STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105119	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilton Manors Healthcare & Rehabilitation Center	2675 N Andrews Ave Wilton Manors, FL 33311

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policy and procedure, record review and interview, the facility failed to ensure that residents received appropriate care and treatment to prevent an evolving change in condition and status for 1 of 1 sampled resident reviewed, Resident #113. The findings included: Review of the facility policy, titled, Change in a Resident's Condition or Status, provided the Director of Nursing (DON), revised May 2017, documented in the Policy Statement: Our facility shall promptly notify the resident, his or her Attending Physician, and the representative (sponsor) of changes in the resident's medical / mental condition and/or status (e.g. changes in level of care, billing / payments, resident rights, etc.). Policy Interpretation and Implementation: 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a (an): .d. significant change in the resident's condition . 2. A significant change of condition is a major decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); b. Impacts more than two areas of the resident's health status . 3. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider . 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: .b. There is a significant change in the resident's physical, mental, or psychological status . 8. The nurse will record in the resident's record information relative to changes in the resident's medical/mental condition or status . Record review revealed Resident #113 was originally admitted to the facility on [DATE] with diagnoses that included Paraplegia, Urinary Tract Infection, Iron Deficiency Anemia, Acute Pyelonephritis and Neuromuscular Dysfunction of the Bladder. The record documented a Brief Interview Mental Status (BIMS) score of 15, indicative of intact cognition. Resident #113 was transferred to the hospital on [DATE] and readmitted to the facility on [DATE] with a medical diagnosis of Sepsis. Record review of the facility's computerized progress notes (prior to hospital transfer on 03/30/25) revealed that during the previous four (4) day time-span, in the facility dating from Thursday March 27th to Sunday March 30th (2025), Resident #113 had a documented episode of an elevated temperature, and several subsequent documented on-going episodes of elevated heart rate, abdominal pain complaints, as well as other associated signs and symptoms, during that time. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Computerized record of the subsequent Hospital's Infectious Disease (IF) Doctor's and of the Hospital's History and Physical reports dated 04/01/25 revealed that, resident admitted to the hospital with fever, chills, intractable nausea / vomiting, abdominal pain and severe sepsis Resident was tachycardic with Leukocytosis .On exam, he was seen by Urology, who drained and packed a draining scrotal abscess .urinalysis revealed Pyuria. Microbiology collected on 03/30/25---specimen from urine clean catch revealed the presence of Escherichia Coli (ESBL) and Enterococcus faecalis. On 03/31/25---specimen from Scrotal swab revealed the presence of Escherichia Coli Extended-Spectrum Beta-Lactamases (ESBL), Morganella Morganii SSP Morgani (a species of Gram-negative bacteria) and Enterococcus faecalis. Blood, urinalysis---extra turbid, significant for large leucocyte esterase, proteinuria and moderate [NAME] Blood Count (WBC), and urine cultures were obtained, and the resident was started on intravenous (IV) Vancomycin, Clindamycin and Meropenem since Monday 03/31/25. Infectious Disease was asked to assist in evaluation and antibiotic management Complete Blood Count (CBC) with differential complete with WBC's on Sunday 03/30/25 was 15.43 (high), Monday 03/31/25 the WBC was 13.65 (high) and Tuesday 04/01/25 the WBC was 16.11 (high). Record review of the Resident #113's care plan initiated 01/03/25 indicated Focus: Resident has potential for complications Infection .Interventions: Labs as ordered; report findings to physician .Observe site of infection for increased swelling, inflammation, tenderness, drainage, or necrosis; update physician if noted. Observe for signs and symptoms of recurring infection; notify physician if noted. Goal: Resident will be free of infection . Record review of Resident 113's care plan initiated 01/03/25 indicated Focus: Resident has potential for pain and/or alteration in comfort related to diagnosis and conditions .Interventions: .Administer medication for discomfort as ordered .; observe for effectiveness and for side effects .Encourage resident to voice discomfort at onset as needed. Observe for nonverbal signs and symptoms of discomfort: i.e. grimacing, restlessness, irritability, pulling away, moaning, crying. Assess pain level as needed. Report changes in comfort level to physician as needed. Goal: Resident [#113] will exhibit signs and symptoms that pain is at an acceptable level of comfort thru next review date. Resident will voice acceptable level of comfort thru the next review date. A computerized record review of the nursing progress notes dated 03/27/25 at 17:32 (5:32 PM) and again on 03/27/25 at 18:45 PM (6:45 PM) by Staff C, RN, revealed she had documented, Upon hourly rounding, resident complained of headache with slight abdominal discomfort Vitals assessed as blood pressure (BP) 92/51, heart rate: 148, respiratory rate 19, temperature 103F (Fahrenheit . Call placed to the resident's attending physician's service and awaiting call back ; .still awaiting physician to call back, oncoming nurse made aware to continue monitoring the resident and follow up. There was no documented evidence to indicate the doctor had been notified or made aware of Resident 113's elevated temperature and heart rate, or of his abdominal discomfort, at the time. There was no documented evidence of the physician's call back response with any new written orders obtained. Further computerized record review of the 03/27/25 at 20:26 (8:26 PM) evening nurses' note by Staff O, documented, .the resident had been complaining of abdominal pain at 2 AM in the morning, doctor's office was notified, (but no exact time was given, as to when this had been done). Staff O did not document whether or not the doctor ever received the message or called back with any new orders. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the record and computerized Medication Administration Record (MAR) dated 03/27/25 documented Resident #113 had a temperature of 103 Fahrenheit and a heart rate 148 at 17:34 (5:34 PM) in the evening. There was no documentation in the record to indicate that the doctor had been notified and responded back with any new orders. Further review of the computerized record showed that Resident #113's attending physician was not in the facility to examine this resident until 03/28/25 at 11:58 AM (over 15 hours later the next day). There was no evidence to show that the physician was directly made aware of the resident's change in condition and status and there were no new orders written for this resident regarding the resident's recent complaints of abdominal pain, elevated temperature and elevated heart rate. There was no evidence to show there was any lab work, urinalysis, or urine culture tests ordered for this resident, prior to his transfer from the facility. Computerized record review of the Medication Administration Record (MAR) documented that Resident #113 was only administered Tylenol oral tablet 325 mg to give two (2) tablets by mouth every four (4) hours as needed for pain. Resident complained of stomach and throat pain level five (5)/ten (10), as documented on Sunday 03/30/25 at 12:16 AM by Staff P, LPN. Further computerized record review of the MAR documented that on Sunday 03/30/25 at 2:29 AM, Resident #113's condition had worsened or deteriorated in that his pain level had advanced to a level of six (6)/ten (10); with again only two (2) Tylenol tablets having been administered to him by Staff P. There was no evidence to show that Resident #113's doctor was notified, nor made aware of the resident's elevated temperature and heart rate, nor of his increasing pain level from 5 to 6/10, at the time; with no notation indicating the resident's physician was called to increase the resident's pain medication, as previously requested by the resident. A subsequent computerized nurses' progress note dated 03/30/25 at 2:45 PM (over 48 hours later) by Staff P, documented, Resident #113 had complained of generalized pain, two (2) 325mg tablets of Tylenol were administered as ordered (orally) PO. About 30 minutes later, the resident called and asked to see the doctor for a sleeping medication and for a stronger pain medication and the nurse informed the resident that pain management consult would be needed. The oncoming nurse was made aware to follow-up. Staff P didn't document whether or not the doctor was notified of this request by the resident, nor did she document any information regarding the pain management consult. Record review of the nursing progress note by Staff Q, revealed documentation for 03/30/25 at 18:47 PM (6:47 PM) (4 hours later) on The Change In Condition form that the resident had . Nausea / Vomiting and Pain (uncontrolled) .Call place to medical doctor's on call service. Still awaiting call back. Resident is requesting to go out to the Hospital. Record review of the nursing progress notes by Staff Q revealed that on 03/30/25 at 19:20 (7:20 PM), it was documented that, Resident complained of uncontrollable pain in abdominal area, unable to swallow, feeling malaise, vomiting and nauseated, stating he just does not feel like himself for the past five (5) days, and he would like to be transferred to the hospital to be evaluated. Call placed out to the doctor's call service at 5:30 PM, message left for the resident's physician, at 7:30 PM, still no call back. Resident insisted on being transferred out because he's really not feeling great. Resident's aunt also notified because resident had been telling her, he's not feeling well . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	There was no documented evidence showing the resident's physician had been made aware of the resident's additional deteriorating and worsening symptoms of uncontrollable pain in abdominal area, unable to swallow, feeling malaise, vomiting and nauseated, and stating he just does not feel like himself for the past five (5) days, most occurring almost three (3) hours prior to transfer to the hospital. An interview was conducted on Monday 06/16/25 at 4:57 PM with Resident #113 regarding the past date of Sunday March 03/30/25, who stated that he recalled that he was not feeling well, and he stated that he had vomited at least two to three (2-3) times during the four (4) days prior to this, was not able to eat anything, but that he had been hungry and he was trying to eat, and had been in a lot of pain. Resident #113 also stated he had not thought about it,, but that the nurses were aware of this. Resident #113 stated he had felt hot and had a fever on the second (2nd) or third (3rd) day. Resident #113 said that he was given something for the nausea, but it did not work; and was given Tylenol. Resident #113 indicated that a doctor came to see him around that time, but the doctor provided no additional information to him. Resident #113 stated that prior to his last few days in the facility in March 2025, he had not had any episodes of nausea and vomiting; he indicated that he did become concerned and then wanted to go the hospital. On 06/18/25 at 1:35 PM, during an interview and side-by-side record review conducted of the nursing progress notes dated from 03/27/25 at 17:32 PM to 03/30/25 at 2:45 PM, with the Registered Nurse (RN) / Infection Control (IC) Nurse, it was revealed that Resident #113 had been first admitted to this facility on 01/03/25 with a UTI from the hospital in which he was given the ordered oral antibiotics. The computerized record review revealed there had been no subsequent lab work ordered and collected from the resident since 01/06/25. The IC Nurse emphasized there had been no other lab work, urinalysis, or urine cultures ordered for this resident, prior to his transfer from the facility to the hospital on [DATE]. During a subsequent interview conducted with Resident #133 on 06/19/25 at 10:42 AM, regarding Sunday 03/30/25, he recalled that he had smelled some odor to his urine prior to his hospitalization, just the day before. The resident said that he thought nothing of it, but stated the abdominal pain got worse and he learned later that it was a Urinary Tract Infection (UTI). He said that he had a UTI in the past with the same smell. An interview was conducted 06/19/25 at 12:59 PM with Staff C, who was aware that on 03/27/25 at 17:32 PM and on 03/27/25 at 18:45 PM, Resident #113 had a fever of 103 F, indicative of some type of infection. She stated his blood pressure was low at 95/51, and that his heart rate was high at 148. She stated she had placed a call to the attending physician's service and was awaiting a call back. Staff C acknowledged she had not made any other documented attempts to contact the doctor's service again regarding the resident's headache, abdominal pain level, elevated temperature and elevated heart rate. She had not documented any contact made to the resident's family to notify them of the resident's current status at that time. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A telephone interview was conducted on 06/19/25 at 1:35 PM with Staff P, Licensed Practical Nurse (LPN), who verbalized that on 03/30/25 at 2:45 AM (2 days later), around 12:15 AM, the resident was alert and oriented, complained of generalized pain. Two (2) 325 mg tabs Tylenol administered as ordered oral (PO). About thirty (30) minutes later, the resident called and asked to see the doctor for sleeping medication and a stronger pain medication, the nurse informed the resident that that a pain management consult was needed; on-coming nurse made aware to follow-up (F/U). Staff P stated she had not made any other documented attempts to contact the doctor again regarding the resident's continued generalized pain complaints and elevated heart rate. A telephone interview was conducted on 06/19/25 at 1:51 PM with Staff O, LPN, who stated the following on 03/27/25, around 2 AM, Resident #113 had been complaining of abdominal pain his heart rate was 131 (high) on assessment Call placed to Dr. [name provided] office, Spoke to [name] to report the situation Resident had one episode of vomiting around 7:32 AM. Waiting for Dr. [name] to call back. Report given to the oncoming nurse to follow up. Staff O acknowledged she had not made any other attempts to contact the doctor again regarding the resident's continued abdominal pain concerns, vomiting and elevated heart rate after the 3 AM call earlier or again at 7 AM. A telephone interview was conducted on 06/19/25 at 2:09 PM with Staff Q, RN, Daytime Supervisor, who stated on Sunday 03/30/25 at 18:47 PM (6:47 PM), she documented in the resident's record that, The Change In Condition .: Nausea/Vomiting, Pain (uncontrolled), at the time of evaluation .Call place to MD on call service. Still awaiting call back. Resident is requesting to go out to the Hospital, at 5:30 PM with still no return call back from the doctor at 7:30 PM. Staff Q stated that she had been called in by the resident's assigned nurse because the resident had said that he had not been feeling well and was complaining of abdominal pain for five (5) days. Staff Q stated she had been assisting the assigned nurse with paperwork to send Resident #113 out to the hospital due to his continued complaints of pain and because the resident had told her that he was not able to keep anything down. Staff Q acknowledged she had not called the doctor again and was not aware if the assigned nurse had called the doctor. Staff Q stated that the calls to the doctor's office had not been returned. An interview was conducted on 06/19/25 at 2:35 PM with Staff R, Certified Nursing Assistant (CNA), who stated she did recall that between the days of Thursday 03/27/25 through Sunday 03/30/25, in the morning while she was caring for Resident #113, that the resident was eating and then told her that he felt like he was going to throw up. Staff R said that she reported this episode to his nurse. An interview was conducted on 06/19/25 at 3:05 PM with Staff N, LPN Supervisor South wing, who revealed that none of her staff, nor the resident, told her anything of the resident's change in condition or status. Staff N stated she did not find out about any of the above until she returned to work on the following Monday, 03/31/25. A telephone interview was conducted on 06/19/25 at 4:00 PM with Staff S LPN, who stated that on 03/28/25 at 11:08 AM the following day, Resident #113 still complained of pain in the abdomen .heart rate was now up to 145 and a call was placed to the resident's physician. Waiting for him to call back. Staff S stated that specific orders obtained from the doctor and pertaining to the resident had not been recorded and documented in the resident's record. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A telephone interview was conducted on 06/19/25 at 4:17 PM, with Resident #113's attending physician, who was asked if he had been routinely, consistently and specifically notified and made aware by the facility staff of all of the Resident #113's symptoms of having a temperature of 103 F, during the resident's entire 4-day time span from Thursday 03/27/25 through Sunday 03/30/25, of the elevated heart rate, of the uncontrolled abdominal pain, inability to swallow, feeling of malaise, vomiting and nausea and of the resident stating that he just did not feel like himself for the past five (5) days. The doctor did not respond to this information specifically. The physician indicated that the resident did not have any signs and symptoms of UTI, had no lab work, no urinalysis and no urine culture ordered at the time. In summary, both record review and interviews revealed that Resident #113 had been suffering from continued, documented, abdominal and generalized pain, at a level of six (6) out of ten (10) during a four (4) day-time frame, and having only Tylenol administered with unresolved results. Resident #113 spiked a fever of 103 F. on Thursday 03/27/25, as well as having exhibited, at least two (2) episodes of an elevated heart rate of 148 on Thursday 03/27/25, and an elevated heart rate of 145 on Friday 03/28/25 at 11:08 AM; with no documented physician response, nor any new written physician's orders documented, at the time, to address the resident's change in condition or status. Resident #113 had not been transferred to the hospital until three (3) days after his symptoms had begun, on March the 30th, by the staff. On 06/19/25 at 5 PM, the DON acknowledged the nursing staff should be contacting a resident's physician for notification, promptly following up to ensure a response, and documenting the actions in the resident's record.