

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Park Meadows Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3250 SW 41st Place Gainesville, FL 32608	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>40559</p> <p>Based on observation, interview, and record review, the facility failed to provide a clean, orderly, and comfortable environment in two of six shower rooms and in the memory care unit (Photographic evidence obtained).</p> <p>Findings include:</p> <p>1) During an interview on 10/14/2024 at 9:55 AM, Resident #121 stated, The shower rooms are always dirty and full of mold.</p> <p>During an observation on 10/15/2024 at 2:00 PM, there was a black substance in a circular pattern on the ceiling over the shower area and a brown discoloration on the ceiling leading to the shower area in the 100 Hall Shower Room.</p> <p>During an observation on 10/15/2024 at 2:45 PM, there was a line of black substance spots on the ceiling over the area leading into the shower in the 500 Hall Shower Room.</p> <p>During an interview on 10/15/2024 at 2:46 PM, the Maintenance Director stated he was not aware of the black substance on either of the shower ceilings.</p> <p>2) During an observation on 10/15/2024 at 10:00 AM, the hallway exterior exit door had a large piece of plywood attached to where glass would have been in the memory care unit. There was an approximately a 2-inch gap between the plywood and the metal door frame at the bottom of the door, which was open to the outside.</p> <p>During an observation on 10/15/2024 at 2:15 PM with the Maintenance Director and the Housekeeper Supervisors, the door in the memory care unit had a gap between the plywood and the metal door frame at the bottom of the door.</p> <p>During an interview on 10/15/2024 at 2:15 PM, the Maintenance Director stated he was not aware that the duct tape that he had placed on the bottom of the wood had come off. He verified there was a gap between the wood and the doorframe, which was open to the outside.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy and procedure titled Maintenance Work Order System reviewed on 1/31/2024 showed it read, Guidelines: To establish an effective means of requesting, coordinating and completing maintenance of a corrective nature . Procedure . On a daily basis, the Director Plant Operations/designee will assign Work Requests to personnel and review completed work orders for completeness and correctness of repairs and/or the need for purchase or outside assistance.</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free from neglect by failing to implement the policies and procedures for neglect for 1 (Resident #45) of 10 residents reviewed for nutrition. Resident #45 had a physician's order for a mechanical soft diet. On 10/15/2024 at 12:20 PM, Resident #45 was sitting in the dining room. Resident #45 requested an alternative food item from Staff J, Licensed Practical Nurse. Staff J went to the kitchen and returned with a hotdog and hotdog bun on a plate. Resident #45's diet was not verified in the kitchen. Staff I, Registered Nurse, stated to Staff J Resident #45 was not supposed to have a hotdog. Neither Staff I nor Staff J removed the food item after identifying the error. Staff I again instructed Staff J Resident #45 was not supposed to have a hotdog. Staff I and Staff J did not remove the food item. Staff K, Certified Nursing Assistant cut the hotdog in half for Resident #45 to consume.</p> <p>The facility's failure to implement their policies and procedures for neglect when Resident #45 was identified to have been served a food that did not meet the physician ordered diet and the food item was not removed led to the determination of Immediate Jeopardy at a scope and severity of isolated, (J). The Nursing Home Administrator was notified of the Immediate Jeopardy on November 13, 2024, at 5:25 PM. The Immediate Jeopardy began on October 15, 2024, and was removed on site on November 13, 2024.</p> <p>Findings include:</p> <p>During an observation on 10/15/2024 at 12:20 PM, Resident #45 was sitting in the common dining room. Resident #45 called Staff J, Licensed Practical Nurse (LPN), and asked to have something else to eat than what had been served to him. Staff J went to the kitchen and returned with a hotdog and hotdog bun on a plate. Staff J placed the plate in front of Resident #45 and Staff I, Registered Nurse (RN), stated to Staff J Resident #45 was not supposed to have a hotdog. Staff J did not remove the food item. Staff I mentioned again Resident #45 should not have a hotdog. Neither Staff I nor Staff J removed the food item. Resident #45 picked up the hotdog and put it in his mouth. Resident #45 placed the hotdog back down on the plate without chewing or swallowing any pieces of the hotdog. Staff K, Certified Nursing Assistant (CNA), came over and cut the hotdog in half. Resident #45 grabbed one of the halves and placed it in his mouth. Resident #45 placed the half of the hotdog back down on the plate without chewing or swallowing any portion of the hotdog.</p> <p>Review of Resident #45's medical record showed the resident was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, diastolic (congestive) heart failure, generalized muscle weakness, other reduced mobility, unspecified protein-calorie malnutrition, metabolic disorder, adjustment disorder with anxiety, chronic or unspecified gastric ulcer with hemorrhage, disorder of adult personality and behavior, type 2 diabetes mellitus without complications, gastro-esophageal reflux disease without esophagitis, and legal blindness.</p> <p>Review of Resident #45's physician order dated 7/9/2024 read, CCHO [Controlled Carbohydrates] diet, Mechanical Soft texture, thin consistency for nutrition and hydration.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #45's Speech Therapy SLP [Speech Language Pathology] Evaluation & Plan of Treatment dated 9/30/2023 read, Current Referral. Reason for Referral: Patient referred to ST [Speech Therapy] due to new onset of decreased oral function, risk for aspiration, decreased functional activity tolerance and dysphagia indicating the need for ST to analyze oral/pharyngeal function, minimize aspiration/risk of, develop & instruct in compensatory strategies, assess and determine least restrictive diet and design and implement strategies. Resident on a regular diet with thin liquids upon discharge to the hospital. He returned on a puree diet with thin liquids. Resident exhibiting a significant weight loss of 15.5% over the last 4 months . Objective tests/measures & additional analysis . additional analysis: Other: [NAME] Assessment of Swallowing Ability) administered with a score of 176 indicating mild dysphagia; however, resident is exhibiting a severe deficit with oral phase of swallow . Assessment Summary: Skilled Justification: Reason for Skilled services: Skilled SLP services for dysphagia are warranted to analyze oral/pharyngeal function, develop & instruct in compensatory strategies, minimize risk of weight loss with swallow analysis, assess and determine the least restrictive diet and design and implement strategies in order to enhance patient's quality of life by improving ability to meet primary nutrition/hydration needs, efficiently consume least restrictive diet, safely consume least restrictive diet, improve oral transit time and use strategies/compensatory techniques. Risk factors: Due to the documented physical impairments and associated functional deficits, the patient is at risk for: aspiration and weight loss.</p> <p>Review of Resident #45's Speech Therapy Treatment Encounter Notes dated 10/10/2023 read, Swallow Tx [treatment]: instructions in altering liquids/solids to increase pharyngeal clearance, analysis of /instruction in presentation techniques to increase safety & nutrition, modification to bolus sizes and order/method of food/liquid presentation and facilitation of body positioning to increase safety with intake. Swallow Tx: techniques to improve safe & efficient nutrition/hydration, analysis of diet texture to increase oral intake, therapeutic trial feedings to increase safety and development & training in use of compensatory strategies. Trial of mechanical soft consistency presented with modifications to bolus size and rate of intake. Resident is declining to eat puree diet consistency per nursing. Resident able to consume mechanical soft consistency without any s/s [signs/symptoms] of deficit in pharyngeal phase of swallow.</p> <p>During an interview on 10/16/2024 at 11:53 AM, Staff I, RN, stated, [Resident #45's name] has a mechanical soft diet. Cutting the hotdog in half does not make it a mechanical soft diet. I am not sure if the cook said it was okay or not when she [Staff J] went to get it from the kitchen.</p> <p>During a telephonic interview on 10/17/2024 at 1:13 PM, Staff J, LPN, stated, He [Resident #45] asked me to get him another plate and I asked him what he wanted. He said maybe a hamburger or something like that. I went to the kitchen and told the cook I need an alternate and I mentioned his name. The cook, I do not remember who it was, told me he had no hamburger, and they gave me a hotdog. I brought it out and [Resident #45's name] started eating the hotdog without a problem. When I turned around the nurse [Staff I] told me he [Resident #45] could not have a hotdog. I just didn't want to grab his plate. I just froze and kept looking at [Resident #45's name]. He finished the hotdog without a problem. I did not grab the plate because I did not want to make a big commotion.</p> <p>During an interview on 10/17/2024 at 1:28 PM, Staff K, CNA, stated, Residents' diets sometimes change. I saw him [Resident #45] sitting around and I went to help him out so [Resident #45's name] could start eating. I thought I cut it in multiple pieces for him to be able to eat it. Cutting the hotdog does not make it a mechanical soft diet. Usually, they have a ticket. I did not see a ticket next to him. I did not pay more attention to his meal.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/12/2024 at 8:36 AM while discussing Resident #45's therapeutic diet, the Administrator stated, We put the fault in every department. The issues came from the dining room, but the kitchen could have stopped it.</p> <p>During an interview on 11/12/2024 at 8:44 AM, Staff I, RN, stated, I think I was a little overwhelmed and had a lot going on and when I told her [Staff J] No, he should not have it [referring to the hotdog meal served], nothing was done. I assumed she was going to take it away the second time I told her. It was busy. I would have taken it away, but I was doing a million things reading the tickets and handing out the meals, and I was just overwhelmed. When I noticed the second time, he [Resident #45] had the meal in front of him that I told her he should not have. I told her [Staff J] a second time. She turned around and looked at me and she heard what I said. I assumed she was going to take it from him [Resident #45]. Looking back, I should have owned it and removed his plate instead of expecting someone to do it. Some potential risk for the resident would be choking. You can say that about any resident but for him, he is at a higher risk. I would not say aspiration.</p> <p>During an interview on 11/12/2024 at 9:20 AM, Staff R, Speech Therapist, stated, If a resident is mechanical soft, they should not be given a meal outside of their recommendations. There is a possibility of coughing, choking, and aspiration. Depending on the health status of the person, there is a risk of aspiration pneumonia and an increased risk of hospitalization .</p> <p>During an interview on 11/12/2024 at 9:37 AM, Staff Q, Cook, stated, We were serving the lunch line. A nurse came in asking for an alternate regular tray. I asked her who it was for and what the diet was. She said it was a regular diet for the dining room. I finished serving more on the line and remembered she was still there, and I gave her the hotdog. After that I realized she didn't say who it was for, but she never came back in, and I finished serving the lunch line. She did not have a meal ticket with her.</p> <p>During an interview on 11/12/2024 at 9:51 AM, the Food Service Director stated, Our procedure is that staff is informed to ask if they have a diet ticket and if they do not have the diet ticket, we ask for the name and room number and look in the book. If they are not in the book, they need to go to the nurse to verify. The book is updated daily. The nurse did not have a slip and at that time, the procedure was not followed that day. It has always been that way. We are to check for the diet and name, and it was just very chaotic that day and the nurse was just amending with the hotdog. Choking can be a concern if a mechanical soft diet resident gets a hotdog or any diet that is a regular diet. The food should not be placed in front of the resident until the nurses find out the proper diet for the residents.</p> <p>During an interview on 11/12/2024 at 9:56 AM, Registered Dietitian #1 stated, A resident who is on a mechanical soft diet should not get a whole hotdog not without being mechanically altered. Mechanically altered food particles should be reduced to less than one half of an inch or less. Choking is a potential harm they can face and/or aspiration. My expectation is if the staff has a misunderstanding or disagreement, the staff should pause and verify the correct diet and ask the resident not to consume the food.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/12/2024 at 10:15 AM, the Director of Nursing (DON) stated, The staff should know the patient diet and who it is for and the room number. Whoever is in the kitchen should verify looking at the person's ticket to make sure the diet is correct. I feel it was a breakdown of that individual. If she [Staff I] told her [Staff J] from the beginning that was not his [Resident #45's] diet, she should have taken the plate away from him or not even put it in front of the resident. If it was me as the RN, I would have taken it from him and had the LPN step out of the dining room and later address the incident with the staff. The LPN should have verified the diet before giving the resident the alternate. The nurses are responsible for making sure residents are taken care of safely.</p> <p>During an interview on 11/12/2024 at 10:26 AM, the Administrator stated, After all the investigation, it was an individual staff mistake. The RN herself who saw the situation and she did not act either. The food should have been taken away immediately from the resident. They are supposed to get the slip and get the diet order and mention who the patient was and say what the patient needs and what diet they were supposed to be. I know it was a [NAME] day, but that is no excuse at all. The staff was not recognizing the mistake and the level it can reach. This was the policy prior to the event.</p> <p>During an interview on 11/12/2024 at 12:12 PM with the Administrator, when asked if identifying the wrong diet order served and not removing the meal was neglectful behavior, the Administrator stated, We took it as both ways because no action happened. We worked the event as a near miss.</p> <p>During an interview on 11/12/2024 at 12:13 PM, the Regional Nursing Consultant stated, We worked it as a near miss like if someone had a medical error. If we reported every near miss med error or error, we would be doing that every day. This was a [NAME] employee. A nurse who failed to act.</p> <p>During an interview on 11/12/2024 at 12:40 PM, the Registered Dietitian #1, stated, Choosing the word neglect makes it hard to answer since it's a legal term. Would I consider this a mistake or not following the procedure, yes. I do not feel comfortable answering and using that kind of language. A mistake is anything that occurs that is outside the realm of norm, deviation from the norm. I consider the staff giving the wrong diet order and identifying it was the wrong diet order and not doing anything to correct it would be considered a mistake. It falls under the definition I gave you of a deviation from the norm. It was a clinical error. He was a mechanical soft diet at that time.</p> <p>During an interview on 11/12/2024 at 12:45 PM with the Food Service Director, when asked if not removing a food item after identifying it was a wrong diet would this be considered neglectful, the Food Service Director stated, I do not feel comfortable answering the question.</p> <p>During an interview on 11/12/2024 at 1:32 PM, the Medical Director stated, I was notified of the incident. To be honest, it depends on the amount of dysphagia the patient has. This resident [Resident #45] has mental issues and will do things he is not supposed to do. He is followed by the speech therapist. A potential harm outcome all depends on the resident. He was a patient with failure to thrive and has improved. I understand your question if it was a weak patient or had dysphagia, it could cause aspiration pneumonia. When asked if the nurse's inaction after identifying the incorrect diet order and not removing the tray was neglectful, the Medical Director stated, I would consider this to be a situation with a nurse that needs to be suspended and educated.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the written statement authored by Staff J, LPN, dated 10/15/2024 read, Assisting in the Dining Rm [room] for lunch. [Resident #45's initials] had the ravioli and string beans but was asking for an alternative. He requested a hot dog. I had gotten the hot dog from the kitchen and brought it to the table. Took the hot dog and added condiments as per his request. The CNA, then cut up the hotdog for him to eat. Resident had eaten the hot dog without any difficulties. He was not coughing. Resident had same meal as everyone else therefore, I thought that he had a regular meal also. I stayed to observe the table to make sure he had no swallowing issues and no signs or symptoms of aspiration. When I realized I had made a mistake I panicked and did not remove the resident's food because I saw the surveyor standing there watching me and I did not want to raise any red flags by taking his food back, I felt as though she would sense something was wrong and I would cause more harm than good.</p> <p>Review of the written statement authored by Staff J, LPN, dated 10/16/2024 read, Yesterday I was asked to assist in the dining room, due to the increase in the resident population during lunchtime. Resident observed a fellow resident having a hot dog and decided that he would like to have one as well. I proceeded to the kitchen and requested a hot dog platter from the kitchen staff. I returned the plate to the residents' request; I then gave the resident condiments and the RN that was present pointed out that the resident was on a mechanical diet. Residents' meal was properly mechanicalized prior to him eating.</p> <p>Review of Employee Statement/ Interview Record authored by Staff I, RN, dated 10/16/2024 read, Date of Event 10/16/2024 . [Resident #45's name] requested alternative for lunch during lunch time in the dining room. Other LPN in dining room brought resident a full hotdog w/ [with] bun. Before she brought it to him and sat it in front of him I told he can't have it b/c [because] he is MS [Mechanical Soft] diet. She looked at me then looked at the state woman standing in the corner and moved to grab a cart. I was running plates and assisting other residents upon returning to food counter LPN began putting mustard on hotdog for resident [Resident #45's name] I said again he cannot have that he is mechanical soft you need to take it. LPN looked at me a slightly shrugged shoulder. I was called away again and when I returned a bite was taken out of [Resident #45's name] hotdog and he had it in his hands. LPN was gone resident [Resident #45's name] left dining room soon after.</p> <p>Review of the written statement authored by Staff Q, Cook, dated 10/16/2024 read, On October 15 between 12:30-12:45 pm I was serving the lunch line. A nurse came in saying she needed a hotdog. We asked who for? She said she needed it for the dining room. We asked what their diet was and she said she didn't know. I made the hotdog and then handed it to her.</p> <p>During an interview on 11/13/2024 at 9:57 AM, the Administrator stated, Part of the incident after looking at it, yes it was neglectful behavior. To me, neglect is the unwillingly action made against somebody. Since the staff was told twice, she should have removed it.</p> <p>During an interview on 11/13/2024 at 10:08 AM, the Medical Director stated, Neglect to me is to do something that would harm a patient on purpose. In this case, it was a request from a patient. Even if they have a lower BIMS [Brief Interview for Mental Status] than usual or dementia, but they understand they can ask and we have to respect them. We would consider those pleasure feed. Another staff tried to resolve the issue by cutting the hotdog.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/13/2024 at 12:01 PM, the DON, stated, Neglect is intentionally not taking care of the patient. A dietary scenario that would be considered neglect would be not making sure that a patient got a meal. Referring to the two nurses not providing the best care for the patient, that would be neglect. We should have followed through.</p> <p>During an interview on 11/13/2024 at 12:20 PM, Food Service Director stated, The residents have the right to good and services. Basically, the situation that happened in the dining room with [Resident #45's name] and that nurse not removing the tray is considered neglect because it can possibly do harm to the resident.</p> <p>During an interview on 11/13/2024 at 12:26 PM, Registered Dietician #1, stated, [Neglect is] The failure to provide goods and services as deemed medically necessary. I would consider the case you are here for neglect. I did not want to answer it yesterday until I was completely familiar with the situation and all the definitions.</p> <p>Review of the facility policy and procedure titled Nutrition and Hydration Assistance with the last review date of 1/31/2024 read, Policy: It will be the policy that this facility will provide the level of assistance required to the residents while maintaining their highest practicable level of function and personal preferences. Staff will help ensure residents receive adequate assistance and provision of services for nourishment and hydration.</p> <p>Review of the facility policy and procedure titled Provide Diet to Meet Needs of Each Resident with the last review date of 1/31/2024 read, Policy: The purpose of the food and nutrition services (FNS)/dietary department is to provide high quality, nutritious, palatable and attractive meals in a safe, sanitary manner. Food will be prepared in a form to accommodate resident allergies, intolerances and personal, religious and cultural preferences, based on reasonable effort. Therapeutic diets will be served as prescribed by the attending physicians or their designee.</p> <p>Review of the facility policy and procedure titled ANE [Abuse, Neglect, Exploitation] and Investigations with the last review date of 1/31/2024 read, Policy: It will be the policy of this facility to honor residents' rights and to address with employees the seven (7) components regarding mistreatment, abuse, neglect, sexual misconduct, injuries of unknown source, involuntary seclusion, corporal punishment, misappropriation of resident property or funds or use of physical or chemical restraints not required to treat their resident symptoms in accordance with Federal Law. It will be the policy of this facility to ensure that all alleged violations of Federal or State laws, which involve mistreatment, neglect, abuse (verbal, mental, physical or sexual), injuries of undetermined source, involuntary seclusions, corporal punishment, misappropriation of resident property or funds or use or physical or chemical restraint not in accordance with regulation to treat resident symptoms to be reported immediately to the Administrator/DNS [Director of Nursing Services]/Abuse Coordinator/designee. Appropriate agencies will be notified in accordance with existing laws . Definitions . Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy and procedure titled Accidents and Supervision with the last review date of 1/31/2024 read, Policy: The resident environment will remain as free of accident hazards as is possible. Each resident will receive supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary. Definitions . Hazards refers to elements of the resident environment that have the potential to cause injury or illness . Supervision/Adequate/Supervision refers to intervention and means of mitigating risk of an accident . Procedure: The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. 1. Identification of Hazards and Risks - the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. a. The facility should make a reasonable effort to identify the hazards and risk factors for each resident . 5. Supervision - Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents.</p> <p>The Immediate Jeopardy (IJ) was removed on site on 11/13/2024 after the receipt of an acceptable IJ removal plan. The facility has completed the following steps to remove the immediate jeopardy. On 10/16/2024, Resident #45 was re-evaluated by the licensed nurse and the speech therapist. On 10/16/2024, Resident #45's chest x-ray was completed. On 10/16/2024 and on 11/13/2024, residents were interviewed regarding abuse and neglect, and skin evaluations for residents who are not able to be interviewed were carried out to identify abuse or neglect. On 10/16/2024, facility-wide reconciliation of the dietary system/tray tickets with physician orders were carried out. On 10/16/2024, the DON provided training and education to the dietary staff and nursing staff on providing the diet to meet the residents' needs, nutrition and hydration assistance, and accuracy of diet. On 10/17/2024, a root cause analysis was conducted and Ad Hoc [from the Latin and means for this] Quality Assurance and Performance Improvement (QAPI) meeting was held to review the concerns related to accuracy of diets. On 11/12/2024, the facility Administrator, Director of Nursing, and Regional Nursing Consultant were educated by the Chief Nursing Officer Consultant on the components of abuse, neglect, exploitation, and injury of unknown origin to include reporting requirements. On 11/12/2024, a performance improvement plan for abuse and neglect was developed and executed with the QAPI Committee and Medical Director. On 11/12/2024, an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was convened to review the Removal of Immediate Jeopardy draft plan and added daily alternate diet audit form to track alternate diet check process to ensure accuracy of diets after alternative diet is requested after meal delivery. By 11/13/2024, 227 out of 233 facility staff members (112 out of 112 certified nursing assistants, 37 out of 38 licensed practical nurses, 14 out of 15 registered nurses, and 16 out of 16 dietary staff members) were reeducated on the accuracy of diets and abuse, neglect, exploitation, and injury of unknown origin. Beginning 10/18/2024, the facility administration will ensure that the safety and well-being as it relates to accuracy of diets is maintained by continued participation, evaluation and intervention through clinical standup review of 24-hour report to identify change in condition, and maintaining QAPI process.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #45's records showed the resident was evaluated on 10/16/2024 by X-Ray with no focal consolidation, effusion or pneumothorax. Review of Resident #45's SLP evaluation showed the resident was evaluated for oral and pharyngeal swallow function on 10/16/2024. Review of the facility records showed the facility completed interviews and skin checks with all residents for identification of abuse/neglect on 10/16/2024 and 11/13/2024. Review of Order Listing Report showed the Registered Nursing Consultant completed reconciliation of the dietary system with physician orders on 10/16/2024. Review of Education In-service Attendance Record showed the staff members received training through SNF Clinic on mechanically altered diets, accuracy of diet, and importance of correct diet orders, and on abuse and neglect by 11/13/2024. During staff interviews completed on 11/13/2024, two RNs, two LPNs, three CNAs, two therapy staff, five dietary staff, and Social Services Assistant verified having received education and verbalized understanding on abuse/neglect and accuracy of diets.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523</p> <p>Based on observation, interview, and record review, the facility failed to implement a comprehensive care plan for 1 of 4 residents reviewed for falls, Resident #43, and failed to develop a comprehensive care plan for 1 of 3 residents reviewed for activities of daily living, Resident #119.</p> <p>Findings include:</p> <p>1) During an observation on 10/14/2024 at 9:38 AM, Resident #43 was lying in bed, with one fall mat on the left side of the bed in place.</p> <p>During an observation on 10/16/2024 at 4:50 AM, Resident #43 was sleeping in bed comfortably. There was one fall mat on the left side of the bed.</p> <p>Review of Resident #43's physician order dated 6/1/2023 read, Floor mats to both sides when resident in bed every day and evening shift.</p> <p>Review of Resident #43's care plan initiated on 12/13/2022 read, Focus: [Resident #43's name] is at risk for falls and/or fall related injury r/t [related to]: generalized weakness . Interventions: Floor mats to sides of bed.</p> <p>During an observation on 10/16/2024 at 8:32 AM with Staff C, Registered Nurse (RN), Resident #43 was lying in bed, with one fall mat on the left side of the bed.</p> <p>During an interview on 10/16/2024 at 8:35 AM, Staff C, RN, stated, [Resident #43's name] has orders for bilateral fall mats when he is in bed. I will have one of the staff members bring one to put down.</p> <p>During an interview on 10/16/2024 at 12:10 PM, the Director of Nursing (DON) stated, Staff are expected to follow physician orders and the care plan. If it specifies on both sides, then fall mats should be placed on both sides of the bed.</p> <p>50123</p> <p>2) Review of Resident #119's quarterly Minimum Data Set (MDS) dated [DATE] showed that the resident was occasionally incontinent of bowel and bladder under Section H- Bladder and Bowel.</p> <p>Review of Resident #119's physician order showed an order for administration of one Tamsulosin HCl oral capsule 0.4 mg (milligram) by mouth one time a day for urinary retention.</p> <p>During an interview on 10/16/2024 at 12:15 PM, Staff G, RN, stated, If he [Resident #119] doesn't let the CNAs clean him up, I try to intervene.</p> <p>During an interview on 10/16/2024 at 1:00 PM, Staff F, Certified Nursing Assistant (CNA), stated, [Resident #119's name] is usually incontinent and a lot of times he refuses to get cleaned up.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #119's comprehensive care plan revealed no focus for incontinence care.</p> <p>Review of the facility policy and procedure titled Comprehensive Assessments and Care Plans with the last review date of 1/31/2024 read, Standard: It will be the standard of this facility to make a comprehensive assessment of a resident's needs, strengths, goals, life history, and preferences, using the resident assessment instrument (RAI) specified by CMS [Centers for Medicare and Medicaid Services] . Guidelines . 8. The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at S483.10(c)(2) and S483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>46523</p> <p>Based on record review and interview, the facility failed to ensure residents received blood pressure medication as prescribed by physician for 1 of 6 residents reviewed for medication administration, Resident #125.</p> <p>Findings include:</p> <p>Review of Resident #125's physician order dated 3/6/2024 read, Midodrine HCl Tablet 10 MG [milligram], Give 1 tablet by mouth every 8 hours for hypotension, Hold for SBP [Systolic Blood Pressure] greater than 110.</p> <p>Review of Resident #125's Medication Administration Record (MAR) for October 2024 for administration of Midodrine HCl Tablet 10 mg showed the medication was held per parameters on 10/2/2024 at 6:00 AM for the SBP of 101; and the medication was administered on 10/3/2024 at 2:00 PM for SBP of 116, on 10/5/2024 at 2:00 PM for SBP of 122 and at 10:00 PM for SBP of 126, on 10/6/2024 at 2:00 PM for SBP of 124, and at 10:00 PM for SBP of 114; on 10/8/2024 at 2:00 PM for SBP of 127, on 10/10/2024 at 2:00 PM for SBP of 125, and at 10:00 PM for SBP of 123, and on 10/11/2024 at 2:00 PM for SBP of 112.</p> <p>During an interview on 10/16/2024 at 7:12 AM, the Director of Nursing (DON) stated, I reviewed [Resident #125's name] medication record. The medication was given out of parameters. The resident recently went to a cardiology appointment and was fine. It did not have any negative impact on the resident.</p> <p>During an interview on 10/17/2024 at 2:10 PM, the Medical Director stated, The facility notified me, and I reviewed the order and revised the parameters. This would not have had a negative effect on the resident's health. We monitor his blood pressure, and he has been stable.</p> <p>Review of the facility policy and procedure titled Medication Administration with the last review date of 1/31/2024 read, Policy: It will be the policy of this facility to administer medications in a timely manner and as prescribed by the physician, unless otherwise clinically indicated or necessitated by other circumstances such as lack of availability of medication or refusals of medication by the resident.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free from accidents and hazards when residents were served an inappropriate therapeutic diet for 1 (Resident #45) of 10 residents reviewed for nutrition. Resident #45 had a physician's order for a mechanical soft diet. On 10/15/2024 at 12:20 PM, Resident #45 was sitting in the dining room. Resident #45 requested an alternative food item from Staff J, Licensed Practical Nurse. Staff J went to the kitchen and returned with a hotdog and hotdog bun on a plate. Resident #45's diet was not verified in the kitchen. Staff I, Registered Nurse, stated to Staff J Resident #45 was not supposed to have a hotdog. Neither Staff I nor Staff J removed the food item after identifying the error. Staff I again instructed Staff J Resident #45 was not supposed to have a hotdog. Staff I and Staff J did not remove the food item. Staff K, Certified Nursing Assistant cut the hotdog in half for Resident #45 to consume.</p> <p>The facility's failure to provide a safe environment free from hazards when Resident #45 was identified to have been served a food that did not meet the physician ordered diet and the food item was not removed led to the determination of Immediate Jeopardy at a scope and severity of isolated, (J). The Nursing Home Administrator was notified of the Immediate Jeopardy on November 13, 2024, at 5:25 PM. The Immediate Jeopardy began on October 15, 2024, and was removed on site on November 13, 2024.</p> <p>Findings include:</p> <p>During an observation on 10/15/2024 at 12:20 PM, Resident #45 was sitting in the common dining room. Resident #45 called Staff J, Licensed Practical Nurse (LPN), and asked to have something else to eat than what had been served to him. Staff J went to the kitchen and returned with a hotdog and hotdog bun on a plate. Staff J placed the plate in front of Resident #45 and Staff I, Registered Nurse (RN), stated to Staff J Resident #45 was not supposed to have a hotdog. Staff J did not remove the food item. Staff I mentioned again Resident #45 should not have a hotdog. Neither Staff I nor Staff J removed the food item. Resident #45 picked up the hotdog and put it in his mouth. Resident #45 placed the hotdog back down on the plate without chewing or swallowing any pieces of the hotdog. Staff K, Certified Nursing Assistant (CNA), came over and cut the hotdog in half. Resident #45 grabbed one of the halves and placed it in his mouth. Resident #45 placed the half of the hotdog back down on the plate without chewing or swallowing any portion of the hotdog.</p> <p>Review of Resident #45's medical record showed the resident was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, diastolic (congestive) heart failure, generalized muscle weakness, other reduced mobility, unspecified protein-calorie malnutrition, metabolic disorder, adjustment disorder with anxiety, chronic or unspecified gastric ulcer with hemorrhage, disorder of adult personality and behavior, type 2 diabetes mellitus without complications, gastro-esophageal reflux disease without esophagitis, and legal blindness.</p> <p>Review of Resident #45's physician order dated 7/9/2024 read, CCHO [Controlled Carbohydrates] diet, Mechanical Soft texture, thin consistency for nutrition and hydration.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #45's Speech Therapy SLP [Speech Language Pathology] Evaluation & Plan of Treatment dated 9/30/2023 read, Current Referral. Reason for Referral: Patient referred to ST [Speech Therapy] due to new onset of decreased oral function, risk for aspiration, decreased functional activity tolerance and dysphagia indicating the need for ST to analyze oral/pharyngeal function, minimize aspiration/risk of, develop & instruct in compensatory strategies, assess and determine least restrictive diet and design and implement strategies. Resident on a regular diet with thin liquids upon discharge to the hospital. He returned on a puree diet with thin liquids. Resident exhibiting a significant weight loss of 15.5% over the last 4 months . Objective tests/measures & additional analysis . additional analysis: Other: [NAME] [[NAME] Assessment of Swallowing Ability] administered with a score of 176 indicating mild dysphagia; however, resident is exhibiting a severe deficit with oral phase of swallow . Assessment Summary: Skilled Justification: Reason for Skilled services: Skilled SLP services for dysphagia are warranted to analyze oral/pharyngeal function, develop & instruct in compensatory strategies, minimize risk of weight loss with swallow analysis, assess and determine the least restrictive diet and design and implement strategies in order to enhance patient's quality of life by improving ability to meet primary nutrition/hydration needs, efficiently consume least restrictive diet, safely consume least restrictive diet, improve oral transit time and use strategies/compensatory techniques. Risk factors: Due to the documented physical impairments and associated functional deficits, the patient is at risk for: aspiration and weight loss.</p> <p>Review of Resident #45's Speech Therapy Treatment Encounter Notes dated 10/10/2023 read, Swallow Tx [treatment]: instructions in altering liquids/solids to increase pharyngeal clearance, analysis of /instruction in presentation techniques to increase safety & nutrition, modification to bolus sizes and order/method of food/liquid presentation and facilitation of body positioning to increase safety with intake. Swallow Tx: techniques to improve safe & efficient nutrition/hydration, analysis of diet texture to increase oral intake, therapeutic trial feedings to increase safety and development & training in use of compensatory strategies. Trial of mechanical soft consistency presented with modifications to bolus size and rate of intake. Resident is declining to eat puree diet consistency per nursing. Resident able to consume mechanical soft consistency without any s/s [signs/symptoms] of deficit in pharyngeal phase of swallow.</p> <p>During an interview on 10/16/2024 at 11:53 AM, Staff I, RN, stated, [Resident #45's name] has a mechanical soft diet. Cutting the hotdog in half does not make it a mechanical soft diet. I am not sure if the cook said it was okay or not when she [Staff J] went to get it from the kitchen.</p> <p>During a telephonic interview on 10/17/2024 at 1:13 PM, Staff J, LPN, stated, He [Resident #45] asked me to get him another plate and I asked him what he wanted. He said maybe a hamburger or something like that. I went to the kitchen and told the cook I need an alternate and I mentioned his name. The cook, I do not remember who it was, told me he had no hamburger, and they gave me a hotdog. I brought it out and [Resident #45's name] started eating the hotdog without a problem. When I turned around the nurse [Staff I] told me he [Resident #45] could not have a hotdog. I just didn't want to grab his plate. I just froze and kept looking at [Resident #45's name]. He finished the hotdog without a problem. I did not grab the plate because I did not want to make a big commotion.</p> <p>During an interview on 10/17/2024 at 1:28 PM, Staff K, CNA, stated, Residents' diets sometimes change. I saw him [Resident #45] sitting around and I went to help him out so [Resident #45's name] could start eating. I thought I cut it in multiple pieces for him to be able to eat it. Cutting the hotdog does not make it a mechanical soft diet. Usually, they have a ticket. I did not see a ticket next to him. I did not pay more attention to his meal.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/12/2024 at 8:44 AM, Staff I, RN, stated, I think I was a little overwhelmed and had a lot going on and when I told her [Staff J] No, he should not have it [referring to the hotdog meal served], nothing was done. I assumed she was going to take it away the second time I told her. It was busy. I would have taken it away, but I was doing a million things reading the tickets and handing out the meals, and I was just overwhelmed. When I noticed the second time, he [Resident #45] had the meal in front of him that I told her he should not have. I told her [Staff J] a second time. She turned around and looked at me and she heard what I said. I assumed she was going to take it from him [Resident #45]. Looking back, I should have owned it and removed his plate instead of expecting someone to do it. Some potential risk for the resident would be choking. You can say that about any resident but for him, he is at a higher risk. I would not say aspiration.</p> <p>During an interview on 11/12/2024 at 9:20 AM Staff R, Speech Therapist stated, If a resident is mechanical soft, they should not be given a meal outside of their recommendations. There is a possibility of coughing, choking, and aspiration. Depending on the health status of the person aspiration pneumonia and an increased risk of hospitalization .</p> <p>During an interview on 11/12/2024 at 9:37 AM, Staff Q, Cook, stated, We were serving the lunch line. A nurse came in asking for an alternate regular tray. I asked her who it was for and what the diet was. She said it was a regular diet for the dining room. I finished serving more on the line and remembered she was still there, and I gave her the hotdog. After that I realized she didn't say who it was for, but she never came back in, and I finished serving the lunch line. She did not have a meal ticket with her.</p> <p>During an interview on 11/12/2024 at 9:51 AM, the Food Service Director stated, Our procedure is that staff is informed to ask if they have a diet ticket and if they do not have the diet ticket, we ask for the name and room number and look in the book. If they are not in the book, they need to go to the nurse to verify. The book is updated daily. The nurse did not have a slip and at that time, the procedure was not followed that day. It has always been that way. We are to check for the diet and name, and it was just very chaotic that day and the nurse was just amending with the hotdog. Choking can be a concern if a mechanical soft diet resident gets a hotdog or any diet that is a regular diet. The food should not be placed in front of the resident until the nurses find out the proper diet for the residents.</p> <p>During an interview on 11/12/2024 at 9:56 AM, Registered Dietitian #1 stated, A resident who is on a mechanical soft diet should not get a whole hotdog not without being mechanically altered. Mechanically altered food particles should be reduced to less than one half of an inch or less. Chocking is a potential harm they can face and/or aspiration. My expectation is if the staff has a misunderstanding or disagreement, the staff should pause and verify the correct diet and ask the resident not to consume the food.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/12/2024 at 10:15 AM, the Director of Nursing (DON) stated, The staff should know the patient diet and who it is for and the room number. Whoever is in the kitchen should verify looking at the person's ticket to make sure the diet is correct. I feel it was a breakdown of that individual. If she [Staff I] told her [Staff J] from the beginning that was not his [Resident #45's] diet, she should have taken the plate away from him or not even put it in front of the resident. If it was me as the RN, I would have taken it from him and had the LPN step out of the dining room and later address the incident with the staff. The LPN should have verified the diet before giving the resident the alternate. The nurses are responsible for making sure residents are taken care of safely.</p> <p>During an interview on 11/12/2024 at 10:26 AM, the Administrator stated, After all the investigation, it was an individual staff mistake. The RN herself who saw the situation and she did not act either. The food should have been taken away immediately from the resident. They are supposed to get the slip and get the diet order and mention who the patient was and say what the patient needs and what diet they were supposed to be. The staff was not recognizing the mistake and the level it can reach. This was the policy prior to the event.</p> <p>During an interview on 11/12/2024 at 12:40 PM, the Registered Dietitian #1, stated, I consider the staff giving the wrong diet order and identifying it was the wrong diet order and not doing anything to correct it would be considered a mistake. It was a clinical error. He was a mechanical soft diet at that time.</p> <p>During an interview on 11/12/2024 at 1:32 PM, the Medical Director stated, I was notified of the incident. To be honest, it depends on the amount of dysphagia the patient has. This resident [Resident #45] has mental issues and will do things he is not supposed to do. He is followed by the speech therapist. A potential harm outcome all depends on the resident. He was a patient with failure to thrive and has improved. I understand your question if it was a weak patient or had dysphagia, it could cause aspiration pneumonia.</p> <p>Review of the written statement authored by Staff J, LPN, dated 10/15/2024 read, Assisting in the Dining Rm [room] for lunch. [Resident #45's initials] had the ravioli and string beans but was asking for an alternative. He requested a hot dog. I had gotten the hot dog from the kitchen and brought it to the table. Took the hot dog and added condiments as per his request. The CNA, then cut up the hotdog for him to eat. Resident had eaten the hot dog without any difficulties. He was not coughing. Resident had same meal as everyone else therefore, I thought that he had a regular meal also. I stayed to observe the table to make sure he had no swallowing issues and no signs or symptoms of aspiration. When I realized I had made a mistake I panicked and did not remove the resident's food because I saw the surveyor standing there watching me and I did not want to raise any red flags by taking his food back, I felt as though she would sense something was wrong and I would cause more harm than good.</p> <p>Review of the written statement authored by Staff J, LPN, dated 10/16/2024 read, Yesterday I was asked to assist in the dining room, due to the increase in the resident population during lunchtime. Resident observed a fell ow resident having a hot dog and decided that he would like to have one as well. I proceeded to the kitchen and requested a hot dog platter from the kitchen staff. I returned the plate to the residents' request; I then gave the resident condiments and the RN that was present pointed out that the resident was on a mechanical diet. Residents' meal was properly mechanicalized prior to him eating.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Employee Statement/ Interview Record authored by Staff I, RN, dated 10/16/2024 read, Date of Event 10/16/2024 . [Resident #45's name] requested alternative for lunch during lunch time in the dining room. Other LPN in dining room brought resident a full hotdog w/ [with] bun. Before she brought it to him and sat it in front of him I told he can't have it b/c [because] he is MS [Mechanical Soft] diet. She looked at me then looked at the state woman standing in the corner and moved to grab a cart. I was running plates and assisting other residents upon returning to food counter LPN began putting mustard on hotdog for resident [Resident #45's name] I said again he cannot have that he is mechanical soft you need to take it. LPN looked at me a slightly shrugged shoulder. I was called away again and when I returned a bite was taken out of [Resident #45's name] hotdog and he had it in his hands. LPN was gone resident [Resident #45's name] left dining room soon after.</p> <p>Review of the written statement authored by Staff Q, Cook, dated 10/16/2024 read, On October 15 between 12:30-12:45 pm I was serving the lunch line. A nurse came in saying she needed a hotdog. We asked who for? She said she needed it for the dining room. We asked what their diet was and she said she didn't know. I made the hotdog and then handed it to her.</p> <p>Review of the facility policy and procedure titled Accidents and Supervision with the last review date of 1/31/2024 read, Policy: The resident environment will remain as free of accident hazards as is possible. Each resident will receive supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary. Definitions . Hazards refers to elements of the resident environment that have the potential to cause injury or illness . Supervision/Adequate/Supervision refers to intervention and means of mitigating risk of an accident . Procedure: The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. 1. Identification of Hazards and Risks - the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. a. The facility should make a reasonable effort to identify the hazards and risk factors for each resident . 5. Supervision - Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Immediate Jeopardy (IJ) was removed on site on 11/13/2024 after the receipt of an acceptable IJ removal plan. The facility has completed the following steps to remove the immediate jeopardy. On 10/16/2024, Resident #45 was re-evaluated by the licensed nurse and the speech therapist. On 10/16/2024, Resident #45's chest x-ray was completed. On 10/16/2024, facility-wide reconciliation of the dietary system/tray tickets with physician orders were carried out. On 10/16/2024, the DON provided training and education to the dietary staff and nursing staff on providing the diet to meet the residents' needs, nutrition and hydration assistance, and accuracy of diet. On 10/17/2024, a root cause analysis was conducted and Ad Hoc [from the Latin and means for this] Quality Assurance and Performance Improvement (QAPI) meeting was held to review the concerns related to accuracy of diets. On 11/12/2024, an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was convened to review the Removal of Immediate Jeopardy draft plan and added daily alternate diet audit form to track alternate diet check process to ensure accuracy of diets after alternative diet is requested after meal delivery. By 11/13/2024, 227 out of 233 facility staff members (112 out of 112 certified nursing assistants, 37 out of 38 licensed practical nurses, 14 out of 15 registered nurses, and 16 out of 16 dietary staff members) were reeducated on the accuracy of diets. Beginning 10/18/2024, the facility administration will ensure that the safety and well-being as it relates to accuracy of diets is maintained by continued participation, evaluation and intervention through clinical standup review of 24-hour report to identify change in condition, and maintaining QAPI process.</p> <p>Review of Resident #45's records showed the resident was evaluated on 10/16/2024 by X-Ray with no focal consolidation, effusion or pneumothorax. Review of Resident #45's SLP evaluation showed the resident was evaluated for oral and pharyngeal swallow function on 10/16/2024. Review of Order Listing Report showed the Registered Nursing Consultant completed reconciliation of the dietary system with physician orders on 10/16/2024. Review of Education In-service Attendance Record showed the staff members received training through SNF Clinic on mechanically altered diets, accuracy of diet, and importance of correct diet orders by 11/13/2024. During staff interviews completed on 11/13/2024, two RNs, two LPNs, three CNAs, two therapy staff, five dietary staff, and Social Services Assistant verified having received education and verbalized understanding on accuracy of diets.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>46523</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received dietary services as prescribed by physician for 2 of 10 residents reviewed for nutrition, Residents #43 and #128.</p> <p>Findings include:</p> <p>1) During an observation on 10/14/2024 at 12:15 PM, Resident #43 was eating lunch in the common dining room. The resident had a burger cut into four pieces and fruit punch in a glass. There was no frozen nutritional treat.</p> <p>During an observation on 10/15/2024 at 9:01 AM, Resident #43 was eating in his room. There was a glass of orange juice, two pieces of bacon, one boiled egg cut in half and a toast cut into four pieces. There was no frozen nutritional treat.</p> <p>During an observation on 10/15/2024 at 12:17 PM, Resident #43 was eating in the common dining room. The resident had a hot dog with a hot dog bun cut in half and a hash brown cut into sections. There was no drink or frozen nutritional treat.</p> <p>During an observation on 10/16/2024 at 12:10 PM, Resident #43 was eating penne pasta, meatballs, and brussels sprouts with a cup of coffee in the dining room. There was no frozen nutritional treat.</p> <p>Review of Resident #43's physician order dated 9/4/2024 read, Regular diet finger food texture, thin consistency, large portions.</p> <p>Review of Resident #43's physician order dated 9/15/2021 read, Frozen Nutritional Treat with meals for wt [weight] loss.</p> <p>Review of Resident #43's Weights and Vitals Summary showed the resident weighed 147 lbs (pounds) on 9/11/2024 and 149 pounds on 10/8/2024, which is a 1.36% weight gain. The resident weighed 152 lbs on 3/5/2024 and 149 pounds on 10/8/2024, which is a 1.97% weight loss.</p> <p>Review of Resident #43's Nutrition Risk Evaluation dated 9/3/2024 read, Summary: 81 y/o [years old] male for annual review with a dx [diagnosis] of Alzheimer's dementia, feeding difficulties, hypothyroidism, HTN [hypertension], basal cell carcinoma of skin, ESRD [End Stage Renal Disease], dysphagia, OAB [overactive bladder], apraxia, reduced mobility, MDD [Major Depressive Disorder], pain, hx [history of] falls, weakness, mood disorder. Diet is regular finger foods, thin. Intake of meals offered is good. Resident requires assistance with all meals . Snacks TID [three times a day], Frozen Nutritional Treat w [with]/meals, House Nutritional Supplement 180 ml [milliliters] QID [four times a day]. Recent labs reviewed and unremarkable. Skin intact. Recommend maintaining current dietary orders. Continue to monitor and follow prn [as needed].</p> <p>Review of Resident #43's care plan revised on 9/12/2024 read, Focus: [Resident #43's name] is at risk for an alteration in nutrition and/or hydration . Interventions: Finger foods and large portions.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/16/2024 at 9:56 AM, the Registered Dietitian #1 stated, Residents who have large portions order should receive more starch and more vegetables. The nutritional treat comes from the kitchen. It is supposed to show up in the meal ticket. The weight fluctuation [Resident #43's name] is having is expected.</p> <p>50695</p> <p>2) During an observation on 10/14/2024 at 9:40 AM, Resident #128's breakfast meal consisted of scrambled eggs, toast, and one slice of bacon. The drinks served were four ounces of coffee and four ounces of juice.</p> <p>During an interview on 10/15/2024 at 9:39 AM, Resident #128 stated, Dinner is not sufficient. First, they feed us every four hours, so we get used to eating like that. They serve dinner at 5, and sometimes it's just a sandwich, like one piece of ham and a piece of cheese on dry bread. So then, I end up snacking all night. It kind of defeats the purpose.</p> <p>During an observation on 10/16/2024 at 5:40 PM, Resident #128's meal tray consisted of a Polish sausage, a scoop of rice, a scoop of sauerkraut, a small bowl of mixed vegetables, and a small bowl of diced peaches.</p> <p>During an observation on 10/17/2024 at 8:15 AM, Resident #128's bagged lunch, to be sent with the resident to dialysis center, consisted of half of a peanut butter and jelly sandwich, one packaged sugar free cookie, two packaged oatmeal cream cakes, and one 16-ounce bottle of water.</p> <p>Review of Resident #128's Weights and Vitals Summary revealed the resident weighed 155 pounds on 9/10/2024, and 128.2 pounds on 10/10/2024, which is a 17.29% weight loss.</p> <p>Review of Resident #128's post-dialysis weights revealed that the resident weighed 151.8 pounds on 9/10/2024, and 138.4 pounds on 10/12/2024, which is a 8.83% weight loss.</p> <p>Review of Resident #128's Nutrition Risk Evaluation dated 8/5/2024 read, Summary: 47 y/o F [Female] admitted to the facility with a dx of DM2 [type 2 diabetes mellitus], ESRD, dependence on renal dialysis, weakness, COPD [Chronic Obstructive Pulmonary Disease], HTN, chest pain, HPLD [hyperlipidemia], constipation, anemia, reduced mobility, dysphagia, pneumonia. Allergic to cherries, pineapple. Diet is renal/CCHO [controlled carbohydrates], regular, thin. Intakes of meals offered is fair. Feeds self w/ setup. No recent labs currently available during this admission. Skin intact. Resident expressed that she does not wish to receive supplements (e.g. Nepro shake). Recommend double meat/protein with all meals. Continue to monitor and follow prn.</p> <p>Review of Resident #128's physician order dated 7/30/2024 read, Renal CCHO diet. Regular texture, thin consistency, double meat/protein w/ meals.</p> <p>Review of Resident #128's care plan initiated on 7/16/2024 read, Focus: [Resident #128's name] is at risk for an alteration in nutrition and/or hydration . Interventions: Provide diet as ordered. Offer and provide alternate as needed.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/17/2024 at 9:45 AM, the Registered Dietitian #1 stated, A lunch with half of a peanut butter and jelly sandwich is not sufficient to meet the needs of a resident on a diet of double protein/meat.</p> <p>During an interview on 10/17/2024 at 11:05 AM, the Registered Dietitian #2 stated, I last met with [Resident #128's name] on 10/15/2024. Her weight has been ranging from 60-62 kilograms, which I consider to be stable for her. Her dry weight four months ago was 61.5 kilograms, and now her dry weight is 61 kilograms. Her weight on 10/12/2024 was 62.8 kilograms [138.4 pounds]. I don't believe a lunch of half a peanut butter and jelly sandwich is sufficient to meet the protein needs of a dialysis patient.</p> <p>Review of the facility policy and procedure titled Provide Diet to Meet Needs of Each Resident with the last review date of 1/31/2024 read, Policy: The purpose of the food and nutrition services (FNS)/dietary department is to provide high quality, nutritious, palatable and attractive meals in a safe, sanitary manner. Food will be prepared in a form to accommodate resident allergies, intolerances, and personal, religious, and cultural preferences, based on reasonable efforts. Therapeutic diets will be served as prescribed by the attending physicians or their designee. The FNS/dietary department will follow policies and procedures developed in accordance with local, state and federal regulations and will plan, organize, and evaluate all aspects of food and nutrition services. Procedure . 3. To promote optimal nutritional status of each resident through medical nutrition therapy (MNT), in accordance with written orders for nutrition care and consistent with each individual's physical, cultural, and religious needs and personal preferences.</p> <p>Review of the facility policy and procedure titled Nutrition and Hydration Assistance with the last review date of 1/31/2024 read, Procedure: 1. Resident's hydration and nutritional needs are met throughout the day from various sources. A major portion of the total fluids and foods are provided at meal times, either in a dining room setting or on trays served in the rooms.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523</p> <p>Based on record review and interview, the facility failed to provide laboratory services to meet the residents' needs for 1 of 6 residents reviewed for medication review, Resident #86.</p> <p>Findings include:</p> <p>Review of Resident #86's physician order dated 6/18/2024 read, HGBA1C [Hemoglobin A1c], Depakote level Q3 [every three] months.</p> <p>Review of Resident #86's medical record showed no documentation indicating laboratory done in September 2024.</p> <p>During an interview on 10/17/2024 at 9:46 AM, the Director of Nursing (DON) stated, After reviewing the record, the lab was not done on [DATE]. We had them come out today and they draw her blood in the morning today.</p> <p>Review of the facility policy and procedure titled Diagnostics Labs Radiology Notification with the last review date of 1/31/2024 read, Policy: It will be the policy of this facility to provide or obtain timely laboratory, radiology and diagnostic services when ordered by a physician; physician assistant (PA); nurse practitioner (NP) or clinical nurse specialist (CNS) in accordance with State law, including scope of practice laws.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>40559</p> <p>Based on observation, interview, and record review, the facility failed to ensure the served food was at an appetizing temperature.</p> <p>Findings include:</p> <p>During an interview on 10/14/2024 at 10:25 AM, Resident #105 stated, Breakfast trays don't come sometimes until 9:30, instead of 8:00. When it gets here, the food is ice cold.</p> <p>During an interview on 10/14/2024 at 11:15 AM, Resident #109 stated, The food is ice cold when they pass the trays.</p> <p>During the test tray observation on 10/15/2024 at 12:42 PM, food was checked in the presence of Food Service Director in the 100 Hallway. A calibrated thermistor digital thermometer was utilized for the verification of the test tray. Food was placed on the tray and in the cart at 12:10 PM. Insulated cart left the kitchen at 12:14 PM. The test food tray was taken out of the cart as the last resident began to eat at 12:42 PM. There were 20 trays on the cart. Items on the tray included ravioli with meat sauce (temperature: 109 degrees Fahrenheit), Italian green beans (temperature: 89.6 degrees Fahrenheit) and an Italian breadstick.</p> <p>During an interview on 10/16/2024 at 10:03 AM, the Registered Dietitian #1 stated that optimal food temperatures when served to the residents is above 110 degrees Fahrenheit and that the kitchen ensures the food is above 135 degrees when placed on the plates and covered.</p> <p>Review of the facility policy and procedure titled Provide Diet to Meet Needs of Each Resident with the last review date of 1/31/2024 read, Policy: The purpose of the food and nutrition services (FNS)/dietary department is to provide high quality, nutritious, palatable and attractive meals in a safe, sanitary manner. Food will be prepared in a form to accommodate resident allergies, intolerances, and personal, religious, and cultural preferences, based on reasonable efforts. Therapeutic diets will be served as prescribed by the attending physicians or their designee. The FNS/dietary department will follow policies and procedures developed in accordance with local, state and federal regulations and will plan, organize, and evaluate all aspects of food and nutrition services. Procedure . 2. To provide food and drink that is nutritious, palatable, attractive and at a safe and appetizing temperature to meet individual needs. 3. To promote optimal nutritional status of each resident through medical nutrition therapy (MNT), in accordance with written orders for nutrition care and consistent with each individual's physical, cultural, and religious needs and personal preferences.</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523</p> <p>Based on observation, interview, and record review, the facility administration failed to administer the facility in a manner that enables it to use its resources effectively and efficiently to attain and maintain the highest practicable physical well-being of each resident by failing to implement policies and procedures related to neglect and therapeutic diets. Resident #45 had a physician's order for a mechanical soft diet. On 10/15/2024 at 12:20 PM, Resident #45 was sitting in the dining room. Resident #45 requested an alternative food item from Staff J, Licensed Practical Nurse. Staff J went to the kitchen and returned with a hotdog and a hotdog bun on a plate. Resident #45's diet was not verified in the kitchen. Staff I, Registered Nurse, stated to Staff J, Resident #45 was not supposed to have a hotdog. Neither Staff I nor Staff J removed the food item after identifying the error. Staff I again instructed Staff J Resident #45 was not supposed to have a hotdog. Staff I and Staff J did not remove the food item. Staff K, Certified Nursing Assistant cut the hotdog in half for Resident #45 to consume.</p> <p>The facility's failure to implement the policies and procedures for neglect and to provide a safe environment free from hazards when Resident #45 was identified to have been served a food that did not meet the physician ordered diet and the food item was not removed led to a determination of Immediate Jeopardy at a scope and severity of isolated, (J). The Nursing Home Administrator was notified of the Immediate Jeopardy on November 13, 2024, at 5:25 PM. The Immediate Jeopardy began on October 15, 2024, and was removed on site on November 13, 2024.</p> <p>Findings include:</p> <p>Review of the Job Description titled Administrator signed by the Administrator on 11/1/2024 read, Purpose of Your Job Position: The primary purpose of your position is to direct the day-to-day functions of the Facility in accordance with current federal, state and local standards guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times . Duties and Responsibilities: Administrative Functions . Develop and maintain written policies and procedures and professional standards of practice that govern the operation of the Facility . Assist department directors in the development, use, and implementation of departmental policies and procedures and professional standards of practice . Ensure that all employees, residents, visitors, and the general public follow the Facility's established policies and procedures.</p> <p>Review of the Job Description titled Director of Nursing Services signed by the Director of Nursing on 10/1/2023 read, Purpose of Your Job Position: The primary purpose of your position is to plan, organize, develop, and direct the overall operations of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines and regulations that govern our Facility and as may be directed by the Administrator to ensure that the highest degree of quality care is maintained at all times . Duties and Responsibilities: Administrative Functions: Plan, develop, organize, implement, evaluate, and direct the nursing service department, as well as its programs and activities, in accordance with current rules, regulations, and guidelines that govern nursing care facilities.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Job Description titled Dietitian signed by the Registered Dietician #1 on 10/1/2023 read, Purpose of Your Job Position: The primary purpose of your position is to plan, organize, develop, and direct the overall clinical operation of the Food Services Department in accordance with current federal, state, and local standards guidelines, and regulations, that govern the Facility, and as may be directed by the Administrator, to assure the quality nutritional services are being provided on a daily basis . Duties and Responsibilities: Administrative Functions . Develop, implement, and maintain written departmental policies that apply to your area. Ensure staff is aware of and follows the established policies . Assist in planning regular and special diet menus as prescribed by the attending physician . Review therapeutic and regular diet plans and menus to assure they comply with physician orders.</p> <p>Review of the Job Description titled Food Service Supervisor signed by the Food Service Director on 10/1/2023 read, Purpose of Your Job Position: The primary purpose of your job position is to plan, organize, develop, and oversee the operations of the Nutritional Services/Food Services Department in accordance with current federal, state, and local standards, guidelines, and regulations governing our Facility, and as may be directed by the Administrator or the Food Services Director to assure that quality nutritional services are provided on a daily basis and that the Nutritional Services/Food Department is maintained in a clean, safe, and sanitary manner . Duties and Responsibilities. Administrative Functions . Review therapeutic and regular diet plans and menus to assure they are in compliance with the physician's orders.</p> <p>Review of the Medical Director Retainer Agreement signed by the Medical Director on 2/23/2020 read, Consultant Responsibilities: Supervise the overall functions of our facility's medical services in that the medical director shall . Participate in the development of written policies, rules, and regulations to govern the nursing care and related medical and other health services provided. The medical director is responsible for seeing that these policies reflect an awareness of and have provisions for meeting the total needs of the residents. Ensure the residents receive adequate services appropriate to their needs.</p> <p>During an observation on 10/15/2024 at 12:20 PM, Resident #45 was sitting in the common dining room. Resident #45 called Staff J, Licensed Practical Nurse (LPN), and asked to have something else to eat than what had been served to him. Staff J went to the kitchen and returned with a hotdog and hotdog bun on a plate. Staff J placed the plate in front of Resident #45 and Staff I, Registered Nurse (RN), stated to Staff J Resident #45 was not supposed to have a hotdog. Staff J did not remove the food item. Staff I mentioned again Resident #45 should not have a hotdog. Neither Staff I nor Staff J removed the food item. Resident #45 picked up the hotdog and put it in his mouth. Resident #45 placed the hotdog back down on the plate without chewing or swallowing any pieces of the hotdog. Staff K, Certified Nursing Assistant (CNA), came over and cut the hotdog in half. Resident #45 grabbed one of the halves and placed it in his mouth. Resident #45 placed the half of the hotdog back down on the plate without chewing or swallowing any portion of the hotdog.</p> <p>Review of Resident #45's medical record showed the resident was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, diastolic (congestive) heart failure, muscle weakness (generalized), other reduced mobility, unspecified protein-calorie malnutrition, metabolic disorder, adjustment disorder with anxiety, chronic or unspecified gastric ulcer with hemorrhage, disorder of adult personality and behavior, type 2 diabetes mellitus without complications, gastro-esophageal reflux disease without esophagitis and legal blindness.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #45's Speech Theory SLP [Speech Language Pathologist] Evaluation & Plan dated 9/30/2023 read, Current Referral. Reason for Referral: Patient referred to ST [Speech Therapy] due to new onset of decreased oral function, risk for aspiration, decreased functional activity tolerance and dysphagia indicating the need for ST to analyze oral/pharyngeal function, minimize aspiration/risk of, develop & instruct in compensatory strategies, assess and determine least restrictive diet and design and implement strategies. Resident on a regular diet with thin liquids upon discharge to the hospital. He returned on a puree diet with thin liquids. Resident exhibiting a significant weight loss of 15.5% over the last 4 months .Objective tests/measures & additional analysis: .additional analysis: other [NAME] [[NAME] Assessment of Swallowing Ability] administered with a score of 176 indicating mild dysphagia however, resident is exhibiting a severe deficit with oral phase of swallow .Assessment Summary: Reason for skilled services: skilled SLP services for dysphagia are warranted to analyze oral/pharyngeal function, develop & instruct in compensatory strategies, minimize risk of weight loss with swallow analysis, assess and determine the least restrictive diet and design and implement strategies in order to enhance patient's quality of life by improving ability to meet primary nutrition/hydration needs, efficiently consume restrictive diet, safely consume least restrictive diet, improve oral transit time and use strategies/compensatory techniques. Risk factors: due to the documented physical impairment and associated functional deficits, the patient is at risk for: aspiration and weight loss .</p> <p>Review of Resident #45's Speech Therapy Treatment encounter notes dated 10/10/2023 read, Swallow Tx [treatment]: instructions in altering liquids/solids to increase pharyngeal clearance, analysis of /instruction in presentation techniques to increase safety & nutrition, modification to bolus sizes and order/method of food/liquid presentation and facilitation of body positioning to increase safety with intake. Swallow Tx: techniques to improve safe & efficient nutrition/hydration, analysis of diet texture to increase oral intake, therapeutic trial feedings to increase safety and development & training in use of compensatory strategies. Trial of mechanical soft consistency presented with modifications to bolus size and rate of intake. Resident is declining to eat puree diet consistency per nursing. Resident able to consume mechanical soft consistency without any s/s [signs/symptoms] of deficit in pharyngeal phase of swallow.</p> <p>Review of Resident #45 physician order dated 7/9/2024 read Physician ordered CCHO [Consistent Carbohydrates] diet, Mechanical Soft texture, thin consistency for nutrition and hydration.</p> <p>During an interview on 10/16/2024 at 11:53 AM, Staff I, RN, stated, [Resident #45's name] has a mechanical soft diet. Cutting the hotdog in half does not make it a mechanical soft diet. I am not sure if the cook said it was okay or not when she [Staff J] went to get it from the kitchen.</p> <p>During a telephonic interview on 10/17/2024 at 1:13 PM, Staff J, LPN, stated, He [Resident #45's name] asked me to get him another plate and I asked him what he wanted. He said maybe a hamburger or something like that. I went to the kitchen and told the cook I need an alternate and I mentioned his name [Residents #45's name]. The cook, I do not remember who it was, told me he had no hamburger, and they gave me a hotdog. I brought it out and [Resident #45's name] started eating the hotdog without a problem. When I turned around the nurse [Staff I] told me he [Resident #45] could not have a hotdog. I just didn't want to grab his plate. I just froze and kept looking at [Resident #45's name]. He finished the hotdog without a problem. I did not grab the plate because I did not want to make a big commotion.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/17/2024 at 1:28 PM, Staff K, CNA, stated, Residents' diets sometimes change. I saw him [Resident #45] sitting around and I went to help him out so [Resident #45's name] could start eating. I thought I cut it in multiple pieces for him to be able to eat it. Cutting the hotdog does not make it a mechanical soft diet. Usually, they have a ticket. I did not see a ticket next to him. I did not pay more attention to his meal.</p> <p>During an interview on 11/12/2024 at 8:36 AM while discussing Resident #45's therapeutic diet, the Administrator stated, We put the fault in every department. The issues came from the dining room, but the kitchen could have stopped it.</p> <p>During an interview on 11/12/2024 at 8:44 AM, Staff I, RN, stated, I think I was a little overwhelmed and had a lot going on and when I told her [Staff J] No, he should not have it [referring to the hotdog meal served], nothing was done. I assumed she was going to take it away the second time I told her. It was busy. I would have taken it away, but I was doing a million things reading the tickets and handing out the meals, and I was just overwhelmed. When I noticed the second time, he [Resident #45] had the meal in front of him that I told her he should not have. I told her [Staff J] a second time. She turned around and looked at me and she heard what I said. I assumed she was going to take it from him [Resident #45]. Looking back, I should have owned it and removed his plate instead of expecting someone to do it. Some potential risk for the resident would be choking. You can say that about any resident but for him, he is at a higher risk. I would not say aspiration.</p> <p>During an interview on 11/12/2024 at 9:20 AM Staff R, Speech Therapist stated, If a resident is mechanical soft, they should not be given a meal outside of their recommendations. There is a possibility of coughing, choking, and aspiration. Depending on the health status of the person aspiration pneumonia and an increased risk of hospitalization .</p> <p>During an interview on 11/12/2024 at 9:37 AM, Staff Q, Cook, stated, We were serving the lunch line. A nurse came in asking for an alternate regular tray. I asked her who it was for and what the diet was. She said it was a regular diet for the dining room. I finished serving more on the line and remembered she was still there, and I gave her the hotdog. After that I realized she didn't say who it was for, but she never came back in, and I finished serving the lunch line. She did not have a meal ticket with her.</p> <p>During an interview on 11/12/2024 at 9:51 AM, the Food Service Director stated, Our procedure is that staff is informed to ask if they have a diet ticket and if they do not have the diet ticket, we ask for the name and room number and look in the book. If they are not in the book, they need to go to the nurse to verify. The book is updated daily. The nurse did not have a slip and at that time, the procedure was not followed that day. It has always been that way. We are to check for the diet and name, and it was just very chaotic that day and the nurse was just amending with the hotdog. Choking can be a concern if a mechanical soft diet resident gets a hotdog or any diet that is a regular diet. The food should not be placed in front of the resident until the nurses find out the proper diet for the residents.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/12/2024 at 9:56 AM, Registered Dietitian #1 stated, A resident who is on a mechanical soft diet should not get a whole hotdog not without being mechanically altered. Mechanically altered food particles should be reduced to less than one half of an inch or less. Chocking is a potential harm they can face and/or aspiration. My expectation is if the staff has a misunderstanding or disagreement, the staff should pause and verify the correct diet and ask the resident not to consume the food.</p> <p>During an interview on 11/12/2024 at 10:15 AM, the Director of Nursing (DON) stated, The staff should know the patient diet and who it is for and the room number. Whoever is in the kitchen should verify looking at the person's ticket to make sure the diet is correct. I feel it was a breakdown of that individual. If she [Staff I] told her [Staff J] from the beginning that was not his [Resident #45's] diet, she should have taken the plate away from him or not even put it in front of the resident. If it was me as the RN, I would have taken it from him and had the LPN step out of the dining room and later address the incident with the staff. The LPN should have verified the diet before giving the resident the alternate. The nurses are responsible for making sure residents are taken care of safely.</p> <p>During an interview on 11/12/2024 at 10:26 AM, the Administrator stated, After all the investigation, it was an individual staff mistake. The RN herself who saw the situation and she did not act either. The food should have been taken away immediately from the resident. They are supposed to get the slip and get the diet order and mention who the patient was and say what the patient needs and what diet they were supposed to be. I know it was a [NAME] day, but that is no excuse at all. The staff was not recognizing the mistake and the level it can reach. This was the policy prior to the event.</p> <p>During an interview on 11/12/2024 at 12:12 PM with the Administrator, when asked if identifying the wrong diet order served and not removing the meal was neglectful behavior, the Administrator stated, We took it as both ways because no action happened. We worked the event as a near miss.</p> <p>During an interview on 11/12/2024 at 12:13 PM, the Regional Nursing Consultant stated, We worked it as a near miss like if someone had a medical error. If we reported every near miss med error or error, we would be doing that every day. This was a [NAME] employee. A nurse who failed to act.</p> <p>During an interview on 11/12/2024 at 12:40 PM, the Registered Dietitian #1, stated, Choosing the word neglect makes it hard to answer since it's a legal term. Would I consider this a mistake or not following the procedure, yes. I do not feel comfortable answering and using that kind of language. A mistake is anything that occurs that is outside the realm of norm, deviation from the norm. I consider the staff giving the wrong diet order and identifying it was the wrong diet order and not doing anything to correct it would be considered a mistake. It falls under the definition I gave you of a deviation from the norm. It was a clinical error. He was a mechanical soft diet at that time.</p> <p>During an interview on 11/12/2024 at 12:45 PM with the Food Service Director, when asked if not removing the food item after identifying it was wrong diet order would be considered neglectful behavior, The Food Service Director stated, I do not feel comfortable answering the question.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/12/2024 at 1:32 PM, the Medical Director stated, I was notified of the incident. To be honest, it depends on the amount of dysphagia the patient has. This resident [Resident #45] has mental issues and will do things he is not supposed to do. He is followed by the speech therapist. A potential harm outcome all depends on the resident. He was a patient with failure to thrive and has improved. I understand your question if it was a weak patient or had dysphagia, it could cause aspiration pneumonia. When asked if the nurse's inaction after identifying the incorrect diet order and not removing the tray was neglectful, the Medical Director stated, I would consider this to be a situation with a nurse that needs to be suspended and educated.</p> <p>During an interview on 11/13/2024 at 9:57 AM, the Administrator stated, Part of the incident after looking at it, yes it was neglectful behavior. To me, neglect is the unwillingly action made against somebody. Since the staff was told twice, she should have removed it.</p> <p>During an interview on 11/13/2024 at 10:08 AM, the Medical Director stated, Neglect to me is to do something that would harm a patient on purpose. In this case, it was a request from a patient. Even if they have a lower BIMS [Brief Interview for Mental Status] than usual or dementia, but they understand they can ask and we have to respect them. We would consider those pleasure feed. Another staff tried to resolve the issue by cutting the hotdog.</p> <p>During an interview on 11/13/2024 at 12:01 AM, the DON, stated, Neglect is intentionally not taking care the patient. A dietary scenario that would be considered neglect would be not making sure that a patient got a meal. Referring to the two nurses not providing the best care for the patient, that would be neglect. We should have followed through.</p> <p>During an interview on 11/13/2024 at 12:20 PM, Food Service Director stated, The residents have the right to good and services. Basically, the situation that happened in the dining room with [Resident #45's name] and that nurse not removing the tray is considered neglect because it can possibly do harm to the resident.</p> <p>During an interview on 11/13/2024 at 12:26 PM, Registered Dietician #1, stated, [Neglect is] the failure to provide goods and services as deemed medically necessary. I would consider the case you are here for neglect. I did not want to answer it yesterday until I was completely familiar with the situation and all the definitions.</p> <p>Review of the facility policy and procedure titled Nutrition and Hydration Assistance with the last review date of 1/31/2024 read, Policy: It will be the policy that this facility will provide the level of assistance required to the residents while maintain their highest practicable level of function and personal preferences. Staff will help ensure residents receive adequate assistance and provision of services for nourishment and hydration.</p> <p>Review of the facility policy and procedure titled Provide Diet to Meet Needs of Each Resident with the last review date of 1/31/2024 read, Policy: The purpose of the food and nutrition services (FNS)/dietary department is to provide high quality, nutritious, palatable and attractive meals in a safe, sanitary manner. Food will be prepared in a form to accommodate resident allergies, intolerances and personal, religious and cultural preferences, based on reasonable effort. Therapeutic diets will be served as prescribed by the attending physicians or their designee.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy and procedure titled ANE [Abuse, Neglect, Exploitation] and Investigations with the last review date of 1/31/2024 read, Policy: It will be the policy of this facility honor residents' rights and to address with employees the seven (7) components regarding mistreatment, abuse, neglect, sexual misconduct, injuries of unknown source, involuntary seclusion, corporal punishment, misappropriation of resident property or funds or use of physical or chemical restraints now required to treat their resident symptoms in accordance with Federal Law. It will be the policy of this facility to ensure that all alleged violations of Federal or State laws, which involve mistreatment, neglect, abuse (verbal, mental, physical or sexual), injuries of undetermined source, involuntary seclusions, corporal punishment, misappropriation of resident property or funds or use of physical or chemical restraint not in accordance with regulation to treat resident symptoms to be reported immediately to the Administrator/DNS [Director of Nursing Services]/Abuse Coordinator/designee. Appropriate agencies will be notified in accordance with existing laws . Definitions . Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>Review of the facility policy and procedure titled Accidents and Supervision with the last review date of 1/31/2024 read, Policy: The resident environment will remain as free of accident hazards as is possible. Each resident will receive supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary. Definitions . Hazards refers to elements of the resident environment that have the potential to cause injury or illness . Supervision/Adequate/Supervision refers to intervention and means of mitigating risk of an accident . Procedure: The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. 1. Identification of Hazards and Risks- the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. a. The facility should make a reasonable effort to identify the hazards and risk factors for each resident . 5. Supervision- Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Immediate Jeopardy (IJ) was removed on site on 11/13/2024 after the receipt of an acceptable IJ removal plan. The facility has completed the following steps to remove the immediate jeopardy. On 10/16/2024, Resident #45 was re-evaluated by the licensed nurse and the speech therapist. On 10/16/2024, Resident #45's chest x-ray was completed. On 10/16/2024 and on 11/13/2024, residents were interviewed regarding abuse and neglect, and skin evaluations for residents who are not able to be interviewed were carried out to identify abuse or neglect. On 10/16/2024, facility-wide reconciliation of the dietary system/tray tickets with physician orders were carried out. On 10/16/2024, the DON provided training and education to the dietary staff and nursing staff on providing the diet to meet the residents' needs, nutrition and hydration assistance, and accuracy of diet. On 10/17/2024, a root cause analysis was conducted and Ad Hoc [from the Latin and means for this] Quality Assurance and Performance Improvement (QAPI) meeting was held to review the concerns related to accuracy of diets. On 11/12/2024, the facility Administrator, Director of Nursing, and Regional Consultant were educated by the Chief Nursing Officer Consultant on the components of abuse, neglect, exploitation, and injury of unknown origin to include reporting requirements. On 11/12/2024, a performance improvement plan for abuse and neglect was developed and executed with the QAPI Committee and Medical Director. On 11/12/2024, an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was convened to review the Removal of Immediate Jeopardy draft plan and added daily alternate diet audit form to track alternate diet check process to ensure accuracy of diets after alternative diet is requested after meal delivery. By 11/13/2024, 227 out of 233 facility staff members (112 out of 112 certified nursing assistants, 37 out of 38 licensed practical nurses, 14 out of 15 registered nurses, and 16 out of 16 dietary staff members) were reeducated on the accuracy of diets and abuse, neglect, exploitation, and injury of unknown origin. On 11/13/2024, education was completed by the Regional Nurse Consultant with the Administrator and the DON to review job descriptions and the components of QAPI. Beginning 10/18/2024, the facility administration will ensure that the safety and well-being as it relates to accuracy of diets is maintained by continued participation, evaluation and intervention through clinical standup review of 24-hour report to identify change in condition, and maintaining QAPI process.</p> <p>Review of Resident #45's records showed the resident was evaluated on 10/16/2024 by X-Ray with no focal consolidation, effusion or pneumothorax. Review of Resident #45's SLP evaluation showed the resident was evaluated for oral and pharyngeal swallow function on 10/16/2024. Review of the facility records showed the facility completed interviews and skin checks with all residents for identification of abuse/neglect on 10/16/2024 and 11/13/2024. Review of Order Listing Report showed the Registered Nursing Consultant completed reconciliation of the dietary system with physician orders on 10/16/2024. Review of Education In-service Attendance Record showed the staff members received training through SNF Clinic on mechanically altered diets, accuracy of diet, and importance of correct diet orders, and on abuse and neglect by 11/13/2024. Review of the education in-service attendance record dated 11/13/2024 showed the Administrator, Director of Nursing, Assistant Director of Nursing, and Registered Nursing Consultant received education by the Chief Nursing Officer on abuse and neglect, job description, monitoring of facility systems and 5 elements of QAPI. During staff interviews completed on 11/13/2024, two RNs, two LPNs, three CNAs, two therapy staff, five dietary staff, and Social Services Assistant verified having received education and verbalized understanding on abuse/neglect and accuracy of diets. During interviews conducted on 11/13/2024, the Regional Nursing Consultant, the Administrator, and the DON verified having received education and verbalized understanding.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>46523</p> <p>Based on observation, interview, and record review, the facility failed to ensure medical records were accurately documented for 1 of 10 residents reviewed for nutrition, Resident #43.</p> <p>Findings include:</p> <p>During an observation on 10/14/2024 at 12:15 PM, Resident #43 was eating lunch in the common dining room. The resident had a burger cut into four pieces and fruit punch in a glass. There was no frozen nutritional treat.</p> <p>During an observation on 10/15/2024 at 9:01 AM, Resident #43 was eating in his room. There was a glass of orange juice, two pieces of bacon, one boiled egg cut in half and a toast cut into four pieces. There was no frozen nutritional treat.</p> <p>During an observation on 10/15/2024 at 12:17 PM, Resident #43 was eating in the common dining room. The resident had a hot dog with a hot dog bun cut in half and a hash brown cut into sections. There was no drink or frozen nutritional treat.</p> <p>During an observation on 10/16/2024 at 12:10 PM, Resident #43 was eating penne pasta, meatballs, and brussels sprouts with a cup of coffee in the dining room. There was no frozen nutritional treat.</p> <p>Review of Resident #43's physician order dated 9/15/2021 read, Frozen Nutritional Treat with meals for wt [weight] loss.</p> <p>Review of Resident #43's Medication Administration Record (MAR) for October 2024 showed the resident received Frozen Nutritional Treat on 10/14/2024 at 12:00 PM, on 10/15/2024 at 9:00 AM and 12:00 PM, and on 9/16/2024 at 12:00 PM.</p> <p>During an interview on 10/16/2024 at 3:15 PM, the Director of Nursing stated, Staff is expected to document accurately and complete documentation in the system.</p> <p>During an interview on 10/17/2024 at 8:18 AM, with Staff D, Licensed Practical Nurse (LPN) stated, I check trays before they are delivered to the room. I also ask the residents if they are confused or not eating in his room. I ask the certified nursing assistant they are my right hand.</p> <p>Review of the facility policy and procedure titled Charting and Documentation with the last review date of 1/31/2024 read, Policy: It is the policy of this facility that services provided to the resident, or any changes in the resident's medical condition, shall be documented in the resident clinical record as is needed. Procedure: 1. Observations, medications administered, services performed, etc., should be documented in the residents' clinical records.</p>		

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<p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523</p> <p>Based on interview, record review, and observation, the facility failed to utilize the Quality Assessment and Performance Improvement (QAPI) process to investigate, develop and implement an effective performance improvement plan (PIP) when the facility identified policies and procedures were not implemented for neglect and therapeutic diets. On 10/15/2024 at 12:20 PM, Resident #45 was sitting in the dining room. Resident #45 requested an alternative food item from Staff J, Licensed Practical Nurse. Staff J went to the kitchen and returned with a hotdog and hotdog bun on a plate. Resident #45's diet was not verified in the kitchen. Staff I, Registered Nurse, stated to Staff J Resident #45 was not supposed to have a hotdog. Neither Staff I nor Staff J removed the food item after identifying the error. Staff I again instructed Staff J Resident #45 was not supposed to have a hotdog. Staff I and Staff J did not remove the food item. Staff K, Certified Nursing Assistant cut the hotdog in half for Resident #45 to consume.</p> <p>The facility's failure to develop and implement appropriate plans of action after identifying the systemic breakdown for failure to implement policy and procedures for neglect and therapeutic diets served to Resident #45 led to a determination of Immediate Jeopardy at a scope and severity of isolated (J). The Nursing Home Administrator was notified of the Immediate Jeopardy on November 13, 2024, at 5:25 PM. The Immediate Jeopardy began on October 15, 2024, and was removed on site on November 13, 2024.</p> <p>Findings include:</p> <p>During an observation on 10/15/2024 at 12:20 PM, Resident #45 was sitting in the common dining room. Resident #45 called Staff J, Licensed Practical Nurse (LPN), and asked to have something else to eat than what had been served to him. Staff J went to the kitchen and returned with a hotdog and hotdog bun on a plate. Staff J placed the plate in front of Resident #45 and Staff I, Registered Nurse (RN), stated to Staff J Resident #45 was not supposed to have a hotdog. Staff J did not remove the food item. Staff I mentioned again Resident #45 should not have a hotdog. Neither Staff I nor Staff J removed the food item. Resident #45 picked up the hotdog and put it in his mouth. Resident #45 placed the hotdog back down on the plate without chewing or swallowing any pieces of the hotdog. Staff K, Certified Nursing Assistant (CNA), came over and cut the hotdog in half. Resident #45 grabbed one of the halves and placed it in his mouth. Resident #45 placed the half of the hotdog back down on the plate without chewing or swallowing any portion of the hotdog.</p> <p>Review of Resident #45's medical record showed the resident was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, diastolic (congestive) heart failure, generalized muscle weakness, other reduced mobility, unspecified protein-calorie malnutrition, metabolic disorder, adjustment disorder with anxiety, chronic or unspecified gastric ulcer with hemorrhage, disorder of adult personality and behavior, type 2 diabetes mellitus without complications, gastro-esophageal reflux disease without esophagitis, and legal blindness.</p> <p>Review of Resident #45's physician order dated 7/9/2024 read, CCHO [Controlled Carbohydrates] diet, Mechanical Soft texture, thin consistency for nutrition and hydration.</p> <p>(continued on next page)</p>		

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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)		
<p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/12/2024 at 8:36 AM while discussing Resident #45's therapeutic diet, the Administrator stated, We put the fault in every department. The issues came from the dining room, but the kitchen could have stopped it. Right now, when someone asks for something else, they have to show the dietary slip for the cook to release any food items. Every department involved got a disciplinary action and training.</p> <p>During an interview on 11/12/2024 at 10:26 AM, the Administrator stated, After all the investigation, it was an individual staff mistake. The RN herself who saw the situation and she did not act either. The food should have been taken away immediately from the resident. They are supposed to get the slip and get the diet order and mention who the patient was and say what the patient needs and what diet they were supposed to be. I know it was a [NAME] day, but that is no excuse at all. The staff was not recognizing the mistake and the level it can reach. This was the policy prior to the event.</p> <p>During an interview on 11/12/2024 at 12:12 PM with the Administrator, when asked if identifying the wrong diet order served and not removing the meal was neglectful, the Administrator stated, We took it as both ways because no action happened. We work the event as a near miss.</p> <p>During an interview on 11/12/2024 at 12:13 PM, the Regional Nursing Consultant stated, We worked it as a near miss like if someone had a medical error. If we reported every near miss med error or error, we would be doing that every day. This was a [NAME] employee. A nurse who failed to act.</p> <p>During an interview on 11/13/2024 at 9:57 AM, the Administrator stated, Part of the incident after looking at it, yes it was neglectful behavior. To me, neglect is the unwillingly action made against somebody. Since the staff was told twice, she should have removed it. After yesterday, we had a meeting and analyzed the situation and called it what it is. We filed the reportable and reported the staff members.</p> <p>A request was made for the policy and procedures for QAPI. Review of the provided document titled QAPI at a Glance: A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home read, What is QAPI? QAPI is the merger of two complementary approaches to quality management, Quality Assurance (QA) and Performance Improvement (PI). Both involve using information, but differ in the key ways: QA is a process of meeting quality standards and assuring that care reaches an acceptable level. Nursing homes typically set QA thresholds to comply with regulations. They may also create standards that go beyond regulations. QA is reactive, retrospective effort to examine why a facility failed to meet certain standards. QA activities do improve quality, but efforts frequently end once the standard is met. PI (also called Quality Improvement - QI) is a pro-active and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems. PI in nursing homes aims to improve processes involved in health care delivery and resident quality of life. PI can make good quality even better . Why QAPI is important? Once QAPI is launched and sustained, many people report that is a rewarding and even an enjoyable way of working. The rewards of QAPI include: Competencies that equip you to solve quality problems and prevent their recurrences; Competencies that allow you to seize opportunities to achieve new goals; Fulfillment for caregivers, as they become active partners in performance improvement; and above all, better care and better quality of life for your residents.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Immediate Jeopardy (IJ) was removed on site on 11/13/2024 after the receipt of an acceptable IJ removal plan. The facility has completed the following steps to remove the immediate jeopardy. On 10/16/2024, Resident #45 was re-evaluated by the licensed nurse and the speech therapist. On 10/16/2024, Resident #45's chest x-ray was completed. On 10/16/2024 and on 11/13/2024, residents were interviewed regarding abuse and neglect, and skin evaluations for residents who are not able to be interviewed were carried out to identify abuse or neglect. On 10/16/2024, facility-wide reconciliation of the dietary system/tray tickets with physician orders were carried out. On 10/16/2024, the DON provided training and education to the dietary staff and nursing staff on providing the diet to meet the residents' needs, nutrition and hydration assistance, and accuracy of diet. On 10/17/2024, a root cause analysis was conducted and Ad Hoc [from the Latin and means for this] Quality Assurance and Performance Improvement (QAPI) meeting was held to review the concerns related to accuracy of diets. On 11/12/2024, the facility Administrator, Director of Nursing, and Regional Consultant were educated by the Chief Nursing Officer Consultant on the components of abuse, neglect, exploitation, and injury of unknown origin to include reporting requirements. On 11/12/2024, a performance improvement plan for abuse and neglect was developed and executed with the QAPI Committee and Medical Director. On 11/12/2024, an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was convened to review the Removal of Immediate Jeopardy draft plan and added daily alternate diet audit form to track alternate diet check process to ensure accuracy of diets after alternative diet is requested after meal delivery. By 11/13/2024, 227 out of 233 facility staff members (112 out of 112 certified nursing assistants, 37 out of 38 licensed practical nurses, 14 out of 15 registered nurses, and 16 out of 16 dietary staff members) were reeducated on the accuracy of diets and abuse, neglect, exploitation, and injury of unknown origin. On 11/13/2024, education was completed by the Regional Nurse Consultant with the Administrator and the DON on the components of QAPI. Beginning 10/18/2024, the facility administration will ensure that the safety and well-being as it relates to accuracy of diets is maintained by continued participation, evaluation and intervention through clinical standup review of 24-hour report to identify change in condition, and maintaining QAPI process.</p> <p>Review of Resident #45's records showed the resident was evaluated on 10/16/2024 by X-Ray with no focal consolidation, effusion or pneumothorax. Review of Resident #45's SLP evaluation showed the resident was evaluated for oral and pharyngeal swallow function on 10/16/2024. Review of the facility records showed the facility completed interviews and skin checks with all residents for identification of abuse/neglect on 10/16/2024 and 11/13/2024. Review of Order Listing Report showed the Registered Nursing Consultant completed reconciliation of the dietary system with physician orders on 10/16/2024. Review of Education In-service Attendance Record showed the staff members received training through SNF Clinic on mechanically altered diets, accuracy of diet, and importance of correct diet orders, and on abuse and neglect by 11/13/2024. Review of the education in-service attendance record dated 11/13/2024 showed the Administrator, Director of Nursing, Assistant Director of Nursing, and Registered Nursing Consultant received education by the Chief Nursing Officer on abuse and neglect, job description, monitoring of facility systems and 5 elements of QAPI. Review of the facility records showed the facility held an Ad Hoc QAPI meeting on 10/17/2024 and conducted a root cause analysis for the concerns on accuracy of diets, held an Ad Hoc QAPI meeting on 11/12/2024 on accuracy of diets and abuse and neglect, and an Ad Hoc QAPI meeting 11/13/2024 on approval of removal plan and review of supervisor monitoring tool. During staff interviews completed on 11/13/2024, two RNs, two LPNs, three CNAs, two therapy staff, five dietary staff, and Social Services Assistant verified having received education and verbalized understanding on abuse/neglect and accuracy of diets. During interviews conducted on 11/13/2024, the Regional Nursing Consultant, the Administrator, and the DON verified having received education and verbalized understanding.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46523</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff performed hand hygiene during 2 of 7 observations of medication administration, failed to ensure staff sanitized reusable medical equipment, and failed to provide a clean storage for clean linen to prevent the possible spread of infection and communicable diseases.</p> <p>Findings include:</p> <p>1) During an observation on 10/15/2024 at 3:10 PM, Staff A, Certified Nursing Assistant (CNA), took Resident #12's vitals without sanitizing the machine. Staff A proceeded to take Resident #22's vitals without cleaning the vital sign machine. Staff A exited the room and entered Resident #79's room and took the resident's vitals without sanitizing the machine. Staff A closed the door and exited the room, took the vital sign machine to the nursing station and left it by medication cart.</p> <p>During an interview on 10/15/2024 at 3:23 PM, Staff A, CNA, stated, I should wipe the machine between use with the wipes. I did not have in my cart so that is what I was going to go and get. I did have hand sanitizer for my hands in the cart to clean my hands in between residents.</p> <p>2) During an observation on 10/16/2024 at 5:25 AM, Staff B, Licensed Practical Nurse (LPN), poured Resident #59's medications into a medication cup without performing hand hygiene. Staff B grabbed another medication cup and put pudding inside the cup. Staff B donned a pair of gloves and opened the capsule and poured the medication into the pudding. Staff B closed the medication cart and walked over to Resident #59's room. There was a linen cart with a blue cover in front of the resident's room door. Staff B pushed the cart with gloved hands. Staff B entered Resident #59's room and the resident refused to take medication. Staff B exited Resident #59's room without performing hand hygiene and returned to the medication cart. Staff B doffed her gloves and discarded the medication. Without performing hand hygiene, Staff B began to pour medication into a medication cup for Resident #291 and drew Heparin in a syringe. Staff B donned a pair of gloves without performing hand hygiene and entered Resident #291's room. Staff B administered the medication to Resident #291. Staff B exited the resident's room without performing hand hygiene and discarded the syringe in the sharp's container. Staff B doffed her gloves and walked to the medication room and retrieve a suppository for Resident #291 without performing hand hygiene. Staff B walked over to the treatment cart and removed a packet of lubricating ointment. Staff B returned to the medication cart and donned gloves without performing hand hygiene, opened the packet of lubricating ointment and placed it in a medication cup followed by the suppository. Staff B entered Resident #291's room without performing hand hygiene. Resident #291 refused suppository and Staff B exited the resident's room without performing hand hygiene. Staff B doffed her gloves when she returned to her medication cart and began to document refusal of medication in the computer system without performing hand hygiene.</p> <p>During an interview on 10/16/2024 at 5:41 AM, Staff B, LPN, stated, I should have used hand sanitizer in between residents before donning the gloves. If not, it does not work.</p> <p>During an interview on 10/17/2024 at 8:50 AM, the Director of Nursing stated, Staff are expected to clean the vital sign machine with the disinfecting wipes between residents. Before or after gloves staff needs to sanitize and in between residents.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy and procedure titled Hand Hygiene with the last review date of 1/31/2024 read, Policy: This facility considers hand hygiene the primary means to prevent the spread of infections. Procedure . 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . 5. Use an alcohol-based hand rub containing at least 62% alcohol or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations . b. Before and after direct contact with residents; c. Before preparing or handling medications . m. After removing gloves . 7. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.</p> <p>48708</p> <p>3) During an observation on 10/14/2024 at 1:20 PM, clean laundry cart was located on the 500 Hall. The front drape of the cart was pulled open near a resident room where staff were getting linens off of it. Inside the clean linen cart, there was one 16-ounce bottle of coke and one plastic bag containing chips in the center of the clean sheets on the second to the bottom shelf (Photographic evidence obtained).</p> <p>During an interview on 10/16/2024 at 10:43 PM, the Housekeeping Supervisor confirmed that the 16-ounce bottle of coke and plastic bag of chips do not belong on the clean linen cart.</p> <p>Review of the facility policy and procedure titled Handling Linens to Prevent and Control Infections revised on 3/29/2021 read, Purpose: To provide clean, fresh linen to each resident and prevent contamination of linen.</p>