STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Heritage Health & Rehabilitation Center	718 Lakeview Ave S Saint Petersburg, FL 33705

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observations, interviews and facility record review, the facility failed to ensure resident spaces and equipment were maintained in a sanitary manner in two of two units (Main, West), during three of three days observed (2/11/2025, 2/12/2025, and 2/13/2025). Findings included: On 2/11/2025 at 10:55 a.m. 2/12/2025 at 8:30 a.m. and 2/3/2025 at 11:00 a.m. the following was observed: 1. Resident room [ROOM NUMBER] bathroom was observed with a recent wall repair between the sink and the toilet. It was further observed a white panel approximately two feet by two feet covering a hole in the wall. The panel was observed torn off the wall. The bathroom was also observed without a trash can, and the toilet tank was observed without a lid. Photographic evidence was taken. 2. Resident room [ROOM NUMBER] shared bathroom was observed with a metal glove box holder affixed to the wall on the left side of the sink wall. The metal box was observed heavily rusting and with paint chipped and peeling, leaving a non-cleanable surface; The bathroom door (inside) was observed with heavy chipping, peeling and leaving injury hazard and non-cleanable surface. On 2/13/2025 at 2:00 p.m. an interview with the Director of Maintenance (DOM) and the housekeeping director. Both confirmed they were not aware of the above listed areas of concern. They both confirmed the concerns and revealed they should have been made aware by either nursing staff who are in the rooms, as well as housekeeping staff who clean the spaces. (Photographic Evidence Obtained) 48223 On 2/11/2025 at 10:10 a.m. room [ROOM NUMBER]'s bathroom was observed with a brown substance surrounding the toilet base on the floor. The substance was on both sides of the toilet and the base of the toilet did not appear to be sealed. On 2/11/2025 at 9:52 a.m. room [ROOM NUMBER]'s toilet base was observed not to be sealed at the base and a brown substance surrounded the toilet. (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: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER: South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 718 Lakeview Ave S Saint Petersburg, FL 33705	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/11/2025 at 10:02 a.m. the shower room on Main Unit was observed with door not closing, the shower chair had pink/brown bio-growth on all four of the legs of the shower chair. Under the seat of the chair, there was a brown substance. The shower stall had pink/brown bio-growth in the grout of the shower. On 2/11/2025 at 10:14 a.m. the bathroom between room [ROOM NUMBER] and room [ROOM NUMBER] (shared bathroom of 4 residents) was observed with the following: the light did not function properly, the toilet paper roll holder was not available. The toilet paper was observed sitting on the back of the toilet and the shower had brownish bio-growth on the shower tiles. On 2/12/2025 at 11:50 a.m. the bathroom of room [ROOM NUMBER] had an uncovered toilet plunger sitting next to the toilet. The above observations above were still observed on 2/13/2025 at 9:00 a.m. (Photographic Evidence Obtained) 46234 3-An observation was conducted on 2/11/25 at 10:18 a.m. in room [ROOM NUMBER]. The cove base was coming off the wall behind the bed. There was a plastic glove box holder hanging on the wall that was broken with pieces missing. A resident in the room said the box had been broken for over a month. An observation was conducted on 2/11/25 at 10:26 a.m. in room [ROOM NUMBER]. There was a large patch on the wall under the window that had been repaired but not painted. The windowsill had a broken tile with a piece missing. The room also contained an armchair with the top of the covering material rubbed off, creating a non-cleanable surface. An observation and interview was conducted on 2/13/25 at 2:06 p.m. with the Regional [NAME] President. She was observed going to room [ROOM NUMBER] and looking at the broken glove box. She said it should be removed and not be on the wall broken. She also confirmed the cove base should not be coming off the wall. She was then observed entering room [ROOM NUMBER] and inspecting the room. She said the patch on the wall should have been painted and the broken tile repaired. She also confirmed the armchair was a non-cleanable surface and should be removed. 50570 4. On 2/11/25 at 10:14 a.m., an observation of the privacy curtain in room [ROOM NUMBER] revealed multiple dark orange stains along the middle and bottom part of the curtain. An observation of the bathroom in room [ROOM NUMBER] revealed the light fixture in the ceiling had multiple black spots/debris. Further observations of the bathroom revealed the lining of the bathroom floor had cracked tiles and black particles/debris in between the tiles. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 718 Lakeview Ave S Saint Petersburg, FL 33705	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/11/25 at 10:59 a.m., an observation of room [ROOM NUMBER] revealed the handrail of the B-bed was detached and resting on the wall. Observations of the floor by the B-bed revealed a large black hole with cracked/missing tile. An observation of the bathroom in room [ROOM NUMBER] revealed the shower head was detached and laying in a bed pan on a shower chair. Further observations of the bathroom revealed a bed pan, which contained water and the end of the shower hose inside the pan. Observations of the soap and toilet paper holder revealed it was rusted and oxidized as evidenced by green and white residue/spots, (Photographic Evidence Obtained). On 2/12/25 at 9:48 a.m., observations of room [ROOM NUMBER] and 134 had the same concerns observed on 2/11/25. An interview with Resident #16 revealed the handrail detached from the bed had been like that, For a couple of days. On 2/13/25 at 12:20 p.m., an interview and review of work orders was conducted with the Director of Maintenance (DOM). A review of work orders from 11/1/24 to 2/11/25 revealed room [ROOM NUMBER]'s work orders were not related to the floor, the detached bed handrail or bathroom concerns. The DOM stated he was not aware of the observations in room [ROOM NUMBER]. He stated the hole in the floor and detached handrail could have occurred when the previous bed was replaced with the current hospice bed. He stated an outside company brought and installed the hospice bed for Resident #16. The DOM stated he expected staff to put a work order in regarding the observations in room [ROOM NUMBER]. He stated he completed rounds every Friday and picked a few rooms to round. He could not confirm when the last time room [ROOM NUMBER] was included in his rounds. The DOM stated he was not aware of the environment concerns in room [ROOM NUMBER]. He stated he looked at bathrooms during rounds. He stated all staff had access to the work order system, with an automatic log-in. The DOM stated when staff communicate to him about an environment concern, he encouraged them to put a work order in. On 2/13/25 at 1:25 p.m., an interview with the Housekeeping Manager revealed each housekeeping staff had their own section of the facility they were responsible for. He stated the housekeeping team was considered fully staffed. An observation of the privacy curtain in room [ROOM NUMBER] was conducted with the Housekeeping Manager. He stated he could replace the curtain today. The Housekeeping Manager stated he wasn't aware of the stained privacy curtain. A review of the facility's policy titled, Physical Environment, effective date August 2024, revealed the following, Policy - A safe, clean, comfortable, and home-like environment is provided for each resident, allowing the use of personal belongings to the greatest extent possible . (Photographic Evidence Obtained)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 718 Lakeview Ave S Saint Petersburg, FL 33705	

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223 Based on observation interview and record review, the facility did not ensure prompt efforts were made to resolve grievances for two (#33 and #13) of six residents sampled. Findings included: During an interview on 2/12/2025 at 9:20 a.m. Resident #33 stated during the hurricane evacuation their wheelchair was lost. Resident #33 stated speaking to the Social Service Director (SSD) upon returning from the evacuation, as the chair given is not as wide as the prior chair. Resident #33 stated notifying the SSD that someone else was in the chair (as Resident #33's name was on the chair). Resident #33 stated not having any resolution as Resident #33 is still in this chair that was too small and preferred the wider chair. Review of the grievance log from September 2024 to January 2025 showed an absence of grievances for Resident #33. 50570 2.On 2/11/25 at 10:44 a.m., an observation of Resident #13 revealed he was sitting in his wheelchair to the left of the bed, by the door. He expressed concerns related to his wheelchair bearings that needed to be fixed. He stated he goes out every day and sometimes his wheelchair gets stuck, and he had difficulty rolling. Resident #13 stated he had been telling staff, for a couple of months. He stated he was offered a new wheelchair, but that's not what he wanted. Resident #13 stated purchasing a new wheelchair, Is it not fixing the problem. Resident #13 stated, The bearings just need to be fixed, that's all I want. He stated he asked for the, [NAME] of sale, for the new wheelchair, and it was not provided to him. During the interview, Resident #13 called for his nurse Staff E, Registered Nurse (RN) who confirmed staff were aware of his concerns. Review of Resident #13's admission record revealed an original admitted [DATE] and re-admitted [DATE] with diagnoses to include other lack of coordination, unsteadiness on feet, other abnormalities of gait and mobility, unspecified lack of coordination, and generalized muscle weakness. Review of Resident #13's quarterly Minimum Data Set (MDS), Section C - Cognitive Patterns, dated 1/1/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. Review of the grievance/concern log for January 2025 revealed a grievance for Resident #13, on 1/14/25, related to environment. Further review of the log revealed Resident #13's grievance was resolved on 1/14/25. The grievance did not show documented concerns relate to the wheelchair. Review of Resident #13's progress notes on 1/29/25 revealed the following, Resident was given a new wheelchair which was personally ordered for him, which he decline to use. resident stated that he does not want a new chair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Heritage Health & Rehabilitation Center	718 Lakeview Ave S Saint Petersburg, FL 33705

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of work orders from 1/1/24 to 2/11/25, provided by the Director of Maintenance (DOM), revealed the following, Wheelchair Bearing . Resident [room number] Wheelchair . Assigned To DOM. Further review of this work order revealed no documentation of the date it was submitted or a completion date. On 2/13/25 at 12:20 p.m., an interview and review of work orders was conducted with the DOM. He stated the work order for Resident #13's wheelchair bearing was communicated to him on 1/10/25. The DOM stated the resident told him his wheelchair bearing, Was going out. He stated a new wheelchair was ordered, but Resident #13 refused. The DOM stated, We don't mess with personal items. He stated he could order the part needed, if the serial number on the wheelchair was legible. The DOM stated he could order the part through direct supply and an, outside company, could possibly fix it. He stated he had not tried to order a replacement part for the wheelchair, but confirmed the facility could do it. On 2/13/25 at 2:44 p.m., an interview was conducted with the Social Services Director (SSD) related to Resident #13's grievance on 1/14/25. She stated the Resident said the wheels were loose on his wheelchair, making it hard to ambulate down the hallway. The SSD stated herself, the business office and the NHA were aware of and were involved with the related grievance. She stated they offered him a new wheelchair, with his permission, and it was ordered. The SSD stated, He wants his own wheelchair to be fixed. She stated maintenance was looking into purchasing the part to see if his wheelchair can be fixed. The SSD stated, I'm not sure what happened, but I will have to get with maintenance on that. Regarding resolution of the grievance, the SSD confirmed, It isn't what he wanted. Review of the facility policy titled Grievance/ Concern Management, effective February 2021, revealed the following, Policy . These rights also include the right to prompt efforts by the facility to resolve resident concerns, including concerns/grievances with respect to the behavior of other residents. Further review of the policy revealed the following, .5. The Social Services Representatives/Grievance Official in collaboration with the NHA [Nursing Home Administrator] will be responsible for assigning the concern to the appropriate department for investigation. Social Services will monitor and document resident/family satisfaction upon completion of the investigation and the summary of findings/conclusion. 6. The department involved will document the concern and record the resident/resident representative's satisfaction with the resolution to the concern. 13. Social Services staff will provide information regarding compliance line information for unresolved concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 718 Lakeview Ave S Saint Petersburg, FL 33705	

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on record review and interviews the facility did not ensure Preadmission Screening and Resident Review (PASARR) Level I screens were completed accurately for three residents (#64, #65, and #40) out of sixteen sampled residents. Findings included: Review of Admission Records showed Resident #64 was admitted on [DATE] with diagnoses including post-traumatic stress disorder. Review of Resident #64's physician orders showed an order for Bupropion HCL ER 150mg for depression. Review of Resident #64's Care plans revealed a focus area of Psychotropic medication use related to antidepressant to manage depression, dated 12/9/24. Review of Resident #64's PASARR Level I screen, dated 11/8/24, did not indicate the resident had any mental illness or suspected mental illness. An interview was conducted on 2/12/25 at 5:15 p.m. with the Director of Nursing (DON). She reviewed resident #64's PASARR Level 1 screen and confirmed it was not correct and should have been updated. An interview was conducted on 2/12/25 at 5:24 p.m. with the Admission Director. She stated upon admission she ensured every resident had a PASARR Level 1 screen but did not check for accuracy. The Admission Director said nursing should check for accuracy of the diagnoses and information, she had not had any training to do that. 50570 2. Review of Resident #65's admission record revealed an original admitted [DATE], and a re-admitted [DATE]. With diagnoses to include multiple sclerosis, other lack of coordination, weakness, vitamin deficiency, unspecified, benign prostatic hyperplasia without lower urinary tract symptoms, and depression, unspecified. Review of Resident #65's Level I PASARR, dated 12/5/24, under Section I-Part A MI (Mental Illness) or suspected MI, revealed the diagnosis of depression was not indicated. Review of Resident #65's current care plan revealed the following, Psychotropic med [Medication]: [Resident name] uses psychotropic medications r/t [related to] Antidepressant to manage: depression Anticonvulsant for neuropathic pain, with an initiated/revision date of 12/13/2024. Review of Resident #65's Comprehensive Minimum Data Set (MDS) dated [DATE], Section I - Active Diagnoses, revealed depression was indicated under psychiatric/mood disorder. Section N - Medications revealed antidepressant was indicated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 718 Lakeview Ave S Saint Petersburg, FL 33705	

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #40's Admission Record revealed an admitted [DATE] with diagnoses to include cerebral infarction, unspecified, weakness, anxiety disorder, unspecified, polyneuropathy, unspecified, and chronic pain syndrome. Review of Resident #40's Level I PASARR, dated 2/24/23, under Section I-Part A MI or suspected MI, revealed the diagnosis of anxiety was not indicated. Review of Resident #40's Comprehensive MDS dated [DATE], Section I - Active Diagnoses, revealed anxiety disorder was indicated under psychiatric/mood disorder. Section N - Medications - revealed antianxiety was indicated. On 2/12/25 at 5:15 p.m., an interview and review of Resident #65 and #40's PASSARs was conducted with the Director of Nursing (DON). She stated she was responsible for PASSAR review and updating if needed. The DON stated the Level I PASSAR is reviewed upon admission. She stated for newly admitted resident's, the admissions staff member should verify their Level I PASSAR is accurate. The DON stated she updated Level I PASSAR's based on the resident's diagnoses and medication. She stated when the MDS assessment is completed, she initiates the resident review. The DON stated if the resident is not a new admission, she would update the Level I PASSAR and/or submit for a Level II PASSAR if there is a new diagnosis, medication, or if the resident's behavior changed. Review of Resident #65's Level I PASSAR, with the DON, revealed it should have been checked on admission. She stated the diagnosis of depression should have been indicated on the Level I PASSAR and she confirmed it needed to be updated. Review of Resident #40's Level I PASSAR, with the DON, revealed it should have been checked on admission. She stated the diagnosis of anxiety should have been indicated on the Level I PASSAR and she confirmed it needed to be updated. Review of a facility policy and procedure titled PASARR Requirement Level I & Level II revealed the following, Policy . Preadmission screening will be conducted prior to admission as the PASARR process is a federally mandated pre-admission screening program required to be performed on all individuals prior to admission to a Nursing Home. The screening is reviewed by Admission for suspicion of serious mental illness & intellectual disability to ensure appropriate placement in the least restrictive environment & to identify the need to provide applicants with needed specialized services. Further review of the policy revealed the following, Procedure . 2. Determine if a serious mental illness &/or intellectual disability or a related condition exists while reviewing the PASARR form completed by the Acute Care Facility. (Trigger for Level II completion).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Heritage Health & Rehabilitation Center	718 Lakeview Ave S Saint Petersburg, FL 33705

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 20536 Based on observation interview and record review, the facility failed to develop a contracture management splinting care plan with goals and interventions for one (#45) of thirty-two sampled residents. Findings included: Review of the current care plan for Resident #45 with next review date of 5/27/2025 revealed an ADL focus - [Resident #45] has an ADL Self Care Performance Deficit r/t (related to) weakness, impaired mobility, activity intolerance, multiple comorbidities, with interventions in place as reviewed. The review showed there was no care plan problem area with goals and interventions related to contracture management and use of a Right-hand splint/orthotic. Further, there were no other assessments, progress notes, Medication Administration Record and Treatment Administration Record for months 1/2025 and 2/205 revealing treatment for contracture management with use of Right-hand splint/orthotic. On 2/11/2025 at 9:45 a.m. Resident #45 was noted in his room and seated in a wheelchair next to his bed. On top of the dresser was observed with a blue color hand splint/orthotic. Observation of Resident #45 revealed he was not wearing any splint/orthotic on either of his hands. The resident revealed he was knowledgeable of the hand splint/orthotic and that he has worn it at times. He could not explain why staff had not assisted him with the splint/orthotic on his Right hand. His right hand was observed with the last two-digit fingers contracted. He was observed to use his Left-hand fingers to stretch out the two fingers on his Right hand due to lack of movement. Continued interview with Resident #45 confirmed the splint/orthotic was his and it was to help with the pain. He could not remember when he first started wearing the splint/orthotic, but he did say staff have to put it on for him. On 2/11/2025 at 1:45 p.m. Resident #45 was observed in his room and seated in his wheelchair. He was observed not wearing any splints/orthotics on either of his hands, and the blue splint/orthotic was still placed on top of the dresser under the television. On 2/11/2025 at 2:20 p.m. Resident #45 was noted self-propelling while in his wheelchair down the hall to the outside courtyard. He was noted using both hands and feet to propel himself. He was again noted not wearing a hand splint/orthotic on either of his hands. Observation in his room revealed the hand splint/orthotic was still on top of the dresser. The resident was not offered or assisted with the orthotic during the entire 7 a.m.-3 p.m. On 2/12/2025 at 7:30 a.m. and 8:17 a.m. Resident #45 was noted in his room, lying in bed and not wearing any splints/orthotics on either of his hands. The orthotic hand splint was observed in the same place on top of the dresser in his room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Heritage Health & Rehabilitation Center	718 Lakeview Ave S Saint Petersburg, FL 33705

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/2025 at 10:07 a.m. Resident #45 self-propelled out of his room while seated in his wheelchair. He was observed not wearing any splints/orthotics on either of his hands. The room was observed with his splint/orthotic placed on the over the bed table. A Certified Nursing Assistant (CNA) Staff B was in the room cleaning and changing linen. She was not observed assisting the resident with the splint before he left the room. On 2/12/2025 at 10:00 a.m. and at 11:45 a.m. Resident #45 was not wearing an orthotic on either of his hands. Observations in the room revealed a blue hand splint/orthotic placed on the over the bed table, on top of a closed container of food. Resident #45 was again observed in his room seated in his wheelchair next to his bed on 2/12/25 at 1:30 p.m., 2:00 p.m. and at 2:45 p.m. and not wearing a hand splint/orthotic on his Right hand. The splint was still observed placed on top of the dresser. Resident #45 was asked about the splint, and he said, they don't put that thing on me anymore. On 2/12/2025 at 2:45 a.m. an interview with Staff B, CNA confirmed she had remembered seeing the hand splint in the room on the dresser. She stated it was not the responsibility of nursing staff to put it on and or take it off. She revealed it was the responsibility of Occupational Therapy (OT) staff to do that. She again could not say where the hand splint/orthotic went, and that it was no longer in the room. Review of the medical record revealed Resident #45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include but not limited to muscle wasting, unsteady on feet, muscle wasting atrophy. Review of the most current modification significant change Minimum Data Set (MDS) dated [DATE], revealed - Cognition - a Brief Interview Mental Status (BIMS) score of 13 of 15, which indicated the resident was able to be interviewed related to his medical care and services. Behaviors - none documented as exhibited during this timeframe. ADL (Activities of Daily Living) showed - Upper Extremity documented as Impairment on both sides and use of wheelchair. The resident required substantial/maximal staff assistance for showering/bathing, personal hygiene and upper body dressing. The resident was dependent for putting shoes/socks. Active Diagnosis - CVA (Cerebrovascular accident)/Stroke. Review of the current POS (point of service) for the month of 2/2025 for OT (Occupational Therapy) and PT (Physical Therapy) revealed there were no orders related to use of an orthotic or hand splint for Resident #45 to use on his Right hand. Review of the Occupational Therapy Recertification and Updated Plan of Treatment for certification period 2/12/2025 - 3/13/2025, revealed admission diagnosis to include Muscle wasting and Atrophy, and Lack of Coordination. The Summary revealed LTG (long term goal) LTC goal #7.0 - Continue with patient will wear Right hand grip splint to prevent worsening risk of contractures for 5-6 hours as tolerated with skin checks to be provided, with a baseline start date/order date of 11/14/2024 and updated previous 1/29/2025 date with 3-4 hours wear as tolerated. Review of the progress summary of the assessment revealed; Maximum improvement is yet to be attained and patient is compliant with POT. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 718 Lakeview Ave S Saint Petersburg, FL 33705	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/2025 at 12:52 p.m. an interview with the Occupational Therapist Staff C revealed she is currently seeing the resident on OT caseload. Staff C revealed OT picked the resident up for caseload regarding wearing of Right-hand grip splint to prevent worsening risk of contractures for 5-6 hours as tolerated with skin checks to be provided. Staff C revealed this intervention baseline started on 1/14/2025 and it was the responsibility of therapy staff to don and doff the splint daily at this point. She revealed they did not actually receive the Right-hand splint until 1/22/2025. Staff C revealed this splint was ordered and OT is monitoring the use of, application of, participation from resident on a daily basis. On 2/13/2025 at 2:00 p.m., the Director of Nursing (DON) and Nursing Home Administrator (NHA) provided for review a delivery ticket showing the Right-hand splint was delivered and started for resident use on 1/22/2025. The NHA, and Staff C, Occupational Therapist could not show documentation to support application of, offering of, use of the Right-hand splint/orthotic use since 1/22/2025. Review of the facility policy titled Care plan, effective February 2024 showed the facility shall support that each resident must receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The facility shall assess and address care issues that are relevant to individual residents, to include, but not limited to, monitoring resident condition, and responding with appropriate interventions. The comprehensive care plan is an interdisciplinary communication tool. It includes measurable objectives, and time frames and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan is reviewed and revised periodically, and the services provided or arranged are consistent with each resident's written plan of care. The overall care plan should be oriented towards: 1. Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence (e.g., palliative approaches in end-of-life situation, coordination with Hospice plan of care). Managing risk factors to the extent possible or indicating the limits of such interventions. a. Addressing ways to try to preserve and build upon a resident's strengths, needs, personal, and cultured preferences. b. Applying current standards of practice in the care planning process. c. Evaluating treatment of measurable objectives, timetables, and outcomes of care. d. Respecting the resident's right to choose to decline treatment, request treatment, or discontinue treatment. e. Offering alternative treatments, as applicable. 2. Using an appropriate interdisciplinary approach to care plan development to improve the resident's functional abilities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105117	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Heritage Health & Rehabilitation Center	718 Lakeview Ave S Saint Petersburg, FL 33705

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Involving the resident to have a role in care planning even if adjudged incompetent, and the resident's family and / or other resident representatives as appropriate to participate in the development and implementation of his or her person-centered plan of care. b. Assessing and planning for care to meet the resident's medical, nursing, mental, and psychosocial needs. d . Addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting. Procedure revealed: 2. Update to Care Plans a. Ongoing updates to care plans are added by a member of the IDT, as needed. 3. Dates and documentation on the care plan a. New, revised, or discontinued problems, goals, or interventions are dated for the date the documentation was made. 5. Comprehensive Plan of Care a. The comprehensive care plan is developed by members of the IDT and the resident, resident's family , or representative, as appropriate, in conjunction with completion of the Admission, Annual, Significant Change in Assessment or other comprehensive assessment, and the associated Care Area Assessments. b. The comprehensive care plan describes or includes: i. The services that are to be furnished and goals that reflect the Resident's wishes, choices, and exercise of rights. vi. Adequate information provided to make informed choices regarding treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105117	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Heritage Health & Rehabilitation Center	718 Lakeview Ave S Saint Petersburg, FL 33705

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50570 Based on observation interviews and record review, the facility failed to ensure nail care was provided to a resident who needed assistance for one (#55) of three residents reviewed for activities of daily living (ADL). Findings included: On 2/11/25 at 10:06 a.m. an observation of Resident #55 revealed he was laying down in bed, facing the window. The resident's hands were observed and revealed long, untrimmed fingernails on both hands with dark brown/black debris underneath three of his nails. Resident #55 stated he could not recall when he last received nail care. He stated he wanted his nails trimmed. On 2/12/25 at 9:42 a.m., an observation of Resident #55 revealed the same concerns observed on 2/11/25. (Photographic Evidence Obtained) Review of Resident #55's admission record revealed an admitted [DATE] with diagnoses to include muscle wasting and atrophy, not elsewhere classified, multiple sites, type 2 diabetes mellitus without complications, other lack of coordination, other abnormalities of gait and mobility, unsteadiness on feet, schizoaffective disorder, unspecified, and major depressive disorder, single episode, unspecified. Review of Resident #55's current care plan revealed the following, [Resident name] has an ADL Self Care Performance Deficit r/t [related to] recent hosp. [hospital] stay, with an initiated date of 6/28/24 and revision date of 8/9/24. Interventions to include, Personal hygiene - assist of 1 Date Initiated: 10/02/2024. Further review of Resident #55's record revealed there was no documentation related to refusing nail care. Review of Resident #55's quarterly Minimum Data Set (MDS) assessment, Section GG - Functional Abilities, dated 12/18/24, indicated the following, Personal Hygiene . Supervision or touching assistance. A progress note dated 10/30/24 showed, Resident agreed to take a shower today, nail care and shave also completed at that time. Resident stated he sometimes refuses showers because staff comes too early to give showers, he prefers to have his showers after lunch. Further review of Resident #55's progress notes from 1/21/25 to current revealed there was no documentation related to nail care to include providing or refusing nail care. Review of Resident #55's tasks related to nail care, dated 1/15/25 to 2/2/25, revealed no documentation that nail care was provided. Further review of the tasks related to nail care revealed documentation showing - No Nail Care, or a few times it was documented, Resident Refused. There was no other documentation related to nail care from 2/2/25 to 2/13/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105117	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Heritage Health & Rehabilitation Center	718 Lakeview Ave S Saint Petersburg, FL 33705

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's shower schedule revealed the following, When showering residents the C.N.A. [Certified Nursing Assistant] is responsible for providing assistance with all grooming including shaving and nail care. Further review of the shower schedule revealed Resident #55's scheduled days are Tuesday and Friday. Review of the facility's weekly grooming schedule revealed the following, . Wednesday - Nail care - All resident's nails should be clean and trimmed. On 2/13/25 at 10:05 a.m., an interview was conducted with Staff I, CNA. She stated CNAs provided nail care to include cleaning and trimming. She stated if the resident has diabetes the nurse completed nail care. Staff I, CNA stated nail care is documented on the kiosk for daily ADL tasks. She stated if the resident refused, CNAs are expected to report to the nurse and document in their tasks. She stated documentation of, No Nail Care, on the tasks means it wasn't done or the resident completed it themselves and the CNA didn't assist. Staff I, CNA stated completing Resident #55's nail care, Is a challenge. She stated when she offered to assist with nail care, Resident #55 will tell her no. Staff I, CNA stated she tells the nurse when the resident refuses. On 2/13/25 at 10:57 a.m., an interview was conducted with the Director of Nursing (DON). She stated if a resident refused ADL care, she expected the CNA to tell the nurse, and the nurse should be documenting in the electronic Medication Administration Record (eMAR) or progress notes. She stated if the resident is refusing care, to include nail care, That should be care planned. The DON stated, No Nail Care, indicated in the tasks means the resident refused and no nail care was provided. She stated she did not know why Resident #55 did not have a care plan related to nail care refusal as they've known about the refusals since October 2024, due to a grievance. She stated she hasn't observed Resident #55's nails recently. On 2/13/25 at 11:03 a.m., an interview with the DON revealed she couldn't locate current shower sheets for Resident #55. The shower sheets observed were from 11/2024. On 2/13/25 at 2:34 p.m., an interview was conducted with the Social Services Director (SSD) related to a grievance dated 9/22/24 from Resident #55. She stated the resident wanted his fingernails cut. She stated she communicated with the nursing department and asked a staff member to cut his fingernails. Another grievance was reviewed with the SSD, dated 10/30/24, related to Resident #55's nails, skin and shaving. She stated the grievance was initiated by the resident's family member. The SSD stated Resident #55 refused care at times. She stated they figured out it was the timing of when nail care, and other ADL assistance, was being provided. The SSD stated part of the resolution was the DON educated the resident on the shower schedule. She stated the grievance was resolved and Resident #55's nails were cut. The SSD confirmed he should have a care plan for refusing ADL's, to include nail care, and could not confirm if he has one. On 2/13/25 at 2:01 p.m., the DON stated the facility does not have an ADL policy and she expected staff to follow the resident's care plan. Review of a facility policy and procedure titled, Care Plan - Interdisciplinary Plan of Care Interim to Meeting, dated February 2024, revealed the following, Policy . The care is reviewed and revised periodically, and the services provided or arranged are consistent with each resident's written plan of care. Further review of the policy revealed the following, . 2. Update to Care Plans a. Ongoing updates to care plans are added by a member of the IDT (interdisciplinary team), as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER: South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 718 Lakeview Ave S Saint Petersburg, FL 33705	

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223 Based on interviews, observations, and record reviews the facility failed to provide enteral nutrition per physician orders for one (#220) out of five residents with enteral nutrition orders. Findings included: An interview and observation was conducted with Resident #220 on 2/11/2025 at 10:25 a.m. Resident #220 was lying in bed, looking out the window. Resident #220 said his enteral feeding had not been on for a while. Upon observation of the enteral feeding pump, it was noted it was not running, the [brand name] 1.5 calorie bottle was observed with approximately 450 ml (milliliters) of enteral feeding remaining of the 1000 ml bottle. The date 2/10/25 was the only other piece of information seen written on the label that was not from the manufacturer. An interview and observation was conducted with Resident #220 on 2/11/2025 at 4:10 p.m. Resident #220 was lying in bed, listening to the TV. Resident #220 said the enteral pump had not been running. Observation of the enteral feeding pump confirmed it was not running, the [brand name] 1.5 calorie bottle was observed with approximately 450 ml of enteral feeding remaining of the 1000 ml bottle. The date 2/10/25 appearing as the same 2/10/25 seen at the 10:25 a.m. visit, the bottle was observed with the following information written on the label: Resident #220 name, 2/11/2025, 12:10 a.m., and 65 ml/hour. An interview and observation was conducted with Resident #220 on 2/12/2025 at 9:37 a.m. and 11:50 a.m. Resident #220's enteral feeding pump was not powered on and not running. The enteral feeding formula was observed hanging with approximately 875 ml of formula in the bottle. The bottle label was observed with the following writing: Resident #220 name, date: 2/12/25 at 5 AM, 65 ml. Resident #220 stated the pump has not been running. An interview and observations was conducted with Resident #220 on 2/13/2025 at 10:10 a.m. Resident #220 stated the bottle was taken down earlier in the morning. Upon observation no bottle was observed on the enteral pump and the pump was powered off. During an interview on 2/13/2025 at 10:15 a.m. Staff J, Registered Nurse (RN) stated Resident #220 had an order for continuous feeding at 65 ml/hr. (milliliter/hour) and flushes every 6 hours of 250 ml of water. Staff J, RN confirmed removing Resident #220's enteral feed bottle earlier in the shift, while passing medications to the room. Staff J, RN stated she needed to replace the bottle and was waiting to finish the medication pass. Staff J, RN stated she would be finished with the medication pass in about an hour. On 2/13/2025 at 11:50 a.m. Resident #220's enteral pump was noted off and no formula was hanging. On 2/13/2025 at 2:20 p.m. Resident #220's enteral pump was noted to be on and running. The label of the bottle showed: Resident #220's name, Room number, Date: 2/13, product name, rate: 65 ml/hr., volume:1300 Time:1400. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER: South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 718 Lakeview Ave S, Saint Petersburg, FL 33705	

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/2025 at 11:22 a.m. the Registered Dietitian (RD) stated the order is for 65 ml/hr. to be infusing for a total of 1300 ml. The calculation for the needs of the resident are based on the formula running for 20 hours, 4 hours is given for care/services to be completed when the formula is not running. The RD stated the review of the information above is concerning as the resident missed nutrition. She said, We will need to contact the physician. During an interview on 2/13/2025 at 2:05 p.m. the Director of Nursing (DON) stated being concerned about how the tube feeding was being handled, stating, would need to investigate the handling of Resident #220's orders. The DON's expectation is that the nurses follows the physician's orders. Review of Resident #220's admission record revealed an original admitted [DATE] with diagnoses to include malignant neoplasm of larynx, chronic obstructive pulmonary disease, and other co-morbidities. Review of Resident #220's physician orders revealed an order dated 2/10/2025 for enteral feed: Jevity 1.5 Cal continuous via tube to infuse at a rate of 65 ml/hr. for a total volume of 1300 ml infused in 24 hours. Review of Resident #220's physician orders revealed an order dated 2/10/2025 to flush enteral tube with 250 ML of water every 6 hours for hydration. Review of Resident #220's progress notes from 2/10/2025 to 2/13/2025 revealed an absence of entries regarding the enteral feeding. Review of the facility's policy and procedures titled: nutrition - enteral/parental nutrition & hydration dated effective October 2021 revealed under overview - Enteral/Parental nutrition and hydration palliative care will focus on the resident/patient's enjoyment, relief of symptoms, and maintenance of energy and strength. Optimizing nutritional status to delay decline will be an appropriate goal only if in accordance with resident/patient or legal guardian's wish.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER: South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 718 Lakeview Ave S Saint Petersburg, FL 33705	

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 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 record review and interviews the facility did not ensure pharmacy recommendations were implemented for two residents (#64 and #2) out of five residents sampled for unnecessary medications. Findings included: Review of the admission records showed Resident #64 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD). Review of Resident #64's physician orders showed an order for Breo Ellipta Inhalation Aerosol Power Breath Activated 200-25 mcg/act. 1 inhalation one time a day for asthma, dated 12/2/24. Review of Resident #64's Consultant Pharmacist's Medication Regimen Review, dated 12/6/24 showed the following: This resident is receiving Breo. Steroid inhalers can cause oral thrush which may be minimized by rinsing the mouth with water after each dose of the inhaler. Please consider adding the following verbiage to the order as a reminder. Rinse mouth with water and spit back into cup after use. The recommendation was not signed and there was no indication it was reviewed and completed. Review of physician orders on 2/11/25 showed the order had not been changed or updated to add the recommended verbiage. 48223 Review of the admission record showed Resident #2 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), Respiratory Disorders, Epilepsy, Mild protein-calorie malnutrition, major depressive disorder, anxiety, restless legs syndrome, metabolic acidosis, hypertension and other co-morbidities. Review of Resident #2's physician orders showed an order for Topiramate 50 mg (milligram) give twice a day for weight management, dated 8/28/24. Review of Resident #2's consultant pharmacist's medication regimen review dated 11/1/24 to 11/4/24 showed the following: Please clarify the following incomplete orders: Please document BP [blood pressure] to assess need/use of prn (as needed) midodrine every 8 hours. Clarify/update dx [diagnosis] of use on Lamictal to SZ [seizure] Instead of weight management Review of physician orders on 2/12/25 showed the order had not been changed or updated to add the recommended verbiage. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 718 Lakeview Ave S Saint Petersburg, FL 33705	

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's consultant pharmacist's medication regimen review dated 8/23/2024 showed the following: rather than offering the treatment as an adult after reviewing the current medications, please consider evaluating use of medications for possible discontinuation or change it as it has a high potential for causing or contributing to falls and possible fracture . ASA (aspirin) 81mg (milligram) daily; Lipitor 80mg hs (hours of sleep) (assess for lower dose, Lipid panel, and CPK (creatine phosphokinase) level ; FML (fluorometholone) (blurred vision); Remeron 30mg hs-assess for gdr (gradual dose reduction); Zyprexa 7. 5mg hs-assess for gdr; Requip 0.25mg hs-monitor for dizziness, weakness muscle cramps vertigo; Klonopin 0.5mg bid-assess for gdr; Keppra 750mg bid (check renal fxn [frataxin]), Protonix 40mg bid (may cause dizziness); Topamax 25mg bid-monitor renal fxn monitor for dizziness weakness (clarify dx[diagnosis] of use); gabapentin 300mg tid [three times daily]-monitor renal fxn monitor for dizziness weakness tremor blurred vision; Midodrine 5mg tid hold for SBP>110; Norco 5/325mg one tablet every 6 hours prn. The provider checked the box: disagree and wrote see psych note from 8/28/24 for reasoning, dated 8/28/24. Review of Resident #2's psych note dated 8/28/24 showed current psychiatric medications: Zyprexa 7.5mg hs; Remeron 30mg hs; Klonopin 0.5mg every 12 hours; and reasoning for medically needed medication. No other medications were reviewed or mentioned. Review of physician orders on 2/12/25 showed the orders had not been changed or updated to add the recommended verbiage. During an interview on 2/13/2025 at 1:34 p.m. the Director of Nursing (DON) reviewed the pharmacy recommendations for Resident #2 and #64. She verified the pharmacy recommendation had not been addressed and should have been referred to the physician for follow-up. The facility did not provide the requested policy and procedure for Pharmacy Recommendations. Class III

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Heritage Health & Rehabilitation Center	718 Lakeview Ave S Saint Petersburg, FL 33705

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 0759

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure medication error rates are not 5 percent or greater.

46234

Based on observation, record review, interview and policy review the facility failed to ensure the medication error rate was less than 5.0%. Thirty medications opportunities were observed, and three medication errors were identified for three residents (#32, #36, #11) of three residents observed. These errors constituted a 10.0% medication error rate.

Findings included:

An observation was conducted during medication administration for Resident #32 on 2/12/25 at 9:20 a.m. with Staff F, Licensed Practical Nurse (LPN). Staff F prepared and administered the following medications:

-Vitamin B-12 500 mcg (microgram) x 1tablet

-Cetirizine HCL 10 mg (milligram) x 1tablet

-Folic Acid 1 mg x 1 tablet

-Famotidine 20 mg x 1 tablet

-Allopurinol 300mg x 1 tablet

-Acetaminophen 500 mg x 2 tablets.

Review of Resident #32's physician orders showed the following:

-Claritin Oral tablet 10 mg. Give 1 tablet by mouth one time a day for allergic rhinitis, dated 11/28/23.

There was no order for Cetirizine HCL 10 mg x 1.

Review of Resident #32's Medication Administration Record (MAR) showed Claritin Oral tablet 10 mg was signed off as given.

An interview was conducted on 2/12/25 at 12:43 p.m. with Staff F, LPN. She reviewed Resident #32's orders and looked in her medication cart. She confirmed the medication order was Claritin and she accidently grabbed the Cetirizine and administered it. She said she didn't realize she had administered the wrong medication. Staff F demonstrated that both medications in were in the medication cart close together.

An observation was conducted during medication administration for Resident #36 on 2/12/25 at 9:50 a.m. with Staff F, LPN. Staff F prepared and administered the following medications:

-Artificial tears 1 drop each eye

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 718 Lakeview Ave S Saint Petersburg, FL 33705	

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Docusate sodium 100 mg x 1 tablet -Aspirin 81mg x 1 tablet -Vit B 12 500 mcg x 1 tablet -Eliquis 5 mg x 1 tablet -Spironolactone 25 mg x 1 tablet -Fluoxetine HCL 10 mg x 1 tablet -Famotidine 10 mg x 1 tablet -Metoprolol ER 25 mg x 1 tablet -Entresto 49-51 mg Was not in the medication cart. -Aspercreme Lidocaine cream 4% -Breyna inhaler 160mcg/4.5 mg 2 puffs Review of Resident #36's physician orders showed the following: -Entresto oral tablet 49-51 mg. Give 1 tablet by mouth two times a day for essential (primary) hypertension, dated 9/30/24. Review of Resident #36's MAR showed Staff F documented 5, which indicated to hold/see nurse note, on 2/12/25 for the 9:00 a.m. administration of Entresto. Review of Resident #36's nurse notes showed a note dated 2/12/25 at 9:50 a.m. showing Entresto was awaiting pharmacy. There was no documentation a doctor was notified the resident did not receive the medication. An interview was conducted with a representative from the facility's delivery pharmacy on 2/12/25 at 3:29 p. m. The representative said Resident #36's Entresto had not been reordered until the evening of 2/11/25. An interview was conducted on 2/12/25 at 3:12 p.m. with Resident #36's primary care physician (PCP). She stated she had not been notified Resident #36 did not receive their ordered Entresto. The PCP said sometimes her Nurse Practitioner (NP) is called. An interview was conducted on 2/13/25 at 4:06 p.m. with Resident #36's NP. The NP said she had not been made aware Resident #36 did not receive her Entresto the morning of 2/12/25. An observation was conducted during medication administration for Resident #11 on 2/12/25 at 10:08 a.m. with Staff G, LPN. Staff G prepared and administered the following medications: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 718 Lakeview Ave S Saint Petersburg, FL 33705	

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Risperidone 1mg/ml. 1.5 ml -Levothyroxine 125 mcg x 1 tablet -Amantadine HCL 100mg x 1 capsule -Diazepam 5mg x 1 tablet -Lamotrigine 100 mg x 2 tablet -Diltiazem ER 120 mg x1 capsule -Carbidopa levodopa 25-100mg x 1 tablet -Docusate Sodium 100 mg x 1 tablet -Multi-vitamin x 1 tablet -Levetiracetam (Keppra) 500 mg x 1tablet -Divalproex DR 125 mg x 4 capsules -Aspirin 81 mg chewable x 1 tablet When the nurse poured the Risperidone, she confirmed the amount poured was 1.5 ml. All medications were crushed/opened and administered to the resident dissolved in to drink, per orders. Review of Resident #11's physician orders showed the following: -Risperidone oral solution 1 mg/ml. Give 1 ml by mouth one time a day related to schizoaffective disorder, Give 1 mg q a.m. (in the morning). Dated 7/31/24. -Risperidone oral solution 1mg/ml. Give 1.5 ml by mouth at bedtime related to schizoaffective disorder. Dated 4/11/24. An interview was conducted on 2/12/25 at 12:47 p.m. with Staff G, LPN. Staff G reviewed the orders for Resident #11. Immediately upon review, Staff G realized the mistake that had been made. She confirmed she administered 1.5 ml to Resident #11 instead of the ordered 1.0 ml. Staff G showed the screen of her electronic charting system that listed the 9:00 a.m. order as Risperidone oral solution 1mg/ml. Give 1 ml by mouth one time a day related to schizoaffective disorder. Underneath that it showed Dispensed Supply: RISPERIDONE 1 MG/ML SOLUTION. GIVE 1.5 ML (S) BY MOUTH DAILY AT BEDTIME. Staff G said she read the bottom of the 9:00 a.m. order and saw give 1.5 ml so that is what she administered. She said she did not know why the bedtime order showed up on the 9:00 a.m. order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 718 Lakeview Ave S Saint Petersburg, FL 33705	

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 2/12/25 at 12:55 p.m. with the Director of Nursing (DON). The DON was observed reviewing Staff G's computer screen with Resident #11's orders. She said she did not know why the orders showed up with the bedtime order linked with the morning order. She said she could see why it could lead to a mistake, and she was going to see if it could be fixed. The DON also reviewed the orders for Resident #32. She confirmed Cetirizine cannot be administered in place of Claritin. She said Cetirizine should only be administered if the doctor was called and the order was changed. The DON said the doctor should be notified of any missed medications or medication errors. Review of a facility policy titled Medication Administration General Guidelines, dated 09/18, showed: Policy - Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Procedures - Medication Preparation: 3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. Compare the medication and dosage schedule on the resident's MAR with the medication label. If the label and MAR are different, and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule. Apply a direction change sticker to label if directions have changed from the current label. Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication. If necessary, the nurse contacts the prescriber for clarification. This interaction with the pharmacy and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate. 9. Verify medication is correct three (3) times before administering the medication. a. When pulling medication package from med cart b. When dose is prepared. c. Before dose is administered. (Photographic Evidence Obtained)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER: South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 718 Lakeview Ave S, Saint Petersburg, FL 33705	

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation interview and policy review, facility did not ensure medication was stored appropriately on three out of three units in the facility related to medication in resident rooms on the north and main units, unsecured medication is an office on the central unit, and improperly stored medication in two medication carts on the north and central units. Findings included: An audit of the central medication cart and interview was conducted on [DATE] at 3:34 p.m. with Staff H, Licensed Practical Nurse (LPN). The cart contained a bottle of Sodium Bicarbonate 10 gr (grain) that had been opened on [DATE] and expired on ,d+[DATE]. The drawers of the cart had dirt, debris, pieces of packaging, rubber bands, and glucose test strips in them. Staff H said the night shift is supposed to clean the medication cart and check them for expired medication. She agreed the cart was dirty and said night shift obviously hadn't cleaned it. An audit of the north medication cart and interview was conducted on [DATE] at 3:48 p.m. with Staff E, Registered Nurse (RN). The medication cart contained a box of Bisacodyl suppositories that expired , d+[DATE]. There was one loose pill in the medication cart. The narcotics drawer contained a box of medical gloves being stored with the medication. Another drawer contained medication being stored in the same compartments as plastic bags, syringes, and lancets. Staff E confirmed the box of Bisacodyl suppositories was expired and said she would dispose of them. She confirmed there should be no loose medication in the cart, but she was unaware the medication could not be stored in the same compartment as other items. An observation was conducted on [DATE] at 3:00 p.m. of a medication cart on the central hall unlocked with no staff in sight. Residents were ambulating and self-propelling in the hall. 20536 2. On [DATE] at 11:00 a.m. the Main unit was observed with a long hallway with resident rooms and other unidentified rooms. An unidentified room between resident rooms [ROOM NUMBERS] was observed with the door closed. There was no signage indicating what the space was. The door was unlocked. Upon entrance, the room was noted very small, and it appeared to be an employee's office. Further observations revealed there was no staff in the room. Upon glancing at the floor to the right of the door when it was opened, revealed a cardboard box with many cards of medications. The box was not labeled as to what the medications were. There was no nursing staff in, at, nor around this unlocked space. Further observations revealed residents ambulate or self-propel while seated in a wheelchair past this room which was in a high traffic area. Some residents who reside on this hallway were noted with confusion and dementia and ambulate at and near this unlocked space. There were observations of two residents who were seated in wheelchairs, and who were with cognition deficits, going in and out from rooms that were not theirs. Photographic evidence was taken of the room and unsecured medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 718 Lakeview Ave S Saint Petersburg, FL 33705	

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:00 p.m. the unlocked room with unsecured medications was observed unlocked, unsupervised and the box of cards of medications were still accessible to anyone walking by the space. An interview with the West/Main Unit Manager Staff D, RN on [DATE] at 12:11 p.m. revealed the space/office between resident rooms [ROOM NUMBERS] was her personal office. Staff D stated the office door is usually locked and monitored and a key was needed to access it. When asked about the room being unlocked with open box of medications on the ground yesterday, she stated that the box of medications were go backs and they have a process for how they return them. Staff D, RN stated that yesterday she was right in the middle of getting that form completed before moving the box to the medication room where it usually stays secured until the pharmacy picks up. She explained that there were no narcotics in the box but stated she understands the potential issues that could arise from having the medications in her office unlocked and accessible by any foot traffic in that hall, specifically several cognitively impaired residents near the office. 50570 3.On [DATE] at 11:05 a.m. an observation of Resident #65's bedside table revealed a clear, plastic medicine cup with medicine inside. The plastic medicine cup appeared to have approximately six different colored pills. During the interview Resident #65 said, I was supposed to take the medications. He stated he would take them now. Review of Resident #65's admission record revealed the following diagnoses: multiple sclerosis, other lack of coordination, weakness, vitamin deficiency, unspecified, benign prostatic hyperplasia without lower urinary tract symptoms, and depression, unspecified. Review of Resident #65's Active Orders revealed the following under pharmacy, Baclofen Oral Tablet 5 MG [milligrams] (Baclofen) Give 1 tablet by mouth every 12 hours for musculoskeletal therapy Celebrex Oral Capsule 200 MG (Celecoxib) Give 1 capsule by mouth one time a day for DJD [Degenerative Joint Disease] Cyanocobalamin Oral Tablet (Cyanocobalamin) Give 1000 mcg [micrograms] by mouth one time a day for hematopoietic therapy Ergocalciferol Oral Capsule 1.25 MG (50000 UT [upper-level intake]) (Ergocalciferol) Give 1 capsule by mouth one time a day every 7 day(s) for vitamin supplement Folic Acid Oral Tablet 1 MG (Folic Acid) Give 1 mg by mouth one time a day for preventive measures Glatiramer Acetate Subcutaneous Solution Prefilled Syringe 40 MG/ML [milliliters] (Glatiramer Acetate) Inject 40 mg subcutaneously one time a day every Wed related to MULTIPLE SCLEROSIS (G35) Lyrica Oral Capsule 100 MG (Pregabalin) *Controlled Drug* Give 1 capsule by mouth three times a day for nerve pain for 30 Days (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105117	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Heritage Health & Rehabilitation Center	718 Lakeview Ave S Saint Petersburg, FL 33705

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Tamsulosin HCl [hydrochloride] Oral Capsule 0.4 MG (Tamsulosin HCl) Give 1 capsule by mouth one time a day for prostate Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) *Controlled Drug* Give 50 mg by mouth four times a day for Acute Pain Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen)Give 2 tablet by mouth every 6 hours as needed for Pain, headache or fever (Temp GREATER than 100.4F [Fahrenheit]). Review of Resident #65's physician orders did not reveal an order for self-administration order. Review of a care plan for Resident #65 initiated on ,d+[DATE] did not shower a focus related to self-administration of medications. 48223 3. On [DATE] at 10:12 a.m. and [DATE] 10:21 a.m. an observation occurred of Resident #221's inhaler on the over the bed table and later on the nightstand. Review of Resident #221's physician orders did not reveal an order for self-administration order. On [DATE] at 9:54 a.m. and [DATE] at 10:22 a.m. an observation occurred of Resident #54's over the bed table, in front of the resident, an inhaler (with the prescription label affixed) and a bottle of anti-diarrheal medication. Review of Resident #54's physician orders did not reveal an order for self-administration. (Photographic Evidence Obtained) During an interview on [DATE] at 1:34 p.m. the Director of Nursing (DON) stated no residents in the facility have an order for self-administration of medications. DON stated no residents in the facility should have any medications on the bedside, over the bed table or in their rooms in general. The expectation would be that the staff member who notes the medication would alert the nurse, and the nurse would educate, remove the medication from the bedside, and notify the physician for orders if necessary. Review of the facility's policy and procedures titled: Medication Storage - Storage of Medication dated , d+[DATE] showed: 4.1 Storage of Medication Policy: Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Heritage Health & Rehabilitation Center	718 Lakeview Ave S Saint Petersburg, FL 33705

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The provider pharmacy dispenses medications in containers that meet state and federal labeling requirements, including requirements of good manufacturing practices established by the United States Pharmacopeia (USP). Medications are to remain in these containers and stored in a controlled environment. This may include such containers as medication carts, medication rooms, medication cabinets, or other suitable containers. 2. Controlled medications must be stored separately from non-controlled medications. The access system (key, security codes) used to lock Schedule IJ medications and other medications subject to abuse, cannot be the same access system used to obtain the nonscheduled medications. Schedule II medications and preparations must be stored in a separately locked permanently affixed compartment. (See Section 4.2 - Controlled Medication Storage.) 3. In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access. 4. Internally administered medications are stored separately from medications used externally such as lotions, creams, ointments, and suppositories. 5. Intravenously administered medications are stored separately from orally administered medications, under appropriate temperature and sterility conditions, and following the manufacturer's recommendations. 6. Eye medications are stored separately from ear medications and inhalers, etc. 7. Medications for oral inhalation are stored in the dispensed containers following manufacturer guidelines for positioning and priming. 8. Medications for nasal inhalation are stored in dispensed containers following manufacturer guidelines for positioning and priming. The following information is provided as general guidelines for proper storage of specific nasal inhaler products and is not meant to be all inclusive. 9. Potentially harmful substances (such as urine test reagent tablets, household poisons, cleaning supplies, disinfectants) are clearly identified and stored in an area separate from medications. 10. Medications requiring storage at room temperature are kept at temperatures ranging from 15 C (59 F) to 30 C (86 F). Controlled room temperature is defined as 20 C (68 F to 25 C (77 F). 11.Medications requiring refrigeration or temperatures between 2 C (36 F) and 8 C (46 F) are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage in a cool place may be refrigerated unless otherwise directed on the label as cool temperatures are those between 8 C (46 F) and 15 C (59 F). A temperature log or tracking mechanism is maintained to verify that temperature has remained within accepted limits. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 718 Lakeview Ave S Saint Petersburg, FL 33705	

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. Insulin products should be stored in the refrigerator until they are opened. Note the date on the label for insulin vials and pens when first used. The opened insulin vial may be stored in refrigerator or at room temperature. Opened insulin pens must be stored at room temperature. Do not freeze insulin. If insulin has been frozen, do not use. (Refer to Section 9.10 - Medications with Shortened Expiration Dates) 13. Refrigerated medications should be kept in closed and labeled containers, with internal medications separated from external medications and all medications segregated from fruit juices, applesauce, and other foods used in administering medications. Any other foods such as employee lunches and activity department refreshments should not be stored in this refrigerator. The refrigerator should be kept clean and frost-free. To protect refrigerated medications from freezing, store them away from the freezer section. 14. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal (Refer to Section 5 - Disposal of Medications, Syringes and Needles), and reordered from the pharmacy (Refer to Section 3.2 - Ordering and Receiving Non-Controlled Medications), if a current order exists. 15. Medication storage should be kept clean, well lit, organized and free of clutter. 16. Medication storage conditions are monitored on a regular basis as a random quality assurance (QA) check. As problems are identified, recommendations are made for corrective action to be taken.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 718 Lakeview Ave S Saint Petersburg, FL 33705	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on observation, interview and record review facility did not ensure proper infection control practices for one resident (#64) out of sixteen sampled residents related to scabies treatment. Findings included: An observation and interview was conducted on 2/11/25 at 11:03 a.m. with Resident #64. She was observed to have raised several scabbed spots covering both legs. She said she had been itching. A follow-up interview was conducted with Resident #64 on 2/13/25 at 11:55 a.m. The resident said she was still itching. She explained the bumps and itching started on her arms and chest then moved to her legs. She said when she lays down her back was starting to itch. She said the nurse puts medication on that helps some. Review of admission record showed Resident #64 was admitted on [DATE] with diagnoses including peripheral vascular disease and chronic pain syndrome. Review of Resident #64's 1/2/25 quarterly Minimum Data Set (MDS) Section C, Cognitive patterns showed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact. Review of Resident #64's progress notes showed the following: -1/6/25 6:20 a.m. Resident observed with red raised areas on chest and bilateral arms also complains of itch. PRN (as needed) Benadryl given. Will reach out to MD (medical doctor) for advice. -1/7/25 10:21 p.m. Resident ID Betamethasone Valerate External Cream 0.1 %. NARN at this time. Reddened rash remains to bilateral upper extremities and chest region. Encouraged resident to refrain from scratching, as tolerated. VS WNL (vital signs within normal limits). Afebrile. Patient is currently resting in bed. Safety precautions in place. No signs of pain, discomfort, or distress. Current plan of care will continue. Review of Resident #64's primary care provider (PCP) notes dated 1/14/25 showed, However tast [sic] week I did start her on Permethrin and a topical steroid for suspected scabies dermatitis. Today rash and pruritus have improved tremendously. Assessments listed scabies as primary, and treatment showed new pruritic maculopapular rash consistent with scabies dermatitis. Responded well to Permethrin and topical steroid. CTM [continue to monitor]. Ensure proper hygiene Review of Resident #64's physician orders for January 2025 showed the following: -Permethrin External Cream 5 % (Permethrin) Apply to torso and bilateral arms topically one time only for pediculosis, scabies for 1 day. Leave on for 10 hours prior to washing off. Dated 1/7/25. Review of Resident #64's Medication Administration Record (MAR) for January 2025 showed the order for Permethrin External Cream ordered 1/7/25 was documented as X meaning Did Not Occur. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER: South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 718 Lakeview Ave S Saint Petersburg, FL 33705	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #64's progress notes showed the following: -2/4/25 8:19 a.m. Patient complains of itching on arms. Betamethasone d/c'd (discontinued). -2/4/25 11:45 a.m. Resident was notified of getting a new roommate. Resident stated ok. Review of Resident #64's PCP notes, dated 2/4/25, showed However today she notes a recurrent rash on chest and arms similar to the rash she had a few weeks ago. Assessments listed scabies as primary, and treatment showed Recurrent pruritic maculopapular rash consistent with scabies dermatis [sic]. Responded well to Permethrin and topical steroid in the past. Will resume this and also add Ivermectin. Review of Resident #64's physician orders for February 2025 showed the following: -Diphenhydramine HCl Oral Tablet 50 MG (Diphenhydramine HCl) Give 50 mg by mouth as needed for Itching. Dated 2/4/25. -Ivermectin Oral Tablet 3 MG (Ivermectin) Give 15 mg by mouth two times a day for Anti-parasitic. Dated 2/4/25-2/12/25. Review of Resident #64's Medication Administration Record (MAR) for February 2025 showed the resident requested and received the PRN Diphenhydramine for itching six out of eight days from 2/4-2/11/25. The Ivermectin order to be administered twice a day from 2/4-2/12/25 was only administered nine out of the fifteen times it was ordered. Three times (2/5, 2/8, 2/9/25 morning dose) it was documented as X meaning Did Not Occur, once (2/4/25 evening dose) documented as 9 meaning Other/See Nurse Notes, and once (2/11/25 morning dose) as 5 meaning Hold/See Nurse Notes. Review of Resident #64's MAR Progress notes showed: -2/4/25 5:07 p.m. eMar -(electronic) Medication Administration Note: Ivermectin Oral Tablet 3 MG Give 15 mg by mouth two times a day for Anti-parasitic- on order. -2/5/25 9:41 a.m. eMar - Medication Administration Note: Ivermectin Oral Tablet 3 MG Give 15 mg by mouth two times a day for Anti-parasitic - med is not in RX Now. -2/8/25 3:41 p.m. eMar - Medication Administration Note: Ivermectin Oral Tablet 3 MG Give 15 mg by mouth two times a day for Anti-parasitic - med completed. 2/9/25 3:47 p.m. eMar - Medication Administration Note: Ivermectin Oral Tablet 3 MG Give 15 mg by mouth two times a day for Anti-parasitic - medication complete. 2/9/25 8:08 p.m. eMar - Medication Administration Note: Ivermectin Oral Tablet 3 MG (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER: South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 718 Lakeview Ave S, Saint Petersburg, FL 33705	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give 15 mg by mouth two times a day for Anti-parasitic - on order. 2/11/25 9:31 a.m. eMar - Medication Administration Note: Ivermectin Oral Tablet 3 MG Give 15 mg by mouth two times a day for Anti-parasitic - awaiting pharmacy. An interview was conducted on 2/13/25 at 1:32 p.m. with Staff G, LPN. She said she is a regular nurse for Resident #64. She said she hadn't heard anything about scabies, but she said they do put some cream on the resident for itching. An interview was conducted on 2/13/25 at 12:36 p.m. with Staff D, Registered Nurse (RN)/Unit Manager (UM). Staff D said Resident #64's rash had started smaller and is now all over. She said the resident had Ivermectin and they are going to get a dermatologist consult. Staff D said she didn't think the doctor was saying possible scabies. She said if they thought it was scabies the resident would be in a room by herself and would be isolated while they did treatment for three days. She said during that time all of her clothes would be rewashed, and her room would have a deep cleaning. Staff D then reviewed Resident #64's providers notes and said OMG [oh my god] She said if she had known the resident wouldn't have gotten a roommate. Staff D also said it is a waste to do the treatment without cleaning her room and belongings. An interview was conducted on 2/13/25 at 12:24 p.m. with the Housekeeping Manager. He stated there had been no request to deep clean a room related to infections or bugs. He said they had only been doing their scheduled deep cleanings and daily cleanings of rooms. He said the only requests he had was to clean rooms when a resident relocated to another room or was discharged . He said rooms are scheduled to be deep cleaned every 3-4 weeks. He explained a deep clean as wiping down everything you can reach, move nightstands and cleaning under/behind them, wiping down the bed frame and mattress if the resident is out of bed and if they do not want to get up they clean under it and wipe down the poles. He said a deep clean does not include changing privacy curtains. He said he rounds to check for curtains that are dirty and need to be changed and they are changed when a resident discharged . The housekeeping manager said there had been no request to do a special clean of Resident #64's room. An interview was conducted on 2/13/25 at 1:06 p.m. with the Director of Nursing (DON). She said she had not heard anything about Resident #64 being treated for possible scabies. The DON reviewed the resident's provider notes and said she had no idea. An interview was conducted on 2/13/25 at 12:59 p.m. with the Nursing Home Administrator (NHA). She said she had not been aware of any scabies or potential scabies in the facility. She said if they were treating someone for scabies staff should follow the facility's policy. Review of a facility policy titled Scabies: Management, dated October 2021, showed: Policy: The facility will strive to identify the early stages of potential resident infestation with scabies during daily personal care and weekly skin assessments. It is important to remember that the first time a person gets scabies they usually have no symptoms. Symptoms can typically take 4-8 weeks to develop after they are infested; however, they can still spread scabies during this time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 718 Lakeview Ave S Saint Petersburg, FL 33705	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Excessive scratching can lead to bacterial infection of the irritated skin. Secondary skin infections often obscure the rash of scabies, which makes correct diagnosis difficult. Scabies - In the elderly, infestation can result in a generalized dermatitis or sometimes with extensive scaling and crusting. When mites are present and occasionally itching is completely absent, which creates a highly contagious situation. a. Because a large number of mites inhabit the sloughed skin. Scales, scabies is highly contagious with prolonged direct skin to skin contact. b. The large number of mites involved may hasten the sensitization process, allowing symptoms to surface in as short a time as seven days. Procedure 1. Include any history or clinical findings consistent with scabies in the preadmission assessment. 2. Conduct a thorough visual assessment of the entire skin surface upon admission. 3. Implement Contact Precautions (due to the communicability of scabies) until a diagnosis is confirmed by a physician, nurse practitioner. a. A private room is indicated but if this is not possible, obtain a physician's order to treat the roommate. b. Utilize a private room for the resident who cannot use good hygiene c. May cohort residents during an outbreak. 4. Wear long sleeve gowns during close contact with the resident, their clothing, or bed linens. Cover wrist area by the gown and pull the gloves over the cuff. 5. Obtain an order for the treatment of scabies and apply as directed. -Most common topical treatment is 5% Permethrin cream or equivalent often Ivermectin or equivalent for oral use. -Treatment of roommates and close contacts that the resident might have had prolonged skin to skin contact with for an outbreak is recommended. -Contacts who have had prolonged skin-to-skin contact with the infested person, should be treated. -Retreatment may be necessary if itching continues more than 2-4 weeks after treatment or if new burrows or rash continue to appear. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER: South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 718 Lakeview Ave S Saint Petersburg, FL 33705	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Coordinate treatment of residents with scabies and contacts for the treatment to be effective per physician order. -Additional prophylaxis is determined case-by-case according to the Medical Director or the local Public Health Department. 6. Require infested (symptomatic) employees to remain off work until 24 hours after treatment. 7.Double bag clothes, bedding, privacy curtains and towels (in the room) used by the resident prior to treatment Place in laundry hamper and transport to laundry. a. Laundry personnel should follow Standard Precautions and use hot water for washing. Scabies mite generally do not survive more than 2 to 3 days away from human skin. 8. Place all items that cannot be laundered in a plastic bag. Maintain items in plastic bag for 7 days before using. 9. Request housekeeping thoroughly clean the infected resident's room and thoroughly vacuum upholstered furniture. 10. Place resident in contact precautions and encourage resident to remain in room for 24 hours post treatment if possible. 11. Discontinue steps 3 - 4 24 hours after treatment 12. Retreat with ordered medication one week later. - Itching may last for one week or more after treatment has killed the mites. - The risk of transmission between treatments is possible. 13. Notify hospital/health care facility before the transferred or discharged , if known or suspected scabies in the resident being transferred or discharged to that facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER: South Heritage Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 718 Lakeview Ave S Saint Petersburg, FL 33705	

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 20536 Based on observation staff interview and facility record review, the facility failed to ensure the kitchen dish washing machine was operating at optimum levels, to include excessive concentration with the chemical sanitizer delivery, in one of one facility kitchen, during one (2/11/25) of three days observed. Findings included: On 2/11/2025 at 9:08 a.m. the facility's kitchen was toured with the Dietary Manager, Staff A. Staff A, the only staff member in the kitchen demonstrated on how the dish washing machine is used. He revealed he had primed the machine for operation just minutes before. Staff A revealed the dish washing machine was a Low Temperature operation and indicated the wash temperature was to reach 120 degrees F. (Fahrenheit), and the final rinse was to reach 120 degrees F. Staff A continued to say the machine has a chemical chlorine agent delivery system and the chemical chlorine sanitizer should be measured between 50 - 100 Parts Per Million (PPM), via litmus testing strip. Review of the dish machine's specification plate attached to the bottom frame revealed the machine is operated at Low Temperature/Chemical Sanitizer and with Wash temperature to reach 120 degrees F., the Rinse temperature to reach 120 degrees F., and the Chemical Sanitizer to be at a range of 50 ppm. The machine did not identify a range, but revealed ppm must be at least 50. On 2/11/2025 at 9:15 a.m. Staff A ran a rack of soiled bowls through the dirty side of the dish machine and through to the inside. The machine wash temperature reached 120 + degrees F., and the rinse temperature reached 120 + degrees F., After the machine had ran it's cycle, the rack of cleaned bowls was pulled out from the clean side of the machine. Staff A had a bottle of litmus test strips and used a clean, unused white test strip. He mentioned the ppm should be within a range of 50 and 100. He was able to show the test strip bottle with a color legend, showing light purple in color less ppm, and very dark purple in color more ppm. Staff A then placed the clean unused test strip on a clean bowl that had some puddling of water on, and it immediately turned very dark purple. He revealed he had a problem with the test strip and asked if he could do another demonstration. On 2/11/2025 at 9:19 a.m. Staff A ran another rack of bowls and immediately when the test strip touched the water, it turned from white to a very dark purple. Staff A held the test strip bottle showing the color ranges and placed the tested strip on the bottle which revealed the test strip chemical chlorine sanitizer was a very dark purple, well over the range of 100 ppm. Staff A confirmed this observation. Photographic evidence Obtained. At the time, Staff A did not say what he and his dietary staff would do with the dishes that had already been ran through the dish machine the morning of 2/11/2025. The dishes were not rewashed through the three-compartment sink, nor was there plastic eating ware used until the dish machine was evaluated by the machine's maintenance technician. Staff A and dietary staff operated and used the machine after the lunch meal service, after the dinner meal service on 2/11/2025, as well as again after the breakfast meal service on 2/12/2025. Staff A revealed he had tested the chemical chlorine sanitizer prior to each use on 2/11/2025 and 2/12/2025, and the test strip still read the chemical chlorine sanitizer delivery system was still too concentrated and still above 100 ppm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Heritage Health & Rehabilitation Center	718 Lakeview Ave S Saint Petersburg, FL 33705

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Dietary Manager, Staff A revealed the facility's county Department of Health inspection occurred on 1/24/2025. The report revealed a violation to include chlorine sanitizer in dish machine not at proper minimum strength of 50-100 ppm. Use manual sanitation until dish machine is repaired. Staff A confirmed the machine technician came out and repaired the machine about two days later. Staff A was not aware the dish machine's chemical chlorine sanitizer delivery system was not overconcentrating, until it was observed on 2/11/2025. Also, he did not have any documentation of in-services/education to his staff related to dish washing machine operation since the health department inspection. On 2/13/2025 at 1:00 p.m. an interview with the Dietary Manager, Staff A, and upon request, revealed he did not have the facility's dish washing machine operations manual, nor did he have a policy with relation to the dish washing machine's operating procedure.