STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105320	A. Building B. Wing	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dade City Health and Rehabilitation Center	37135 Coleman Ave Dade City, FL 33525

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. (continued on next page)

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

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

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record review, and interview, the facility failed to ensure accurate generally accepted accounting principles were implemented for two residents (#3 and #7) of three residents reviewed for Resident Trust Fund monies out of nine sampled residents. Resident #3 was not being charged the correct patient liability (cost of care) or allocated his personal needs allowance of $160.00 per month; Resident #7, a Supplemental Security Income (SSI) recipient, was not being charged the correct patient liability and the facility had not safeguarded his funds by ensuring the Social Security office had been notified of his residence in the Nursing Home.Findings included: 1. A review of Resident #3's clinical chart, the admission Record, documented an admission of 10/2023, with a readmission of 07/11/2025. His diagnosis information included but not limited to: dementia, muscle weakness, and need for personal care.A family member was listed as the resident's responsible party, power of attorney for financial and care. An observation and interview were conducted on 07/15/2025 at 10:15 a.m. with Resident #3, sitting in a wheelchair, dressed in seasonally appropriate clothing, he stated his family will bring in what he needs, and takes care of his finances. A review of Resident #3's eligibility recipient information for Medicaid for the dates of 07/2024 through 12/2024, documented Resident #7 had been determined eligible for Medicaid in the nursing home with a monthly patient liability (room and board) of $1,303.63 and for 01/2025 on going, a monthly patient liability of $1,338.63. A review of Resident #3's Resident Fund Management System (RFMS) (patient trust account) for the date of 12/13/2024 through the date of survey (07/15/2025) reflected Resident #3's Social Security check was direct deposited into his patient trust account. Review of the patient trust account debit column, which reflected the withdrawal by the facility for the monthly cost of care for room and board (patient liability) documented the following cost being charged the resident:01/03/2025=$1,438.0001/31/2025=$272.6302/03/2025=$1,438.0003/03/2025=$1,438.0004/03/2025=$1,438.0005/03/2025=$1,438.0006/03/2025=$1,466.0007/03/2025=$1,466.00 Further review of the RFMS (patient trust account) for 12/2024 through 07/15/2025 reflected no evidence the facility was setting aside Resident #3's personal needs allowance of $160.00 per month A review of Medicaid ESS (Economic Self Sufficiency) policy manual section 2640.0118 reflected Florida allows nursing home residents on the Medicaid long-term care program to retain a personal needs allowance of $160.00 per month. A review of Resident #3's billing statement for room and board, print date of 07/15/2025, for the time period of 01/01/2024 through the date of survey, 07/15/2025, was reviewed. For the 06/2024 through 12/2024, the charge for room and board was reflected to be $1,303.63 per month. For the 01/2025 through 04/2025, the charge for room and board was reflected to be $1,338.63.For 05/2025, $1,295.45;For 06/2025, $1,338.63;For 07/2025, $1,209.09As of 07/15/2025, Resident #3's room and board charge statement reflected a credit of $3,163.02. (over payment). The BOM was interviewed on 07/15/2025 at 2:48 p.m. while reviewing the RFMS statement and the room and board billing. The BOM confirmed what had been billed for room and board was not the same as what was being pulled from the RFMS (patient trust system). 2. A review of Resident #7's clinical chart, the admission Record, documented an admission to the facility in 01/2023; readmission in 11/2024. His diagnosis information included, but not limited to: Dementia, muscle weakness, and chronic kidney disease. A review of Resident #7's eligibility recipient information for Medicaid for the dates of 07/2024 through 07/2025, documented Resident #7 had been determined eligible for Medicaid in the nursing home with a monthly patient liability (cost of care) of $0.00. A review of Resident #7's RFMS (patient trust) Account for the dates of 12/13/2024 through the date of survey, 07/15/2025, documented Resident #7 had been charged a monthly patient liability (cost of care) each month of $807.00. The RFMS account reflected a monthly SSI (Supplemental Security Income) check deposit of $967.00. The BOM was interviewed on 07/15/2025 at 1:13 p.m. regarding Resident #7. She stated she became aware the facility was Representative Payee for Resident #7 when the Social Security office reached out, they were auditing his account. She stated prior to Social Security reaching out, she was unaware the facility was Representative Payee for Resident #7. When asked if the facility had notified the Social Security office of Resident #7's residing in a nursing home, she said she would see. When asked if the facility had a process to notify the Social Security office, she stated she did not have a form, but she could ask what the process was for the corporation. A review of the Social Security website, SSA.gov, section GN 00502.114 Representative Payee Responsibilities and Duties, included: The payee responsibilities and duties are to: report events that may affect the beneficiary's entitlement or amount of payment. A review of the Social Security website, SSA.gov, regarding living arrangements for an SSI recipient and reduction of SSI benefits

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews, the facility failed to ensure a prompt effort to resolve a grievance for one resident (#3) of three residents sampled for grievances of a total of nine sampled residents. Resident #3's family member had voiced a concern on 02/24/2025 regarding Resident #3's patient trust monies, an accounting of the withdrawals, an inquiry of a $400.00 deposit, an $1800.00 refund, and a concern regarding the posting of Resident #3's $160.00 monthly patient allowance. The concern was still outstanding as of 07/15/2025.Findings included: A review of Resident #3's clinical chart, the admission Record, documented an admission of 10/2023, with a readmission of 07/11/2025. His diagnosis information included but not limited to dementia, muscle weakness, and need for personal care.A family member was listed as the resident's responsible party, power of attorney for financial and care. An observation and interview were conducted on 07/15/2025 at 10:15 a.m. with Resident #3, sitting in a wheelchair, dressed in seasonally appropriate clothing, he stated his family will bring in what he needs and takes care of his finances.A review of a grievance for Resident #3 was conducted with the Social Service Director on 07/15/2025 at approximately 11:20 a.m. She stated, the (family member) is complaining about $400.00; it has not been resolved. A review of a grievance / complaint form, dated 06/19/2025, documented a concern: has multiple ongoing concerns about (Resident #3's) account. Issue has been ongoing since 2024. The form documented the staff assigned responsibility for the investigation was the Business Office Manager (BOM), assigned on 06/19/2025 with a due date of 06/23/2025. Further review of the grievance reflected no findings of an investigation, and no plan to resolve the complaint.A letter was attached to the complaint, dated 06/19/2025, from the family member which listed concerns regarding Resident #3's personal trust account, regarding a $400.00 deposit to the account she had made in August of last year, that Resident #3 should have $160.00 allocated monthly for personal expenses from his gross income, and that she had a concern about the balance in the account due to the limited number of expenses he had incurred. I need to know the balance in his account and an accounting of what monies was used.An attached e-mail, dated 05/27/2025, documented a note to the facility's corporate Account Receivable Specialist from the BOM: I am so confused about this one; the (family member) is saying that there was supposed to be a refund check since last year of $1,800. 00 something. Can you please check on this account for me.An attached e-mail, dated 05/14/2025, from the (family member), This email is a follow up regarding (Resident #3's) funds. I still have not received his funds please provide status.An attached e-mail, dated 03/20/2025, from the (family member), which listed concerns identical to the 06/19/2025 e-mail from the family member regarding Resident #3's personal trust account, regarding a $400.00 deposit to the account she had made in August of last year, that Resident #3 should have $160.00 allocated monthly for personal expenses from his gross income, and she had a concern about the balance in the account due to the limited number of expenses he had incurred. I need to know the balance in his account and an accounting of what monies was used.An e-mail, dated 02/24/2025, from the (family member), which stated, here is the receipt of the $400.00 I had put in his trust account. In addition to his monthly personal allowance of $160.00 which the nursing home was supposed to be putting away each month. That's the amounts that I am concerned about. An interview was conducted on 07/15/2025 at 11:00 a. m. with the Assistant Business Office Manager. She stated, for Resident #3, there was a grievance submitted by the (family member) of the resident. She wanted a printout of how the transactions for the resident trust account were debited and credited to the account. An interview was conducted on 07/15/2025 at 1:13 p.m. with the Business Office Manager. When asked about the 06/19/2025 grievance, she stated the (family member) had a concern about $1800.00 amount; $400.00, which was located in a different account; and the dental premiums. We switched banks with the RFMS (Resident Fund Management System). The BOM was unable to present documentation that would indicate the (family member's) concern had been addressed as of 07/15/2025.A review of the facility policies and procedures: Resident Right-Grievances, issued 11/07/2024, documented the policy: It is the policy of the facility to allow the resident and or legal representative to voice a grievance in such a manner to acknowledge and respect resident rights.The procedure included: .2. The resident has the right to and the facility will make prompt efforts by the facility to resolve grievances the resident may have in accordance with this paragraph. 8. The facility will establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide adequate supervision to prevent falls for three (#3, #8, and #9) of three residents sampled for fall events out of a total of nine sampled residents, related to lack of an IDT (Interdisciplinary Team) assessment post fall and identifying and / or implementing appropriate post fall interventions for Resident #3, #8 & #9, and accurate neuro check monitoring for Resident #3.Findings included: 1. A review of Resident #3’s clinical chart, the admission Record, documented an admission of 10/2023, with a readmission of 07/11/2025. His diagnosis information included but not limited to dementia, muscle weakness, and need for personal care. An observation and interview were conducted on 07/15/2025 at 10:15 a.m. with Resident #3, sitting in a wheelchair, dressed in seasonally appropriate clothing, he stated he had fallen two times. Nothing broken. Hurt, yes, his right leg. He was observed to pat his right leg which had a soft brace that wrapped around his leg above and below his knee. He did not remember how he fell. Review of Resident #3’s progress notes revealed the following: Dated 06/29/2025 at 7:28 p.m.: While providing care to (Resident #3’s) roommate. The Certified Nursing Assistant (CNA) observed (Resident #3) attempting to exit his bed independently. The CNA promptly responded and assisted the resident to the bathroom. During this interaction, (Resident #3) reported that he had stood up using the bed for support and then slowly lowered himself to his knees on the floor. The CNA and Registered Nurse subsequently utilized a (mechanical) lift to safely return the resident to bed. A full assessment was completed revealing no impairment to the integumentary system. The resident communicated to the Spanish-speaking nurse that he was not experiencing any pain. … Review of the fall report log revealed this fall was not on the fall report log. Progress note dated 06/30/2025 at 11:22 a.m.: Patient experienced a fall while attempting to transfer without assistance. Right elbow is bruised with no open areas noted. Patient reported pain at the site. Md (Medical Doctor) has been notified of fall and x-ray will be ordered. Dated 07/03/ 2025 at 12:44 p.m.: Resident was seen lying on the floor at the nurses’ station facing park hallway. He was lying on his right side. There were multiple drops of blood on the floor near his head. A 3 cm (centimeter) laceration noted to right eyebrow. He was assessed by floor nurse and (provider nurse practitioner) who was at facility when fall occurred. Resident’s eyeglass arm was broken off. He remained on the floor with nursing supervisor until 911 arrived. Resident right eyebrow laceration was assessed by wound nurse. … Resident was last seen sitting outside of dayroom in his w/c (wheelchair) with no concern. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #3’s Care Plan, reflected a focus: (Resident #3) is at risk for falls and fall related injury…, initiated 01/10/2023. A review of the interventions revealed on 06/29/2025, an intervention of “staff education” was added. No specific instructions were identified in the intervention. On 06/30/2025, an intervention of “Increased toileting”. No further additional interventions were revealed. A review of the facility’s Neuro check Assessment Form, copyright 2020, documented instructions for Neuro checks: q (every) 15 min (minutes) x 1 hr (hour). q 30 min x 1 hr q 1 hr x 4 hrs q 4 hrs x 24 hrs q shift until 72 hours For Resident #3, the facility provided two Neuro check forms, for the 06/30/25 fall, which occurred at 8:15 a.m. The form recorded monitoring from 06/30/25 to 07/03/25. Review of the form revealed staff did not document the time Resident #3 was monitored during the “q shift until 72 hours”, but documented the type of shift, i.e. “night”, “day”, or “eve” (evening), through 07/03/25 evening shift. On 07/03/25, Resident #3 had another fall at 11:55 a.m., he had a laceration above right eyebrow. He was transferred to a higher level of care. On 07/15/2025 at 3:26 p.m., an interview and review of Resident #3’s falls was conducted with the Regional Nurse Consultant (RNC) and the Director of Nursing. During the review of the Neuro check forms, the RNC stated that the times of observation should have been recorded, not the shift. For Resident #3’s 06/30 fall, the RNC said the fall occurred at 8:15 a.m., unwitnessed, the post fall assessment said they were going to remove clutter from the resident’s room and assist with toileting. When asked about the clutter, she said there was not enough detail to determine the clutter issue. For the toileting, she said he was near the bathroom, his shoelaces were untied, they tied his shoes, and he was able to stand. When asked if the Interdisciplinary Team (IDT) had reviewed the fall event, she stated they reviewed the 06/30, 07/02/25, and 07/03/25 fall events on 07/07/2025. “The usual practice is for IDT to review everything after the fall, or the morning after the fall. The RNC said the 07/02/25 fall occurred at 10:50 p.m., unwitnessed, the resident was found on the bathroom floor. The proactive measure implemented was “assist with toileting again”. This fall was reviewed by IDT on 07/07/2025. The RNC said the 07/03/25 fall occurred at 11:55 a.m., unwitnessed, she did not have the location of the fall. She said the resident had a laceration above the right eyebrow. He was transferred out and then came back. Progress notes were reviewed for the 07/02/25 fall event description without successful location of the event documentation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	For Resident #3, he had a fall at 10:50 a.m. in the bathroom on 07/02/25. No new Neuro check sheet was provided that would indicate the monitoring had been re-implemented for the 07/02 fall. 2. Resident #8 was admitted on [DATE]. Review of the Admissions record showed diagnoses included but not limited to cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery, other specified disorders of the brain, frontal lobe and executive function deficit following cerebral infarction, myocardial infarction, chronic obstructive pulmonary disease (COPD), epilepsy, occlusion and stenosis of right carotid artery, hypertension, muscle weakness, and lack of coordination. Review of the progress notes on 07/01/2025 showed, during med pass resident was observed rolling out of bed while drowsy in blankets with pillow, Review of the Post Fall Evaluation dated 07/01/2025 showed fall occurrence was 07/01/2025 at 5:00 a.m. the fall was witnessed. The resident rolled out of bed in the resident’s room. The resident was sleeping. Environmental factors present was poor lighting. Vital signs were documented. Neuro checks were normal. No changes observed in mental status. Resident was not experiencing any pain. Range of Motion was within normal limits. Injuries? Yes. Bruise left forearm, 7.62 cm (centimeter) x 5.08 cm, superficial and not bleeding. Immediate New measures included low bed and frequent checks to coincide with neuro checks. Physician was notified on 07/01/2025 at 5:47 a.m. Family notified on 07/01/2025 at 5:48 a.m. Review of the IDT (Interdisciplinary Team) Post Fall Review dated 07/08/2025 showed fall occurred on 07/01/2025 at 7:00 a.m. (different time). Conditions that may have contributed included unsteady gait and history of falls. 5. IDT recommendations included a. equipment (specify below). 5a. if equipment was selected, specify: staff education. Review of the care plans showed Resident #8 was at risk for falls and fall related injury related to metabolic encephalopathy, chronic alcohol dependence, seizure disorder as of 11/16/2023. Interventions included but were not limited to Early Get Up as of 07/05/2025; staff education was initiated on 07/01/2025 and resolved on 07/10/2025. During an interview on 07/15/2025 at 4:52 p.m., the Regional Nurse (RN) and Director of Nursing (DON) stated the Post Fall Evaluation under the assessment section was to show the description of the fall. The RN stated the IDT Post Fall Review was to occur the next day after a fall or within 1-2 days. The RN reviewed the IDT Post Fall Review dated 07/08/2025 for Resident #8 and verified it was completed 6 days after the fall. The RN stated she would expect to see it completed on 07/02/2025 or 07/03/2025. The DON stated the staff was educated to make sure a resident was not tangled up in the sheets or comforters. The DON verified the “staff education” provided was not documented in the e-medical record. The RN and the DON reviewed the care plan and stated the interventions should have addressed the resident’s needs at the time of the fall. The DON stated the fall was unwitnessed even though the documentation in the progress notes showed it was witnessed. The RN stated the documentation was confusing as to whether the fall was witnessed or unwitnessed. The DON stated the Unit Managers (UM) bring a fall “packet” to the morning meetings for review. The UMs do not necessarily keep all the documentation they bring to the morning meetings. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #9 was admitted on [DATE] and readmitted on [DATE]. Review of the admission record showed diagnoses included but not limited to Huntington’s disease, dementia, history of falls, and muscle weakness. Review of the progress notes showed on 07/10/2025, Certified Nursing Assistant (CNA) entered the room for rounds and observed the resident lying in a supine position in the bathroom with his head towards the toilet. The resident was lying on the raised toilet seat which was lying in front of toilet on its side. Vital Signs and neuro checks were within normal limits. No signs and symptoms (s/s) of a head injury. The resident was fully clothed with non-slip socks on. The resident was removed from the bathroom. Full range of motion at baseline for the resident with no deficits noted. The CNA and I assisted the resident to bed. Scratches noted to mid/upper back and chest with no bleeding. A 3cm scratch noted to right upper chest with scant amount of bleeding noted. Redness noted to upper back and back of neck. No s/s of pain noted. Scratch to right upper chest cleansed with Normal saline, patted dry and covered with dry dressing. ARNP (Advanced Practice Registered Nurse), resident's family, hospice and nurse management notified of incident. Review of the Post Fall Evaluation dated 07/11/2025 at 12:21 a.m. showed the fall occurred on 07/10/2025 at 9:45 p.m. The fall was unwitnessed. CNA entered room for rounds and observed resident lying in supine position in bathroom with head towards the toilet. Resident was lying on the raised toilet seat which was lying in front of toilet. Resident fell in the bathroom. Resident was unassisted transfer, unassisted ambulation, Huntington’s disease progression. The resident was in bed prior to fall. The resident had non-skid socks on and raised toilet seat. No environmental factors. Vital signs were taken. Neuro checks were normal. No changes in mental status. Not experiencing any pain. Range of motion was within normal limits. Injuries included abrasion and redness right upper chest, medial chest and mid/upper back. Skin integrity alteration was 3 cm by 1 cm, superficial and not bleeding. Immediate new measures included other. Vital signs and neuro checks. APRN notified on 07/10/2025 at 10:00 p.m. and family notified on 07/10/2025 at 10:00 p.m. Review of the IDT Post Fall Review dated 07/11/2025 at 4:52 p.m. showed time of fall was 07/10/2025 at 4:52 p.m. (different times). Predisposing diseases included Hunting Disease. Conditions that may contribute were unsteady gait, history of falls, muscle weakness. IDT recommendations included Medication Regimen Review. Review of the care plans showed Resident #9 was at risk for falls and fall related injury related to impaired mobility, medication usage, chronic disease process as of 11/07/2023. No new interventions were found for the 07/01/2025 fall. During an interview on 07/15/2025 at 4:52 p.m. the Regional Nurse (RN) and the DON verified the fall care plan had not been updated with a new intervention for the 07/01/2025 fall. The DON stated the hospice doctor would be responsible for the Medication Regimen Review for the resident. She verified there was no documentation in the medical record verifying this recommendation had been performed. The DON verified there was no documentation the neuro checks had been performed. The DON stated they would have been completed yesterday (07/14/2025), maybe they had not been scanned into the medical record yet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility’s policy and guidelines for Accidents and Supervision, dated 11/03/2020, last reviewed on 10/18/2022, documented the policy: The resident environment will be free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary. Included in the definitions: “Supervision/Adequate Supervision” refers to intervention and means of mitigating risk of an accident. The policy explanation and compliance guidelines included: 1. Identification of Hazards and risks-the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. … b. The facility should make a reasonable effort to identify the hazards and risk factors for each resident. 2. Evaluation and Analysis-the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. Interdisciplinary involvement is a critical component of this process. … 4. Monitoring and Modification-Monitoring is the process of evaluating the effectiveness of care plan interventions. Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks. Monitoring and modification processes include: a. Ensuring that interventions are implemented correctly and consistently. b. Evaluating the effectiveness of interventions. c. Modifying or replacing interventions as needed. d. Evaluating the effectiveness of new interventions. 5. Supervision-Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision: a. Defined by type and frequency b. Based on the individual resident’s assessed needs and identified hazards in the resident environment.