STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105140	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bristol Care Center	1818 E Fletcher Ave Tampa, FL 33612

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on interviews and record review, the facility failed to obtain consent prior to utilizing funds for one resident (#46) of two reviewed. Findings included: During a telephone interview on 01/27/25 at 2:05 p.m., Resident #46's Responsible Party (RP) and POA (Power of Attorney) stated he was upset. He said, The facility owed her [Resident #46] $3000. They bought her a new chair without consent. The RP stated the resident was incapacitated and she did not move, she was in bed 24 hours a day, 7 days a week and does not utilize the new chair. He stated, the facility had to spend her money, for whatever reason and thought they could decide on their own. The RP stated he was the designated RP. He stated the facility did not ask if they could purchase the chair. The RP stated he wanted the facility to reimburse the account because that was not a wise use of Resident #46's money, as she was recently enrolled in hospice. The POA said, I did not authorize the purchase. He stated he had spoken with the Business Office Manager (BOM). Review of the admission record confirmed the resident had a designated resident - representative, for medical decisions, care conference person, emergency contact #1, Health care proxy and the responsible party. Review of a notarized Florida Durable Power of Attorney form dated 8/19/24 showed Resident #46 had a designated POA. Review of the admission record revealed Resident #46 was originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses to include seizures, unspecified dementia, and unspecified sequelae cerebrovascular disease. Review of a quarterly Minimum Data Set (MDS) dated [DATE] showed in section C1000 the resident was severely impaired and never/rarely makes decisions. Review of a grievance filed on 01/24/25 showed- concern: Questions about RMFS -Resident Fund Management System Under Resolution the form showed Business office showed/Therapy. Action take not resolve: Therapy discussed chair usage (spend down). Review of a document titled, Withdrawal Record - Name of facility, dated 12/23/24 showed, credit petty cash account $2,924 for medical equipment. The unsigned document was created by the BOM. (continued on next page)

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

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a document titled, Quotation dated 12/12/24 showed description of item, [brand name of chair] 20" tilt/recline with full Trendelenburg. On 01/29/25 at 1:18 p.m., an interview was conducted with the BOM and the Director of Rehabilitation (DOR). The BOM stated she had received a grievance that the POA was concerned about the purchase of a chair that was purchased on 12/24/24 because of a Medicaid spend down. She stated the chair was worth approximately $3000. The BOM stated the facility was her payee at the time. The BOM stated she had spoken to the DOR to see if there was something Resident #46 could use therapeutically that could help the resident. The DOR said they did an Occupational Therapy (OT) evaluation. She said Resident #46 was dependent and was usually in bed, all the time. The chair was purchased on 12/12/24, she was assessed for positioning. The DOR stated they had the resident on case load previously for contraction management and caregiver training. She stated resident was not trialed for the new purchase because she was bed-bound before that and had not been in a chair. The BOM said, The goal was to spend down the money. During this interview, the BOM and DOR confirmed they did not try to contact Resident #46's family or POA regarding the purchase of a $3000 chair for the resident who could not consent. On 01/29/25 at 2:35 p.m., an observation and interview was attempted with Resident #46. The resident did not speak. An immediate interview was conducted with Resident #46's roommate who was alert and oriented. She stated prior to the chair purchase, Resident #46 never got out of bed, but sometime mid-December they got her a chair. She confirmed her roommate could not speak for herself and that the staff got her out of bed every now and then. On 01/29/25 at 03:26 p.m., an interview was conducted with Resident #46's Occupational Therapist. She stated she had conducted an assessment on 12/12/24 to assess sitting position and determined the resident needed a chair. She stated they trialed it at least 3 times. She stated she did not notify the POA/family because, it was my understanding the BOM was going to do so. Resident #46's OT stated they did not notify the family of the change in care plan. The OT stated they should have consulted with the family. She said, We felt we were doing the right thing. During an interview on 01/29/25 at 4:19 p.m., the Director of Nursing (DON) stated she did not know Resident #46 was no longer on therapy case load. The DON could not confirm how often Resident #46 had been up in the chair and who was assisting her. She stated she thought caregiver training was still on-going. The DON stated she could not speak of the consent as she was not directly involved. On 01/30/25 at 3:36 p.m., the Nursing Home Administrator (NHA) stated Resident #46's POA had reached out. He was uncomfortable with how the money was spent. The NHA stated to his knowledge the resident had used the [brand name of chair], and his plan was to follow up with the POA and discuss how they were going to handle the issue going forward. Review of a facility policy titled, Management of Resident' Personal Funds, dated March 2021, showed under policy implementation - #5. The resident is informed in advance of any charges imposed to his or her personal funds.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on record review and interview, the facility failed to assess a resident within the three months required for one (#196) of three residents reviewed for submission of the quarterly Minimum Data Set (MDS). Findings included: Review of the Admission Record showed Resident #196 was admitted to the facility on [DATE] with diagnoses that included but not limited to cerebral infarction, confusional arousals, white matter disease, cognitive communication deficit and major depressive disorder, recurrent mild. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] showed a completion date of 01/03/25. During an interview on 01/29/25 at 5:44 p.m., Staff A Registered Nurse (RN) Minimum Data Set (MDS) Coordinator stated Resident #196's quarterly MDS dated [DATE] was closed late. Staff A stated there was a certain date that the MDS had to be closed by and if it was closed even one second past midnight, it was considered late. Staff A stated the Quarterly MDS dated [DATE] was closed on 01/03/25 and then not submitted until 01/07/25. Staff A stated she did not know when the actual due date was for Resident #196's quarterly MDS, but it looked like it could have been due on 01/02/25. Staff A stated even one minute past the due date it is considered late.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 37999 Based on observations, record reviews, and interviews, the facility failed to submit one (#188) of forty-one initially sampled residents for a Level II Pre-admission Screening and Resident Review (PASRR). Findings included: On 1/27/25 at 1:59 p.m., Resident #188 was observed lying in bed with significant other at bedside. The resident allowed an interview regarding an abuse allegation and when the significant other left the room, the resident covered up her head with a blanket. Review of Resident #188's admission comprehensive assessment, dated 6/18/24 revealed the resident had not been evaluated for a Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition. The assessment revealed active psychiatric/mood admission diagnoses of depression other than bipolar and manic depression (bipolar disease). Review of Resident #188's Level I PASRR, dated 12/15/23 uploaded into clinical documents showed the resident had been requesting admission to another non-local facility. The PASRR had been completed by the requested non-local facility. The diagnoses showed mental illnesses of bipolar disorder and depressive disorder. The PASRR revealed the individual did not have a diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated, Level II PASRR evaluation not required. Review of Resident #188's Level II PASRR Determination Summary Report, dated 9/23/24 revealed mental health diagnoses included Major Depressive Disorder Recurrent Moderate, Bipolar Disorder Current Episode Mixed Moderate, and Primary Insomnia. The report revealed the Resident Review Evaluation Report completed on 9/11/24 showed the patient had a decline in status stated as behavioral, psychiatric or mood related symptoms that have not responded adequately to ongoing treatment. The determination revealed Resident #188 was considered to have a Serious Mental Illness based on categories of diagnosis, level of impairment and recent treatment and Specifically , without continued treatment or intervention, this individual is likely to have a significant disruption to the normal living situation, due to mental illness. Should there be a significant change in mental status, it is recommended that an additional Level II review be conducted. Review of Resident #188's Level I PASRR screening, dated 1/7/25 revealed the resident had diagnoses of Anxiety disorder, Bipolar disorder, and Depressive disorder, was receiving services for Mental Illness (MI) based on documented history and medications. The resident did not have any disorder resulting in functional limitations, no issue with interpersonal functioning, concentration, persistence, and pace, or adaptation to change. The completion showed Resident #188 had no diagnosis or suspicion of Serious Mental Illness or Intellectual Disability and no Level II PASRR was required. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the psychiatric meeting dated 1/22/25 for Resident #188 showed the resident was started on Prozac for depression during the last visit on 12/26/24 and increased Zoloft on 12/18/24. The documentation revealed Bolded diagnoses are Serious Mental Illness requiring PASRR II while nonbolded need PASRR I. The document showed the resident's diagnoses of Major Depressive Disorder without Psychotic features and Bipolar disorder was bolded. The form revealed additional diagnoses of general anxiety disorder (GAD) and insomnia. The psychiatric meeting form, provided by the facility, included a handwritten note update PASSR crossed out and L2 review circled. An interview was conducted on 1/29/25 at 3:51 p.m. with the Social Service Director (SSD). The SSD stated the facility had started a process to update PASRR's by unit after review with the Interdisciplinary Team (IDT) psych meetings. The staff member stated then they decide if a Level II needed to be done. The SSD stated the facility did not have to resubmit Resident #188 for a Level II after adding the diagnosis of anxiety due to the resident already having one but she could ask for a review. Review of the policy, Pre-Admission Screening and Resident Review, revised March 2019, revealed the following: 1. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility reviews all new admission Level I PASARR screenings with input from psych services for all potential/new admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID, or RD. b. If the Level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. (1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID, or RD. (2) The social worker is responsible for making referrals to the appropriate state-designated authority. c. Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on record review and staff interviews, the facility failed to complete/update the Pre-admission Screening and Resident Reviews (PASRRs) for residents with a mental disorder and individuals with intellectual disability following qualifying mental health diagnoses for five (#228, #145, #163, #25 and #60) of eight residents reviewed for PASRRs. Findings included: 1. Review of Resident #228's admission record revealed an admitted [DATE] with the following diagnoses: Generalized anxiety disorder, upon admitted d 12/23/24 Bipolar disorder diagnosis upon admitted d 12/23/24. Depression diagnosis upon admitted d 12/23/24. New diagnosis of brief psychotic disorder was added on 01/22/25. The review showed the level I PASRR was not updated, and a level II was not submitted for consideration. On 01/28/25 at 3:38 p.m., an interview was conducted with the Social Services Director (SSD). She stated the expectation was to review PASRRs upon admission, and update when the resident has a new diagnosis. The SSD stated she sent information to psych and during the IDT (Interdisciplinary team) meeting they determine if PASRRs should be updated. She stated they had reviewed resident #228 on 1/22/25. The SSD stated there was a timing issue. She said, The PASRR should have been reviewed and updated sooner. 50732 2. Review of the Admission Record showed Resident #145 was admitted to the facility on [DATE] with diagnoses which included major depressive disorder and anxiety. Review of Resident #145's Level 1 PASRR screening revealed the date of the PASRR was 03/10/2022 and was the admission PASRR from another facility. The resident was admitted to the current facility in 2024 and the PASRR was not updated for the current admission. During an interview on 01/30/2025 at 9:08 a.m., the Social Services Director said she reviewed the PASRR when the resident was admitted . She was not aware that the PASRR for Resident #145 was not updated when the resident was admitted . (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the Admission Record showed Resident #163 was originally admitted to the facility on [DATE] with a subsequent admitted [DATE]. Admitting diagnoses included dementia with other behavioral disturbance, Alzheimer's disease, anxiety disorder, major depressive disorder recurrent, encephalopathy. Review of the PASRR dated 04/03/2024 for Resident #163, Section 1: PASRR Screen Decision-Making Part A. revealed the qualifying diagnoses of anxiety disorder and major depressive disorder were not marked. 37999 4. On 1/27/25 at 10:40 a.m., Resident #25 was observed in the hallway, propelling self in wheelchair. During the survey the resident was observed on the patio with other residents and had moved to another unit. Review of Resident #25's Admission Record revealed the [AGE] year old resident was admitted to the facility on [DATE] and recently readmitted on [DATE] following a short acute care stay. The record included diagnoses not limited to brief psychotic disorder, major depressive disorder recurrent moderate (MDD), uncomplicated sedative, hypnotic or anxiolytic abuse, unspecified single episode major depressive disorder, generalized anxiety disorder, unspecified post-traumatic stress disorder (PTSD), unspecified not intractable epilepsy without status epilepticus, and cognitive communications deficit. Review of Resident #25's Pre-Admission Screening and Resident Review (PASRR) dated 12/23/24, included the resident's mental illness diagnoses of anxiety disorder, depressive disorder, psychotic disorder, substance abuse, PTSD, and the related intellectual disorder (ID) condition of epilepsy. The screening showed the functional criteria was likely to continue indefinitely and resulted in substantial functional limitations in three or more major life activities: capacity for independent living, mobility, and self-care. The review of section II of the screening's decision-making revealed there was no indication the individual had or might have had a disorder resulting in functional limitations in major life activities that would otherwise be appropriate for the individual's developmental stage, did not have an issue with interpersonal functioning, concentration, persistence and/or pace, or adaptation to change in a continuing or intermittent basis. The screening did not reveal the resident had a recent history of more intensive psychiatric treatment than outpatient care or had experienced an episode of significant disruption to the normal living situation. The PASRR revealed the resident did not have a diagnosis or suspicion of Serious Mental Illness or Intellectual Disability and a Level II PASRR evaluation was not required. Review of Resident #25's Interdisciplinary Team (IDT) Psych meeting form showed Bolded diagnoses are Serious Mental Illness requiring PASRR II while nonbolded need PASRR I. The IDT psych form for Resident #25, dated 11/6/24, included the bolded diagnosis of PTSD. The plan was to change the indication of alprazolam and hydroxyzine to generalized anxiety disorder (GAD), for gradual dose reduction (GDR) decrease quetiapine to 25 milligrams (mg) every bedtime (qhs) and to increase trazodone to 100 mg qhs. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #25's IDT Psych meeting form, dated 12/4/24 continued to include the bolded diagnosis of PTSD. The form instructed Bolded diagnoses are Serious Mental Illness requiring PASRR II while nonbolded need PASRR I. The IDT team received instructions to discontinue hydroxyzine for a GDR and to increase trazodone to 25 mg twice daily (BID) (and) 100 mg q hs. During an interview on 1/30/25 at 9:08 a.m., the Social Service Director (SSD) reviewed Resident #25's PASRR and IDT psych notes then stated the resident would be reviewed again. 5. On 1/27/25 at 1:54 p.m., Resident #60 was observed lying in bed, yelling, restless, and pulling at his shirt. The door to the resident's room was shut. Staff L, Certified Nursing Assistant (CNA) reported this was a behavior of the resident and the aide had already dressed the resident multiple times. The staff member reported not having enough time to go to the laundry to get a mechanical lift pad to get the resident out of bed. On 1/27/25 at 4:11 p.m. the resident continued to be yelling out from his room. Review of Resident #60's Admission Minimum Data Set (MDS) revealed the resident was admitted on [DATE]. The MDS revealed the resident did not require a Level II PASRR at the time of admission. The comprehensive assessment did not include any mental illnesses or intellectual disabilities, however did include the diagnosis of non-Alzheimer's dementia. Review of Resident #60's Quarterly MDS, dated [DATE], revealed the resident continued with the diagnosis of non-Alzheimer's dementia and depression other than bipolar. The MDS revealed the resident was receiving antipsychotic and antidepressant medication(s). Review of the IDT Psych form, dated 1/22/25, showed Resident #60 had the diagnoses of major depressive disorder (MDD), unspecified severity dementia with other behavioral disturbance, and brief psychotic disorder. The note showed on 12/18/24 the resident had a gradual dose reduction (GDR) to decrease quetiapine to 50 mg qhs (every bedtime) and increase Trazodone to 25 (mg) BID and 125 mg qhs. Review of Resident #60's PASRR dated 1/8/25, revealed mental illness diagnoses of depressive disorder, psychotic disorder, and unspecified mood disorder. The screening showed the resident had a primary diagnosis of dementia with validating documentation to support the diagnosis. The decision-making box revealed A Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder, and a suspicion or diagnosis and serious mental illness, intellectual disability, or both. A Level II PASRR may only be terminated by the level II PASRR evaluator in accordance with 42 CFR 483.128(m)(2)(i) or 42 CFR 483.128(m)(2)(ii). The PASRR completion box showed the individual did not have a diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required. Review of Resident #60's psych Nurse Practitioner (PMHNPN) note, dated 7/24/24 the resident had a chief complaint of depression and dementia. The reason for the evaluation was for the psychiatric evaluation and treatment of depressed mood and disorganized and confused thinking. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #60's psych Nurse Practitioner note, dated 12/26/24 showed the resident had a past psychiatric history of depression, dementia, and psychosis. The note revealed during the last visit the resident was combative and uncooperative with care for staff report and the resident was started on Depakote twice daily for mood, increased Trazodone to 25 mg twice daily (BID) and 125 mg every bedtime (QHS) and decreased quetiapine to 50 mg QHS. The practitioner revealed during the visit on 12/26/24 the resident had no worsening mood with the decrease of quetiapine and was cooperative and compliant with care. An interview was conducted on 1/30/25 at 9:08 a.m. with the Social Service Director (SSD). The SSD reported reviewing PASRR's when residents were admitted and reviewed new diagnoses twice a month at the psych meeting. The SSD stated the system would notify her if a Level II PASRR was to be done and should be done anytime there was an update. She confirmed Resident #60's diagnoses of depressive disorder, psychotic disorder, unspecified mood disorder, and a primary diagnosis of dementia. The SSD stated the resident did not need a Level II because the system did not tell them the resident needed one. Review of the policy, Pre-Admission Screening and Resident Review, revised March 2019, revealed the following: 1. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID), or related disorders (RD) per of the Medicaid Pre- Admission Screening and Resident Review (PASARR) process. a. The facility reviews all new admission Level I PASARR screenings with input from psych services for all potential/ new admissions, regardless of payer source, to determine with the individual meets the criteria for a MD, ID, or RD. b. If the Level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the level II (evaluation and determination) screening process. (1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID or RD. (2) The social worker is responsible for making referrals to the appropriate state-designated authority. c. Upon completion of the Level II evaluation, the state PASSAR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in their facility is appropriate. d. The state PASARR representative provides a copy of the report to the facility. e. The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential resident that are outlined in the evaluation. f. Once a decision is made, the state PASARR representative, the potential resident and his or her representative are notified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observation, record review, and interview, the facility failed to provide needed care and services for one resident (#200) of three residents reviewed with an immune deficiency syndrome, one resident (#170) of two residents reviewed for therapy services, and one resident (#60) of two residents reviewed for maintaining routine lab work. Findings included: 1. During an interview on 01/27/25 at 10:37 a.m., Resident #200 stated, the last time the doctor was at the facility, I had to beg the doctor to order blood work to see if my antiretroviral therapy medication was working for my [immune deficiency syndrome]. The facility completed my blood work, but I still have not heard any results yet. Review of the Admission Record showed Resident #200 was admitted to the facility on [DATE] with diagnoses that included but not limited to unspecified cirrhosis of liver, severe protein-calorie malnutrition, immune deficiency syndrome, pancytopenia, acute kidney failure and candidal stomatitis. Review of the Medication Discharge Report showed Medications to continue taking that have changed: Start Taking: bictegravir/emtricitabine/tenofovir (Biktarvy 50 mg [milligrams]-200 mg-25 mg oral tablet) 1 tablet (s) by mouth once a day. Refills 0. Review of the Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form showed Section C. Decision Making Capacity marked Resident #200 was capable to make his own healthcare decisions. Review of the Care Plan showed Resident #200 was at risk for decline in mental or physical condition related to diagnosis of [immune deficiency syndrome] and the disease process. The goal included Resident will remain free of avoidable complications [related to] r/t [immune deficiency syndrome] process, Cirrhosis of the Liver. The interventions included: - Administer medications as ordered; observe for effectiveness and for SEs - Provide diet as ordered. Offer alternatives as needed. Weights as ordered - Obtain labs as ordered; report results to physician - Provide emotional support as needed - Psych consult/treatment as ordered - Observe for new onset of sx/sx [sign and symptoms] of disease progression and for complications related to disease progression; update physician if noted. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] showed Section C-Cognitive Patterns Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). (continued on next page)

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	105140	A. Building B. Wing	01/30/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of active physician orders showed: - A physician order dated 04/25/24 showed Biktarvy Oral Tablet 50-200-25 MG (Bictegravir-Emtricitabine-Tenofovir Alafenamide Fumarate)- Give 1 tablet by mouth one time a day for [immune deficiency syndrome]. - A physician order dated 01/16/25 showed, Infectious disease consult for [immune deficiency syndrome] follow-up. - A physician order dated 06/11/24 showed, [Appointment] Appt December 11 at 1215 pm with Dr [name] MD at [address]. - A physician order dated 06/06/24 showed, [Name, Address and phone number of Community Health] on 07/02/24 at 1:30 p.m. - A physician order dated 06/06/24 showed, FL Health Department [address and phone number] on 06/11/24 at 8:00 a.m. Review of the completed physician orders showed: - A physician order dated 05/07/24 showed, [Cluster of Differentiation 4]CD4/[Cluster of Differentiation 8]CD8 Ratio (Lymphocyte Subset Panel 4) | HIV-1 DNA, Qualitative, PCR- one time only related to [immune deficiency syndrome]. - A physician order dated 01/17/25 showed, CD4/CD8 Ratio (Lymphocyte Subset Panel 4)- one time only related to [immune deficiency syndrome]. - A physician order dated 05/08/24 showed, Infectious Disease appointment with Florida Department of Health [address and phone number] every day and night for anti-viral meds for 1 day. - A physician order dated 05/10/24 showed, Infectious Disease [name of clinic} June 10 at 1:00 p.m. [address and phone number] one time only until 06/10/24. Review of the Lab Results Reports showed the following: - A review of the Lab Results Report showed the CD4/CD8 Ratio (Lymphocyte Subset Panel 4) results were collected on 05/08/24, received on 05/10/24 and reported on 05/13/24. The CD4 showed a L (low) result score of 7 with a reference range of 30-61. The Absolute CD4+ Cells showed a L (low) result score of 65 with reference range of [PHONE NUMBER]. The CD8 showed a H (high) result score of 80 with reference range of 12-42. The Absolute CD8 + Cells showed a score of 784 with reference range of [PHONE NUMBER]. - A review of the Lab Results Report showed the CD4/CD8 Ratio (Lymphocyte Subset Panel 4) results were collected on 01/17/25, received on 01/19/25 and reported on 01/21/25. The CD4 showed a L (low) result score of 13 with a reference range of 30-61. The Absolute CD4+ Cells showed a L (low) result score of 119 with reference range of [PHONE NUMBER]. The CD8 showed a H (high) result score of 64 with reference range of 12-42. The Absolute CD8 + Cells showed a score of 595 with reference range of [PHONE NUMBER]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/29/25 at 12:22 p.m., the Director of Nursing (DON) stated she was the one who was responsible for everything including immunodeficiency medications and lab work to ensure the antireoviral therapy medication (ART) being administered was effective for residents with a immune deficiency syndrome. The DON stated Resident #200 was not being treated for an immune deficiency syndrome. The State Agency (SA) surveyor reviewed Resident # 200's physician orders and lab work with the DON who then stated, Oh I guess he is. The DON stated that she did not follow up timely lab work for residents with immune deficiency syndrome as the lab work was prescribed by the physician and when lab work was due the physician would order it. The DON stated, as lab work results are received by the facility the nurse would contact the physician if any lab results were flagged or abnormal. The DON stated that the nurse who would be responsible for Resident #200 lab work results was identified as Licensed Practical Nurse (LPN) Unit Manager East (UME). During an interview on 01/29/25 at 12:30 p.m., Staff B, Licensed Practical Nurse (LPN) Unit Manager East (UME) stated any flagged or abnormal labs would be called in by the nurse on duty and then I would be the nurse's second set of eyes to ensure the lab results were called and the physician was notified. Staff B LPN, UME stated she reviewed Resident #200's lab work physically on the computer on 01/22/24 however it appeared that the nurse had already spoken with the Nurse Practitioner on 01/20/24. During an interview on 01/29/25 at 12:41 p.m. Staff C, Nurse Practitioner (NP) stated she was notified of Resident #200's abnormal lab work by the nurse and was also notified that Resident #200 tested positive for detection of an immune deficiency syndrome. Staff C stated that the physician had ordered antireoviral therapy medication (ART) however Resident #200 had refused to take the medications all the time and refused consultations set up for him for Infectious Disease (ID) Consults. Staff C stated the physician had set up Infectious Disease (ID) before in the past and he refused to go. Staff C stated as far as the required lab work testing goes the general blood work testing for residents with immune deficiency syndrome labs should be every 6 months. Staff C stated, Once the lab results are received, the facility will notify myself or the physician of any irregularity and it is the responsibility of the physician if they want to order anything new. During an interview on 01/29/25 at 12:55 p.m., the DON stated Resident #200 had a long history of refusing his medications and going to the Infectious Disease Doctor (ID) at the local health department. The DON reiterated, We set things up for him and then he refuses to go. During an additional interview on 01/29/25 at 2:18 p.m., the DON stated Resident #200 will tell you he does not like to go sit at the Health Department. The DON stated that when Resident #200 first came to the facility there was no antireoviral therapy medication being administered to Resident #200. During an interview on 01/29/25 at 2:23 p.m., Resident #200 stated that he was in the process of being transferred to an assisted living facility soon. Resident #200 stated he would not have to beg for blood work to see if the antireoviral therapy medications were working there. Resident #200 stated, I do not refuse my medications or any appointments. A review of the Medication Administration Records (MAR) showed the following: May 2024 MAR (continued on next page)

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	105140	A. Building B. Wing	01/30/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Biktarvy Oral Tablet 50-200-25 MG (Bictegravir-Emtricitabine-Tenofovir Alafenamide Fumarate)- Give 1 tablet by mouth one time a day for [immune deficiency syndrome]. Resident #200 received this medication daily per physician orders except for the dates of 05/15/24 and 05/16/24 documented with the number 1 (Medication Refused). June 2024 MAR - Biktarvy Oral Tablet 50-200-25 MG (Bictegravir-Emtricitabine-Tenofovir Alafenamide Fumarate)- Give 1 tablet by mouth one time a day for [immune deficiency syndrome] . Resident #200 received this medication daily per physician orders. No refusals noted. July 2024 MAR - Biktarvy Oral Tablet 50-200-25 MG (Bictegravir-Emtricitabine-Tenofovir Alafenamide Fumarate)- Give 1 tablet by mouth one time a day for [immune deficiency syndrome]. Resident #200 received this medication daily per physician orders. No refusals noted. August 2024 MAR - Biktarvy Oral Tablet 50-200-25 MG (Bictegravir-Emtricitabine-Tenofovir Alafenamide Fumarate)- Give 1 tablet by mouth one time a day for [immune deficiency syndrome]. Resident #200 received this medication daily per physician orders. No refusals noted. [DATE] MAR - Biktarvy Oral Tablet 50-200-25 MG (Bictegravir-Emtricitabine-Tenofovir Alafenamide Fumarate)- Give 1 tablet by mouth one time a day for [immune deficiency syndrome]. Resident #200 received this medication daily per physician orders. No refusals noted. October 2024 MAR - Biktarvy Oral Tablet 50-200-25 MG (Bictegravir-Emtricitabine-Tenofovir Alafenamide Fumarate)- Give 1 tablet by mouth one time a day for [immune deficiency syndrome]. Resident #200 received this medication daily per physician orders. No refusals noted. - November 2024 MAR - Biktarvy Oral Tablet 50-200-25 MG (Bictegravir-Emtricitabine-Tenofovir Alafenamide Fumarate)- Give 1 tablet by mouth one time a day for [immune deficiency syndrome]. Resident #200 received this medication daily per physician orders. No refusals noted. December 2024 MAR - Biktarvy Oral Tablet 50-200-25 MG (Bictegravir-Emtricitabine-Tenofovir Alafenamide Fumarate)- Give 1 tablet by mouth one time a day for [immune deficiency syndrome]. Resident #200 received this medication daily per physician orders. No refusals noted. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	January 2025 MAR - Biktarvy Oral Tablet 50-200-25 MG (Bictegravir-Emtricitabine-Tenofovir Alafenamide Fumarate)- Give 1 tablet by mouth one time a day for [immune deficiency syndrome]. Resident #200 received this medication daily per physician orders. No refusals noted. A review of the Treatment Administration Record (TAR) showed the following: May 2024 TAR - Infectious Disease appointment with Florida Department of Health on 05/10/24 at 8:00 a.m. [address and phone number] every day and night for anti-viral meds for 1 day. The TAR showed a y for yes revealing Resident #200 went to the appointment on 05/09/24 Night and on 05/10/24 Day shifts. June 2024 TAR - Infectious Disease [name of clinic} June 10 at 1:00 p.m. [address and phone number] one time only until 06/10/24. The TAR had a blank spot in the space for the date of 06/10/24. - FL Health Department [address and phone number] on 06/11/24 at 8:00 a.m. The TAR showed X in the space for the date of 06/11/24. July 2024 TAR - [Name, Address and phone number of Community Health] on 07/02/24 at 1:30 p.m. The TAR showed X in the space for the date of 07/02/24. August 2024 TAR - No appointments scheduled for the month of August 2024 September 2024 TAR - No appointments scheduled for the month of September 2024 October 2024 TAR - No appointments scheduled for the month of October 2024 November 2024 TAR - No appointments scheduled for the month of December 2024 December 2024 TAR - [Appointment] Appt December 11 at 1215 pm with [name of physician] MD at Florida [address]. The TAR showed X in the space for the date of 12/11/24. (continued on next page)

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	105140	A. Building B. Wing	01/30/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	January 2025 TAR - Infectious disease consults for [immune deficiency syndrome] follow-up. The TAR showed no date or time for the follow-up with X in the space for all days in the Month of January 2025. In a further interview on 01/29/25 at 3:18 p.m., Resident #200 stated that the facility provided only one appointment when he was taken to the Health Department (HD). Resident #200 stated this appointment occurred when he was first admitted to the facility. Resident #200 stated he was in a lot of pain as he waited for over an hour at the HD and told the driver he was in pain and wanted to go back to the facility. Resident #200 stated the driver refused to take him back to the facility. Resident #200 stated after two more hours of waiting he made a big scene in the lobby and the driver finally drove him back to the facility missing the HD appointment. Resident #200 stated he was never re-scheduled for another outside appointment again because no one had ever discussed any appointments with him again until today. Resident #200 stated he figured after the HD episode when he first came in, he figured it was like a one and done thing, so the facility never scheduled him for an appointment again. Resident #200 stated he was approached by the DON today and was informed of his abnormal lab work results that showed his antireoviral therapy medication (ART) was not working as he figured it was not. Resident #200 stated he was off ART for about a year until he went into the hospital back in February 2024 or March of 2024. Resident #200 stated he had such a bad experience with the HD that he did not want to go back but would like to go to a local Community Health facility. Resident #200 stated he had made a new appointment with the local Community Health facility for 02/18/25 at 1:00 p.m. for his immune deficiency syndrome needs. Resident #200 stated that he should be in the assisted living facility by then and he will be sure to go to his self-scheduled appointment. During an interview on 01/29/25 at 3:36 p.m., the DON stated that she did not discuss any lab work with Resident #200 and would never tell him his medications were not working. The DON stated, I would never discuss lab work with a resident. The DON stated she spoke with Resident #200 today and asked him if he was ready to go back to the health department again. The DON stated Resident #200 responded don't push it. During an interview on 01/30/25 at 10:00 a.m., the DON stated if the MAR had an order documented on it but there was an X in all boxes that meant the order was not active for those days. The DON stated if the MAR had an order documented on it but there were holes for those days, that meant the staff forgot to document. The DON stated if a resident refused medications or treatment that refusal would be documented on the MAR or TAR by a number usually 1 meaning medication refused or in a progress note. During an interview on 01/30/25 at 10:31 a.m., the Social Services Director (SSD) stated the social services department was responsible for scheduling transportation for residents outside appointments. The SSD stated she would look to see if Resident #200 had any scheduled outside appointments in the last six months but stated, I don't think so. During an additional interview on 01/30/25 at 11:03 a.m., the SSD stated Resident #200 had no scheduled outside appointments in the last six months, so no transportation was needed to be scheduled. Review of Progress Notes showed the following: (continued on next page)

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	105140	A. Building B. Wing	01/30/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A Behavior Note dated 5/10/2024 showed, Pt LOA to Health Department appt. for Biktarvy drug assistance. Calls received from this facility's staff escort stating resident refused appt and requested to be returned to facility. Added that resident became loud and aggressive and threw items on the floor. Writer spoke with resident via phone reminding resident of the purpose of appointment for ADAP and the importance of medication compliance per our previous educational conversation. Resident verbalized understanding of teaching but Health Department staff called shortly after stating resident could not be be seen due to refusal of appt. Psych ARNP made aware. - A Palliative Care Note dated 07/06/24 showed, Palliative care follow up visit for comfort measures and chronic disease symptom management of [immune deficiency syndrome], liver cirrhosis, debility and chronic pain. On 06/12/24 discussion with patient due to refusing [immune deficiency syndrome] medications and infectious disease appointments. Patient reports he would like to follow up with [Name of Community Health] and ensure he had his anxiety medications prior to appointment. Patient has capacity to make his own medical decisions. - A review of all progress notes for June 2024, July 2024 and December 2024 showed with no progress notes that revealed Resident #200 refused any medications or appointments. During an interview on 01/30/25 at 8:56 a.m., Resident #200's Attending Physician (AP) stated Resident #200 was a resident who had an immune deficiency syndrome, however, as his AP he follows this resident but does not monitor Resident #200's immune deficiency syndrome progress or antireoviral therapy medications (ART). Resident #200's AP stated Resident #200 should have an Infectious Disease (ID) doctor that would monitor and order Resident #200's ART and lab work as none of that was in his scope of practice as Resident #200's AP. Resident #200's AP stated that he had never ordered Resident #200's ART. Resident #200's AP did not know who Resident's Infectious Disease doctor (ID) was. Resident #200's AP stated that the lab work results came back abnormal, it was probably because Resident #200 refused his medications. Resident #200's AP stated according to the DON and nursing staff, Resident #200 refused to take his medications and refused to go to appointments all the time. The AP stated that in general all residents who have an immune deficiency syndrome should have blood work every three to six months. The AP stated Resident #200's lab work completed 8 months apart (one collected on 05/08/24 and the second collected on 01/17/25) could be because Resident #200 refused. Resident #200 AP stated if the lab work results showed abnormal then it would be up to Resident #200's Infectious Disease Doctor to make changes in his ART. An additional review of the physician order dated 04/25/24 showed Biktarvy Oral Tablet 50-200-25 MG (Bictegravir-Emtricitabine-Tenofovir Alafenamide Fumarate)- Give 1 tablet by mouth one time a day for [immune deficiency syndrome]. The medication was ordered by Resident #200's Attending Physician with an end date of indefinite. Review of Resident #200's Census Page showed no Infectious Disease Doctor (ID) identified. During an interview on 01/30/25 at 9:22 a.m., Staff B LPN, UME stated she did not believe Resident # 200 had an ID at this time, as he was just followed by the Attending Physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/30/25 at 9:28 a.m., the DON stated that Resident #200 was not established with an ID because he would not go to the Health Department. The DON stated the facility did not have an ID who came to the facility. The DON stated, she did think Resident #200 was established with an ID in the community. The DON stated, I think he has an appointment with them, but he will not tell me who it is. During an interview on 01/29/25 at 1:38 p.m., the DON stated, We have no policy on immune deficiency syndrome Management. During an interview on 01/30/25 at 3:00 p.m., the DON stated We have no policy on Quality of Care. Review of the facility's policy Resident Rights revised date February 2021 showed 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: h. be supported by the facility in exercising his or her rights; i. exercise his or her rights as a resident without interference, coercion, discrimination or reprisal from the facility; o. be notified of his or her medical condition and of any changes in his or her medical condition; s. choose an attending physician and participate in decision-making regarding his or her care. Review of the facility's policy Administering Medications/Physician Orders revised date April 2019 showed, Policy and Implementation 18. If medication is withheld, refused or administered outside the scheduled time, the person giving the medication must document this in the medical record. Review of the facility's [NAME] of Rights showed, Residents of nursing homes shall not be deprived of any rights, benefits or privilege's guaranteed by law and the Florida and United States Constitutions. You, as a long-term care resident, have the right to: Receive adequate and appropriate health care; choose your own physician and pharmacy; be informed of your medical condition and treatment including the right to make an informed decision to refuse treatment. Review of the facility's Residents' Rights 101 showed: Right to Self-Determination - Choice of activities, schedules, health care and providers, including attending physician. - Request, refuse and/or discontinue treatment. Right to be fully informed of: -The type of care to be provided, and risks and benefits of proposed treatments -Changes to the plan of care, or in medical or health status -Rules and Regulations, including the long-term care ombudsman program and the state survey agency (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #170's evaluations revealed a note titled, LCSV [unknown abbreviation] IDT [interdisciplinary team] Referral to Therapy, dated 12/11/24, which included the following documentation, . Therapy Referral . Date of referral: 12/11/24 . IDT Evaluation: . Resident and family requesting diet upgrade . referred to therapy . Therapy response . SLP [Speech Language Pathology] Evaluation & Treatment . Response to Referral Completed by: . DOR [Director of Rehab] Date of Response: 12/11/24. A review of Resident #170's speech therapy notes revealed certification periods of 8/31/24 - 9/29/24, and 9/30/24 - 10/29/24. A review of the speech therapy discharge summary, dated 10/19/24, revealed the following documentation, Baseline (8/1/2024) mod cues to use css [communication severity scales] and aspiration precaution mech soft/nectar . Previous (10/7/2024) Mechanical soft solid, thin liquids diet-Mild . Discharge (10/16/2024) Mechanical soft solid, thin liquid diet-Mild . Further review of the speech therapy discharge summary revealed the following documentation, D/C [discharge] destination: Long term care setting, D/C reason: Exhausted benefits, patient/RSP [unknown abbreviation] declines treatment . Diet/Liquids Diet Recs - Solids = Mechanical Soft textures Diet Recs - Liquids = Thing liquids . On 1/29/25 at 11:20 a.m., an interview was conducted with Staff D, Registered Dietitian (RD) who stated Resident #170's current diet order is, Regular mechanical soft, thin liquids. She stated the original order date was on 9/30/24, with a revision on 1/27/25. Staff D, RD stated if she received a consult for diet advancement she would refer to speech therapy. On 1/29/25 at 12:15 p.m., an interview was conducted with Staff E, SLP. She stated she's been working at the facility for three months. A review of the speech therapy evaluations was conducted with Staff E, SLP. She stated Resident #170 had an evaluation, dated 8/1/2024, which revealed severely impaired swallowing, eating unsafe amounts and decreased safety awareness. As a result of the evaluation, the previous SLP recommended the following diet for Resident #170, Mechanical soft and nectar thick liquid diet, with goals to advance that diet. Staff E, SLP stated Resident #170's last speech evaluation was 8/1/24, and she was last screened on 8/14/24. She stated Resident #170, Will be coming up on her quarterly evaluation soon. Staff E, SLP stated there are no recent orders for speech therapy. She stated she could not confirm what happened with the referral on 12/11/24. Staff E, SLP stated the DOR receives the referral and puts the evaluation on their calendar. On 1/29/25 at 12:35 p.m., an interview with the DOR revealed the last time Resident #170 was on the speech therapy caseload was on 10/16/24. She stated she is not sure what happened with the therapy referral dated 12/11/24. The DOR confirmed she marked on the referral for speech therapy to evaluate Resident #170. She stated the resident will be screened today by Staff E, SLP. The facility confirmed they do not have a policy related to coordinating care with therapy, to include referrals to therapy. 3. On 1/27/25 at 1:54 p.m. Resident #60 was heard yelling out and pulling at his shirt appearing to be trying to remove it. Staff L, Certified Nursing Assistant (CNA) stated this (trying to remove clothing) was a behavior and had already dressed the resident multiple times. Review of Resident #60's Admission Minimum Data Set, dated dated dated [DATE] revealed the resident had been admitted on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105140	A. Building B. Wing	01/30/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #60's Psychiatry note, dated 12/26/24 revealed the resident was started on Depakote 250 milligrams (mg) twice daily for mood. Review of Resident #60's Order Summary, active as of 1/30/25, included diagnoses of hypokalemia, unspecified anemia, unspecified protein-calorie malnutrition, unspecified chronic kidney disease, unspecified hypothyroidism, Type 2 Diabetes mellitus with other specified complication, dementia and other diseases classified elsewhere unspecified severity without behavioral disturbance, psychotic disturbance mood disturbance and anxiety, moderate recurrent major depressive disorder, and unspecified severity vascular dementia with agitation. The summary revealed the following orders: - Levothyroxine Sodium 50 microgram (mcg) - Give 50 mcg by mouth in the morning for thyroid. - Simvastatin 20 mg- Give 1 tablet by mouth at bedtime for hyperlipidemia. - Valproic Acid Oral Solution 250 mg/5 milliliter (mL) - Give 10 ml by mouth at bedtime for mood. - Valproic Acid Oral Solution 250 mg/5 mL - Give 5 mL by mouth one time a day for mood. - Complete Blood Count (CBC) with auto differential/Basic Metabolic Panel with estimated glomerular filtration rate (eGFR)/Lipid panel with Calculation of Low-Density Lipoprotein Cholesterol (Calc LDL)/Hemoglobin A1c/ Thyroid-Stimulating Hormone (TSH)/Valproic Acid (Depakote) **Scheduled 1/10/25; Auto-Send 1/10/25 12:00 a.m.** one time only related to hypothyroidism unspecified, chronic kidney disease unspecified, unspecified protein-calorie malnutrition, essential (primary) hypertension, hypokalemia, anemia unspecified, type 2 diabetes mellitus with other specified complication. The order was ordered on 1/9 and started on 1/10/25. - Valproic Acid (Depakote) **Sent to lab 1/23/25 12:04 a.m. one time only related to chronic kidney disease unspecified. This order was obtained on 1/22 and was to start on 1/23/25 with no end date. Review of Resident #60's progress notes dated 1/9/25, showed routine lab orders received from the Advanced Practitioner Registered Nurse (APRN). New orders received and noted. Review of Resident #60's electronic results tab revealed no results for the testing ordered to be completed on 1/10/25. An interview was conducted on 1/30/25 at 3:42 p.m. with the Director of Nursing (DON). The DON provided the Lab log dated 1/10/25 which showed the bloodwork had been refused. The DON stated the lab

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, record reviews, and interviews, the facility failed to screen one (#123) resident for orthotic use and failed to apply orthotics for two (#14 and #31) of 23 residents. Findings included: 1. On 1/27/25 at 10:22 a.m., Resident #123 was observed lying in bed with the head of the bed raised. The observation showed a left-hand brace/splint lying on the bedside dresser out of reach of the resident. The resident reported previously wearing the orthotic device when on therapy. The resident stated nobody puts it on now, don't have anyone to put it on me, and reported his niece put it on him last Thursday. On 1/28/25 at 8:55 a.m., Resident #123 was observed lying in bed with orthotic on bedside dresser. Review of Resident #123's Admission Record revealed the resident was admitted on [DATE] with diagnoses that included but not limited to hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, unspecified rheumatoid arthritis, and unspecified site unspecified osteoarthritis. Review of Resident #123's quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 of 15, which indicated intact cognition. The functional ability assessment of the resident revealed a range of motion impairment of one upper extremity and bilateral lower extremities. Review of Resident #123's Certified Nursing Assistant (CNA) [Brand name for a desktop file system] did not reveal staff were to apply the observed left hand orthotic. Review of Resident #123's Physical/Occupational Therapy Screening form, effective 9/27/23 at 12:57 p.m., revealed there was no change in condition, would not benefit from skilled services at that time, and the resident was performing at prior level. Review of Resident #123's Range of Motion: Functional Limitation Screen, effective 9/27/23 at 12:51 p.m., revealed the resident had moderate limitation in range of motion (ROM) of the left shoulder and slight ROM limitation in the left wrist. The comment revealed the resident operated at prior level of function since discharge (d/c) from caseload. Review of Resident #123's care plan did not reveal the observed orthotic was to be applied to the resident left upper extremity. An interview was conducted on 1/29/25 at 11:15 a.m. with Staff F, Licensed Practical Nurse (LPN). The staff member stated therapy put Resident #123's orthotic on, don't quote me on that. Staff F stated the resident did not wear it daily but believed therapy had worked with the resident at one point of time. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 1/29/25 at 1:52 p.m. with the Director of Rehabilitation (DoR). The DoR reported the resident did not have a contracture, had trialed a splint but did not require it anymore. The staff member stated therapy had received a referral today at 11:54 p.m. The DoR stated the resident felt the need for the splint. She said therapy waited for a referral or a quarterly screen, screened 9/27/23 and not sure why the resident had not had a quarterly screen since April. 2. On 1/27/25 at 2:07 p.m. Resident #14 was observed lying in bed, with bilateral hands with contractures and was not wearing orthotic devices. On 1/29/25 at 11:39 a.m. Resident #14 was observed wearing a right-hand palm protector. Staff N, Certified Nursing Assistant (CNA) observed and stated the resident had been a resident at the facility for a long time and the staff member did not normally work this hall. Staff N attempted to open the left hand that did not have a palm guard. On 1/30/25 at 7:57 a.m. Resident #14 was observed with Staff O, Registered Nurse (RN). The staff member confirmed the resident was not wearing either bilateral elbow braces or a left- hand palm guard. Review of Resident #14's Admission Record revealed the resident was admitted on [DATE] and readmitted on [DATE]. The record included diagnoses not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, functional quadriplegia, right and left foot contractures, and right ankle contracture. Review of Resident #14's Order Summary Report revealed the following orders: - Patient (Pt) to wear bilateral elbow orthotics for up to 2 hours (hrs) daily to reduce skin breakdown in between elbow crease. Order date: 4/22/2024 Review of Resident #14's care plan revealed the following focuses and interventions: - Potential for alteration in comfort-pain related to (r/t) decreased mobility and limited movement of multiple joints. The interventions included instructed nursing to use pillows to support in position of comfort for the resident. - (Resident) has a potential for complication r/t contractures of bilateral hands and bilateral elbows - bilateral palm guards and bilateral elbow splints. The interventions instructed CNAs and nursing to Apply/remove splint/brace for joint protection as ordered. - (Resident) has contractures to upper extremities and bilateral foot drop r/t an old Cerebral vascular Accident (CVA). The interventions included: (Resident) has a left elbow extension, may wear this up to 6 hours daily as tolerated. Remove for hygiene and check skin integrity. an B palm guards, B elbow splints. Patient to wear left hand roll splint and left elbow extension splint up to 6 hours daily. Review of Resident #14's CNA [Brand name for a desktop file system] revealed the resident to wear bilateral palm guards on right (R) and left (L) hand to reduce skin breakdown at all times except when bathing. Check skin integrity. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #14's Treatment Administration Record (TAR) revealed the order to wear bilateral palm guards on R and L hands at all times was ordered 6/12/24 and discontinued 1/22/25. The administration line for this order had X's for all days of January and did not reveal if nursing staff had applied the palm guards prior to discontinuation. Review of the Splint Audit Form revealed Resident #14 was to have bilateral palm guards At all times except when bathing and bilateral elbow splints up to 2 hours. The audit forms received revealed the following: - Wednesday 1/22: did not reveal the bilateral pal guards or bilateral elbow splints had been applied. - Thursday 1/23: revealed the bilateral palm guards had been applied, and bilateral elbow splints had been applied. The form did not reveal a time the splints had been applied or when they had been removed. - Friday 1/24: revealed the bilateral palm guards had been applied, and bilateral elbow splints had been applied. The form did not reveal a time the splints had been applied or when they had been removed. - Monday 1/27: revealed bilateral palm guards had been applied. The form did not show the resident's bilateral elbow splints had been applied. - Tuesday 1/28: revealed bilateral palm guards had been applied. The form did not show the resident's bilateral elbow splints had been applied. The audit did not reveal a time the bilateral elbow splints had been applied or taken off. The request for CNA documentation for the task of bilateral palm guards was not provided. The facility provided a Task List Report which instructed nursing that Pt was to wear bilateral palm guards on R and L had to reduce skin breakdown at all times except when bathing. The task was initiated on 6/12/24 and did not show a resolved/canceled date. The task report did not reveal if nursing had applied Resident #14's bilateral elbow splints or palm guards on Saturdays or Sundays when Staff P was not working. An interview was conducted on 1/29/25 at 2:03 p.m. with the Director of Rehabilitation (DoR). The DoR stated Resident #14 wears bilateral elbow splints and bilateral palm guards which the Rehab tech put on. The DoR reported the left palm guard was missing, and the CNA yesterday had informed her of throwing it away because it was soiled. The DoR reported the palm guards are washable. An interview was conducted on 1/29/25 at 5:18 p.m. with the DoR and Staff P, Rehab Tech. The DoR stated the facility was working on the process on who applied the splints on the weekends. Staff P reported she worked Monday through Friday. The DoR stated the process was for the CNAs to apply them on the weekends and sometimes they still do. 3. On 1/27/25 at 10:15 a.m., Resident #31 was observed asleep in bed, wearing a right elbow orthotic and another brace/splint was observed lying on bedside dresser. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/28/25 at 8:53 a.m. Resident #31 was observed lying in bed with orthotic sitting on top of bedside dresser. On 1/29/25 at 11:10 a.m. Resident #31 was observed lying in bed with orthotic on bedside dresser. On 1/29/25 at 11:28 am. Resident #31 was observed not wearing brace/splint on right hand and orthotic (previously seen on dresser) was not observed on dresser. An observation of Resident #31 was conducted on 1/29/25 at 11:30 a.m. with Staff Q, Certified Nursing Assistant (CNA). Staff Q reported not normally working this hallway. On 1/29/25 at 11:37 a.m. Staff Q removed brace/splint from a drawer of the bedside dresser. Staff Q stated she would put the brace on the resident when she got to the resident if it [Brand name for a desktop file system] told her to. On 1/30/25 at 8:04 a.m. Resident #31 was observed lying in bed and was not wearing right-hand orthotic and the device was not observed on bedside dresser. Review of Resident #31's Admission Record revealed the resident was admitted on [DATE] and readmitted on [DATE]. The record included diagnoses not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, other seizures, and type 2 diabetes mellitus with hyperglycemia. Review of Resident #31's Order Summary Report included an order active as of 7/18/24, Occupational Therapy (OT) skilled intervention: Continue with OT treatment (tx) 5 times(x)/week for 30 days for tx codes M24.541, M24.521,(and) R29.3. TX may include therapeutic exercise (there ex), there activities (act), self care, NRME, orthotic management/training (mgmt), manual there, (and) wheelchair (wc) mgmt. Review of Resident #31's CNA [Brand name for a desktop file system] instructed: - Maintenance Program - Splint/Brace program: Patient (Pt) to wear right (R) elbow orthotic for up to 4 hours daily or as tolerated. Check skin integrity. - Maintenance Program - Splint/Brace program: Pt to wear R resting skin splint for up to 4 hours daily or as tolerated. Check skin integrity. Review of the Resident #31's Splint Audit Form revealed Staff P had documented the following: - Wednesday 1/22/25 R elbow splint, scheduled for 4 hours was applied without a time on and did not reveal a time the splint was removed. - Wednesday 1/22/25 R hand splint, scheduled for 4 hours was not applied. - Thursday 1/23/25 R elbow splint and R hand splint scheduled for 4 hours had been applied however the audit did not reveal when the splints had been applied or when they were removed, did not document if resident was able to tolerate up to 4 hours. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Friday 1/24/25 R elbow splint and R hand splint scheduled for 4 hours had been applied however the audit did not reveal when the splints had been applied or when they were removed, did not document if resident was able to tolerate up to 4 hours. - No audit for Saturday 1/25 or Sunday 1/26/25 was provided. - Monday 1/27/25 R elbow splint, scheduled for 4 hours was applied without time on and did not reveal the time splint was removed. - Monday 1/27/25 R hand splint, scheduled for 4 hours was not applied. - Tuesday 1/28/25 R elbow splint, Staff P documented nurse will remove. The audit did not reveal a time the splint was applied or taken off. - Tuesday 1/28/25 R hand splint, scheduled for 4 hours was not applied. Review of Resident #31's CNA daily task revealed staff were to document q (every) shift the Maintenance Program - Splint/Brace program: Patient (Pt) to wear right (R) elbow orthotic for up to 4 hours daily or as tolerated. Check skin integrity and the Maintenance Program - Splint/Brace program: Pt to wear R resting skin splint for up to 4 hours daily or as tolerated. Check skin integrity. The documentation showed CNA's were documenting once per day, did not document the time splints/braces were applied or taken off. The CNAs documented the splint/brace program at approximately the same time documentation was completed for the resident's ability for oral hygiene, to position from lying to sitting on side of bed and of bathe/shower evening shift Tuesday and Friday, shower every Tuesday and Friday 3-11 (p.m.) shift (which CNA's were instructed to chart as completed every day every shift). The CNAs did not document the time of splint/brace application or removal and did not document the application of the right-hand splint on 1/22/25. An interview was conducted on 1/29/25 at 1:57 p.m. with the Director of Rehabilitation (DoR). The DoR stated Resident #31 did wear an elbow and hand splint, and the rehab department was working on a process, the rehab tech puts on splints daily for all residents. She stated the facility had started the process for the rehab tech a week or two ago. The DoR stated the tech took them off at 4 hours that way they are put on and off at the right times and did not have a scheduled time braces were put on, the tech documented on paper, had issue with (computer) access but was fixed yesterday. Review of the policy - Range of Motion, undated, showed The purpose of this procedure is to exercise the resident's joints and muscles. 1. Verify that there is a physician's order for this procedure. If there is no order for treatment, contact attending physician to obtain treatment orders. (Note: Document the receipt of telephone orders in the resident's medical record.) 2. Review the resident's care plan to assess for any special needs of the resident. The policy instructed staff to Report other information in accordance with facility policy and professional standards of practice. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy - Specialized Rehabilitative Services, revised December 2009, showed Our facility will provide rehabilitative services to residents as indicated by the Minimum Data Set (MDS). 1. In addition to rehabilitative nursing care, the facility provides specialized rehabilitative services by qualified professional personnel. 2. Specialized rehabilitative services include the following: a. Physical therapy; b. Speech pathology/audiology; c. Occupational/activity therapy; 3. Therapeutic services are provided only upon written order of the resident's attending physician. 4. Only licensed or certified personnel who are registered to provide specialized therapy or rehabilitative services will be permitted to perform such services. 5. Once a resident has met his/ her care goals, a licensed professional can either discontinue treatment or initiate a maintenance program which either nursing or certified nurses' aides will implement to ensure that the resident maintains his/ her functional and physical status.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, record reviews, and interviews, the facility failed to ensure urinary drainage bags and tubing for two (#91 and #18) of 16 residents with urinary catheters were stored in a manner to prevent infections. Findings included: 1. On 1/27/25 at 1:46 p.m., Resident #91 was observed sitting in a wheelchair in the unit's common area. The resident's urinary drainage bag was hanging from the wheelchair frame under the seat with the catheter tubing lying on the floor. Staff O, Registered Nurse (RN) confirmed the tubing was dragging on the floor as the staff member began to assist the resident into the unit's shower room to adjust the tubing. Review of Resident #91's Admission Record revealed the resident was admitted on [DATE] and included diagnoses not limited to presence of urogenital implants and other retention on urine. Review of Resident #91's January Treatment Administration Record (TAR) revealed staff were to ensure the resident had a securing device for urinary catheter, were to perform urinary catheter care with soap and water every shift, and to change urinary catheter bag and tubing as needed for blockage or signs of infection. 2. On 1/28/25 at 8:58 a.m., Resident #18's was observed lying in bed. The observation revealed the resident's urinary drainage bag was on the floor and under the over-bed table. Staff R, Certified Nursing Assistant (CNA) entered the room at the time of the observation and stated no ma'am the bag is supposed to be below the bladder but not on the floor. The staff member hung the bag from the bed frame and reiterated the bag was not to be on the floor. Review of Resident #18's Admission Record revealed the resident was admitted on [DATE] and readmitted on [DATE] and 1/4/25. The record included diagnoses not limited to infection and inflammatory reaction due to indwelling urethral catheter subsequent encounter, other obstructive and reflux uropathy, and unspecified hematuria. Review of Resident #18's January Treatment Administration Record revealed staff were to ensure the resident had a securing device for urinary catheter every shift, perform urinary catheter care with soap and water every shift, and to change urinary catheter bag and tubing as needed for blockage or signs of infection. During an interview on 1/30/25 at 4:54 p.m., the Director of Nursing/Infection Preventionist stated urinary bags should not be on the floor. Review of the policy - Urinary Catheter Care, undated revealed The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. The policy did not reveal how the drainage bag should be stored however instructed staff to main infection control standards.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on observation, record review and interview, the facility failed to ensure a physician order was available prior to providing oxygen administration for one resident (#150) of three residents reviewed for oxygen administration. Findings included: An observation on 01/27/25 at 11:00 a.m., revealed an oxygen concentrator with nasal cannula hanging from the concentrator located at Resident #150's bedside. Review of the Admission Record showed Resident #150 was admitted to the facility on [DATE] with diagnoses that included but not limited to Chronic Obstructive Pulmonary Disease (COPD), unspecified, ataxia, heart failure and major depressive disorder, recurrent, moderate. Review of the physician orders showed no current physician order for oxygen administration. Review of the care plan showed Focus- [Resident #150] has a potential for complications of respiratory distress related to dx (diagnosis) of: COPD and [head of bed] HOB elevated becomes shortness of breath while lying flat. Goal: - Resident will be able to maintain patent airway and will not exhibit signs of respiratory distress daily thru next review Interventions: - Administer medications as ordered; observe for effectiveness and for [side effects] SEs. - Nebulizer/inhaler treatments as ordered; observe for effectiveness - [oxygen] O2 sats (saturations) as ordered. Administer O2 as ordered. - Perform lung sounds / respiratory assessment as needed - Elevate [head of bed] HOB >30 degrees to minimize SOB - Observe for [sign and symptoms] sx/sx of respiratory infection; update physician if noted. - Observe for [sign and symptoms] sx/sx of respiratory distress; update physician if noted. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Nurses Note dated 01/06/25 showed, [immediate check x-ray] STAT CXR 2 view ordered in shift for residents noted to have congestion with coughing and low grade fever noted. Skin is hot to touch. Resident did have Nebulizer Albuterol treatments in shift as needed with good effect as resident states able to breathe better after each treatment completed. Sleeping in bed at this time. Oxygen tank placed in room as needed for saturation levels below 89%. During an interview on 01/28/24 at 11:50 a.m., Resident #150 stated he was just recently started on oxygen, about a couple weeks ago. Resident #150 stated he obtained oxygen therapy through the nasal cannula at night. Resident #150 stated no one else touched his oxygen concentrator and that he put his oxygen via nasal cannula on at night and took it off himself in the mornings. During an interview on 01/29/25 09:43 a.m., the Director of Nursing (DON) stated there should always be a physician order prior to administering residents' oxygen. The DON stated the physician order was what informed staff how many liters of oxygen the concentrator should be set on, the frequency in which the resident should receive oxygen and in what form the oxygen should be obtained such as nasal cannula or mask. The DON confirmed there was no physician order for Resident #150 to receive oxygen therapy even though Resident #150 was provided with oxygen therapy that started on 01/06/25 as noted in the Nurses Note dated 01/06/25. Review of the facility's policy Oxygen Administration not dated showed, Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105140	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bristol Care Center	1818 E Fletcher Ave Tampa, FL 33612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 46234 Based on observations, interviews and record review, the facility failed to ensure the medication error rate was less than five percent. Twenty-nine medication administration opportunities were observed, and four errors were identified for two residents (#135 and #220) out of five residents observed. These errors constituted a 13.79% medication error rate. Findings included: 1. On 01/29/25 at 9:15 a.m., an observation was made of Staff G, Licensed Practical Nurse, (LPN). Staff G dispensed the following medication for Resident #135: - Calcium Carbonate 750 milligram (mg) chew tablet Upon entering the resident room, Resident #135 was alert. Staff G administered the medication, performed hand hygiene, and exited the room. Review of Resident #135's Active orders revealed the following order related to the observed administration of medications: - Calcium Carbonate Oral Tablet 600 mg (Calcium Carbonate) Give 1 tablet by mouth one time a day for supplement On 01/30/25 10:50 a.m., an interview with the Director of Nursing (DON) was conducted. She stated during medication administration, nurses utilized the Medication Administration Record (MAR) to compare and made sure medications being pulled and given matched what the order was on the MAR. It would not be appropriate to sign off on medications showing that they were administered when they were not given. 2. An observation was conducted on 1/28/25 at 9:37 a.m. of medication administration with Staff F, LPN. Staff F was observed preparing the following medications for Resident #220: -Fluoxetine 60 mg x 1 tablet -Fluoxetine 10 mg x 1 tablet -Bupropion HCL SR 150 mg x 1 tablet -Amlodipine 10 mg x 1 tablet -Docusate Sodium 100 mg x 1 tablet -Loratadine 10 mg x 1 tablet -Fluticasone Propionate and Salmeterol 250 mcg/50 mcg x 1 puff. (continued on next page)

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	105140	A. Building B. Wing	01/30/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Flonase 2 sprays each nostril Review of Resident #220's MAR showed Staff F, LPN also signed off Metoprolol 50 mg, Omeprazole 20 mg, and Metformin HCL 100 mg as given during medication administration, however, those medications were not observed. Review of Resident #220's physician orders showed Fluoxetine 60 mg x 1 tablet, Fluoxetine 10 mg x 1 tablet, Bupropion HCL SR 150 mg x 1 tablet, Amlodipine 10 mg x 1 tablet, Docusate Sodium 100 mg x 1 tablet, Loratadine 10 mg x 1 tablet, Fluticasone Propionate and Salmeterol 250 mcg/50 mcg x 1 puff, Flonase 2 sprays each nostril, Metoprolol 50 mg x 1 tablet, Omeprazole DR 20 mg x 1 tablet, and Metformin HCL 1000 mg x 1 tablet were all scheduled to be given at 9:00 a.m. An interview was conducted on 1/28/25 at 12:25 p.m. with Staff F, LPN. She reviewed Resident #220's medication orders and said the Metoprolol, Omeprazole, and Metformin were the last three medications listed, and they showed up on a different screen. Staff F said I didn't go over and click on the next screen and I didn't do that. Oh no. Staff F said she went back later and gave those three medications. When told the times would be verified on the Medication Admin Audit Report, Staff F then said oh they may show up at the same time. I clicked on them and just didn't give them. I went back and gave them. When asked to clarify what she said previously about not going to the last screen and not seeing those three medications during the medication administration that was observed, Staff F said, Oh I don't know. Review of Resident #220's Medication Admin Audit Report for 1/28/25 showed all the medications listed above, including the three that were not administered were signed off as given at 10:06 a.m. on 1/28/25 during the observed medication administration. Review of a facility policy titled Administering Medications, revised April 2019, showed: Policy Statement Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 4. Medications are administered in accordance with prescriber orders, including and required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience. 6. Medications can be administered within one (1) hour before or after their prescribed time, unless otherwise specified. 10. The individual administer the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	18. If a medication is withheld, refused, or administered outside the scheduled time, the person giving the medication must document this in the medical record. 51097