STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105037	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palms at Sebring Nursing and Rehabilitation The	725 S Pine St Sebring, FL 33870

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46234 Based on observations and interviews, the facility did not ensure dignity was maintained for residents in one out of two dining rooms related to residents at a single table not being served meals at the same time. Findings included: An observation was conducted on 2/23/25 during lunch in the second-floor dining room. At 12:20 p.m., the first tray cart arrived in the dining room. There were 14 residents in the dining room for lunch: - At a table with two residents, the first resident was served their tray at 12:25 p.m. and the second resident was not served until 12:44 p.m. - At a table with three residents, the first two residents were served their trays at 12:34 p.m. and the third resident was not served until 12:45 p.m. - At a table with two residents, the first resident was served their tray at 12:42 p.m. After a couple of minutes, the resident was overheard asking her table mate if she minded if she went ahead and began eating. The second resident was not served until 12:46 p.m. - At 12:46 p.m., 5 of the 14 residents in the dining room were not served. - At 12:48 p.m., two residents were overheard asking where their food was, and the Certified Nursing Assistant (CNA) said they were on another tray cart coming up soon. 48223 An observation was conducted on 2/22/25 at 12:08 p.m. in the dining room of the second floor during meal service: - Staff were observed removing trays from the meal cart, looking around the dining room for the resident whose tray they were holding, and determining if the resident was in the dining room. If the resident was not in the dining room, the staff member proceeded to exit the dining room with the tray. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At a table with two residents, the first resident was served their tray at 12:19 p.m. and the second resident was not served until 12:34 p.m. - At a table of two residents, the first resident was served their tray at 12:19 p.m. and the other resident was not served until 12:26 p.m. - At a table with three residents, two residents were served their trays at 12:20 p.m. The third resident was not served until 12:44 p.m. Meanwhile, the other two residents completed the meal and one exited the dining room. An interview was conducted on 2/23/25 at 12:45 p.m. with Staff L, CNA and Staff N, CNA. Staff L, CNA said the trays arrive in the meal carts by room number and there are three meal carts total. Staff take the tray to the room from the dining room, then come back to the dining room and finish the tray pass. Staff N, CNA said this makes it hard to serve everyone at the table at the same time as one person's tray might arrive on the first cart and the other resident's tray doesn't arrive until the third cart. An interview was conducted on 2/24/25 at 10:15 a.m. with the Food Service Director (FSD). The FSD confirmed the meal carts arrive to the units with resident trays in room number order. The FSD said she was not aware numerous residents dine in the dining room, I was told only about five residents eat in the dining room. The FSD stated, absolutely not should a resident have to watch someone else eat while they wait for their meal. An interview was conducted on 2/25/25 at 5:48 p.m. with the Director of Nursing (DON). The DON stated the expectation is residents are served at the same time. Review of the facility's policy and procedure titled Dignity, not dated, showed: Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy Interpretation and Implementation: 1. Residents are treated with dignity and respect at all times. 2. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facility stay. 3. Individual needs and preferences of the resident and identified through the assessment process. 4. Residents may exercise their rights without interference, coercion, discrimination, or reprisal from any person or entity associated with this facility. 5. When assisting with care, residents are supported and exercising their rights .

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223 Based on interviews and record review, the facility failed to honor resident rights to formulate advance directives for two residents (#259 and #94) of 22 residents sampled for advance directives. Findings included: 1. During an interview on 2/26/25 at 9:36 a.m., the court appointed guardian for Resident #259 stated contacting the facility on multiple occasions to inform and ascertain information related to Resident #259, including the resident being intellectually disabled since birth and not able to make decisions. The guardian also stated the hospital had the paperwork from the court and the paperwork was sent with Resident #259 upon admission to the facility. The guardian stated they verbally told the nurses and sent the court documents of the guardianship to the facility. The facility not only had him sign to papers of disenrollment of healthcare coverage, but the facility also had Resident #259 sign vaccination consents and discharge paperwork, all being a violation of the court order. Review of Resident #259's Admission Record revealed an admitted [DATE] with a diagnosis of genetic related intellectual disability. Review of Resident 259's, Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form dated 12/16/24 revealed under section C - Decision Making Capacity (Patient), the resident required a surrogate. Section D - Emergency Contact revealed the name and phone number of Resident #259's guardian. Review of Resident 259's Preadmission Screening and Resident Review (PASRR) dated 12/16/24 revealed the resident was receiving services for a Mental Illness (MI) and has a current diagnosis of an Intellectual Disability. Review of Resident #259's Clinical Admission nursing note dated 12/17/24 at 1:07 a.m. revealed Resident #259 is only oriented to person and place. Review of Resident #259's Social Service note dated 12/17/24 at 10:24 a.m. revealed, Resident was observed to be alert, disoriented but able to follow instruction. Review of Resident #259's Brief Interview for Mental Status dated 12/17/24 at 12:04 p.m. revealed a score of 9 out of 15, indicating moderate cognitive impairment. Review of Resident #259's Guardianship paperwork, signed and sealed by a Circuit Judge in Highlands County, Florida, dated 7/6/16, revealed Resident #259 lacks capacity to take care of person, property, and estate. The document was uploaded to the facility electronic medical record on 12/24/24. Review of Resident #259's nursing notes dated 12/26/24 at 6:31 p.m. revealed a note created by the Director of Nursing (DON), spoke to resident POA [power of attorney] . (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #259's Discharge Summary dated 1/2/25 at 11:42 a.m. revealed: Pt [patient] discharged back to group home with group home staff. D/c [discharge] paperwork gone over and all signed by resident and copies made for pt/group home staff. Meds sent home with pt (given to staff). Pt A&O [alert and oriented] and denies and [sic] pain, discomfort or SOB [shortness of breath]. Review of Resident #259's discharge paperwork dated 1/2/25 revealed, Resident #259's signature. Review of Resident #259's vaccination consent form dated 12/17/24 revealed Resident #259's signature and vaccination received on 12/19/24. Review of Resident #259's Disenrollment Request form dated 12/27/24 revealed Resident #259's signature to disenroll from Medicare Advantage and enroll in Medicare. During an interview on 2/24/25 at 4:29 p.m., the Business Office Manager (BOM) stated the facility did not have paperwork stating the resident was not competent and the family brought in the documents after the resident was already asked to disenroll. The BOM stated when learning of the error, they immediately emailed the case manager liaison of the facility, with that particular Medicare Advantage program. The BOM confirmed not notifying the Medicare official website. During an interview on 2/25/25 at 12:56 p.m., the Nursing Home Administrator (NHA) stated the facility should have honored Resident #259's guardianship paperwork that was uploaded to the system on 12/24/24. 41015 2. During an attempted interview on 2/22/25 at 3:00 p.m., Resident #9 was sitting at the edge of his bed playing with paper. Resident #94 did not acknowledge the State Agency (SA) Surveyor and began to have a conversation with himself. Review of the Admission Record showed Resident #94 was admitted to the facility on [DATE] with diagnoses including but not limited to adult failure to thrive and schizophrenia. The Contacts section of the Admission Record showed Resident #94 was his own responsible party. Review of the Medical Certifications for Medicaid Long-Term Care Services and Patient Transfer Form (Form 3008) dated 12/5/24 showed section C - Decision Making Capacity, Resident #94 required a surrogate. Review of the care plan showed Focus: [Resident #94] is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t [related to] Cognitive deficits. Goals: The resident will maintain involvement in cognitive stimulation, social activities as desired through review date. Interventions: - All staff to converse with resident while providing care. - Assist with arranging community activities. Arrange transportation. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Encourage ongoing family involvement. Invite the resident's family to attend special events, activities, meals. - Ensure that the activities the resident is attending are: Compatible with physical and mental capabilities; Compatible with known interests and preferences; Adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation), Compatible with individual needs and abilities; and Age appropriate. - Establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary. - Introduce the resident to residents with similar background, interests and encourage/facilitate interaction. Review of the Modification (02) Admission/Medicare - 5 Day Minimum Data Set (MDS) dated [DATE], Section C - Cognitive Patterns, revealed Resident #94 had a Brief Interview for Mental Status (BIMS) score of 99 indicating the resident was unable to complete interview. Section C0100 showed no BIMS was conducted resident is rarely/never understood. During an interview on 2/22/25 at 3:04 p.m., Staff A Certified Nursing Assistant (CNA) stated Resident #94 was usually in his own world and the resident does smile at times, but was not coherent very often or for too long. During an interview on 2/22/25 at 3:10 p.m., Staff B Registered Nurse (RN) stated to find out if a resident has capacity to make their decisions, staff would look on the a residents profile page to see if that resident was their own responsible party. Staff B, RN stated Resident # 94 had a POA as he was very confused. Staff B, RN reviewed Resident #94's profile page and stated Resident #94 did not have a POA, but he was very confused. Staff B, RN stated the profile page showed Resident #94 was his own responsible party, but stated he was not. Staff B, RN stated Resident #94 had an emergency contact, so she would call the emergency contact for medical decisions. Staff B, RN stated there was a discrepancy between the Form 3008 and Resident #94's profile page. During an interview on 2/23/25 at 12:27 p.m., Staff C Licensed Practical Nurse (LPN) stated to find residents' emergency contact information, look in the electronic medical record for emergency contact under the profile on the administration record. Staff C, LPN stated the profile page would tell who information can be given to and who to contact for the resident. Staff C LPN stated the admitting nurse would be responsible for entering emergency contact information from the Form 3008 to the profile page for new admissions. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/23/25 at 4:45 p.m., the Social Service Director (SSD) stated the process for advanced directives started with Admissions Department as the Admission Department would receive the Form 3008 and enter the information from the 3008 form to create a resident's profile page. The SSD stated to find out if a resident had capacity or not staff could find the information in the electronic medical record on the profile page. The SSD stated Resident #94 should never have been placed as his own responsible party on the profile page because the 3008 form showed he needed a surrogate. The SSD also stated the discrepancy was a mistake and someone should have caught the discrepancy and followed up on it. The SSD stated according to Resident # 94's medical record, he did not have a Power of Attorney (POA), Health Care Surrogate (HCS), or an assigned Guardian at this time and stated the record did not show where a physician declared Resident #94 with capacity either. The SSD stated the original discharge plan was for Resident #94 to go back and live with family. However, it was determined the family would not be able to provide the care for Resident #94 he would need so Resident #94 would now be staying at the facility in long term care. The SSD stated that someone in the facility should have caught that Resident #94 was not his own responsible party. During an interview on 2/24/25 at 10:15 a.m., the Assistant Administrator (AA), formerly the Admissions Director, stated the admitting nurse would be responsible for taking the information off a new resident's Form 3008, reviewing the hospital record, and inputting the information into the resident's electronic medical record. The AA stated the admitting nurse should have reviewed Resident #94's 3008 form and saw the resident required a surrogate. The AA also stated even if the information on the 3008 form was wrong then it should have been fixed. The AD stated even with Resident #94's mental health decline, she was not sure why the 3008 form showed a needing surrogate was not caught. The AA/AD said, I am not disagreeing with you there was a discrepancy between the advance directive information on Resident #94's 3008 form and what was transcribed onto Resident #94 profile page. During an interview on 2/24/25 at 10:30 a.m., Staff D CNA and Concierge stated Resident # 94 was seen talking to himself more and was showing more and more incoherent behaviors lately. During an interview on 2/25/25 at 10:58 a.m., the Director of Nursing (DON) stated the admitting nurse puts in all the information in the chart from the 3008 form, which is considered the facility's starting orders. The DON also stated the process for advanced directives are for the admitting nurse to put the information in the medical record and then the social service department would also review the chart and the 3008 form to ensure all advanced directives are in place. The DON stated if a resident needs a surrogate, it would be the Social Service Department that would act on that and contact the court system to initiate a court appointed guardian. The DON also stated she knew nothing about that process. Review of the facility's policy and procedure titled Resident Rights, not dated, showed: Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. be treated with respect, kindness, and dignity; . k. appoint a legal representative of his or her choice, in accordance with state law; . t. privacy and confidentiality; . Review of the facility's policy and procedure titled Advance Directives, not dated, showed: Policy Statement: The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Policy Interpretation and Implementation: Definitions: 1. The facility defines the following in accordance with current OBRA (Omnibus Budget Reconciliation Act) definitions and guidelines: . b. Advance Directive - a written instruction, such as living will or durable power of attorney for health care, recognized by state law (whether statutory or as recognized by the courts of the state), relating to the provisions of health care when the individual is incapacitated (per S489.100). c. Healthcare decision-making capacity - refers to possessing the ability (as defined by State law) to make decisions regarding health care and related treatment choice. Determining Existence of Advance Directive: 1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. 5. If the resident is incapacitate and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident legal representative. Decision-Making Capacity: 1. Upon admission the interdisciplinary team assesses the resident's decision-making capacity and identifies the primary decision-maker if the resident is determined not to have decision-making capacity. 2. The interdisciplinary team conducts ongoing review of the resident's decision-making capacity and invokes the resident representative or health care agent if the resident is determined not to have decision-making capacity. [NAME] are documented in the care plan and medical record.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 41015 Based on observation, record review, and interviews, the facility failed to ensure three residents (#41, #167, and #168) out of three residents reviewed for beneficiary notifications were provided with the correct notification prior to changes of skilled services and related changes. Findings included: Review of the Beneficiary Notice-Residents discharged within the Last Six Months form, completed by the facility, revealed 20 residents. Three randomly selected residents were chosen for review. Resident #41 was selected and identified as remained in facility, Resident #167 was selected and identified as remained in facility, and Resident #168 was selected and identified as discharged Home. Review of Resident #41's Skilled Nursing Facility Beneficiary Notification Review form, completed by the facility, showed the following information: - Skilled Services Start Date: 1/5/24. - Last Day of Services Covered: 11/15/24. - Voluntary Discharge from Services. - Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) was provided and signed by Resident #41 on 11/15/24. - Notice of Medicare Non-coverage (NOMNC) was not provided. - Additional information: Resident #41 and Daughter requested to be discharged back to [Name of Assisted Living Facility] Assisted Living. Review of Resident #167's Skilled Nursing Facility Beneficiary Notification Review form, completed by the facility, showed the following information: - Skilled Services Start Date: 11/13/24. - Last Day of Services Covered: 12/8/24. - Voluntary Discharge from Services. - SNF ABN was provided and signed by Resident #167 on 11/15/24. - NOMNC was not provided. Review of Resident #168's Skilled Nursing Facility Beneficiary Notification Review form, completed by the facility, showed the following information: (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Skilled Services Start Date: 1/10/25. - Last Day of Services Covered: 2/3/25. - Voluntary Discharge from Services. - SNF ABN was provided and signed by Resident #168 on 2/3/25. - NOMNC was not provided. - Additional Information: Resident expressed his wish to be discharged as soon as he arrived at [Name of Facility]. Resident requested to be discharged . During an interview on 2/25/25 at 3:04 p.m., the Social Services Director (SSD) said the facility quit giving NOMNC forms as of 10/31/24. The SSD also stated he received an email from the Administrator on 10/31/24 advising the use of the new SNF ABN form effective 10/31/24 and to provide all residents with changes in skilled services using this form. The SSD stated, I was told it was just one page now. The SSD stated prior to the direction of the Administrator in October 2024, he used to provide residents that were being discharged from the facility the required NOMNC. An observation on 2/25/25 at 3:06 p.m. revealed an email dated 10/31/24 from the Administrator to the SSD titled new SNF ABN with the form attached to the email. On 2/25/25 at 3:08 p.m., the SSD stated the SNF ABN form was the only notification given to residents when services were terminated or exhausted since 10/31/24. The SSD also stated he used to give the NOMNC form to those residents who were being discharged from the facility but had not since 10/31/24 per the Administrators instruction. The SSD stated there was a mistake on the Beneficiary Notice-Residents discharged within the Last Six Months form as all three residents reviewed were discharged from the facility and did not remain in the facility as identified on the form. The SSD stated since all three residents were all discharged from the facility, a NOMNC form should have been provided to all three residents instead of the SNF ABN. The SSD stated those residents who were identified as remaining in the facility were discharged to the adjoining Assisted Living Facility (ALF) that shared a lobby with the Long-Term Care (LTC) Facility. The SSD stated he assisted residents from both the LTC Facility and ALF and had to remember to treat the LTC and ALF as separate entities.

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F 0583

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Keep residents' personal and medical records private and confidential.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46234

Based on observation and interview, the facility did not ensure privacy of residents' personal health information on one unit (East) out of two units in the facility.

Findings included:

An observation was conducted on 2/22/25 at 10:28 a.m. of a medication cart outside of room [ROOM NUMBER]. The computer screen was unlocked with a resident's medical record displayed. The nurse was in a resident room and people were observed moving through the halls.

An observation was conducted on 2/22/25 at 10:44 a.m. of a lab book sitting on the top counter at the nurses' station with a resident's face sheet sticking out of the book. The book was visible to anyone walking past the nurses' station. At the time, four residents were sitting at the nurses' station and no staff were present.

An observation was conducted on 2/22/25 at 12:10 p.m. of a second-floor medication cart sitting in a resident hall with the computer screen unlocked and a resident's medical record displayed on the screen. No staff were present and residents were moving through the hall to the dining room for lunch.

An observation was conducted on 2/23/25 at 12:50 p.m. of a second-floor medication cart sitting at the nurses' station with the computer screen unlocked and a resident's medical record displayed. The screen was partially covered with a sheet of paper. However, information could be seen and it was logged in to the nurses' account.

An observation was conducted on 2/24/25 at 3:20 p.m. of a second-floor medication cart with the computer screen unlocked and a resident's medical record displayed. The nurse walked away from the cart, leaving the screen unlocked, and went to another medication cart. Residents were in the hall near the cart.

An interview was conducted on 2/25/25 at 10:12 a.m. with Staff Q, Certified Nursing Assistant (CNA). She said staff are educated to make sure computer screens are locked and papers are turned over so no one can see resident information.

An interview was conducted on 2/25/25 at 10:30 a.m. with Staff L, CNA. She said computers should be logged off when staff are not using them. She also said they try not to put papers on the top counter of the nurses' station, papers should be placed on the lower counter behind the nurses' station.

An interview was conducted on 2/25/25 at 10:54 a.m. with Staff R, Licensed Practical Nurse (LPN). She said the computer screens on the medication cart should be locked when the nurse is not at the cart and all papers should be turned over.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 2/25/25 at 5:54 p.m. with the Director of Nursing (DON). She said absolutely staff should be locking computer screens when they are not using them. The DON said papers with resident information should not be on the top counters at the nurses' station. She confirmed computer screens should not just be covered with a piece of paper; they should be locked. Review of a facility policy titled Resident Rights, revised December 2021, showed: Policy Statement Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation 2. The unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues. All inquiries concerning the release of resident information should be directed to the HIPAA (Health Insurance Portability and Accountability Act) compliance officer. Photographic Evidence Obtained

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NAME OF PROVIDER OR SUPPLIER: Palms at Sebring Nursing and Rehabilitation The		STREET ADDRESS, CITY, STATE, ZIP CODE: 725 S Pine St Sebring, FL 33870	

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on record review and interview, the facility failed to ensure the comprehensive Minimum Data Set (MDS) assessments were accurately coded for four residents (#80, #91, #56, and #39) out of 22 sampled residents. Findings included: 1. Review of the Admission Record showed Resident #80 was admitted to the facility on [DATE] with diagnoses that included but not limited to epilepsy unspecified, unspecified dementia without behavioral disturbance, anxiety disorder unspecified, major depression recurrent, moderate, and seizures. Review of a physician order for Resident #80 dated 11/21/24 showed Memantine HCI [hydrochloride] Oral Tablet 10 [milligrams] MG. Give one tablet by mouth two times a day for Alzheimer/Dementia. Review of a Psychiatry Subsequent Note dated 11/19/24 showed Resident #80 presented with major depression recurrent, moderate, unspecified dementia without behavioral disturbance, primary insomnia and other specified persistent mood disorders. The plan of action was to continue Memantine because in general, it helps Dementia related cognitive decline and maintaining of daily living. Review of the Modification (02) of Admission /Medicare - 5 Day Minimum Data Set (MDS) dated [DATE] showed Section I - Active Diagnoses (Check all that apply), the diagnosis of Non-Alzheimer's Dementia was not marked. During an interview on 2/24/25 at 10:00 a.m., Staff E MDS, Registered Nurse (RN) stated the diagnosis of Dementia for Resident #80 was not marked because it was overlooked. 2. Review of the Admission Record showed Resident #91 was admitted to the facility on [DATE] with diagnoses that included but not limited to bipolar disorder unspecified, major depressive disorder, recurrent, moderate, generalized anxiety disorder, bipolar disorder, current episode, mixed moderate and brief psychotic disorder. Review of Resident #91's physician orders showed the following: - A physician order dated 2/11/25 showed, Olanzapine Oral Tablet 5 MG (Olanzapine) - Give 1 tablet by mouth in the evening related to brief psychotic disorder. - A physician order dated 2/11/25 showed, Alprazolam Oral Tablet 2 MG (Alprazolam) *Controlled Drug*--Give 1 tablet by mouth in the morning related to generalized anxiety disorder. - A physician order dated 12/5/24 showed, Paroxetine HCl Oral Tablet 20 MG (Paroxetine HCl)- Give 2 tablet by mouth in the morning related to major depressive disorder, recurrent, moderate. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Quarterly MDS dated [DATE] showed Section N - Medications (Check all that apply) the antipsychotic and antianxiety medication boxes were not marked. During an interview on 2/24/25 at 10:00 a.m., Staff E MDS, RN stated the antipsychotic and antianxiety medications were not selected on the Quarterly MDS because they were overlooked. 46234 3. Review of Admission Records showed Resident #56 was admitted on [DATE] with diagnoses including morbid obesity and diabetes mellitus with diabetic neuropathy. Review of Resident 56's care plan showed a focus area of ADL self-care performance deficit with interventions including TRANSFER: The resident requires partial/moderate assistance by staff to move between surfaces, dated 8/13/24. Review of Resident #56's 2/7/25 Quarterly MDS, Section GG, Functional Abilities, showed for chair/bed-to-chair transfer the resident is partial/moderate assistance. An interview was conducted on 2/24/25 at 2:52 p.m. with the Director of Rehab (DOR). He said Resident #56 needed a mechanical list with maximum assistance to get out of bed and has always needed that. 4. Review of Admission Records showed Resident #39 was admitted on [DATE] with diagnoses including protein-calorie malnutrition. Review of Resident #39's 1/14/25 Quarterly MDS, Section B, Hearing, Speech, and Vision indicated the resident had adequate vision. Section C, Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of 13, indicating she was cognitively intact. An interview was conducted on 2/22/25 3:08 p.m. with Resident #39. She said she had no idea what she was eating each meal because she could only see shadows and staff do not tell her what she had and where it was. She said she just pokes her finger around it to try and figure out what she had. Resident #39 said it would be nice to know what she is eating each meal. Review of an eye doctor note, dated 10/11/24, showed Resident #39 had highly impaired vision and cataracts in both eyes Review of Resident #39's care plan did not reveal any focus area or interventions related to vision loss. 48223 During an interview on 2/25/25 at 5:48 p.m., the Director of Nursing (DON) stated the expectation is the facility mark the MDS assessments accurately.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on record review and interview, the facility failed to ensure the Level I Preadmission Screening and Resident Review (PASRR) were accurately completed for nine residents (#44, #55, #91, #94, #33, #39, #56, #6, and #5) out of 22 sampled residents. Findings included: 1. Review of the Admission Record showed Resident #44 was admitted to the facility on [DATE] with diagnoses that included but not limited to major depressive disorder, recurrent, moderate and muscular dystrophy. Review of a psych note dated 2/6/25 showed Resident #44 presented with major depressive disorder, recurrent, moderate, other specified anxiety disorders, primary insomnia, and muscular dystrophy. Review of the Level I PASRR, dated 1/9/25, showed in Section I, Part A. MI (Mental Illness) or suspected MI (Mental Illness) the diagnosis of Depressive Disorder was not marked. Section I, Part B Intellectual Disability (ID) or suspected ID (check all that apply) Muscular Dystrophy was not marked under Related Condition. 2. Review of the Admission Record showed Resident #55 was admitted to the facility on [DATE] with diagnoses that included but not limited to bipolar disorder unspecified, epilepsy unspecified, other seizures, major depressive disorder recurrent, mild, and bipolar disorder, current episode mixed, mild. Review of a psych note dated 12/9/24 revealed under New evaluation, Resident #55 presented with major depressive disorder, recurrent, moderate and bipolar disorder, current episode, mixed and mild. Review of the Level I PASRR, dated 11/8/24, showed in Section I , Part A. MI (Mental Illness) or suspected MI (Mental Illness), the diagnosis of Depressive Disorder was not marked. Section I, Part B. Intellectual Disability (ID) or suspected ID (check all that apply) Epilepsy was not marked under Related Condition. 3. Review of the Admission Record showed Resident #91 was admitted to the facility on [DATE] with diagnoses that included but not limited to bipolar disorder unspecified, major depressive disorder, recurrent, moderate, generalized anxiety disorder, bipolar disorder, current episode, mixed moderate, and brief psychotic disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a psych note dated 12/5/24 showed Resident #91 present with major depressive disorder, generalized anxiety disorder, primary insomnia, bipolar disorder, current episode mixed, moderate, and a brief psychotic disorder. Review of the Level I PASRR, dated 9/24/24, showed in Section I, Part A. MI (Mental Illness) or suspected (Mental Illness) MI (check all that apply), the diagnoses of Anxiety Disorder, Bipolar Disorder, and Depressive Disorder were not marked. 4. Review of the Admission Record showed Resident #94 was admitted to the facility on [DATE] with diagnoses that included but not limited to depression unspecified and schizophrenia unspecified. Review of a psych note dated 2/18/25 showed Resident #94 presented with major depressive disorder, recurrent, mild, other specified persistent mood disorders, and disorganized schizophrenia. Review of the Level I PASRR, dated 12/3/24, showed in Section I, Part A. MI (Mental Illness) or suspected (Mental Illness) MI (check all that apply), the diagnosis of Bipolar Disorder and Schizophrenia were not marked. 48441 5. A review of Resident #33's Admission Record showed an original admitted [DATE] with a readmitted [DATE]. Resident #33's Admission Record showed the following diagnoses: major depressive disorder recurrent, moderate and conversion disorder with seizures or convulsions. A review of Resident #33's February 2025 physician orders showed the following orders: - Divalproex Sodium oral capsule delayed release sprinkle 125 milligrams (mg), give two capsules by mouth in the evening for mood disorder, ordered 2/13/25. - Divalproex Sodium oral capsule delayed release sprinkle 125 milligrams, give two capsules by mouth in the morning for mood disorder, ordered 2/13/25. - Levetiracetam oral tablet 500 mg, give one tablet by mouth in the evening related to conversion disorder with seizures or convulsions, ordered 11/4/24. - Levetiracetam oral tablet 500 mg, give one tablet by mouth in the morning related to conversion disorder with seizures or convulsions, ordered 11/4/24. - Escitalopram oxalate oral tablet 10 mg, give one tablet by mouth in the morning for depression, ordered 11/4/24. - (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #33's Level I PASRR dated 9/13/24 showed under Section I, Part A. Mental Illness or suspected Mental Illness (check all that apply, conversion disorder with seizures or convulsions was not marked. 46234 6. Review of Admission Records showed Resident #39 was admitted on [DATE] and readmitted on [DATE] with diagnoses including depression, added during her stay on 6/20/23, major depressive disorder, added during her stay on 2/27/24, and generalized anxiety disorder, added during her stay on 2/27/24. Review of Resident #39's PASRR Level I screen, dated 12/22/21, only indicated depressive disorder as a diagnosis. Anxiety was not indicated on the PASRR Level I screen. The facility was unable to provide an updated PASRR Level I screen. 7. Review of Admission Records showed Resident #56's was admitted on [DATE] with diagnoses including schizoaffective disorder, post-traumatic stress disorder (PTSD), schizoaffective disorder bipolar type, major depressive disorder, other specified persistent mood disorders, depression, anxiety disorder, and psychotic disorder with delusions due to known physiological condition. Review of Resident #56's PASRR Level I screen, dated 8/27/24, only indicated depressive disorder, and psychotic disorder as diagnoses. Schizoaffective disorder, bipolar disorder, PTSD, mood disorder, and anxiety disorder was not indicated on the Level I screen. The facility was unable to provide an updated PASRR Level I screen. 48223 8. Review of Resident #6's Admission Record revealed an admitted [DATE] with diagnoses of senile degeneration of brain and delusional disorders. Review of Resident #6's psych note dated 11/7/24 showed a diagnosis of anxiety disorder. Review of Resident #6's Level I PASRR, dated 10/4/19, showed in Section I, Part A. MI or suspected MI, Anxiety and Delusional Disorder was not marked. 9. Review of Resident #5's Admission Record revealed an admitted [DATE] with diagnoses of brief psychotic disorder, insomnia, moderate major depressive disorder, persistent mood disorder, and anxiety disorder. Review of Resident #5's psych note dated 11/7/24 showed the resident had been a harm to himself or others in the past. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's Level I PASRR, dated 9/24/24, showed in Section I, Part A. MI or suspected MI, anxiety, persistent mood disorder, and psychotic disorder were not marked; Section II: #4. Is marked no for has the individual exhibited actions or behaviors that may make them a danger to themselves or others. During an interview on 2/25/25 at 10:10 a.m., the Director of Nursing (DON) stated she was responsible for reviewing and ensuring all PASRRs for residents were accurate when a resident was first admitted to the facility. The DON stated she tried to review all PASRRs and make sure the diagnoses were accurate on the PASARR. The DON also stated should a resident get diagnosed with a new diagnosis, the PASRR should be evaluated and updated to reflect the new diagnosis. The DON reviewed the PASRRs for Residents #5, #33, #39, #44, #55, #56, #91, and #94 and confirmed the Level I PASRRs were not correct for these residents. Review of the facility's policy PASRR Completion Policy showed: Policy Statement: The Center will a make sure that all admissions have the appropriate Patient Assessment ad Resident Review (PASRR) completed. Practice Guidelines: 1. Center Administrator will designate either the Admissions Director or Social Worker to make sure that the PASRR and/or Level of Care (LOC) is done on all potential residents. If the referral indicates anything which night constitute an SMI [Severe Mental Illness] or ID [Intellectual Disability], the PASRR must be completed prior to admission. If the resident is deemed hospital except that must be clearly documented in the transfer documents to admission from the acute care facility. 2. Administrator will also designate a backup in case the designated person is not available. 3. Administrator is accountable for monitoring the process of completing the necessary paperwork for the admission. 4. Business Office Manager (BOM) must have copies of the LOC ad or PASRR in the Business Office resident file.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441 Based on observations, interviews, and record review, the facility did not ensure the development and implementation of the comprehensive care plan for five residents (#104, #4, #56, #39, and #6) out of twenty-two residents sampled. Findings included: 1. A review of Resident #104's Admission Record showed an admitted [DATE] with a diagnosis of tobacco use. A review of Resident #104's care plans did not show a care plan for tobacco use. 46234 2. Review of Admission Records showed Resident #4 was admitted on [DATE] with diagnoses including morbid obesity, idiopathic gout, and age-related osteoporosis. Review of Resident #4's care plan showed a focus area of ADL (Activities of Daily Living) self-care performance deficit with interventions including TRANSFER: The resident requires partial/moderate assistance by staff to move between surfaces, dated 7/24/24. An interview was conducted on 2/24/25 at 2:21 p.m. with Staff J, Certified Nursing Assistant (CNA). She stated Resident #4 has always needed a mechanical lift and was definitely not a partial assist. An interview was conducted on 2/24/25 at 2:52 p.m. with the Director of Rehabilitation (DOR). He stated Resident #4 needed a mechanical lift with maximum assistance to get up. 3. Review of Admission Records showed Resident #56 was admitted on [DATE] with diagnoses including morbid obesity and diabetes mellitus with diabetic neuropathy. Review of Resident 56's care plan showed a focus area of ADL self-care performance deficit with interventions including TRANSFER: The resident requires partial/moderate assistance by staff to move between surfaces, dated 8/13/24. An interview was conducted on 2/24/25 at 2:52 p.m. with the DOR. He said Resident #56 needed a mechanical list with maximum assistance to get out of bed and has always needed that. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Admission Records showed Resident #39 was admitted on [DATE] with diagnoses including protein-calorie malnutrition. Review of Resident #39's 1/14/25 Quarterly MDS, Section C, Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of 13, indicating she was cognitively intact. An interview was conducted on 2/22/25 3:08 p.m. with Resident #39. She said she had no idea what she was eating each meal because she could only see shadows and staff do not tell her what she had on her meal tray and where it was. She said she just pokes her finger around it to try and figure out what she had. Resident #39 said it would be nice to know what she is eating each meal. Review of an eye doctor note, dated 10/11/24, showed Resident #39 had highly impaired vision and cataracts in both eyes Review of Resident #39's care plan did not reveal any focus area or interventions related to vision loss. 48223 5. Review of Resident #6's Admission Record revealed readmitted on [DATE] with diagnoses of senile degeneration of brain, delusional disorders, hypertension, and other co-morbidities. Review of Resident #6's Hospice Comprehensive Assessment and Plan of Care Update Report dated 1/22/25 showed a start of service date of 10/27/24 and the Hospice interdisciplinary group discussed the resident's hospice care and Resident #6 remains eligible for hospice services. Review of Resident #6's current care plan showed no focus, goal, or interventions for Hospice Care. During an interview on 2/25/25 at 3:00 PM, Staff E MDS Registered Nurse (RN) stated Residents #104, #4, #56, #39, and #6 should have a comprehensive care plan for the services provided to them and a care plan should be developed or an explanation in the record to as why it is not. During an interview on 2/25/25 at 5:48 p.m., the Director of Nursing (DON) stated the expectation is to have a care plan developed and implemented based on the care the resident requires. Review of the facility's policy and procedures titled Care Plans, Comprehensive Person-Centered, not dated, showed: Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: a. participate in the planning process; b. identify individuals or roles to be included; c. request meetings; d. request revisions to the plan of care; e. participate in establishing the expected goals and outcomes of care; f. participate in determining the type, amount, frequency and duration of care; g. receive the services and/or items included in the plan of care; and h. see the care plan and sign it after significant changes are made. 5. The resident is informed of his or her right to participate in his or her treatment and provided advance notice of care planning conferences. 6. If the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: 1. services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. any specialized services to be provided as a result of PASARR recommendations; and 3. which professional services are responsible for each element of care; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions. 8. Services provided for or arranged by the facility and outlined in the comprehensive care plan are: a. provided by qualified persons; b. culturally competent; and c. trauma informed. 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. 13. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46234 Based on interviews and record reviews the facility did not ensure care plans were revised for five residents (#13, #10, #6, #65, and #89) out of twenty-two sampled residents. Findings included: 1. Review of Admission Records showed Resident #13 was admitted on [DATE] with diagnoses including dementia, chronic cough, and dysphagia. Review of the Dining Assistance list provided by the Director of Nursing (DON) had Resident #13 listed as cue and assist, prefers bowls. Review of Resident #13's care plan showed a focus area of ADL (Activities of Daily Living) self-care performance deficit with interventions including, Eating: The resident is a feeder, at times feeds self, adaptive device of sippy cup and sided dishes. 2. Review of Admission Records showed Resident #10 was admitted on [DATE] with diagnoses including dementia and gastro-esophageal reflux disease. Review of the Dining Assistance list provided by the DON had Resident #10 listed as cue and assist. Review of Resident #10's care plan showed a focus area of ADL self-care performance deficit with interventions including EATING: The resident is able to eat with set up assistance. An additional focus area was risk for malnutrition and altered mental status with interventions included assist with set up at meals, dated 7/12/24, and monitor/document/report PRN (as needed) any signs/symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concern during meals, dated 8/18/24. An interview was conducted on 2/25/25 at 10:10 a.m. with a hospice aide. She said Resident #10 needs assistance with eating and someone should be with her to cue her. 48223 3. Review of Resident #6's Admission Record revealed an admitted [DATE] with diagnoses of senile degeneration of brain, delusional disorders, and hypertension. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #6's progress notes dated 12/22/24 showed Resident #6 had a small open area to left side of the coccyx. The physician was contacted and order given for treatment, which was still active as of 2/24/25. Review of Resident #6's current care plan showed no evidence of skin impairment. During an interview on 2/25/25 at 3:00 p.m., Staff E, RN/MDS confirmed Resident #6 had a treatment order for impaired skin and there should be a care plan for this, but there is not one. 4. Review of Resident #65's Admission Record revealed an admitted [DATE] with diagnoses of mood disorder due to known physiological condition, moderate major depressive disorder, and delusional disorder. Review of Resident #65's progress notes dated 1/29/25 showed Resident #65 was fighting with staff, yelling at them, calling them names. Review of Resident #65's progress notes dated 2/2/25 showed Resident #65 was standing in the hallway and main dining, yelling and cursing at other residents and staff. Review of Resident #65's current care plan showed the following: Focus dated 8/16/24: Resident #65 is verbally aggressive related to mood disorder and delusions. Resident #65 confabulates, manipulates, and blames staff and residents consistently for verbal abuse and neglect, follows staff around and torments them. Goal dated 1/21/25: Resident #65 will verbalize understanding of need to control verbally abusive behavior through the review date. Resident #65 will demonstrate effective coping skills through the review date. Interventions dated 8/23/24: 2 Certified Nursing Assistants (CNA) at all times while providing care. Administer medications as ordered. Monitor/document for side effects and effectiveness. Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc. Assess resident's understanding of the situation. Allow time for the resident to express self and feelings toward the situation. Monitor behaviors. Document observed behavior and attempted interventions. Provide positive feedback for good behavior. Emphasize the positive aspects of compliance. Psychiatric/Psychogeriatric consult as indicated. When the resident becomes agitated: intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. During an interview on 2/25/25 at 3:00 p.m., Staff E, RN/MDS confirmed Resident #65's care plan for behaviors has not been revised with alternate interventions since 8/23/24. 5. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palms at Sebring Nursing and Rehabilitation The	725 S Pine St Sebring, FL 33870

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #89's Admission Record revealed an admitted [DATE] with diagnoses of cerebral infarction due to thrombosis of bilateral cerebellar arteries (stroke), chronic obstructive pulmonary disease (COPD), brief psychotic disorder, moderate major depressive disorder, and anxiety. During an interview on 2/24/25 at 3:30 p.m., Staff X, RN stated Resident #89 had a history of picking at his skin. Review of Resident #89's current care plan showed a Focus area dated 2/5/25, Resident #89 has a psychosocial well-being problem, hallucination, resident reaching for items not there, no other changes were made to the care plan. During an interview on 2/25/25 at 3:00 p.m., Staff E, RN/MDS confirmed Resident #89's care plan for behaviors was not revised with alternate interventions, nor implemented for behaviors. During an interview on 2/25/25 at 5:48 p.m., the Director of Nursing (DON) stated the expectation is for the facility to update the care plans when an incident/behavior/condition of a resident has changed. This permits the staff to try something different. Review of the facility's policy and procedure titled Care Plan, Comprehensive Person-Centered, not dated, revealed the following: Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: l. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: a. participate in the planning process; b. identify individuals or roles to be included; c. request meetings; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. request revisions to the plan of care; e. participate in establishing the expected goals and outcomes of care; f. participate in determining the type, amount, frequency and duration of care; g. receive the services and/or items included in the plan of care; and h. see the care plan and sign it after significant changes are made. 5. The resident is informed of his or her right to participate in his or her treatment and provided advance notice of care planning conferences. 6. If the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: 1. services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; 2. any specialized services to be provided as a result of PASARR recommendations; and 3. which professional services are responsible for each element of care; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions. 8. Services provided for or arranged by the facility and outlined in the comprehensive care plan are: a. provided by qualified persons; b. culturally competent; and c. trauma informed. 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. 13. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46234

Based on observations, interviews, and record review, the facility failed to provide care treatment and care in accordance with professional standards of practice related to 1.) did not ensure three residents (#13, #10, and #39) were assisted with eating, 2.) did not ensure two residents (#4 and #56) were assessed for transfers and provided wheelchairs, 3.) did not ensure notification of change in condition was completed appropriately for one resident (#29), 4.) did not ensure one resident (#309) was assessed appropriately for pain, and 5.) did not ensure wound care was provided for two residents (#71 and #89) out of twenty-two sampled residents.

Findings included:

1.

An observation was conducted on 2/22/25 at 12:52 p.m. of Resident #13 lying in bed with the head of the bed elevated and his tray table in front of him. The resident's lunch was on the tray table and he was feeding himself. His food was placed in bowls and he had a regular cup with no lid. The resident had food spilled down the front of his shirt. Resident #13's tray card showed he should have a cup with lid. The resident was observed struggling to hold the regular cup between his hands to drink from it. Both of the resident's hands were contracted.

Review of Admission Records showed Resident #13 was admitted on [DATE] with diagnoses including dementia, chronic cough, and dysphagia.

Review of Resident #13's 12/2/24 Quarterly Minimum Data Set (MDS) assessment, Section C - Cognitive Patterns, revealed the resident is rarely/never understood.

Review of Resident #13's orders showed an order for a regular diet, pureed texture, nectar consistency, uses sippy cup, dated 8/17/24.

Review of the Dining Assistance list provided by the Director of Nursing (DON) had Resident #13 listed as cue and assist, prefers bowls.

Review of Resident #13's care plan showed a Focus area of ADL (activities of daily living) self-care performance deficit with interventions including Eating: The resident is a feeder, at times feeds self, adaptive device of sippy cup and sided dishes.

A second observation was conducted on 2/23/25 at 12:39 p.m. of Resident #13 lying in his bed with the head of the bed elevated and his tray table with lunch was in front of him. The resident had a regular cup with no lid and bowls. The resident was eating independently with no staff in sight. He continued to pick up and drop the bowls on his bed. He had food down his shirt and on his face.

An interview was conducted on 2/23/25 at 1:12 p.m. with the Director of Rehabilitation (DOR). He said Resident #13 had contractures in both hands and needed a sippy cup and assistance with eating.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 2/23/25 at 1:33 p.m. with Staff C, Licensed Practical Nurse (LPN). She said Resident #13 fed himself pretty well, but she did not know he needed a sippy cup. She said she checked on him during lunch on 2/22/25 and confirmed he was served a regular cup with no lid. She said she did not know where to get information related to which residents need assistance with eating. An interview was conducted on 2/23/25 at 1:37 p.m. with Staff O, Certified Nursing Assistant (CNA). She said the DON has a list of residents that need queuing or assisting with eating. Staff O, CNA also said she knew Resident #13 had thickened liquids but did not know he needed a sippy cup. An interview was conducted on 2/23/25 at 2:32 p.m. with Staff R, LPN/ MDS. She looked at the nurses' station and said the list of residents who need assistance or special equipment is not in the book it should be in. She said the other problem is the kitchen only has a few sippy cups, not enough for what is needed. An interview was conducted on 2/25/25 at 1:22 p.m. with Staff Q, LPN. She confirmed Resident #13 should not be in his room by himself with his meal tray. An observation as conducted on 2/23/25 at 9:27 a.m. of Resident #10 sitting in bed with her breakfast tray in front of her. She was having a difficult time eating and was very slowly moving the utensil from her plate to her mouth. Review of Admission Records showed Resident #10 was admitted on [DATE] with diagnoses including dementia and gastro-esophageal reflux disease. Review of the Dining Assistance list provided by the DON had Resident #10 listed as cue and assist. Review of Resident #10's care plan showed a Focus area of ADL self-care performance deficit with interventions including EATING: The resident is able to eat with set up assistance. An additional Focus area was risk for malnutrition and altered mental status with interventions included assist with set up at meals, dated 7/12/24, and monitor/document/report PRN (as needed) any signs/symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concern during meals, dated 8/18/24. An interview was conducted on 2/25/25 at 10:10 a.m. with Resident #10's hospice aide. She said Resident #10 needs assistance with eating, and someone should be with her to cue her. She said if the resident is in the dining room eating, she did ok but if she was in her room she needed a staff member to be with her cueing her and keeping her awake. The hospice aide said she came in multiple times and Resident #10 had her breakfast tray in front of her. She said when she came in the day prior, on 2/24/25, the resident was in bed with her tray in front of her and the resident was bent over asleep with food all over. An interview was conducted on 2/25/25 at 1:10 p.m. with Staff Q, LPN. She said Resident #10 needs cueing and assisting with meals and the resident should not be in her room with her tray by herself. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation as conducted on 2/25/25 at 1:31 p.m. of Resident #10. She was lying in bed with the head of the bed elevated. Her lunch tray was in front of her, and she was attempting to eat. The resident said someone should help her and she couldn't do those with a spoon, referring to her carrots. The resident said no one helped her eat her lunch. An observation and interview was conducted on 2/25/25 at 1:37 p.m. with Staff C, LPN. Staff C, LPN was observed entering Resident #10's room. She said the resident should not be in her room eating on her own. Staff C, LPN said it had been over an hour since the lunch trays were passed to residents. Staff C, LPN asked Resident #10 is she was still hungry and the resident replied yes I could be if the carrots were lined up right and I could eat them. Staff C, LPN was observed assisting the resident with completing her lunch. An interview was conducted on 2/25/25 at 2:00 p.m. with Staff P, CNA. She said she was assigned to Resident #10 and she had gone in and checked on the resident. Staff P, CNA said Resident #10 is set up only for her meals according to her care plan. Staff P, CNA also said it is frustrating because different documents will say different things. An interview was conducted on 2/22/25 3:08 p.m. with Resident #39. She said she had no idea what she was eating for each meal because she could only see shadows and staff did not tell her what she had and where it was. She said she just pokes her finger around it to try and figure out what she had and it would be nice to know what she is eating each meal. Review of Admission Records showed Resident #39 was admitted on [DATE] with diagnoses including protein-calorie malnutrition, abnormal weight loss, and need for assistance with personal care. Review of Resident #39's 1/14/25 Quarterly MDS assessment, Section C - Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of 13 indicating she was cognitively intact. Review of an eye doctor note dated 10/11/24 showed Resident #39 had highly impaired vision and cataracts in both eyes. Review of Resident #39's care plan did not reveal any Focus area or interventions related to vision loss. An interview was conducted on 2/25/25 at 10:12 a.m. with Staff P, CNA. She said Resident #39 had vision issues and can only see shadows, but staff don't have to help her with meals. An interview was conducted on 2/25/25 at 10:40 a.m. with Staff C, LPN. Staff C, LPN said Resident #39 had glasses and her vision is adequate. When told Resident #39 could only see shadows, Staff C, LPN said she had no idea and would have thought it would have been on the resident's care plan with interventions to help her. 2. An interview was conducted on 2/22/25 at 1:27 p.m. with Resident #4. The resident was observed lying in bed with the head of the bed elevated. Resident #4 said she was not able to get out of bed because she did not have a wheelchair and the mechanical lift hurt when they got her up. The resident said she would like to be able to get up. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Admission Records showed Resident #4 was admitted on [DATE] with diagnoses including morbid obesity, idiopathic gout, and age-related osteoporosis. Review of Resident #4's MDS assessment dated [DATE], Section C - Cognitive Patterns, showed a BIMS score of 14, indicating the resident was cognitively intact. Review of Resident #4's care plan showed a focus area of ADL self-care performance deficit with interventions including TRANSFER: The resident requires partial/moderate assistance by staff to move between surfaces, dated 7/24/24. An interview was conducted on 2/24/25 at 2:21 p.m. with Staff J, CNA. She stated Resident #4 would need a mechanical lift and was not a partial assist. Staff J, CNA also said Resident #4 doesn't get up, not that I am aware of. An interview was conducted on 2/24/25 at 2:52 p.m. with the DOR. He stated Resident #4 needed a mechanical lift with maximum assistance to get up and he agreed it would be a problem if a staff member attempted to get the resident up with a partial/moderate assist. The DOR said they had no record of Resident #4 being screened by therapy. The DOR also said residents are typically rescreened at their quarterly and annual review. An interview was conducted on 2/22/25 at 10:40 a.m. with Resident #56. The resident said she lays in bed all day and doesn't get up. She said she had a wheelchair and then it got taken for someone else. She also said the facility had been working on getting her a new wheelchair for a year. Review of Admission Records showed Resident #56 was admitted on [DATE] with diagnoses including morbid obesity and diabetes mellitus with diabetic neuropathy. Review of Resident #56's Quarterly MDS assessment dated [DATE], Section C - Cognitive Patterns showed a BIMS score of 13, indicating she was cognitively intact. Review of the MDS assessment also there was no therapy screen completed during the quarterly review. Review of Resident 56's care plan showed a focus area of ADL self-care performance deficit with interventions including TRANSFER: The resident requires partial/moderate assistance by staff to move between surfaces, dated 8/13/24. An interview was conducted on 2/24/25 at 2:52 p.m. with the DOR. He said Resident #56 needed a mechanical list with maximum assistance to get out of bed and has always needed that. The DOR also said Resident #56 had her own wheelchair but someone is borrowing it because she doesn't ever get up. The DOR provided a therapy screen request, dated 11/4/24, showing Resident does not get out of bed. No changes observed. The responses on 11/7/24 from occupational therapy was no change in function and from physical therapy was no change in LOF [level of function] at this time. The DOR said a therapy screen is conducted at the residents quarterly and annual review and he did not know the resident had a quarterly MDS review on 2/8/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 2/24/25 at 2:21 p.m. Staff J, CNA. She said Resident #56 is not a partial/moderate assist. She said the resident can move her arms around and help but cannot do very much. Staff J, CNA said she had never seen Resident #56 out of bed and confirmed Resident #56 did not have a wheelchair. An interview was conducted on 2/24/25 at 3:11 p.m. with Staff L, CNA. She said for the last 5 months or more when she would ask Resident #56 if she wanted to get up she would say no because they took my chair. She said if the resident wanted to get out of bed staff would have found her a chair. A follow-up interview was conducted on 2/24/25 at 3:29 p.m. with Resident #56. She said staff did not ask her if she wanted to get up but it wouldn't have mattered because she hasn't had a wheelchair in a year. 3. An interview was conducted on 2/23/25 at 7:30 p.m. with a family member of Resident #29. The family member said there was an incident of alleged abuse that occurred on 1/24/25 and she was not notified until the next day, over 14 hours after the incident occurred. An interview was conducted on 2/25/25 at 2:19 p.m. with Resident #29's primary care Nurse Practitioner (NP). The NP said she was not notified of the incident with Resident #29 until the next day. She said she would have expected to have been called right away. The NP said Resident #29 was sent out to the hospital the day after the event when the provider was notified. Review of Admission Records showed Resident #29 was admitted on [DATE] with diagnoses including Alzheimer's disease. An interview was conducted on 2/25/25 at 4:32 p.m. with Staff AA, Registered Nurse (RN). She said she was assigned to care for Resident #29 on 1/24/25 when the incident of alleged abuse occurred. She said she notified the DON immediately. She also said she did not call the resident's provider or emergency contact because the DON said she was coming to the facility and would take care of notifying the appropriate parties when she arrived. An interview was conducted on 2/25/25 at 5:24 p.m. with the DON. She said she was called immediately on 1/24/25 regarding the incident with Resident #29 and she went to the facility. The DON said she did not call the family until the next day and the NP was not called. She said, honestly I don't know why I didn't call that minute. The DON said she wanted to get more details about what happened. The DON also said she was overwhelmed the night of the incident and she should have called the resident's primary care NP and the family. 48441 4. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/22/25 at 11:24 a.m., an observation and interview were conducted with Resident #309 in his room with his family member at his bedside. The resident had his right arm wrapped in several neutral colored pressure wrappings from his shoulder down to his wrist. A large black brace with a metal joint over the elbow was observed over the pressure wraps from the shoulder to the wrist and a large bulky padding was attached to the black brace under the elbow for support. Under Resident #309's pressure wrappings was a tube extended out from his wrist connected to a portable wound vacuum device, secured under the black brace. The resident and his family member stated he had a fall and he sustained an open comminuted fracture to his right arm and elbow. Resident #309 stated he was having a great deal of pain from the weight of the brace on his shoulder and back pain from a previous back surgery. Resident #309 also stated the facility was slow to address his pain. The resident stated most of the pain was from his back where he had a previous back surgery but his right shoulder ached from the weight of the brace on his arm. The resident also stated he could only sleep in small increments in the bed and would often have to get up and sit in the chair to try and relieve his back and shoulder pain. Resident #309 stated one night a male nurse came in, dropped off medication on his bedside table, and walked away. The resident stated he was not asked why he was out of bed, how he was doing, or if he needed anything. The resident stated a day shift nurse asked him about his night one day and he told her how hard it was to sleep due to his right shoulder and chronic back pain. The resident stated the nurse practitioner came in with the day nurse and a mutual decision was made to have acetaminophen prescribed at nighttime. Resident #309 stated the same night shift nurse came into his room, dropped off medication in a cup, and left before the resident could ask what the medication was. The resident stated he was not given the opportunity to ask for pain medication. Resident #309 stated he had the same day shift nurse the following day and she was able to rectify the situation. Resident #309 stated moving forward he has been given Tylenol every evening and can remove his brace while in bed. Resident #309 stated this has made a big difference for him in a positive way, but he could not understand how something so simple took so long to rectify. Review of Resident #309's Admission Record showed an admitted [DATE] with diagnoses of displaced comminuted fracture of shaft of ulna, right arm subsequent encounter for closed fracture with routine healing, unspecified open wound of right upper arm subsequent encounter, and unspecified arthritis unspecified site. A review of Resident #309's February 2025 physician orders showed an order for acetaminophen extra strength tablet 500 milligram, give two tablets by mouth at bedtime for pain, ordered 2/21/25. Resident #309's physician orders did not reveal an order related to pain monitoring. A review of Resident #309's care plan showed a Focus area of Pain initiated 2/18/25 related to arthritis and fracture of the right ulna. The Goal for Resident #309's Focus area for pain revealed the resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. Interventions include but are not limited to: - Administer analgesia as per orders. Give 1/2 hour before treatments or care - Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. - Monitor/record/report to nurse any signs or symptoms of non-verbal pain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease in ROM (range of motion), withdrawal or resistance to care. A review of Resident #309's initial Pain Evaluation dated 2/18/25 revealed the following under Pain Indicators: 3. Staff Evaluation for Pain. Check all that apply: a. Non-verbal sounds (e.g., crying, whining, gasping, moaning, or groaning). 4. Frequency with which Resident complains or shows evidence of pain or possible pain: a. indicators of pain 1 to 2 days. On 2/24/25 at 12:00 p.m., an interview was conducted with Staff U, LPN , Staff C, LPN, and Staff V, RN. All three nursing staff members stated they will ask their residents if they are having any discomfort/pain, especially any new admissions and during their morning rounds if there is any indication the resident was having any discomfort or pain. On 2/24/25 at 12:08 p.m., an interview was conducted with Staff V, RN. Staff V, RN stated the first day she had Resident #309 she asked him how he slept and he stated he did not have a good night's sleep. Staff V, RN also stated the resident had a large bulky post-operative dressing and brace to his right arm. Staff V, RN stated she reviewed his medical records and noted no pain medication was ordered for the resident so she notified the primary physician's nurse practitioner, who was in the facility. She and the nurse practitioner went into the resident's room together and the resident agreed to acetaminophen but preferred to have the medication administered at nighttime. Staff V, RN assumed the medication was ordered by the nurse practitioner until she followed up the next day with Resident #309, who stated he did not have a good night again and confirmed he did not receive acetaminophen. Staff V, RN stated when she reviewed Resident #309's medical record, she noticed the acetaminophen was not ordered and obtained an order for the acetaminophen to be administered at nighttime. On 2/25/25 at 3:21 p.m., an interview was conducted with Staff W, RN/weekend supervisor. Staff W, RN stated she will ask her residents if they are having any pain during her morning rounds and in the medical records, any nurse can add to a resident order to check for pain every shift and added there are batch orders for pain to be considered as well. On 2/25/25 at 5:58 p.m., an interview was conducted with the (DON. The DON stated all residents' pain should be addressed when they are first admitted . Residents with a fracture should be addressed on a day-to-day basis. If the resident stated no pain upon admission, an ongoing assessment should be made of the potential for unforeseen future pain or non-verbal cues for pain, such as facial grimacing. The nursing staff can place a batch order for pain in the resident's medical record to assess for pain every shift. A review of the facility's policy and procedures titled Admission Assessment and Follow Up: Role of the Nurse, revised in September 2012, showed the following: Purpose: The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, including the MDS. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Palms at Sebring Nursing and Rehabilitation The		STREET ADDRESS, CITY, STATE, ZIP CODE 725 S Pine St Sebring, FL 33870	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	. Steps in the Procedure 7. Conduct an assessment (history and physical), including: a. A summary of the individual's recent medical history, including hospitalization s, acute illnesses, and overall status prior to admission. b. Relevant medical, social and family history. c. A list of active medical diagnosis and patient problems (such as recurrent falling or impaired mobility), especially those most related to reasons for admission to the facility and those that are affecting function, behavior, cognition, nutrition, hydration, quality of life, likelihood of functional recovery, and ability to participate in activities and to socialize. d. Current medications and treatments. . 9. Conduct supplemental assessments following facility forms and protocols including: a. Activity level b. Pain assessment c. Fall risk assessment d. Neurological assessment e. Skin assessment f. Functional assessment ability to perform ADL's (Activities of Daily Living), and g. Behavioral assessment A review of the facility's policy and procedures titled Pain Assessment and Management, last revised in October 2022, showed the following: Purpose: The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. General Guidelines: 1. The pain management program is based on a facility wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the residents choices related to pain management. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	. 3. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain b. Recognizing the presence of pain c. Identifying the characteristics of pain d. Addressing the underlying causes of the pain e. Developing and implementing approaches to pain management f. Identifying and using specific strategies for different levels and sources of pain g. Monitoring for the effectiveness of interventions and h. Modifying approaches as necessary . Steps in the Procedure: . 4. Ask the resident if he or she is experiencing pain. Be aware that the resident may avoid the term pain and use other descriptions such as throbbing, aching, hurting, cramping, numbness or tingling. Assessing Pain: 1. Assess the resident at admission and during ongoing assessments to help identify the resident who is experiencing pain or for whom pain may be anticipated during specific procedures, care, or treatment. 2. Monitor the resident for the presence of pain and the need for further assessment when there is a change of condition. 3. Assess the resident whenever there is a suspicion of new pain or worsening of existing pain. 4. Assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level. 5. During the pain assessment gather the following information as indicated from the resident or legal representative): (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. History of pain and its treatment, including pharmacological and non-pharmacological interventions . b. Characteristics of pain: 1. Location of pain 2. Intensity of pain (as measured on a standardized pain scale); 3. Characteristics of pain (aching, burning, crushing, numbness, burning, etcetera); 4. Pattern of pain (constant or intermittent); and 5. Frequency, timing and duration of pain Identifying the Causes of Pain: 1. Residents may experience pain from several different causes simultaneously 2. in addition, common procedures such as moving the resident, physical therapies, or wound care can cause the resident pain. 3. Review the residents clinical record to identify conditions or situations that may predispose the resident to pain, including: A. Musculoskeletal conditions. a. degenerative joint disease b. rheumatoid arthritis c. osteoporosis d. fractures, and e. amputation B. Skin/ wound conditions: a. Pressure, venous or arterial ulcers; and b. surgical incision(s) Defining Goals and Appropriate Interventions: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The pain management interventions are consistent with the resident's goals for treatment which are defined and documented in the care plan. Pain management interventions reflect the source, type and severity of pain. 2. Pain management interventions shall we address the underlying causes of the resident's pain. 3. For those situations where the cause of the resident's pain has not been or cannot be determined, current standards of practice for managing pain are followed to help determine appropriate options. Monitoring and Modifying Approaches: 1. Monitor the resident's pain and consequences of pain at least each shift for your acute pain or significant changes in levels of chronic pain and at least weekly and stable chronic pain. 2. Monitor the resident by performing a basic assessment with enough detail, and as needed, with standardized assessment tools (for example approved pain scales, etcetera) and relevant criteria for measuring pain management (for example target signs and symptoms.) 3. Monitor the following factor to determine if the resident's pain is being adequately controlled: a. The resident's response to interventions and level of comfort over time; b. The status of the underlying causes of pain, if identified previously; and c. The presence of adverse consequences to treatment Documentation: 1. Document the resident's reported level of pain with adequate detail (for example enough information to gauge the status of pain) and the effectiveness of interventions for pain as necessary and in accordance with the pain management program. 2. Upon completion of the pain assessment, the person conducting the assessment shall record the information obtained from the assessment in the resident's medical record. 48223 5. Review of Resident #89's Admission Record revealed an admitted [DATE]. During an observation and interview on 2/22/25 at 3:09 p.m., Resident #89's Responsible Party (RP) stated Resident #89 scraped forearm during an incident last week. Resident #89's right forearm was observed with a bandage from the wrist to the elbow. The bandage was not dated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 2/23/25 at 1:14 p.m., Resident #89's RP stated a dressing was on the wound yesterday, not sure why there is not one today. The RP raised Resident #89's right sleeve of the sweatshirt and the right forearm was observed with no bandage. The skin impairment had a bright red middle and black scab surrounding the edges. During an observation on 2/24/25 at 10:05 a.m., Resident #89's right forearm was observed without a bandage. The right forearm had an impairment with bright red middle and black scab area surrounding. Four additional open skin areas were noted above the elbow, uncovered. During an interview on 2/24/25 at 11:18 a.m., Staff X, RN stated Resident #89 hurt their arm during an incident at the end of last week and the resident has orders for treatment to the areas. Review of Resident #89's February 2025 order summary showed an order dated 2/20/25 treatment as follows: right antecubital. Cleanse with wound cleanser then apply silicone cream and dry dressing every day for skin tear. Right elbow. cleanse area with wound cleanser then apply silicone cream and dry dressing every day shift for skin tear. Treatment as follows: right elbow. cleanse area with wound cleanser then apply silicone cream and dry dressing every day shift for skin tear. Review of Resident #71's Admission Record revealed an admitted [DATE] with diagnoses of multiple sclerosis, stage 4 pressure ulcer, and need for assistance with personal care. During an interview on 2/22/25 at 12:47 p.m., Resident #71 stated the facility does not complete the wound care as ordered by the physician and the facility misses dressing changes. Review of Resident #71's February 2025 order summary showed a physician order dated 1/11/25: Cleanse wound with wound cleanser then apply Mupirocin ointment to wound base then Santyl and cover with calcium alginate, secure with border gauze, twice daily. The order was discontinued on 2/5/25. Review of Resident #71's electronic Treatment Administration Record for January and February 2025 revealed the dressings were not completed on 1/16/25 p.m. shift; 1/21/25 p.m. shift; 1/24/25 a.m. shift; 1/27/25 p.m. shift; 1/28/25 p.m. shift; and 1/31/25 a.m. shift. A total of 6 dressing changes were not completed. During an interview on 2/23/25 at 12:33 p.m., Staff Z, Licensed Practical Nurse (LPN) stated she ran out of time on occasions to complete dressing changes for Resident #71. During an interview on 2/25/25 at 5:48 p.m., the DON stated the expectation is the facility follow the physician orders and dressings should be dated. Review of the facility's policy and procedure titled Wound Care, not dated, revealed the following: Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation: 1. Verify that there is a physician's order for this procedure. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palms at Sebring Nursing and Rehabilitation The	725 S Pine St Sebring, FL 33870

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review the resident's care plan to assess for any special needs of the resident. a. For example, the resident may have PRN (as needed) orders for pain medication to be administered prior to would care . Steps in the Procedure: . 11. Place one (1) gauze to cover all broken skin. Wash tissue around the wound that is usually covered by the dressing, tape or gauze with antiseptic or soap and water. 13. Dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initials, time, date and apply to dressing. Be certain all clean items are on clean field. Documentation: The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data. Reporting: 1. Notify the supervisor if the resident refuses the wound care. 2. Report other information in accordance with facility policy and professional standards of practice. [TRUNCATED]

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441 Based on observations, interviews, and record review, the facility failed to ensure the prevention of the development of pressure wounds for one resident (#28) out of eight residents sampled. Findings included: On 2/22/2025 at 10:15 a.m., an observation and interview were conducted with Resident #28 and his family member in his room. Resident #28 was in bed and stated he was in a car accident and broke both his legs. Resident #28's family member stated the resident has several new open wounds on his right leg and bottom since he has been in the facility. An observation was made when Resident #28 lifted his right leg to reveal a dressing on the lateral lower area. The dressing had dried light to dark brown drainage and was dated 2/20. Resident #28's family member stated the wounds to his legs were from the brace he was wearing after his accident, but added he no longer wears the brace while he is in bed. An observation was made of two soft boots on the resident's wheelchair seat. The family member stated sometimes the staff will place the soft boots on the resident when he is in bed. On 2/22/2025 at 11:30 a.m., an observation was made of a nursing staff with a wound treatment cart in front of Resident #28's room. On 2/23/2025 at 12:30 p.m., an observation and interview were conducted with Resident #28 in his room. Resident #28 was sitting in his wheelchair with bilateral braces to his lower extremities. Resident #28 had his lunch tray on his bedside table. Resident #28 stated he would like to get back to bed because he had been up since 7:00 in the morning. An observation was made of a seat cushion shaped in a donut on the resident's chair in his room. Resident #28 stated he was not sure why it was there and could not recall if the cushion is supposed to be used while sitting in his wheelchair. On 2/25/2025 at 2:10 p.m., an observation was conducted in Resident #28's room. Resident #28 was in his bed and two soft boots were observed on top of the resident's wheelchair. A review of Resident #28's Admission Record showed an admitted [DATE] with diagnoses of displaced bicondylar fracture of the left tibia subsequent encounter for closed fracture with routine healing, displaced bicondylar fracture of the right tibia subsequent encounter for closed fracture with routine healing, wedge compression fracture of second lumbar vertebra subsequent encounter for fracture with routine healing, unspecified protein-calorie malnutrition, and need for assistance with personal care A review of Resident #28's February 2025 physician orders showed the following: - House supplement two times a day related to unspecified protein-calorie malnutrition ordered 2/19/2025 - Immobilizer to BLE (bilateral lower extremities) when out of bed only every shift ordered 2/15/2025 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Prevalon boot to right and left heel as tolerated when in the bed with lateral lift for foot drop/AFO (ankle foot orthosis) every shift for DTI (deep tissue injury)/Foot drop, ordered 1/21/2025. - Treatment as follows: right outer lower extremity. Cleanse with wound cleanser and then apply xeroform every day shift every Monday, Thursday, and Saturday for skin tear, ordered 2/20/2025 discontinued 2/23/2025. - Treatment as follows: right lower calf cleanse with wound cleanser then pat dry and apply Santyl alginate calcium and dry dressing every day shift for wound care ordered 2/24/2025. - Treatment as follows: right upper calf cleansed with wound cleanser then apply Santyl alginate calcium and dry dressing as every day shift for wound care order 2/24/2025. - Treatment as follows: skin prep to both heels every shift for right heel DTI (deep tissue injury), left red/soft ordered 1/19/2025. - Treatment as follows: zinc oxide to right buttock as needed every day shift for wound care order 2/17/2025. - Wound consult for active wounds right lower extremity ordered 1/19/2025 On 2/25/25 at 1:51 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated nurses should remove a brace or sling for skin assessments. The DON also stated Resident #28 should be on an air mattress, if he's not already, he will be on one. The DON stated anyone can put a work order for an air mattress. The DON was made aware of the dressing dated 2/20 on 2/22/2025's observation for Resident #28 and stated the dressing change should have been addressed daily. On 2/25/2025 at 2:15 p.m., an interview was conducted with Staff W, (Registered Nurse) RN. Staff W, RN stated she is the wound nurse during the weekends and will make wound rounds with the wound physician every Monday and Thursday during wound rounds. Staff W, RN also stated she provided wound care for Resident #28 on 2/22/2025 and agreed the wound dressing was dated 2/20. Staff W, RN stated the resident initially arrived with bilateral lower leg braces, which made it a challenge for potential development of pressure wounds, but stated the resident has an order to now remove the resident's immobilizers while in bed. Staff W, RN stated nurses should be removing the immobilizers to do skin checks and during bathing. Staff W. RN agreed Resident #28 has two areas to his legs from the immobilizer and a pressure area on his sacrum. Staff W, RN stated the resident was not on an air mattress but he should be. Staff W, RN stated Resident #28 may refuse to wear the Prevalon boots ordered but his heels are good. A review of Resident #28 Treatment Administration Record for the month of February 2025 showed Resident #28 as compliant and wearing his bilateral boots with no refusals documented. A review of Resident #28's weekly skin check dated 1/19/2025 showed in Section B - Skin Impairment items (a) bruise and (c)skin tear as checked items. In Section D - New Skin Impairment Interventions items (c) wound care consult and (d) treatment order were checked. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #28's Initial Wound Evaluation and Management Summary dated 1/20/2025 showed a focused wound exam (Site 1) to the right calf partial thickness as a trauma injury with wound size (L [length] x W [width] x D [depth]) = 6 x 6.3 10.2 cm [centimeters] with a total surface area of 37.80 cm2 [square centimeters]. A follow up Wound Evaluation and Management Summary dated 1/27/2025 showed the trauma wound to right calf as resolved. A record review of Resident #28's Wound Evaluation and Management Summary dated 2/10/2025 showed a new wound to right buttocks (Site 2) partial thickness with wound size (L x W x D) =1 x 1 x 0.1 cm with a total surface area of 1.00 cm2. Under section Musculoskeletal System, chair with pressure reduction cushion and feet with pressure relieving boot were documented by the wound therapy physician. A record review of Resident #28's Wound Evaluation and Management Summary dated 2/20/2025 showed a new wound to the right calf (Site 3). Site 2 right buttock partial thickness showed the following measurements 1.5 x 2 x 0.1 cm with a total surface area of 3.00 cm2 and wound progress noted as not at goal. Site 3 was described as unstageable (due to necrosis) of the right calf full thickness and measured 2 x 1 x 0.3 cm with a total surface area of 2.00 cm2. Site 3 underwent a surgical excisional debridement procedure by the wound care physician with post procedural orders for wound care treatment. A record review of Resident #28's Weekly Pressure Wound Note dated 2/24/2025 showed the right buttocks pressure measured at 1 x 1 x 0.1 cm Stage II, right lower calf pressure wound measured 2.5. x 1 x 0.3 cm unstageable and right upper calf pressure wound measured at 3.5 x 1 unstageable. All three wounds were documented by the wound care physician as in-house acquired. A review of the facility's policy and procedures titled Pressure Ulcers/Skin Breakdown-Clinical Protocol showed the following: Assessment and Recognition 1. The nursing staff and practitioners will assess and document an individual's significant risk factors for developing pressure ulcers, for example, mobility, recent weight loss, and a history of pressure ulcers. 2. In addition, the nurse should describe and document report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue. b. Pain assessment. c. Resident's mobility status d. Current treatments include support surfaces; and e. All active diagnosis 3. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. The physician will assist the staff to identify the type (for example, arterial or stasis ulcer and characteristics presence of necrotic tissue, status of wound bed, etcetera) of an ulcer. 5. The physician will identify and define any complications related to pressure ulcers. Cause Identification 1. The physician will help identify factors contributing or predisposing residents to skin breakdown; (for example, medical comorbidities such as diabetes or congestive heart failure, overall medical instability, cancer or sepsis causing a catabolic state, and macerated or friable skin. 2. The physician will clarify the status of relevant medical issues; for example, whether there is a soft tissue infection or just wound colonization, whether the wound has necrotic tissue, and the impact of comorbid conditions on healing and existing wound period. Treatment /Management 1. The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etcetera), and application of topical agents 2. The physician will help identify medical interventions related to wound management; For example, treating a soft tissue infection surrounding an ulcer, removing necrotic tissue, addressing comorbid medical conditions, managing pain related to the wound or to wound treatment, etcetera. a. The poor nutritional status is associated with increased risk of pressure ulcer development, no specific nutritional interventions clearly prevent or heal pressure ulcers. b. Beyond trying to maintain a stable weight and providing approximately 1.2 to 1.5 grams per kilogram protein daily, there are no routine pressure ultra specific nutritional measures for those with or at risk for developing the pressure ulcer c. Any nutritional supplementation should be based on realistic appraisal of an individual's current nutritional status and minimizing any medications and conditions that may be affecting appetite and weight. 3. The physician will help staff characterize the likelihood of wound healing, based on a review of pertinent factors, For example: a. healing or prevention likely: the resident's underlying physical condition, prognosis, personal goals and wishes, care instructions, and ability to cooperate with the treatment plan make wound healing and subsequent wound prevention realistic. b. Healing or prevention possible: healing may be delayed or may occur only partially; Wounds may occur despite appropriate preventative efforts. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Healing or prevention unlikely: the resident is likely to decline or die because of his or her overall medical instability; Wounds reflect the individual's overall medical instability; An existing wound is unlikely to improve significantly; Additional wounds are likely to occur despite preventative efforts. 4. As needed, the physician will help identify medical and ethical issues influencing wound healing, For example, the impact of end stage heart disease or because the resident or family declines artificial nutrition and hydration. a. Advance directives may limit the scope, intensity, duration, and selection of various wound related or adjunctive treatments such as a choice to forego artificial nutrition and hydration. Monitoring 1. During resident visits, the physician will evaluate and document the progress of wound healing, especially for those with complicated, extensive, or poorly- healing wounds. 2. The physician will guide the care as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions. a. Healing may be delayed or may not occur, or additional ulcers may occur because of other factors which cannot be modified. b. Current approaches should be reviewed for whether they remain pertinent to the resident /patient's medical conditions, are affected by factors influencing wound development or healing, and the impact of specific treatment choices made by the resident /patient or a substitute decision maker.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105037	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palms at Sebring Nursing and Rehabilitation The	725 S Pine St Sebring, FL 33870

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441 Based on observations, interviews, and record reviews, the facility did not ensure the environment was free of possible accident hazards related to smoking materials for one resident (#104) of one resident sampled for smoking and related to razors and scissors in two resident rooms (room [ROOM NUMBER] and room [ROOM NUMBER]) of thirty-one resident rooms observed. Findings included: 1. On 2/22/2025 at 12:20 p.m., an observation was made of Resident #104 in his room during the initial tour of the facility. In Resident #104's room there were two packs of cigarettes and three cigarette lighters in view. Resident #104 stated he was in the facility for therapy in hopes to discharge home. On 2/23/2025 at 9:25 a.m., an observation was made of Staff T, Certified Nursing Assistant (CNA) in Resident #104's room, cleaning. Resident #104 was not present in the room. The smoking materials observed the day before in Resident #104's room were no longer present. On 2/23/2025 at 12:49 p.m., an observation and interview were conducted with Resident #104 in the designated smoking area. The staff assigned to the smoking area was not aware Resident #104 had his own smoking paraphernalia. Resident #104 stated he was unaware he could not hold onto his smoking paraphernalia. The staff member explained to Resident #104 he had signed a smoking agreement with the facility and Resident #104 stated he did not receive a smoking agreement. The staff member pulled a sign from the doorway to the smoking patio and presented it to the resident. The staff member told the resident the signage was the contract presented to him. The staff member presented the resident with his smoking agreement he signed on admission. The resident apologized and stated he did not remember signing the smoking policy agreement. On 2/23/2025 at 1:26 p.m., an interview was conducted with Staff T, CNA, who stated she did not observe smoking material in the resident's room when she was cleaning up earlier today. Staff T, CNA stated smoking material should be held in a box in the nurses' station. On 2/23/2025 at 1:35 p.m., an interview was conducted with Staff S, Licensed Practical nurse (LPN). Staff S, LPN stated she did notice smoking paraphernalia in Resident 104's room this morning, but by the time she got back to his room the smoking material was gone. Staff S, LPN could not state who took his smoking paraphernalia out, but stated she thought upper management was making a sweep of all residents' rooms this morning. A review of Resident #104's Admission Record showed an admitted [DATE] with a diagnosis of tobacco use. A review of Resident #104 medical record did not show a smoking evaluation completed by staff for safe smoking. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Palms at Sebring Nursing and Rehabilitation The		STREET ADDRESS, CITY, STATE, ZIP CODE: 725 S Pine St Sebring, FL 33870	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #104's care plan did not show a care plan related to smoking. On 2/24/2025 at 3:20 p.m., an interview was conducted with Staff C, LPN and Staff U, LPN. Both confirmed when a resident arrives new to the facility there is a section in the initial assessment to ask the resident if they smoke. If the resident answers yes, they would have the resident read the smoking policy and have the resident sign the acknowledgment. A review of Resident 104's Minimal Data Set (MDS) assessment dated [DATE], in Section I - Active Diagnoses showed tobacco use. Section C - Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. A review of current physician orders for Resident #104 showed an order, dated 1/29/2025, for Nicotine patch 24-hour 14 milligram/24 hour to apply one patch transdermally in the morning for nicotine abuse. On 2/24/2025 at 2:39 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated Resident #104 told the facility he was not a smoker, but acknowledged he signed his smoking policy agreement in January. The DON also stated normally a Smoker Evaluation is done upon admission and quarterly and there is a smoker binder on the first-floor nurses' station of which all smokers are listed along with their evaluation and care plan. The DON stated the book is updated weekly by herself or the Assistant Director of Nursing and all smoking paraphernalia is held in a box for the residents on the first-floor nurses' station. The DON stated she will be calling families too to review the smoking policy. A record review of the facility's policy and procedures titled Smoking Policy - Residents, last revised in August 2022, in showed the following: Policy Statement: This facility has established and maintained safe resident smoking practices. The Policy Interpretation and Implementation: 1. Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate for smoking and non-smoking preferences. . 6. Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes: a. Current level of tobacco consumption b. Method of tobacco consumption (traditional cigarettes, electronic cigarettes, pipe, etcetera) c. Desire to quit smoking, and d. Ability to smoke safely with or without supervision per a completed safe smoking evaluation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. The staff consults with the attending physician and the director of nursing services to determine if safety restrictions need to be placed on a resident's smoking privileges based on the safe smoking evaluation. 8. A resident's ability to smoke safely is reevaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. 9. Any smoking related privileges, restrictions, and concerns (for example, need for close monitoring) are noted in the care plan, and all personnel caring for the resident shall be alerted to these issues. 11. Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking. . 14. Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etcetera except under direct supervision. 41015 2. An observation on 2/22/2025 at 11:52 a.m. revealed a pair of silver colored metal scissors and a razor stored in the bathroom of room [ROOM NUMBER]. An observation on 2/22/2025 at 11:56 a.m. revealed a razor stored in the bathroom of room [ROOM NUMBER]. During an interview on 2/25/2025 at 9:30 a.m., Staff F CNA stated newly admitted residents who were male received a razor in their welcome hygiene basket and male residents could have razors, but female residents were only given razors as needed. During an interview on 2/25/2025 at 9:35 a.m., Staff G CNA stated all razors are stored in the locked supply room and when a resident needs a razor, a razor would be provided to the resident to use. Once the resident is done with the razor it would be taken and disposed of in a sharp's container. During an interview on 2/25/2025 at 9:40 a.m., Staff B Registered Nurse (RN) stated residents are not allowed to have any kind of razors or scissors in their rooms and all razors and scissors should be locked up and residents should have supervision when using. During an interview on 2/25/2025 at 9:45 a.m., Staff H, Activity Director stated there should be no sharps, including razors or scissors of any kind, stored in residents' rooms. During an interview on 2/25/2025 at 9:51 a.m., Staff I CNA stated the staff provided razors when the resident needed it with supervision. The razors in the facility are disposable and one time use, so staff would throw away the razor in the sharps container on the nurse cart. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/2025 at 10:13 a.m., the Director of Nursing stated no residents should have razors or scissors in residents' rooms. During an interview on 2/25/2025 at 12:17 p.m., the Administrator stated there was no policy or procedure regarding residents not being allowed to have razors or scissors in their room and stated, we just educate and the staff just know. Photographic Evidence Obtained.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441 Based on observations, interviews, and record review, the facility did not ensure post-dialysis communication was implemented and documented in the medical records for one resident (#33) of one resident sampled for dialysis. Findings included: A review of Resident #33's Admission Record showed an original admitted [DATE], with a readmitted [DATE], and a diagnosis of end stage renal disease (ESRD). A review of Resident #33's February 2025 physician orders showed an order dated 2/5/2025 for dialysis weekly on: Monday/Wednesday/Friday at [dialysis center]. A review of Resident #33's dialysis communication records from 1/25/2025 to 2/21/2025 did not show a section for post-dialysis assessment or vital signs upon return to the facility. Upon further record review, no orders to address the resident's central line access for dialysis and/or documentation for post-dialysis assessment or vital signs were revealed. On 2/24/2025 at 12:00 p.m., an interview was conducted with Staff U, Licensed Practical Nurse (LPN) , Staff C, LPN and Staff V, Registered Nurse (RN). All three nursing staff members stated a resident on dialysis should have an order for dialysis and from there a drop-down option is available to assess the hemodialysis site, whether an AV (arteriovenous) fistula or a central catheter used, specifically for dialysis. Staff C, RN stated she checks when a resident returns from dialysis by assessing their port/fistula and vital signs. Staff C, RN also stated nursing staff should assess the dialysis site for any complications such as bleeding. Staff C, RN stated she does not think there is an area on the communication sheet from the dialysis center where she can document this information. Staff U, LPN stated there is an option to assess post-dialysis documentation in the medical record, but stated she does not think the facility utilizes this option. Staff U, LPN demonstrated the drop-down option to her other two nursing staff. At this point, the Director of Nursing (DON) arrived to continue with the interview and stated she was unaware of the option to document in the medical record post-assessment after dialysis. The DON acknowledged the current dialysis communication sheet does not have a section for the nurse to document the resident's assessment post-dialysis. A review of the facility's policy and procedures titled Care of the AV-Fistula-Graft, undated, showed the following: 1. Look for signs of infection: Redness, swelling, pain, warmth to site, drainage, or elevated temperature. Pay special attention to the most recent cannulation sites (where you were stuck last). . 11. Check cannulation (puncture) site carefully for bleeding after dialysis. If bleeding starts again, place pressure over the area for 5-10 minutes. If unable to stop bleeding, call the dialysis center and go to the nearest emergency facility.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on interview and record review, the facility did not ensure pharmacy recommendations were completed for two residents (#57 and #5) out of five reviewed for unnecessary medications. Findings included: Review of Admission Records showed Resident #57 was admitted on [DATE] with diagnoses including atherosclerotic heart disease. Review of Resident #57's February 2025 physician orders showed an order for Peridex mouth/throat solution 0.12%. Give 15 ml (milliliters) by mouth every 12 hours for gum/teeth pain, dated 11/20/24 and a second order for Peridex mouth/throat solution 0.12%. Give 15 ml by mouth every 12 hours as needed for mouth pain for 2 weeks, dated 2/9/25 to 2/23/25. A review of a Consultant Pharmacist Medication Regimen Review dated 12/16/24 revealed: Peridex 0.12% (Chlorhexidine Gluconate) should not be swallowed. Please add to the order: Swish 15ml for 15-20 seconds, the expectorate- do not swallow A review of a Consultant Pharmacist Medication Regimen Review dated 2/16/25 revealed: Perdix should not be swallowed. Please add to the order. use 15ml to swish for 20-30 sec[onds], then expectorate- do not swallow. Review of orders showed neither of the recommendations were completed. The recommendations were not signed by the physician. An interview was conducted on 2/25/25 2:35 p.m. with the Consultant Pharmacist. He said he does monthly reviews of resident medication and the recommendations go to the Director of Nursing (DON). He said in the past they had issues getting the pharmacy recommendations completed at the facility. He also said if it isn't critical he will give it one month and if the facility doesn't complete the recommendation he will make another recommendation for the same thing. 48223 Review of Resident #5's Admission Record revealed an admitted [DATE] with diagnoses of brief psychotic disorder, insomnia, moderate major depressive disorder, persistent mood disorder, and anxiety disorder. Review of Resident #5's Consultant Pharmacist Medication Regimen Review dated 12/16/24 showed: Diclofenac [brand name] gel, please add dosage amount to complete this order. Suggest dosing: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. For upper extremities: Apply 2 grams q [every] 6 hours-not to exceed 8 grams/day to any single joint. 2. For lower extremities: Apply 4 grams q 6 hours- not to exceed 16 grams/day to any single joint. Review of Resident #5's February 2025 physician orders showed: Diclofenac gel, apply to affected areas topically every 6 hours as needed for pain, dated 8/24/24. The recommended dosing was not documented in the order. Review of Resident #5's Consultant Pharmacist Medication Regimen Review dated 1/16/25 showed: 1. Midodrine 10 mg PRN [as needed] frequency, Midodrine is usually given three times daily. Please review Midodrine 10 mg every 1 hour PRN order and consider changing to 10 mg three times daily PRN for SBP<110 [systolic blood pressure]. 2. Calcitonin Nasal solution for COPD [chronic obstructive pulmonary disease] Calcitonin Nasal Solution should only be used in one nostril each day. Suggest clarifying directions to read: one spray in one nostril one time daily, alternate nostrils each day. Also, please update the diagnoses list and the reason for using the Calcitonin Nasal Spray. [Calcitonin is typically used for osteoporosis]. 3. Mupirocin Ointment 2%; Please check on a stop date for both Mupirocin topical antibiotic orders. Review of Resident #5's February 2025 physician order revealed an order for Midodrine 10 mg, give 1 tablet by mouth every 1 hours as needed for Hypotension related to Other hypotension, administer for systolic b/p (blood pressure) greater 110/60, dated 7/16/24. The recommendation was not addressed. Review of Resident #5's February 2025 physician orders revealed an order for Calcitonin Nasal solution, 1 spray in both nostrils one time a day r/t [related to] Chronic obstructive pulmonary disease w/[with] (acute) exacerbation alternate nostrils daily, dated 10/2/23. The pharmacist recommendations were not addressed. During an interview on 2/25/25 at 5:48 p.m. the DON stated they receive the pharmacy recommendations and tries to complete them, but stated she, must have missed those, I got behind. I try to get them completed within the week. The DON confirmed the recommendations for Resident #5 and #57 should have been completed timely and were not. A policy and procedure for Pharmacy Recommendations was requested on 2/23/25. On 2/25/25 at 6:00 p.m., the DON stated the facility does not have a policy for Pharmacy Recommendations.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on observations and interviews, the facility did not ensure medications were stored properly on two out of two units in the facility related to unlocked medication carts, unsecured medication, and medication in resident rooms. Findings included: An observation was conducted on 2/22/25 at 10:23 a.m. of a medication cart at the second-floor nurses' station. There were two bottles of medication sitting on top of the cart, one was a stool softener and the other a multivitamin. Both bottles contained medication. No staff were in sight of the medication cart and three residents were sitting within 10 to 15 feet of the cart. An observation was conducted on 2/22/25 at 10:47 a.m. of an unlocked medication cart at the first floor nurses' station. No staff were near the cart. An observation was conducted on 2/22/25 at 11:51 a.m. of an unlocked medication cart on the second floor. No staff were in sight of the medication cart and a resident was sitting approximately 5 feet away from the cart. A nurse walked back up to the cart, grabbed something, and walked away with the cart without locking it. An observation was conducted on 2/22/25 4:11 p.m. of a box of over the counter (OTC) medication sitting in an open bedside drawer in room [ROOM NUMBER]. An interview was conducted on 2/25/25 at 2:35 p.m. with the Consultant Pharmacist. He said he does spot checks on medication carts and medication rooms monthly and he found a medication cart unlocked as well. He said nurses need to keep an eye out for medication in resident rooms that families may have brought in. 48223 An observation was conducted on 2/22/25 at 12:46 p.m. in resident room [ROOM NUMBER] b. A resident was lying in the bed with an over the bed table next to the bed. On the table were two medication cups, one was almost full of an orange colored liquid and the other was one fourth full of a dark liquid. An observation was conducted on 2/23/25 at 9:24 a.m. in resident room [ROOM NUMBER] a. A resident was lying in the bed and next to the bed was the over the bed table. On the table was a medication cup one half full of an orange-colored liquid. The resident stated the nurse leaves the medication with them. On 2/23/25 at 10:02 a.m. in resident room [ROOM NUMBER] b, a resident was observed sitting in a recliner and on the table next to the recliner was a bottle of wound cleanser. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 2/25/25 at 5:49 p.m. with the Director of Nursing (DON). She said she would expect all medication carts to be locked and medications put up. The DON also said medications should not be left in cups at a resident's bedside and residents should not have over the counter medication in their rooms. Review of the facility's policy and procedure titled Medication Storage and Labeling dated 6/2023 showed: . Medications and biologicals in medication rooms, carts, boxes, and refrigerators were maintained within: - Secured (locked) locations, accessible only to designated staff; - Clean and sanitary conditions; Photographic Evidence Obtained

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441 Based on observations, interviews, and record review, the facility did not ensure food preferences were honored for four residents (#309, #28, #39, and #71) out of twenty-two residents sampled. Findings included: 1. On 2/22/2025 at 11:24 a.m., an observation and interview were conducted with Resident #309 in his room with his family at his bedside. Resident #309 stated he requested hot tea in the morning since his arrival and so far, tea has not been offered to him. Resident #309 stated the facility continued to offer coffee when the resident dislikes coffee. He stated each time they ask him he would request hot tea instead, but no one would bring him a hot tea. The resident denied meeting any representatives from the kitchen regarding his food preferences. The resident stated, at this point, I've given up on getting a hot cup of tea in the morning. On 2/24/2025 at 9:30 a.m., an interview was conducted with the Food Service Director (FSD). The FSD stated her team will conduct a food preference interview with every new admission. On the food preference sheet, options are provided for food preferences and likes and dislikes for foods such as fruits, vegetables, and meats. The FSD stated the usual timeframe to complete the food preferences sheet is within three days but stated it may take a day or two more depending on the number of new admissions. The FSD also stated the food preference sheet responses are placed in the resident's medical record and dated. The kitchen will have a list of the resident's food preference sheet and the original paper will be placed in a binder in her office. Long-term residents will have a reevaluation done every three months prompted by the medical record for review. The FSD stated she did not see a Food Preference Sheet completed for Resident #309 and hot tea is an option for beverages preferences, but stated any staff member could have honored his wishes. 2. On 2/23/2025 at 12:30 p.m., an observation and interview were conducted with Resident #28 in his room. Resident #28 was sitting in his wheelchair with his lunch tray on his bedside table. On the lunch tray there was the remainder of a baked potato skin, a chicken breast, three asparagus stalks, a full cup of a light creamy soup and small remnants of a yellow cake in a cup. Resident #28 stated he could only eat the baked potato and dessert because he could not chew the chicken or the asparagus. Resident #28 also stated he only has three teeth in his mouth so sometimes he can't eat what is served to him because he cannot chew the food. The resident stated at home he would eat food that is softer or ground up and if his chicken was ground up, he could eat it today. On 2/23/2025 at 12:40 p.m., an interview was conducted with Staff U, Licensed Practical Nurse (LPN), who was assigned to Resident #28. Staff U, LPN was unaware of Resident #28's lack of dentation and difficulty in chewing his food. 46234 (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. An interview was conducted on 2/22/25 at 3:08 p.m. with Resident #39. She said she would love to have yogurt, fruit, and/or muffins sometimes. She said she asked but never gets them. Review of the Admission Record showed Resident #39 was admitted on [DATE] with diagnoses including protein-calorie malnutrition. Review of Resident #39's 1/14/25 Quarterly Minimum Data Set (MDS) assessment, Section C - Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of 13, indicating she was cognitively intact. Review of Resident #39's Food Preferences, dated 10/12/24, showed the resident preferred hot tea, oatmeal, bacon, fruit, and yogurt for breakfast options. A follow-up interview was conducted on 2/24/25 at 11:47 a.m. with Resident #39. The resident said she does not get the hot tea she requested for breakfast except occasionally one Certified Nursing Assistant (CNA) will go downstairs and find her some. She reiterated the fact she never gets fruit and yogurt. 48223 4. During an interview and observation on 2/22/25 at 12:47 p.m., Resident #71 stated they did not receive condiments on the meal tray. No ketchup, mustard, salt, pepper, and crackers if they have soup. Resident #71 stated not being on a restrictive diet, so they don't understand why they cannot provide the items. No condiments were observed on the resident's meal tray. An observation was made on 2/23/25 at 12:25 p.m. of Resident #71's lunch tray and no condiments were on the meal tray. During an interview on 2/23/25 at 12:45 p.m., Staff L, CNA stated condiments don't come on the trays and if a resident requests something we get the item for them. During an interview on 2/24/25 at 10:15 a.m., the FSD stated condiments are supposed to be on the trays and extras are available in the dining room if anyone requests them. Review of the facility's policy and procedure titled Resident Food Preferences, not dated, revealed: Policy Statement: Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to diet will only be ordered with the resident's or representative's consent. Policy Interpretation and Implementation (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER: Palms at Sebring Nursing and Rehabilitation The		STREET ADDRESS, CITY, STATE, ZIP CODE: 725 S Pine St Sebring, FL 33870	

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Upon the resident's admission the Dietitian or nursing staff will identify a resident's food preferences. 2. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. 3. Nursing staff will document the resident's food and eating preferences in the care plan. 4. The Dietitian and nursing staff, assisted by the Physician, will identify any nutritional issues and dietary recommendations that might be in conflict with the resident's food preferences. 5. The Dietitian will discuss with the resident or representative the rationale of any prescribed therapeutic diet. The Physician and Dietitian will communicate the risks and benefits of specialized therapeutic vs. liberalized diets. 6. The resident has the right not to comply with therapeutic diets. 7. The Food Services Department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night. 8. The facility's Quality Assessment and Performance Improvement (QAPI) Committee will periodically review issues related to food preferences and meals to try to identify more widespread concerns about meal offerings, food preparation, etc.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on observations, record review, and interviews, the facility failed to implement protocols from the facility's antibiotic stewardship program for one resident (#3) out of three residents reviewed for antibiotic use. Findings included: An observation and interview on 2/22/25 at 2:32 p.m. showed Resident #3 lying in bed with an Intravenous Therapy (IV) pole at the bedside. The IV pole contained two empty bags of Vancomycin, both dated 2/22/25. Resident #3 stated she was getting IV antibiotics because she recently had a severe Urinary Tract Infection (UTI) that sent her to the hospital. Resident #3 stated she did not know how long she would be on IV antibiotics but stated she was feeling much better. Review of the Admission Record showed Resident #3 was readmitted to the facility on [DATE] with diagnoses that included but not limited to infection and inflammatory reaction due to other urinary tract infection (UTI) unspecified, urinary catheter initial encounter, infection and inflammatory reaction due to indwelling urethral catheter, and bacterial infection. Review of Resident #3's February 2025 physician orders showed: - A physician order dated 2/18/25, Vancomycin [Hydrochloride Salt] HCl in NaCl Intravenous Solution 750-0. 9 [milligrams] MG/250 [milliliters] ML- [percent] % (Vancomycin HCl-Sodium Chloride)- Use 750 MG intravenously two times a day related to urinary tract infection unspecified. There was no end date for the order. - A physician order dated 2/18/25, Cefepime HCl Intravenous Solution 2 [grams] GM/100 ML (Cefepime HCl)- Use 2 gram intravenously every 12 hours related to urinary tract infection unspecified. There was no end date to the order. Review of the care plan showed a Focus: The resident is on antibiotic therapy related to infection (UTI). The Goal showed the resident will be free of any discomfort or adverse side effects of antibiotic therapy through the review date. During an interview on 2/25/25 at 10:18 a.m. the Director of Nursing (DON) stated she worked with Staff R, Licensed Practical Nurse (LPN) Minimum Data Set (MDS) and acting Infection Preventionist (IP) on infection control in the facility. The DON also stated she was usually on top of all the clinical aspects of infection control in the facility. The DON reviewed Resident # 3's current physician orders and stated all antibiotics should have an end date so appropriate monitoring of antibiotic duration occurred. The DON stated antibiotic monitoring was part of the facility's antibiotic stewardship program and, in Resident #3's case, no end date was added to the order and stated that was a problem. The DON also stated Resident #3 just returned from the hospital with a severe UTI and no one seemed to know how long she was going to need the IV antibiotics. Review of the facility's policy titled Antibiotic Stewardship, revised in December 2016, showed: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Statement: Antibiotics will be prescribed and administered under the guidance of the facility's Antibiotic Stewardship Program. Policy Interpretation and Implementation: . 4. If an antibiotic is indicated, prescribers will provide complete antibiotic orders including the following elements: a. Drug name b. Dose c. Frequency of administration d. Duration of treatment; 1. Start and Stop date, or 2. Number of days of therapy. e. Route of administration f. Indications for use.