STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	103037	A. BUILDING _____ B. WING _____	C 03/18/2022

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ENCOMPASS HEALTH REHABILITATION HOSPITAL OF LARGO	901 CLEARWATER LARGO RD N LARGO, FL 33770

(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
A 000	INITIAL COMMENTS A complaint survey for complaint # 2021009727 and 2022002485, was conducted on through at Encompass Health Rehabilitation Hospital of Largo. The facility was not in compliance with CFR 482.13 Patient's Rights and 482.23 Nursing Services at a condition level. An Immediate Jeopardy (IJ) was identified for complaint # 2022002485 beginning on . Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, , , or to a patient. The facility failed to protect patients safety and well-being after reports of allegations. On at 6:38 PM, the Director of Quality/Risk Manager, Chief Nursing Officer, Regional Director of Quality/Risk Manger, and via phone the Chief Executive Officer were informed of the Immediate Jeopardy which began . The hospital implemented an immediate action plan on at 3:15 PM. The Immediate jeopardy was removed on after verification of the implementation of removal actions.	A 000		
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on interviews, observations, and review of facility policy and medical records, the hospital failed to fully investigate a grievance of alleged	A 115		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 115	Continued From page 1 . . . . . for one (Patient #1) of one patient sampled for ; and (Refer to A0119) No other Patient . . . . . or neglect grievances were noted. The facility failed to promote the safety and well-being of Patient #1 after allegations of . . . . assault were made on . (Refer to A0145). Patient #1 made a . . . . assault allegation on at approximately 5:00 PM to the physical . . . . . The Chief Nursing Officer talked to Patient #1 on between 5:00 PM and 6:00 PM and proceeded to give her a business card in case she needed anything over the weekend. Patient #1 remained in the room adjacent to the alleged , , . . . for 4 days. No , exam was conducted for Patient #1 for 7 days. The alleged , , was not placed on any additional monitoring. The facility failed to thoroughly investigate the allegation of allegation which could result in the hospital failure to take actions to prevent from occurring again. . . . . / assault has serious , , , emotional and physical effects on survivors. The systemic failures constitute an immediate jeopardy situation. The Immediate Jeopardy was removed on . . . . . at 3:15 PM after verification of implementation of removal actions.	A 115		
A 119	PATIENT RIGHTS: REVIEW OF GRIEVANCES CFR(s): 482.13(a)(2)	A 119		

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A 119	Continued From page 2	A 119		

[The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee.

This STANDARD is not met as evidenced by:
Based on interviews, observations, and review of facility policy and medical records, the hospital failed to fully investigate a grievance of alleged [redacted] in one (Patient #1) of one patient sampled for [redacted].

Findings included:

Review of the facility policy and procedures titled, "Patient and Customer Complaint or Grievance", #8, reviewed [redacted] ...Page 3 ... Grievances involving situations that potentially endanger the patient such as neglect, or [redacted] should be reviewed immediately. Upon notification, the patient will be immediately removed from any situation that may endanger the patient.

On [redacted] at 12:20 PM, a tour was conducted of the West unit, which is a locked unit, accessible with employees' badges. Upon entering the unit, the nursing station is to the left. Down a hallway to the right, rooms located on the left-side of hall were: Patient # 1's semi-private room, Patients #2 and #3's room, and a third room. The doors to the Patient #1's room and Patients #2 and #3's room are directly adjacent to each other.

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A 119	Continued From page 3 On . . . . . at 2:07 PM, an interview with Chief Nursing Officer (CNO) revealed that she was aware of an allegation of . . . . assault on Friday ( ) and spoke to Patient #1 and she described a man with a black hat and tattoos (which fit Patient #2 per the CNO). CNO left a business card with her in case she needed anything over the weekend. On at 8:58 AM an interview conducted with Director of Quality/ Risk Manager (DQR) revealed that Largo Police Officer interviewed Patient #1 and she described to that the patient was wearing red shorts Bermuda length with a faded white T-Shirt that says "Lets Roll" with a tear under the right (described Patient #3). Review of the Largo Police report completed at 2:33 PM states the report documents the . . . . battery allegations between a bed ridden victim in the Encompass health facility. The suspect (Patient #3) named. There was insufficient probable cause to . . . . Patient #3 based on allegations alone. On . . at 2:25 PM, an interview conducted with Staff F, Physical . . , . . , revealed that on at approximately 5:00 PM, Patient #1 informed her that a man came into her room and exposed his . to her. Staff F went to the nursing suite and informed the Chief Executive Officer (CEO), Chief Nursing Officer (CNO) and the Nurse Manager on approximately 5:00 PM. An interview was conducted on at 10:15 AM with Patient #1 regarding the alleged assault that occurred on . Patient #1 stated she was terrified all weekend	A 119		

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because her (patient #1) room is in an [illegible] location at the end of the hall and the man who [illegible], assaulted her room was just next door. Patient #1 said she was not safe where she was and asked an unknown staff member on Sunday, [illegible] to move her room and the staff member told me that we will on Monday [illegible].

On [illegible] at 12:00 PM, a second interview with Staff D revealed that Patient #1's room was moved on Monday ([illegible]) per Patient #1's request because she did not feel safe.

Review of Patient #1's nursing progress note dated [illegible] 4:30 PM revealed that the patient reported allegations of [illegible] assault to a psychologist. Director of Quality met with patient and investigation initiated. There was no evidence the allegations of [illegible] assault that took place on [illegible] were documented in the medical record prior to this note, four days later.

Review of Patient #1's Emergency Room (ER) visit from [illegible] at 9:52 PM note revealed Patient #1 presented with [illegible]. She states she was [illegible], assaulted while at the rehab by another patient (#2) there last Friday ([illegible]). She states with all the [illegible], a police officer did not come until Tuesday ([illegible]). She states that she did not have any examination to her [illegible] area and is concerned that she has a [illegible] ([illegible]). She has an [illegible] in place. She states she could not get him (the alleged [illegible]) off of her because she was so weak. She states she has not had a shower since the incident and has not even

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A 119	Continued From page 5 washed under her nails in case of any evidence. , exam revealed a , in place. Patient has a 3mm in the 7:00 position in the entry of the . This in (the free dictionary defines as a cut, gash, notch, or incisiveness). In the 6:00 position there is evidence of increased tension to the wall at the entry of the . On at 2:40 PM, interview with Staff A revealed the facility did not conduct a Root Cause Analysis for the event that occurred .	A 119		
A 145	PATIENT RIGHTS: FREE FROM /HARASSMENT CFR(s): 482.13(c)(3) The patient has the right to be free from all forms of or harassment. This STANDARD is not met as evidenced by: Based on observation, staff interviews, patient interview, and review of facility policy and medical records, the facility failed to promote the safety and well-being of Patient #1 after reporting allegations of assault. Findings included: Review of Facility Policy and Procedure title, "Allegations of / Neglect", # 688, reviewed revealed: Purpose: To make every effort to protect patient from or neglect while a patient in the hospital and properly investigate reports of / neglect occurring in the hospital ... Hospital staff will take necessary steps to ensure that patient are kept safe from / neglect and that allegations of / neglect ... are investigated promptly, thoroughly,	A 145		

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and reported to the proper authorities ... Unwitnessed report of 1. Take immediate action to protect the patient from harm 2. Unit staff must contact their supervisor and or a supervisor on duty immediately upon notifications of allegations/ findings of any form of /neglect. 3. The patient must be: A. Examined immediately for injury B. treated, if necessary, C. Secure from harm by taking any additional necessary actions to ensure the patient safety and welfare, including but not limited to i. moving patient to another unit ... Documentation: a. allegations of / neglect are pertinent to assessment/ treatment decision and should be reflected as reported in the medical record.

On at 12:20 PM, a tour was conducted of the West unit, which is a locked unit, accessible with employees' badges. Upon entering the unit, the nursing station is to the left. Down a hallway to the right, rooms located on the left-side of hall were: Patient # 1's semi-private room, Patients #2 and #3's room, and a third room. The doors to the Patient #1's room and Patients #2 & #3's room are directly adjacent to each other.

at 12:33 PM, an interview was conducted with Staff B regarding the allegations. Staff B stated that another staff member informed her that Patient #1 said that male patient exposed his to her and tried to get into bed with her. Staff B stated she took it upon herself to sit where she could keep an on both rooms and stated that Patient #2 attempted to go into Patient #1's room and Staff B stopped him.

On at 12:50 PM, an interview was

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conducted with Staff C regarding the [redacted] allegations and Staff C said she tried to post herself outside of the patient room (Patient #2) but could not stay there because she had other patients to take care of.

On [redacted] at 2:07 PM, an interview was conducted with the Chief Nursing Officer (CNO) regarding the [redacted] assault that occurred on [redacted]. The CNO said it was a Friday between 5:00 PM and 6:00 PM on [redacted] when Staff F (Physical [redacted]) informed Nursing administration that Patient #1 made an allegation. The CNO then recalled that she went into speak to Patient #1 and gave Patient #1 her business card in case she needed anything over the weekend. The CNO stated that after she left Patient #1 room, she verbally informed the nursing staff to make sure that Patient #2 does not enter Patient #1's room, and to pass on the information to the oncoming shift and have increased surveillance at the end of the hall. The CNO informed the surveyors that Patient #2 was not with a one-to one sitter nor was patient #1 moved at that time.

On [redacted] at 2:25 PM, an interview conducted with Staff F, Physical [redacted], revealed that on [redacted] at approximately 5:00 PM, Patient #1 informed her that a man came into her room and exposed his [redacted] to her. Staff F went to the nursing suite and informed the Chief Executive Officer (CEO), Chief Nursing Officer (CNO) and the Nurse Manager on [redacted] approximately 5:00 PM.

On [redacted] at 3:33 PM, an interview conducted with Psychologist revealed she spoke to patient #1 on [redacted] and Patient #1

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informed her that Patient #2 had entered her room on and said something "Crude" and exposed his to her. Patient #2 crawled on top of her as she tried to fight him off. Staff N described the patient as "fragile and crying and sobbing." Staff N reported the discussion she had with Patient #1 to Nursing administration. Staff N spoke to Patient #1 again on and Patient #1 was concerned about the possibility of a ( ).

On at 9:53 AM, and interview conducted with Patient #4's family revealed that she was told on by Patient #1 that a male patient came into her room and tried to get under the covers with her.

An interview conducted on at 10:15 AM with Patient #1 regarding the assault that occurred on Patient #1 stated she was terrified all weekend because where her (patient #1) room is located, it is at the end of the hall and the man (Patient #2) room in proximity, just next door. Patient #1 said she was not safe where she was and asked an unknown staff member on Sunday to move her room and the staff member told me that we will on Monday .

On at 1:35 PM, an interview was conducted with Staff E regarding when Patient #1 was moved and was informed she was moved either Monday ( ) or Tuesday ( ).

Review of Patient #1's Emergency room visit from at 9:52 PM note revealed Patient #1 presented with , . She states she was

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A 145	Continued From page 9 , assaulted while at the rehab by another patient last Friday ( ). She states with all the , a police officer did not come until Tuesday ( ). She states that she did not have any examination to her , area and is concerned that she has an . She has an in place. She states she could not get him off of her because she was so weak. She states she has not had a shower since the incident and has not even washed under her nails in case of any evidence. , exam revealed a , in place. Patient has a 3mm in the 7:00 position in the entry of the . This in (the free dictionary defines as a cut, gash, notch, or incisiveness). In the 6:00 position there is evidence of increased tension to the wall at the entry of the . Review of Patient #2's Medical record Physicians progress notes reveal that on the nightshift, patient was lying on the floor in front of another patient's bed. Interview conducted on at 11:01 AM with Nurse Practitioner CC revealed that when Patient #2 was in his roommate and the roommate's wife were uncomfortable, scared and concerned about Patient #2. Nurse Practitioner CC revealed that on going into another female patient informed him that while she was on the bedside commode a man in a wheelchair came into her room and she yelled at him, and he left. This was relayed to the charge nurse. The patient that day was moved to the locked unit of the hospital .	A 145		
A 385	NURSING SERVICES	A 385		

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A 385	Continued From page 10 CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on facility staffing sheets, staff interviews, facility policy review, and job description the facility failed to ensure precautions in place to prevent possible to the other 19 patients on the unit. The facility became aware of the allegation of on approximately 5:00 PM regarding a male patient on the West unit. The facility created a potential harm for the 20 patients on the West Unit. Refer to tag A 0386, refer to Tag A 0392 The system failure constitutes an immediate jeopardy situation. The facility failed to provide standard nursing services to protect patients safety and well-being after reports of allegations. On at 6:38 PM the Director of Quality/ Risk Manager, Chief Nursing Officer, Nurse Manager, Regional Director of Quality/ Risk Manager and via phone the Chief Executive Officer was informed of the Immediate Jeopardy which began on . The facility implemented an immediate action plan on . The Immediate Jeopardy was removed on at 3:15 PM after verification of implementation of removal actions.	A 385		
A 386	ORGANIZATION OF NURSING SERVICES CFR(s): 482.23(a)	A 386		

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A 386	Continued From page 11 The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. This STANDARD is not met as evidenced by: Based on staff interviews, review of facility policy, facility staffing sheets, and job descriptions, the facility failed to monitor patient location and activity after allegations of . . brought against the male patient. Findings included: Review of Policy and Procedure title, "Nursing Staffing", #400, review , ...Purpose to develop a nursing staffing plan that will support the provision of quality patient care in a safe, cost-effective manner using qualified, skilled personnel ...A registered Nurse will be immediately available to assist and supervise patient care as well as to respond to emergency situation ... Patient care assignment will be made by a Registered Nurse and take into consideration A. The training, experience, and capability of the person to whom the task is delegated. B. the degree and availability of supervision required for the staff member, including student nurses and staff orientation. C. The condition of the patients' identified needs, . . . of assessment and care required. D. Patient safety and control issues.	A 386		

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Review of the job description for Chief Nursing Officer (CNO) revealed ...The CNO holds full responsibility for the quality of nursing care provided ... Develop and implements the plan for providing nursing care, treatment, and services. Determines of the types and numbers of nursing personnel necessary to provide nursing care ...

On . . . . . Patient #1 made an allegation of a male patient coming into her room and exposing himself to her. On . . . . . to the CNO she described Patient #2. On , she described Patient #3 to the Largo Police Officer.

On . . . . . at 12:33 PM an interview was conducted with Rehab Nursing Technician (RNT) stated when she found out about the alleged on she sat near the room and noticed Patient #2 trying to go into Patient #1's room again.

On at 12:50 PM an interview was conducted with staff C regarding the allegation of . Staff C stated that they tried to post themselves outside of the room but had other patients to take care of and could not stay posted at the doorway.

On . . . . . at 10:47 AM an interview was conducted with Staff K; inquired if there was a specific instruction regarding the allegation of assault on and she stated she worked the weekend of . . . . . and . She keep an , on Patient #3 because he . . . . around and she has never seen Patient #2 . . around.

On at 11:29 AM, an interview with the Chief Nursing Officer in which she stated that

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(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
A 386	Continued From page 13 there was an increase in staff on . . . . . through for the West Unit. The West Unit is a locked unit, accessible with employees' badges. Review of the facility staffing sheets from . . . . . through . . . . . revealed no increase in the staffing for the west unit and no decrease in patients noted during that time frame.	A 386		
A 392	STAFFING AND DELIVERY OF CARE CFR(s): 482.23(b) The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for care of any patient. This STANDARD is not met as evidenced by: Based on staffing schedules reviewed, staff interviews, job descriptions and facility policies the facility failed to provide adequate staffing to ensure the safety and well-being of all the patients on the West Unit after an allegation of brought against a male patient on the unit. Findings included: Review of the Policy and procedure title, "Plan for the Provision of Patient Care", #100, reviewed . . . . Ensures a sufficient number of qualified, competent, professional and support personnel are available to meet the objectives of each service and the needs of the patient population ... The needs of each patient are	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	103037	A. BUILDING _____ B. WING _____	C 03/18/2022

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ENCOMPASS HEALTH REHABILITATION HOSPITAL OF LARGO	901 CLEARWATER LARGO RD N LARGO, FL 33770

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A 392	Continued From page 14 assessed every shift and as needed, to determine the level of patient acuity and to plan or adjust staffing needs. The final determination is made through the experience and knowledge provided by the nurse executive in a daily assessment of the acuity needs of the patients ... Review of the Policy and procedure title, "Allegations of . . . . / Neglect", # 688, reviewed , ... Hospital staff will take necessary steps to ensure that patient are kept safe from / neglect ... Secure from harm by taking any additional necessary actions to ensure the patient safety and welfare ... Review of the job description for Chief Nursing Officer (CNO) revealed ...The CNO holds full responsibility for the quality of nursing care provided ... Develop and implements the plan for providing nursing care, treatment, and services. Determines of the types and numbers of nursing personnel necessary to provide nursing care ... On at 2:07 PM with the Chief Nursing Officer the surveyor conducted an interview and inquired why the patient was not on a one-one sitter to protect every patient in the facility, the CNO stated that Patient #2 has not done anything like this, he had a . . ,. , and very forgetful but pleasant. at 11:29 AM, an interview with the Chief Nursing Officer in which she stated that there was an increase in staff on through . . . . . for the West Unit. The West Unit is a locked unit, accessible with employees' badges. Review of the facility staffing sheets from	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 392	Continued From page 15 . . . . . through . . . . . revealed no increase in the staffing for the west unit and no decrease in patients noted during that time frame.	A 392		