STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105234	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation and Healthcare Center of Tampa	4411 N Habana Ave Tampa, FL 33614

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40775 Based on observations, interviews, and record review, the facility failed to provide an accommodation of resident needs related to mobility devices for one resident (#39) out of fifty-two sampled residents. Findings included: A review of the medical record revealed Resident #39 was admitted to the facility on [DATE] with diagnoses including Multiple Sclerosis (MS), obesity, and Lupus Erythematosus. An interview was conducted on 5/14/2024 at 9:55 AM with Resident #39 in the resident's room. Resident #39 was observed resting in bed during the interview. Resident #39 stated she wanted to plan some outings for the upcoming summer season, but the facility had taken her wheelchair and left her without one. A tour of Residents #39's room and bathroom was conducted, and a wheelchair was not observed in the resident's room. Resident #39 stated she required use of a high back wheelchair due to having Lupus. A review of Resident #39's care plan revealed the following: Focus, last revised 2/3/2023, Resident #39 had an activity of daily living (ADL) self-care performance deficit as evidence by Lupus, MS, morbid obesity, impaired mobility, and lack of participation/motivation. Interventions/Tasks included locomotion with use of a wheelchair and total mechanical lift with use of 2 staff to the chair for transferring. A review of Resident #39's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 4/9/2024, revealed under Section C-Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #39 was cognitively intact. The MDS assessment also revealed, under Section GG-Functional Abilities and Goals, Resident #39 used a wheelchair for mobility within the last 7 days. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 5/16/2024 at 11:09 AM with Staff I, Occupational Therapist (OT). Staff I, OT stated residents are assessed by therapy for the type of chair they may need, but they do not always assign a chair for the resident. Staff I, OT also stated Resident #39 did not normally use a wheelchair at all and the resident, Just wants it to sit in her room. Staff I, OT was not able to state why Resident #39 was not assigned a wheelchair or why the resident did not have a wheelchair available to use in her room. An interview was conducted on 5/16/2024 at 12:56 PM with the facility's Director of Nursing (DON). The DON stated therapy staff assessed residents upon admission for the use of assistive devices. After the completion of the assessment, the facility provides the needed assistive device to the resident. The DON stated even if a resident does not use the device often, it is left with the resident for the entirety of their stay at the facility for their use. The DON also stated Resident #39 often refuses to get out of bed and is encouraged to get out of bed by staff, but the DON was not able to state why the resident did not have a wheelchair available for her use.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20311 Based on observations, interviews, and record review, the facility failed to ensure a safe, clean, comfortable, and homelike environment for two patient floors (3rd and 4th) out of three patient floors in the facility. Findings included: During an observation of room [ROOM NUMBER] on 05/13/24 at 11:42 AM at the side of the resident bed located closest to the window, the flooring was noted to be lifting. (Photographic Evidence Obtained). A review of the facilities electronic maintenance system report for the past month revealed no concerns related to the floor lifting in room [ROOM NUMBER]. A review of the Concierge rounds report for the month of May 2024 revealed no concerns related to the floor lifting in room [ROOM NUMBER]. During an interview on 05/16/24 at 10:10 AM with the Nursing Home Administrator (NHA), he stated the facility utilizes a concierge rounds system and all concerns are documented on the rounds form. He stated if it is a serious concern it is placed on the electronic maintenance system and monitored for completion. He stated all concerns are discussed during the morning meetings, but he was unsure about the floor lifting in room [ROOM NUMBER]. An observation conducted on 5/13/2024 at 10:46 AM inside of room [ROOM NUMBER] revealed large portions of peeled laminate flooring next to bed B in the room. The flooring was observed unattached to the floor and was able to be freely moved while walking over it with small portions of the tile flooring underneath of the laminate visible. The wall behind bed B was observed to have several deep scratch marks with missing paint and visible debris on the floor below. An interview was conducted on 05/14/2024 at 1:23 PM with Staff H, Registered Nurse (RN), Unit Manager (UM) inside of room [ROOM NUMBER]. Staff H, RN UM stated any maintenance concerns are documented in the facility's electronic maintenance system or the concerns can be relayed directly to the maintenance staff by phone. Staff H, RN UM observed the flooring by the air conditioning unit in room [ROOM NUMBER] and the damaged wall behind bed B. Staff H, RN UM stated maintenance staff have been working on fixing concerns related to the flooring and paint in the resident rooms on the unit but was not sure if maintenance staff were aware of the concerns in room [ROOM NUMBER]. An observation conducted on 5/14/2024 at 1:35 PM inside of room [ROOM NUMBER] revealed visible moisture in front of the air conditioning unit near bed B. The flooring in front of the air conditioning unit was observed unattached to the floor and was able to be freely moved while walking over it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation was conducted on 5/16/2024 at 11:20 AM inside of room [ROOM NUMBER]. Staff M, Maintenance Assistant (MA) was observed inside of the room with a large vacuum in front of the air conditioning unit, which was removed from the wall. An interview was conducted with Staff M, MA following the observation, with assistance of a translation application. Staff M, MA stated the air conditioning unit inside of the room was leaking and he was in the room to repair the issue, which was brought to his attention today. Staff M, MA also stated if staff identify a maintenance concern within the facility, they can document the concern in the facility's electronic maintenance log, which is relayed to an application on his phone. Staff M, MA stated he was informed of the flooring concern in 409 today but did not have knowledge of the concern prior to 5/16/2024. An interview was conducted on 05/16/2024 at 1:04 PM with the facility's Director of Nursing (DON). The DON stated any environmental or maintenance concerns identified by staff should be relayed to the floor's Unit Manager, who documents the concern in the facility's electronic maintenance log. The DON also stated any concerns related to damage to the flooring, walls, or equipment should be addressed and reported. Photographic evidence obtained. An observation on 05/13/24 at 12:00 p.m. and 5/15/24 at 3:20 p.m. was conducted inside of room [ROOM NUMBER]. The observation revealed 311- B had a wall that was damaged. The corner of the wall beside the bed had patches of silver and white paint coming out from underneath the peach-colored wall. The corner of the wall had deep scratches and missing paint. Behind the head of the bed there was white and silver color paint coming out from underneath the peach-colored wall. During an interview on 05/15/24 at 3:20 p.m., Staff A Registered Nurse (RN), Unit Manager (UM) stated resident rooms were inspected daily by both the Certified Nursing Assistant (CNA) and Unit Manager. Staff A RN, UM stated when there was a concern in a room staff documented the concern in an electronic maintenance system and stated she personally reported the problem to the housekeeping department or maintenance department pending the concern. Staff A RN, UM stated she had never noticed the damaged walls before in room [ROOM NUMBER]. During an interview on 05/16/24 at 9:54 a.m., the Administrator stated all rooms are inspected by the department heads which was called the concierge service. The Administrator stated the department heads were assigned specific rooms throughout the facility and those rooms were observed for any damage or environmental concerns that needed to be fixed. The Administrator stated any concerns would be documented on the electronic maintenance system. He stated the entries develop into work orders to be fixed. Review of the Concierge Program Rounds-Resident Interview/Room Observations form, undated, showed guidance for employees with a list of questions to interview residents, and a list of items in the areas of Environmental Issues, Safety Issues and Clinical Issues to be observed. There was a section of the form with blank lines for additional information on the bottom of the form. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/16/24 at 10:07 a.m., the Administrator stated Department Heads completed the Concierge Program Rounds-Resident Interview/Room Observations form and report the findings in the morning meeting daily. The Administrator stated even though walls and floors were not on the list of issues to circle, the section on the form with blank lines was to be used for areas of concerns. The Administrator stated he would expect his department heads to complete the blank section of the form with any additional issues that would include any damaged walls or floors. The Administrator stated all environmental and safety issues would need to be documented in the electronic maintenance system to be fixed. Review of the facility's policy Physical Environment, effective date 01/01/2020, revealed the following: Policy: A safe, clean, comfortable and home-life environment is provided for each resident/patient, allowing the use of personal belongings to the greatest extent possible. Sufficient space and equipment in dining, health services, recreation and program areas are provided to enable staff to provide resident/patients with needed services. All essential mechanical, electrical and resident/patient care equipment is maintained in a safe operating condition through the facility's Preventative Maintenance Program. 40775 41015

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39438 Based on observations, interviews, and record review, the facility failed to resolve a resident grievance, to their satisfaction, in a timely manner for one resident (#143) out of the fifty-one sampled residents. Findings included: A review of the Admission Record for Resident #143 showed he was initially admitted to the facility on [DATE] with a primary diagnosis of muscle wasting and atrophy. A review of the Minimum Data Set (MDS), dated [DATE], in Section C-Cognitive Patterns Resident #143 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. On 05/13/24 at 9:30 a.m., Resident #143 reported he had concerns regarding missing clothes. The resident stated he had to wear other residents' clothes because the facility had been unable to locate his clothes. He stated he reported this concern to staff from the laundry and to the social services department, and they still could not find his clothing. The resident stated the clothing went down to the laundry in a bag with his name on it and the clothing was still lost. On 05/15/24 at 1:25 p.m., Resident #143 reported he had one sweater while tugging at the sweater he had on. He stated his clothes had been gone for weeks. The resident stated someone from social services came and spoke with him on Monday and took a list of the items he had missing and photocopied it. The resident had listed the following items as missing: 03/30 2 pairs blue denim jeans (34x29 long) 1 pair black cotton acrylic slacks 1 black cotton acrylic sweater 1 black cotton acrylic hoodie 2 pairs medium T-shirts black 2 pairs cotton T-shirts grey 4 pairs black socks 4 pairs white ankle socks 4 pairs cotton acrylic boxer underwear (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 lime green long sleeve acrylic sweater 04/30 (wash bag) 4 pairs black ankle socks 1 pair grey socks 1 cap 1 pair brown gloves 3 pairs black boxer shorts 1 pair of shorts 1 pair of black shorts 1 dark green sweater 1 blue medium sweater 1 black v neck T-shirt 1 red medium T-shirt 1 large violet T-shirt 1 grey T-shirt 1 dark blue T-shirt 1 dark grey T-shirt (Photographic evidence obtained). Resident #143 stated the Unit Manager told him she was going to take care of the concern 4 to 5 weeks ago. He stated the facility kept telling him the same thing, that they reported it to the laundry manager and that person tried to push some other stuff on him that did not belong to him. He stated he was missing underwear, socks, and matching sweaters and pants. He stated originally the staff said they would reimburse him. He stated he was frustrated because this had been ongoing for so long. Resident #143 reported he was reluctant to send the second bag down because he didn't want his items lost. He stated his name was on the second bag, and the Certified Nursing Assistant (CNA) made sure his name was on it. A review of the Grievance/Concern Log from January 2024 to present showed Resident #143 had only filed one grievance on 04/29/24 for missing items. The date resolved was listed as 05/06/24. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Grievance/Concern Report, dated 04/29/24, revealed the following: Description: missing laundry. Resident stated he sent down a mesh bag with his items. The grievance was assigned on 04/29/24 and resolved by 05/08/24. The action taken to resolve the grievance was laundry and lost and found searched and the items were not found that matched the list given. Items were not listed on the inventory sheet. The resident was offered items from donated clothing on 05/06 and he declined. It was offered again on 05/13. The summary of findings showed the resident stated the items were not labeled and were mostly dark so he couldn't write in them. He was educated on the iron on capability the facility had. Will continue to periodically search for items listed and follow up with the resident. On 05/15/24 at 1:35 p.m., Staff E, Registered Nurse (RN)/Unit Manager (UM), confirmed Resident #143 reported to her he was missing clothing. He had a list of items he was missing. A grievance was filed, and they were going to reimburse him. This was reported to her a couple of weeks ago. She went to file a grievance but someone else had already filed the grievance. On 05/15/24 at 2:18 p.m., the Social Services Director (SSD) reported that the items the resident alleged were missing were not listed on his inventory sheet. She stated the facility staff, and the resident were responsible for documenting things on the inventory sheet during admission. They offered him items from the lost and found but he did not want those items. They asked him if he wanted them to reorder things and he didn't want them to do that. On 05/15/24 at 2:24 p.m., an interview was conducted with Resident #143. The resident stated the facility had not mentioned anything to him about helping him reorder things. On 05/16/24 at 9:32 a.m. the Administrator reported they offered the resident clothes from the lost and found and he didn't want those. He stated he would get it taken care of, but they had to get approval from corporate to cut a check for the items. On 05/16/24 at 11:31 a.m., the Training Coordinator Area Manager stated Resident #143 told her the clothes were in a bag and the bag was given to a CNA. She interviewed all the laundry staff and none of the staff confirmed they received a bag from a CNA. They were unable to identify who the CNA was. The policy and procedure provided by the facility Grievance/Concern Management with an effective date of February 2021 revealed the following: Policy: -Residents/representative has the right to present concerns on behalf of themselves, and/or others to the staff and/or administrator of the facility, to governmental officials, or to any other person. The concern may be filed verbally or in writing, and the reporter may request to remain anonymous. -Residents/representative have the right to recommend changes in policies and services of facility personnel; and to join with other residents or individuals within or outside the facility to work for improvements in resident care, free from restraint, interference, coercion, discrimination, or reprisal. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-These rights include access to ombudsman and advocates and the right to be a member of, to be active in, and to associate with, advocacy or special interest groups. -These rights also include the right to prompt efforts by the facility to resolve resident concerns, including concerns/grievances with respect to the behavior of other residents. Procedure: I. At, during, or after admission, staff will provide: o An explanation of the facility concern process o A copy of the concern/grievance form o An explanation of where concern forms are located, and that staff will provide a form should it be requested o Guidance on assistance available to residents/family members who are unable to complete the form unassisted o The names, job titles, and telephone numbers of employees responsible for implementing the facility's concern procedure. This information is found in the Admission Booklet and includes the address and toll-free telephone numbers and email addresses for the Ombudsman and the Agency and other survey agencies. o Outside resources available to the resident: - Ombudsman -Department of Health -Facility specific options such as a toll-free number for reporting concerns 2. The facility will prominently display a poster that includes the following: o The contact information of the Grievance Official to include his/her name, business address (mailing and email address), and business phone number; o A reasonable expected time for completing a review of the concern; o The right to obtain a written decision regarding the concern; o Reference to independent entities with whom concerns may be filed 3. Residents/resident representative who are unable to complete a written concern will be assisted by staff to prepare and submit the form. 4. The NHA is responsible for oversight of the concern process. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. The Social Services Representatives/Grievance Official in collaboration with the NHA will be responsible for assigning the concern to the appropriate department for investigation. Social Services will monitor and document resident/family satisfaction upon completion of the investigation and the summary of findings/conclusion. 6. Social Services Director in collaboration with the NHA will be the Grievance Official at the facility 7. The facility leadership team will review and discuss concerns and the progress of an investigation(s) and resolution(s). 8. The department involved will document the concern and record the resident/resident representative's satisfaction with the resolution to the concern. 9. The Resident Council will be reminded of the name and location of the grievance officer; how to file a concern; that they may file verbally or in writing and may file anonymously. This reminder will include where they can find the poster with the number where they can make an anonymous concern. 10. The concern process will be reviewed at a minimum annually with resident council. 11. Concern forms are confidential, protected QI documents and are not copied. 12. Concerns are tracked, trended and reported in the monthly QAPI Committee Meeting. 13. Retain grievance concern report and logs for 3 years. Others will be shredded. 14. Complete a concern report investigation with summary and conclusion. 15. Social Services staff will provide information regarding compliance line information for unresolved concerns .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40775 Based on interviews and record review, the facility failed to ensure accuracy of resident comprehensive assessment for three residents (#64, #81, and #158) out of fifty-two sampled residents. Findings included: A review of Resident #64's medical record revealed Resident #64 was admitted to the facility on [DATE] with diagnoses of dementia, psychosis, anxiety disorder, and need for assistance with personal care. An observation was conducted on 5/13/2024 at 10:49 AM of Resident #64 in the resident's room. Resident #64 was observed resting in bed with bilateral, one quarter length bed rails up. Resident #64's representative was observed in the room and was interviewed. Resident #64's representative stated Resident #64 has bed rails to her bed because They keep her in the bed. A review of Resident #64's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 4/15/2024, revealed under Section P-Restraints and Alarms, Bed Rails: Not used. An observation was conducted on 5/14/2024 at 10:10 AM of Resident #64 in the resident's room. Resident #64 was observed resting in bed with bilateral, one quarter length bed rails up. A review of Resident #81's medical record revealed Resident #81 was admitted to the facility on [DATE] with diagnoses of psychosis, dementia, anxiety disorder, and Hemiplegia and Hemiparesis following cerebrovascular disease affecting the right side. An observation was conducted on 5/13/2024 at 11:19 AM of Resident #81 in the resident's room. Resident #81 was observed sleeping in bed with bilateral, one quarter length bed rails up. A review of Resident #81's annual MDS assessment, with an ARD of 3/24/2024, revealed under Section P-Restraints and Alarms, Bed Rails: Not used. An observation was conducted on 5/14/2024 at 1:35 PM of Resident #81 in the resident's room. Resident #81 was observed sleeping in bed with bilateral, one quarter length bed rails up. A review of the medical record for Resident #158 revealed she was admitted to the facility on [DATE] from an acute care hospital. A review of physician orders, dated 3/8/2024, revealed Resident #158 may be discharged to home. A review of progress notes, dated 3/8/2024, revealed [Resident #158] is stable and was discharged home today with resident's medications given to the family with documentation of discharge instructions. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of medical record Minimum Data Set (MDS), dated [DATE], for Resident #158 revealed in Section A-Identification Information, discharge date [DATE] and Discharge Status Short Term General Hospital. An interview was conducted on 5/15/2024 at 11:30 AM with Staff G, Licensed Practical Nurse (LPN), Clinical Reimbursement Specialist (CRS). Staff G, LPN/CRS verified the MDS Section A, dated 3/8/2024, revealed Resident #158 was discharged to a short-term general hospital, return not anticipated. Staff G LPN/CRS verified the progress note dated 3/8/2024 indicated Resident #158 was discharged home. Review of the Policy and Procedure titled Discharge Management, dated October 2021, revealed the following: Policy: The facility's preadmission process is designed to provide residents with access to the appropriate care, health plan professional(s), and service(s) based on their level of care, evaluated needs, and the facility's ability to meet those needs. Residents are referred, transferred, or discharged based on their evaluated needs and by order of their attending physician. Discharges will be based on the resident's clinical condition and will occur as soon as reasonably possibly following the physician's discharge order. Procedure: 1. Formulate the initial discharge plan and projected date (based on diagnosis, level of functioning, rehab prognosis, clinical goals) through the Interdisciplinary Team (IDT) at the initial IDT Plan of Care meeting. 2. The Director of Nursing (DON) is accountable for discharge management coordination. Review of the Policy and Procedure titled Resident Assessment Instrument: MDS Section Completion by Discipline, dated October 2023, revealed the following: Overview: The IDT members participate in the Resident Assessment Instrument (RAI) to assess each Resident's individual needs and strengths through an approach that assesses problems or conditions and collaboration on appropriate interventions to achieve a Residents' highest level of functioning possible and maintain their sense of individuality. Guidelines: The RAI will be coordinated by a Registered Nurse (RN) who signs and certifies the completion of the assessments. Section A Identification Information is completed by Nursing. 48823

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Rehabilitation and Healthcare Center of Tampa	4411 N Habana Ave Tampa, FL 33614

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20311 Based on interviews and record review, the facility failed to ensure the accuracy of Level I Pre-Admission Screening and Resident Review (PASRR) assessments for three residents (#24, #38, and #81) out of eight residents sampled for PASRR's. Findings included: 1. Review of Resident #24's medical record revealed she was admitted to the facility on [DATE] with diagnoses including: -ALZHEIMER'S DISEASE, UNSPECIFIED-9/15/22 primary -BIPOLAR DISORDER, UNSPECIFIED-12/30/20 -DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY-9/15/22-Secondary. -OTHER SPECIFIED DEPRESSIVE EPISODES-9/8/22 -SCHIZOAFFECTIVE DISORDER, UNSPECIFIED-9/15/22 Review of the Level I PASRR, completion date 5/7/24, revealed in Section IA of the form identified the resident as having diagnosis of Bipolar Disorder, Depressive Disorder and Schizoaffective Disorder. A review of Section II of the form revealed the resident had a primary diagnosis of dementia and the resident does not have a secondary diagnosis of dementia or Alzheimer's. The PASRR form revealed A Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder, and a suspicion or diagnosis of Serious Mental Illness, . A review of Resident#24's medical record revealed there was no request made for a Level II PASRR evaluation for the resident. During an interview on 05/14/24 at 02:55 PM with the Director of Nursing (DON) and the Social Service Director, the Director of Social Services stated her department was responsible for completion of PASRR assessments, and oversight is done by nursing. The DON stated Resident #24 had a primary diagnosis of Alzheimer's and a secondary diagnosis of dementia and a request for a Level II PASRR should have been made. The Social Service Director stated there was confusion when completing the PASRR, as they had assistance from an outside vendor. 2. A review of Resident #81's medical record revealed Resident #81 was admitted to the facility on [DATE] with diagnoses including unspecified psychosis, dementia, anxiety disorder, depressive episodes, and insomnia. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 81's annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/24/2024, revealed under Section I-Active Diagnoses, Resident #81 had a diagnoses of Non-Alzheimer's dementia, anxiety disorder, depression (other than bipolar), and psychotic disorder (other than schizophrenia). A review of Resident #81's Level I PASRR assessment, dated 5/6/2024, revealed under the section titled A. MI (Mental Illness) or suspected MI (check all that apply), the checkboxes for the selections Other (specify): unspecified psychosis, insomnia, anxiety disorder and depressive disorder were checked. Review of the medical record for Resident #81 revealed a PASARR Level II assessment was not completed. 3. During an observation on 05/13/2024 at 9:40 a.m., Resident #38 was observed in bed dressed in a gown sleeping. During an observation on 05/15/2024 at 10:00 a.m., Resident #38 was observed sitting in a wheelchair near the nurse's station interacting with staff and other residents. Attempted to interview Resident #38, she was not able to answer any questions. Review of Resident #38's admission record showed Resident #38 was admitted to the facility on [DATE] with diagnoses of major depressive disorder, Bipolar Disorder, vascular dementia, and schizoaffective disorder. The Level I PASRR, dated 05/07/2024, shown in Section I-Part A was marked for anxiety disorder, depressive disorder, and schizoaffective disorder. Section II: Other Indications for PASRR Screen Decision-Making questions 1 through 5 were marked No. Question 6, Does the individual have a secondary diagnosis of dementia, related neurocognitive disorder (including Alzheimer's disease) and the primary diagnosis is a serious mental illness or intellectual disability), was also marked No. Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption Not a Provisional Admission was marked. Section IV: PASARR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASARR evaluation not required was marked. A Registered Nurse (RN), from the facility signed and completed the PASRR on 05/07/2024. An interview was conducted on 05/15/2024 at 10:30 a.m. with the Social Services Director (SSD). She reviewed Resident #38's medical diagnoses and noted the resident had a diagnosis of major depressive disorder, schizoaffective disorder, bipolar type and vascular dementia. She reviewed the PASRR, dated 05/07/2024, and stated question 6 of Section II was marked incorrectly. She stated she would submit a Level II screening. The SSD provided a copy of the PASRR, dated 10/20/2022, the updated PASRR, dated 05/07/2024, and the copy of the Level II screening submission, dated 05/15/2024. Review of facility's PASRR Policy revealed the following: (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Page 2 of 4 of the facilities PASARR Policy, under PASARR Level II, 3. Level II PASARR must be completed if the below are listed but not limited to: Is there an indication the resident has or may have had a disorder resulting in functional limitations in major life activities that would otherwise be appropriate for the individuals developmental stage, the resident has a primary or secondary diagnosis of dementia or related neurocognitive disorder, and suspicion, or diagnosis of SMI [serious mental illness], ID [intellectual disability], or both and 40775 50434

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on observations, interviews, and record review, the facility failed to review and revise the care plan for one resident (#63) out of two residents reviewed for rehabilitation and restorative services. Findings included: An observation on 05/13/24 at 10:49 a.m., revealed Resident #63 sitting in a wheelchair beside her bed. Resident #63 had no socks or shoes on her right foot. Resident #63 stated her shoe for her right foot was in the dresser drawer, she opened the drawer and showed her shoe that laid in the drawer. Resident #63 stated she did not want her shoe on at the time of interview. A review of the Admission Record showed Resident #63 was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Hemiparesis following cerebral infarction affecting right dominate side, contracture of muscle, multiple sites, muscle wasting and atrophy, lack of coordination and multiple sclerosis. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], showed Resident #63 had a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact). A review of Resident #18's care plan revealed the following: Focus: ROM: The resident is at risk for developing and/or has an impairment in functional joint mobility because of: Actual Impairment with inability to achieve full functional range of motion in the: Right Elbow. Goals: Will demonstrate benefits from increased circulation in the involved extremities (i.e. decreased edema, improved comfort or skin condition, Will minimize the risk of complications related to splint application and Limitation will not interfere with daily functions. Interventions: - NURSING REHAB: Adaptive Device Task Adaptive Device Type: AFO right foot ankle brace Apply to right foot. - Adaptive Device to right foot. On when OOB [out of bed] as tolerated, assist resident with application of brace. - Discontinue & report pain during session. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Passive ROM [range of motion], (The Staff completes the exercise for the resident) to the following joints: provide gentle stretch to right shoulder, elbow, wrist and digits prior to splint application. Review of a current physician order, dated 08/24/23, showed Apply Right hand splint for up 4 hours daily as patient tolerates one time a day for Splinting program. Review of the discontinued physician orders revealed two discontinued orders as follows: - A physician order with a discontinued date 04/26/21 showed CNA OR Restorative aid to assist resident in applying right AFO brace daily when Out of Bed as resident tolerates- every day shift. - A physician order with a discontinued date 04/26/21 showed Apply right ankle foot brace (Boot) daily. - every day shift for to correct right ankle foot drop/ prevent contracture. During an interview on 05/15/24 at 9:30 a.m., Staff B, Licensed Practical Nurse (LPN) stated Resident #63 did not have a foot brace that she used and there was no current physician order for a foot brace. During an interview on 05/15/24 at 11:07 a.m., the Director of Nursing (DON) stated all care plans should be revised to reflect the resident's current health status. The DON stated Resident #63's care plan should have been revised when Resident #63's physician order for the foot brace was discontinued on 06/06/21. Review of the facility's policy titled Care Plan- Interdisciplinary Plan of Care from Interim to Meeting, effective date February 2024, showed the following: The comprehensive care plan is an interdisciplinary communication tool. It includes measurable objectives and tie frames and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The care plan is reviewed and revised periodically, and the services provided or arranged are consistent with each residents' written plan. The Procedure included 2. Update to Care Plans a. Ongoing updates to care plans are added by a team member of the Interdisciplinary Team, as needed. 3. Dates and documentation on the care plan a. New, revised or discontinued Problems, Goals or Interventions are dated for the date the documentation was made.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39438 Based on observations, interviews, and record review, the facility failed to provide nail care for one resident (#100), who was unable to carry out Activities of Daily Living (ADLs), out of one sampled resident. Findings included: On 05/13/24 at 9:30 a.m., Resident #100 stated she needed her nails cut. The resident stated the staff does not offer to cut her nails and she wants them cut. On 05/15/24 at 1:40 p.m., Resident #100 was observed with elongated, uneven, jagged, nails with visible dirt underneath her nails. She stated she had asked a Certified Nursing Assistant (CNA) to cut her nails and was told the staff member did not have a nail clipper. The resident stated she told the CNA she had nail clippers she could use, but she had not gotten them cut yet. A review of the Admission Record revealed Resident #100 was initially admitted to the facility on [DATE] with muscle wasting and atrophy, not elsewhere classified, and multiple sites. A review of the Minimum Data Set (MDS), dated [DATE], Section C-Cognitive Patterns showed Resident #100 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating intact cognition. A review of the care plan for Resident #100 revealed the following: Resident #100 had an ADL self-care performance deficit related to weakness and impaired balance. Interventions included needing the assistance of one for personal hygiene and during bathing check nail length and trim and clean on bath day and as necessary. On 05/15/24 at 2:25 p.m., Staff F, CNA, stated if she observes a resident that needed nail care, she will get nail clippers from the Unit Manager and cut them. She walked to the resident's room with the State Surveyor and confirmed Resident #100 nails were as described above. On 05/16/24 at 9:55 a.m., the Director of Nursing (DON) stated the CNAs were not responsible for cutting nails. The nurse or the nurse manager would cut the resident's nails if a resident needed nail care. No policy related to nail care was provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on observations, interviews, and record review, the facility failed to ensure active and ongoing communication was received between the facility and hospice providers for two residents (#18 and #24) out of four residents reviewed for hospice services. Findings included: 1. During an interview on 05/13/24 at 11:33 a.m., Resident #18 stated hospice comes to the facility for her and assists with her care. Resident #18 stated, When I first got put on hospice I cried because I thought I was dying, but I am still here. A review of Resident #18's medical record revealed no hospice notes or communication forms from Resident #18's hospice program. A review of the Admission Record revealed Resident #18 was originally admitted to the facility on [DATE] with diagnoses including malignant neoplasm of unspecified part of unspecified bronchus of lung, abnormal posture, cognitive communication deficit, major depressive disorder, anxiety disorder, and other seizures. A review of the quarterly Minimum Data Set (MDS), dated [DATE], showed Resident #18 had a Brief Interview for Mental Status (BIMS) score of 10 (moderately cognitively impaired). During an interview on 05/14/24 at 3:18 p.m., Staff A , Registered Nurse (RN) Unit Manager (UM) stated it was expected that hospice staff leave communication notes in the residents' medical record as a way of communicating with the facility. Staff A RN, UM reviewed Resident #18's medical record and confirmed there were no hospice notes in the medical record. Staff A stated sometimes hospice would stop and tell staff what resident they are visiting and the reason for the visit, then the facility staff could put a progress note in. Staff A RN, UM verified there was no hospice communication available in Resident #18's medical record. Staff A RN, UM did not know the last time hospice visited Resident #18 or what services hospice provided. During an interview on 05/14/24 at 4:00 p.m., The Director of Nursing (DON) stated she expected hospice notes to be a part of a resident's medical record or placed in a resident's hospice binder when services were provided. During an interview on 05/14/24 at 4:20 p.m., Staff C, Medical Records Custodian (MRC) stated she heard about the lack of hospice notes and stated she was going to look to ensure the hospice notes were not thinned from the chart. Staff C MRC stated she understood not having the hospice notes in a resident's medical record was a problem and the facility was going to correct the problem to ensure hospice notes were present in the medical record from now on. Review of the facility's Hospice Agreement, effective date 08/26/13, between the Facility and Resident #18' Hospice Provider revealed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Article 4- Coordination of Services 4.2 Communication Concerning Hospice Patients: The parties, through their designated personnel, shall communicate on an on-going basis regarding the care and services provided each Hospice Patient to ensure that the needs of the Hospice Patient are addressed and met on a twenty-four-hour basis. Documentation of such communications shall be maintained by each party in their respective clinical records concerning each Hospice Patient. 4.3 Clinical Records Facility and Hospice will each maintain and, subject to applicable laws and regulations regarding confidentiality of patient information, make available to each other for inspection and copying, detailed clinical records concerning each Hospice Patient in accordance with federal and state laws and regulations and applicable Medicare and Medicaid guidelines. 2. Review of Resident #24's medical record revealed she was admitted to the facility on [DATE] and had diagnosis that included Alzheimer's Disease. During an interview with Resident #24 on 05/13/24 at 12:13 PM, the resident reported she was in pain at a level of 10 (Severe pain). The resident reported she has medication for pain, but the medication does not work. During an interview with Resident #24 on 05/15/24 at 10:29 AM the resident reported she was in pain all over at a level of 10 (Severe pain). Review of the resident's physician orders revealed she had current orders for the following medications for pain: -2/12/24-HYDROcodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) *Controlled Drug*, Give 1 tablet by mouth every 6 hours for PAIN. -4/26/23- Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical), Apply to bilateral wrists topically every day shift for pain. -2/1/23- Acetaminophen Tablet 325 MG. Give 2 tablet via G-Tube every 6 hours as needed for Pain Do not exceed 3GM / 24hours OTC Medication provided by facility. -2/1/23- Monitor pain every shift and record pain number on a 0-10 scale. every shift for Pain Monitoring. -2/1/23-May change medication form as condition warrants (solid, liquid, crush) An interview was conducted on 05/15/24 at 10:30 AM with Staff H, Registered Nurse (RN), Unit Manager. Staff H reported Resident 24 was on hospice and stated she was not sure if hospice was aware of the resident being in pain. She stated the hospice visit notes are in the resident record. A review of the medical record revealed the last visit note, dated 5/8/24, with a fax date of 5/15/24. The Unit Manager reported she was unaware if there was a hospice book, and she would review the resident's physician orders and notify the hospice nurse about the pain An interview on 05/15/24 at 10:32 AM with Staff K, RN revealed she had not given the resident her routine pain medication and she was not sure of the residents pain level because she had not checked on the resident yet. Staff H, Unit manager who was present for the interview reported she would check for physician orders for medication for breakthrough pain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of Resident #24 on 05/15/24 at 10:41 AM was conducted. Staff K, RN was observed trying to give the resident a Tylenol pill with applesauce and water. The resident was noted to have difficulty with swallowing the pill. On 05/15/24 at 10:44 AM Staff K, RN continued to encourage the resident to swallow. Resident #24 reported that it was hard for her to swallow the pill. Staff K stated she was not aware if the resident had orders to give medications in an alternate form. During a phone interview on 05/15/24 at 10:53 AM with Staff L, Hospice RN, she stated she was the RN Care Coordinator assigned to the case. She reported that when she comes to visit the resident she speaks with nurses on the floor. She reported she does not leave the visit reports at the facility but keeps her reports in the resident's hospice chart. During an interview with the Director of Nursing (DON) on 05/15/24 at 11:01 AM, she reported that prior to yesterday the hospice staff would just come into the building see the residents but were not leaving paperwork. She stated the expectation was the hospice staff communicate with the staff and leave a visit note. She stated the resident should be comfortable at all times and if the resident has a PRN medication for pain it should be utilized for breakthrough pain and the nurses should be communicating with hospice if the residents pain is not managed well. 20311 40775

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40775 Based on interviews and record reviews, the facility failed to ensure informed consent for the use of bedrails was obtained prior to installation of bedrails and failed to ensure residents were assessed properly for the use of bedrails prior to installation for three residents (64, #81, and #311) of three residents sampled for bedrail use. Findings included: 1. A review of Resident #64's medical record revealed Resident #64 was admitted to the facility on [DATE] with diagnoses of dementia, psychosis, anxiety disorder, and need for assistance with personal care. An observation was conducted on 5/13/2024 at 10:49 AM of Resident #64 in the resident's room. Resident #64 was observed resting in bed with bilateral, one quarter length bed rails up. Resident #64's representative was observed in the room and was interviewed. Resident #64's representative stated Resident #64 has had bed rails to her bed because, They keep her in the bed. Resident #64's representative stated Resident #64 was not informed of the risk of bed rail use and did not sign a consent for the bed rail use. A review of Resident #64's Physical Therapy Discharge Summary, dated 4/3/2024, revealed under the section titled Analysis of Functional Outcome/Clinical Impressions at the time of discharge, Resident #64 continued to require maximum assistance with all functional bed mobility/repositioning tasks and was discharged from therapy having likely achieved her maximum functional potential. The Physical Therapy Discharge Summary did not address the use of bedrails. A review of Resident #64's care plan revealed a focus area, last revised 8/11/2021, Resident #64 had an activities of daily living (ADL) self-care performance deficit related to impaired cognition and limited range of motion to the lower extremities with contracture. Interventions included to provide assistance of two staff for bed mobility when turning and/or repositioning. Resident #64's care plan did not reveal interventions related to the use of bedrails. A review of Resident #64's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 4/15/2024, revealed under Section P-Restraints and Alarms, Bed Rails: Not used. A review of Resident #64's medical record did not reveal documentation related to alternative methods used prior to installation of the bed rails or informed consent related to the use of bed rails. An observation was conducted on 5/14/2024 at 10:10 AM of Resident #64 in the resident's room. Resident #64 was observed resting in bed with bilateral, one quarter length bed rails up. 2. A review of Resident #81's medical record revealed Resident #81 was admitted to the facility on [DATE] with diagnoses of psychosis, dementia, anxiety disorder, and hemiplegia and hemiparesis following cerebrovascular disease affecting the right side. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation was conducted on 5/13/2024 at 11:19 AM of Resident #81 in the resident's room. Resident #81 was observed sleeping in bed with bilateral, one quarter length bed rails up. A review of Resident #81's Occupational Therapy Plan of Care, dated 2/23/2024, revealed under the section titled Initial Assessment, Resident #81 required maximum assistance (76% to 99%) with rolling bed mobility with a long term goal to roll to the left side with minimal (1% to 25%) assistance in order to improve the resident's ability to assist caregivers during brief changes. The Occupational Therapy Plan of Care did not address the use of bedrails. A review of Resident #81's care plan revealed a focus area, last revised 2/22/2024, Resident #81 had an ADL self-care performance deficit related to impaired cognition, weakness, impaired balance, and decline in function. Interventions included to provide assistance of two staff for bed mobility when turning and/or repositioning. Resident #81's care plan did not reveal interventions related to the use of bedrails. A review of Resident #81's annual MDS assessment, with an ARD of 3/24/2024, revealed under Section P-Restraints and Alarms, Bed Rails: Not used. A review of Resident #81's medical record did not reveal documentation related to alternative methods used prior to installation of the bed rails or informed consent related to the use of bed rails. An observation was conducted on 5/14/2024 at 1:35 AM of Resident #81 in the resident's room. Resident #81 was observed sleeping in bed with bilateral, one quarter length bed rails up. 3. A review of Resident #311's medical record revealed Resident #311 was admitted to the facility on [DATE] with diagnoses of need for assistance with personal care, dementia, maxillary fracture, fracture of right orbital floor, and pathological hip fracture. An observation was conducted on 5/13/2024 at 2:04 PM in Resident #311's room. Resident #311 was observed sleeping in bed, positioned on her back, with bilateral, one quarter length bed rails up. A review of Resident #311's Occupational Therapy plan of care, with a start of care date of 5/13/2024, revealed Resident #311 had a functional deficit in rolling bed mobility, and was dependent on facility staff for rolling side to side in bed. The Physical Therapy plan of care did not address the use of bedrails. A review of Resident #311's care plan revealed a focus area, initiated on 5/13/2024, Resident #311 was at risk of developing wounds and had actual wounds. Interventions included to encourage/remind/assist to turn/reposition as needed or requested, observe for any new areas of skin breakdown, treatment as ordered, and observe that dressing is covering and adhering. Report loose dressings to the nurse. Resident #311's care plan revealed a focus area, initiated on 5/13/2024, Resident #81 had an ADL self-care performance deficit. Interventions included to provide assistance of one staff for bed mobility when turning and/or repositioning. Resident #311's care plan did not reveal interventions related to the use of bedrails. A review of Resident #311's medical record did not reveal documentation related to alternative methods used prior to installation of the bed rails or informed consent related to the use of bed rails. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105234	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation and Healthcare Center of Tampa	4411 N Habana Ave Tampa, FL 33614

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation was conducted on 5/14/2024 at 10:09 AM in Resident #311's room. Resident #311 was observed sleeping in bed, positioned on her back, with bilateral, one quarter length bed rails up. An interview was conducted on 5/14/2024 at 1:14 PM with Staff H, Registered Nurse (RN) and Unit Manager (UM). Staff H, RN UM stated new residents were assessed for the use of bedrails by the admitting nurse and therapy staff. When the assessment is completed, nursing staff will notify the maintenance staff to install the appropriate bedrails. Staff H, RN UM was not able to state if Resident #81 was able to use bedrails and stated Resident #64 did use bedrails. A follow up interview was conducted on 5/16/2024 at 11:06 AM with Staff H, RN UM. Staff H, RN UM stated the bedrails to Resident #311's bed were already installed when the resident was admitted to the facility, and she was not sure if the resident was able to use them for turning and repositioning. An interview was conducted on 5/16/2024 at 12:43 PM with the facility's Director of Nursing (DON). The DON stated therapy staff evaluate residents for the safe use of bedrails upon admission to the facility. Once the therapy referral is received, therapy staff will evaluate the resident to ensure the bedrail use is appropriate. The DON also stated a bedrail assessment is completed upon admission by the admitted nurse, but the DON was not able to state how the nursing staff perform the assessment. The DON stated she would expect bedrails to be installed only after the resident was assessed to ensure the use is appropriate because bedrails may not be safe for the resident to have. The DON was not able to state if a consent for bedrails was required or how often an assessment for bedrail use should be performed, but the DON stated the use of bedrails should be reflected in the resident's care plan. A review of the facility policy titled Side Rails-Assistive Device, effective in October 2021, revealed under the section titled Overview side rail(s) will not be used unless or until all other alternatives have been exhausted. If a side rail is used the facility must ensure correct installation, use, and maintenance of rail. The policy also revealed under the section titled Guidelines on admission, readmission, quarterly, and with significant change in condition, the resident will be assessed for ability to turn, reposition, enter and exit the side to determine if an assistive device or a side rail is required for mobility. The Assistive Device/Side Rail Algorithm may be used to determine necessity of the assistive device/side rail and alternatives. The interdisciplinary team (IDT) will review with the resident and/or representative the assessment findings as part of the resident care plan process. The facility will include a risk/benefit discussion and obtain informed consent. Resident and resident representative, if indicated, will be educated on the use of the assistive device. Update the Care Plan and Kardex to include use of assistive device. Re-evaluate resident status at least quarterly or with significant changes at the plan of care and/or standards of care meeting to determine if assistive device is still required.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40775 Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5%. A total of 27 medication administration opportunities were observed with two medication errors for two residents (#56 and #4) of four residents sampled for medication administration, which resulted in a medication administration error rate of 7.41%. Findings included: A review of Resident #56's medical record revealed Resident #56 was admitted to the facility on [DATE] with diagnoses of muscle wasting and atrophy and polyosteoarthritis. A review of Resident #56's physician orders revealed the following orders: - An order dated 11/8/2023 for Docusate sodium 100 milligrams (mg) by mouth every morning and at bedtime. - An order dated 11/9/2023 for Folic acid 1 mg by mouth one time a day. - An order dated 3/25/2024 for Gabapentin 100 mg 2 capsules by mouth every 12 hours. - An order dated 11/8/2023 for Acetaminophen 325 mg 2 tablets by mouth every four hours as needed. An observation of medication administration was conducted on 5/15/2024 at 8:57 AM with Staff K, Registered Nurse (RN). Staff K, RN removed the following medications from the medication cart for administration to Resident #56: - Docusate sodium 100 mg one capsule. - Folic acid 400 micrograms (mcg) one tablet. - Gabapentin 100 mg two capsules. - Acetaminophen 325 mg two tablets. After gathering the medications, Staff K, RN crushed Resident #56's medications and placed them in applesauce. Staff K, RN performed hand hygiene and entered Resident #56's room with the medications. Staff K, RN administered the medications to Resident #56 without difficulty. Staff K, RN performed hand hygiene and exited the resident's room. Staff K, RN did not address the incorrect dose of folic acid was administered to Resident #56. A review of Resident #4's medical record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses of atrial fibrillation and cognitive communication deficit. A review of Resident #4's physician orders revealed the following orders: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order dated 11/1/2023 for Aspirin 81 mg by mouth one time a day. - An order dated 11/1/2023 for Bumetanide 1 mg by mouth one time a day. - An order dated 5/8/2024 for Buspirone hydrochloride (HCl) 5 mg by mouth every 12 hours. - An order dated 3/20/2024 for Carvedilol 3.125 mg by mouth two times a day. - An order dated 12/5/2023 for Saccharomyces bouvardia one capsule by mouth every 12 hours. - An order dated 11/15/2023 for Diltiazem HCl extended release (ER) 20 mg by mouth two times a day. - An order dated 11/1/2023 for Polysaccharide iron complex 150 one tablet by mouth two times a day. - An order dated 11/1/2023 for Apixaban 5 mg by mouth two times a day. - An order dated 11/1/2023 Enalapril maleate 10 mg by mouth one time a day. An observation of medication administration was conducted on 5/15/2024 at 9:09 AM with Staff K, RN. Staff K, RN removed the following medications from the medication cart for administration to Resident #4: - Aspirin 81 mg one tablet. - Bumetanide 1 mg one tablet. - Buspirone HCl 5 mg one tablet. - Carvedilol 3.125 mg one tablet. - Saccharomyces bouvardia one capsule. - Diltiazem HCl ER 20 mg one capsule. - Ferrous sulfate 325 mg one tablet. - Apixaban 5 mg one tablet. - Enalapril maleate 10 mg one tablet. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After gathering the medications, Staff K, RN performed hand hygiene and entered Resident #4's room with the medications. Staff K, RN administered the medications to Resident #4 without difficulty. Staff K, RN performed hand hygiene and exited the resident's room. Staff K, RN did not address the incorrect medication of Ferrous sulfate was administered to Resident #4 instead of Polysaccharide iron complex 150. An interview was conducted with Staff K, RN following the observation. Staff K, RN reviewed Resident #4's physician's orders and addressed she administered Ferrous sulfate 325 mg to Resident #4 instead of Polysaccharide iron complex 150. Staff K, RN also reviewed Resident #56's physician's orders and addressed she administered Folic acid 400 mcg instead of Folic acid 1 mg to Resident #56. Staff K, RN stated when administering medications, nurses are to verify the physician's orders in the resident's record and verify the right dose, right medication, right route, right time, and right resident before administering the medication to the resident. An interview was conducted on 5/16/2024 at 1:08 PM with the facility's Director of Nursing (DON). The DON stated she would expect nursing staff to verify the right dose, right medication, right route, right time, and right resident before administering the medication to the residents and compare the medication they are removing from the cart with the resident's medication administration record and physician's orders. The DON also stated if nursing staff did not verify the five rights, it would result in a medication error A review of the facility policy titled Medication Administration, effective in November 2018, revealed under the section titled Policy medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices, and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. The policy also revealed under the section titled Procedures - Medication Preparation prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record (MAR). Compare the medication and dosage schedule on the resident's MAR with the medication label. The policy revealed under the section titled Procedures - Medication Administration medications are administered in accordance with written orders of the prescriber. Verify medication is correct three (3) times before administering the medication: When pulling medication package from the medication cart, when dose is prepared, and before the dose is administered.