STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105138	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jacksonville Center for Rehabilitation and Healthc	5377 Moncrief Road Jacksonville, FL 32209

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50968 Based on record review and interviews, the facility failed to document the basis for a resident's transfer to an acute care hospital, the specific resident needs that could not be met in the facility, and the service available at the acute care hospital to meet the resident's needs for one (Resident #118) of one hospitalized resident reviewed, from a total survey sample of 35 residents. The findings include: A review of Resident #118's medical record revealed that she was admitted to the facility on [DATE] with a transfer to the emergency roiagnom on [DATE]. Her diagnoses included acute respiratory failure with hypoxia. Further review of the record revealed no documentation of Resident #118's transfer/discharge or information having been provided to the acute care hospital. There was no documentation by the resident's physician of the basis for the transfer, resident needs that could not be met by the facility, or services available at the acute care hospital to meet her needs. Further review of the medical record's progress notes revealed a total of two nursing notes: On 5/17/24 at 6:50 PM, Resident arrived to facility via stretcher accompanied by two attendants. Resident is alert and oriented x 4, no acute distress noted. Resident wears glasses, has her own teeth, mucus membranes are moist and pink, trachea is midline, lung sounds are clear, heart rate and rhythm is normal. Abdomen is soft and nondistended. Bowel sounds present in all four quadrants. Bilateral pedal pulses present. Resident is continent of bowel and bladder, able to make needs known. Currently on oxygen at 3 liters via nasal cannula. Resident did not have any belongings with her. On 5/18/24 at 12:45 AM, Resident sitting in room on the bed, complain of chest pain, resident does not have a history of chest pain, oxygen on via nasal cannula at 3 liters. Resident is her own responsible party, resident requested to be sent to ER (emergency room). No Nursing Home Transfer and Discharge Notice (Agency for Health Care Administration (AHCA) Form 3120-0002 was located in the medical record. Documentation on the Nursing Home Transfer and Discharge Notice for an emergent transfer to an acute care hospital must be completed by a physician or a physician's written order for transfer must be attached. An explanation to support the need for the transfer must be documented on the form with additional documentation attached as needed. The form must be signed and dated by the physician/designee. (continued on next page)

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

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When a facility transfers a resident emergently to an acute care hospital, this is considered a facility-initiated transfer, not a discharge, because the resident is expected to return. Documentation in the resident's medical record must include the basis for the transfer, the specific resident needs that cannot be met by the facility, the facility's attempts to meet the resident's needs, and the services available at the acute care hospital to meet the resident's needs. This documentation must be made by the resident's physician. There was no documented evidence in the resident's medical record of the facility having provided appropriate information to the acute care hospital upon her transfer to the emergency room . The information that must be provided includes the following: Contact information of the practitioner responsible for the resident. Resident representative information including contact information. Advance Directive information. Special instructions or precautions for ongoing care, as appropriate. There was no documented evidence in the resident's medical record verifying that she was provided with a transfer notification or a notification of discharge. On 7/25/24 at 12:15 PM, the Administrator was asked to provide documentation of Resident #118's discharge. She went to her office and returned shortly thereafter stating there was a discharge order. A copy of the order was requested. On 7/25/24 at 12:30 PM, the Director of Nursing (DON) provided a copy of all orders for Resident #118. When asked, the DON confirmed that there was no discharge order. An interview was conducted on 7/25/24 at 2:10 PM with the DON, who stated she was familiar with Resident #118. When asked where Resident #118 was transferred/discharged , she stated the resident went to [acute care hospital] and it would not be documented. She stated she knew where she went because residents automatically went to this acute care facility when 911 was called. When asked to review Resident #118's electronic medical record (EMR) for physician's documentation of an order or authorization of transfer, she confirmed that there was none. When asked if the physician was notified of Resident #118's change in condition and where documentation of that could be found, she stated, I cannot confirm that but assume from the progress note they would have. When asked if in this type of situation the physician would be notified, she stated, Yes, in a situation like this they would normally call the MD (Medical Doctor). When asked if Resident #118 was expected or planned to return, the DON stated, Per word of mouth when she was brought here, she didn't want to stay. She was talked into staying until she complained of chest pain and wanted to go to the ER. When asked if there was any documentation of the resident's leaving the facility such as the time she left or how she was transported, the DON confirmed that it was not documented in the medical record.

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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** 38804 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive, person-centered care plan, including measurable objectives and timeframes for two (Residents #66 and #113) of 35 residents in the total survey sample. This resulted in the facility having failed to provide Resident #66 with needed toenail care and having failed to change Resident #113's midline dressing, which could lead to pain, difficulty mobility and dressing for Resident #66, and potential infection and pain for Resident #113. The findings include: 1. A review of Resident #66's medical record revealed he was admitted to the facility on [DATE] with his most recent readmission on 6/20/24. His diagnoses included seizures; viral hepatitis C without hepatic coma; personal history of TIA (transient ischemic attack - mini stroke); atherosclerotic heart disease; heart failure; protein-calorie malnutrition, and chronic kidney disease. A review of the 5-day minimum data set (MDS) assessment dated [DATE], revealed that Resident #66 scored 14 out of 15 possible points on the brief interview for mental status (BIMS) assessment, indicating he was cognitively intact. Per the MDS assessment, the resident had no upper or lower extremity range of motion impairment. He was independent with eating, oral hygiene and toileting. He required supervision with showering/bathing, upper body dressing and partial assistance with lower body dressing. He required substantial/maximal assistance with putting on/taking off footwear, was occasionally incontinent of urine and always continent of bowel. A review of Resident #66's care plan, initiated on 3/28/24 and revised on 7/3/24, revealed the following Focus Area: I am currently independent with all my ADLs but at times I may need cueing. Goal: I [resident's name] will continue to be independent in ADLs. Interventions: Check my fingernails and toenails and trim as needed unless I am diabetic, then please notify my nurse. During an interview on 7/23/24 at 9:40 AM with the resident's sister/emergency contact, she stated Resident #66 needed his toenails clipped. She had spoken to staff and his toenails had not been clipped since his admission. She stated she was not aware of whether or not the facility had a podiatrist. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 7/24/24 at 10:49 AM with Certified Nursing Assistant (CNA) L. She stated she had been a CNA since 2021 and had been employed at the facility for four months. She had received training on resident rights, abuse and neglect, and activities of daily living (ADL) care. She stated she was familiar with Resident #66. The resident was independent and able to make his needs known. He smoked. His sister was very involved in his care, and the resident liked to sleep a lot. She stated she emptied his urinal and made his bed when she was able to catch him out of it. The facility had a shower team that was responsible for providing baths/showers to all of the residents. The shower team provided showers Monday through Friday and the CNAs were responsible for any showers scheduled or requested on Saturdays and Sundays. She stated the CNAs clipped the residents' fingernails and toenails. The podiatrist came in and clipped the toenails for residents who were diabetic. When asked about Resident #66's toenails, CNA L stated she had never clipped them. She had asked him about them and the resident stated they were alright. She could not provide a date or time that this conversation took place. On 7/24/2024 at 2:55 PM, Resident #66 was observed resting in bed. He stated he had received a shower earlier this morning. The CNA commented that he needed his toenails clipped; however, she did not clip them. He stated he could not remember the last time anyone had clipped them, but he wanted them clipped. He stated he was not a diabetic and his toenail length did not prohibit or hinder his walking; however, it did cause him some pain. His toenails were exceptionally long. The left great toe measured at 3.8 cm (centimeters), the left 2nd toe measured 1.6 cm, the left 3rd toe measured 1.1 cm, the left 4th toe measured 3.2 cm, and the left 5th toe measured 0.5 cm. The right great toe measured 4.2 cm, the right 2nd toe measured 1.6 cm, the right 3rd toe measured 1.5 cm, the right 4th toe measured 2.6 cm, and the right 5th toe measured 1.8 cm in length from the end of each toe. (Photographic evidence obtained) An interview was conducted on 7/25/24 at 11:15 AM with CNA I, a member of the shower team. She stated the shower team was in the facility daily at 5:30 AM. Their duties included shampooing residents' hair, assisting them with dressing, and shaving the men. They were also responsible for cutting residents' fingernails. A facility nurse or podiatrist was responsible for cutting residents' toenails. CNA I was familiar with Resident #66 and stated his showers were scheduled on Mondays, Wednesdays, and Fridays. His toenails needed clipping for some time. She stated the resident had not complained of pain to her. She reported the long toenails to a nurse and wasn't sure what was done with that information. When she was asked for the date she reported the resident's long toenails to the nurse, she replied that she wasn't sure, but It's been a while. During an interview on 7/25/24 at 2:42 PM with the Social Services Director (SSD), she stated the podiatrist was in the facility monthly. Resident could be seen sooner if staff, the resident and/or their representative requested they be seen. She said if the resident could wait, she would add them to be seen the following month. New residents were seen as needed, if they transitioned to long-term care, or when they became Medicaid approved. If they were Medicaid pending and it was not a dire need, the resident would have to wait until they were approved. The staff will notify me if a resident needs to be seen. I announce to all staff when they're coming in and ask if there's anyone who needs to be seen. Sometimes if it's the same day, they'll add the person to the list. She stated she spoke Resident #66's sister one to two weeks ago and she requested the resident be seen by the podiatrist. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/25/24 at 3:19 PM with Licensed Practical Nurse (LPN) E, he stated a member of the shower team made him aware of Resident #66s toenails on the day of this interview. It was the first time he had ever heard anything about the resident's toenails. He stated he talked to the podiatrist about adding the resident to the list to be seen on their next visit to the facility, and they agreed he would be seen the next week. A review of the list of podiatry visits for 7/2024, 6/2024, and 4/2024, provided by the SSD, revealed that Resident #66 was not seen. The SSD confirmed he had not been seen during any of the monthly visits reviewed. 42630 2. On 7/24/24 at 7:50 AM, Resident #113 was observed with an intravenous (IV) line in his right arm. The resident was non-verbal and was unable to converse when asked questions. The IV line was covered by a gauze dressing with 7/6 Midline 20 cm (centimeters) long written on it. The gauze was covered by a transparent dressing. The hub of the IV was visible and the area above the hub was obscured by the gauze dressing. A review of the resident's medical record revealed no orders for IV line care, such as routine flushes or routine dressing changes. Further review revealed that the resident had IV fluids ordered and administered on the following dates: 7/6/24: May insert midline. 7/6/24: Dextrose-Sodium Chloride IV Solution 5-0.9%: use 75 milliliters (ml) per hour for dehydration for 2 days. 7/8/24: Dextrose-Sodium Chloride IV Solution 5-0.9%: use 75 milliliters (ml) per hour for dehydration for 2 days. 7/10/24: Dextrose-Sodium Chloride IV Solution 5-0.45%: use 80 milliliters (ml) per hour for dehydration for 4 days. A review of all orders (current and discontinued) for Resident #113 revealed no IV flushes, dressing changes or other IV maintenance orders. On 7/24/24 at 11:40 AM, during an interview with LPN E, he was asked how often IV midline dressings were changed in the facility. He stated, Normally as needed, if soiled or wet from a shower. Most only have them for a short time, maybe five days for antibiotics. He confirmed that he was caring for Resident #113 today and when asked if this resident had a midline, he replied, Yes, he has his for a longer time because he will get fluids as needed. When he was asked how often the line was flushed, he replied, We do it every shift. He was asked to review the resident's medication administration record (MAR) for orders for IV flushes. He opened the MAR and while reviewing it he stated, The order may have come off; it might have had a stop date. He was asked to observe Resident #113's midline dressing. Upon observing the dressing, he was asked what the date on it said. He stated, It looks like 7/6. We have a company that comes in to place the midlines. He was asked if he had changed this midline dressing and he replied that he had not. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's comprehensive care plan (initiated 5/15/24) revealed no focus areas related to intravenous lines including maintenance, flushes, or dressing changes for the IV line. On 7/24/24 at 1:03 PM during an interview with the Director of Nursing (DON), she was asked who updated residents' care plans. She stated, The MDS (Minimum Data Set) nurse does the majority of them, social services does behaviors and cognitive, and smoking and activities is done by activities staff. She was asked if a resident had a new diagnosis, who was responsible for adding the new care plan focus area. She stated the MDS coordinator was responsible. When asked how the MDS coordinator was made aware of new diagnoses/issues to add to the care plan, she replied, Through our daily meeting and review of the 24-hour reports. On 7/24/24 at 1:09 PM, during an interview with Registered Nurse (RN) F, she confirmed that she was the facility's only MDS coordinator. When she was asked how she was made aware of new diagnoses that required new care plans, she replied, During clinical meetings, we review 24-hour reports, all new orders and new admissions. When she was asked if Resident #113 was care planned for his IV line care/flushes/dressings, she replied, I did resolve that today, because the line was discontinued today. She was asked when she discontinued this care plan and she replied, About twenty minutes ago. She was asked to provide the discontinued care plan for review. She pulled up a care plan on her computer for IV medications related to fluid deficit with a date initiated of 7/10/24 for Resident #113. She confirmed that she created the care plan on 7/10/24. She was asked if any other IV line care/flushes would be expected on the care plan other than the IV Dressings per MD orders that was listed. She replied, No, that would all fall under the dressings, all the flushes and care., referring to the care plan intervention for IV DRESSING: Per MD Orders, and indicating that other interventions such as IV care/flushes were understood under the dressing change intervention with no specifics required. The care plan, as presented by RN F during this interview revealed: Focus Area: RESOLVED: Resident is on IV medications r/t (related to) fluid deficit (date initiated 7/10/24, revision on 7/24/24, resolved on 7/24/24) Goal: RESOLVED: Resident will have no complications r/t IV therapy through the review date.(9/25/24) (date initiated 7/10/24, revision on 7/24/24, resolved on 7/24/24) Interventions: RESOLVED: IV dressings per MD (medical doctor) orders (date initiated 7/10/24, revision on 7/24/24, resolved on 7/24/24) RESOLVED: Monitor/document/report as needed signs of infection at the site: drainage, inflammation, swelling, redness, warmth (date initiated 7/10/24, revision on 7/24/24, resolved on 7/24/24) RESOLVED: Monitor/document/report as needed signs of leaking at the IV site, edema at the insertion site, taut, shiny or stretched skin, leaking of IV solution at the insertion site. This was the facility's only care plan with any interventions for IV lines. This care plan included no specific interventions related to IV line flushes or other care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/24 at 12:27 PM, the Administrator was asked to provide information about when and who placed the midline IV for Resident #113. On 7/25/24 at 8:45 AM, the Administrator provided a form dated 7/6/24 from an outside vascular access provider, which revealed a midline IV was placed for Resident #113 in his right arm, basillic vein on 7/6/24 at 6:30 PM. The form indicated the dressing must be changed in 24 hours. A review of the facility's policy titled Flushing Midline and Central Line IV Catheters (revised 2/2024) revealed: Purpose: The purposes of this procedure are to maintain patency of midline and central line IV catheters; General Guidelines: 1. Prior to procedure, assess catheter type for flushing protocols and the use of saline only or saline/heparin. Flushing Protocols: 1. Flush catheters at regular intervals to maintain patency AND before and after the following: a. administration of intermittent solutions; Documentation: The following information should be documented in the resident's medical record: 2. Type of solution used for flushing and amount administered; 4. The condition of the IV site before and after administration; 6. Resident's response; 7. The signature and title of the person recording the data. A review of the facility's policy titled Midline Dressing Changes (undated) revealed: Purpose: The purpose of this procedure is to prevent catheter-related infections associated with contaminated, loosened, or soiled catheter site dressings. General Guidelines:1. Change the midline dressing 24 hours after catheter insertion, every 5-7 days, or if it is wet, dirty, not intact, or compromised in any way. 5. If a gauze dressing is used, cover the gauze with a TSM (transparent semi-permeable) dressing and change the dressing every 48 hours. Documentation: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The following information should be documented in the resident's medical record: a. date and time the dressing was changed; b. location and objective description of insertion site; d. whether flushed; positive blood return; and whether end cap or extension tubing was changed; f. type of dressing placed (TSM or gauze) h. signature and title of the person recording the date.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42630 Based on observations, staff and resident interviews, medical record review, and facility policy review, the facility failed to ensure that four (Residents #64, #99, #100, and #66) of 35 residents in the total survey sample, received the necessary care and services to maintain good grooming and personal hygiene. The findings include: 1. On 7/22/24 at 1:18 PM, Resident #64 was observed lying in bed awake. His fingernails were elongated with brown debris under them. He was asked if he preferred his nails this length. He stated, No, of course not. He picked up nail clippers from his bedside table and stated, I have nail clippers. He was asked if he trimmed and cleaned his own fingernails. He stated, No,I can't do that. I need the staff to trim them for me. He tossed the nail clippers back on the bedside table. On 7/23/24 at 11:00 AM, Resident #64 was observed lying in bed awake. He was asked if any staff had offered to trim his fingernails. He stated no and showed his hands. He was asked for permission to measure his fingernails. He agreed. (Photographic evidence obtained.) Measurements obtained: Left hand fingernails (from tip of finger to end of nail): Thumb: 1.2 centimeters (cm) Index finger: 0 Middle finger: 0 Ring finger: 1.0 cm Fifth finger: 1.2 cm Right hand fingernails (from tip of finger to end of nail): Thumb: 0.9 cm Index finger: 0 Middle finger: curved over finger tip 0.5 cm Ring finger: curved over finger tip 0.9 cm Fifth finger: 0.7 cm (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's medical record revealed diagnoses including diabetes type 2 and cerebral vascular accident (stroke). Further review revealed a Quarterly Minimum Data Set (MDS) assessment dated [DATE], which documented a Brief Interview for Mental Status (BIMS) score of 15 out of 15 possible points, indicating intact cognition. The assessment also revealed the resident had no behaviors such as refusal or rejection of care. A review of the active person-centered care plan revealed: Focus: Resident is currently independent with all ADLs (activities of daily living) but may need cueing. Goal: Resident will continue to be independent in ADLs. Interventions: Check resident's fingernails and toe nails and trim as needed, unless diabetic, then please notify nurse. A review of the certified nursing assistant tasks completed for the past 30 days revealed no section marked for provision of nail care. 2. On 7/22/24 at 1:10 PM, Resident #99 was observed sitting on the edge of his bed eating lunch. His fingernails were elongated. (Photographic evidence obtained) He was asked if he preferred his nails this length. He replied, No, no, I don't want them this long. If I get an itch and I scratch, I might cut my skin. Look at how long they are. On 7/23/24 at 11:10 Am, Resident #99 was observed lying in bed, dressed for the day. He was asked if any staff had trimmed his nails. He laughed and said no. He was asked for permission to measure his fingernails. He agreed and held his hands out. Measurement obtained: Left hand (from tip of finger to end of fingernail): Thumb: 1.2 cm Index finger: 1.0 cm Middle finger: 1.2 cm Ring finger: 1.0 cm Fifth finger: 1.0 cm Right hand (from tip of finger to end of fingernail) Thumb: 1.2 cm Index finger: 1.0 cm (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Middle finger: jagged but not elongated Ring finger: 1.0 cm Fifth finger: 0.8 cm A review of Resident #99's medical record revealed diagnoses including cerebral infarction (stroke) and macular degeneration (vision impairment). Further review of the record revealed a Quarterly MDS assessment dated [DATE], which documented a BIMS score of 11 out of 15 possible points, indicating moderately impaired cognition. The MDS review also revealed the resident had no behaviors such as refusal or rejection of care. A review of the person-centered care plan created for Resident #99 revealed: Focus: Resident requires extensive assist x1 staff with personal hygiene. Goal: Resident will not have any further decline with ADL function. Interventions: Check resident's fingernails and toe nail length and trim as needed, unless diabetic, then please notify nurse. A review of the certified nursing assistant tasks completed for the past 30 days revealed no section marked for provision of nail care. 3. On 7/22/24 at 1:20 PM, Resident #100 was observed in his bed, stated his toenails were very long, and he had not seen a podiatrist since his admission. His feet were observed and his right great toenail and 2nd and 3rd toenails were elongated. His left great toenail was thickened and half missing. His left 2nd and 3rd toenails were also elongated. (Photographic evidence obtained) A review of the resident's medical record revealed diagnoses including hemiplegia/hemiparesis following cerebral infarction affecting his right side and an 8/19/23 physician's order for: Podiatry PRN (as needed). Further review of the medical record revealed no documented evidence of any podiatry consults/notes. A Quarterly MDS assessment dated [DATE], documented a BIMS score of 15 out of 15, indicating intact cognition. The MDS also revealed the resident had no behaviors such as refusal or rejection of care. A review of the person-centered care plan created for Resident #100 revealed: Focus: Resident requires extensive assist x1 staff with personal hygiene. Goal: Resident will not have any further decline with ADL function. Interventions: Check resident's fingernails and toe nail length and trim as needed, unless diabetic, then please notify nurse. Please notify nurse if toenails need to be trimmed. A review of the certified nursing assistant tasks completed for the past 30 days revealed no section marked for provision of nail care. (continued on next page)

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Jacksonville Center for Rehabilitation and Healthc	5377 Moncrief Road Jacksonville, FL 32209

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/24 at 9:30 AM, during an interview with Certified Nursing Assistant (CNA) D, she stated she was on the shower team and provided the residents' showers. She was asked if she provided fingernail cleaning and trimming. She stated, Yes, we clean under the nails and we try to get the nails trimmed. If we don't have enough time, we will ask the CNAs assigned to the residents to trim their nails. She was asked to observe Resident #64s fingernails. Upon observation, his fingernails were observed to be elongated with brown debris under them. She asked the resident if he would like his nails trimmed today. He stated, Yes, I have a shower today at 10:00. He was asked if staff had offered to clean or trim his nails prior to today. He replied no. He held his hands up and stated, Look, I can trim the first and second finger myself but I can't do the other ones. CNA D was then asked to observe Resident #99s fingernails. Resident #99 held his hands out and his fingernails were observed to be elongated with brown debris under the nails. CNA D asked Resident #99 if he wanted his fingernails trimmed today. He sated yes. CNA D was then asked to observed Resident #100's toenails. She stated, The nurses do the toenails. She was asked if the CNAs were instructed to report the need for toenail trimming to the nurses. She replied yes. She was asked if she had reported to her nurse that Resident #100 was in need of having his toenails trimmed. She replied, I don't recall but I think I did. She was asked when she reported this to her nurse. She replied, I don't remember when but it would have been on one of his shower days. On 7/25/24 at 12:09 PM, during an interview with the Director of Nursing (DON), she was asked who was responsible for trimming residents' toenails. She stated, We usually let the podiatrist do those. If they're not diabetic the nurses could do it, but usually the podiatrist will do the toenails. She was asked how often the podiatrist came to the facility. She replied, He is regularly scheduled monthly, but if there is an urgent need, he will make a special visit. When she was asked who was responsible for trimming residents' fingernails, she replied, CNAs do those. The shower team will do them on their shower day, but if it's in between shower day, the assigned CNA would trim the finger nails. She further stated residents received showers at least three times a week is the schedule, unless they ask for more. 4. A review of Resident #66's medical record revealed he was admitted to the facility on [DATE] with his most recent readmission on 6/20/24. His diagnoses included seizures; personal history of TIA (transient ischemic attack - mini stroke); heart failure; protein-calorie malnutrition, and chronic kidney disease. A review of the 5-day minimum data set (MDS) assessment dated [DATE], revealed that Resident #66 scored 14 out of 15 possible points on the brief interview for mental status (BIMS) assessment, indicating he was cognitively intact. Per the MDS assessment, he required supervision with showering/bathing, upper body dressing and partial assistance with lower body dressing. He required substantial/maximal assistance with putting on/taking off footwear. During an interview on 7/23/24 at 9:40 AM with the resident's sister/emergency contact, she stated Resident #66 needed his toenails clipped. She had spoken to staff and his toenails had not been clipped since his admission. She stated she was not aware of whether or not the facility had a podiatrist. A review of Resident #66's care plan, initiated on 3/28/24 and revised on 7/3/24, revealed the following Focus Area: I am currently independent with all my ADLs but at times I may need cueing. Goal: I [resident's name] will continue to be independent in ADLs. Interventions: Check my fingernails and toenails and trim as needed unless I am diabetic, then please notify my nurse. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 7/24/24 at 10:49 AM with Certified Nursing Assistant (CNA) L. She stated she had been a CNA since 2021 and had been employed at the facility for four months. She had received training on resident rights, abuse and neglect, and activities of daily living (ADL) care. She stated she was familiar with Resident #66. The resident was independent and able to make his needs known. He smoked. His sister was very involved in his care, and the resident liked to sleep a lot. She stated she emptied his urinal and made his bed when she was able to catch him out of it. The facility had a shower team that was responsible for providing baths/showers to all of the residents. The shower team provided showers Monday through Friday, and the CNAs were responsible for any showers scheduled or requested on Saturdays and Sundays. She stated the CNAs clipped the residents' fingernails and toenails. The podiatrist came in and clipped the toenails for residents who were diabetic. When asked about Resident #66's toenails, CNA L stated she had never clipped them. She had asked him about them and the resident stated they were alright. She could not provide a date or time that this conversation took place. On 7/24/2024 at 2:55 PM, Resident #66 was observed resting in bed. He stated he had received a shower earlier this morning. The CNA commented that he needed his toenails clipped; however, she did not clip them. He stated he could not remember the last time anyone had clipped them, but he wanted them clipped. He stated he was not a diabetic and his toenail length did not prohibit or hinder his walking; however, it did cause him some pain. His toenails were exceptionally long. The left great toe measured at 3.8 cm (centimeters), the left 2nd toe measured 1.6 cm, the left 3rd toe measured 1.1 cm, the left 4th toe measured 3.2 cm, and the left 5th toe measured 0.5 cm. The right great toe measured 4.2 cm, the right 2nd toe measured 1.6 cm, the right 3rd toe measured 1.5 cm, the right 4th toe measured 2.6 cm, and the right 5th toe measured 1.8 cm in length from the end of each toe. (Photographic evidence obtained) An interview was conducted on 7/25/24 at 11:15 AM with CNA I, a member of the shower team. She stated the shower team was in the facility daily at 5:30 AM. Their duties included shampooing residents' hair, assisting them with dressing, and shaving the men. They were also responsible for cutting residents' fingernails. A facility nurse or podiatrist was responsible for cutting residents' toenails. CNA I was familiar with Resident #66 and stated his showers were scheduled on Mondays, Wednesdays, and Fridays. His toenails needed clipping for some time. She stated the resident had not complained of pain to her. She reported the long toenails to a nurse and wasn't sure what was done with that information. When she was asked for the date she reported the resident's long toenails to the nurse, she replied that she wasn't sure, but It's been a while. During an interview on 7/25/24 at 2:42 PM with the Social Services Director (SSD), she stated the podiatrist was in the facility monthly. Resident could be seen sooner if staff, the resident and/or their representative requested they be seen. She said if the resident could wait, she would add them to be seen the following month. New residents were seen as needed, if they transitioned to long-term care, or when they became Medicaid approved. If they were Medicaid pending and it was not a dire need, the resident would have to wait until they were approved. The staff will notify me if a resident needs to be seen. I announce to all staff when they're coming in and ask if there's anyone who needs to be seen. Sometimes if it's the same day, they'll add the person to the list. She stated she spoke Resident #66's sister one to two weeks ago and she requested the resident be seen by the podiatrist. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/25/24 at 3:19 PM with Licensed Practical Nurse (LPN) E, he stated a member of the shower team made him aware of Resident #66s toenails on the day of this interview. It was the first time he had ever heard anything about the resident's toenails. He stated he talked to the podiatrist about adding the resident to the list to be seen on their next visit to the facility, and they agreed he would be seen the next week. A review of the list of podiatry visits for 7/2024, 6/2024, and 4/2024, provided by the SSD, revealed that Resident #66 was not seen. The SSD confirmed he had not been seen during any of the monthly visits reviewed. A review of the facility's policy titled Care of Fingernails/Toenails (revised 2/2024) revealed: Purpose: The purposes of this procedure are to clean the nail bed, to keep the nails trimmed, and to prevent infections. General Guidelines: 1. Nail care includes daily cleaning and regular trimming. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. Documentation: The following information should be recorded in the resident's medical record: 1. The date and time that nail care was given. 2. The name and title of the individual who administered the care. 4. Any difficulties in cutting the residents nails. 6. If the resident refused the treatment,the reason, and interventions taken. A review of the facility's policy titled Assisting the Nurse in Examining and Assessing/Evaluating the Resident (undated) revealed: Components of the Observation: Activities of Daily Living: 4. Grooming: As you provide the resident with personal care needs, you should note: b. assistance needed with bathing, hair and nail care, dressing and undressing, mouth care.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42630 Based on observation, staff interview, medical record review, and facility policy review, the facility failed to ensure physician-ordered medication was available and provided to one (Resident #18) of 35 residents in the total survey sample. The findings include: On 7/24/24 at 9:40 AM, Licensed Practical Nurse (LPN) A was observed during medication administration. As she prepared medications for Resident #18, she stated the Prozac 60 mg (milligrams) ordered daily at 9:00 AM and due for administration at this time was not available in the medication cart. She stated the medication was on order from the pharmacy and it would be on the next pharmacy delivery. A 7/25/24 review of the Medication Administration Record (MAR) revealed the Prozac 60 mg ordered daily for Resident #18 was not administered on 7/23/24 or 7/24/24. In an interview with Unit Manager C on 7/25/24 at 9:05 AM, she was asked what the facility's system for back-up medications was. She stated the facility had a Pyxis machine for medications needed on admission or when medications had not been delivered yet. She was asked to review the contents of the Pyxis machine. Upon entering the medication room on the 2nd floor, she was asked if there was a list of medications in the Pyxis. The list was provided and reviewed. Prozac was not found on the list. She was asked if she could look up Resident #18 to confirm that Prozac was not available in the Pyxis for this resident. She did so and was able to confirm that Prozac was not available in the Pyxis for Resident #18, or for any other resident. In an interview with LPN A on 7/25/24 at 9:10 AM, she was asked if the Prozac for Resident #18 had arrived from the pharmacy. She opened the medication cart, reviewed the medications, and stated no. She was asked what the protocol was for a resident not receiving a medication for three consecutive days. She stated, She won't miss it today, I'll get it from the Pyxis. She was advised that a review of the Pyxis revealed Prozac was not available. She stated, I'll call the pharmacy again. The pharmacy delivers three times a day. She was asked if the resident's physician was aware that the resident had not received her Prozac for two days and today, the third day, the medication was not available for timely administration. She stated, I'm not sure if anyone called the physician. She was asked if she called the physician for the dose she was unable to administer yesterday. She stated, No, I didn't call the physician. A review of Resident #18's medical record revealed there was no notification to the resident's physician that the resident had missed her Prozac 60 mg on 7/23/24 and 7/24/24. A review of the facility's policy Administrating Oral Medications (undated) revealed: Purpose: The purpose of this procedure is to provide guidelines for the safe administration of oral medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reporting: 1. Notify the supervisor if the resident refused the procedure. 2. Report other information in accordance with facility policy and profession standards of practice.

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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. 42630 Based on observation, staff and resident interviews, medical record review, and facility policy review, the facility failed to ensure a medication error rate of less than 5%. Two errors were identified from 25 opportunities for error, resulting in a medication error rate of 8%, affecting two (Residents #18 and #52) of eight residents observed during medication administration from a total survey sample of 35 residents. The findings include: 1. On 7/24/24 at 9:40 AM, Licensed Practical Nurse (LPN) A was observed during medication administration. As she prepared medications for Resident #18, she stated the Prozac 60 mg (milligrams) ordered daily at 9:00 AM and due for administration at this time was not available in the medication cart. She stated the medication was on order from the pharmacy and it would be on the next pharmacy delivery. A 7/25/24 review of the Medication Administration Record (MAR) revealed the Prozac 60 mg ordered daily for Resident #18 was not administered on 7/23/24 or 7/24/24. In an interview with Unit Manager C on 7/25/24 at 9:05 AM, she was asked what the facility's system for back-up medications was. She stated the facility had a Pyxis machine for medications needed on admission or when medications had not been delivered yet. She was asked to review the contents of the Pyxis machine. Upon entering the medication room on the 2nd floor, she was asked if there was a list of medications in the Pyxis. The list was provided and reviewed. Prozac was not found on the list. She was asked if she could look up Resident #18 to confirm that Prozac was not available in the Pyxis for this resident. She did so and was able to confirm that Prozac was not available in the Pyxis for Resident #18, or for any other resident. In an interview with LPN A on 7/25/24 at 9:10 AM, she was asked if the Prozac for Resident #18 had arrived from the pharmacy. She opened the medication cart, reviewed the medications, and stated no. She was asked what the protocol was for a resident not receiving a medication for three consecutive days. She stated, She won't miss it today, I'll get it from the Pyxis. She was advised that a review of the Pyxis revealed Prozac was not available. She stated, I'll call the pharmacy again. The pharmacy delivers three times a day. She was asked if the resident's physician was aware that the resident had not received her Prozac for two days and today, the third day, the medication was not available for timely administration. She stated, I'm not sure if anyone called the physician. She was asked if she called the physician for the dose she was unable to administer yesterday. She stated, No, I didn't call the physician. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 7/24/24 at 9:50 AM, LPN A was observed during medication administration. As she prepared medications for Resident #52, she placed six medications in a medication cup. The medication administration record (MAR) was observed at the cart to have seven medications ordered for this resident during this medication pass. LPN A greeted Resident #52 and gave him the medication cup with the six pills. This surveyor asked the resident how many pills were in his cup. He looked in the cup and stated six then took the medication. Upon returning to the medication cart, the nurse went back to the MAR for Resident #52 and checked off each medication as administered. She then moved on to the next resident on the MAR. She was stopped and asked if she had administered all of the ordered medications for Resident #52. She went back to the MAR and re-read the resident's medications. She was asked if there were six medications in the cup. She stated yes. She was asked how many medications were ordered. She replied, let me check and counted seven. She took the card of Lisinopril out of the cart and stated she had not administered the resident's Lisinopril. A review of the facility's policy titled Administration of Oral Medications (undated) revealed: Purpose: The purpose of this procedure is to provide guidelines for the safe administration of oral medications. Steps in the Procedure: 3. Place MAR within easy viewing distance. 5. Select the drug from the unit dose drawer or stock supply. 9. Prepare the correct dose of the medication. Reporting: 1. Notify the supervisor if the resident refused the procedure. 2. Report other information in accordance with facility policy and profession standards of practice.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 38804 Based on observation, interview, and record review, the facility failed to employ staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, by failing to employ either a certified dietary manager or a certified food service manager when a registered dietitian was not employed on a full-time basis. This had the potential to affect all of the residents in the facility. The findings include: A tour of the kitchen was conducted on 7/22/24 at 10:35 AM. The surveyor was greeted by Kitchen Manager O, who was asked if she was the Certified Dietary Manager (CDM). She stated she was the Kitchen Supervisor, not the CDM. She stated she would go get the CDM. She left and returned with Registered Dietitian (RD) P. RD P was asked if she was the CDM and she replied that she was not. Kitchen Manager O then asked, Well who's the CDM? During the interview, RD P stated she was in the facility three days a week. An interview was conducted with the Administrator on 7/22/24 at 3:28 PM. She was asked to provide the dietary manager credentials for Kitchen Manager O. On 7/23/24 at 9:49 AM, the Administrator provided a copy of the job application for Kitchen Manager O. There was no documentation to support the employee was a CDM, had earned an associate's degree, had two or more years of experience in the position of director of food and nutrition services in a nursing facility setting, or had any certification for food service management. On 7/23/24 at 1:13 PM, an interview was conducted with the Administrator. She stated Kitchen Manager O had a high school diploma. There was another RD who was in the facility three days a week and Employee P was the Regional RD. She stated RD P was available to assist by phone as needed. She provided the license for a RD who was not in the facility during the survey. She stated the RD supervised Kitchen Manager O and was responsible for the clinical duties. Kitchen Manager O was responsible for the oversight of the kitchen when the RD was out. She was asked again for the kitchen manager's credentials. She stated she only had the high school diploma, but stated again that the Regional RD was always available by phone for assistance. On 7/23/24 at 2:55 PM, the Administrator stated the facility RD was in the facility three times a week on Mondays, Tuesdays, and Thursdays. During an interview on 7/24/24 at 1:09 PM with the Administrator, she confirmed that RD P was in the facility once a week. She stated the facility RD was in the facility twice a week. RD P was available by phone for any questions. She confirmed that Employee O was the Kitchen Manager; however, she was not certified. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/24/24 at 1:31 PM with RD P, she stated she was not an employee of the facility. She stated she was the Regional Dietitian. She worked for a company that was contracted by the facility. She stated she worked with various dietitians in different buildings and assisted on an as needed basis. She assisted with the clinical duties in the facilities, but she was not responsible for the budget. She stated Kitchen Manager O worked with the individual who handled the budget. She did not identify that individual. During an interview on 7/25/24 at 3:07 PM with the Administrator, she stated there was no specific training in the kitchen process. Kitchen Manager O was not a CDM, nor was she receiving training for that. She stated her understanding of the regulation was that if she had a dietary director and a dietitian that consulted, she didn't need a CDM. The regulation was reviewed with her and she was referred to Florida Administrative Code 59A-4.110 (Food and Nutrition Services). The Administrator stated she was responsible for the food budget. Kitchen Manager O was responsible for ordering and purchasing the food. They put in two orders per week. She stated the RD and Kitchen Manager O were responsible for food storage and food service operations. At approximately 5:00 PM on 7/25/24, the Administrator acknowledged the requirement and the facility's noncompliance.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38804 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Expired buns were used during meal service, dietary staff were unable to explain how to test the dish machine, the dish machine test log was pre-dated with test results, the temperatures in the refrigerators in the 2nd and 3rd floor nourishment rooms were greater than 41 degrees Fahrenheit (F), and an open, unlabeled, undated candy bar was discovered in the 3rd floor nourishment room refrigerator. This could potentially affect every resident residing in the facility. The findings include: An initial tour of the kitchen was conducted on [DATE] beginning at 10:35 AM. A dish machine was observed near the rear of the facility. There were three five-gallon buckets of dish sanitizing soaps and a gallon of bleach on the floor under the machine. One of the buckets was labeled Low Temp Dish Machine Sanitizer (Photographic evidence obtained) A label was affixed to the machine with operation requirements for the model: HOT WATER SANITIZING: Final sanitizing rinse temperature: 180 degrees F (Fahrenheit); CHEMICAL SANITIZING: Final rinse minimum temperature 120 degrees F. (Photographic evidence obtained) At 11:15 AM, an interview was conducted with Kitchen Manager O. She was asked if the dish machine was a high- or low-temperature machine. She stated she did not know. She did not handle the dish machine; it was a task for the maintenance department. At this time Dietary Aide R was called over to test the machine. She was asked if the machine was a high- or low-temperature machine. She stated she was not sure. The final rinse temperature reached 130 degrees F. She was not sure if the chemicals were running. She ran the machine again. There was no evidence of the chemicals running through the lines leading from the buckets on the floor to the back of the machine into the water. When asked about this observation, Dietary Aide R stated she didn't know anything about it. She stated the chemicals should come from the bucket. She was asked what she should do in this instance. She said she didn't know and that maintenance needed to be called. She was asked if she had used the dish machine to wash the dishes that would be used for lunch. She stated that she had. An interview was conducted on [DATE] at 11:20 AM with the Maintenance Director. He stated the dish machine was used as a high temperature machine. He performed a test on the machine. The final rinse temperature reached approximately 130 degrees F. Again, the chemicals in the buckets did not move through the lines to the machine. The Maintenance Director stated the dish machine was not working. It should be pulling the chemicals from the bucket, and he was not sure why this was not happening. At 11:50 AM, several packages of unopened buns were observed on the counter. Several of these packages of buns were past the date of expiration. Per the daily menu, hamburgers were to be served for lunch. (continued on next page)

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	105138	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jacksonville Center for Rehabilitation and Healthc	5377 Moncrief Road Jacksonville, FL 32209

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 12:05 PM the meal assembly line was observed. [NAME] Q retrieved several bags of the expired buns. She tore open one of the bags and put the contents in a warming pan on the assembly line. She retrieved one of the buns and proceeded to place a meat patty on top of it. At this time she was stopped and advised that the buns were expired. She called out to Kitchen Manager O and made her aware of the expired buns. She was advised to discard the buns. The assembly line continued. [NAME] Q retrieved more bags of buns. She opened them and emptied them into a warming pan on the assembly line. [NAME] S retrieved one of the buns and began to place meat on it. She too was stopped and advised that those buns were expired as well. [NAME] Q called out to Kitchen Manager O to notify her of this. Kitchen Manager O began to walk toward the food assembly line. She stated the buns had been delivered earlier that day and asked how the surveyor knew they were expired. She was directed to the dates that were printed on the front of the bags of buns. She acknowledged that the buns were expired. She advised Dietary Aide M that he needed to check the expiration dates on all of the bread that had been received. On [DATE] at 10:38 AM during an interview with Dietary Aide N, he was asked to test the Quaternary space concentration level in the manual dish washing sink. He stated the test read 100 ppm (parts per million) but he wasn't sure if he had the right test strips. Kitchen Manager O came over to assist him. They stated Dietary Aide M had performed the test earlier along with the Regional Nurse Consultant and the Administrator; however, they weren't sure which strips were used to test the sanitation level. They used several strips from the two containers of test strips present. The test strip from the seventh test read 175 ppm. Per the sanitation log, the sanitation level was documented as 275 ppm for [DATE] for breakfast and lunch and 302 ppm for dinner. At this time it was also observed that the log had been completed for [DATE] and [DATE]. (Photographic evidence obtained) Kitchen Manager O was asked which were the correct strips to use and how had the log been completed in advance. She stated she did not know. The sanitation log for the manual was observed with the initials for the dates of [DATE] - [DATE]. On [DATE] at 12:49 PM, Dietary Aide M was interviewed. He stated he worked in the kitchen five days a week. He was responsible for testing the sanitation level in the manual dish washing sink. He stated he had not tested it on the morning of [DATE]. He used the clear strips which turn green to test, and when he did the test, he documented it on the log and initialed it. He was asked if he was the only person in the dietary department with his initials and he stated he was. He was shown the log that was pre-dated and the corresponding initials. He confirmed these were his initials and he had signed the log incorrectly. When asked why had he pre-dated the log he responded by saying he had a lot going on the previous day and he put an inaccurate date on the log. On [DATE] at 12:56 PM, per the Regional Nurse Consultant, the other initials on the sanitation log were for a dietary aide who is out on vacation. The Administrator stated Sunday, [DATE], was the last day she had worked. During a [DATE] tour of the nourishment room on the 2nd floor at 2:42 PM, a refrigerator was observed designated for resident use. A temperature log was present for this refrigerator/freezer. Licensed Practical Nurse (LPN)/Unit Manager C accompanied this surveyor closely during the tour. Upon opening the refrigerator, two thermometers were present. One read 42 degrees F and the other read 44 degrees F. LPN C stated the refrigerator had been in use. She was advised that the temperature could be retaken at another time. She stated she would ensure that this refrigerator would not be opened until the temperature could be retaken. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a [DATE] tour of the 3rd floor nourishment room at 2:49 PM, a refrigerator was observed designated for resident use. A temperature log was present. A review of the log revealed that the neither temperature for the freezer or the refrigerator had been taken for [DATE]. A thermometer in the refrigerator read 48 degrees F. An open, undated candy bar was in the freezer. (Photographic evidence obtained) An interview was conducted on [DATE] at 3:43 PM LPN/Unit Manager K. She was shown the findings in the refrigerator in the nourishment room on the 3rd floor. She stated it was the responsibility of the kitchen staff to clean to refrigerator. She stated the overnight nurses were responsible for the temperature logs, and she could not explain why the log was not completed. She was shown the thermometer which read 48 degrees F. She asked if she could remove it and get another one. She was made aware that a thermometer needed to be present and the refrigerator's temperature needed to be 41 degrees F or less. During a [DATE] follow-up visit to the nourishment room on the 2nd floor at 3;48 PM, LPN C confirmed that the refrigerator had not been reopened. She accompanied the surveyor to check the thermometers in refrigerator. Both thermometers displayed a temperature greater than 43 degrees F. LPN C confirmed the readings. She stated she was not sure what could be going on because it (the refrigerator) had been working. She stated the overnight nurses were responsible for checking the temperatures and she did a follow-up check upon her arrival on Mondays through Fridays at 7:00 AM. During an interview with the Administrator on [DATE] at 3:07 PM, she stated there was no specific training in the kitchen process. She was asked if she was aware that the sanitation log for the manual dish washing sink had been pre-dated and initialed. She stated no. She did not know who one of the dietary staff who signed the log was. She was reminded that she previously advised the survey team that the employee was on leave and had been out since last week. She asked if this could be another staff member. She was informed that Kitchen Manager O confirmed the identity of that Dietary Aide and there were no other staff members with those initials. She stated she would speak with the Kitchen Manager about the problem.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 38804 Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition. The facility's high-temperature dish machine failed to reach the minimum final rinse temperature. This could potentially negatively affect all residents consuming meals from the facility's kitchen by exposing them to foodborne illnesses. The findings include: An initial tour of the kitchen was conducted on 7/22/24 beginning at 10:35 AM. A dish machine was observed near the rear of the facility. There were three five-gallon buckets of dish sanitizing soaps and a gallon of bleach on the floor under the machine. One of the buckets was labeled Low Temp Dish Machine Sanitizer (Photographic evidence obtained) A label was affixed to the machine with operation requirements for the model: HOT WATER SANITIZING: Final sanitizing rinse temperature: 180 degrees F (Fahrenheit); CHEMICAL SANITIZING: Final rinse minimum temperature 120 degrees F. (Photographic evidence obtained) At 11:15 AM, an interview was conducted with Kitchen Manager O. She was asked if the dish machine was a high- or low-temperature machine. She stated she did not know. She did not handle the dish machine; it was a task for the maintenance department. At this time Dietary Aide R was called over to test the machine. She was asked if the machine was a high- or low-temperature machine. She stated she was not sure. The final rinse temperature reached 130 degrees F. She was not sure if the chemicals were running. She ran the machine again. There was no evidence of the chemicals running through the lines leading from the buckets on the floor to the back of the machine into the water. When asked about this observation, Dietary Aide R stated she didn't know anything about it. She stated the chemicals should come from the bucket. She was asked what she should do in this instance. She said she didn't know, and that maintenance should be called. She was asked if she had used the dish machine to wash the dishes that would be used for lunch. She stated that she had. An interview was conducted on 7/22/2024 at 11:20 AM with the Maintenance Director. He stated the dish machine was used as a high temperature machine. He performed a test on the machine. The final rinse temperature reached approximately 130 degrees F. Again, the chemicals in the buckets did not move through the lines to the machine. The Maintenance Director stated the dish machine was not working. It should be pulling the chemicals from the bucket, and he was not sure why this was not happening. On 7/22/24 at 11:27 AM, the Maintenance Director explained to Kitchen Manager O that the dish machine was not pulling the sanitizing products from the sanitizer buckets. She stated she did not know anything about it and always calls them (maintenance) for help. She confirmed the dishes had been washed in the machine that morning. She then advised the dietary staff to get paper products for the lunch service and to have someone go buy more in case the repair company was not in before dinner was served. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was conducted with the Administrator on 7/23/24 at 9:54 AM. She provided documentation for service on the dishwasher dated 7/22/24. Per the invoice, the dishwasher was working properly; however, the dishwasher company did not service the chemicals and therefore could not determine why the chemicals weren't being dispensed. She stated the chemical service provider was scheduled to come on site today. On 7/23/24 at 10:27 AM, this surveyor was notified that the chemical service provider was in the facility, and met with the service technician, the Administrator and the Regional Nurse Consultant. The Administrator stated they were advised that the machine was high temperature and therefore the chemicals were not needed. She stated the machine was operable. They tested the dish machine. She stated the technician advised her that chemicals were not needed, as the machine's final rinse reached 80 degrees C (176 degrees F), therefore, there were no concerns. The service technician explained that additional troubleshooting was needed and advised that a more experienced technician would be coming out to assist him. They requested that the dish machine be retested . It was retested three times and each time it failed to reach the required final rinse temperature of 180 degrees F. The technician stated he was not sure what had happened because it had been working prior to this. The Administrator pointed to the the label affixed to the machine which read: Final rinse minimum temperature 120 degrees F. She was directed to the wording above that which read: CHEMICAL SANITIZING, and reminded her that she confirmed they were not using chemicals as the dish machine was a high-temperature machine, which meant the final rinse temperature needed to reach a minimum of 180 degrees F. The technician ran a fourth test. Again, the dish machine did not meet the minimum final rinse temperature. On 7/24/24 at 11:38 AM, the survey team was advised that the dish machine remained out of service. The Administrator stated a service technician for the dish machine itself, as well as a technician for the chemicals, would report to the facility simultaneously to conduct a diagnostic test. At the time of the survey exit on 7/25/24 at approximately 6:47 PM, neither of the service technicians had returned to the facility.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30905 Based on observations, staff interviews, and facility record and policy review, the facility failed to maintain the physical environment in a safe, comfortable, and sanitary manner in eight (Rooms 215, 219, 221, 223, 302, 305, 318, and 319) of 46 rooms in the facility, as well as the 3rd floor elevator area. Door frames were not maintained structurally, a floorboard was raised near the 3rd floor elevator causing a tripping hazard, and holes in walls were identified as well as broken/missing floor tile. The facility also failed to maintain a comfortable and sanitary environment for one (Resident #87) of two residents reviewed for enteral feeding from a total survey sample of 35 residents, by leaving enteral nutrition product splattered and dried on the pump and pole throughout the survey. These concerns could affect residents' comfort and safety. The findings include: 1. On 7/22/24 at 1:48 PM, room [ROOM NUMBER]'s door frame to the bathroom was observed to be rusted and deteriorating at the bottom near the floor. (Photographic evidence obtained) On 7/23/24 at 9:47 AM, room [ROOM NUMBER]'s door frame to the bathroom was observed to be rusted and deteriorating at the bottom near the floor. A piece of black tape had been applied to one section of the door frame. (Photographic evidence obtained) On 7/22/24 at 11:43 AM, room [ROOM NUMBER]'s door frame to the bathroom was observed to be rusted and deteriorating at the bottom near the floor on both sides of the frame. Tile was missing on the floor. The wall behind the A-bed was observed with a hole in the sheetrock. (Photographic evidence obtained) On 7/22/24 at 11:50 AM, room [ROOM NUMBER]'s door frame to the bathroom was observed to be rusted and deteriorating at the bottom near the floor. Tile was missing on the floor near the door frame, and there was damage to the wall in the corner above the floor molding in the bathroom. (Photographic evidence obtained) On 7/22/24 at 12:01 PM, room [ROOM NUMBER]'s door frame to the bathroom was observed to be rusted and deteriorating at the bottom near the floor. There was a hole through the concrete wall under the sink. The floor molding was absent under the vanity area exposing the glue that was stuck to the wall. (Photographic evidence obtained) On 7/22/24 at 1:43 PM, room [ROOM NUMBER]'s door frame to the bathroom was observed to be rusted and deteriorating at the bottom near the floor. Tile was missing on the floor near the door frame. (Photographic evidence obtained) On 7/22/24 at 11:03 AM, room [ROOM NUMBER]'s door frame to the bathroom was observed to be rusted and deteriorating at the bottom near the floor. The floor molding was peeling back away from the wall. (Photographic evidence obtained) (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/23/24 at 10:57 AM, room [ROOM NUMBER]'s door frame to the bathroom was observed to be rusted and deteriorating at the bottom near the floor. Tile was missing on the floor near the door frame and under the vanity area. (Photographic evidence obtained) On 7/23/24 at 11:03 AM, room [ROOM NUMBER]'s door frame to the bathroom was observed to be rusted and deteriorating at the bottom near the floor. Tile was missing on the floor near the door frame. The closet was in disrepair at the bottom corner. (Photographic evidence obtained) On 7/25/24 at 11:43 AM, a floor board in the hallway near the elevator on the third floor was raised higher than the level of the floor presenting a tripping hazard. (Photographic evidence obtained) During an interview on 7/25/24 at 11:20 AM with the Maintenance Director, he stated he was aware that the door frames were in disrepair. He had tried to reconstruct the frames in some of the rooms; however, in order to fix them he would have to cut the existing frame with a saw because the frames are made of steel. Then he could fill them in with a wood frame and paint them to match the existing frame. In order to cut the frames, they would have to move the residents out of the rooms due to the flying sparks that the sawing would produce. He stated the facility was almost at capacity, so he was not sure how they could accomplish the renovations. He did not know where they would house the residents during renovations. He said he would need to talk with the Administrator about how they could do it. He had not reported the abovementioned disrepairs to the Administrator. During an interview on 7/25/24 at 12:10 PM with the Administrator, she stated she was not aware of the condition of the abovementioned door frames. She was aware of the age of the building, and they had made many improvements/upgrades to the building in the time she had been here as the Administrator. The concerns were described to her and she shook her head to indicate that she was unaware. She stated the facility conducted Angel Rounds in which the department heads made rounds daily and used a checklist to identify whether there were any problems in the residents' rooms. The checklists were given to the Administrator to be used for any repairs that needed to be made. When she was informed of the Maintenance Director's description of the process to make repairs, she stated the facility was almost at capacity, and it would be difficult to move the residents for a long period of time. A review of the Angel Rounds checklists the facility staff used for daily rounds in the rooms identified for the months of May, June, and July 2024, revealed no noted deterioration of the door frames to the bathrooms or holes in the walls. Noted chipping on the floor in room [ROOM NUMBER] on 5/9/24, 5/16/24, 5/20/24, 5/28/24, and 6/11/24. Noted door needed paint in room [ROOM NUMBER] on 6/28/24. (Copies obtained) 42630 2. On 7/22/24 at 1:34 PM, Resident #87 was observed lying in bed with the covers pulled up over her head. Her enteral nutrition pole was observed to the right of her bed. No enteral nutrition product was hanging. The enteral nutrition pump was observed with beige splatters on the screen and the side of the pump. (Photographic evidence obtained) On 7/23/24 at 9:34 AM, Resident #87 was observed in her bed with her eyes closed. Her enteral nutrition pump was observed to the right of her bed on a pole with no enteral nutrition product hanging. The pump screen was sticky to the touch with clear matter smeared on the screen and beige matter observed on the side of the pump. (Photographic evidence obtained) (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/24/24 at 7:20 AM, Resident #87 was not in her room. Her enteral nutrition pump was observed with no enteral nutrition product hanging. The pump was sticky to the touch on the screen with clear matter smeared on the screen and beige matter on the sides of the pump. (Photographic evidence obtained) On 7/25/24 at 9:18 AM, Resident #87 was not in her room. Her enteral nutrition pump was observed with enteral nutrition product hanging. The pump was sticky to the touch on the screen with clear matter smeared on the screen and beige matter on the sides of the pump. (Photographic evidence obtained) On 7/25/24 in an interview with Licensed Practical Nurse (LPN) A at 9:20 AM, she was asked if she was the nurse caring for Resident #87 today. She replied yes. When she was asked who was responsible for cleaning resident care equipment such as enteral nutrition pumps, she replied, I don't know who cleans them. She was asked if she cleaned them. She stated no. On 7/25/24 at 9:25 AM, in an interview with Certified Nursing Assistant B, she was asked who was responsible for cleaning resident care equipment such as enteral nutrition pumps. She stated, I can't answer that, I've never cleaned one. I assume the nurses would clean them, or if they asked us to clean them, I would, but I have never been asked to. A review of the facility's policy titled Cleaning and Disinfection of Resident-Care Items and Equipment (undated) revealed: Policy Statement: Resident care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Centers for Disease Control) recommendations for disinfection.