STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105326	A. Building B. Wing	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Towers Inc	3501 Bayshore Blvd Tampa, FL 33629

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40775 Based on interviews and record reviews, the facility failed to document revisions to the plan of care for one (Resident #18) of 18 sampled residents. Findings included: A review of Resident #18's medical record revealed Resident #18 was admitted to the facility on [DATE] with diagnoses of dementia without behavioral disturbance and adjustment disorder with anxiety. A review of Resident #18's Interdisciplinary (ID) Notes dated 7/5/2023 at 4:50 PM revealed Resident #18 obtained a skin tear upon showering. A treatment for the skin tear was implemented and Resident #18's responsible party and physician were notified. A review of Resident #18's ID Notes dated 7/31/2023 at 1:27 PM revealed Resident #18 had new skin tears from a morning shower to the left hand, right hand, and right forearm. A treatment for the skin tears was implemented. A review of Resident #18's Minimum Data Set (MDS) assessment dated [DATE] revealed under Section C - Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. Resident #18's MDS assessment also revealed under Section E - Behavior, Resident #18 displayed rejection of care behaviors 1 to 3 days in the 7 day assessment period. An interview was conducted on 8/10/2023 at 10:47 AM with Staff A, Licensed Practical Nurse (LPN). Staff A stated Resident #18 had skin tears on her hands and forearms which occurred in the shower on 7/31/2023. Staff A was not able to state how the skin tears developed but stated Resident #18 was typically combative with staff during showers and two staff members assisted Resident #18 with her showers. An interview was conducted on 8/10/2023 at 11:42 AM with Staff B, LPN. Staff B stated Resident #18 could sometimes be combative with staff while being provided care and hates showers. Staff B also stated Resident #18 developed a skin tear to her left arm on 7/5/2023 while being given a shower due to the resident swinging her arm and hitting the side of the shower chair. The skin tear was assessed and a treatment was initiated for the wound. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #18's care plan revealed a problem, dated 8/10/2023, Resident #18 was at times physically abusive towards staff as evidence by resisting assistance and hitting staff during showers. Interventions included to monitor for danger to self and others, provide one to one assistance as needed and re-assurance, and if Resident #18's initial approach is abusive staff should stop and inform the nurse. Resident #18's care plan did not address physically abusive behaviors prior to 8/10/2023. An interview was conducted on 8/10/2023 at 1:21 PM with the facility's Director of Nursing (DON). The DON stated on 7/31/2023, Resident #18 developed skin tears on her bilateral arms and hands due to the resident becoming upset during a shower and flailed her arms. The DON addressed Resident #18's care plan did not address physically abusive behaviors prior to 8/10/2023 and stated interventions were initiated today [8/10/2023] because Resident #18's care plan was up for review. The DON stated Resident #18's behaviors probably should have been part of the resident's care plan prior to 8/10/2023 considering the resident had displayed the behaviors in the past. An interview was conducted on 8/10/2023 at 1:46 PM with Staff C, LPN/MDS. Staff C stated resident care plans were usually revised quarterly or when a medical or behavioral change is identified. Staff C also stated the care plan is revised as incidents occur, usually within 14 days, and Resident #18's care plan should have been revised upon discovery of her combative behaviors. A review of the facility policy titled Care Plans, dated January of 2023, revealed under the section titled Procedures each resident admitted to the nursing home facility shall have a plan of care. The assessment must be reviewed no less than once every 3 months and promptly after a significant change, which is a need to stop a form of treatment because of adverse consequences, or commence a new form of treatment to deal with a problem in the resident's physical or mental condition; and revised as appropriate to assure the continued accuracy of the assessment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40775 Based on observations, interviews, and record reviews, the facility failed to maintain accurate and complete medical records by failing to fully document occurrence of skin tears for one (Resident #18) of 18 sampled residents. Findings included: A review of Resident #18's medical record revealed Resident #18 was admitted to the facility on [DATE] with diagnoses of dementia without behavioral disturbance and adjustment disorder with anxiety. A review of Resident #18's physician's orders revealed an order, dated 7/31/2023, to monitor steri strips to the left wrist, left forearm, right wrist, and right forearm every shift. A review of Resident #18's Interdisciplinary (ID) notes dated 7/5/2023 at 4:50 PM revealed Resident #18 obtained a skin tear upon showering. A treatment for the skin tear was implemented and Resident #18's responsible party and physician were notified. The ID note did not reveal how the skin tears to Resident #18 were obtained. A review of Resident #18's ID notes dated 7/31/2023 at 1:27 PM revealed Resident #18 had new skin tears to the left hand, right hand, and right forearm from a morning shower. A treatment for the skin tears was implemented. The ID note did not reveal how the skin tears to Resident #18 were obtained. A review of Resident #18's Minimum Data Set (MDS) assessment dated [DATE] revealed under Section C - Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. Resident #18's MDS assessment also revealed under Section E - Behavior, Resident #18 displayed rejection of care behaviors 1 to 3 days in the 7 day assessment period. A review of Resident #18's care plan revealed a problem, dated 8/10/2023, Resident #18 was at times physically abusive towards staff as evidence by resisting assistance and hitting staff during showers. Interventions included to monitor for danger to self and others, provide one to one assistance as needed and re-assurance, and if Resident #18's initial approach is abusive staff should stop and inform the nurse. An observation was conducted on 8/8/2023 at 8:49 AM of Resident #18 during the breakfast meal. Resident #18 was sitting up in her bed and eating small amounts of food. Several skin tears dressed in steri strips were observed to Resident #18's bilateral hands and bilateral forearms. No bruising or bleeding was observed. Resident #18 was not able to state how the skin tears occurred and was not alert and oriented during conversation. An interview was conducted on 8/10/2023 at 9:40 AM with the facility's Risk Manager (RM) and Director of Nursing (DON). The RM stated Resident #18 developed skin tears while being given a shower on 7/31/2023 and was not able to state how the skin tears occurred during the shower. The RM was not able to find any documentation in Resident #18's medical record to detail how the skin tears occurred. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 8/10/2023 at 10:47 AM with Staff A, Licensed Practical Nurse (LPN). Staff A stated Resident #18 had skin tears on her hands and forearms which occurred in the shower on 7/31/2023. Staff A was not able to state how the skin tears developed but stated Resident #18 was typically combative with staff during showers and two staff members assisted Resident #18 with her showers. Staff A, LPN stated she did not document how Resident #18 incurred skin tears during the shower and did not ask the nurse's aide how the skin tears occurred. Staff A stated she only treated the wounds. An interview was conducted on 8/10/2023 at 11:42 AM with Staff B, LPN. Staff B stated Resident #18 could sometimes be combative with staff while being provided care and hates showers. Staff B also stated Resident #18 developed a skin tear to her left arm on 7/5/2023 while being given a shower due to the resident swinging her arm and hitting the side of the shower chair. The skin tear was assessed and a treatment was initiated for the wound. Staff B stated skin tear incidents are documented by completing an incident report in the resident's record to document exactly what occurred. Staff B was not able to find an incident report for Resident #18's skin tears on 7/31/2023. An interview was conducted on 8/10/2023 at 1:21 PM with the facility's DON. The DON stated on 7/31/2023, Resident #18 developed skin tears on her bilateral arms and hands due to the resident becoming upset during a shower and flailed her arms. The DON addressed there was not an incident report documented related to the skin tears and stated she would expect the nurse to complete an incident report to document how the incident occurred. A review of the facility policy titled Incidents and Accidents, with no effective date, revealed under the section titled Policy Explanation the purpose of incident reporting can include: - Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care. - Conducting root cause analysis to ascertain causative/contributing factors as part of Quality Assurance Performance Improvement (QAPI) to avoid further occurrences. - Alert risk management and/or administration of occurrences that could result in claims or further reporting requirements. - Meeting regulatory requirements for analysis and reporting of incidents and accidents. A review of the facility policy titled Documentation in the Medical Record Policy, with no effective date, revealed each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. The policy also revealed under the section titled Policy Explanation and Compliance Guidelines licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. Documentation accurate, relevant, and complete, containing sufficient details about the resident's care and/or response to care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40775 Based on observations, interviews, and record reviews, the facility failed to implement an effective infection prevention and control program related to 1.) failing to ensure hand hygiene was performed during observation of medication administration for two (Resident #25, Resident #10) of six residents observed during medication administration, 2.) failing to administer eye drops in a manner to prevent cross contamination for one (Resident #10) of six residents observed during medication administration, and 3.) failing to ensure proper storage and usage of personal protective equipment (PPE) for one (Resident #6) of six residents observed during medication administration. Findings included: An observation of medication administration was conducted on 8/9/2023 at 8:39 AM for Resident #25 with Staff A, Licensed Practical Nurse (LPN). Staff A removed Resident #25's medications from the medication cart and dispensed them into a medication cup. Staff A crushed each medication to prepare them for administration to Resident #25. After preparing the medications, Staff A entered Resident #25's room and administered medications by mouth to the resident. During the administration, Resident #25 had a small emesis due to the taste of the crushed medications. Staff A assisted Resident #25 in cleaning the emesis and gathered paper towels for the resident to wipe her mouth off. After assisting Resident #25, Staff A exited the room and gathered medications for administration to Resident #10. Staff A did not perform hand hygiene during the observation of medication administration to Resident #25. An observation of medication administration was conducted on 8/9/2023 at 9:11 AM for Resident #10 with Staff A. Staff A removed Resident #10's medications from the medication cart and dispensed two medication pills into a medication cup. Staff A removed a vial of eye drops for administration to Resident #10 from the medication cart. After gathering the medications, Staff A removed a pair of gloves from the medication cart and entered Resident #10's room. Staff A explained to Resident #6 she was going to administer medications. Staff A administered Resident #10's medications by mouth before donning gloves to administer eye drop medication. Staff A held Resident #10's bottom eye lid and administered a drop of medication in the resident's right eye. Staff A then held Resident #10's bottom eye lid and administered a drop of medication in the resident's left eye. Staff A then removed her gloves and exited the room. Staff A did not change gloves in between administration of eye drops in the right and left eye and did not perform hand hygiene during the observation. An interview was conducted with Staff A following the observation. Staff A stated she would normally perform hand hygiene frequently throughout medication administration but addressed she did not and stated she was nervous. An observation of medication administration was conducted on 8/9/2023 at 9:16 AM for Resident #6 with Staff A. Staff A performed hand hygiene prior to pulling medications from the medication cart. Staff A removed three medications from the medication cart, including a capsule. Staff A removed a pair of gloves from her left side pocket and donned them. Staff A opened the medication capsule and emptied the contents into a medication cup. Staff A removed the gloves and crushed the other two remaining medications before adding it to the medication cup and mixing the medications with apple sauce. Staff A entered Resident #6's room and administered the medications before exiting the room. Staff A performed hand hygiene following the procedure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow up interview was conducted on 8/9/2023 at 11:03 AM with Staff A. Staff A stated she normally kept gloves in her pocket but she probably shouldn't store the gloves in her pocket. Staff A addressed she did not change gloves when administering eye drops to Resident #10 and stated she would not normally change gloves because she doesn't have pink eye or anything. Staff A stated she should have changed her gloves in between administration of Resident #10's eye drops. An interview was conducted on 8/10/2023 at 10:14 AM with the facility's Infection Control Preventionist (ICP) and the facility's Director of Nursing (DON). The DON stated daily rounding was conducted to ensure hand hygiene was being performed by staff. The ICP stated hand hygiene should be performed before and after meals, after using the bathroom, in between passing resident meal trays, before entering resident rooms, after leaving resident rooms, and before and after use of gloves. The ICP also stated she would not expect staff members to keep gloves inside of their pockets because other items could be inside the pocket and it would compromise the gloves. Gloves should be removed from the manufacturer's box before donning them. The ICP stated she would expect nursing staff to change gloves and perform hand hygiene when administering eye drops to a resident in both eyes to prevent spread of infection. A review of the facility policy titled Medication Administration, with no effective date, revealed under the section titled Policy Explanation and Compliance Guidelines nursing staff are to wash hands prior to administering medication per facility protocol and product. A review of the facility policy titled Hand Hygiene, with no effective date, revealed under the section titled Policy Explanation and Compliance Guidelines staff will perform hand hygiene when indicated using proper technique consistent with accepted standards of practice. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves.