Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105301	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Hills Health and Rehabilitation Center	1350 Sleepy Hill Rd Lakeland, FL 33810

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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, record reviews, and interviews, the facility failed to ensure one (#3) of three sampled residents was free from the abusive behavior of a staff member. Findings included: On 10/30/24 at 9:30 a.m., Resident #3 was observed with Staff C, Certified Nursing Assistant (CNA) lying in bed, dressed, and with eyes closed. The staff member stated the resident would be up (awake) for days then sleep. Staff C reported being educated on abuse approximately 6 months ago and had not witnessed any type of abuse. Review of Resident #3's Admission Record revealed the resident was admitted on [DATE] and included diagnoses not limited to unspecified severity unspecified dementia with other behavioral disturbance, unspecified depression, unspecified anxiety disorder, unspecified psychosis not due to a substance or known physiological condition, and unspecified mood (affective) disorder. Review of six months of the facility's Abuse Logs showed one abuse allegation perpetrated by a staff member against a resident from 5/3 to 10/23/24. The log showed the staff to resident incident involved Resident #3 and occurred on 10/23/24 at 8:30 p.m. on the 500-hall (secure unit). Review of Resident #3's progress notes from 10/23/24 showed behaviors were noted at the 10:16 p.m. administration of the resident's scheduled Ativan and at the 10:17 p.m. administration of the resident's scheduled Trazodone. The progress notes did not include information regarding the type of behavior the resident had exhibited. Review of a progress note written by the Director of Nursing (DON), dated 10/24/24 at 8:43 a.m., revealed it was reported the resident was agitated yesterday evening and hit a staff member. Husband and friend came to visit this morning. Was made aware of the event. He stated, he does not have any problem with this facility, and he knows that his wife is being taken care of. He knows that his wife can easily gets agitated and can be very combative that's why he cannot take care of her at home. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's psychiatry note, effective 10/23/24 at 11:00 p.m., with a date of service 10/24/24 showed the reason for the encounter was Today, I saw patient to assess tolerability and effectiveness after recent medication changes in patient is unstable requiring psychiatric assessment and initiate gradual dose reduction (GDR).The history showed As per collected information, patient seen and the staff reports the patient is doing OK. Staff reports no issues with appetite or sleep at this time period patient appears to be doing OK at this time as she is resting in her bed. Staff does report that patient has been agitated at times and is not easily redirected at times. Patient has no depression. No mood swings are noted. Patient has some behaviors. Patient is eating and sleeping decently. No mania is noted. Patient has psychosis. Patient is tolerating current medications well. No side effects to current psych meds were reported. No other psychiatric symptoms noted. Dementia is persisting, but no behaviors noted. The summary of note revealed on 10/24/24 the Patient (Pt) has psychosis. Pt Has some agitation and (&) behaviors. Discontinued (Dcd) Rexulti. Starting Zyprexa 5 milligram (mg) oral (PO) every (Q) 12 hours (hr). The note showed on 10/22/24 the resident was seen and was anxious, agitated, combative & has behaviors, mood disorder. Increased Depakote sprinkles to 625 mg PO q 8 hours (H) for mood disorder. Ordered Urinalysis Culture & Sensitivity (UA C&S) labs. The Assessments and Plan of the note revealed Pt is unstable requiring med changes: as per collected information and interview, it appears that patient is unstable. I feel the symptoms are occurring due to an exacerbation of underlying psychosis disorder. The symptoms are occurring almost daily and causing severe distress. Therefore, I decided to make medication changes to stabilize the symptoms. Risk, benefits, alternatives discussed. We will do follow up appointment as needed. Review of the Weekly skin sweep, dated 10/23/24 at 8:58 p.m., revealed two discolored bruise-like areas in the upper right arm, multiple discolored bruise-like areas on the upper left arm, and brown discolored patches on upper back. Review of the Weekly Skin Sweep, dated 10/25/24 revealed right antecubital discoloration on the upper arm and left antecubital discoloration on the upper arm. During an interview on 10/30/24 at 12:00 p.m. the Risk Manager, with Regional Director of Clinical Services (RDCS), stated Staff B, CNA reported an incident had occurred on 10/23/24 at 8:30 p.m. between Resident #3 and Staff A, CNA. Staff B reported Staff A was observed pinching Resident #3 on the arm. The interview revealed the resident was upset and hit Staff A, in retaliation Staff A pinched the resident on both arms. The Risk Manager (RM) said staff immediately separated Staff A and the resident, and informed the RM of the incident. Staff A was spoken with, the facility obtained a statement from both the perpetrator and witness, and Staff A was suspended. The RM reported the facility did a skin assessment of Resident #3 and fresh bruising, reddish in color, was found on her bilateral upper arms consistent with the observed incident. The next day bruising was more blue/purplish in color. Review of Staff B's witness statement dated 10/23/24 showed, I was in B-hall between room [ROOM NUMBER] & 513 when [Resident #3] was walking near [Staff A]. [The resident] was already upset and crying about something. As [Staff A] passed, [Resident #3]swung her arm at [Staff A]. [Staff A] stopped and confronted [Resident #3] about her swinging her arm. [The resident] then reached out and grabbed at [Staff A]. [Resident #3] did make contact. [Staff A] pinched her back called her a [slur]. [The resident] was mad at this point and pinched [Staff A] back. [Staff A] pinched [the resident] again. I spoke up and told [Staff A] to walk away. She didn't and continued making [the resident] mad to pinch her and then (Staff A) would pinch her back. I got [the resident] from [Staff A] and comforted her. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Staff A's employee statement dated 10/23/24 read, [Resident #3] hit me on the breast & I held her by the [arm] and put her to sit on the bench. Review of Staff A's employee training revealed the staff member's last abuse training had been conducted on 9/18/24. Review of 3 CNA's statements revealed they had not witnessed any incident on 10/23/24. A Registered Nurse (RN) statement showed they had not seen or witnessed any incident on 10/23/24. The Licensed Practical Nurse (LPN) statement dated 10/23/24 revealed the staff member had been on the 500 hall passing medications and was unaware of the incident until informed by the supervisor. Review of Resident #3's comprehensive assessment, dated 8/27/24, showed the resident's Brief Interview of Mental Status (BIMS) score of 3 out of 15, indicative of a severe cognitive impairment. The behavior assessment revealed the resident had exhibited verbal and other behavioral symptoms not directed toward others which significantly disrupted care or living environment. The resident wandered 1 to 3 days and placed the resident significantly at risk to getting to a potentially dangerous place. The Functional Abilities and Goals of the resident required supervision or touching assistance with ambulation and was independent with mobility and transferring. Review of Resident #3's care plan revealed the following: - Resident was incapable of making health care decisions. A Physician Statement of Incapacity was on file and a Medical Decision Maker had been activated. - Resident had an Activities of Daily Living (ADL) self-care performance deficit related to (r/t) aggressive behavior, confusion, (and) dementia. - Resident was an elopement risk/wanderer r/t impaired safety awareness (and) diagnosis (dx) of dementia. - Resident has potential to be physically aggressive r/t dementia, initiated 12/15/23. - Resident has aggressive mood swings towards staff and other resident's r/t dx of dementia, initiated 12/19/23. The interventions included instructions for staff to Intervene as necessary to protect the rights and safety of others. Approach/ speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. During the conference on 10/30/24 at 5:21 p.m., attended by the Administrator In-Training, the Risk Manager, the Regional Director of Clinical Services, and the Director of Nursing, the Risk Manager reiterated twice that the abuse of Resident #3 had occurred. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy - Administrator/Employment Administration/Nursing Policies/Risk Management/Social Services/Staff Development - Abuse, Neglect, Exploitation & Misappropriation, undated, revealed it is the policy of this facility to take appropriate steps to prevent abuse (be it verbal, sexual, physical, or mental), neglect, exploitation, and misappropriation and the occurrence of an injury of unknown source, and to ensure that all alleged violations of Federal and/ or State laws are reported immediately to the Administrator, the Risk Manager, the Social Service Director, and the Director of Nursing. The Abuse Coordinator/ designee shall report any alleged violations of abuse or serious bodily injury immediately, but no later than two hours to the Agency for Health Care Administration, the Adult Protective Services, and the local law enforcement and faithfully crime has occurred. If the alleged violation involves the collect, misappropriation of resident property, exploitation, or injuries of an unknown source and involves no serious bodily injury, it must be reported no later than 24 hours. The policy showed the definition of Abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the declaration by an individual, including a caretaker, of goods and services that are necessary to attain or maintain physical, mental, or psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The phase Alleged Violation was defines as A situation or occurrence that is observed or reported by staff, resident, relative, visitor, or others but has not yet been investigated and, if verified, could be non compliance with federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, in a misappropriation of resident property. Alleged violations which must be reported includes staff to resident abuse in resident to resident altercations. However resident altercations that are required to be reported include bullying and threats of violence and resident altercations that are not required to be reported include non targeted outburst. The policy defined Person-centered care as for purposes of the subpart, person centered care means to focus on the residents as the focus of control and support the resident in making their own choices and having control over their daily lives.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on record reviews and interviews, the facility failed to screen one (#4) of three sampled residents for trauma-informed care following allegations of abuse. Findings included: Review of the Abuse Log, containing allegations from 5/3/24 to 10/23/24 revealed an allegation made by Resident #4 on 7/23/24 at 11:45 a.m. of a volunteer that had molested the resident. Review of Resident #4's Admission Record showed the resident had been admitted on [DATE] and 9/26/23. The record included diagnoses not limited to Parkinson's disease without dyskinesia without mention of fluctuations, unspecified severity unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and generalized anxiety disorder. Review of the Significant Change in Status assessment completed on 6/24/24, approximately one month prior to the allegation, revealed a Brief Interview of Mental Status (BIMS) score of 10 of 15, which indicated moderate cognitive impairment. The quarterly BIMS score, 9/23/24, revealed a score of 11 of 15, which indicated moderate cognitive impairment. The quarterly assessment revealed the resident had not exhibited any behaviors. An interview was conducted with the Risk Manager (RM) on 10/30/24 at 11:31 a.m. The RM said the Social Service Director (SSD) had spoken with Resident #4 during morning rounds on 7/23/24 and the resident had voiced wanting to make a grievance regarding feeling she had been molested by a volunteer. The SSD informed the RM who interviewed the resident. Resident #4 informed the RM of feeling like she had been molested but it hadn't happened at the facility and did not remember when it had happened. The facility sent the resident to a local hospital for evaluation. The resident returned without finding of trauma and had been diagnosed with a urinary tract infection (UTI). The RM said, during the facility investigation, findings showed on 7/5/24 there was an order to straight cath (obtain urine sample) the resident and the resident had informed two nurses that she would not be drug tested or molested. The RM reported the family had informed the facility Resident #4 had been molested earlier in life. The RM stated the resident has made previous allegations, so the facility encouraged her to do things for herself. The staff member stated the facility tried its best not have male caregivers for the resident, to use two caregivers, and encouraged the resident to do peri care by herself with standby assist of staff. Review of progress notes showed on 7/5/24 at 5:47 p.m., an attempt was made to collect urine via a collection hat and resident took out of toilet, yelling she was not going to pee in that so the facility could check for drugs. After explanation the resident continued to refuse, then staff attempted to explain catheterization and resident stated, Your not molesting me. A progress note on 7/5/24 at 11:44 p.m. revealed the resident was being treated for a UTI. Review of progress notes showed on 7/23/24 at 7:30 p.m. Resident #4 had returned from local hospital without any new orders. A progress note on 7/24/24 at 4:14 p.m. showed the resident continued to refuse showers and bed baths. She said urine had been obtained the day before at the hospital and stated, I don't do drugs. The resident was reassured of safety. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's assessments revealed the last completed Post-Traumatic Stress disorder (PTSD)/Trauma Screening tool was dated 10/3/23 (9 months prior to the allegation) and revealed a score of 6, which a score of 14 or greater indicated a positive screen. The tool asked for answers to the following questions: - Repeated, disturbing memories, thoughts, or images of a stressful experience from the past? - Feeling very upset when someone reminded you of a stressful experience from the past? - Avoided activities or situations because they reminded you of a stressful experience from the past? - Feeling distant or cut off from other people? - Feeling irritable or having angry outbursts? - Difficulty concentrating? The resident had answered Not at all for all of the above questions. The screening showed the resident did not have a diagnosis of PTSD documented. Review of the Care Plan for Resident #4 revealed the following: - Does not have the capacity to make medication decisions at this time, Incapacitation, initiated on 10/5/23. - Has an Activities of Daily Living (ADL) self-care performance deficit related to (r/t) diagnosis (dx) Dementia, Parkinson's, obesity, limited mobility, muscle weakness, difficulty walking. Resident chooses not to have care from staff or showers at this time. The interventions related to this focus included: 2 person assist as ordered, Resident requires moderate assistance by staff for toileting, Maximum assistance by staff with bathing/showering and as necessary, and no assistance by staff with personal hygiene and oral care. - Has a behavior problem r/t dx of dementia. Accuses staff of things that are not true and embellishing the situation that did not occur in the present at times. Will become aggressive and verbally abusive with staff about the situation, initiated 7/12/24. The interventions included: Administer medications as ordered, Anticipate and meet the resident's needs, assist the resident to develop more appropriate methods of coping, and psych to eval as needed. - At risk for potential to be verbally aggressive r/t dx dementia. - Resistive to care r/t dx dementia. Will refuse showers. During an interview on 10/30/24 at 3:20 p.m., the Director of Nursing (DON) stated she was not aware Resident #4 had been previously molested earlier in life. She stated if the resident made the allegation and family had voiced the resident had been molested earlier in life a trauma screen should have been completed. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Risk Manager on 10/30/24 at 3:31 p.m. The RM stated if the allegation of molestation was made, a trauma screen should have been completed. The RM reported the facility did add encouraging no male caregivers to the care plan as they were not always able to do so and did not want to go against the care plan. The DON (who was present) stated one of the regular nurses was male. An interview was conducted with the Social Service Director (SSD) on 10/30/24 at 3:40 p.m. The SSD reported a trauma screen should be done quarterly or if something arises we could go in and speak with them. The SSD stated oh yes if a resident voiced being molested and the family voiced the resident had a history of been molested, a trauma screening would have been triggered. The SSD stated she was not aware of the allegation of Resident #4. Someone else in the SS department could have been notified and did not reflect it on the PTSD/Trauma screen. Review of the policy - Social Service: Trauma-Informed Care, effective October 2019, showed the facility will ensure that residents who are trauma survivors receive culturally competent, trauma informed care in accordance with professional standards of practice period the care provided will consider the residents experiences and preferences in order to eliminate or mitigate triggers that may cause retraumatization of the resident. The procedure included: 2. Residents with a negative screen upon ambition may be rescreened as needed for indicators of past or present trauma. 4. The interdisciplinary team will develop an individualized plan of care to address any acute or chronic stress symptoms related to the identified past trauma or PTSD. 5. The care plan will identify: - Any known triggers - Ways the resident shows that he/she is stressed or overwhelmed - Staff responses that are helpful - non pharmaceutical interventions to reduce stress which may include but are not limited to meditation, exercise, progressive muscle relaxation techniques, any diversionary activities, etc. - Staff responses known to be not helpful. - Which persons to be contacted for assistance as indicated such as family, friends, therapist.