit vial, ed. 2) Novolog Insulin 100 dicated and label from scard 28 days after ulin R 100 units vial, opened label from pharmacy reads as of opening". olog Mix 70/30 vial, opened label from pharmacy reads as of opening". 2) Humulin R are not indicated and label " Discard after 28 days of olin R 100 unit vial, opened label from pharmacy reads as of opening". 2) Humulin R are not indicated and label " Discard after 28 days of olin R 100 unit vial, opened label from pharmacy reads as of opening".	{F 4	31}			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105772	B. WING				₹
NAME OF D	DOVIDED OD CUIDDUED	105772	B. WING _		TREET ARRESTO CITY CTATE 7/D CORE	03/	20/2014
	ROVIDER OR SUPPLIER TATION CENTER OF ST	PETE	435 42ND AVE S		STREET ADDRESS, CITY, STATE, ZIP CODE 135 42ND AVE S SAINT PETERSBURG, FL 33705		
040.15	CHMMADV CT	ATEMENT OF DEFICIENCIES	I.D.		, T		(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 431}	"Discard after 28 day Staff member C and 3 confirmed the vials of puncture marks in the various amounts of lic member C stated "I I write the date on the been used and should 4. 3/18/14 at 1:05 p.r. cart Second Floor No revealed the following One ipratropium brom inhaler solution 0.5 m not indicated and labe Discard after 7 days of Staff member I. 5. 3/18/14 observation Medication cart First with Staff member J rone Bottle of Lorazer Label from Pharmacy opening". "Discard after 3/13/2014 at 6:00 Medication left in the by nurse and stated "refrigerate it". At 1:45 the pharmacy the me 3/18/14 Interview with confirmed medication expired. She stated the responsible to monitor the carts, writh dispose of expired medication been in-serviced.	d label from pharmacy reads as of opening". 3rd Floor Unit Manager insulin had multiple to top rubber stopper with quid remaining in vials. Staff didn't open those because em. But your right they have dhave been dated. " m. observation of Medication with cart with Staff member Hag: and albuterol sulfate el from pharmacy reads by of opening". Confirmed by on at 12:42 p.m. of Floor cart I at 12:42 p.m. revealed the following: coam 0.5 ml. 30 ml dispense of reads "Refrigerate after the 90 days." First date of 0 a.m. 29 ml remaining. The medication cart confirmed I didn't even know it said to 5 p.m. the nurse stated per dication was still viable.	{F 4				
{F 441}	403.00 INFECTION (JONI ROL, FREVENI	F 4	+ 1}			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION			PLETED
		105772	B. WING _				R 20/2014
	ROVIDER OR SUPPLIER	PETE		STREET ADDRESS, CITY, STATE, ZIP CO 435 42ND AVE S SAINT PETERSBURG, FL 33705		, 50.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BI		(X5) COMPLETION DATE
{F 441} SS=D	The facility must esta Infection Control Propagate, sanitary and co to help prevent the doof disease and infect (a) Infection Control I The facility must esta Program under which (1) Investigates, continuinthe facility; (2) Decides what proshould be applied to (3) Maintains a reconactions related to infection determines that a respreyent the spread of isolate the resident. (2) The facility must promunicable disease from direct contact will train (3) The facility must in hands after each direct hand washing is indice professional practice (c) Linens Personnel must hands	ablish and maintain an gram designed to provide a mfortable environment and evelopment and transmission ion. Program ablish an Infection Control in it - irols, and prevents infections cedures, such as isolation, an individual resident; and dof incidents and corrective ections. d of Infection in Control Program is ident needs isolation to finfection, the facility must prohibit employees with a see or infected skin lesions ith residents or their food, if insmit the disease. It is require staff to wash their is ect resident contact for which cated by accepted	{F 4-4	41}			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		105772	B. WING				⋜ 20/2014
	ROVIDER OR SUPPLIER	PETE	•	435	EET ADDRESS, CITY, STATE, ZIP CODE 42ND AVE S NT PETERSBURG, FL 33705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 441}	by: Based on observation and review of the fact Washing, facility staff after each direct care hand washing is indice professional practice to wash their hands a five resident observa # 14), The facility's considents. The findings included 1. The facility admitted with diagnoses included with diagnoses included Rheumatoid Arthritis, Cachexia, according information. Review of the Quarted 2/6/14 revealed the reher Brief Interview for cognitive impairment during the assessme was coded as requiring ADLs. The resident with incontinent. During an observation care for Resident #10 Employee A (CNA) keentered the room. Si washed her hands. Si care to the resident, and provided incontinent.	ons, record review, interview ility 's policy on Hand failed to wash their hands resident contact for which cated by accepted. Employees A and B failed after direct care for two of tions (Resident 's #104 and current census was 151. d: dd Resident # 104 on 4/30/09 ding Hypertension, Enteritis, Contractures, Anemia and to facesheet/demographic erly Minimum Data Set dated esident scored a 15/15 on remember Mental Status indicating no and total staff dependence for	{F 4	.41}			

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Doc 42-2 Filed 08/26/14 Page 12 of 84 PRINTED: 07/28/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 105772 B. WING 03/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S REHABILITATION CENTER OF ST PETE SAINT PETERSBURG, FL 33705 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {F 441} Continued From page 11 {F 441} touch the resident's bare skin. Upon completion the aide removed her gloves, gathered her soiled linen and trash and tied the bags. She then emptied the water basins and stated that there were no paper towels and exited the room. She walked to the soiled utility room and used a key that was on a lanyard around her neck to open the door. She then exited that room and walked down the hallway to the soiled linen room and deposited the linen in a barrel. She then washed her hands. During an observation of wound care for Resident #104 on 3/18/14 at 9:55 AM the treatment nurse, Employee C (LPN) washed her hands and donned gloves. She cleansed the wound and patted it dry. The wound was noted to be an irregularly shaped open wound. There was no evidence of a current fungal infection; however the surrounding skin was de-pigmented. Minor sero-sanguinous drainage was noted with no odor. The nurse washed her hands and donned clean gloves. She applied the alginate treatment and an island dressing. She then removed her gloves and gathered the trash. She exited the room and walking down the hallway, put her right hand in her right pocket and pulled out keys. She then opened the linen room door and put the keys back in her pocket. She exited the room and walked back to her cart, opened her cart and sanitized her hands. Review of the Non-Pressure Wound Assessment

dated 3/14/14 revealed the resident had a right perianal area that measured 2 x 0.5 x 0.4 cm with light serous drainage noted. 20% fibrin tissue, 50% granulating tissue and 30% stable skin. The wound was stable. The wound was not present

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		105772	B. WING				⋜ 20/2014
	ROVIDER OR SUPPLIER	РЕТЕ	•	STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 441}	2014) to the Right Pe wound and apply Silv wound daily. 2. The facility admitted with diagnoses included Failure, Dementia, Ald Hemiplegia, Hyperter according the faceshed information. Review of the Wound 3/12/14 the right anklown stage IV Pressured The current physiciant Santyl QD. She had During an observation # 14 on 3/18/14 at 10 washed her hands, do the old dressing. The yellow in color with mesero-sanguinous drain The Nurse stated the She washed her hands he applied Santyl oid dressing. She then removed her gloves a exited the room and we she pulled a key from opened soiled utility in was observed in the sexited the soiled utility of the pulled a key from opened soiled utility in was observed in the sexited the soiled utility of the sexited the sexited the soiled utility of the sexited the s	t physician's order (March, prineal Area was cleanse the per Calcium Alginate to the defer Calci	{F 4	41}	DEPIGIENCY		
	3. During an interview	v on 3/18/14 at 4:03 PM					

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FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 105772 B. WING 03/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S REHABILITATION CENTER OF ST PETE SAINT PETERSBURG, FL 33705 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {F 441} Continued From page 13 {F 441} Employee B confirmed she did wash her hands after finishing the treatments for Resident #104 and Resident # 14. She stated that she sanitized her hands after she went to two soiled utility rooms to dispose of the trash bags. She confirmed that she reached in her pocket for the keys and did not wash her hands before exiting the resident's room. The nurse stated that she was aware she was supposed to wash her hands before exiting the room. 4. Review of the facility's policy entitled Hand Washing/Hand Hygiene revised 2006 revealed under Policy Interpretation and Implementation item 2. " Employees must wash their hands for 10 to fifteen seconds using antimicrobial or non-antimicrobial soap and under the following condition: a. when hands are visibly dirty or soiled with blood or other body fluids; b. after contact with blood, body fluids, secretions, mucous membranes or non-intact skin; c. after handling items potentially contaminated with blood, body fluids or secretions; and d. before eating and after using a restroom." Item 4. "The use of gloves does not replace hand washing/hand hygiene. " Under the section of General Guidelines, item 4. " If hands are not visibly soiled, use an alcohol based hand rub for all of the following situations: a. before direct contact with residents ...d. before preparing or handling medications. e. before handling clean or soiled dressings, gauze etc. f. before moving from a contaminated body site to a clean body site during resident care; q. after contact with a resident 's intact skin; h. after handling used dressings, contaminated equipment after removing gloves. " 5. During an interview on 3/18/14 at 5:10 PM the

Director of Nurses was informed of the treatment

DEPARTI		D HUMAN SERVICES	JUC 42-2		nieu 08/20/14 Page 15 01 84		D: 07/28/2014 MAPPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES					D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		PLETED
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		105772	B. WING			03/	/20/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REHABILI	TATION CENTER OF ST	РЕТЕ			35 42ND AVE S SAINT PETERSBURG, FL 33705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 441}	Continued From page		{F 4	41}			
(F. 400)	related to hand washi expected her nurses t removing their gloves resident rooms.	aks in infection control ng. She stated that she o wash her hands after and before exiting the	(5.4)	001			
{F 490} SS=J		ESIDENT WELL-BEING	{F 4	.90}			
	enables it to use its re efficiently to attain or	mental, and psychosocial					
	by: Based on review of the description, resident record review, and the procedures related to administration failed to policies related to abus sampled residents (#1 of whom was a known investigate and report abuse to the abuse he failed to provide emo psychosocial services	o operationalize facility use for three of nine 1, #11 and #225), one (#1) o sexual offender; failed to an allegation of sexual offine and state agency and tional support and to Resident # 11. ving knowledge of Resident					

sexual advances.

administration failed to protect Resident # 11 from

The administration failed to provide staff with the necessary information to protect Resident # 11 from the sexual approaches from Resident # 1. The administration failed to ensure that systems were in place and staff trained to prevent a

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L' (DENTIERATION AUGUSES			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105772	B. WING				⋜ 20/2014
	ROVIDER OR SUPPLIER			4	STREET ADDRESS, CITY, STATE, ZIP CODE 135 42ND AVE S SAINT PETERSBURG, FL 33705	<u> </u>	20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 490}	sexual offender. Administration demor commitment to protect elderly and/or disable which resulted in the Immediate Jeopardy Additionally, the facili implement its policy a investigating and repeabuse immediately to state agency related made by resident # 2 residents. Findings include: 1. Review of the fact description revealed to Position." "The primary purposed direct the day-to-day accordance with currestandards, guideline, nursing facilities to a degree of quality care residents at all times. 2. Review of the Admunder the section em Responsibilities - Admincluded: "Plan, develop, organical management of the section of the Admincluded:"	nstrated a lack of action and at Resident # 11 and all desidents of the facility determination of on-going on 3/20/14 at 6: 55 p.m. by administration failed to and procedure for orting all allegations of the abuse hotline and the to an allegation of abuse 25, one of nine sampled and "Purpose of your Job under "Purpose of your Job under "Purpose of your Job and regulations that govern assure that the highest e can be provided to our " Ininistrator's job description titled "Duties and ninistrative Functions" ize, implement, evaluate, as programs and activities in elines issued by the	{F 4	90}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		X2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		105772	B. WING			I	? 20/2014	
	ROVIDER OR SUPPLIER	РЕТЕ	STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705		85 42ND AVE S			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 490}	practice that govern to Interpret the facility's employees, residents government agencies. Assume the administration responsibility and accordination and program. 3. Review of the Admunder the section entravealed: "Ensure that the reside equitable treatment, sindividuality, privacy, including the right to established and main Review resident commake written reports such actions with resident actions with resident actions with resident that on 2/13/1 p.m., his roommate, Funder the curtain and sheet to about ½ inch still have nightmares stated he was in bed this occurred. He stat 1 to stop or he would Resident # 1 then wit 11 stated he could no had recently had a strafial he would come guy, I got really scare night. He stated he defined the stated he defined the stated he defined the stated he defined the stated he would come guy, I got really scare night. He stated he defined the stated h	ession as standards of the operation of the facility policies and procedures to the facility members, visitors, to etc. as necessary. The rative authority, countability of directing the the facility." Ininistrator's job description titled "Resident Rights" Ident's rights to fair and the self-determination, property and civil rights, wage complaints are well tained at all times. plaints and grievances and of action taken. Discuss	{F 4	90}				

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FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING __ 105772 B. WING 03/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S REHABILITATION CENTER OF ST PETE SAINT PETERSBURG, FL 33705 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {F 490} Continued From page 17 {F 490} next morning he was still in the room with Resident #1 when "some Doctor" came and he heard him ask Resident # 1 why he had molested two children. He stated that scared him more and he stated, "he could have hurt me; he could have been a murderer. They needed to check these things before they admit someone like that." He stated that he that he was not made aware of this when they moved his roommate into the room. He stated the Administrator and the Social Worker told him the next day, 2/14/14, that they wanted to talk to him about his roommate and he told him what had happened. He stated that the Administrator told him that he was sorry that had happened to him and they would move him to another room. He stated that after he told them about the incident with Resident # 1, they brought a "Big Nurse" into the room that stayed with him and protected him from Resident # 1. He stated the staff member said to him that he would protect him. He stated when Resident # 1 was moved out of his room "I was so relieved." Review of the record for Resident # 11 revealed that he was admitted to the facility on 2/3/14 from the hospital with diagnosis of weakness due to right sided Cerebrovascular Accident Vascular Accident (CVA), according to an admission nursing note in the resident's record. Review of a Minimum Data Set (MDS) admission assessment, with an assessment reference date of 2/9/14, revealed that the resident scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. The resident was coded as having no speech, vision or hearing problems, able to understand and be understood and no behaviors exhibited. Functional Status on the admission MDS was

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FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 105772 B. WING 03/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S REHABILITATION CENTER OF ST PETE SAINT PETERSBURG, FL 33705 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {F 490} Continued From page 18 {F 490} coded as: "Bed Mobility: Extensive assistance, two person physical assist Transfer: Total dependence Walk in room: Activity did not occur Walk in Corridor: activity did not occur Locomotion on unit and off unit: extensive assist of one person Balance during transfer and walking: 2- Not steady, only able to stabilize with staff assistance. Range Of Motion: Impairment on one side-upper and lower extremity." Nursing Notes in the resident's record indicated that the resident was alert and able to make his needs known. During an interview with the Administrator, on 3/19/14 at 10:40 a.m., he was asked about the cognition of resident # 11, he stated "he was alert and oriented, just like you and me." A review of Physical Therapy discharge notes and progress notes revealed that the resident was not able to transfer out of bed independently on 2/13/14. Review of the physical therapy discharge summary and notes indicated that, as of discharge from physical therapy on 2/20/14, the resident had met the goal on 2/7/14 of transferring from bed to wheelchair with caregiver assistance of one person. Review of a physical therapy progress note, dated 2/14/14, revealed "Patient has begun trials with (quad cane) for 4 hours 2/14/14 on even and uneven surfaces in facility." Review of nursing progress notes for 2/7/14 at

10: 34 am revealed "Up in wheelchair daily and able to propel self slowly on unit, requires assist

of one staff member for all transfers."

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		INSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105772	B. WING				R
	ROVIDER OR SUPPLIER		3	435 4	EET ADDRESS, CITY, STATE, ZIP CODE 12ND AVE S NT PETERSBURG, FL 33705	1 03/	20/2014
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{F 490}	11: 57 a.m. revealed, supervision with transand will ADLS." 5. Review of the recent that he was admitted from a local hospital. In a History and Physic indicated that the resoffender." The reside "generalized weakned deficits, sensory and finger to nose test, go not want to get out of the waste of the property of the property of the property of the hospital to the property of the hospital to the deficits of the hospital to the property of the HCA of the property of the HCA o	ogress notes for 2/20/14 at "Patient requires sfers, toileting, bed mobility ord for Resident # 1 revealed to the facility on 2/13/14. The facility provided a copy is that came with Resident # included in these records was al, dated 1/30/14, which ident was a "prior sex ent was reported to have ss with no focal neurological motor function intact, normal rait not tested as patient did f bed." In the hospital entitled tion statement for Ambulance and 2/13/14, for transport, the la, "Patient has periods of y to get out of chair." In the facility, on 2/12/14, for pre in the facility, on 2/12/14, for pre in the facility, on 2/12/14, for pre in the facility of the f	{F 4	90}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		105772	B. WING _				⋜ 20/2014	
	ROVIDER OR SUPPLIER TATION CENTER OF ST	РЕТЕ	•	4	STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 490}	Designation: Sexual Adjudication dated: 5 Crime Description: U Certain Minors 16/17 Adjudication: Guilty / County Sheriff's Offici Report: Name: Resident # 1 Booking date: 8/21/13 Offense Description: Battery of Elderly/Dis Name: Resident # 1 Booking Date: 3/20/10 Offense Description: Battery of Elderly/Dis Disposition: "Release info/Dismissed" An interview was con Administrator and Dir at 10: 40 a.m. regardi Resident # 1, a know facility on 2/13/14. That the resident came the facility from the hostated he arrived with the hospital which sta offender. She stated a the process of doing ambulance transport handed them another another packet of infoliad with him. She states Director of Nursing st transport came back	lator Flyer: (Resident # 1) - Offender i/9/2008 nlawful Sexual Activity with yr. old; F.S. (794.05(1) Convicted e Website: Subject Charge 3 "Lewd and Lascivious abled Adult." 3 "Lewd and Lascivious abled Adult" d 4/20/13 No ducted with the ector of Nursing on 3/19/14 ng the admission of n sexual offender, to the ne Director of Nursing stated e by ambulance transport to ospital on 2/13/14. She a History and Physical from ted that he was a prior sex she and the nurse were in the admission when the company came back, packet and said this was ormation that the resident ated the packet of papers Attorney's Office. The ated the ambulance	{F 4	90}				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		105772	B. WING			l	⋜ 20/2014
NAME OF P	ROVIDER OR SUPPLIER	100112		Sī	TREET ADDRESS, CITY, STATE, ZIP CODE		20/2014
REHABILI	TATION CENTER OF ST	PETE			85 42ND AVE S AINT PETERSBURG, FL 33705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 490}	papers and told the n some phone calls" an admission. She state Administrator that "we (#1) has done someth stated the papers "procharged with molestar male at the facility he thought the papers sa "September, October The DON stated that the papers as "those belongings." The Administrator state occurred late in the down of the company of the compan	she, the DON, looked at the urse that "I need to make and to continue with the ed that she then alerted the en have papers that said he hing and just recently." She etty much said he was being tion or whatever it was, of a was at." She stated she ed to it occurred in the property of were his personal. It the that he believed this and the way stating "It was late, like meeting and (the DON) have an issue." He stated by goodness, did we not trator stated that he and the with Resident # 1. He stated communication, he just his held." He stated they se and the therapist and that they much bed bound and le to get up unless he was do the therapist had already time he and the DON went to the stated the therapist him because she knew hission and wanted to assess thome. The Administrator I him that the resident was don't move too much, that he	{F 4	490}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105772	B. WING				⋜ 20/2014
	ROVIDER OR SUPPLIER TATION CENTER OF ST	PETE	1	4	STREET ADDRESS, CITY, STATE, ZIP CODE 35 42ND AVE S SAINT PETERSBURG, FL 33705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 490}	going on. He then could that the Psychia 1 in the morning. He 2/14/14, they met with discussed the following admitted him, now with what we do to keep I do room moves." He told him, that since the move around on his someone alert and owould take it from the The DON stated that Resident # 1 on 2/14 concerned because would try not to touch psychiatrist told her needs to go" referrin Administrator and the psychiatrist told them residents and alert the Administrator was record entitled "Note to file:" "February 13, 2014 Time: 7: 30 p.m. Resident: (#1) This Administrator was a registered sex offethis facility unknowing paperwork from the confirmed his status."	e nurse and told her what was alled the Psychiatrist and was trist would assess resident # e stated the next morning, the the psychiatrist and ing concerns with him: "we ee have to take care of him, him safe and do we need to e stated that the Psychiatrist ine resident was not able to own and as long as he had riented in the room, we ere. If the Psychiatrist assessed with a the manyone. She stated the If feel uncomfortable, he is go to Resident # 1. Both the into alert the staff and the into alert the s	{F 4	90}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		105772	B. WING _			l	⋜ 20/2014
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{F 490}	presented as very co speak at length. This the resident alone to Administrator and DC Rehab Director. She assessed by therapy opinion resident was pose a threat to other Next, Administrator pto be seen by staff ps "February 14, 2014 Time: 10: 30 a.m. Resident: (#1) This administrator me DON in the DON's of see patient (Resident him that he would "try his stay at this facility point for psychiatrist. Psychiatrist next notified the roommate sexual predator. Psychiatrist stated th made aware, resident certain minimum radi This administrator, at Worker, went to the room to speak with the smoking section. accompanied the roo office where a private	his prior arrests. Resident infused and was not willing to administrator and DON left rest. ON next consulted with stated resident was already and in their professional too weak to stand let alone residents. Let with in a request for resident sychiatrist." Let with (psychiatrist) and fice. He stated he had just the sychiatrist." Let with in a request for resident sychiatrist." Let with in a request for resident sychiatrist. The stated he had just the sychiatrist. The stated he had just the sychiatrist. The stated he had just the sychiatrist had given the stated he had just the sychiatrist. The stated he had just the stated he had	{F 4	90}			

Case 8:14-bk-09521-MGW

FORM APPROVED

Doc 42-2 Filed 08/26/14 Page 25 of 84 PRINTED: 07/28/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 105772 B. WING 03/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S REHABILITATION CENTER OF ST PETE SAINT PETERSBURG, FL 33705 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {F 490} Continued From page 24 {F 490} roommate interrupted this admin and stated "I know he is gay. You don't have to tell me. He tried to touch me while I was lying in bed through the covers. He didn't touch me but he tried. I yelled at him and told him never to try and touch me again." Resident # 11 went on to say "Now I really like my room and I like him as a roommate. I am fine rooming with him and I'll make sure I watch out for him." This admin immediately went back to the DON's office. Psychiatrist had departed the building by this time. Admin and DON contacted (psychiatrist) on the phone and relayed the information regarding roommate. Psychiatrist stated he would come back to assess patient again given this new information. Admin told DON to immediately put patient (Resident 1) on a 1:1. DON complied and a male CNA was assigned to be with the patient at all times." "February 14, 2014 Time: 5: 00 p.m. Resident: (#1) (Psychiatrist) re-assessed the patient and states his behaviors pose a danger to self and/or others. (Psychiatrist) states resident should be Baker Acted. This Administrator discussed Baker Act with both DON and the Social Services team. The resident is to remain on a constant 1:1 until transport arrives to pick him up and transport to (hospital)."

6. An interview was conducted with employee N. a Licensed Practical Nurse (LPN), by phone on 3/20/14 at 10:15 a.m. She confirmed that she was the 3 p.m. to 11 p.m. shift nurse who cared for Resident # 1 and Resident # 11 on 2/13/14. She stated that she remembered Resident # 1

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105772	B. WING				⋜ 20/2014
	ROVIDER OR SUPPLIER TATION CENTER OF ST	РЕТЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 490}	able to get up out of the encouraged him to casure of his gait until his She stated again, he on his own. She states seeing anyone from the evening on 2/13/1 her shift, Resident # stated "something cawas previously a sex she was not told by a to take any special prhim. She stated that sanything had occurre Resident # 11 nevers of Rehabilitation Server, m. She had previous Administrator as the transledent # 1 on the exaministrator had star Rehabilitation Service that Resident # 1 "previous that Residen	on." She stated "he was beed on his own but I all for help as we were not e was assessed by therapy." was able to get out of bed ed she does not recall herapy assess the resident 14. She stated that during 1 never left his room. She me in with him that said he offender." She stated that dministration or anyone else recautions or keep an eye on she was not aware that d with his roommate, that said anything to her. Conducted with the Director rices, on 3/19/14 at 3:38 ally been identified by the herapist who assessed evening of 2/13/14. (The ted that the Director of es had told him on 2/13/14 etty much bed bound and le to get up unless he was ed the therapist had already time he and the DON went t. He stated the therapist him because she knew dission and wanted to assess thome. The Administrator I him that the resident was don't move too much, that he and and mumbling. bilitation Services stated that or assess Resident # 1 until	{F 4	90}			

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	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		105772	B. WING _				R 20/2014
	ROVIDER OR SUPPLIER TATION CENTER OF ST	РЕТЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
{F 490}	the date of her assess admission for the resi information. She ther that she completed he 1 on 2/14/14 and doc was admitted late on came in late the day it that day, I didn't stay unaware of any other by the therapy depart stated that when she 2/14/14, "he didn't wame he had been in a me a few feet, he couwaddle." Review of Occupation Plan of Treatment, da "Upper Extremity Ran Functional Limit) Lower Extremity Ran Balance: Sitting Balance: Sittin (maintains balance with moderate resistance) Standing Balance: St (maintains standing bupper extremity support Clinical impressions: (shortness of breath) with walker. Risk factor Offender. Admitted he advances to roommat. 8. An interview was of a CNA, on 3/20/14 at that he provided care 2/13/14 on the 3 p.m.	e stated she would check sment and the time of dent and return with the in provided documentation er assessment of Resident # umentation that Resident #1 2/13/14. She stated, "he before; I didn't assess him to assess him. She was assessment of Resident # 1 ment on 2/13/14. She assessed Resident #1, on and to do anything. He told wheelchair. He walked with all ambulate, it was a nal Therapy Evaluation and atted 2/14/14 revealed: age of Motion: WFL (Within and During ADL's = Good ithout support against anding During ADLS's = Fair alance 1-2 minutes without bort without loss of balance. Patient presents with sob after 50 feet assisted gait ors: history of Sexual ere and made sexual	{F 4	90}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		105772	B. WING			l	R 20/2014
	ROVIDER OR SUPPLIER	L	STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705		35 42ND AVE S	03/	20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 490}	and he did not leave stated that Resident # admission and that he about Resident # 1." monitor or watch him other resident which vesidents every two haware of anything occ 1 and Resident #11. An interview was con LPN, on 3/20/14 at 10 she was the 7 a.m. to Residents # 1 and # she was not given an 7 a.m. nurse about an Resident 1 and Resident # 1 and any between Resident # 1 and any between Resident # 1 stated she was not mistory and was not to 2/14/14. She stated therapy, he did not le 9. An interview was com Manager of the unit was not made aware of any concern when he was admitte know what happened she did not know whe Resident # 11 was "a incident with Resident # 12 w	the was "a big heavy guy" the room during his shift. He # 1 was "just a normal e was not aware any history He stated he was not told to any differently than any would be to check all ours. He stated he was not curring between Resident # ducted with Employee K, an 0: 30 a.m. She stated that 13 p.m. nurse who cared for 11 on 2/14/14. She stated by report from the 11 p.m. to nything occurring with lent # 11. She stated "no, usual." She stated that she of any concerns related to incident that occurred I and # 11 until 2/15/14. She ade aware of Resident #1's old to monitor him on that other than going to ave his room on 2/14/14. conducted with the Unit where Resident # 1 and d. She stated she was not is related to Resident #1 d. She stated she did not until the next day and that en it occurred. She stated little irritated" regarding the t # 1. She stated he told her er touched him or put his	{F 4	90}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	105772 B. WING			R 03/20/2014			
NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER OF ST PETE				435 4	EET ADDRESS, CITY, STATE, ZIP CODE 42ND AVE S NT PETERSBURG, FL 33705	03/	20/2014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		l l	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHI TAG CROSS-REFERENCED TO THE APP DEFICIENCY)			(X5) COMPLETION DATE
{F 490}	She stated she went to Resident # 11 on 2 (Resident # 11) of the plan was to tell him the and we were going to stated Resident # 11 me." She stated that he was lying in bed a come under the curta #11, stated that he to he was gay and to go he would hit him with Resident # 11 was ar 11 told them he had rehappened because he stated he told her the them was because the stated at the time of the was in a wheelchair, on strengthing his legular and transfer but we stated that the situation stated "it sounded like 11) and saw a hand courtain." She stated lying in bed or sitting resident # 11 told the day, on 2/14/14, right after breakfast but she was not involved days later I passed he and asked him how he was glad his room.	s conducted with the ker, on 3/19/14 at 2:46 p.m. with the Administrator to talk 2/14/14 and "to notify him e situation." She stated the nat there was an offender o do precautions. She told them "he tried to touch Resident # 11 told them that nd saw Resident #1's hand hin. She stated Resident Id Resident # 1 that he knew et his hand away from him or his cane. She stated ngry. She stated Resident # not told anyone about what he was embarrassed. She his interview, Resident # 11 was still working with therapy ges that he was able to stand has very unsteady. She on was unclear to her. She he was in bed (Resident # coming from underneath the she was not sure if he was in a chair. She thinks m it happened earlier in the around breakfast or shortly he was not sure. She stated in the investigation. "A few him in the hall (Resident # 11) he was doing and he told me himate was gone." She not yother contact she had	{F 4	90}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENITIFICATION NITIMBED		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						R		
		105772	B. WING			03/	20/2014	
NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER OF ST PETE				435 4	ET ADDRESS, CITY, STATE, ZIP CODE 12ND AVE S 1T PETERSBURG, FL 33705			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE API DEFICIENCY)		D BE COMPLETION		
{F 490}	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		{F 4	90}				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
						R	
		105772	B. WING			03/	20/2014
NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER OF ST PETE				435	EET ADDRESS, CITY, STATE, ZIP CODE 42ND AVE S NT PETERSBURG, FL 33705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
{F 490}	to fondle other reside battery." 12. Review of Residential nursing progress note which stated "Writer on the stated service progress note by the Social Service Resident #11 reporte advance from Resided 2/14/14 resident was under a Baker Act batter advance toward his rebuilding administrator roommate to inform has a sexual offender. meeting, (Resident # administrator that the his curtain and was reflected in the sexual advancement. This writer immediate psych consultation resexual advancement. The sexual advancement to hospital." 13. An interview was Administrator on 3/19 stated that prior to the a sexual offender, to facility had no policy.	ent #1's record revealed a e, dated 2/14/14 at 16:48, given in report from 7-3 nt is being BA 52 for y behavior with roommate." 1's record revealed a social e, dated 2/24/14, and signed s Assistant, ten days after d an unwanted sexual ent # 1. The note stated "On discharged to (hospital) sed on an unwanted sexual ent # 1. This writer and met with the resident's sim of the resident's status Upon the beginning of the 11) informed this writer and resident put his hand under eaching toward his genitals. The resident that he never such advancement again. Ely notified (Psychiatrist) for a garding the unwanted Resident was Baker Acted	{F 4	90}			

Case 8:14-bk-09521-MGW

Doc 42-2 Filed 08/26/14 Page 32 of 84 PRINTED: 07/28/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 105772 B. WING 03/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S REHABILITATION CENTER OF ST PETE SAINT PETERSBURG, FL 33705 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {F 490} Continued From page 31 {F 490} He stated since the incident of 2/14/14 with Resident's # 1 and # 11, the facility now checks the Florida Department of Law Enforcement Sexual Offender website prior to accepting an admission to the facility. He stated this is done by admissions. He stated there was no facility policy related to this, stating that it was just a process we do. 14. An interview was conducted, on 3/20/14 at approximately 1:30 p.m., with a staff person who identified herself as a Medicaid Specialist for the management company who was working as the admissions person for the past two days. She stated the facility's admission person left the facility three days ago and she is doing admissions in his place. She stated she does check the Florida Department of Law Enforcement website on any potential admissions. She stated she had not seen a current policy on this from the facility. On 3/20/14 at 7: 52 a.m., further interview with the Administrator revealed that the facility has not checked the status of current residents to see if any of the residents are sexual offenders or predators. He stated there was no need to do this as the police or the sheriff will come in to check on anyone who is a sexual offender and "we will find out that way." 15. On 3/17/14 at 9:00 a.m., the Administrator was asked to provide the facility 's policies and procedures related to abuse, neglect,

mistreatment and misappropriation of property. The Administrator provided a document entitled, "Reporting Abuse to State Agencies and Other Entities /Individuals." The Administrator was asked to provide all policies in effect related to

Case 8:14-bk-09521-MGW DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 105772 B. WING 03/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S REHABILITATION CENTER OF ST PETE SAINT PETERSBURG, FL 33705 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {F 490} Continued From page 32 {F 490} Abuse, neglect, mistreatment and misappropriation of property and he then provided two additional documents for a total of three: A Policy entitled, "Reporting Abuse to State Agencies and Other Entities/Individuals" with a revision date of November 2010. A sheaf of paper clipped documents each entitled "Abuse Policy." Each document was signed by an employee and contained signature dates for 2014. The documents included a statement "Residents in this facility are to be treated with dignity and respect at all times and under any circumstances. Mistreatment in the form of verbal or physical abuse of any nature will not be tolerated." The document defined abuse and included information on reporting abuse. A stapled sheaf of forms with a cover document entitled, "Abuse Reporting" Thursday April 25. Please plan on attending the following in- service." Under the cover document was a policy entitled. "Abuse, Neglect, Exploitation and Misappropriation of Property, Prevention, Protection and Response Policy and Procedures" with a revision date of 9/12. Sign in sheets for staff were attached with an in service date of 4/25/13. On 3/20/14 at 7: 52 a.m., an interview was conducted with the Administrator regarding the documents (2 and 3 above) entitled "Abuse Reporting" and "Abuse Policy." He was asked to review the policies and advise as to which policy was in effect related to the definition of abuse as there were some differences in the wording in the

policies regarding the definition of abuse. He indicated #2, the sheaf of paper clipped documents entitled, "Abuse Policy," stating "because we are training everyone on this one, Case 8:14-bk-09521-MGW Doc 42-2 Filed 08/26/14 Page 34 of 84 PRINTED: 07/28/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		105772	B. WING				⋜ 20/2014
NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER OF ST PETE			STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 490}	training on so this is a cindicated that all of the facility's abuse protocon Review of the documrevealed the following "Residents in this facility and respect as circumstances. Mistre or physical abuse of a tolerated. Abuse is defined as the following and the following and respect as tolerated. Abuse is defined as the following and	sone, this is what we are pur definition of abuse." He e policies were part of the col. ent entitled "Abuse Policy" information: dity are to be treated with all times and under any eatment in the form of verbal any nature will not be the following: ce of action inconsistent with esults in or could result in sident. Institutes sexual activity sident. See language or gestures, which subjects the resident adation. The left of real or personal to of (sic) illegal means. Sigated to report any acts of coordinator, who is (Director of the left) investigated by the could suspected acts of abuse diately by the Abuse R.S. Abuse Hotline 1-800 knowingly and willfully fails known or suspected abuse, in of an aged person or knowingly and willfully son from doing so, is guilty	{F 4	90}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED:		IPLE CONSTRUCTION NG	(X3)	(X3) DATE SURVEY COMPLETED R		
		105772	B. WING _			03/20/2014		
NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER OF ST PETE				STREET ADDRESS, CITY, STATE, ZIP CO 435 42ND AVE S SAINT PETERSBURG, FL 33705	DDE	00/20/2014		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
{F 490}	contained in the Cencomputer system, in abuse, neglects (sic) disable adult id (sic) the second degree. 3. Any person who neglects, or exploits person, and in so do harm, permanent dis disability to such persecond degree. 4. Any person who neglects, or exploits person is guilty of a degree. Review of the policy "Abuse, Neglect, Explisappropriation of Protection and Respwith a revision date of "Policy: Abuse, Negl Misappropriation of Protection and Respwith a revision date of "Policy: Abuse, Negl Misappropriation of Protection and Respwith a revision date of "Policy: Abuse, Negl Misappropriation of Protection and Respwith a revision date of "Policy: Abuse, Negl Misappropriation of Protection and Respwith a revision date of "Policy: Abuse, Negl Misappropriation of Protection and Respwith a revision date of "Policy: Abuse, Negl Misappropriation of Protection and Respwith a revision date of "Policy: Abuse, Negl Misappropriation of Protection and Respwith a revision date of "Policy: Abuse, Negl Misappropriation of Protection and Respwith a revision date of "Policy: Abuse, Negl Misappropriation of Protection and Respwith a revision date of "Policy: Abuse, Negl Misappropriation of Protection and Respwith a revision date of "Policy: Abuse, Negl Misappropriation of Protection and Respwith a revision date of "Policy: Abuse, Negl Misappropriation of Protection and Respwith a revision date of "Policy: Abuse, Negl Misappropriation of Protection and Respwith a revision date of "Policy: Abuse, Negl Misappropriation of Protection and Respwith a revision date of "Policy: Abuse, Negl Misappropriation of Protection and Respwith a revision date of "Policy: Abuse, Negl Misappropriation of Protection and Respwith a revision date of "Policy: Abuse, Negl Misappropriation of Protection and Respwith a revision date of "Policy: Abuse, Negl Misappropriation of Protection and Respwith a revision date of "Policy: Abuse, Negl Misappropriation of Protection and Respwith a revision of Protection and Respwith a revision of Protection and Res	ny confidential information tral Abuse Registry, in the the record of any case of a exploitation of an aged or is guilty of a misdemeanor of a knowingly or willfully abuses, an aged person, or disabled ing causes great bodily figurement or permanent son is guilty of a felony of the a knowingly or willfully abuses, an aged person or a disabled misdemeanor of the first referenced in # 1 above ploitation and property, Prevention, onse Policy and Procedures of 9/12 revealed: ect, Exploitation and property, collectively known of 9/12 revealed: ect, Exploitation and property, collectively known of 9/12 revealed: each, and as hereafter defined, by anyone, including staff, family members or legal any other individuals. Iministrator is responsible for safety, including freedom ds the highest priority. Its designated the following lith center's ANE Prevention the name and phone number on Coordinator)	{F 4	90}				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
						R	
		105772	B. WING			03/20/2014	
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE		
DEHARII I	TATION CENTED OF ST	DETE			435 42ND AVE S		
KEHADILI	TATION CENTER OF 31	FEIE			SAINT PETERSBURG, FL 33705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
{F 490}	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		{F 4	190			
	extent of the injury or	location of the injury, or the					

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AND DI AN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		105772	B. WING			03/	20/2014
	ROVIDER OR SUPPLIER TATION CENTER OF ST	PETE		4	STREET ADDRESS, CITY, STATE, ZIP CODE 135 42ND AVE S SAINT PETERSBURG, FL 33705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE C			(X5) COMPLETION DATE
{F 490}	point in time, or the intime. I. Screening Issues Policy: the center wil have been a. Found guilty of a mistreating patients/reb. Have had a confistate nurse aide regis Procedure: Check ref obtain information fro current employers (win Check board or registry Criminal indicated. II. Training Issues: Policy: The center will orientation and ongoing prevention and respoon Procedure: In Service minimum: What context will be the center. Appropriation and misal property. The registry Check reformed in the center of	served at any particular acidence of injuries over it into temploy individuals who busing, neglecting, or esidents by a court of law; or armed finding entered into the stry concerning abuse erences for all applicants to m previous employers and ith applicant permission) the appropriate licensing all background checks as Ill train all staff, through any in-services in ANE are training will include at a constitutes abuse, neglect, appropriation of patient corting system established viriate interventions to deal viors. The Dementia training module tion) The Constitutes and how to effectively a communication of patient and the patient arining module tion) The Dementia training module tion)	{F 4	90}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		105772	B. WING	_		03/	20/2014
	ROVIDER OR SUPPLIER TATION CENTER OF ST	РЕТЕ		4	STREET ADDRESS, CITY, STATE, ZIP CODE 135 42ND AVE S SAINT PETERSBURG, FL 33705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAN DEFICIENCY)		(X5) COMPLETION DATE
{F 490}	supervision and suppreduce the likelihood Procedure: A identify inappropriate limited to the use of dhandling, ignoring patients who urinate or defecate in immediate steps to consume staff without reprisal. Procedure: The incident is not limited grievance process but complaint to any facility Prompt efforts who concerns. The names, addresse of all pertinent State of as the State survey as State licensure office program and the protinetwork will be provided families in the Admissinformation is also potenter. Policy: Patients with might lead to conflict will be identified by the interventions and followinimize the risk of consumers of the procedure: Any patt behaviors which might such as:	e center will provide out services designed to of abusive behaviors. All supervisory staff will behaviors, including but not erogatory language, rough itents while giving care, oneed toileting assistance to their beds, and will take prect such behaviors. Specially sensitive to signs the frustration. Iter will seek and accept and the right to report a concern or to a formal, written the includes any verbalized try staff. Will be made to resolve as, and telephone numbers elient advocate groups such and certification agency, the athe state ombudsman ection and advocacy and to all patients and their sion Packet and this sted prominently in the meeds and behaviors that with staff or other patients e Care Planning team, with ow through designed to	{F 4	90}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		JLTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
		105772	B. WING			1	⋜ 20/2014	
	ROVIDER OR SUPPLIER TATION CENTER OF ST	РЕТЕ		STREET ADDRESS, CITY, STATE, ZIP CO 435 42ND AVE S SAINT PETERSBURG, FL 33705	DE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE	
{F 490}	while wandering, c. patients with self history of self-inflicted d. patients with con e. Patients who req are totally dependent considered as potent The interventions des such patients will incl a. identification of p histories render them patients or staff, b. assessment of a strategies to prevent c. monitoring the p would trigger abusive d. Reassessment of a regular basis. IV. Identification Issu Policy: Any patient any staff by patient, fo other person will be of if it meets any of the fa a. Any indication of injury to include unex b. Unreasonable co unwanted restriction of the building. c. Any patient or fa harm, pain of mental willful infliction from of d. Any complaint o caregiver of goods ar attain or maintain phy psychological well- be issues.	er other resident's rooms - injurious behaviors, or a injuries, numunication disorders, uire heavy nursing care or on nursing care will be all victims of abuse. Signed to meet the needs of ude but will not be limited to: vatients whose personal at risk for abusing other appropriate intervention occurrences, atient for any changes that behavior, af the protective strategies on the event that is reported to amily, other staff, or any considered as possible ANE following criteria: possible willful infliction of plained bruising. Infinement, to include of access to all patient areas mily complaint of physical anguish, resulting from thers. If deprivation by an individual and services necessary to	{F 4	90}				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY
		105772	B. WING			R 03/20/2014	
	ROVIDER OR SUPPLIER	РЕТЕ		43	TREET ADDRESS, CITY, STATE, ZIP CODE 35 42ND AVE S AINT PETERSBURG, FL 33705		20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
{F 490}	families or within their f. Any complaint of coercion, or sexual as g. Any instances of kicking or other poten h. Any behavior cor corporal punishment. i. Any complaint of threats of punishment j. Any allegation of property. Procedure: Any and a about such events will immediately to the AE 1-800-962-2873. The immediately to the im LEAST ONE OF THE INDIVIDUALS, Social Coordinator), Director Administrator. Any and empowered to initiate appropriate. V. Investigative Issu Policy: Any empindirect knowledge of constitute abuse mus Procedure: Any and hearing about such elimmediately to the AN Administrator. The evimmediately to the en All employees are ento contact the ABUSE 962-2873 if they wither	at willfully includes gatory terms to patients or r hearing distance. sexual harassment, sexual ssault. hitting, slapping, pinching or itially harmful action. htrol strategy involving humiliation, harassment, t or deprivation. misappropriation of patient all staff observing or hearing il report the event BUSE HOTLINE AT event will also be reported mediate supervisor, AND AT FOLLOWING I Worker (ANE Prevention or of Nursing, or all employees are immediate action as les: bloyee having either direct or any event that might t report the event promptly. and all staff observing or vents must report the event IE Prevention Coordinator or ent should also be reported imployee's supervisor. iccouraged and empowered	{F 4	90}			

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FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 105772 B. WING 03/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S REHABILITATION CENTER OF ST PETE SAINT PETERSBURG, FL 33705 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {F 490} Continued From page 40 {F 490} Policy: All events reported as ANE will be investigated to determine whether ANE did or did not take place. Procedure: The ANE PREVENTION COORDINATOR will initiate investigative action. The Administrator of the center, the Director of Nurses and /or the Social Worker (ANE PREVENTION COORDINATOR) will be notified of the complaint and action being taken as soon as practicable. VI. Protection Issues: Policy: Patients will be protected from harm during an investigation. Procedure: any individual found to be in danger or injury will be removed from the source of the suspected abusive behavior. Medical and emotional support will be made immediately available to any individual suffering suspected abuse. Policy: Staff person or persons suspected of ANE will be suspended immediately pending result of investigation. Pay status during suspension is at the discretion of the administrator. Residents who are suspected of initiating abusive behavior toward other residents will be immediately separated from any suspected victim or victims. The specific approach employed to separate victim and perpetrator and to ensure the protection of all potential victims will vary on a case specific basis. In all cases, every appropriate effort will be made to ensure the protection of our residents. The resident's attending physician should be contacted promptly to determine the most appropriate interventions. These may include but are not limited to: One on one assignment of staff to protect resident victims.

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		AND HUMAN SERVICES & MEDICAID SERVICES			· ·	0	FORM AI MB NO. 0	PROVED
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CON	STRUCTION		X3) DATE SUF COMPLET	RVEY
		105772	B. WING _				R 03/20 /	2014
NAME OF P	ROVIDER OR SUPPLIER	-		STREE	T ADDRESS, CITY, STATE, ZIP CODE			
REHABILI	TATION CENTER OF	ST PETE			ND AVE S Γ PETERSBURG, FL 33705			
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{F 490}	c. Review of med. Review of the interventions. e. Involuntary Discontinuous de Involuntary de Involunt	f law enforcement. dication regimen. residents care plan scharge. Response Issues: gations of possible ANE will be ed to the Abuse Hotline and o determine the direction of the investigation of alleged abuse, tion will be reported Administrator and the ANE also be reported to other ance with State and Federal e Report buse, neglect, exploitation, or f property, including injuries of nust be reported immediately. It be reported to the Abuse ective Services) within twenty er an allegation is made. on Coordinator will also submit alth Care Administration AHCA JO Day Report and send it to: int Administration Unit 850-488-5514 0-488-6094	{F 4	90}				

Survey Agency within five working days of the incident. This will be completed using the same AHCA Federal/Five Day Report, and sending it to

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
	105772	B. WING			R	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03	3/20/2014	
			435 42ND AVE S			
REHABILITATION CENTER OF	ST PETE		SAINT PETERSBURG, FL 33705			
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI X (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
C. Designated F Shall immediately Survey Agency, b All necessary corr result of the inves Report any knowl against any employee is unfit other facility staff or other appropria Any report to Adu an internal investi Untoward Events Policy: Trends of analyzed and add committee proces Procedure: An accinvestigations corr maintained as a w Assessment and QA and RM will refer to track and deter Any trends will be the QA TEAM and A review of the pot to State Agencies (with a revision da revealed different Abuse, as to who when to report, the section VII. Report the policy entitled and Misappropria Protection and Reference of the "Reference	Reporters: If make a report to the State If y fax, email, or telephone. Rective actions depending on the Itigation will be taken Redge of actions by a court of law Royee, which would indicate an If or service as a nurse aide or Ito the State nurse aide registry Ited licensing authorities. It Protective Services will trigger It gation following the protocol of Rolicy and Procedure. If investigative findings will be Iressed by the QA RM Its. Its. Inducted by the center will be Iressed by the Committees. It working document of the Quality Risk Management Committees. It working document of the Quality Risk Management Committees. It is rowarded to all members of It center management." In the center will be It is a contained in reting and Response Issues of It or report to, what to report and It in an What was contained in It ing and Response Issues of If a buse, Neglect, Exploitation, It information on Property. Prevention, It is proved to the State It is a report to, It is not the State It is a report to the State It is a rep	{F 4	90}			

Case 8:14-bk-09521-MGW Doc 42-2 Filed 08/26/14 Page 44 of 84 PRINTED: 07/28/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		105772	B. WING				R 20/2014	
	ROVIDER OR SUPPLIER	РЕТЕ		43	REET ADDRESS, CITY, STATE, ZIP CODE 15 42ND AVE S AINT PETERSBURG, FL 33705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 490}	all substantiated incic immediately reported agencies and other e be required by law. Policy Interpretation a 1. Should a suspect incident or mistreatment unknown source, or a resident abuse) be read written of such in a. The State licensi responsible for survey b. The local/State Cc. The resident's Record; d. Adult Protective e. Law enforcement f. The resident's Att g. The facility Media 2. Verbal/written not made within twenty-for occurrence of such in be submitted via spectelephone. Notices with a. The name of the b. The number of the b. The number of the cocurred; c. The date and time occurred; e. The names(s) of alleged incident; and	Il suspected violations and lents of abuse will be to appropriate state ntities or individuals as may and Implementation: ted violation or substantiated ent, neglect, injuries of abuse (including resident to ported, the facility er designee, will promptly ersons or agencies (verbally cident: ng/certification agency ying/licensing the facility; ombudsman; epresentative (Sponsor) of Services; tofficials; tending Physician; and cal Director offices to agencies will be our (24) hours of the cident and such notice may cial carrier, fax, e-mail, or by ill include, as appropriate: resident; ne room in which the resident et that was committed (i.e.,	{F 4	90}				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		105772	B. WING _			R / 20/2014	
	ROVIDER OR SUPPLIER	РЕТЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
{F 490}	provide the approprial listed above with a with the investigation within the occurrence of the 4. Should the investigation within the occurrence of the 4. Should the investigation with the occurrence of the 4. Should the investigation will be notified individuals (s) will be until the State Abuse the claim and found the unfounded. 5. Should the allegations employees(s) will be to should the allegations employees(s) will be former position with the former position with the former position with the allegation, if the employees oncerning the destroyed. 7. The State Abuse at Notify the employimplicated in any to linform the employimplicated in any to linform the employimplicated in any to linform the employimplicated in the employimplicated i	r or his/her designee will te agencies or individuals itten report of the findings of n five (5) working says of incident. tigation reveal findings of will be reported to the State individual (s) involved in the d of such findings, and such suspended, without pay, Registry has investigated ne allegations to be true or ations be true, the erminated from employment. Is be unfounded, the reinstated to his/her /their ack pay. egations will be filed in the personnel record along with employee disputing the oyee chooses to make one. unfounded allegations will be e Registry will: //ee when he/she has been investigation; yee of the nature of the yee of the time and date of yee of his/her right to a yee of the state's intent to dent abuse into the abuse	{F 4	90}			

Case 8:14-bk-09521-MGW DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 105772 B. WING 03/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S REHABILITATION CENTER OF ST PETE SAINT PETERSBURG, FL 33705 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {F 490} Continued From page 45 {F 490} 8. Appropriate professional and licensing boards will be notified when an employee is found to have committed abuse. 9. Any violation of this policy may result in disciplinary action. 10. Inquiries concerning resident abuse should be referred to the Director of Nursing Services or to the Administrator. 11. Inquiries concerning the reporting of abuse to state agencies should be referred to the Administrator." 16. An interview was conducted with the Administrator, on 3/19/14 at 2:15 p.m. regarding Resident # 1 and the investigation conducted by the facility after the incident with Resident #11. The Administrator stated he did not know what time Resident #1 made an unwanted sexual advance to Resident # 11. He stated that it was "probably sometime in the night, he didn't get any specific time." He stated that Resident #11 told him that Resident #1 "put his hand through the cubicle curtain, he saw his hand getting in the area of the sheet and he velled out to stop it." He stated that he understood from Resident #11 that Resident #1 was in his own bed at the time. He stated "I don't know how he could reach him without getting out of the bed; you can get your hand through the cubicle curtain but not physically be able to touch the other bed unless you have eight foot long arms." He stated since it was during the night, he talked to the day nurses to see if they had gotten any information on their 24 hour report about it and they said no. He stated he did not question the night nurse or

the CNA about Resident #1's movements during the night. He stated he did not talk to any other residents or other staff to determine whether any other incidents had occurred with Resident # 1 or Case 8:14-bk-09521-MGW DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 105772 B. WING 03/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S REHABILITATION CENTER OF ST PETE SAINT PETERSBURG, FL 33705 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {F 490} Continued From page 46 {F 490} if Resident # 1 was seen getting out of bed. He stated that the resident was unable to move and was in a room with an alert and oriented resident. He stated the psychiatrist had told him on 2/13/14 on the phone that "in his current state he is not going to harm anyone." He stated that "there was no harm as Resident # 1 did not touch or harm Resident # 11 in any way and that Resident # 11 stated he wanted to keep Resident #1 as his roommate." He stated that the facility would report inappropriate and/or unwanted sexual advances to the abuse hotline but since there was no allegation of inappropriate and/or unwanted sexual advances and "we confirmed no harm was done," it was not reported to the abuse hotline. He stated there was no investigation needed as "nothing happened." An interview was conducted with the Social Service Director, on 3/20/14 at 8: 19 a.m. She stated that she is the Abuse Coordinator. She stated she was not part of the investigation regarding the incident with Resident # 1 and Resident # 11. She stated it was mainly the Administrator and she thinks she was off that day. She stated "They said he (resident # 11) had volunteered information but had not reported it to that point. She stated that she thought it was handled as a grievance but was not able to find it in the grievance log. 17. An observation was conducted on 03/18/14 at approximately 11:20 a.m. of Resident #225. She was sitting in a wheel chair near the nurses' station, she was observed to be heavy set, she was able to answer some questions that were asked of her.

An interview was conducted on 03/18/14 at

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG	(>	X3) DATE SURVEY COMPLETED R
		105772	B. WING _			03/20/2014
	ROVIDER OR SUPPLIER	Г РЕТЕ		STREET ADDRESS, CITY, STATE, ZIP CO 435 42ND AVE S SAINT PETERSBURG, FL 33705	DE	39/20/20 : :
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{F 490}	approximately 11:30 The resident voiced home; her money ar she stated that the substance and she stated if she could in did this to her and she which staff were invested to someone; such as a unsure who she told someone; such approximately 1:00 purector (SSD)/ Abut confirmed that she with that had been made. During a subsequent 03/20/14 at 8:19 a.m. confirmed that she with that the substance and the time. The SS to see the resident, such as wheelchair was by the toilet. The SSD interviewed the staff the roommate. The Resident #225 make 500lbs, "I don't see the non the toilet." It was 43 hours had elapsed became aware of the interview. During the interview had called the Abustance and some substance are substanced in the toilet." During the interview had called the Abustanced in the staff the roommate. The Resident #225 make 500lbs, "I don't see the continuous and the staff the roommate. The Resident #225 make 500lbs, "I don't see the continuous and the staff the roommate." During the interview had called the Abustance and the staff the roommate. The Resident #225 make 500lbs, "I don't see the resident #225 make 500lbs, "I don't see the resident #225 make 500lbs," I don't see the resident #225 make 500lbs, "I don't see the resident #225 make 500lbs," I don't see the resident #225 make 500lbs, "I don't see the resident #225 make 500lbs," I don't see the resident #225 make 500lbs, "I don't see the resident #225 make 500lbs," I don't see the resident #225 make 500lbs, "I don't see the resident #225 make 500lbs," I don't see the resident #225 make 500lbs, "I don't see the resident #225 make 500lbs," I don't see the resident #225 make 500lbs, "I don't see the resident #225 make 500lbs," I don't see the resident #225 make 500lbs, "I don't see the resident #225 make 500lbs," I don't see the resident #225 make 500lbs, "I don't see the resident #225 make 500lbs," I don't see the resident #255 make 500lbs, "I don't see the resident #255 make 500lbs," I don't see the resident #255 make 500lbs, "I don't see the resident	a.m. with Resident #225. concerns about wanting to go and at the end of the interview, staff "throw me on the toilet." It the staff. Resident was lentify the staff members that the was not able to specify blved; Resident was asked if the stated that she had, but, blood. s conducted on 03/18/14 at bloom, with the Social Service se Coordinator. She was unaware of the allegation by Resident #225. t interview conducted on the with the SSD, she and 1 Abuse allegation in the disclosed to her on the stated that when she went the was on the toilet, the the bed and she had walked to	{F 4	90}		

Case 8:14-bk-09521-MGW DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING __ 105772 B. WING 03/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S REHABILITATION CENTER OF ST PETE SAINT PETERSBURG, FL 33705 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {F 490} Continued From page 48 {F 490} federal report as it was not accepted by the hotline. She clarified that she would not submit a 1 day federal report if the allegation was not accepted by the Abuse hotline. F 520 483.75(o)(1) QAA F 520 4/9/14 COMMITTEE-MEMBERS/MEET SS=J QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

by:

This REQUIREMENT is not met as evidenced

Based on resident record review and staff and resident interviews, it was determined that the facility's Quality Assessment and Assurance

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FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 105772 B. WING 03/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S REHABILITATION CENTER OF ST PETE SAINT PETERSBURG, FL 33705 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 49 F 520 Committee failed to identify errors and omissions in staffs interpretation and implementation of facility policies for abuse, and failed to ensure that an issue related to the admission of a known sexual offender was effectively addressed to ensure protection of residents. The facility administrations' lack of investigation and acknowledgement of an allegation of sexual abuse failed to ensure that all issues and concerns related to resident sexual abuse were identified and action plans developed to prevent further occurrences related to an allegation of sexual advances toward Resident # 11 from a known sexual offender (Resident #1) representing two (#1 and #11) of nine sampled residents. The facility administration failed to implement policies and procedures related to investigation of allegations of abuse, protection of residents and reporting of allegations to the abuse hotline and state agency. The facility failed to correct F 490, Effective Administration, from the Annual Survey of January 28, 2014 - February 3, 2014 and was determined to be out of compliance on the complaint survey of 3/17/14-3/20/14. These failures resulted in the determination of ongoing immediate jeopardy identified on 3/20/14 at 6: 55 p.m.. Additionally, the facility failed to ensure the quality assurance committee was actively involved in the effective creation, implementation and monitoring of the plan of correction for deficient practice related to medication storage and infection control practices identified during the January 28, 2014 - February 3, 2014 Annual QIS Survey. Failure to create an effective plan of correction resulted in continued noncompliance with federal standards which has the potential to affect 151 of 151 current residents.

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FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION

AND PLAN OF CORRECTION IDENT		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
					R	
		105772	B. WING		03/20/20	14
NAME OF P	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/20/20	1-1
				435 42ND AVE S		
REHABILI	TATION CENTER OF ST	PETE		SAINT PETERSBURG, FL 33705		
	OLIMANA DV OT	ATEMENT OF REFIGIENCIES				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) PLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI		DATE
				DEFICIENCY)		
F 520	Continued From page	e 50	F 52	0		
	Findings include:					
		4 a.m., a phone interview				
		Resident # 11. Resident # 11				
		4 at approximately 10: 00				
	-	Resident # 1, "put his hand				
		moved his hand on the				
		from my private parts." "I				
	_	about it." Resident # 11				
		with the curtain pulled when				
	I .	ed he yelled for Resident #				
		hit him with his cane and hdrew his hand. Resident #				
		t move away because he				
	I .	oke. He stated he was				
		back at him, "he was a big				
	I .	d and didn't sleep the whole				
		did not tell anyone that night				
	•	arrassed. He stated the next				
		n the room with Resident #1				
	_	came and he heard him ask				
	Resident # 1 why he I	had molested two children.				
	He stated that scared	him more and he stated,				
	"he could have hurt m	ne; he could have been a				
	murderer. They need	led to check these things				
	before they admit son	neone like that." He stated				
		ot made aware of this when				
	l -					
	I .	•				
	1					
	I .					
	they moved his rooms stated the Administrated told him the next day, talk to him about his rowhat had happened. Administrator told him happened to him and another room. He state about the incident with a "Big Nurse" into the	mate into the room. He tor and the Social Worker 2/14/14, that they wanted to oommate and he told him				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			D MINO			l	₹	
		105772	B. WING _			03/	20/2014	
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE			
RFHARII I	TATION CENTER OF ST	PETE		43	85 42ND AVE S			
KLIIADILI	IAHON GENTER OF GT			S	AINT PETERSBURG, FL 33705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 520	was moved out of his Review of the record that he was, a 56 year facility on 2/3/14 from of weakness due to ri Accident Vascular Acan admission nursing record. Review of a ladmission assessment reference date of 2/9/1 resident scored 15 out for Mental Status (BIN resident was coded a or hearing problems, understood and no be Functional Status on coded as: "Bed Mobility: Extendibution physical assist Transfer: Total deper Walk in room: Activity Walk in Corridor: activity walk	e stated when Resident # 1 room "I was so relieved." for Resident # 11 revealed or old male, admitted to the of the hospital with diagnosis ght sided Cerebrovascular cident (CVA), according to of note in the resident 's Minimum Data Set (MDS) ont, with an assessment of 15 on the Brief Interview of 15 on t	F	520				
		led that the resident was not						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		105772	B. WING _			R 03/20/2014	
	ROVIDER OR SUPPLIER TATION CENTER OF ST	PETE		STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOOL CORRECTIVE ACTION SHOOL CORRECTIVE ACTION SHOOL CORRECTIVE ACTION SHOOL CORRECTION SHOULD SHOUL CORRECTION SHOULD SHOUL CORRECTION SHOULD SHOUL CORRECTION SHOULD	OULD BE	(X5) COMPLETION DATE	
F 520	2/13/14. Review of the discharge summary as of discharge from physical the resident had met transferring from bed assistance of one per therapy progress note. "Patient has begun transferring from bed assistance of one per therapy progress note." Patient has begun transferring from 2/14/14 on ever facility." Review of nursing proful: 34 am revealed. "It also for the propel self slot of one staff member of the Review of nursing proful: 57 a.m. revealed, supervision with transferring from a local hospital. It was a History and Phindicated that the resoffender." The reside "generalized weakned efficits, sensory and finger to nose test, go not want to get out of the Review of a form from "Physicians Certificat Transportation," date	f bed independently on the physical therapy and notes indicated that, as ysicial therapy on 2/20/14, the goal on 2/7/14 of to wheelchair with caregiver rson. Review of a physicial et, dated 2/14/14, revealed itals with (quad cane) for 4 an and uneven surfaces in the pages notes for 2/7/14 at the page of t	F	520			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSIDENTIFICATION NUMBER: A. BUILDING		TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY
		105772	B. WING _			l	R 20/2014
	ROVIDER OR SUPPLIER	Г РЕТЕ		STREET ADDRESS, CITY, STATE, ZIP COD 435 42ND AVE S SAINT PETERSBURG, FL 33705	DE	1 03/	20/2014
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 520	from the hospital to admission screening DX UTI, Weakness, Depression" On antiafter being in jail." Review of the HCA (for nursing form senfacility with the patie was alert, and requirambulation and trans. An interview was condadministrator and Diat 10: 40 a.m. regard Resident # 1, a know facility on 2/13/14. If that the resident can the facility from the hospital which st offender. She stated the process of doing ambulance transport handed them another another packet of inthad with him. She swere from the States Director of Nursing stransport came back process. The DON doing the admission papers and told the some phone calls" a admission. She state Administrator that "w (#1) has done some	dmission paperwork, sent the facility, on 2/12/14, for pre present the facility, on 2/12/14, for pre present the facility of 2/12/14, for pre present the facility of 100 Male, HX of IDDM, HTN, A flutter, biotic "rejected from ALF" 23008 Medical Certification the from the hospital to the not revealed that the resident red assistance with sfer.	F	520			

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FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 105772 B. WING 03/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S REHABILITATION CENTER OF ST PETE SAINT PETERSBURG, FL 33705 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 54 F 520 charged with molestation or whatever it was, of a male at the facility he was at." She stated she thought the papers said it occurred in "September, October, November or something." The DON stated that she did not keep a copy of the papers as "those were his personal belongings." The Administrator stated that he believed this occurred late in the day, stating "It was late, like 7: 00 p.m., I was in a meeting and (the DON) knocked and said we have an issue." He stated his response was "my goodness, did we not know?" The Administrator stated that he and the DON went up to talk with Resident # 1. He stated "there was not much communication, he just stared at us and mumbled." He stated they talked to both the nurse and the therapist and that the resident was "pretty much bed bound and wasn't going to be able to get up unless he was assisted up. He stated the therapist had already assessed him by the time he and the DON went up to see the resident. He stated the therapist stayed late to assess him because she knew there was a new admission and wanted to assess him before she went home. The Administrator said the therapist told him that the resident was lying in bed and couldn't move too much, that he just layed there, staring and mumbling. He indicated that the therapist who screened the resident on 2/13/14 was the Director of Therapy and provided her name. The Administrator stated they then went to the nurse and told her what was going on. He then called the Psychiatrist and was told that the Psychiatrist would assess resident # 1 in the morning. He stated the next morning, 2/14/14, they met with the psychiatrist and discussed the following concerns with him: "we admitted him, now we have to take care of him,

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		105772	B. WING				R 20/2014
	ROVIDER OR SUPPLIER TATION CENTER OF ST	PETE		43	TREET ADDRESS, CITY, STATE, ZIP CODE 35 42ND AVE S AINT PETERSBURG, FL 33705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	do room moves." He told him that since the move around on his of someone alert and or would take it from the The DON stated that Resident # 1 on 2/14/concerned because the would try not to touch psychiatrist told her needs to go referring Administrator and the psychiatrist told them residents and alert the The following written the Administrator was record entitled Note to file: "February 13, 2014 Time: 7: 30 p.m. Resident: (#1) This Administrator was (DON) stated that the 1) was a registered sadmitted to this facility accompanied by paper hospital which confirm record. This administrator and room and discussed in presented as very conspeak at length. This the resident alone to Administrator and DOR Rehab Director. She	im safe and do we need to stated that the Psychiatrist e resident was not able to own and as long as he had riented in the room, we ere. Ithe Psychiatrist assessed (14 in the morning and was he resident told him he anyone. She stated the I feel uncomfortable, he go to Resident # 1. Both the DON stated that the to alert the staff and the e schools in the area. Idocumentation, signed by a found in the resident's exoffender and was younknowing. He was erwork from the discharging ned his status and arrest do DON went to resident's his prior arrests. Resident infused and was not willing to administrator and DON left	F	520			

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FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 105772 B. WING 03/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S REHABILITATION CENTER OF ST PETE SAINT PETERSBURG, FL 33705 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 56 F 520 opinion resident was too weak to stand let alone pose a threat to other residents. Next, Administrator put in a request for resident to be seen by staff psychiatrist." "February 14, 2014 Time: 10: 30 a.m. Resident: (#1) This administrator met with (psychiatrist) and DON in the DON's office. He stated he had just see patient (Resident # 1). Resident # 1 stated to him that he would "try" not to touch anyone during his stay at this facility. This was a concerning point for (psychiatrist). (Psychiatrist) next asked if administration had notified the roommate that he was living with a sexual predator. (Psychiatrist) stated that all staff needed to be made aware, residents, and local schools within a certain minimum radius to this facility. This administrator, accompanied by Social Worker, went to the resident's (resident # 1) room to speak with the roommate (Resident # 11). This admin found the roommate outside in the smoking section. Admin and social worker accompanied the roommate into the activities office where a private conversation could be held. This admin started discussing (Resident # 1) to the roommate (Resident # 11) when the roommate interrupted this admin and stated "I know I know he is gay. You don't have to tell me. He tried to touch me while I was lying in bed through the covers. He didn't touch me but he tried. I yelled at him and told him never to try and touch me again." (Resident # 11) went on to say "Now I really like my room and I like him as a roommate. I am fine rooming with him and I'll

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IDENTIFICATION NUMBER:	A. BUILDIN	G		COMPLETED R
105772	B. WING _			03/20/2014
ETE		STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705	,	00/20/2014
IUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
or him." If went back to the DON's dideparted the building by DON contacted one and relayed the bommate. (Psychiatrist) back to assess patient formation. Admin told DON ent (Resident 1) on a 1:1. ale CNA was assigned to a times." It is seed the patient and states anger to self and/or others, ident should be Baker and transport to (hospital)." Inducted with employee N, arse (LPN), by phone on She confirmed that she end sident # 11 on 2/13/14. The stated "he was don his own but I for help as we were not was assessed by therapy." as able to get out of bed	F 5	20		
	ETE EMENT OF DEFICIENCIES JUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) To him." Weent back to the DON's d departed the building by DON contacted one and relayed the commate. (Psychiatrist) back to assess patient formation. Admin told DON ent (Resident 1) on a 1:1. ale CNA was assigned to I times." Seed the patient and states anger to self and/or others. ident should be Baker Jussed Baker Act with both rvices team. The resident ant 1: 1 until transport and transport to (hospital)." Inducted with employee N, Jurse (LPN), by phone on She confirmed that she m. shift nurse who cared desident # 11 on 2/13/14. Thembered Resident # 1 The stated "he was d on his own but I for help as we were not was assessed by therapy." The stated of the state o	## BUILDING B. WING B. WING B. WING B. WING MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) PREFIX TAG For him." Weent back to the DON's dideparted the building by DON contacted one and relayed the bommate. (Psychiatrist) back to assess patient formation. Admin told DON ent (Resident 1) on a 1:1. ale CNA was assigned to a litimes." Feed the patient and states anger to self and/or others, ident should be Baker Jussed Baker Act with both rivices team. The resident ent 1: 1 until transport and transport to (hospital)." Inducted with employee N, urse (LPN), by phone on She confirmed that she ent. shift nurse who cared esident # 11 on 2/13/14. Inducted with employee N is the confirmed that she ent. shift nurse who cared esident # 11 on 2/13/14. The confirmed that she ent. She stated "he was don his own but I for help as we were not was assessed by therapy." The confirmed that she was don his own but I for help as we were not was assessed by therapy." The confirmed that she was don his own but I for help as we were not was assessed by therapy." The confirmed that she was don his own but I for help as we were not was assessed by therapy." The confirmed that she was don his own but I for help as we were not was assessed by therapy." The confirmed that she was don his own but I for help as we were not was assessed by therapy." The confirmed that she was don his own but I for help as we were not was assessed by therapy." The confirmed that she was don his own but I for help as we were not was assessed by therapy." The confirmed that she was don his own but I for help as we were not was assessed by therapy." The confirmed that she was don his own but I for help as we were not was assessed by the confirmed that she was don his own but I for help as we were not was assessed by the confirmed that she was don his own but I for help as we were not was assessed by the confirmed that she was don his own but I for help as we were not was assessed by the confirmed that	THE STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705 ID PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, TAG F 520 TO IT	THE STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705 PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TO OR him." To went back to the DON'S departed the building by 20N contacted one and relayed the commate. (Psychiatrist) back to assess patient formation. Admin told DON ont (Resident 1) on a 1:1. alle CNA was assigned to 1 times." Seed the patient and states anger to self and/or others. ident should be Baker and the state and the

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		105772	B. WING				₹	
NAME OF B	ROVIDER OR SUPPLIER	105772	B. WING	etd.	EET ADDRESS, CITY, STATE, ZIP CODE	03/	20/2014	
	TATION CENTER OF ST	РЕТЕ		435	42ND AVE S NT PETERSBURG, FL 33705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 520	stated "something cawas previously a sex she was not told by a to take any special phim. She stated that anything had occurred Resident # 11 never. 4. An interview was of Rehabilitation Serp.m. She had previous Administrator as the Resident # 1 on the Administrator had staged Rehabilitation Service that Resident # 1 "pri wasn't going to be at assisted up." He staged late to assess there was a new adminimated by the up to see the resident stayed late to assess there was a new adminimated by the up to see the resident stayed late to assess there was a new adminimated by the up to see the resident stayed late to assess there was a new adminimated by the up to see the resident stayed late to assess there was a new adminimated by the up to see the resident stayed there, starify the Up to see the resident stayed late to assess the was a new adminimated by the up to see the resident stayed there, starify the Up to see the resident stayed there, starify the Up to see the resident stayed the there was a new adminimated the up to see the resident stayed the to assess the the there was a new adminimated the up to see the resident stayed the the resident stayed the there was a new adminimated to a see the resident stayed the total stayed the there was a new adminimated the up to see the resident stayed the resident stayed the there was a new adminimated to a see the resident stayed the resident	1 never left his room. She ame in with him that said he coffender." She stated that administration or anyone else recautions or keep an eye on she was not aware that ed with his roommate, that said anything to her. conducted with the Director vices, on 3/19/14 at 3:38 and busly been identified by the therapist who assessed evening of 2/13/14. (The lated that the Director of les had told him on 2/13/14 etty much bed bound and bole to get up unless he was ted the therapist had already time he and the DON went lat. He stated the therapist is him because she knew mission and wanted to assess home. The Administrator do him that the resident was don't move too much, that he ling and mumbling.	F	520				

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		105772	B. WING				R 20/2014
	ROVIDER OR SUPPLIER TATION CENTER OF ST	РЕТЕ	•	STREET ADDRESS, CITY, STATE, 435 42ND AVE S SAINT PETERSBURG, FL 3			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCEE	IN OF CORRECTION E ACTION SHOULD BI D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 520	unaware of any other by the therapy depart stated that when she 2/14/14, "he didn't wa me he had been in a me a few feet, he couwaddle." Review of Occupation Plan of Treatment, da "Upper Extremity Ranguage Extremity Rangua	to assess him. She was assessment of Resident # 1 ment on 2/13/14. She assessed Resident #1, on ant to do anything. He told wheelchair. He walked with ald ambulate, it was a mal Therapy Evaluation and ated 2/14/14 revealed: nge of Motion: WFL (Within age of Motion: WFL (Within age of Motion: WFL) and DL's = Good ithout support against anding During ADLS's = Fair palance 1-2 minutes without ort without loss of balance. Patient presents with sob after 50 feet assisted gait ors: history of Sexual ere and made sexual te today." Conducted with employee M, 11:00 a.m. He confirmed to Resident # 1 and # 11 on to 11 p.m. shift. He stated Resident # 1 that he had to the was "a big heavy guy" the room during his shift. He # 1 was " just a normal erwas not aware any history He stated he was not told to any differently than any	F	520			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONS	(X3) DATE SURVEY COMPLETED		
						r	R
		105772	B. WING			03/	20/2014
	ROVIDER OR SUPPLIER TATION CENTER OF ST	PETE		435 42N	ADDRESS, CITY, STATE, ZIP CODE ID AVE S PETERSBURG, FL 33705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	1 and Resident #11. An interview was cor LPN, on 3/20/14 at 1 she was the 7 a.m. to Residents # 1 and # she was not given ar 7 a.m. nurse about a Resident 1 and Resident 1 and Resident made aware Resident # 1 and any between Resident # stated she was not ms history and was no 2/14/14. She stated therapy, he did not left. 6. An interview was Manager of the unit of Resident # 11 reside aware of any concern when he was admitted know what happeneds she did not know who Resident # 11 was "a incident with Resident # 1 eith hand up to touch him remember. 7. An interview was Social Worker, on 3/ stated she went with Resident # 11 on 2/1 (resident # 11) of the plan was to tell him to	inducted with Employee K, an 0: 30 a.m. She stated that 20 3 p.m. nurse who cared for 11 on 2/14/14. She stated by report from the 11 p.m. to nything occurring with dent # 11. She stated "no, no ual." She stated that she of any concerns related to y incident that occurred 1 and # 11 until 2/15/14. She hade aware of Resident # 1 told to monitor him on that other than going to eave his room on 2/14/14. conducted with the Unit where Resident # 1 and d. She stated she was not his related to Resident #1 and d. She stated she did not d until the next day and that en it occurred. She stated he told her her touched him or put his	F	520			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		105772	B. WING _			R 03/20/2014	
	ROVIDER OR SUPPLIER	Т РЕТЕ		STREET ADDRESS, CITY, STATE, Z 435 42ND AVE S SAINT PETERSBURG, FL 33		1 00/20/2014	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICII	ACTION SHOULD BE TO THE APPROPRIA		
F 520	me." She stated that he was lying in bed come under the curl #11, stated that he it he was gay and to ghe would hit him wit Resident # 11 was a 11 told them he had happened because stated he told her the them was because stated at the time of was in a wheelchair on strengthing his le up and transfer but stated "it sounded li 11) and saw a hand curtain." She stated lying in bed or sitting resident # 11 told the day, on 2/14/14, right after breakfast but she was not involve days later I passed and asked him how he was glad his root that was the only oft Resident #11 about incident. 8. An interview was 11: 41 a.m. with the Resident # 1. He st him about Resident because "they had foffender." He stated	ge 61 It told them "he tried to touch at Resident # 11 told them that and saw Resident # 1's hand tain. She stated Resident old Resident # 1 that he knew get his hand away from him or his cane. She stated angry. She stated Resident # not told anyone about what he was embarrassed. She ee only reason he was telling they brought it up. She if this interview, Resident # 11, was still working with therapy to the was unclear to her; she ke he was in bed (Resident # 1 toming from underneath the if she was not sure if he was in the pened earlier in the intervent around breakfast or shortly the was not sure. She stated in the investigation. A few him in the hall (Resident # 11) he was doing and he told me in the hall (Resident # 11) he was doing and he told	F	520			

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	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105772	B. WING _				⋜ 20/2014
	ROVIDER OR SUPPLIER	РЕТЕ		4	STREET ADDRESS, CITY, STATE, ZIP CODE 135 42ND AVE S SAINT PETERSBURG, FL 33705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 520	him in with a resident capacity and physicia talked about supervision that point. " He stated he made a and see him the next He stated that as far a Resident #1 had not dintent. He stated that someone because the stated that after he sa administration to let that he was a sexual with a plan to keep the stated "Then they four roommate that he had him, that is when I Bathey called me after the Review of a "Neuropsidated 2/14/14, reveal Patient with history serecent from (hospital) "Poor historian but on try not to offend. No dispensive of the "Certific Involuntary Examinat Psychiatrist on 2/14/14 to fondle other reside battery." 9. Review of Resider nursing progress note which stated "Writer ginurse that this residents."	a private room or putting who had both mental I capacity. He stated, "We ed status. We never got to special effort to come in morning after admission. as he knew at the time, done anything and denied the could not just Baker Act ey are a sexual offender. He aw Resident # 1 he told the ne staff and resident's know offender and to come up e resident's safe. He and out after talking to his ditried to do something to aker acted him. Unfortunately ne fact." Sychiatric Consultation," ed "Reason for Consult: ex offender." "Patient admit Has history sex offender." itented x 3." "He says he will current desire." Monitor his behavior." cate of Professional Initiating ion," sgned by the 4, revealed "Patient is trying ants. He has history of sexual of the talk, given in report from 7-3	F	520			

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	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBED:		TIPLE CONSTRUCTION NG	1 '	(X3) DATE SURVEY COMPLETED	
		105772	B. WING _			R 03/20/2014	
	ROVIDER OR SUPPLIER	РЕТЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 520	service progress note by the Social Service Resident #11 reporter advance from Reside 2/14/14 resident was under a Baker Act bate advance toward his rebuilding administrator roommate to inform has a sexual offender. The meeting, (Resident # administrator that the his curtain and was referred (Resident # 11) told the wanted him to make a This writer immediate psych consultation resexual advancement. The to hospital." 10. An interview was Administrator on 3/19 stated that prior to the a sexual offender, to facility had no policy as sexual offenders. He case by case basis." He stated since the irresident # 1 and # 11 Department of Law E website prior to acceptacility. He stated this stated there was no festating that it was justice.	it 1's record revealed a social e, dated 2/24/14, and signed is Assistant, ten days after d an unwanted sexual ent # 1. The note stated "On discharged to (hospital) sed on an unwanted sexual commate. This writer and met with the resident's sim of the resident's status. Upon the beginning of the 11) informed this writer and resident put his hand under eaching toward his genitals. The resident that he never such advancement again. By notified (Psychiatrist) for a garding the unwanted. Resident was Baker Acted.	F	520			

Case 8:14-bk-09521-MGW Doc 42-2 Filed 08/26/14 Page 65 of 84 PRINTED: 07/28/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED	
		105772	B. WING				R 20/2014
	ROVIDER OR SUPPLIER TATION CENTER OF ST	РЕТЕ	•	STREET ADDRESS, CITY, STATE, ZIP CODI 435 42ND AVE S SAINT PETERSBURG, FL 33705	Ē		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE		(X5) COMPLETION DATE
F 520	approximately 1:30 p identified herself as a management compar admissions person for stated the facility's adfacility three days aga admissions in his place check the Florida Dep Enforcement website admissions. She state current policy on this 12. On 3/20/14 at 7: with the Administrator has not checked the see if any of the reside predators. He stated this as the police or the check on anyone who "we will find out that we will find out that the will find out that we will find out that we will find out that we will find out that the will find out that we will find out that the will find out that the will find	conducted, on 3/20/14 at .m., with a staff person who Medicaid Specialist for the my who was working as the r the past two days. She Imission person left the and she is doing ce. She stated she does cartment of Law on any potential red she has not seen a from the facility. 52 a.m., further interview revealed that the facility status of current residents to lents are sexual offenders or there was no need to do ne sheriff will come in to o is a sexual offender and way." 00 a.m., the Administrator the facility 's policies and abuse, neglect, cappropriation of property. State Agencies and Other The Administrator was olicies in effect related to eatment and roperty and he then all documents for a total of eporting Abuse to State Entities/Individuals" with a	F	520			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		105772	B. WING			03/	20/2014
	ROVIDER OR SUPPLIER TATION CENTER OF ST	PETE		435 42ND A	DDRESS, CITY, STATE, ZIP CODE AVE S ETERSBURG, FL 33705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520	2014. The document "Residents in this fact dignity and respect at circumstances. Mistre or physical abuse of a tolerated." The document included information of A stapled sheaf of for entitled, "Abuse Reporting." Under the centitled, "Abuse, Neg Misappropriation of Protection and Responsition of Protection and	stained signature dates for as included a statement sility are to be treated with all times and under any eatment in the form of verbal any nature will not be ment defined abuse and on reporting abuse. In with a cover document orting "Thursday April 25. It ding the following incover document was a policy lect, Exploitation and roperty, Prevention, onse Policy and Procedures" of 9/12. Sign in sheets for ith an in service date of a.m., an interview was administrator regarding the above) entitled "Abuse as to which policy to the definition of abuse. He are of paper clipped Abuse Policy," stating hing everyone on this one, as one, this is what we are our definition of abuse." He epolicies were part of the col. Jument entitled "Abuse ollowing information: litty are to be treated with a call times and under any eatment in the form of verbal	F	520			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		105772	B. WING _			l	R 20/2014	
	ROVIDER OR SUPPLIER	РЕТЕ		STREET ADDRESS, CITY, STATE, ZIP C 435 42ND AVE S SAINT PETERSBURG, FL 33705		1 0011	20/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG		ION SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE	
F 520	human rights which rephysical injury to a re 2. Any act which co directed towards a re 3. Insulting or coars directed at a resident to humiliation or degr. 4. Depriving a resid property by fraudulen All employees are oblabuse to the abuse co of Social Services). All suspected, alleged of abuse shall be thor Abuse Coordinator. A will be reported imme Coordinator to the H.I96ABUSE. 1. Any person, who to report a case of un neglect, or exploitation disabled adult or who prevents another persof a misdemeanor of 2. Any person who public or discloses a contained in the Cent computer system, in the abuse, neglects (sic), disable adult id (sic) is the second degree. 3. Any person who neglects, or exploits a person, and in so doin harm, permanent disf	the following: ce of action inconsistent with esults in or could result in sident. Institutes sexual activity sident. Se language or gestures, which subjects the resident adation. Ident of real or personal trof (sic) illegal means. Iligated to report any acts of coordinator, who is (Director and the county investigated by the coughly in	F	520				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		105772	B. WING			R	
NAME OF PROVIDER OR SUPPLIER			1	-	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	20/2014
TO TWIL OF TH	TO VIDER OR OUT FEET				35 42ND AVE S		
REHABILI	TATION CENTER OF ST	PETE			SAINT PETERSBURG, FL 33705		
24.0.15	CLIMMADY CT	TATEMENT OF DEFICIENCIES					(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ID PREFIX TAG	X		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
F 520	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 67 second degree. 4. Any person who knowingly or willfully abuses, neglects, or exploits an aged person or a disabled person is guilty of a misdemeanor of the first degree." b. Review of the policy referenced in # 1 above "Abuse, Neglect, Exploitation and Misappropriation of Property, Prevention, Protection and Response Policy and Procedures" with a revision date of 9/12 revealed: "Policy: Abuse, Neglect, Exploitation and Misappropriation of Property, collectively known and referred to as ANE and as hereafter defined, will not be tolerated by anyone, including staff, patients, volunteers, family members or legal guardians, friends or any other individuals. The health center Administrator is responsible for assuring that patient safety, including freedom from risk of ANE, holds the highest priority. The Administrator has designated the following individual as the health center's ANE Prevention Coordinator: (Lists the name and phone number of the ANE Prevention Coordinator) Definitions: Abuse: the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Verbal Abuse: the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance			520	DEFICIENCY)	ATE	DATE
		in their hearing distance je, ability to comprehend or					
	disability.	, same, to compromond of					
	•	e: includes but is not limited					
	to, sexual harassmer	nt, sexual coercion, or sexual					
	assault.						
	Physical Abus	se: includes hitting, slapping,					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		105772	B. WING			03/20/2014	
NAME OF P	ROVIDER OR SUPPLIER		•	,	STREET ADDRESS, CITY, STATE, ZIP CODE		
DELIABILI	TATION CENTER OF ST	DETE		٠	435 42ND AVE S		
KEHADILI	TATION CENTER OF 31	PEIC			SAINT PETERSBURG, FL 33705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page 68 pinching or kicking. It also includes controlling behavior through corporal punishment. Mental Abuse: includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Involuntary Seclusion: the separation of a patient from other patients, or from her/his room or confinement to her/his room against the patient's will." Neglect: The failure to provide goods and services necessary to avoid physical harm, mental anguish, or illness. Neglect occurs when facility staff fails to monitor and/ or supervise the delivery of patient care and services to assure that care is provided as needed by the resident. Misappropriation of Patient Property: the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a patient's belongings or money without the patient's consent. Injuries of Unknown Source: An injury for which both of the following conditions exist: 1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident. AND 2. The injury is suspicious because of; the extent of the injury or location of the injury, or the number of injuries observed at any particular point in time, or the incidence of injuries over time. 1. Screening Issues: Policy: the center will not employ individuals who have been			520	DEFICIENCY)		
	have been a. Found guilty of a mistreating patients/re b. Have had a confi State nurse aide regis						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		105772	B. WING _	B. WING		R 03/20/2014	
NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER OF ST PETE			1	435 42ND	DDRESS, CITY, STATE, ZIP CODE AVE S ETERSBURG, FL 33705	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 520	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPR			
	directing patients who urinate or defecate in immediate steps to co	tients while giving care, oneed toileting assistance to their beds, and will take borrect such behaviors. Specially sensitive to signs					

Case 8:14-bk-09521-MGW DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 105772 B. WING 03/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S REHABILITATION CENTER OF ST PETE SAINT PETERSBURG, FL 33705 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 70 F 520 and symptoms of acute frustration. Policy: The center will seek and accept complaints from patients, patient families and staff without reprisal. Procedure: The right to report a concern or incident is not limited to a formal, written grievance process but includes any verbalized complaint to any facility staff. Prompt efforts will be made to resolve concerns. The names, addresses, and telephone numbers of all pertinent State client advocate groups such as the State survey and certification agency, the State licensure office, the state ombudsman program and the protection and advocacy network will be provided to all patients and their families in the Admission Packet and this information is also posted prominently in the center. Policy: Patients with needs and behaviors that might lead to conflict with staff or other patients will be identified by the Care Planning team, with interventions and follow through designed to minimize the risk of conflict. Procedure: Any patient identified as having behaviors which might lead to conflict or neglect, such as: patients with a history of aggressive a. behaviors. patients who enter other resident's rooms while wandering, c. patients with self- injurious behaviors, or history of self - inflicted injuries, patients with communication disorders. e. Patients who require heavy nursing care or are totally dependent on nursing care will be

considered as potential victims of abuse. The interventions designed to meet the needs of such patients will include but will not be limited to:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		105772	B. WING _	B. WING		R 03/20/2014	
NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER OF ST PETE				STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705	, ,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 520	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	520			

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		105772	B. WING				R 20/2014
	ROVIDER OR SUPPLIER TATION CENTER OF ST	РЕТЕ		435	REET ADDRESS, CITY, STATE, ZIP CODE 5 42ND AVE S INT PETERSBURG, FL 33705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	property. Procedure: Any and a about such events wi immediately to the AE 1-800-962-2873. The immediately to the im LEAST ONE OF THE INDIVIDUALS, Socia Coordinator), Director Administrator. Any and empowered to initiate appropriate. V. Investigative Issu Policy: Any empindirect knowledge of constitute abuse mus Procedure: Any a hearing about such e immediately to the AN Administrator. The evimmediately to the en All employees are ento contact the ABUSE 962-2873 if they wither reasonable cause to soccurred. Policy: All events repinvestigated to determine take place. Procedure: The ANE COORDINATOR will The Adminis Director of Nurses and ANE PREVENTION Control of the ARE COORDINATOR will The Adminis Director of Nurses and ANE PREVENTION Control of the ARE COORDINATOR will The Adminis Director of Nurses and ANE PREVENTION Control of the ARE COORDINATOR will The Adminis Director of Nurses and ANE PREVENTION Control of the ARE COORDINATOR will The Adminis Director of Nurses and ANE PREVENTION Control of the ARE COORDINATOR will The Adminis Director of Nurses and ANE PREVENTION Control of the ARE COORDINATOR will The Adminis Director of Nurses and ANE PREVENTION Control of the ARE COORDINATOR will The Adminis Director of Nurses and ANE PREVENTION Control of the ARE COORDINATOR will The Adminis Director of Nurses and ANE PREVENTION Control of the ARE COORDINATOR will The Adminis Director of Nurses and ANE PREVENTION Control of the ARE COORDINATOR will The Adminis Director of Nurses and ANE PREVENTION Control of the ARE COORDINATOR will The Adminis Director of Nurses and ANE PREVENTION Control of the ARE COORDINATOR will The Adminis Director of Nurses and ANE PREVENTION Control of Nurses and	all staff observing or hearing all report the event august Hotaline And event will also be reported mediate supervisor, AND AT a FOLLOWING and Worker (ANE Prevention of Nursing, or all employees are a immediate action as a ses: loyee having either direct or any event that might at report the event promptly, and all staff observing or events must report the event all Prevention Coordinator or ent should also be reported apployee's supervisor. Accouraged and empowered and empowered are HOTLINE AT 1-800-ess such event or have suspect such an event has a sorted as ANE will be an ine whether ANE did or did and action being taken e.	F	520			

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	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER TATION CENTER OF ST	РЕТЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705	1 - 3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 520	during an investigation Procedure: any indivicinjury will be removed suspected abusive be emotional support will available to any indivicabuse. Policy: Staff person of ANE will be suspender result of investigation suspension is at the cadministrator. Residents who are subehavior toward othe immediately separate or victims. The specific separate victim and protection of all potencase specific basis. In all cases, every apto ensure the protection resident's attending prontacted promptly to appropriate interventiare not limited to: a. One on one assignesident victims. b. Involvement of lac. Review of medical. Review of the resinterventions. e. Involuntary Discharge and Repolicy: All allegatimmediately reported.	be protected from harm n. dual found to be in danger or d from the source of the ehavior. Medical and I be made immediately idual suffering suspected or persons suspected of ed immediately pending . Pay status during discretion of the uspected of initiating abusive or residents will be d from any suspected victim ic approach employed to repetrator and to ensure the atial victims will vary on a propriate effort will be made on of our residents. The hysician should be of determine the most ons. These may include but gnment of staff to protect at wenforcement. ation regimen. sidents care plan	F	520		

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FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 105772 B. WING 03/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S REHABILITATION CENTER OF ST PETE SAINT PETERSBURG, FL 33705 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 74 F 520 Procedure: Any investigation of alleged abuse, neglect or exploitation will be reported immediately to the Administrator and the ANE Coordinator. It will also be reported to other officials, in accordance with State and Federal A. The Immediate Report All allegations of abuse, neglect, exploitation, or misappropriation of property, including injuries of unknown source, must be reported immediately. This allegation must be reported to the Abuse Hotline (Adult Protective Services) within twenty four hours whenever an allegation is made. The ANE Prevention Coordinator will also submit The Agency for Health Care Administration AHCA Federal Immediate/5 Day Report and send it to: Complaint Administration Unit Phone: 850-488-5514 Fax: 850-488-6094 E-Mail: fedrep@ahca.myflorida.com B. The Report of Investigation (Five Day Report): The facility ANE Prevention Coordinator will send the result of facility investigations to the State Survey Agency within five working days of the incident. This will be completed using the same AHCA Federal/Five Day Report, and sending it to the Complaint Investigation Unit as noted above. C. Designated Reporters: Shall immediately make a report to the State Survey Agency, by fax, email, or telephone. All necessary corrective actions depending on the result of the investigation will be taken Report any knowledge of actions by a court of law against any employee, which would indicate an employee is unfit for service as a nurse aide or other facility staff to the State nurse aide registry or other appropriated licensing authorities.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		105772	B. WING _			1	R 20/2014	
	ROVIDER OR SUPPLIER	PETE	•	STREET ADDRESS, CITY, STATE, ZIP CO 435 42ND AVE S SAINT PETERSBURG, FL 33705	DE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BI IE APPROPRIA		(X5) COMPLETION DATE	
F 520	an internal investigat Untoward Events Pol Policy: Trends of inv analyzed and addres committee process. Procedure: An accura investigations conduct maintained as a work Assessment and Risi QA and RM will revie to track and determin Any trends will be for the QA TEAM and ce c. A review of the pol Abuse to State Agent Entities/Individuals" (November 2010), rev on reporting of Abuse what to report and wh contained in section is Issues of the policy e Exploitation, and Mis Prevention, Protection Procedures (revision Review of the "Report Agencies and Other in revealed: "Policy Statement: A all substantiated incid immediately reported agencies and other e be required by law. Policy Interpretation a Should a suspected incident or mistreatm	rotective Services will trigger ion following the protocol of licy and Procedure. estigative findings will be seed by the QA RM attention and the center will be seed by the center will be seed and analyze investigations are presence of any trends. In the worded to all members of senter management." Alicy entitled, "Reporting cies and Other with a revision date of sealed different information are, as to who to report to, then to report, than what was well. Reporting and Response entitled "Abuse, Neglect, appropriation of Property. In and Response Policy and date 9/12)." Tring Abuse to State Entities/Individuals" Policy all suspected violations and dents of abuse will be a to appropriate state entities or individuals as may	F	520				

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		105772	B. WING			l	R
NAME OF P	ROVIDER OR SUPPLIER	103772	D. WING	S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	20/2014
REHABILI	TATION CENTER OF ST	PETE			35 42ND AVE S AINT PETERSBURG, FL 33705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	notify the following per and written of such in a. The State licensi responsible for survey b. The local/State Cc. The resident's Record; d. Adult Protective e. Law enforcement f. The resident's At g. The facility Medic Verbal/ written notices within twenty- four (24 such incident and such via special carrier, fax Notices will include, a. The name of the b. The number of the b. The number of thresides; c. The type of abus verbal, physical, sexued. The date and time occurred; e. The names(s) of alleged incident; and f. What immediate facility. The Administrator or I the appropriate agency above with a written rinvestigation within fix occurrence of the incisence	ported, the facility er designee, will promptly croms or agencies (verbally cident: ng/certification agency ying/licensing the facility; ombudsman; epresentative (Sponsor) of Services; tofficials; tending Physician; and cal Director is to agencies will be made it hours of the occurrence of it hours of the resident in the resident; he room in which the resident in the alleged incident all persons involved in the action was taken by the inis/her designee will provide cies or individuals listed eport of the findings of the vereal findings of abuse, reported to the State Abuse	F	520			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	TIPLE CONSTRUCTION NG	1, ,	(X3) DATE SURVEY COMPLETED	
		105772	B. WING _		0:	R 3/20/2014	
	ROVIDER OR SUPPLIER	РЕТЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705	, ~		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE	
F 520	the claim and found the unfounded. Should the allegations will be terminated from allegations be unfoun be reinstated to his/he back pay. Records of all allegations accused employees any statement by the allegation, if the employed extraoyed. The State Abuse Regallegation; The S	Registry has investigated ne allegations to be true or as be true, the employee(s) memployment. Should the ded, the employees(s) will er /their former position with sons will be filed in the personnel record along with employee disputing the oyee chooses to make one. Infounded allegations will be sistry will: It we when he/she has been investigation; yee of the nature of the oyee of the time and date of the yee of the state 's intent to dent abuse into the abuse of the allegation. In all and licensing boards will mployee is found to have of Nursing Services or to the reporting of abuse to	F	520			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						R	
		105772	B. WING			03/	20/2014
	ROVIDER OR SUPPLIER	PETE		435 42ND A	DRESS, CITY, STATE, ZIP CODE VE S TERSBURG, FL 33705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page	e 78	F s	520			
	resident # 1 and the in the facility after the in The Administrator statime Resident #1 man advance to Resident "probably sometime in specific time." He state him that Resident #1 cubicle curtain, he sand area of the sheet and stated that he unders Resident #1 was in his stated "I don't know his without getting out of hand through the cubic physically be able to you have eight foot low was during the night, to see if they had got 24 hour report about stated he did not que CNA about Resident might. He stated he did not que CNA about Resident might. He stated he did not que contained that the resident was in a room with an He stated the psychia on the phone that "in going to harm anyone no harm as Resident # 11 in any stated he wanted to be stated the wanted the wanted to be stated the wanted the wanted the wante	9/14 at 2:15 p.m. regarding investigation conducted by incident with Resident #11. Atted he did not know what de an unwanted sexual #11. He stated that it was in the night, he didn't get any atted that Resident #11 told "put his hand through the law his hand getting in the late of the food from Resident #11 that is own bed at the time. He now he could reach him the bed; you can get your					

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	IENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		105772	B. WING _		03	R 3/20/2014
	ROVIDER OR SUPPLIER TATION CENTER OF ST	РЕТЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 520	was no allegation of i unwanted sexual adv harm was done," it whotline. He stated the needed as "nothing has been stated that she is the stated she was not paregarding the incident Resident # 11. She shadministrator and she She stated "They sa volunteered information that point. She stated handled as a grievance in the grievance log. She described her publication of abuse. Staff report abuse "I of the hotline." If a residual handled as a grievance in the grievance log. She described her publication of abuse. Staff report abuse "I of the hotline." If a residual hotline. She stated the day Federal Immedia did not accept the call she would do a 1 Day was if the abuse hotling abuse. Review of the Home Federal reports p.m. determined that reports had been subtined. Observation on a first floor medication wexpired medication were stated the sexpired medication were serviced in the sexual services of the sexpired medication of a sexpired medication were sexual adversarial sexual se	nappropriate and/or ances and "we confirmed no ras not reported to the abuse ere was no investigation appened." s conducted with the Social 3/20/14 at 8:19 a.m. She Abuse Coordinator. She art of the investigation to with Resident # 1 and stated it was mainly the enthinks she was off that day. In the investigation of an She stated if a resident or to the investigation and call dent says something rough investigation, interview other residents and call the nat she would not submit a 1 the report if the abuse hotline I. She stated the only time of Immediate Federal Report in the accepted to report of the State Agency's Nursing is site on 3/21/14 at 4:05 no federal one and five day	F	520		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		105772	B. WING	B. WING			⋜ 20/2014
	ROVIDER OR SUPPLIER TATION CENTER OF ST	РЕТЕ		43	REET ADDRESS, CITY, STATE, ZIP CODE 85 42ND AVE S AINT PETERSBURG, FL 33705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	floor medication storal medication and biolog Interview with the 3rd the observation confinexpired items. Observation on 3/18/medication cart on the bottles of undated insulterview during this of Member C and the 3rd confirmed the present Observation on 3/18/medication cart on the of a benzodiazepine of	14 at 12:40 p.m. of the third age room revealed expired gicals were present. If all at 10:40 a.m. of a get third floor revealed 6 sulin for 6 facility residents. Observation with Staff d floor unit manager ce of these undated items. 14 at 12:42 p.m. of a get first floor revealed a bottle which was not properly attor per pharmacy label ot contain an open date per gesence of this undated and dication was verified by Staff of the observation. 14 at 1:05 p.m. of a get 2nd floor revealed the ption inhaler which did not and inhaler which did not. The presence of this infirmed by Staff Member I at	F	520			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI		(X3) DATE SURVEY COMPLETED			
		105772	B. WING	B. WING		R 03/20/2014	
	ROVIDER OR SUPPLIER TATION CENTER OF ST	РЕТЕ	•	435	REET ADDRESS, CITY, STATE, ZIP CODE 5 42ND AVE S AINT PETERSBURG, FL 33705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	All staff has been in-second to the factor correction from the Alf February 2014 reveal information related to a. All nurses were remedication carts and for out dated medicated dispose of them proper b. Unit Managers will treatment carts at lear report to the ADON at c. DON will make any assure that medication out dated are not in the d. This will be reported for 3 months. e. Continued investignurses out of a total of in-serviced on expired the employee listing pon 3/17/14. Seven of received the in-service after the 3/5/2014 corbenoted that all of the during the 3/17/14 and storage observations in-service training. 18. Interview with the on 3/19/14 at 2:55 p.r relevant information:	cose of expired medications. Serviced. Ility's written plan of conual QIS Survey ending in ed the following relevant medication storage (F431): educated to observe the medication storage rooms ions and treatments and early monitor the medication and st weekly for 4 weeks and and DON. It adjustments necessary to ans and treatments that are ne patient care areas. In did to QA committee monthly ation revealed a total of 23 of 38 facility nurses were did medications according to provided to the survey team of the 23 nurses who had the training had received it rection date. It should also the enurses who were present	F	520			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · · · · · · · · · · · · · · · · · ·			(X3) DATE SURVEY COMPLETED	
		105772	B. WING _				⋜ 20/2014
	ROVIDER OR SUPPLIER	РЕТЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S SAINT PETERSBURG, FL 33705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORI X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 520	assurance (QA) comminto teams to create the sign-in sheets were min addition to this med QA meeting at 9:00 a meeting at the end of Sign-in sheets are not meetings but notes at The facility held their March 4, 2014. The I include a sign-in sheet indicated that F431's discussed. Interview with the DO in the presence of the relevant information in storage (F431): I do audits where I "cl The DON stated my at the med rooms, med Periodically, I go behi everything to include surveyors came out of the bag full of needles surveyor that someon We are a needleless have set us up and be everything that the suregards to insulin that When I do my random this and pharmacy was their checks too. If I sexpired, I would pull it came in this morning	n 2/17/2014 the quality mittee met and broke out he plan of correction. No naintained for this meeting. eting, the facility has a daily .m. and a stand down each day Monday - Friday. t maintained for these re kept of the discussions. "bigger" QA meeting on March 4th, 2014 meeting did et and an agenda which plan of correction was N on 3/19/2014 at 3:19 p.m. NHA revealed the following in regards to medication heck the checker, checker." audit consists of checking carts, and treatment carts. Ind and I check through the refrigerators. When the in Monday, 3/17/2014, with is dated 2010; I told the he has to be sabotaging us. facility so someone had to rought them in. I pulled inveyors had found in it didn't have open dates. In checks I never saw any of his here last week and did he something that is he, and destroy it. When I here were other items which all expired in 2012.	F	520			

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FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING ___ 105772 B. WING 03/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 435 42ND AVE S **REHABILITATION CENTER OF ST PETE** SAINT PETERSBURG, FL 33705 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY)