PRINTED: 11/03/2021

		ID HUMAN SERVICES MEDICAID SERVICES				APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE COMP	SURVEY
		106121	B. WING			C 04/2021
	ROVIDER OR SUPPLIER		3:	TREET ADDRESS, CITY, STATE, ZIP CODE 212 JENKS AVENUE ANAMA CITY, FL 32405		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
F 725 SS=E	number 2021013176 Pruitthealth Panama was not in compliance	City on . The facility e with 42 CFR 483, ig Term Care Facilities, at : Iff	F 725			
	the appropriate comp provide nursing and r resident safety and at practicable physical, well-being of each re- resident assessments and considering the diagnoses of the facili	s sufficient nursing staff with etencies and skills sets to leated services to assure tain or maintain the highest mental, and, sident, as determined by s and individual plans of care				
	by sufficient numbers types of personnel or nursing care to all res resident care plans: (i) Except when waive this section, licensed	sonnel, including but not				
	designate a licensed nurse on each tour of	section, the facility must nurse to serve as a charge				
ABORATORY	DIRECTOR'S OR PROVIDERA	SUPPLIER REPRESENTATIVE'S SIGNATUR	F	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

/2021

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				D. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		106121	B. WING		I	C /04/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
PRUITTHE	EALTH - PANAMA CITY		1	3212 JENKS AVENUE PANAMA CITY, FL 32405			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 725	staff interviews the fas sufficient nursing staff required assistance a manner for 5 of 12 sa (Residents 2, 3, 4, 5, The findings include: During an interview w, the faceplate observed to be hangi surveyor asked the reto report the faceplate observed to be hangi surveyor asked the reto report the faceplate observed to be hangi surveyor asked the reto report the faceplate observed to be hangi surveyor asked the reto report the faceplate observed and the room but did not on the resident. At 11 passed by the room the native of the resident of the residen	ns, resident interviews, and cility failed to provide for ensure residents receive and services in a timely impled residents. and 11) with resident number 3 on a of the call light was ng from the wall. The sident highlight and 11 interviews a new form the wall. The sident to intitlate the call light to staff. The resident to intitlate the call light or check of the call light was a different call light for be on. At approximately the call light for be on. At approximately observed to answer the call ursing assistants were on the couch in the middle on the call ursing assistant were on the couch in the middle of the call ursing a call	F 728	This plan of correction consti written Allegation of Complian federal and state requirement Preparation and submission or Allegation of Compliance doe constitute and admission or a the provider of truth of the fac the corrections of the conclus forth on the statement of defic The plan of correction is personal submitted solely because of n under state and federal law. 1. Administration met with Re 43, #4, #5, #11 and formally n their concerns and entered is Grievance Process. Residen faceplate in room was repaire staff were educated regarding responses and department responsibilities. 2. All residents and staff have potential to be affected by this practice. Department leaders all shifts received education of to call lights, the department responsibilities, and on the as locations for staff break areas 3. Daily compliance rounding the work week, random comp rounds during off hours and w be conducted by the Leaders!	ce with s. s. of this s not greenent by ts alleged or toons set elections are a man and a quirements sident #2, eviewed suses into the #3 d. Facility call light the cited and staff on n response signed throughout liance eleckends will inp team and		
	2 on at appro	ximately 9:10 AM. She taken 2 hours for staff to		Administration will address Re Council and inform them of th			

answer her call light and assist her. An interview

NHA will review quarterly family/resident

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPL(ER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		106121	B. WING		_		04/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			1	3212 JENKS AVENUE			
PRUITTHE	ALTH - PANAMA CITY			PANAMA CITY, FL 3246	05		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE INCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	at approximately 10.4 her call light daily and call the main phone in She usually needs to sometimes has to wa medications. She inc sometimes has to wa medications. She inc have to wait so long interview was conduct on at approximate the she had to wait 1 hou, she was soiled with respond to her call fo she has had to wait 3 times to be changed it mes per day she wa for staff to answer he An interview was con at approxima had been in the facilit times he had to wait answer his call light, bed. Multiple anonymous a conducted on fearful of losing their much during the inter inconducted with anony stated the facility doe meet the resident nearer on of getting done that call light respons staff member further.	esident number 4 on a Man. She stated she uses of no one answers, she has to ne to the facility to get help. If me the facility to get a facility about 2 weeks and rand 45 minutes once when for the staff to a facility about 2 weeks and or and 45 minutes once when for the staff to a facility to the fac	F 72	interview results for Concerns will be a and discussed dur meetings. 4. Results of comp reviewed in month:	ddressed immediate ing morning stand up bliance rounds will be ly QAPI meeting x 3 erly thereafter until	ń	

from management, they may be able to address

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CENTERS FOR MEDICARE & MEDICAID SERVICES O					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED		
			С		

106121 B. WING 10/04/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

PRUITTHEALTH - PANAMA CITY			3212 JENKS AVENUE PANAMA CITY, FL 32405			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 725	Continued From page 3 this issue.	F 725				
	In the afternoon on, an interview was conducted with anonymous staff member B, who stated that legally the facility has enough staff to meet the residents needs but that certain CNAs will sit around and staff have trouble getting the CNAs to work. They need leadership. They need backup.					
	In the afternoon on, an interview was conducted with anonymous staff member C, who stated staffing is terrible, they are always shorthanded, and that many people have quit. The staff member stated some CNAs will stay on the hall and do their jobs while others sit on the porch outside. The staff member further stated that call lights just go off. The staff member offered that the supervisors are aware of it, including the Director of Nursing (DON). The facility has hired a new group of people they just started have not been here 2 weeks. The staff member stated that they cannot do the CNAs job as well as their own and stated the management staff seem to be scared of some CNAs and afraid to discipline staff.					
	In the afternoon on an interview was conducted with anonymous staff member D, who stated there are problems with staffing here. The staff member also verified that sometimes CNAs will be outside on the porch or in TV area, then other staff have to text them and tell them their call lights are on. There is not a process to sign out for breaks and sign in. The staff member stated some of the CNAs will yell at staff if they say anything.					

PRINTED: 11/03/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 35961066 10/04/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3212 JENKS AVENUE PRUITTHEALTH - PANAMA CITY PANAMA CITY, FL 32405 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 000 INITIAL COMMENTS N 000 An unannounced complaint survey (2021013176) was conducted at Pruitthealth Panama City on . Deficient practice was identified at the time of the survey. N 063 N 063 400.23(3)(a)1,2 &4 FS; 59A-4.108(4) FAC Minimum Nursing Staff 59A-4.108(4) In accordance with the requirements outlined in subsection 400.23(3)(a), F.S., the nursing home licensee must have sufficient nursing staff, on a 24-hour basis to provide nursing and related services to residents in order to maintain the highest practicable physical, mental, and well-being of each resident, as determined by resident assessments and individual plans of care. 400.23(3)(a)1. The agency shall adopt rules providing minimum staffing requirements for nursing home facilities. These requirements must include, for each facility: a. A minimum weekly average of certified nursing assistant and licensed nursing staffing combined of 3.6 hours of direct care per resident per day. As used in this sub-subparagraph, a week is defined as Sunday through Saturday.

400.211(2) may be included in computing the staffing ratio for certified nursing assistants if their LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

b. A minimum certified nursing assistant staffing of 2.5 hours of direct care per resident per day. A facility may not staff below one certified nursing

assistant per 20 residents. A minimum licensed nursing staffing of 1.0 hour of direct care per resident per day. A facility may not staff below one licensed nurse per 40 Nursing assistants employed under s.

TITLE (X6) DATE Electronically Signed 121

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PRINTED: 11/03/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 35961066 10/04/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3212 JENKS AVENUE PRUITTHEALTH - PANAMA CITY PANAMA CITY, FL 32405 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 063 Continued From page 1 NIGRA job responsibilities include only nursing-assistant-related duties. 3. Each nursing home facility must document compliance with staffing standards as required under this paragraph and post daily the names of staff on duty for the benefit of facility residents and the public. 4. The agency shall recognize the use of licensed nurses for compliance with minimum staffing requirements for certified nursing assistants if the nursing home facility otherwise meets the minimum staffing requirements for licensed nurses and the licensed nurses are performing the duties of a certified nursing assistant. Unless otherwise approved by the agency, licensed nurses counted toward the minimum staffing requirements for certified nursing assistants must exclusively perform the duties of a certified

counted twice.

nursing assistant for the entire shift and not also be counted toward the minimum staffing requirements for licensed nurses. If the agency approved a facility's request to use a licensed nurse to perform both licensed nursing and certified nursing assistant duties, the facility must allocate the amount of staff time specifically spent on certified nursing assistant duties for the purpose of documenting compliance with minimum staffing requirements for certified and licensed nursing staff. The hours of a licensed nurse with dual job responsibilities may not be

This Statute or Rule is not met as evidenced by: Based on observations, resident interviews, and

1. Administration met with Resident #2.

Agency for Health Care Administr	X1) PROVIDER/SUPPLIER/CLIA				
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	35961066	B. WING		C 10/0	4/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PRUITTHEALTH - PANAMA CITY		S AVENUE			
	PANAMA (ITY, FL 32405	5		
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
N 063 Continued From page 2	2	N 063			
sufficient nursing staff in required assistance an manner for 5 of 12 sam (Residents 2, 3, 4, 5, at The findings include: During an interview with the faceplate observed to be hanging surveyor asked the rest to report the faceplate initiated the call light at was visible outside the housekeeper and main the room but did not an on the resident. At 10: passed by the room but light or check on the re answered by a certified at 10:11 AM. On PM, the surveyor was hall, the bathroom eme was observed to be slitting ohall TV area near approximately 2:32 PM assistants were observed room on the middle hall of the middle hall on the middle hall on the middle hall on the middle hall on the middle hall of the middle hall on the middle	During an interview with resident number 3 on the faceplate of the call light was observed to be hanging from the wall. The surveyor asked the resident to initiate the call light to report the faceplate to staff. The resident initiated the call light at 9:34 AM and the call light was visible outside the door. A 9:46 AM, a housekeeper and maintenance staff passed by the room but did not answer the call light or check on the resident. At 10:10 AM, a staff passed by the room but did not answer the call light was the call light or check on the resident. The call light was answered by a certified nursing assistant (CnX)		#3, #4, #5, #11 and formally reviewed concerns and entered issues into the Grievance Process. Resident #3 faceplate in room was repaired. Facilistaff were educated regarding call ligh responses and department responsibilities. 2. All residents and staff have the potential to be affected by this cited practice. Department leaders and staff on all streetived education or response to callights, the department responsibilities, on the assigned locations for staff breares. 3. Daily compliance rounding through the work week, random compliance rounds during off hours and weekends be conducted by the Leadership team monitored by Administration. Administration will address Resident Council and inform them of the concentral will review quarterly family/reside interview results for similar concerns. Concerns will be addressed immediate and discussed during morning stand to meetings. 4. Results of compliance rounds will b reviewed in monthly QAPI meeting x months then quarterly thereafter until resolved.	ential ifts II and ak but s will and rn. ent	

AHCA Form 3020-0001

was conducted with resident number 4 on at approximately 10:47 AM. She stated she uses her call light daily and no one answers, she has to

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this issue.

much during the interview. In the afternoon on

, an interview was

conducted with anonymous staff member A, who stated the facility does not have adequate staff to meet the resident needs, but was not aware of care not getting done, the staff member stated that call light response time could be better. The staff member further stated that they had noticed CNAs sitting around and if they had more support from management, they may be able to address

In the afternoon on, an interview was conducted with anonymous staff member B, who

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Agency f	or Health Care Adminis	stration				D: 11/03/2021 M APPROVED
Agency for Health Care Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (Y1) PROVIDER/SUPPLER/CLIA IDENTIFICATION NUMBER: 35961066		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
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N 063	Continued From page	e 4	N 063			
	meet the residents ne will sit around and sta CNAs to work. They backup. In the afternoon on conducted with anony stated staffing is terril shorthanded, and that The staff member state the hall and do their jorch outside. The softered that call lights just go offered that the super including the Director facility has hired a ne started have not beer member stated that it as well as their own a staff seem to be scated that the action of the control of the staff. In the afternoon on conducted with anony stated there are prob staff member also we will be outside on the other staff have to te call lights are on. The other staff shave to te call lights are on. The	ifacility has enough staff to each such that certain CNAs aff have trouble getting the need leadership. They need staff have trouble getting the need leadership. They need staff member C, who bloe, they are always it many people have quit. Ited some CNAs will stay on obs while others sit on the taff member further stated off. The staff member rivisors are aware of it, or for Nursing (DON). The w group of people they just here? 2 weeks. The staff ney cannot do the CNAs job and stated the management ed of some CNAs and afraid when the staff member D, who lems with staffing here. The nified that sometimes CNAs porch or in TV area, then them and tell them their ere is not a process to sign pin. The staff member D, who lems with staffing here. The nified that sometimes CNAs porch or in TV area, then it has not staff member D. Who lems with staffing here. The nified that sometimes CNAs porch or in TV area, then				
	say anything.	·····,····,····,				

AHCA Form 3020-0001

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