STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105009	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golfcrest Nursing Center	600 North 17th Ave Hollywood, FL 33020

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policy and procedure, interview and record review, the facility failed to timely order to obtain and document proper admission physician orders for immediate care involving surgical site and Foley catheter care, and for pain medication for a resident; re-assess and document a resident's pain level; and administer routinely ordered medications to a resident, for 1 of 2 sampled residents reviewed for admission orders after surgery, Resident #1. The findings included: Review of the facility policy and procedure titled, Pain Observation and Record, provided by the Director of Nursing (DON) reviewed April 21, 2021, documented in the Policy Statement: Pain Observation and Record UDA will be completed on every resident as part of the admission process. Pain will be re-observed and recorded any time a resident states that his/her pain level has changed/when pain medication or dosage is changed, or anytime the resident's condition significantly changes. Purpose: The management of pain is essential to enhance quality of life by routinely reviewing a resident's level of pain and providing and managing pain control in collaboration with the attending physician/Medical Director. General Guidelines: 1. A. Pain observation and Record UDA will be completed on every resident as part of the admission process, quarterly and upon significant change in resident status and become part of the medical record. 2. If a resident states, or shows signs that he/she is having pain and does not currently have a prescribed pain medication, or is not receiving relief from current type dosage frequency of pain medications; and this is considered unstable, the nurse will contact the attending physician to discuss pain observations and interventions and develop a plan of care to better control the pain. Record review of the facility policy and procedure titled, Assisting the Nurse in Examining the Resident, provided by the DON reviewed August 2017 documented in the Policy Statement: .Purpose: The purposes of this procedure are to examine the condition of the resident's body and to observe the resident's performance admission Notes/admission Data Collection: admission Notes/admission Forms should include as a minimum documentation of the admission of a resident (as they may apply): .f. Vital signs and condition of resident upon admission (i.e. confused, weak, alert, etc.) g. Time physician was notified of the admission. h. Time physician's orders were received and verified I. Medications were ordered from the pharmacy (continued on next page)

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.

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

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed Resident #1 was admitted to the facility on [DATE] at 6:46 PM with diagnoses that included Encounter for other Orthopedic Aftercare and Malignant Stage 4 Neoplasm of Prostate with metastasis to multiple sites to include bone and Hypertension. Resident #1 had been previously admitted to the hospital on [DATE], he was status-post (s/p) second (2nd) major spinal surgery performed on 04/24/25. Resident #1 was noted, in facility records, as being Independent with Cognitive Skills for Daily Decision Making---Made decisions regarding tasks of daily life. A telephone interview was conducted on 05/21/25 at 2:25 PM, with Resident #1's family member regarding the resident's care and treatment upon admission to the facility on [DATE] at 6:46 PM. The resident's family member stated Resident #1's pain medication was never given to him, and he said that the resident told him that he had pain all over his body, while family members were waiting there in the resident's room with him. The family member stated one (1) of his other family members spoke to the Supervisor at the time, but he said that the nurse gave no solution. Review of Resident #1's progress notes dated 05/02/25, documented the day after admission to the facility, a family member called 911 to send the resident back to the hospital because she felt Resident #1's needs could not be met at the facility. The resident was transported to the hospital at 12:07 PM. On 04/24/25 at 6:12 AM Resident #1's Hospital's Physician's History and Physical documented, Medications . Morphine Sulfate (MS) Contin 15mg extended release (ER) to give one (1) tablet (15mg) by mouth two (2) times daily. Indications: Non-acute pain, non-acute pain (Cancer), non-acute pain (Palliative Care) Oxycodone five (5) mg every eight (8) hours as needed for Pain up to 30 days. Indications: Non-acute pain. Record review dated 05/01/25 at 1:43 PM of Resident #1's Hospital's Advanced Practice Registered Nurse's Progress Notes also documented, 1. Patient to continue with Morphine Sulfate (MS) Contin 15mg extended release (ER) scheduled every eight (8) hours for pain control. Patient to have Oxycodone five (5) mg every six (6) hours as needed for moderate/severe breakthrough pain .For the safety of the patient we ask that you not make any changes in their pain medications without speaking with us. If you feel that the medications need to be addressed, please feel free to contact us. We are always open to conversation Further record review of both the 3008 Agency for Healthcare Administration (AHCA) Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form and of the facility's admission Nursing Data Collection form dated 05/01/25, documented that the Mental/Cognitive Status of Resident #1 at transfer was: Alert, oriented to person, place time and situation and follows instructions. Review of the Minimum Data Set (MDS) assessment, Section GG 'Functional Abilities and Goals documented the resident was dependent for all of the following: Self-care, oral hygiene, toileting, shower/bath, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, mobility, roll left and right, chair-to-bed-to-chair transfer, toilet transfer, tub/shower transfer; with impairment on both sides. Review of the Physician's Order Sheet (POS), May 2025 Medication Administration Record (MAR), Treatment Administration Record (TAR), and the progress notes dated 05/01/25 to 05/04/25 failed to document any on-going assessments for pain levels being done, for this resident. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no alternative pain medication, and as needed pain medication ordered for this resident, during his facility stay. There was no documented evidence in the facility's record to show that the facility had contacted the physician to obtain orders for pain medication, to address the resident's Foley catheter care needs (not entered in facility computer system until the next day on 05/02/25), nor were there any orders to address the resident's surgical site care with staples. Record review of the facility's Nursing Admission/Quarterly Observation form, section C2 pages five (5) and six (6), Pain Interview, revealed that this section had not even been started or completed by Staff A, Registered Nurse (RN), working on 05/01/25 on the 7 PM to 7 AM shift. There was no physician's order written, nor entered to, Check for pain every shift, into the facility's computer system by Staff A, until 05/02/25, the next day. During a side-by-side record review conducted with the Director of Nursing (DON), it was revealed that Resident #1 had not been administered any of the following physician ordered routine medications until the next day on 05/02/25, for the resident: *Methocarbamol Oral Tablet 750 mg (Methocarbamol) to give 1 tablet by mouth three (3) times a day: *Aspirin Oral Tablet Chewable 81 mg to give one (1) tablet by mouth one time a day; *Sodium Chloride oral tablet one (1) gram to give one (1) tablet by mouth three (3) times a day for fifteen (15) days; *Famotidine oral tablet twenty (20) mg to give one (1) tablet by mouth two (2) times a day; *Docusate Sodium oral capsule 100 mg to give one (1) capsule by mouth every twelve (12) hours as needed for Constipation; *Xtandi oral tablet 80 mg to give two (2) tablets by mouth one (1) time a day; *Morphine Sulfate ER Tablet Extended Release 15 mg *Controlled Drug* to give one (1) tablet by mouth every twelve (12) hours for pain. *Naloxone HCl nasal liquid 4 mg/0.1 ml 4 mg in nostril as needed for in one (1) nostril may repeat every two (2) to three (3) minutes until medical assessment; *Metoprolol Tartrate oral tablet fifty (50) mg to give one (1) tablet by mouth two (2) times a day; *Lidocaine-Prilocaine External Kit 2.5-2.5 % apply to affected area topically two (2) times a day for leg pain. The listed medications were not placed into the facility's computer system until the next day on 05/02/25. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 05/21/25 at 3:36 PM, with Staff D, RN working on 05/01/25 on the 7 AM to 7 PM shift, regarding Resident #1's admission to the facility. Staff D stated that she only took the report from the hospital over the phone at change of shift, and she said that she reported this to the next shift. Staff D added that if a resident is admitted after 6 PM on the day shift, the evening/night shift would take over and handle following up with the new admission. Staff D stated she had not actually seen the resident at all that night. Staff D explained part of the admission process, that if a resident does not come with a narcotic prescription and states they are in pain, then the nurse would contact the Medical Director to get the order/script to be faxed to pharmacy. Staff D stated a resident comes into the facility with the history and summary report; the nurse would review the report and go to the Point-Click-Care (PCC) computer system, and under progress notes would enter a brief admission summary, discuss the diagnosis, vital signs and, if there are any ordered Antibiotics, etc. Staff D stated that a pain assessment is done along and in conjunction with the vital signs and is added to the admission summary report. An interview was conducted on 05/21/25 at 3:54 PM with Staff A, regarding Resident #1's admission to the facility. Staff A acknowledged that she recorded a nursing progress note entry at 6:46 PM, . admit, awake, alert, oriented to person, place, time and situation (AAOX4) surgical site upper back with forty-one (41) staples, cover with dressing no s/s infection noted Foley catheter 18 French drainage clear yellow urine 500cc . Staff A was asked the potential for this resident's pain needs and contact the physician to obtain orders for his surgical site, pain management and Foley catheter care. Staff A stated that she forgot to do so. When asked , Staff A stated she did not reassess the resident for pain. When asked if a newly admitted resident with a recent surgical history comes to the facility, when she expects them to come to the facility having a script for some type of routine or as needed pain medication, Staff A said, yes. When asked if the nurse should re-assess and document the resident's pain, upon admission Staff A , responded, yes, but she acknowledged that she had not done so. When asked if she documented that Resident #1 was administered any of his ordered medications, during her shift , Staff A stated no, not to her knowledge. During a telephone interview conducted on 05/21/25 at 5:16 PM with Resident #1's primary physician, he was asked if the doctor would be contacted or notified by the facility, of the resident's admission needs. The resident's doctor stated that the nurses ordinarily reach out to him, regarding medications and other orders. The DON acknowledged on 05/21/25 at 5:04 that, if a resident is transferred to the facility from a hospital needing pain medication, she would expect them to have a script or the nurse is expected to contact the on call Medical Director's service, who in turn would notify the Pharmacy to obtain their medications. The DON further stated that the nurse is expected to do a pain assessment and evaluation on the resident, upon admission to the facility. The DON ended by saying Resident #1 should have received his ordered medication and that the nurse should have re-assessed, and documented the resident's pain level, during his facility stay.