STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105302	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Haven Rehab and Nursing Center	919 Old Winter Haven Rd Auburndale, FL 33823

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on record review and interview the facility failed to code the Minimal Data Set (MDS) accurately at discharge for one resident (#111) of three residents reviewed for close records. Findings included: Review of the Admission record showed Resident #111 was originally admitted to the facility on [DATE] with diagnoses that included but not limited to malignant neoplasm of unspecified part of right bronchus or lung, chronic obstructive pulmonary disease, unspecified atrial fibrillation, chronic kidney disease, stage 3 B and generalized muscle weakness. Review of a physician order dated 04/22/24 showed, Send to Hospital for [treatment]Tx and [Evaluation] Eval. Review of progress notes revealed the following two progress notes: Change in Condition dated 04/20/24 showed, Situation: The change in conditions reported on the Evaluation are/were: Falls Nausea/Vomiting. Primary Care Provider Feedback Recommendations: Send to ER for treatment and evaluation. Physical Medicine and Rehabilitation Subsequent Evaluation dated late entry 04/23/24 showed, hospitalized . Review of the Discharge Return Anticipated /End of PPS Part A Stay MDS dated [DATE] revealed Section A 2105. Discharge Status was marked 01. Home/Community. During an interview on 07/17/24 at 3:20 p.m., Staff M, MDS Director reviewed Resident #111's medical record and stated stated Resident #111 was hospitalized at discharge. Staff M, MDS Director confirmed Resident #111's Discharge MDS was marked incorrectly as Resident #111 did not go home to the community but was hospitalized .

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105302	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50732 Based on record review and staff interviews, the facility failed to ensure the Level I Preadmission Screening and Resident Review (PASRR) was accurate for two residents (# 7, #19) of 25 residents sampled. Findings included: 1. Review of Resident #19's Admission Record revealed an admitted [DATE] with diagnoses to include Anxiety Disorder and Major Depressive Disorder. Review of the Level I PASRR, dated 08/24/2023, showed in Section I-Part A MI (Mental Illness) or suspected MI (Mental Illness) the diagnosis of Depressive Disorder was not marked. Section II: Other Indications for PASRR Screen Decision-Making questions 1 through 7 were marked no. Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption Not a Provisional Admission was marked no. Section IV: PASRR 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 PASRR evaluation not required was marked. 2. Review of Resident #7's Admission Record revealed an admitted [DATE] with diagnoses to include Bipolar Disorder, Generalized Anxiety Disorder, Major Depressive Disorder and Generalized Epilepsy and Epileptic Syndromes. Review of the Level I PASRR, dated 08/30/2023, showed in Section I-Part A MI (Mental Illness) or suspected MI (Mental Illness) the diagnoses of Bipolar Disorder and Depressive Disorder were marked. Part B Intellectual Disability (ID) or suspected Intellectual Disability (ID) the related condition of Epilepsy was not marked. Section II: Other Indications for PASRR Screen Decision-Making questions 1 through 7 were marked no. Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption Not a Provisional Admission was marked no. Section IV: PASRR 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 PASRR evaluation not required was marked. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 07/17/2024 at 2:55 p.m. with the Nursing Home Administrator (NHA) and the Admissions Director. The Admissions Director said she receives the PASRR's from the hospital and uploads them into the system. She also said once the resident is in the building the PASRR is reviewed by the clinical team; it does not get reviewed pre-admission. The NHA said the clinical team has a daily clinical meeting in which PASRR's are reviewed. She said the clinical team consists of the Director of Nursing (DON), the Assistant Director of Nursing (ADON), Unit Managers and Social Services.

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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 record review, interview and review of the Resident Assessment Instrument (RAI), the facility failed to ensure one resident (#106) of five residents reviewed for unnecessary medications had the care plan revised after a medication was discontinued. Findings included: Review of the Admissions Record showed Resident #106 was admitted to the facility on [DATE] with diagnoses that included but not limited to unspecified dementia, unspecified severity, with other behavioral disturbance, unspecified convulsions, muscle weakness, and cognitive communication deficit. Review of the Medication Review Report showed Resident #106 had no antipsychotic drug regimen. Review of the Discontinued Physician Orders revealed Olanzapine Tablet 5 [milligrams] MG- Give 0.5 tablet by mouth two times a day for psychotic disorder. with discontinued date 06/12/24. Review of Care Plan showed the following care area: Focus- The resident uses antipsychotic medications r/t Behavior management Date Initiated: 05/31/2024. Goal- The resident will be/remain free of antipsychotic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. Interventions: Administer antipsychotic medications as ordered by physician. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms as indicated. Medication review as indicated/PRN. Consult with pharmacy, MD to consider dosage reduction when clinically appropriate. Monitor/document/report PRN any adverse reactions of antipsychotic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Date Initiated: 05/31/2024 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Psych Services consult and follow up as ordered/indicated. During an interview on 07/16/24 at 3:44 p.m., the Director of Nursing (DON) reviewed Resident #106 current physician orders and care plan and stated the care plan should have been revised to reflect the discontinued antipsychotic use. During an interview on 07/17/24 at 1:55 at p.m., the Director of Nursing (DON) was asked for the facility's care plan policy. The DON stated the facility did not have a policy for care plans as the facility followed the RAI manual for care plans instructions. Review of the MDS 3.0 [Resident Assessment Instrument] RAI User's Manual for Long-Term Care Version 1. 18.11 dated October 2023 showed, Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Based on observation, interview and record review the facility failed to ensure the weekly skin assessments were performed for 8 of 39 sampled residents (#19, #362, #90, #58, #8, #267, #5). The facility also failed to ensure wound care assessments were performed for 2 of 2 sampled residents of 14 non-pressure wounds (#90, #267). Findings included: 1. On 07/15/2024 at 4:30 p.m. Resident #19 was observed sitting in her wheelchair at bedside. She was dressed and groomed for the day. She stated she went out to breakfast with her son. Her oxygen via nasal cannula was in place and at 2 liters per minute. Resident #19 stated that the staff cares for her. They answer the call lights and give her showers. She stated she had been to the hospital a couple of times for breathing problems. No odors were noted. No skin impairments were observed. Her personal items were noted. Resident #19 was admitted on [DATE] and readmitted on [DATE]. Review of the admission record showed diagnoses included but not limited to Chronic Respiratory Failure with hypoxia, diabetes, Chronic Obstructive Pulmonary Disease (COPD), obesity, Congestive Heart Failure (CHF), hypertension with HF, stage IV chronic kidney disease, ischemic cardiomyopathy, anemia, muscle weakness, Transient Ischemia Attack (TIA). Review of the annual, Minimum Data St (MDS) dated [DATE] showed Brief Interview of Mental Status (BIMS) score of 14 (cognitively intact). Section GG, Functional Abilities and Goals showed the resident needed moderate assistance. Review of the Weekly Skin Checks dated 06/21/2024 showed no areas of concern at this time. Weekly Skin Checks were not documented 06/28/2024, 07/05/2024, 07/12/2024. Review of the care plans showed Resident #19 was at risk for skin impairment related to anemia, diabetes, incontinence, obesity, use of antiplatelet medications, weakness/decreased mobility, initiated on 06/20/2023. Interventions included but not limited to monitor/observe skin while providing routine care. Notify nurse for any area of concern as indicated as of 06/20/2023; skin checks weekly and as indicated. Report any signs and symptoms of skin breakdown to MD [medical doctor]/wound team as indicated as of 06/20/2023. 2. On 07/15/24 12:58 p.m. Resident #90 was sitting in bed eating her lunch. She was slumped down in the bed, her feet were almost touching the footboard. She was dressed in a hospital gown. A dressing was noted on her right lower leg and was dated 7/14/24. The television was playing. She had juice and fluids on her overbed table. She stated she had been in the hospital a few times for surgery. She stated she had been on antibiotics since being in the hospital for a urinary tract infection. She stated she had a nephrotomy tube. She stated she was not walking but receiving therapy. She stated the last time she was in the hospital was for her leg injury. She gets transferred to the wheelchair in the Hoyer lift. She stated, she was walking, something happened, started screaming. they called 911 and sent her to the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #90 was admitted on [DATE] 24 and readmitted on [DATE]. Review of the admission record showed diagnoses but not limited to laceration without foreign body right lower leg on 06/27/2024, Urinary Tract Infection (UTI), diabetes, Chronic Obstructive Pulmonary Disease (COPD), cirrhosis of the liver, obesity, hypertensive heart disease, muscle weakness, anemia. Review of the 5-day MDS showed a BIMS score of 10 (moderately impaired). Section GG, Functional Abilities and Goals showed the resident was dependent for care. Review of the Admission / Readmission Nursing Evaluation dated 06/27/2024 showed under the Skin Evaluation: warm and intact. The skin diagram was blank. The wound of the right lower leg was not documented. Review of the Weekly Skin Check dated 06/28/2024 showed a right lower leg (front) with soft cast in place. Review of the Weekly Skin Check dated 07/02/2024 showed right lower leg hematoma ruptured. Review of the e-chart showed the Weekly Skin Checks for 07/09/2024 and 07/16/2024 was not documented. Review of the Wound Care Physician note dated 07/16/2024 showed the visit was the initial visit. The right lower leg trauma wound was not healed. It was 1 x 2 x 0.1 in size. There was 10% slough and 90% granulation. Wound to right lower leg with open wound from hematoma due to traumatic injury. Sutures in place with wound well approximated. Review of the Resident #90 care plans showed the resident was at risk for skin impairment related to anemia, diabetes, incontinence, obesity, weakness/decreased mobility, history of chronic stasis ulcers to bilateral lower extremities, initiated 06/19/2024. Interventions included but limited to monitor/observe skin while providing routine care. Notify nurse for any area of concern as indicated as of 06/19/2024; skin checks weekly and as indicated. Report any signs and symptoms of skin breakdown to MD/wound team as indicated as of 06/19/2024. Review of the Resident #90 care plans showed the resident had an open area on the right anterior lower leg as of 06/19/024. Interventions included but not limited to administer medications and treatments as ordered by the MD as of 06/19/2024, complete weekly skin checks. Measure length, width, and depth, if possible. Document status of wound and healing progress. Monitor for signs and symptoms of infection. Report changes to MD as indicated as of 06/19/2024; encourage and assist resident to float heels when in bed, as tolerated as of 06/19/2024; medicate prior to wound treatments if indicated. Notify MD for unrelieved pain as of 06/19/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/17/2024 at 9:20 a.m. the Director of Nursing (DON) stated the wound care nurse performs the weekly skin checks on the residents who have wounds and are followed by the wound care doctor. If the resident was not followed by the facility's wound care nurse the floor nurses were responsible for performing the weekly skin assessment. The wound sizes are documented on the wound care doctor's notes and are to be uploaded weekly. The wound care doctor was not here last week due to being ill. The facility's wound care nurse was to measure the wounds last week and document them. The DON stated whether the skin impairment was new or old, it should be documented on the Weekly Skin Assessment. The admission nurse does look at the skin and then the wound care nurse follows-up with a skin assessment the next day or Monday if it was a weekend. The wound nurse schedules the wound care doctor, if needed. If the resident does not have a pressure ulcer or major surgical wound a Weekly Skin Check was to be scheduled. The floor nurse has to do a head-to-toe and document anything found. The DON stated if the note stated, nothing new it meant there was nothing on the body. The DON verified there was not a Weekly Skin Check performed on 07/09/2024 and 07/1602024 for Resident #90. She also verified the Weekly Skin Sheets were not performed as per the protocol for Resident #19. The DON stated the wound nurse follows the pressure ulcers which are stage III or IV or complicated surgical wounds, the floor nurses follow the other wounds. During an interview on 07/17/2024 at 11:30 a.m. Staff A, Licensed Practical Nurse (LPN), facility wound care nurse stated Resident #90 was seen by the wound care doctor yesterday (07/16/2024). Staff A stated Resident #90 was to be seen last week but the wound care doctor did not visit the facility. Staff A stated she was out after the wound care doctor was out ill for a few days. Staff A stated she does not normally follow the surgical wounds. The nurse on the floor will normally follow the small wounds and surgical wounds. Staff A stated she did not know when the soft cast was removed from Resident #90. Staff A, LPN stated she saw the wound for the first time on 07/02/2024. She stated she did not document in the chart what the wound looked like on 07/02/2024. Staff A stated it looked like a surgical site, with the incision intact, and a blistering hematoma around the surgical area. She stated she did not measure the wound at that time. Staff A stated she did not count the sutures at that time. She stated wound care orders had been put in. She stated she had seen the wound every day due to the hematoma and was performing the wound care. Staff A stated the wound care doctor saw the wound per the nurse practitioner's request. The wound care doctor changed the wound care on 07/16/2024. Staff A, LPN stated the expectation was for the wound to be seen and documentation to occur. She stated the admission nurse was to look at it (wound) and document that they looked at it (the wound). She will follow up the next day or Monday. She stated she follows the residents herself. She stated she does a head-to-toe assessment on them. The nurses are expected to go to the weekly wound care doctor notes if needed to check for wound changes. She stated weekly they were supposed to do skin assessments. During an interview on 07/17/2024 at 11:52 a.m. the Director of Nursing (DON) stated a Weekly Skin Sheet Assessment should be performed once a week. She stated all the nurses have access to the wound doctor's notes. The Wound Nurse was responsible for uploading the wound doctor's assessment notes weekly. The DON stated all the nurses have access to the wound care doctor's notes. The wound care doctor visits on Tuesday and turns his notes in on Tuesday afternoon for Wednesday to upload into the computer system. The DON stated the wound care nurse performs the Weekly Skin Sheets on residents with wounds and the other nurses are to perform the Weekly Skin Sheets weekly. The DON stated the Skilled Documentation Notes were not a substitute for the Weekly Skin Sheets. The DON verified the Weekly Skin Sheets were missing as well as the Skilled Documentation Notes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 07/15/24 12:29 p.m. Resident #8 was observed sitting in her wheelchair beside her bed, eating her lunch, of hamburger, carrots, soup, pudding, salad and fluids. She was dressed and groomed for the day. She stated she had no complaints or concerns. She stated the staff answers all the call lights. She stated she was able to take her own shower. A bruise was observed on her left upper hand. Record reviewed revealed Resident #8 was admitted on [DATE] and readmitted on [DATE]. Review of the admission record showed the diagnoses included but were not limited to Urinary Tract Infection (UTI), diabetes, Chronic Obstructive Pulmonary Disease (COPD), chronic respiratory failure, obesity, CHF, Pulmonary HTN, atrial fibrillation, stage III chronic kidney disease, anemia, and weakness. Review of the MDS dated [DATE] showed a BIMS score of 15 (cognitively intact). Section GG Functional Abilities and Goals showed the resident needed maximal assistance with care. Review of the Resident #8 care plans showed the resident was at risk for skin impairment related to diabetes, incontinence, obesity, weakness/ decreased mobility, routine use of antiplatelet, initiated 09/12/2023. Interventions included but limited to monitor/observe skin while providing routine care. Notify nurse for any area of concern as indicated as of 09/12/2023; skin checks weekly and as indicated. Report any signs and symptoms of skin breakdown to MD/wound team as indicated as of 09/12/2023. Review of the Admission / Readmission Nursing Evaluation dated 07/04/2024 showed no skin impairments or no documentation. Review of the Weekly Skin Check dated 07/05/2024 showed right lower leg (front) vascular ulcer 1 x 1 x 0. Upon re-admission from hospital rest of skin clear and intact at this time. Review of the e-chart showed the Weekly Skin Checks for 07/12/2024 was not documented Review of the Skilled Documentation Note showed the following: On 07/07/2024, under skin: bruise On 07/10/2024, under skin: bruise On 07/11/2024, under skin: bruise On 07/14/2024, under skin: bruise On 07/16/2024, under skin: abrasion, see below. Skin check today and nurse reported her observation on the Botox area, redness on the left side, and the right side is starting to change in color. Wound nurse for resident needs, to consult wound care doctor for evaluation and treatment. Review of the nursing progress note for 07/17/2024 showed upon skin assessment the resident was noted with unknown boil-like mass to left buttocks with purulent drainage and right lower buttocks with an excoriation, and bilateral lower extremity with redness. No edema noted at this time. When resident was asked how it happened, the resident claims to have history of boils to the buttock area. Resident made aware and MD made aware. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/17/2024 at 12:10 p.m. the DON verified the bruise was documented but location was not documented, and it should be. The DON verified the Weekly Skin Check was not performed weekly. The DON verified the chart was missing Skilled Documentation notes. 4. During an interview on 07/15/24 at 12:00 p.m. Resident #267 was sitting at bedside in his wheelchair. He was dressed and groomed for the day. The resident's family member was with the resident. No odors were noted. The resident had a dollar size wound area on the right side of his head with smaller areas circling it. The left foot had a dressing in place. He stated he was non-weight bearing (NWB) at this time due to the heel wound. He had a right above the knee amputation. The facility used a Hoyer lift due to his NWB of left foot, ulcer. They stated he had an ulcer on his bottom. Resident #267 was admitted on [DATE]. Review of the admission record showed the diagnoses included but not limited to surgical amputation (Right above knee), diabetes, protein-calorie malnutrition, dementia, chronic kidney disease, anemia, hypertension, squamous cell carcinoma of skin on right lower limb, muscle weakness, and abnormal gait. Review of the admission MDS dated [DATE] showed a BIMs of 15 (cognitively intact). Section GG Functional Abilities and Goals showed the resident required maximum assistance. Review of the physician orders showed: cleanse the right above knee amputation site with normal saline, pat dry, apply abdominal pad, wrap with kerlix secure with ace wrap daily and as needed as of 07/03/2024 cleanse left 1st digit / lateral foot with normal saline/wound cleanser, pat dry, apply Santyl and calcium alginate, cover with border gauze daily and as needed for the diabetic ulcer as of 07/03/2024 cleanse sacrum with normal saline/wound cleanser, pat dry, apply nystatin cream cover with border gauze daily and as needed for stage II ulcer as of 07/03/2024. cleanse left heel with normal saline/wound cleanser pat dry, apply Santyl and calcium alginate, cover with border gauze daily and as needed for stage II pressure ulcer. Review of the Admission / Readmission Nursing Evaluation dated 07/02/2024 showed skin tear to right antecubital, redness blanchable and open on coccyx, right knee (front) surgical incision, left heel Deep Tissue Injury (DTI), bilateral bruises to upper extremities, and bottom of left foot DTI. Review of the Weekly Skin Check dated 07/03/2024 showed 6 hemorrhoids nodules not in coccyx, AKA with 26 sutures noted right knee front, left heel DTI, fungal rash/MASD on sacrum, first digit lateral foot diabetic ulcer, and right forearm skin tear. Review of the Weekly Skin Check dated 07/13/2024 showed no new abnormalities noted. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the wound doctor's note dated 7/16/24 showed the visit was an initial visit. The left, medial diabetic foot ulcer was 1 x 1.5 x 1, grade I, with moderate sero-sanguineous exudate, 20% slough, and 80% granulation. The wound was to be cleansed, pat dry, apply Santyl, calcium alginate daily and prn. The left heel pressure ulcer was not healed. It was not healed. It was 3 x 5 x 0 and an unstageable pressure injury with 100% eschar. The wound was to be cleaned with betadine and leave open to air daily and prn. Review of the care plans for Resident #267 showed resident was at risk for further skin impairment related to anemia, diabetes, risk for malnutrition, weakness/ decreased mobility and cancer of right lower extremity including the hip as of 07/04/2024. Interventions included but limited to monitor/observe skin while providing routine care. Notify nurse for any area of concern as indicated as of 07/08/2024; skin checks weekly and as indicated. Report any signs and symptoms of skin breakdown to MD/wound team as indicated as of 07/08/2024. Review of the care plan open area left heel and sacrum initiated 07/04/2024. Interventions included but not limited to complete weekly skin checks. Measure length, width, and depth, if possible. Document status of wound and healing progress. Monitor for signs and symptoms (s/s) of infection. Report changes to MD as indicated as of 07/04/2024. PT/OT consult/referral as needed as of 07/04/2024. Wound Care MD/APRN consult as ordered/indicated as of 07/04/2024. Review of the care plan for surgical wound to (R) above knee amputation and was at risk for complications as of 07/04/2024. Interventions included but not limited to notifying MD for any s/s of infection (redness, increased pain, purulent drainage, swelling, foul odor, etc.) as of 07/04/2024. Observe/monitor for s/s of potential complications of wound. Notify MD as indicated as of 07/04/2024. Review of the care plan for diabetic ulcer of the 1st digit lateral foot as of 07/04/2024. Interventions included but not limited monitor for worsening of wound, change in skin status ie: s/s infection, non-healing, new areas to MD and update resident/representative as indicated as of 07/08/2024. Monitor/document wound: Size, Depth, Margins: peri-wound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis. Notify MD as indicated as of 07/08/2024. Monitor/document/report PRN any s/sx of infection: [NAME] drainage, Foul odor, Redness and swelling, Red lines coming from the wound, Excessive pain, Fever as of 07/08/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105302	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Oak Haven Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 919 Old Winter Haven Rd Auburndale, FL 33823	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/17/2024 at 3:40 p.m. Staff A, Licensed Practical Nurse (LPN) wound care nurse stated the resident was admitted with a (R) AKA and he had multiple wounds before admission. She stated he had a diabetic ulcer on the side of his big toe on the left foot. He had a DTI on the left heel as well. She stated the resident came in with a fungal rash on his sacrum. Staff A stated there were no wound sizes or assessment since on the resident since 07/02/2024. She stated the resident was admitted after the wound care doctor had left the faciity on [DATE]. Staff A stated on 07/09/2024 she was not at the facility and the wound care doctor did not send anyone to the facility either. Staff A, LPN stated the expectation for someone to have documented something about the wounds. Staff A stated she saw the resident yesterday (07/17/2024) and today (07/18/2024) and the coccyx was closed. She stated he scratches his head constantly. On admission it looked like a regular old skin area on his head. She stated when she saw him today, it looked like he had scratched the area. Staff A stated it should have been added to a Weekly Skin Sheet when it was observed. She stated that she had not documented yes today. Staff A stated the negative outcome for lack of assessment and documentation was not being able to see if the wounds had increased and got worse. Staff A stated, No one would know. She stated the head area was a scabbing area on his head. She stated, His wound on his toe had improved, more granulation than first when she first saw it. She stated the heel wound was still bothering him and was tender. She stated they were offloading his heel. She stated she called for an order to add more cushion to the dressing for the heel. During an interview on 07/17/2024 at 3:45 p.m. the DON verified the lack of wound care assessments for the resident. 50836 5. A review of Resident #362's Admission Record revealed an admitted [DATE] with a readmitted [DATE] and diagnoses to include pressure ulcer of sacral region, stage 4. A review of Resident #362's July 2024 physician orders revealed the following: -Cleanse Coccyx with Normal Saline/wound cleanser pat dry Apply skin prep to coccyx skin prep, apply collagen particle (collagen particle with Normal saline slurry) to wound bed cover with border foam dressing. QD (every day) and PRN (as needed). every day shift for wound AND as needed for damaged or missing dressing Active 7/3/2024 08:00 (a.m.). An attempt to interview Resident #362 was conducted on 7/15/2024 at 10:30 a.m. Resident #362 is not interviewable. A record review of the resident's Quarterly Minimum Data Set (MDS) revealed in Section C- Cognitive Patterns, dated 07/12/2024, a Brief Interview for Mental Status (BIMS) summary score of 00, showing the resident is not cognitively intact. In section M- Skin Conditions it revealed the presence of 1 stage 4 pressure injury that was present on admission. A review of Resident #362's care plan, dated 05/16/2024, revealed Resident #362 had an unavoidable pressure injury to his coccyx and was at risk for further skin impairment. The goal was to show signs of improvement. Interventions included: Skin checks to be weekly and as indicated. A review of the Resident #362's Skin Check records from 05/24/24 through 07/16/24 revealed four Skin Checks dated: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/11/2024 - Section 1. Site/description are absent from the form; Section 2. Comments: Treatment is in place to coccyx. no new skin concerns noted. 07/01/2024 - Section 1. Site/description are absent from the form; Section 2. Comments: no new skin concern. 06/22/2024 - Section 1. Site/description are absent from the form; Section 2. Comments: under wound care provider with tx [treatment] noted improving at this time no other skin integrity abnormalities noted at this time. 06/14/2024 - Section 1. Site/description are absent from the form; Section 2. Comments: Treatment continue. No new skin concern noted. An interview was conducted on 07/17/2024 at 9:43 AM with the Director of Nursing (DON). The DON stated if a resident has an identified wound they should have a weekly wound assessment. She went on to state the bedside nurse and wound care nurse will do a weekly wound assessment not just a weekly skin check. 6. A review of Resident #58's Admission Record revealed an admitted [DATE] and diagnoses to include type 2 diabetes mellitus with hyperglycemia, and type 2 diabetes mellitus with foot ulcer, unspecified open wound, right foot, subsequent encounter. A review of the July 2024 physician orders revealed the following: -cleanse Right lateral foot with normal saline/ wound cleanser apply collagen powder to wound bed, biopad collagen dressing, tritec silver cover with border gauze and PRN. every day shift for wound care AND as needed for missing/ damaged dressing, Active 5/28/2024 15:00 (3:00 p.m.). A review of Resident #58's care plans, initiated on 01/11/2023, revealed Resident #58 was at risk of skin impairment. Interventions included: Skin checks to be weekly and as indicated. A review of Resident #58's Quarterly MDS, Section M, dated 04/08/2024, revealed the presence of 1 pressure wound that was facility acquired. It revealed Resident #58 has a stage 3 pressure injury. A review of Resident #58's Skin Check documents revealed skin checks dated: 07/10/2024 - Section 1. Site/description are absent from the form; Section 2. Comments: Treatment to right lateral foot in place, no new skin concerns noted. 07/03/2024 - Section 1. Site/description are absent from the form; Section 2. Comments: no new areas. Treatment in place for wound to foot. 06/25/2024 - Section 1. Site/description are absent from the form; Section 2. Comments: no new skin concerns noted. 7. A review of Resident #5's Admission Record revealed an admitted [DATE] with diagnoses to include unspecified superficial injury of right ankle, subsequent encounter. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #5's July 2024 physician orders revealed: -cleanse Right Medial Ankle with ns [normal saline]/ wound cleanser pat dry apply Honey gel, Calcium Alginate cover with Border Gauze. QD & PRN every day shift for DTI (deep tissue injury) AND as needed, start date:7/16/2024. A review of Resident #5's care plans, dated 11/09/2022, revealed Resident #5 is at risk for skin impairment with a goal of no new skin impairments. Interventions included: monitor/observe skin while providing routine care, notify nurse of any area of concern as indicated, skin checks weekly and as indicated. Report any s/s (signs and symptoms) of skin breakdown to MD/wound team as indicated. A review of Resident #5's Quarterly MDS, 07/07/2024, revealed in Section C- Cognitive Patterns a BIMS score of 09, which showed moderate cognitive impairment. Section M- Skin Conditions showed the resident had a stage 3 pressure injury present at the time of that assessment. A review of Resident #5's Skin Check documents revealed skin checks dated: 07/16/2024 -Section 1: site: is a body diagram that is not marked; Section 2. Comments: open dti found to the inner right heel, family and MD (Medical Doctor) made aware. 07/09/2024 - Section 1. site, Other (specify) no further documentation in that area; Section 2: comments: open dti to the inner right heel family and MD made aware. 07/02/2024 -Section 1: site: 49) right heel- dti; Section 2: Comments: open dti found to the inner right heel family and md made aware. An interview conducted on 07/17/2024 at 11:31 AM with Staff A, Licensed Practical Nurse (LPN)/wound care, and stated she has not had a chance to document the current wound assessments, but she has the measurements and descriptions in her personal notes. She stated Resident #5 wasn't seen last week because she was off sick. Staff A went on to state that she loaded the wound care doctor's note from yesterday. Staff A stated typically anything in the wound evaluation assessment would be done by the wound care nurse. She also stated Skin Checks were not her responsibility, but that generally when she is already seeing the resident she will do the Skin Check in addition to the Wound Evaluation. She stated Because a weekly skin assessment is done, I don't do measurements in the weekly skin check, wound assessments should be done weekly She further stated, I don't monitor [Resident #5] , she is seeing outside wound care. I would still take measurements. I still try to assess her weekly. During an interview conducted on 07/17/2024 at 11:51 AM the DON stated the outside doctor should send measurements. She stated that she would expect the staff to document measurements and descriptions of wounds weekly. The DON stated she was going to call the doctor this week to get measurements, but without them being uploaded the bedside nurses wouldn't have access to the records. She stated Staff A is responsible for uploading the note so the nurse can see them. The nurses have access to review the notes. She also stated if the doctors don't send notes the unit managers should call for the documents. She said, I follow who has appointments. She stated she expects weekly documentation on wounds the wound care doctor is following to be uploaded to the electronic medical record weekly. They should also have weekly skin assessments. She stated skilled notes are not skin assessments. Every week there should be an assessment apart from the Daily Skilled Nurses Note (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Haven Rehab and Nursing Center	919 Old Winter Haven Rd Auburndale, FL 33823

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy titled Standards and Guidelines: Prevention of Skin Impairments/Pressure Injury, effective October 2020, revised January 2024, revealed under the section titled Procedure: Risk Assessment: 1. Assess the resident on admission for existing wound risk factors. 2.Conduct a comprehensive skin assessment upon admission, including: a. Skin integrity- any evidence of existing or developing pressure ulcers or injuries; b. Areas of impaired circulation due to pressure from positioning or medical devices. 3. Inspect the skin when performing or assisting with personal care or ADLs. a. Identify any signs of developing skin wound (i.e. nonblanchable erythema/rashes). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency; b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.) c. Wash the skin after episodes of incontinence. d. Reposition resident as indicated on the care plan. A review of the facility policy titled, Standards and Guidelines: Documentation, effective October 2020, revised January 2024, revealed under the section titled Procedure: 1. Documentation in the medical record may be electronic, manual or a combination. 2.The following information is to be documented in the resident medical record: a) objective observations; c) Treatments or services performed; d) Changes in the resident's condition; 3. documentation in the medical record is required as updates/ changes in the resident's plan of care are made. 4. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 8. Documentation of procedures and treatments will include care-specific details, including: a) the date and time the procedure /treatment was provided; b) the name and title of the individual(s) who provided the care; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c) the assessment data and/or any unusual findings obtained during the procedure/treatment; d) whether the resident refused the procedure/ treatment; e) whether the resident refused the procedure/treatment; e) notification of family, physician or other staff, if indicated; and f) the signature and title of the individual documenting. 14161

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50836 Based on observations, interviews, and record reviews, the facility failed to ensure treatment and services for pressure ulcers were consistent with professional standards for three residents (#5, #362, and #58) of three sampled residents. Findings included: 1. A review of Resident #362's Admission Record revealed an admitted [DATE] with a readmitted [DATE] and diagnoses to include pressure ulcer of sacral region, stage 4. A review of Resident #362's July 2024 physician orders revealed the following: -Cleanse Coccyx with Normal Saline/wound cleanser pat dry Apply skin prep to coccyx skin prep, apply collagen particle (collagen particle with Normal saline slurry) to wound bed cover with border foam dressing. QD (every day) and PRN (as needed). every day shift for wound AND as needed for damaged or missing dressing Active 7/3/2024 08:00 (a.m.). A review of Resident #362's July 2024 Treatment Administration Record revealed the resident's wound care was being completed as ordered. An attempt to interview Resident #362 was conducted on 07/15/2024 at 10:30 a.m. Resident #362 is not interviewable. A record review of the resident's Quarterly Minimum Data Set (MDS) revealed in Section C- Cognitive Patterns, dated 07/12/2024, a Brief Interview for Mental Status (BIMS) summary score of 00, showing the resident is not cognitively intact. In section M- Skin Conditions it revealed the presence of 1 stage 4 pressure injury that was present on admission. A review of Resident #362's care plan, dated 05/16/2024, revealed Resident #362 had an unavoidable pressure injury to his coccyx and was at risk for further skin impairment. The goal was to show signs of improvement. Interventions included: Skin checks to be weekly and as indicated. A review of Resident #362's Wound Evaluation- Weekly forms dated 06/20/2024 through 07/16/2024 revealed three Wound Evaluation forms in the electronic medical record (EMR). The Wound Evaluations were as follows: 06/20/2024: I. Wound Summary: Length: 1.4, Width: 1, Depth:0.2 1. Site: coccyx, 2. Type: Pressure Ulcer (In-House Acquired),2b. Pressure Ulcer Stage: e) Stage IV IV. Wound bed - 2. Evaluation: a. Erythema, b. warm to touch, 3b. granulation %-100%; 4. Wound color: a. Pink. 06/26/2024: I. Wound Summary: Length: 1, Width: 0.6, Depth: 0.2 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Site: coccyx, 2. Type: Pressure Ulcer (In-House Acquired) 2b. Pressure Ulcer Stage: e) Stage IV IV. Wound bed - 2. Evaluation: a. Erythema, b. warm to touch, 3b. granulation %-100%, 4. Wound color: a. Pink. 07/04/2024: I. Wound Summary: Length: 1.2, 3b. Width: 0.5, 3c. Depth:0.1 1. Site: coccyx, 2. Type: Pressure Ulcer (In-House Acquired) 2b. Pressure Ulcer Stage: e) Stage IV IV. Wound bed - 2. Evaluation: a. Erythema, b. warm to touch, 3b. granulation %-100%, 4. Wound color: a. Pink. An interview was conducted on 07/17/2024 at 9:43 AM with the Director of Nursing (DON). The DON stated if a resident has an identified wound they should have a weekly wound assessment. She went on to state the bedside nurse and wound care nurse will do a weekly wound assessment not just a weekly skin check. 2. A review of Resident #58's Admission Record revealed an admitted [DATE] and diagnoses to include type 2 diabetes mellitus with hyperglycemia, and type 2 diabetes mellitus with foot ulcer, unspecified open wound, right foot, subsequent encounter. A review of the July 2024 physician orders revealed the following: -cleanse Right lateral foot with normal saline/ wound cleanser apply collagen powder to wound bed, biopad collagen dressing, tritec silver cover with border gauze and PRN. every day shift for wound care AND as needed for missing/ damaged dressing, Active 5/28/2024 15:00 (3:00 p.m.). A review of Resident #58's July 2024 Treatment Administration Record revealed the resident's wound care was being completed as ordered. A review of Resident #58's care plans, initiated on 01/11/2023, revealed Resident #58 was at risk of skin impairment. Interventions included: Skin checks to be weekly and as indicated. A review of Resident #58's Quarterly MDS, Section M, dated 04/08/2024, revealed the presence of 1 pressure wound that was facility acquired. It revealed Resident #58 has a stage 3 pressure injury. A review of Resident #58's Wound Evaluations revealed three Wound Evaluations in the EMR from 04/30/2024 through 07/16/2024. The Wound Evaluations were as follows: 05/08/2024: I. Wound Summary: Length: 1.5, Width: 1.7, Depth:0.01, 1. Site: Other: 1a. Other: Right lateral foot, 2. Type: Pressure Ulcer (In-House Acquired) 2b. Pressure Ulcer Stage: f) Unstageable (continued on next page)

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

IV. Wound Bed - 4. Wound color: a. Pink, b. White.

05/23/2024: I. Wound Summary: Length: 0.4, Width: 0.5, Depth:0,

1. Site: Other: 1a. Other: Right lateral foot, 2. Type: Pressure Ulcer (In-House Acquired) 2b. Pressure Ulcer Stage: f) Unstageable

IV. Wound bed - 3b. granulation %-100%, 4. Wound color: a. Pink, b. white.

05/29/2024: I. Wound Summary: Length: 2.3, Width: 3.5, Depth:0,

1. Site: Other: 1a. Other: Right lateral foot, 2. Type: Pressure Ulcer (In-House Acquired) 2b. Pressure Ulcer Stage: f) Unstageable

IV. Wound bed - 3b. granulation %-100%, 4. Wound color: a. Pink,

b. white.

3. A review of Resident #5's Admission Record revealed an admitted [DATE] with diagnoses to include unspecified superficial injury of right ankle, subsequent encounter.

A review of Resident #5's July 2024 physician orders revealed:

-cleanse Right Medial Ankle with ns [normal saline]/ wound cleanser pat dry apply Honey gel, Calcium Alginate cover with Border Gauze. QD & PRN every day shift for DTI (deep tissue injury) AND as needed, start date:7/16/2024.

A review of Resident #5's July 2024 Treatment Administration Record revealed the resident's wound care was being completed as ordered.

A review of Resident #5's care plans, dated 11/09/2022, revealed Resident #5 is at risk for skin impairment with a goal of no new skin impairments. Interventions included: monitor/observe skin while providing routine care, notify nurse of any area of concern as indicated, skin checks weekly and as indicated. Report any s/s (signs and symptoms) of skin breakdown to MD/wound team as indicated.

An interview conducted on 07/15/2024 at 11:00 a.m. Resident #5 was found to be verbal but not interviewable.

A review of Resident #5's Quarterly MDS, 07/07/2024, revealed in Section C- Cognitive Patterns a BIMS score of 09, which showed moderate cognitive impairment. Section M- Skin Conditions showed the resident had a stage 3 pressure injury present at the time of that assessment.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #5's Electronic Medical Record revealed no weekly Wound Evaluations were completed between 6/17/2024 and 07/16/2024. Review of the EMR revealed skin checks dated: 07/16/2024: section 1: site: is a body diagram that is not marked. Section 2. Comments: open dti found to the inner right heel, family and MD (Medical Doctor) made aware., 07/09/2024: section 1. site, Other (specify) no further documentation in that area. Section 2: comments: open dti to the inner right heel family and MD made aware07/02/2024: section 1: site: 49) right heel- dti. Section 2: Comments: open dti found to the inner right heel family and md made aware. An interview conducted on 07/17/2024 at 11:31 AM with Staff A, Licensed Practical Nurse (LPN)/wound care, stated she has not had a chance to document the current wound assessments, but she has the measurements and descriptions in her personal notes. She stated Resident #5 wasn't seen last week because on Tuesday, she tested positive for COVID-19; which was about the same time the wound care doctor was out with COVID-19 also. Staff A stated she loaded the wound care doctor's note yesterday. Staff A stated typically anything in the wound evaluation assessment would be done by the wound care nurse. She also stated skin checks were not her responsibility, but that generally when she is already seeing the resident she will do the skin check in addition to the Wound Evaluation. She stated, Because a weekly skin assessment is done, I don't do measurements in the weekly skin check; wound assessments should be done weekly. She further stated, I don't monitor [Resident #5]. She is seeing outside wound care. I would still take measurements. I still try to assess her weekly. During an interview conducted on 07/17/2024 at 11:51 AM the DON stated the outside doctor should send measurements. She stated that she would expect the staff to document measurements and descriptions of wounds weekly. The DON stated she was going to call the doctor this week to get measurements, but without them being uploaded the bedside nurses wouldn't have access to the records. She stated Staff A is responsible for uploading the note so the nurse can see them. The nurses have access to review the notes. She also stated if the doctors don't send notes, the unit managers should call for the documents. She said, I follow who has appointments. She stated she expects weekly documentation on wounds the wound care doctor is following to be uploaded to the electronic medical record weekly. They should also have weekly skin assessments. She stated skilled notes are not skin assessments. Every week there should be an assessment apart from the daily skilled nurses note. A review of the facility policy titled, Standards and Guidelines: Prevention of Skin Impairments/Pressure Injury, effective October 2020 and revised January 2024, revealed under the section titled Procedure: Risk Assessment: 1. Assess the resident on admission for existing wound risk factors. 2.Conduct a comprehensive skin assessment upon admission, including: a. Skin integrity- any evidence of existing or developing pressure ulcers or injuries; b. Areas of impaired circulation due to pressure from positioning or medical devices. 3. Inspect the skin when performing or assisting with personal care or ADLs (activities of daily living). a. Identify any signs of developing skin wound (i.e. nonblanchable erythema/rashes). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.) c. Wash the skin after episodes of incontinence. d. Reposition resident as indicated on the care plan. A review of the facility policy titled, Standards and Guidelines: Documentation, effective October 2020 and revised January 2024, revealed under the section titled Procedure: 1. Documentation in the medical record may be electronic, manual or a combination. 2.The following information is to be documented in the resident medical record: a) objective observations; c) Treatments or services performed; d) Changes in the resident's condition; 3. documentation in the medical record is required as updates/ changes in the resident's plan of care are made. 4. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 8. Documentation of procedures and treatments will include care-specific details, including: a) the date and time the procedure /treatment was provided; b) the name and title of the individual(s) who provided the care; c) the assessment data and/or any unusual findings obtained during the procedure/treatment; d) whether the resident refused the procedure/ treatment; e) whether the resident refused the procedure/treatment; e) notification of family, physician or other staff, if indicated; and f) the signature and title of the individual documenting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105302	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Oak Haven Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 919 Old Winter Haven Rd Auburndale, FL 33823	

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on record review, interview and review of the facility's policy Dialysis Care, the facility failed to ensure ongoing communication was established between the facility and dialysis center for three residents (#33, #35 and #268) of three residents reviewed for dialysis services. Findings included: Review of the Admission Record showed Resident #33 was admitted to the facility on [DATE] with diagnoses that included but not limited to End stage renal disease, Hemiplegia and Hemiparesis following cerebral infarction affecting left non-dominant side, and Dysphasia following cerebral infarction. Review of the Order Summary Report showed a current physician order dated 07/15/24 that revealed Dialysis [Tuesday]T, [Thursday]TH, {Saturday}Sat, [Local Dialysis Center] [Local Dialysis Center phone number] chair time: 12 Noon Transport Through [Local Transport Company] between 11:00- 11:15 am. Review of the Care Plan showed,Focus- At risk for complications r/t Hemodialysis dx: ESRD [end stage renal disease]. Goal- The resident will be compliant with dialysis appointments, nursing interventions and physician orders through the review date. Interventions: - Hemodialysis-Resident receives [Hemodialysis]HD every [Tuesday]T-[Thursday]TH-[Saturday]S at [Local Dialysis Center], Local Dialysis Center Phone Number]. Chair time is 11:30 am-transported by [Local Transport Company], [Local Transport Company phone number], via W/C with P/U time of 10:45 am. - Hemodialysis-Right Upper Chest dialysis access port. Monitor site for s/s of infection, pain, drainage, increased temp, edema, etc. Notify physician of abnormal findings. Encourage resident to attend the scheduled dialysis appointments. Avoid blood pressure, blood work, IV insertion on affected arm. Monitor for dry skin and apply lotion as needed. Monitor VITAL SIGNS as ordered and PRN. Notify MD of significant abnormalities. Monitor/document/report PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. Review of Resident #33's Dialysis Communication Book on 07/16/24 at 4:20 p.m., showed no communication book available and one single Dialysis Communication Form found at the nurses station. Review of the single Dialysis Communication Form dated 07/13/24 showed section Dialysis Nurse completes this section was blank. Photographic evidence obtained. During an interview on 07/15/24 at 1:48 p.m., Resident #33 stated he went to dialysis on Tuesdays, Thursdays and Saturdays. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/16/24 at 4:21 p.m. Staff D Registered Nurse (RN) stated, sometimes Dialysis writes back but most of the time they do not. Staff D stated the facility was responsible for completing pre and post checks on Residents before and after dialysis treatments. Review of Resident #33's dialysis book on 07/17/24 at 8:45 AM showed no communication dialysis book available. During an interview on 07/17/24 at 9:02 a.m., the Director of Nursing (DON) stated that Resident # 33's communication book must have been left at the dialysis center yesterday as the facility cannot find it. The DON stated the Nurse was calling the Dialysis Center to see if they have it. Review of Resident #33's Progress Notes revealed no ongoing communication between the facility and dialysis center. Review of the Admission Record showed Resident #35 was originally admitted to the facility on [DATE] with diagnoses that included but not limited to End Stage Renal Disease [ESRD], Type 2 Diabetes Mellitus, muscle weakness (generalized), need for assistance with personal care and aneurysm of unspecified site. Review of the Order Summary Report showed a current physician order dated 10/27/23 Hemodialysis-Resident receives [Hemodialysis] HD every [Monday] M - [Friday]F at [Local Dialysis Center] - [Local Dialysis Center phone number]. Chair time is 0900 -transported by [Local Transport Company] , [Local Transport Company phone number] via wheelchair with P/U time of 0815. Review of the Care Plan showed, Focus- At risk for complications related to Hemodialysis dx: ESRD. Goal- The resident will be compliant with dialysis appointments, nursing interventions and physician orders through the review date. Interventions: - Hemodialysis- Right Chest Permacath dialysis access port/line. Monitor site for s/s of infection, pain, drainage, increased temp, edema, etc. Notify physician of abnormal findings. - Provide snacks/meals to go with resident on dialysis days - Resident receives [Hemodialysis] HD every [Monday] M - [Friday]F at [Local Dialysis Center] - [Local Dialysis Center phone number]. Chair time is 0900 -transported by [Local Transport Company] , [Local Transport Company phone number] via wheelchair with P/U time of 0815. - Avoid blood pressure, blood work, IV insertion on affected arm- right. - Monitor/document/report PRN any s/sx of infection to access site: Redness, Swelling, warmth or drainage. - Monitor for dry skin and apply lotion as needed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Monitor VITAL SIGNS as ordered and PRN. Notify MD of significant abnormalities. - Report abnormal labs to doctor as indicated. - Monitor/document/report PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. Review of Resident #35's Dialysis Communication Book revealed the following Dialysis Communication Form entries: - Resident #35's Dialysis Communication Form dated 07/15/24 showed section Dialysis Nurse completes this section was blank. Photographic evidence obtained. - Resident #35's Dialysis Communication Form dated 07/08/24 showed section Dialysis Nurse completes this section was blank. Photographic evidence obtained. - Resident #35's Dialysis Communication Form dated 07/01/24 showed section Dialysis Nurse completes this section was blank. Photographic evidence obtained. Review of Resident #35's Progress Notes revealed no ongoing communication between the facility and dialysis center. Review of the Admission Record showed Resident #268 was admitted to the facility on [DATE] with diagnoses that included but not limited to Chronic kidney disease stage four (severe), chronic obstructive pulmonary disease, anxiety disorder, major depressive disorder, recurrent, mild and muscle weakness (generalized). Review of the Order Summary Report showed a current physician order dated 07/15/24 Hemodialysis-Resident receives [Hemodialysis] HD every Tuesday, Thursday and Saturday at [Local Dialysis Center]-[Local Dialysis Center address]-Chair time is-10:20 am. Transported by [Local Transport Company] [Local Transport Company phone number] w/c with P/U time of 9:30 am. Review of the Care Plan showed,Focus- At risk for complications related to Hemodialysis dx: [Chronic Kidney Disease] CKD 4. Goal- The resident will be compliant with dialysis appointments, nursing interventions and physician orders through the review date. Interventions: - [Hemodialysis] HD-Type: Right upper chest port-Permacath. Dialysis access port/line: Do not access this line-for Hemodialysis use only. - Hemodialysis- Right upper chest port-Permacath) dialysis access port/line: HD center to complete routine dressing changes. May reinforce the dressing if dislodged. May replace the dressing if unable to reinforce using sterile technique. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Hemodialysis-Offer Resident a packaged meal and/or snack on Tuesday., Thursday., Saturday. before HD appointment. -Hemodialysis-Resident receives [Hemodialysis] HD every [Monday] M - [Friday]F at [Local Dialysis Center] - [Local Dialysis Center phone number]. Chair time is 0900 -transported by [Local Transport Company] , [Local Transport Company phone number] via wheelchair with P/U time of 0815. - Avoid blood pressure, blood work, IV insertion on affected arm HD- Right upper chest port precautions-no lab draws, no BP's, etc. - Monitor/document/report PRN any s/sx of infection to access site: Redness, Swelling, warmth or drainage. - Monitor VITAL SIGNS as ordered and PRN. Notify MD of significant abnormalities. - Report abnormal labs to doctor as indicated. - Monitor/document/report PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. - Work with resident to relieve discomfort for side effects of the disease and treatment. (Cramping, fatigue, headaches, itching, anemia, bone demineralization, body image change and role disruption.) Review of Resident #268's Dialysis Communication Book revealed the following Dialysis Communication Form entries: - Resident #268's Dialysis Communication Form dated 07/04/24 showed section Dialysis Nurse completes this section was blank. Photographic evidence obtained. - Resident #268's Dialysis Communication Form dated 07/11/24 showed section Dialysis Nurse completes this section was blank. Photographic evidence obtained. Review of Resident #268's Progress Notes revealed no ongoing communication between the facility and dialysis center. During an interview on 07/17/24 at 10:50 a.m., Staff F Licensed Practical Nurse (LPN), Unit Manager (UM) stated that the Dialysis Center will fill out the Dialysis Communication Form sometimes and sometimes not. Staff F LPN, UM stated that she does not call the Dialysis Center for an update when the Dialysis Communication Form was blank but stated I will call monthly to the Dialysis Center to get updated treatment and care notes. Staff F LPN, UN stated, when the forms are not completed, I do not want to bother the Dialysis Center all the time so I just call and get the dialysis care notes monthly and then have them scanned in the resident's medical record. Staff F LPN, UM stated the facility was completing resident pre and post assessments when a Resident goes out and returns from dialysis services. Staff F LPN, UM stated we just do not always get communication back from the dialysis center. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/17/24 at 11:00 a.m., Staff G Licensed Practical Nurse (LPN), Unit Manager (UM) stated it is my responsibility to make the dialysis books and have flow sheets in those books. Staff G LP, UM stated if the facility did not get any communication back from the dialysis center I will call and ask for each residents' treatment notes weekly. Staff G LPN, UM stated sometimes we get a call from the Dialysis Center or we call them for ongoing communication. Staff G LPN, UM stated when phone communication occurs with the dialysis center it will be documented in the progress notes. Staff G LPN, UM stated she called the Dialysis Center and they found Resident #33's dialysis communication book and will send the book back to the facility with the Resident #33 on his next scheduled dialysis appointment tomorrow 07/18/24. During an interview on 07/17/24 at 11:36 a.m., the Director of Nursing (DON) stated that she would expect the nurses to follow up with the dialysis center every time a resident comes back from dialysis. The DON stated there should be some sort of follow up whether it is on the communication form or by a phone call. The DON stated, if the Dialysis Communication Form comes back incomplete by the dialysis center the nurse should call the dialysis center, get a follow up, and then document communication in a progress note. The DON stated that the all Dialysis Communication Forms should be scanned into the medical record under the documents tab. The DON stated, there should be ongoing communication with the dialysis center every time a Resident returns from the Dialysis Center and be documented in the Resident's medical record. Review of the facility's policy Dialysis Care revised date 08/2023 showed, Procedure: 4. Correspondence from the dialysis center will be addressed by facility staff and will be recorded in the plan of of care. 5. The facility will communicate nonadherence of the dialysis regimen to the dialysis center as well as attending physician.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Based on observation, interview and record review, the facility failed to ensure the Plan of Care was followed for 1 of 39 sampled residents (#267) related to an order for a medication, documentation of administering the medication and follow-up documentation. Findings included: During an interview on 07/15/24 at 12:00 p.m. Resident #267 was sitting at bedside in his wheelchair. He was dressed and groomed for the day. The resident's family member was with the resident. No odors were noted. The resident had a dollar size wound area on the right side of his head with smaller areas circling it. The left foot had a dressing in place. He stated he was non-weight bearing (NWB) at this time due to the heel wound. He had a right above the knee amputation. The facility used a Hoyer lift due to his NWB of left foot, ulcer. They stated that on Saturday at 3 p.m., they told the aide he was in pain due to constipation. They requested a suppository. They stated the nurse came in an hour later and stated she would come back after she performed medication pass. The stated it was 3-4 hours later before he got a suppository. The wife stated she performed the majority of the care, bathing, cleaning him, lotion. She stated he wants her to provide his care. They stated he had an ulcer on his bottom. Resident #267 was admitted on [DATE]. Review of the admission record showed the diagnoses included but not limited to surgical amputation (Right above knee), diabetes, protein-calorie malnutrition, dementia, chronic kidney disease, anemia, hypertension, squamous cell carcinoma of skin on right lower limb, muscle weakness, and abnormal gait. Review of the admission MDS dated [DATE] showed a BIMs of 15 (cognitively intact). Section GG Functional Abilities and Goals showed the resident required maximum assistance. Review of the physician orders showed no orders for bowel regimen, Dulcolax suppository. Review of the physician orders showed no order for Dulcolax suppository on 07/13/2024. Review of the July 2024 MAR (medication administration record) did not show a Dulcolax Suppository had been administered on 07/13/2024. Review of the progress notes for 07/13/2024 showed no documentation related to abdominal pain, notification of physician for an order, receiving an order for a suppository or suppository administration for constipation. There was lack of documentation of results of the suppository. Review of the care plan for at risk for bowel irregularity related decreased mobility as of 07/08/2024. Interventions included but not limited to administer medications as per MD orders as of 07/08/2024. Monitor for and document resident's bowel movements as of 07/08/2024. Monitor medications for side effects of constipation/loose stools. Notify MD as indicated as of 07/08/2024. Monitor/observe for abdominal distention, abdominal pain/tenderness/discomfort, decreased bowel sounds, N/V, s/s of constipation, unresolved diarrhea, changes in mental status and notify MD/NP/PA as indicated as of 07/08/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/17/2024 at 3:45 p.m. the Director of Nursing (DON) stated they normally review the bowel needs on admission, including review of the drugs and diagnoses to see if constipation or diarrhea medications are needed to be a standing order. The DON stated she would have to look into it (administration of suppository for constipation). The DON verified the resident did not have any bowel regimen orders. She stated the staff can call the medical provider 24-hours a day to get a medication order. During an interview on 07/17/2024 at 4:43 p.m. the DON confirmed there was not an order or a progress note about the constipation and suppository in the chart. The DON stated the wife told her the resident normally takes an oral medication daily at home. The DON stated she called the MD (medical doctor) for an order for Senna at bedtime for constipation while he was at the facility. During an interview on 07/17/2024 at 5:15 p.m. the DON stated she spoke with the resident's APRN (advanced practice registered nurse). The APRN told her she gave a nurse an order for a suppository. The APRN told the her she does not remember the nurse's name but it was an order for Docusate. The DON stated the Docusate suppository was an over-the-counter medication. The DON stated she spoke with Staff I, Licensed Practical Nurse (LPN) and Staff I stated she gave Resident #267 a suppository but forgot to document it. Staff I told the DON she gave the suppository around 5 p.m. She told the resident she would check on him again after medication pass. The DON state the normal process was for the nurse to call the MD for orders, document the order and give the medication, and document. During an interview on 07/18/2024 at 9:47 a.m., the APRN stated a nurse from the facility called her over the weekend about Resident #267 being constipated. The APRN stated she does not remember which nurse called. APRN stated she ordered a bowel regime. She stated she will either order an oral or a suppository depending on the resident's needs. She stated she ordered a suppository, because the nurse stated the resident had not had a bowel movement in a couple days, and that (suppository) works best. The APRN stated she expected the nurse to write an order based on the verbal order, give the medication and document. During an interview on 07/18/2024 at 9:56 a.m. Staff I, LPN stated she worked the weekends on the .3-11 p. m. shift. She stated she got report from the prior nurse. She stated she checked the resident's room and was told he was constipated and needed a suppository. She told the resident she would need an order for the suppository. She told him she would have to see if he had an order and if he didn't, she would need to call the MD for an order. Staff I, LPN told the resident to give her time to get the order. Staff I stated she got an order from the APRN between him asking and him getting it. She stated, He got the suppository about 5 pm. It was a crazy day. I was running. I went back around 7 p.m. and asked him any results. He had a bowel movement. She stated he said he was okay and relieved. The resident thanked her for the suppository. She stated she saw the resident during p.m. rounds. Staff I, LPN stated the resident told the nurse he was trying to pass the stool and needed help. The APRN gave her the order, but she did not write the order for the suppository. Staff I, stated, She was trying to just give it to him and try to eliminate (another task), made sure he had results. She stated she could not remember if the resident got any other meds. Staff I stated, When I get orders I am putting it in while talking to them, reading it back to them. I was trying to focus on the patient. I was making sure the patient was okay. I normally after giving the med, document. People were on the computer. She stated she normally document prn medications, new orders. Staff I stated, I did not document the results of the bowel movement, went back and asked him, if it worked. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy, Standards and Guidelines: Medication Administration, revised 01/2024 showed Standard: Medications are ordered and administered safely and as prescribed. Guideline: Medications will be administered safely and as prescribed by only licensed personnel. Procedure: 3. Medications are administered in accordance with prescriber orders, including any required time frame. 15. During administration of medications, the medication cart is kept closed and locked when out of sight of the individual administering the medication. It may be kept in the doorway of the residence room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart when not within sight of the individual administering medications. The cart should be clearly visible to the personnel and ministering medications, and all outward sides should be inaccessible to residents or others passing by. 17. As required or indicated for a medication, the individual administering the medication records in the residence medical record: a. The date and time the medication was administered; B. The dosage; C. The route of administration; E. Any complaints or symptoms for which the drug was administered if applicable; F. Any results achieved and when those results were observed if applicable; and G. The signature and title of the person administering the drug. 19. Staff follows established facility infection control procedures (e.g., hand washing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. Review of the facility's policy, Standards and Guidelines: Physician Orders, revised 01/2024 showed Guideline: Orders and administration of medications and treatments will be consistent with principles of safe and effective order writing. Procedure: 1. Medications shall be administered upon the written order of a person duly licensed and authorized to prescribe such medications in this state as soon as practicable. 2. Authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record. 3. Drug and biological orders must be recorded on the physician's order sheet and the resident's electronic chart. 4. The staff and practitioner shall use approved abbreviations and symbols when ordering and or charting medications. 5. Verbal orders should be recorded in the resident's chart by the authorized person receiving the order and should include the prescriber's name, credentials, the date and the time of the order. 6. Verbal telephone orders may be received by licensed personnel. Orders should be transcribed by the authorized personnel receiving the order and recorded in the resident's medical record. 7. The entry should contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information. 8. Orders for medication should include: a. Name and strength of the drug b. Number of doses, start and stop date, and or specific duration of therapy; c. Dosage and frequency of administration; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Route of administration; e. Clinical condition or symptoms for which the medication is prescribed and 9. Physician orders should be followed and prescribed, and if not followed, this should be recorded in the resident's medical record during that shift. The physician should be notified and the responsible party if indicated. 10. The resident will be informed of medication changes as they occur. If the resident is deemed incapable of making health care decisions, the residents responsible party will be informed of medication changes as they occur.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34768 Based on observation, interview and record review, the facility failed to ensure medications were stored properly for 2 (#272 and #19) out of 6 medication administration observations. Findings included: On 07/16/2024 at 8:40 a.m. Resident #272 was observed during medication pass with Staff J, Licensed Practical Nurse (LPN). Staff J was observed entering the resident's room with her inhaler. Staff J exited the room and placed the inhaler on the medication cart and went into the bathroom to wash her hands. The LPN was unable to visualize the unattended medication while she was in the bathroom. On 07/16/2024 at 10:50 a.m. Resident #19 was observed during blood glucometer monitor use and insulin injection by Staff H, LPN. The LPN placed the insulin bottle on the computer keyboard on the medication cart, entered the resident's room and injected the insulin. The LPN was unable to visualize the unattended medication while in the resident's room. During an interview on 07/17/2024 at 5;32 p.m. the DON was apprised of the medication administration observation. The DON the expectations were medications were not to be left unattended out of a locked medication cart. Review of the facility's policy, Standards and Guidelines: Medication Storage and Labeling, revised 01/2024 showed Guideline: the facility stores all drugs and biological in a safe, secure, and orderly manner. Procedure: 1 drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 41015 Based on observation, interview, record review and review of the facility's policy Menu and Meals Service: Nourishment/Snacks, the facility failed to ensure one resident (#73) of one resident reviewed was provided a snack when requested. Findings included: During an interview on 07/15/24 at 10:56 a.m., Resident #73 stated, I am still hungry, I got two eggs but I still would like a snack. During an interview on 07/15/24 at 11:00 a.m., Staff C, Certified Nursing Assistant (CNA) was notified of Resident #73's snack request. Staff C, CNA stated, I am not his CNA but he gets double portions for his meals. An observation on 07/15/24 at 11:19 a.m., revealed Resident #73 continued to sit beside his bed in wheelchair with no snack visible on the bedside table. During an interview on 07/15/24 at 11:20 a.m., Resident #73 stated, No one ever brought me that snack. During an interview on 07/15/24 at 11:22 a.m., Staff D, Registered Nurse (RN) Nurse stated, I will go get him a snack and the CNA should have provided it when requested. During an interview on 07/15/24 at 11:36 a.m., Staff C, CNA stated, she never got the snack for Resident #106 but she told Resident #106's assigned CNA. During an interview on 07/15/24 at 11:51 a.m., Staff E, CNA stated Staff C, CNA never told her Resident #73 wanted a snack or she would have provided him one. During an interview on 07/15/24 at 11:55 a.m., Staff D, RN stated that any CNA could have provided Resident #73 with a snack, it did not have to be the assigned CNA. During an interview on 07/17/24 at 3:58 p.m., the Director of Nursing (DON) stated that any CNA can provide a resident a snack when requested, even if they are not assigned to that Resident. The DON stated the only consideration and what the facility educates on with snack requests is the CNA talks with the nurse prior to providing the snack so that the appropriate snack may be given. Review of the facility's policy Menu and Meals Service: Nourishment/Snacks revised date July 2024 showed, Snacks will be available for residents between meals based on request or as part of appropriate therapeutic diet, dietitian recommendation, or physician order.

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NAME OF PROVIDER OR SUPPLIER Oak Haven Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 919 Old Winter Haven Rd Auburndale, FL 33823	

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Based on observation, interview and record review, the facility failed to ensure the medical record was accurate and complete related to to documentation of Skilled Nursing Documentation Notes for 3 (#8, #19, #267) of 39 sampled residents. Findings included: 1. On 07/15/2024 at 4:30 p.m. Resident #19 was observed sitting in her wheelchair at bedside. She was dressed and groomed for the day. She stated she went out to breakfast with her son. Her oxygen via nasal cannula was in place and at 2 liters per minute. Resident #19 stated that the staff cares for her. They answer the call lights and give her showers. She stated she had been to the hospital a couple of times for breathing problems. No odors were noted. No skin impairments were observed. Her personal items were noted. Resident #19 was admitted on [DATE] and readmitted on [DATE]. Review of the admission record showed diagnoses included but not limited to Chronic Respiratory Failure with hypoxia, diabetes, Chronic Obstructive Pulmonary Disease (COPD), obesity, Congestive Heart Failure (CHF), hypertension with HF, stage IV chronic kidney disease, ischemic cardiomyopathy, anemia, muscle weakness, Transient Ischemia Attack (TIA). Review of the annual, Minimum Data St (MDS) dated [DATE] showed Brief Interview of Mental Status (BIMS) score of 14 (cognitively intact). Section GG, Functional Abilities and Goals showed the resident needed moderate assistance. Review of the physician orders showed Resident #19 was receiving therapy services, physical therapy, speech therapy and occupational therapy. Review of the Medication Administration Record (MAR) for July 2014 showed Skilled Patient to be charted daily in assessment as of 06/11/2024 to 07/09/2024. Review of the Skilled Documentation notes showed the following were not documented: 06/07/2024, 06/10/2024, 06/11/2024, 06/12/2024, 06/16/2024, 06/17/2024, 06/21/2024, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/27/2024, 06/28/2024, 06/29/2024, 07/01/2024 07/05/2024, 07/07/2024, 07/11/2024, 07/13/2024, 07/14/2024, 07/15/2024 2. On 07/15/24 12:29 p.m. Resident #8 was sitting in her wheelchair beside her bed, eating her lunch, of hamburger, carrots, soup, pudding, salad and fluids. She was dressed and groomed for the day. She stated she had no complaints or concerns. She stated the staff answers all the call lights. She stated she was able to take her own shower. A bruise was observed on her left upper hand. Resident #8 was admitted on [DATE] and readmitted on [DATE]. Review of the admission record showed the diagnoses included but were not limited to Urinary Tract Infection (UTI), diabetes, Chronic Obstructive Pulmonary Disease (COPD), chronic respiratory failure, obesity, CHF, Pulmonary HTN, atrial fibrillation, stage III chronic kidney disease, anemia, and weakness. Review of the MDS dated [DATE] showed a BIMS score of 15 (cognitively intact). Section GG Functional Abilities and Goals showed the resident needed maximal assistance with care. Review of the physician orders showed Resident #8 was receiving therapy services, physical therapy and occupational therapy as of 07/05/2024. Admit resident to facility for skilled services as of 07/04/2024. Review of the Skilled Documentation notes showed the following were not documented: 07/05/2024, 07/06/2024, 07/08/2024, 07/09/2024, 07/12/2024, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/13/2024, 07/15/2024 During an interview on 07/17/2024 at 12:10 p.m. the Director of Nursing (DON) verified the bruise was documented but location was not documented, and it should be. The DON verified the Weekly Skin Check was not performed weekly. The DON verified the chart was missing Skilled Documentation notes. 3. During an interview on 07/15/24 at 12:00 p.m. Resident #267 was sitting at bedside in his wheelchair. He was dressed and groomed for the day. The resident's family member was with the resident. No odors were noted. The resident had a dollar size wound area on the right side of his head with smaller areas circling it. The left foot had a dressing in place. He stated he was non-weight bearing (NWB) at this time due to the heel wound. He had a right above the knee amputation. The facility used a Hoyer lift due to his NWB of left foot, ulcer. They stated that on Saturday at 3 p.m., they told the aide he was in pain due to constipation. They requested a suppository. They stated the nurse came in an hour later and stated she would come back after she performed medication pass. The stated it was 3-4 hours later before he got a suppository. The wife stated she performed the majority of the care, bathing, cleaning him, lotion. She stated he wants her to provide his care. They wanted him to go home so he does not get COVID. They stated he had an ulcer on his bottom. Resident #267 was admitted on [DATE]. Review of the admission record showed the diagnoses included but not limited to surgical amputation (Right above knee), diabetes, protein-calorie malnutrition, dementia, chronic kidney disease, anemia, hypertension, squamous cell carcinoma of skin on right lower limb, muscle weakness, and abnormal gait. Review of the admission MDS dated [DATE] showed a BIMs of 15 (cognitively intact). Section GG Functional Abilities and Goals showed the resident required maximum assistance. Review of the physician orders showed: Resident #267 was receiving therapy services, physical therapy and occupational therapy. Skilled patient to be charted daily in assessment as of 07/09/2024. Review of the July MAR showed skilled patient to be charted daily in assessment every day as of 07/10/2024. Review of the Skilled Documentation notes showed the following were not documented: 07/05/2024, 07/06/2024, 07/07/2024, 07/08/2024, 07/09/2024 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy, Standards and Guidelines: Documentation, revised 01/2024 showed Guideline: Services provided to the resident shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Procedure: 1. Documentation in the medical record may be electronic, manual, or combination. 2. The following information is to be documented in the resident medical record: a) Objective observations; b) Medication administered; c) Treatments or services provided performed; d) Changes and the resonance condition; 3. Documentation in the medical record is required as updates / changes and the resident's plan of care are made. 8. Documentation of procedures and treatments will include care specific details, including: a) the date and time the procedure slash treatment was provided; b) the name and title of the individual (s) who provided the care; c) the assessment data and / or for any unusual findings obtained during their procedure / treatment; e) notification of family, physician or other staff, if indicated; and f) the signature and title of the individual documenting.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Based on observations, record review and interviews, the facility failed to ensure hand hygiene was performed during medication administration, the blood glucose monitoring machines were adequately disinfected, and blood pressure cuffs were cleaned between residents for 6 (#66, #86, #272, #67, #19, and #97) of 39 sampled residents; and the facility failed to ensure staff doffed Personal Protective Equipment (PPE) before entering/exiting two resident rooms (234 and 248) on droplet precautions. Findings included: On 07/16/2024 at 8:00 a.m. Resident #66 was observed during medication pass with Staff D, Registered Nurse (RN). Staff D, RN pushed the medication cart from the nurse's station to the resident's room. She was observed to not hand sanitize prior to medication pass. She entered the resident's room with a blood pressure machine. Staff D sat the blood pressure machine on the resident's bed and proceeded to take his blood pressure. The blood pressure was 117/68. Staff D exited the room with the blood pressure machine and sat it on the top of the mediation cart without cleaning it. Staff D proceeded to open the medication cart and started removing his medications. She had not hand sanitized. After administering the resident's medications, she exited the room and still had not performed hand sanitizing or cleaned the blood pressure machine. On 07/16/2024 at 8:15 a.m. Resident #86 was observed during medication pass with Staff H, Licensed Practical Nurse (LPN). Staff H was observed pushing the medication cart from the nurses' station and entered the resident's room with a blood pressure cuff, without hand sanitizing. Staff H took the resident's blood pressure. Staff H exited the room, applied gloves and cleaned the blood pressure cuff, removed his gloves, and did not hand sanitize. Staff H was observed touching his hair throughout the medication pass. Staff H entered the resident's room with gloves in place and took the box with the inhaler in it, into the resident's room. The resident was handed the inhaler to the resident and he took his medication. Staff put the inhaler back into the box and brought it back out of the resident's room. Staff H removed his gloves at the medication cart, he did not hand sanitize. He opened the cart and replaced the boxed inhaler back into the medication cart. He still had not hand sanitized. Staff H left the medication cart, went to the nurses' station, then down the hallway to another nurse's medication cart and retrieved insulin syringes. While returning to his medication cart, he stopped in room [ROOM NUMBER] due to the call light being on. He progressed to his cart. On his return he still had not hand sanitized. Staff H opened the medication cart and retrieved a multiple dose bottle of insulin. Staff H applied gloves without hand sanitizing. He removed the alcohol wipe from the cart and cleaned the top of the vial. He withdrew 10 units of insulin. Staff H entered the resident's room with glove in place and injected the insulin in the right arm of the resident. He removed his gloves, disposed of the syringe and washed his hands. On 07/16/2024 at 8:40 a.m. Resident #272 was observed during medication pass with Staff J, LPN. Staff J was observed applying gloves without hand sanitizing before entering the resident's room with her inhaler. Staff J exited the room and placed the inhaler on the medication cart without a barrier. Staff J removed her gloves and washed her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/16/2024 at 8:45 a.m. Resident #67 was observed during medication pass with Staff J, LPN. Staff J was observed to not perform hand sanitizing prior to medication administration. Staff J took a blood pressure machine into the resident's room and the blood pressure was taken, 141/65. Staff J returned to the medication cart and placed the used blood pressure cuff on the medication cart. Staff J did not clean the blood pressure cuff or hand sanitize. Staff J administered the medications to the resident. She returned to the medication cart and did not hand sanitize. Staff J was observed taking the dirty blood pressure cuff back into room [ROOM NUMBER]B and taking the blood pressure of the roommate in the room. She returned to the cart with the blood pressure cuff and laid it on the cart. On 07/16/2024 at 8:50 a.m. Resident #97 was observed during medication pass with Staff K, RN. Staff K did not hand sanitize prior to medication administration. Staff K placed the used blood pressure cuff on the medication cart without cleaning it. Upon leaving the room, she had not hand sanitized. Hand sanitizing was not performed after passing the medications. Staff K was observed using the uncleaned blood pressure cuff on Resident #12. On 07/16/2024 at 10:50 a.m. Resident #19 was observed during blood glucometer monitor use and insulin injection by Staff H, LPN. Staff H was sitting at nurses' station, moved the medication cart to the resident's room. Staff H washed his hands. Staff H laid the blood glucose monitor, lancet, bottle of strips and plastic cup on top of medication cart as well as 2 alcohol wipes. Staff H applied gloves. Staff H took the blood glucose monitor, lancet, bottle of strips and laid them on the (dirty) overbed table. The table had not been cleaned and had personal items as well as food on it. Staff H placed a strip in the blood glucose monitor. He laid the blood glucose monitor back on the overbed table as well as the bottle of strips. He opened an alcohol wipe and wiped the left pointer finger. He used a lancet. wiped the finger again with alcohol and placed a drop of blood on the strip. The blood sugar level was 140. He laid the blood glucose monitor on overbed table. He then picked up the blood glucose monitor, bottle of strips and used lancet and exited room. He put the used lancet and strip in the hazardous waste. He placed the dirty blood glucose monitor in the plastic cup and placed the bottle of strips on the cart. He took the blood glucose monitor out of the cup and wrapped a wipe from the Microdot Minute container and replaced into the same cup. 1/4 of the blood glucose monitor was not covered by the wrap. Staff H removed his gloves and hand washed. He had left the computer open to names and a paper with names on the medication cart while performing the blood glucose monitoring. During an interview Staff H, LPN stated he wraps the blood glucose monitor and leaves it for 3 minutes. During the interview he locked his cart and left and walked toward the nurses' station and then down the hallway out of view. The blood glucose monitor, and bottle of strips were left on the medication cart. He returned with insulin syringes in his hand. When he returned, he washed his hands. He replaced his gloves. He removed the insulin from the medication cart, removed it from the baggie and box. He used an alcohol wipe and cleaned the top of the insulin bottle. He removed 4 units on insulin. He entered the resident room and injected the insulin into her left arm post use of alcohol. Staff H returned to the cart and threw away the syringe in the hazardous container and removed his gloves. Staff H washed his hands. During an interview following the observation, Staff H stated he wraps the blood glucose monitor and leaves it for 3 minutes. then removes the wipe and lets it dry. He stated the blood glucose monitor was to be cleaned after each use and placed in the cart. Staff H stated the blood pressure cuffs are to be cleaned with the Microdot wipes also, after each resident. Staff H stated he lets the blood pressure cuff sit also. He stated he was supposed to hand sanitize between each resident, before and after medication pass, before and after glove changes. Staff H stated he washes his hands after gloves are removed and before gloves are put on. Staff H stated he washes his hands because the hand sanitizer breaks his hands out, so he just hand washes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/17/2024 at 5;32 p.m. the DON was apprised of the medication administration observation. The DON stated the staff was supposed to clean the blood pressure cuffs between residents. She stated they are supposed to hand sanitize before and after med pass, with gloves changes. The expectations were for medication boxes to not go into the resident's room, insulin was not to be left on the computer and out of a locked medication cart. The blood pressure cuffs, and blood glucose monitors need to be cleaned between residents. The DON stated they needed to instruct the staff on infection control, which included hand sanitizing or hand washing. Review of the facility's policy, Standards and Guidelines: Medication Administration, revised 01/2024 showed Standard: Medications are ordered and administered safely and as prescribed. Guideline: Medications will be administered safely and as prescribed by only licensed personnel. Procedure: 19. Staff follows established facility infection control procedures (e.g., hand washing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. Review of the facility's policy, Standards and Guidelines: Hand Hygiene Infection Control, revised 6/2023 showed Standard: This facility shall require facility personnel use accepted hand hygiene after each direct resident contact for which hand hygiene is indicated. Hand hygiene is a general term that applies to washing hands with water and either plain soap or thoroughly applying an alcohol-based hand rub (ABHR). Procedure: The facility acknowledges the CDC (Centers for Disease Control) guidelines to improve adherence to hand hygiene and healthcare settings. The hand hygiene guidelines are part of an overall CDC strategy to reduce infections in healthcare settings to promote resident safety. These guidelines state that hand washing is necessary when health care personnel hands are visibly soiled. When the hands are not visibly soiled, the CDC recommends the use of alcohol-based hand rubs by healthcare personnel for resident care to address the obstacles that health care professionals face when taking care of residents. Situations that require hand hygiene include, but are not limited to: Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice) Before and after performing any invasive procedure (e.g., finger stick blood sampling) Before and after entering isolation precaution settings Before and after medication administration After removing gloves or aprons Review of the facility's policy, Standards and Guidelines: Disinfecting, revised 01/2024 showed Guideline: The facility will ensure that appropriate infection prevention and control measures are taken to provide a safe, sanitary, and comfortable environment to prevent the spread of infection in accordance with State and Federal regulations, and national guidelines. Procedure: 1. EPA-registered healthcare disinfectant wipes will be used in accordance with manufacturer's instructions. An EPA- approved intermediate level disinfectant wipe is required for surfaces soiled with body fluid. Disinfectant wipes are used to clean the following items: B. Non-critical (i.e. contact with intact skin only) resident care equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EvenCare Proview Blood Glucose Monitoring System User's Guide, dated 2018 showed on page 40, 6. Caring for the Meter: caring for the meter is easy. Single-use medical protective gloves should be worn during disinfection procedures and also by anyone performing blood glucose testing on another person. Glucose meters used in a clinical setting for testing multiple persons must be cleaned and disinfected between patients. Use gloves should be removed and hands washed before proceeding to the next patient. Cleaning and Disinfecting Procedures for the Meter: the EVENCARE are ProView meter should be cleaned and disinfected between each patient. Disinfection Instructions: the meter must be disinfected between patient uses by wiping it with a CaviWipe towelette or EPA-registered disinfecting wipe in between tests and be cleaned prior to disinfecting. The disinfection process reduces the risk of transmitting infectious diseases if it is performed properly. Disinfection Instructions: step 1. Before disinfecting, clean the meter as described in Cleaning Your Meter process. Step 2. Wash hands with soap and water, put on single-use medical protective gloves. Step 3. Prepare the CaviWipe towelette or EPA-registered disinfecting wipe. Take out a wipe from the container and follow the instructions on the package. If needed squeeze the wipe slightly to remove the excess liquid. Step 4. Wipe the glucose meter thoroughly including the front, back and sides and take care not to get any liquid in the test strip port or serial port. Do not wrap the meter in a wipe. Step 5. If using the CaviWipe towelette, allow to remain wet for two minutes. For other EPA- registered disinfectant wipes allow the surface of the meter to remain wet for the contact time listed on the disinfecting wipes instructions for use. Dispose of wipe when finished. Step 6. After disinfection, users should take off gloves and wash hands thoroughly with soap and water before proceeding to the next patient 41015 An observation on 07/16/24 at 12:01 p.m., revealed Staff A, Licence Practical Nurse (LPN) exiting room [ROOM NUMBER] with the face shield still donned. The signage on the door stated Droplet Precautions. The Droplet Precautions sign showed, Remove face protection before room exit. Photographic evidence obtained. During an interview on 07/16/24 at 12:03 p.m., Staff A, LPN stated Sorry that was my bad; the face shield should have been taken off before I left the room. An observation on 07/16/24 at 12:13 p.m., revealed Staff B Certified Nursing Assistant (CNA) exiting room [ROOM NUMBER] with a blue surgical mask under the face shield still donned. The signage on the door stated Droplet Precautions. The Droplet Precautions sign showed, Remove face protection before room exit. Photographic evidence obtained. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/16/24 at 12:13 p.m., Staff B, CNA stated , I forgot to take it off when I left the room. During an interview on 07/17/24 at 5:46 p.m., the Director of Nursing (DON) stated, she would have expected the staff to don a N95 mask prior to entering a droplet precaution room and also doff the face shield and mask prior to leaving the room. The DON stated staff are expected to follow the instructions on the transmission based precaution signs. A review of the facility's Policy Standards and Guidelines: Screening, Testing, Return to work, Personal Protective Equipment, Isolation, Reporting revised date 06/24/24 showed, PPE (Personal Protective Equipment)/Hand Hygiene 1. Covid Unit- If the facility has an active Covid unit, then facility staff and visitors on the unit should wear full PPE including N95 mask and eye wear. 3. Transmission Based Precautions will be implemented and signage instructing the appropriate use of PPE's will be posted outside the resident's door.