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	(X3) DATE SURVEY COMPLETED
	105926	A. BUILDING _____ B. WING _____	C 04/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER SUNCOAST	**1095 PINELLAS POINT DR 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey for complaint numbers 2022002994 and 2022004156 was conducted at Westminster Suncoast on , in conjunction with a revisit to a recertification survey (Event ID: YCBY12). The facility was in compliance with 42 CFR, Part 483, Requirements for Long Term Care Facilities.	F 000		

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

Electronically Signed /2022

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.

Agency for Health Care Administration

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N 000	INITIAL COMMENTS A complaint survey for complaint numbers 2022002994 and 2022004156 was conducted at Westminster Suncoast on , in conjunction with a revisit to a relicensure survey (Event ID: YCBY12). Deficiencies were identified at the time of the survey.	N 000		
N 917 SS=D	400.147(8), FS Report . . . ., Neglect, & , (8) , neglect, or , must be reported to the agency as required by 42 C.F.R. s. 483.13(c) and to the department as required by chapters 39 and 415. This Statute or Rule is not met as evidenced by: Based on observation, record review, interviews and facility policy review, the facility failed to report an allegation of within 24 hours related to an allegations of mistreatment for one resident (#4) of four sampled residents. Findings include: On at 10:45 a.m. an observation was conducted of Resident #4 sitting in her wheelchair with a family member in the room. Resident #4 was observed to have her entire right arm wrapped at an approximate 60-degree angle up to almost her . . . . . . The family member reported the resident had a hearing . . . but was able to read , . to compensate. The family member stated the resident had a concern, that either occurred on Friday (. . . .) or Saturday ( ), and the concern had been reported to a nurse. The concern was an aide in the night took her to the bathroom and told her to "wipe." The aide then returned later in the night, had to change her in bed, the aide was rough. Resident	N 917	Resident #4 discharged on . The allegation made by Resident #4 was reported to Adult Protective Services, local law enforcement and the State Agency on . The report was not accepted by the Adult Protective Services agency. The aide was removed from providing care to Resident #4 on . . . . . the aide was placed on do not return status the staffing agency the aide works for. An investigation was completed. Residents, on the care assignments this aide had, were interviewed and no other residents had complaints about care from the aide or others. The aide was placed on do not return status with the staffing agency the aide works for and is not able to work in the facility A random audit will be done monthly regarding satisfaction with care/allegations of by interviewing residents. The results of the interviews will be reviewed by the	

AHCA Form 3020-0001

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N	Continued From page 1 #4 gave a description of the aide and stated she had reported the concern to the nurse the next morning. The family member stated the resident was afraid to go to sleep, and afraid the aide would come . . . in the room. The family member stated the aide had bent down close to the resident's . . , but the resident did not hear what she said. Resident #4 stated she did not know what kind of threats she was making, and she did not want the aide to come in and pull the privacy curtain. Resident #4 stated she was afraid she would not see the aide come in her room. She stated if there was a way that she could go home at night, and then return in the morning, she would do it. The family member stated the day shift was very good and attentive but was not sure what happens at night. On . . . . . at 9:45 a.m., during the entrance conference with the Nursing Home Administrator (NHA) and the Director of Nursing (DON), the facility was asked to provide the log for and Neglect allegations and the log for Grievances from through . When the logs were provided during the survey, no listing for Resident #4's allegation was present on either of the logs. On . . . . . at 12:33 p.m., an interview was conducted with the Assistant Director of Nursing (ADON) and the Social Worker (SW). The ADON reported Staff A, Licensed Practical Nurse (LPN), called the Director of Nursing (DON) on Friday morning ( ) before 8:00 a.m.to report Resident #4 had a complaint. Staff A stated Resident #4 told her the aide (Staff B, Certified Nursing Assistant) made her wipe herself. She stated Resident #4 told her she could not do that. Staff A said the event happened between 12 (midnight)-1:00 a.m., then, later that night, around	N 917	Administrator/designee to ensure any allegations of are reported. Social Services staff will educate nursing center staff on the policy. The facility will use the CMS Critical Element Pathway to direct investigations of . The clinical and administrative staff will be educated on . . . . . investigation and reporting by the Vice President of Clinical Services. The Director of Social Services will report all allegations of . . . . . and the status of mandatory reporting to the QAPI committee monthly for six months and then quarterly thereafter. The QAPI committee will monitor for compliance with the policy on .	

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N 917	Continued From page 2 4:00 a.m., the resident put the light on, and by the time the aide got to the resident she had gone in her brief. Staff A stated the aide changed the resident and the resident reported the aide was a "little rough." The DON instructed Staff A to take the aide off of the floor and have her wait until she arrived to get a statement. The ADON stated, she and another ADON, took the aide (Staff B) and asked her what happened. Staff B told them when she took the resident into the bathroom, she was "encouraging" the resident to wipe with her non-dominant . Staff B, Certified Nursing Assistant (CNA) told them when she went in around 4:00 a.m. she rolled the resident over and the resident had a brief on. So, instead of pulling the brief down, she ripped the sides of the brief. Staff B told them the resident may have thought she was rough. The ADON reported no training had been conducted as a result of the allegation. On . . . . . at 2:00 p.m., an interview was conducted with the DON, she reported she had received a call from Staff C, LPN who was relaying what Staff A, LPN had told her. The DON reported the concern was Resident #4 did not want Staff B, CNA to take care of her. The resident alleged during toileting in the night, the aide had taken her to the bathroom and the resident felt like the aide was not listening to her because the aide told the resident to wipe herself. The DON stated the second time, the resident was changed in bed and the resident felt the aide was rough with her. The DON stated she told them to take the CNA off the floor, had them sit her in the lobby and wait for their arrival. The managers get here at 7:30 a.m. The DON stated she called the Nursing Home Administrator (NHA) right afterwards. The DON stated she did not know how long the aide took to answer the call light, she reported the aide had stated she had	N 917		

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N 917	Continued From page 3 been in another room assisting another resident prior to going into Resident #4's room. The DON stated the two ADONs interviewed Staff B, CNA and then the NHA and the SS (Social Services) Director took over. The DON provided a grievance form for review. A review of the Complaint/Grievance Report, provided by the facility on . . . . . , revealed Staff A, LPN, had completed the form on . . . . . , which documented a concern about treatment: "Complaint of care given during brief change and toileting earlier during the night. Resident stated that aide refused to assist her with wiping after she explained that her dominant arm is broken. Again, when she was assisting with brief change in bed, she stated aide pushed her onto her side rough. She did not want the aide to come . . . into her room, she stated that she was afraid of her." The form was blank in the area listed for documentation of investigation and resolution. On at approximately 4:30 p.m., the NHA reported to her knowledge, the facility had not put Staff B, CNA, on the do not return list. She stated they had gone down to interview the resident, and they would be reporting based on the information received during the interview. The NHA reported no other residents had been interviewed regarding the allegation. A review of the facility . . . . , Neglect, and , Policy, revised , indicated the following: Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent . . . . , neglect , ... and misappropriation of resident property.	N 917		

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N 917	Continued From page 4 Definitions included: " " means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, , or mental anguish. also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and , well-being. Instances of of all residents, irrespective of any mental or physical condition, cause physical harm, , or mental anguish. It includes , and mental including facilitated or enabled through the use of ..." Mental " " includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation ... "Neglect" means the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, , mental anguish, or emotional distress ... "Mistreatment" means inappropriate treatment or , of a resident. The Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent , neglect, and , of residents and misappropriation of resident property; b. Establish policies and procedures to investigate such allegations; and c. Include training for new and existing staff on activities that constitute , neglect, , , and misappropriation of resident property, reporting procedures, and management and resident prevention; and d. Establish coordination with the QAPI program. 2. The facility will designate an Coordinator	N 917		

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N 917	Continued From page 5 in the facility who is responsible for reporting allegations or suspected , neglect or to the state survey agency and other officials in accordance with state law. 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. The components of the facility prohibition plan included: ...B. Possible indicators of include, but are not limited to: 1. Resident, staff, or family report of ...10. Sudden or unexplained changes in behaviors and/or activities such as fear of a person or place, or feelings of guilt or shame ... VII Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specific timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve and do not result in serious bodily injury. 2. Assuring that reporters are free from retaliation or reprisal; 3. Reporting to the state nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service; 4. Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following: a. Analyzing the occurrence(s) to determine why , neglect, misappropriation of resident property or occurred, and what	N 917		

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N 917	Continued From page 6 changes are needed to prevent further occurrences; b. Defining how care provision will be changed and/or improved to protect residents receiving services; c. Training of staff on changes made and demonstration of staff competency after training is implemented; d. Identification of staff responsible for implementation of corrective actions; e. The expected date for implementation; and f. Identification of staff responsible for monitoring the implementation of the plan. B. The Administrator should follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. The facility had not reported the allegation to Adult Protective services or the State Agency as of [redacted], 2:00 p.m. CLASS III	N 917		