STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105287	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Oaks Rehabilitation & Nursing Center	2061 Hyde Park Rd Jacksonville, FL 32210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility and resident records, the facility's policy and procedure titled Abuse, Neglect, Exploitation, Mistreatment, Misappropriation of Property and Injury of Unknown Source Prevention (ANEMMI), and interviews with staff and outside medical professionals, the facility failed to protect Resident #1's right to be free from neglect, by failing to ensure adequate supervision and safeguards to prevent the resident, with a known history of pica (an eating disorder characterized by a compulsive and recurrent consumption of non-nutritive and non-food items), from consuming his incontinence pad, choking and dying. On June 20, 2025 at 1:49 PM, Resident #1 was found in his bed unresponsive with feces and bits of blue plastic resembling incontinence pad pieces in his mouth. Resuscitation efforts were initiated, and he was transported to the hospital by Emergency Medical Services (EMS), but resuscitation efforts failed. The Medical Examiner discovered during an autopsy that Resident #1 was full of foreign blue matter. The facility's failure to adequately supervise a resident with behavioral issues, resulting in his death, has the potential to negatively affect 52 other residents with behavioral care plans from a total of 173 residents residing in the facility. Immediate Jeopardy (IJ) at a scope of J (isolated) was identified at 4:20 PM on July 1, 2025. On June 20, 2025 at 1:49 PM, Immediate Jeopardy (IJ) began. On July 2, 2025, at 6:30 PM, the Administrator was notified of the IJ determination, IJ templates were provided, and Immediate Jeopardy was ongoing as of the survey exit on July 2, 2025.The findings include:Cross reference F610, F835, and F867A review of a facility report authored by the Director of Nursing (DON) on 6/27/25, revealed that on 6/20/25 at 1:49 PM, Resident #1 was observed unresponsive in bed by a certified nursing assistant (CNA). The CNA called the Unit Manager (UM) immediately and upon entering the room, the UM observed brown stuff coming from Resident #1's mouth. A Code Blue (term used for a medical emergency involving respiratory or cardiac arrest) was paged overhead and chest compressions were initiated. Emergency Medical Services (EMS) was also called. EMS arrived at the facility and took over cardiopulmonary resuscitation (CPR). Resident #1 was taken to the emergency room but did not survive. An adult protective investigator (API) came to the facility, following a call she received from the sheriff's office, to investigate. The facility's report noted that Resident #1 was care planned for his behavior of eating his briefs/disposable incontinence pads. The report concluded that there was no diagnosis received from the emergency room (ER) and autopsy and toxicology reports were pending but normally took two months to receive. (Photographic evidence obtained)A review of the Adult Protective Investigator's (API's) 6/21/25 investigative report revealed that on 6/20/25, Resident #1 was pronounced deceased while in the care of the facility. He required 24-hour supervision, and the facility knew he liked to put things in his mouth. Resident #1 was left around those things and should have been supervised. He was able to put things in his mouth which possibly led to his death, but it was unknown if that was the cause. On 6/21/25, the API visited the facility and obtained interviews with staff involved. Supervisor A stated she was not in the building when the incident occurred but was aware that Resident #1 was hospitalized two or three months ago for placing inappropriate items in his mouth, including plastic forks, [disposable incontinence] pads, and adult diapers (briefs). According to Supervisor A, Resident #1's care plan should have included instructions for keeping these items out of his room. She also noted that this resident was not on one-on-one (1:1) supervision at the time. The report noted that CNA A stated 6/20/25 was her first day assigned to Resident #1 but no one informed her that he was not supposed to have incontinence pads in his room. CNA A also stated it was CNA B and CNA C who discovered Resident #1 with a disposable pad in his mouth, which had feces wrapped in it. When CNA A arrived at Resident #1's room, CNA B was attempting to remove the pad from the resident's mouth while the supervisor retrieved the emergency cart. CNA A reported she was informed by the UM at 3:00 PM that Resident #1 was not supposed to have disposable incontinence pads or briefs in his room due to his tendency to ingest them. CNA A stated she believed that Resident #1 should have been on one-on-one (1:1) supervision due to his behavior. During the API's interview, CNA A became emotional, began to cry and stated she had previously told the UM this resident needed one-on-one supervision. The staff dismissed her concerns saying she was trying to act like a supervisor. In the API's interview with Resident #1's family member, he explained that the facility contacted him and reported that Resident #1 was found eating his feces and an incontinence pad; behavior Resident #1 exhibited while living with family, which was part of the reason he was placed in a facility. (Photographic evidence obtained)An interview was conducted with CNA B on 7/1/25 at 10:36 AM

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility and resident records, facility's policy and procedure titled Abuse, Neglect, Exploitation, Mistreatment, Misappropriation of Property and Injury of Unknown Source Prevention (ANEMMI), and interviews with staff and outside medical professionals, the facility failed to conduct a thorough investigation to rule out abuse or neglect after one (Resident #1) of one resident with a known history of pica (an eating disorder characterized by a compulsive and recurrent consumption of non-nutritive and non-food items), who chewed and consumed incontinence briefs and disposable incontinence pads, was found unresponsive with feces and bits of blue plastic resembling incontinence pad pieces in his mouth. As a result of the incident, Resident #1 died. Despite direct observation of the event by CNAs A, B, C, the Unit Manager (UM) and Nurse Practitioner (NP), no interviews were obtained and there was no evidence verifying that a thorough record review was conducted. Only written statements, which omitted relevant information, were gathered for the investigation. Without a thorough analysis of adverse resident events, the facility was unable to identify causes and measures needed to ensure the safety and protection of other residents at risk. This failure had the potential to negatively impact all 52 residents in the facility who were care planned for behaviors. Immediate Jeopardy (IJ) at a scope of J (isolated) was identified at 4:20 PM on July 1, 2025. On June 20, 2025 at 1:49 PM, Immediate Jeopardy (IJ) began. On July 2, 2025, at 6:30 PM, the Administrator was notified of the IJ determination, IJ templates were provided, and Immediate Jeopardy was ongoing as of the survey exit on July 2, 2025. The findings include:Cross Reference F600, F835, and F867An electronic medical record (EMR) review for Resident #1 revealed he was admitted to the facility on [DATE], discharged on 9/4/24, and readmitted on [DATE]. The EMR landing page included a Special Instructions warning on the dashboard advising that Resident #1 should not be given, have within reach, or be left unattended if items were made from plastic, sponge, foam and/or paper. As a result, all following items are barred from use [disposable incontinence pads]/bed padding/under padding, brief/ [adult disposable incontinence briefs]/diaper and pull-ups, except for mattresses. Items made from fabric are ideal . (Photographic evidence obtained) Diagnoses included, but were not limited to, traumatic brain injury (TBI), hip fracture, unspecified protein -calorie malnutrition, muscle weakness, hemiplegia and hemiparesis (one sided weakness or paralysis) following cerebral infarction (stroke) affecting left non-dominant side, dysphagia oropharyngeal phase (difficulty initiating swallowing), cognitive communication deficit, need for assistance with personal care, anxiety, depression, restlessness and agitation.The quarterly minimum data set (MDS) assessment, with a reference date of 6/7/25, revealed that Resident #1's brief interview for mental status score was 7 out of a possible 15 points, indicating severe cognitive impairment. He was frequently incontinent of bowel with no active toileting program. He was care planned on 6/2/24 for impaired or inappropriate behaviors related to his TBI (traumatic brain injury). On 6/20/25, the care plan was revised to add the following details: Resident removes his diapers, puts self on floor, slams leg against footrest/mattress, and eats briefs/[disposable pads]. Interventions did not address supervision or removal of such objects from his room. (Photographic evidence obtained)A review of the physician's order dated 6/13/25 prohibited exposure to plastic, sponge, foam and paper and barred disposable incontinence pads/bed padding/under padding, brief/disposable briefs/diaper and pull-ups, except for mattresses. There was no corresponding progress note to explain why this order was entered at this time.A progress note authored by the Unit Manager (UM) on 6/20/25 at 2:43 PM, revealed that at approximately 1:49 PM, a certified nursing assistant (CAN) called the UM to [Resident #1's] room. Resident #1 was found in bed, unresponsive, and in respiratory distress. Two CNAs were at bedside and a brown substance was coming from the resident's mouth. He had no pulse, was warm to the touch, and was difficult to arouse with a sternal rub. Fecal matter was scattered over the bed, the resident's body, hands and face. Chest compressions were initiated, Code Blue (term used for a medical emergency involving respiratory or cardiac arrest) was called, and Emergency Medical Services (EMS) was called for assistance. Rescue arrived at approximately 2:07 PM and the resident was transferred to the hospital at 2:25 p.m. (Photographic evidence obtained)A review of a facility report authored by the Director of Nursing (DON) on 6/27/25, revealed that on 6/20/25 at 1:45 PM, Resident #1 was observed unresponsive in bed by a certified nursing assistant (CNA). The CNA called the Unit Manager (UM) immediately and upon entering the room, the UM observed brown stuff coming from Resident #1's mouth. A Code Blue (term used for a medical emergency involving respiratory or cardiac arrest) was paged overhead and chest compressions were

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility and resident records, a review of the facility's policy and procedure titled Care Plan-Comprehensive, and interviews with staff and medical professionals, the facility failed to develop and implement a comprehensive person-centered care plan detailing a focused problem area and specific interventions needed to protect one (Resident #1) of one resident with a known history of pica (an eating disorder characterized by a compulsive and recurrent consumption of non-nutritive and non-food items), from consuming incontinence pads. This affected one (Resident #1) of three residents reviewed for behavioral issues, from a total of 52 residents with behavioral care plans.The findings include:A review of a facility report authored by the Director of Nursing (DON) on 6/27/25, revealed that on 6/20/25 at 1:49 PM, Resident #1 was observed unresponsive in bed by a certified nursing assistant (CNA). The CNA called the Unit Manager (UM) immediately and upon entering the room, the UM observed brown stuff coming from Resident #1's mouth. A Code Blue (term used for a medical emergency involving respiratory or cardiac arrest) was paged overhead and chest compressions were initiated. Emergency Medical Services (EMS) was also called. EMS arrived at the facility and took over cardiopulmonary resuscitation (CPR). Resident #1 was taken to the emergency room but did not survive. The facility's report noted that Resident #1 was care planned for his behavior of eating his briefs/disposable incontinence pads. (Photographic evidence obtained)A review of the Adult Protective Investigator's (API's) 6/21/25 investigative report revealed that she visited the facility and obtained interviews with staff involved about the 6/20/25 event. Supervisor A (no longer employed) stated she was not in the building when the incident occurred but was aware that Resident #1 was hospitalized two or three months ago for placing inappropriate items in his mouth, including plastic forks, [disposable incontinence] pads, and adult briefs. According to Supervisor A, Resident #1's care plan should have included instructions for keeping these items out of his room. She also noted this resident was not on one-on-one (1:1) supervision at the time. Certified Nursing Assistant (CNA) A stated 6/20/25 was her first day assigned to Resident #1 but no one informed her that he was not supposed to have incontinence pads in his room. CNA A further stated it was CNA B and CNA C who discovered Resident #1 with a disposable incontinence pad in his mouth, which had feces wrapped in it. CNA A reported she was informed by the Unit Manager (UM) at 3:00 PM on the day of the event that Resident #1 was not supposed to have disposable pads or diapers in his room due to his tendency to ingest them. She concluded by saying she believed Resident #1 should have been on one-on-one supervision due to his behaviors. During the API's interview with Resident #1's family member, the family member explained that Resident #1 exhibited these behaviors while living with family, which was part of the reason he was placed in a facility. (Photographic evidence obtained)An interview was conducted with CNA B on 7/1/25 at 10:36 AM. She reported finding (Resident#1) unresponsive with pieces of disposable incontinence pad in his mouth. Feces were on the pad and several pieces were in his mouth. She removed them with her fingers. Resident #1 did not wear briefs or use disposable incontinence pads anymore. He had a brain injury and would chew on his socks, shirt and the pads or briefs. She did not know how he got the incontinence pad. The UM had recently advised the CNAs never to use the plastic pads, as he would chew on them. Resident #1's CNA that day was new to him and had only worked in the locked unit two or three times. CNA B did not know if that CNA put the pad in the room, nor did she know where the rest of the pad was.CNA C was interviewed on 7/1/25 at 11:13 AM. She worked on 6/20/25 and was across the hall when she heard CNA B yelling for the nurse. She ran into Resident #1's room and CNA B was trying to pull disposable incontinence pads out of Resident #1's mouth. There were strands of pads and feces in his mouth, and feces on his hand and leg. There was no plastic pad under Resident #1, and he was not wearing a brief, but he had been doing that, eating them. The CNAs reported it, and the UM was trying to figure out what to do and what to tell everyone to do. She thought the resident's physician knew about it. As far as she was aware, this behavior was new and had only been occurring for about four weeks.CNA A was interviewed on 7/1/25 at 1:40 PM. She explained that the first time she worked in the locked unit was about two weeks ago. She saw Resident #1 eating his brief and told the UM. He told her, We have it under control. and accused the CNAs of breaking protocol. The CNAs also told Licensed Practical Nurse (LPN) A but were told the residents on that unit always did that. CNA A was assigned to Resident #1 on 6/20/25 for the first time and was warned that he would hit and kick. She stated no one told her he couldn't have plastic incontinence pads or briefs. She checked on him periodically. He

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility and resident records, facility job descriptions, policies and procedures, and interviews with staff and medical professionals, the facility's Administration failed to provide oversight of the facility in a manner that ensured necessary interventions, including supervision, were in place for Resident #1's safety when he had a known history of pica (an eating disorder characterized by a compulsive and recurrent consumption of non-nutritive and non-food items), and consistently chewed/consumed his briefs and disposable incontinence pads. On June 20, 2025 at 1:49 PM, Resident #1 was found in his bed unresponsive with feces and bits of blue plastic resembling incontinence pad pieces in his mouth. Resuscitation efforts were initiated, and he was transported to the hospital by Emergency Medical Services (EMS), but resuscitation efforts failed, and the resident expired. Despite numerous staff members' awareness of the resident's behaviors, neither the Administrator nor the Medical Director had knowledge of the behaviors or risk factors for this resident's safety. Administration failed to exact immediate action following an event resulting Resident #1's death, failed to implement measures for resident safety, and failed to thoroughly investigate the incident to identify system failures and facility needs. This affected one (Resident #1) of three residents reviewed for behavioral issues, from a total of 52 residents with behavioral care plans. Immediate Jeopardy (IJ) at a scope of J (isolated) was identified at 4:20 PM on July 1, 2025. On June 20, 2025 at 1:49 PM, Immediate Jeopardy (IJ) began. On July 2, 2025, at 6:30 PM, the Administrator was notified of the IJ determination, IJ templates were provided, and Immediate Jeopardy was ongoing as of the survey exit on July 2, 2025. The findings include:Cross reference F600, F610, and F867 A review of a facility report authored by the Director of Nursing (DON) on 6/27/25, revealed that on 6/20/25 at 1:49 PM, Resident #1 was observed unresponsive in bed by a certified nursing assistant (CNA). The Unit Manager (UM) responded and observed brown stuff coming from Resident #1's mouth. Code Blue (a term used for a medical emergency involving respiratory or cardiac arrest) was paged overhead, chest compressions were initiated, and Emergency Medical Services (EMS) was called. Upon arrival, EMS took over cardiopulmonary resuscitation (CPR). Resident #1 was transported to the emergency room but did not survive. An Adult Protective Investigator (API) came to the facility following a call she received from the sheriff's office. The facility's report noted that Resident #1 was care planned for his behavior of chewing/eating his briefs/disposable incontinence pads. The report concluded that there was no diagnosis received from the emergency room (ER) and autopsy and toxicology reports were pending. (Photographic evidence obtained)A review of the Adult Protective Investigator's (API's) 6/21/25 investigative report revealed that on 6/20/25, Resident #1 was pronounced deceased while in the care of the facility. He required 24-hour supervision, and the facility knew he liked to put things in his mouth. Resident #1 was left around those things and should have been supervised. During her visit to the facility on 6/21/25, the API interviewed Supervisor A, who reported Resident #1 was hospitalized two or three months ago for placing inappropriate items in his mouth, including plastic forks, [disposable incontinence] pads, and adult diapers/briefs. According to Supervisor A, Resident #1's care plan should have included instructions for keeping these items out of his room. The report noted that Certified Nursing Assistant (CAN) A was assigned to Resident #1 on 6/20/25, but no one informed her that he was not supposed to have incontinence pads in his room. CNA B and CNA C discovered Resident #1 with a disposable incontinence pad in his mouth, which had feces wrapped in it. CNA A saw CNA B attempting to remove the pads from the resident's mouth. At 3:00 PM that day, the UM told the API that Resident #1 was not supposed to have disposable pads or diapers in his room due to his tendency to ingest them. The API concluded by saying she believed Resident #1 should be on one-on-one supervision due to his behavior. CNA A became emotional, began to cry and stated she had previously told the UM this resident needed one-on-one supervision. The staff dismissed her concerns, saying she was trying to act like a supervisor. In the API's interview with Resident #1's family member, the family member explained that the facility contacted him and reported that the resident was found eating his feces and an incontinence pad; behavior Resident #1 exhibited while living with family, which was part of the reason he was placed in a facility. (Photographic evidence obtained)An interview was conducted with CNA B on 7/1/25 at 10:36 a.m. She reported recently finding (Resident#1) unresponsive with disposable incontinence pad pieces in his mouth. Feces were on the pad. She stated she could not say that was why he coded though. She picked up a hand full of leaves from the ground as an example of much material she found in his mouth (a small

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility and resident records, the facility's policy titled Charting and Documentation, and interviews with staff, the facility failed to maintain medical records for each resident that were accurately documented and reflective of one (Resident #1) of three residents reviewed for behavioral issues, from a total of 52 residents with behavioral care plans.The findings include:A review of a facility report authored by the Director of Nursing (DON) on [DATE], revealed that on [DATE] at 1:49 PM, Resident #1 was observed unresponsive in bed by a certified nursing assistant (CNA). The CNA called the Unit Manager (UM) immediately and upon entering the room, the UM observed brown stuff coming from Resident #1's mouth. A Code Blue (term used for a medical emergency involving respiratory or cardiac arrest) was paged overhead and chest compressions were initiated. Emergency Medical Services (EMS) was also called. EMS arrived at the facility and took over cardiopulmonary resuscitation (CPR). Resident #1 was transported to the emergency room but did not survive. There was no mention of disposable incontinence pads at the scene other than Resident #1's care plan, which indicated that he had a behavior of eating them. (Photographic evidence obtained)A review of the Adult Protective Investigator's (API's) [DATE] investigative report revealed that she visited the facility and obtained interviews with staff involved in the [DATE] event. Supervisor A (no longer employed) stated Resident #1 was hospitalized two or three months ago for placing inappropriate items in his mouth, including plastic forks, [disposable incontinence] pads, and adult briefs. Certified Nursing Assistant (CNA) A, CNA B and CNA C discovered Resident #1 with a disposable incontinence pad in his mouth, which had feces wrapped in it. Resident #1 was not supposed to have disposable pads or briefs in his room due to his tendency to ingest them. (Photographic evidence obtained)In an interview with CNA B on [DATE] at 10:36 AM, she said she found Resident#1 unresponsive with feces and disposable incontinence pad pieces in his mouth. Resident #1 would chew on his socks, shirt and the pads or briefs. She stated she did not know how he got the incontinence pad.CNA C was interviewed on [DATE] at 11:13 AM. She stated she worked on [DATE] and when she ran into Resident #1's room during the event, CNA B was trying to pull disposable pads out of his mouth. There were strands of pads and feces in his mouth. There was no plastic pad under Resident #1, and he was not wearing a brief, but he had been doing that, eating them. She said this behavior had been occurring for about four weeks.CNA A stated in an interview on [DATE] at 1:40 PM that the first time she worked in the locked unit was about two weeks ago, and at that time she saw Resident #1 eating his brief. She said she told the Unit Manager (UM) and he replied, We have it under control. He then accused the CNAs of breaking protocol. The CNAs also told Licensed Practical Nurse (LPN) A but were told the residents on that unit always did that. On [DATE], CNA A responded to the call to Resident #1's room and witnessed CNA B pulling stuff out his mouth with a hanger. A piece of a disposable pad this long (she used both hands to gesture the length of approximately 14 inches) came out. When paramedics arrived and took over compressions, another piece of a pad came out of his rectum. He pooped the pads out. The next day ([DATE]) adult protective services came to the facility. Resident #1's entire chart was down/inaccessible, and when it became available again, a banner appeared on the chart. It was this whole huge warning about not providing incontinence pads or diapers.The UM was interviewed on [DATE] at 2:38 PM. He stated when a behavior was reported or observed, it was documented and added to the care plan. CNAs could document on behaviors and a care warning could be placed on the electronic medical record's (EMR's) dashboard. The nurse would also notify the psychiatric nurse practitioner (PNP) or the physician. Resident #1 had a TBI (traumatic brain injury) with craniotomy (surgery to remove part of the skull to access the brain). On the day of the event, the UM responded to the call for help. The UM stated the CNA said it looked like the resident was choking on feces. There were some blue particles he later realized were particles of an incontinence pad. The UM stated he had seen Resident #1 picking at his brief and trying to eat his socks; he would eat anything. The UM stated he wrote orders and added them on the chart on [DATE] for no more briefs. This was also put on the EMR dashboard. Resident #1 had a history of this behavior according to CNA B, but that information was nowhere in the chart. The UM stated the behavior resurfaced maybe a week before he put it into the chart.During an interview with Licensed Practical Nurse (LPN) A on [DATE] at 9:54 AM, she said Resident #1 He would eat anything if you let him, anything. The CNAs once reported he was trying to eat his brief. He would even tear his mattress and try to eat it. It was a new behavior every week.In an interview with the Director of Nursing (DON) on [DATE] at 10:30 AM, he said Resident #1 would try to eat everything

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105287	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Oaks Rehabilitation & Nursing Center	2061 Hyde Park Rd Jacksonville, FL 32210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility and resident records, staff interviews, and review of the Quality Assurance and Performance Improvement (QAPI) plan, the facility failed to have an effective QAPI process that used adverse event data to identify a Root Cause Analysis (RCA) and develop relevant performance improvement activities to prevent similar future events. Resident #1, with a known history of pica (an eating disorder characterized by a compulsive and recurrent consumption of non-nutritive and non-food items), who chewed and consumed briefs and disposable incontinence pads, was found unresponsive with feces and bits of blue plastic resembling incontinence pads in his mouth. As a result of the incident, Resident #1 died. Despite direct observation of the event by CNAs A, B, C, the unit manager (UM) and nurse practitioner (NP), the facility failed to thoroughly investigate in order to identify an RCA and develop measures needed to ensure the safety and protection of other residents at risk. This had the potential to affect 52 residents in the facility who were care planned for maladaptive behaviors. Immediate Jeopardy (IJ) at a scope of J (isolated) was identified at 4:20 PM on July 1, 2025. On June 20, 2025 at 1:49 PM, Immediate Jeopardy (IJ) began. On July 2, 2025, at 6:30 PM, the Administrator was notified of the IJ determination, IJ templates were provided, and Immediate Jeopardy was ongoing as of the survey exit on July 2, 2025. The findings include:Cross Reference F600, F610 and F835A review of a facility report authored by the Director of Nursing (DON) on 6/27/25, revealed that on 6/20/25 at 1:49 PM, Resident #1 was observed unresponsive in bed by a certified nursing assistant (CNA). Upon entering the room, the Unit Manager (UM) observed brown stuff coming from Resident #1's mouth. Code Blue (a term used for a medical emergency involving respiratory or cardiac arrest) was paged and chest compressions were initiated. Emergency Medical Services (EMS) was also called. EMS arrived at the facility and took over cardiopulmonary resuscitation (CPR). Resident #1 was transported to the emergency room but did not survive. The report noted Resident #1's care plan indicated he had a behavior of eating his briefs/disposable incontinence pads. (Photographic evidence obtained)An interview was conducted with CNA B on 7/1/25 at 10:36 a.m. She reported finding (Resident#1) unresponsive with disposable incontinence pad pieces and feces in his mouth on 6/20/25. Resident #1 did not wear briefs or use disposable pads anymore. He had a brain injury and would chew on his socks, shirt and the incontinence pads or briefs. She stated she did not know how he got the incontinence pad.CNA C was interviewed on 7/1/25 at 11:13 AM. She worked on 6/20/25 and responded to a call for help in Resident #1's room. CNA B was trying to pull disposable incontinence pad pieces out of the resident's mouth. Strands of pads and feces were in his mouth, and feces was on his hand and leg.CNA A was interviewed on 7/1/25 at 1:40 PM. She was assigned to Resident #1 on 6/20/25 for the first time. At approximately 2:00 PM, she heard CNA B and someone else call for help. She responded to Resident #1's room and witnessed CNA B pulling stuff out his mouth with a hanger. A piece of a disposable pad this long (she used both hands to gesture the length of approximately 14 inches) came out. CNA B started chest compressions, and the Unit Manager (UM) arrived and took over. Pieces of the incontinence pad were on the floor. When paramedics arrived and took over compressions, another piece of a pad came out of his rectum. He pooped the pads out. She stated she heard Resident #1 passed away on the way to the hospital.The UM was interviewed on 7/1/25 at 2:38 PM. He stated Resident #1 had traumatic brain injury (TBI) with craniotomy (surgery to remove part of the skull to access the brain). On the day of the event, the UM was called to Resident #1's room. He entered the room and saw that Resident #1 was not exchanging air. The CNA said it looked like the resident was choking on feces, and there were some blue plastic particles mixed in that he later realized were pieces of the incontinence pad. CNA B started CPR. Resident #1 was in and out of consciousness and CPR continued until the paramedics arrived. Resident #1 expired, but the cause of death was not certain. The UM had seen him picking at his brief and trying to eat his socks in the past; he would eat anything. During a telephone interview with the Medical Examiner (ME) on 7/1/25 at 4:20 PM, he stated he performed the autopsy on Resident #1. When medics arrived at the facility, Resident #1's oral cavity was filled with feces mixed in with small pieces of disposable incontinence pad; feces and plastic stuff. He stated believed Resident #1 choked and that was how he died. When he opened the resident's cavity, it was full of the plastic material. The presence of feces in Resident #1's mouth indicated he was recycling it (defecating then eating the pad-tainted pieces).During an interview with Licensed Practical Nurse (LPN) A on 7/2/25 at 9:54 AM, she said Resident #1 was once reported trying to eat his incontinence brief. He would even tear his