STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105321	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocala Health and Rehabilitation Center	1201 SE 24th Rd Ocala, FL 34471

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** 45576 Based on record review and interview, the facility failed to ensure resident assessment were completed accurately to reflect the resident discharge status for 1 of 3 residents reviewed for discharge, Resident #158. Findings include: Review of Resident #158's physician order dated 3/29/2024 read, Discharge Resident 4/2/24 at 2:00 PM via Medical Transport to [Name of the facility] SNF [Skilled Nursing Facility]. Review of Resident #158's Planned Discharge to Home Instructions dated 4/2/2024 read, Resident moving to [Name of the State]- Follow up with SNF physician. Review of Resident #158's Minimum Data Set (MDS) dated [DATE] under Section A2105 read, 4. Short Term General Hospital. During an interview on 6/26/2024 at 11:10 AM, Staff A, Long Term Care MDS Coordinator, stated that Section A 2105 was entered as a 4. Short term- General Hospital and should have been entered as 3. Skilled Nursing Facility. Resident #158 was sent to a skilled nursing facility out of state. During an interview on 6/26/2024 at 11:16 AM, Staff B, MDS Coordinator, stated that Resident #158 was discharged to a SNF out of state and MDS discharge status was coded in error as discharged to short term-General Hospital and should have been coded as discharged to SNF.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105321	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocala Health and Rehabilitation Center	1201 SE 24th Rd Ocala, FL 34471

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 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** 39371 Based on record review and interview, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR) was completed for 1 of 3 residents reviewed for PASRR, Resident #90. Findings include: Review of Resident #90's medical chart showed the resident was admitted to the facility on [DATE] for respite care for one month with diagnoses including unspecified dementia, depression, brief psychotic disorder, and mood disorder due to known physiological condition. Review of Resident #90's progress note authored by Staff C, Social Worker, on 3/23/2023 showed Resident #90's spouse was unsure about the resident's status regarding respite. Review of Resident #90's progress note authored by Staff C, Social Worker, on 4/24/2023 showed the facility educated Resident #90's spouse on the extension process and would send clinicals to the insurance company. Review of Resident #90's progress note authored by Staff C, Social Worker, on 5/2/2023 showed the facility inquired with insurance company if the resident was eligible for long term care and confirmation was obtained. Review of Resident #90's progress note authored by Staff C, Social Worker, on 5/29/2023 showed the late entry for 5/26/2024 indicating that the facility has met with Resident #90's spouse on 5/26/2024 to review overall status. Resident #90's spouse was unable to manage resident at home and requested assistance to apply for long term rehab contract. Review of Resident #90's insurance records showed the resident was authorized for contract nursing home services for respite effective 3/17/2024 through 4/17/2023, and upon expiration of the initial respite stay, an extension was authorized until 6/4/2023 for rehabilitation services. On 5/31/2023, the resident was approved for long term care effective 6/4/2023 to 6/4/2024. Review of PASRR Evaluation Request for Resident #90 showed the request was completed on 3/6/202. Review of Section II showed the resident was admitted for a respite stay. Review of Resident #90's medical chart revealed no results for level I screen for serious mental illness and/or intellectual disability or related conditions. During an interview on 6/26/2024 at 2:22 PM, Staff C, Social Worker, stated, [Resident #90's name] was here only for respite care. After the respite stay, the spouse decided to leave [Resident #90's name] for long term care. The resident's PASRR should have been updated. During an interview on 6/27/2024 at 7:39 AM, the Director of Nursing stated, I was told about [Resident #90's name] PASRR wasn't correct. It should have been caught. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105321	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocala Health and Rehabilitation Center	1201 SE 24th Rd Ocala, FL 34471

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedure titled Social Service Manual with an effective date of 7/15/2009 and the last review date of 1/18/2024 read, Process: Level I Determinations must be signed and dated by an RN [Registered Nurse] at the admitting nursing facility on or before the date of admission. The nursing facility is responsible for ensuring that a Level I screening is completed, submitted and has a Level I Determination and/or a Level II if indicated, on or before nursing home admission and regardless of payment source . The Original documents for the Level I and/or Level II determinations will be retained the medical chart behind the Social Services tab.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105321	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocala Health and Rehabilitation Center	1201 SE 24th Rd Ocala, FL 34471

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46523 Based on interview and record review, the facility failed to ensure residents received blood pressure medication as ordered by the physician for 1 of 7 residents reviewed for medication administration, Resident #43. Findings include: Review of Resident #43's physician order dated 11/16/2022 read, Midodrine HCL 5 mg [milligrams] tablet. 1 tablet by mouth daily. Hold for SBP [Systolic Blood Pressure] >110 Dx [Diagnosis]: Hypotension. Review of Resident #43's Medication Administration Record (MAR) for June 2024 documented the resident received Midodrine 5 mg on 6/9/2024 at 9:00 AM for a blood pressure of 120/80, 6/10/2024 at 9:00 AM for a blood pressure of 122/80, 6/17/2024 at 9:00 AM for a blood pressure of 120/80, 6/18/2024 at 9:00 AM for blood pressure of 120/78 and 6/24/2024 for a blood pressure of 122/74. During an interview on 6/26/2024 at 3:56 PM, the Director of Nursing stated, Nursing staff should follow the physician order and hold the medication when it is ordered to do so. During an interview on 6/26/2024 at 5:08 PM, the Advance Practice Registered Nurse (APRN) #1 stated, Normally staff would check the blood pressure and follow the parameters given. For Midodrine, some guidelines for the systolic are greater than 120 or 110. [Resident #43's name] has not had any problems receiving the medication. I wanted to be conservative due to the resident's age. The parameters of 110 is on the lower side and the medication dosage is minimal. The whole point of parameters is for staff to follow them. Review of the facility policy and procedure titled General Dose Preparation and Medication Administration with the last review date of 1/18/2024 read, Procedure . 3. Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but no limiting to the following: 3.1 Verify each time a medication is administered that is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105321	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocala Health and Rehabilitation Center	1201 SE 24th Rd Ocala, FL 34471

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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 50695 Based on observation, interview, and record review, the facility failed to ensure restriction of the use of assistive devices for fluids was implemented for 1 of 8 residents reviewed for nutrition, Resident #26. Findings include: During an observation of Resident #26's lunch tray on 6/24/2024 at 1:30 PM, there were one plastic glass with an opaque lid containing a brown liquid and one white Styrofoam cup with an opaque lid. Both glasses contained drinking straws (photographic evidence obtained). Staff D, Registered Nurse (RN), entered the room, picked up the Styrofoam cup and stated, I'll go get you more water. Review of Resident #26's lunch ticket dated Monday 6/24/2024 read, Mech [mechanical] Soft Rancher's Chicken- 3 Oz [ounces]; Seasoned Mashed Potatoes- 1/2 Cup; Seasoned Collard Greens- 1/2 Cup; Dinner Roll- 1 Ind [individual]; Margarine- 1 Ea [each]; Pumpkin Pie- 1/2 Pc [piece]; Iced tea- 8 Oz; No Straws. During an observation on 6/24/2024 at 1:40 PM in the 100/North Hallway outside of Resident #26's room, Staff D, RN, was holding a Styrofoam cup with a lid and a straw with the Resident #26's room number on it. During an interview on 6/24/2024 at 1:40 PM regarding restrictions of the use of straws for Resident #26, Staff D, RN, stated, I will have to check her meal ticket about straws. During an interview on 6/26/2024 at 11:55 AM, Staff D, RN, stated, We expect CNAs [Certified Nursing Assistants] to read the meal tickets. We are the last line of defense for the residents. I should have known better than to get [Resident #26's name] water and put a straw in it. Review of Resident #26's physician order dated 5/30/2024 read, CCD [Carbohydrate Controlled Diet]/CCHO [Consistent Controlled Carbohydrate] Mechanical Soft thin liquid, no straws. Review of Resident #26's Communication Form completed by the Speech Language Pathologist on 5/30/2024, read, To: Nursing . From: Rehab [rehabilitation services] . Recommendation: Discontinue Reg [regular]/ thin diet consistency. Change to mechanical soft/thin diet consistency . Comments: No straws. Please provide bowl of gravy w/ [with] every lunch [and] dinner. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105321	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocala Health and Rehabilitation Center	1201 SE 24th Rd Ocala, FL 34471

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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/2024 at 2:45 PM, the Speech Language Pathologist, stated, She [Resident #26] coughs when she drinks with straws. It seems to be related to facial weakness and really poor dentition. There is a possible risk for choking and aspiration pneumonia, but she does pretty well. After my clinical evaluation, watching her, and a swallow study, as a precaution, I said not to use straws. It is more as a precaution. It is better to air at the side of caution than not to do it. It is not a hard absolute, more as a precaution. If it was something we consider harmful, we would do a FMP [Functional Maintenance Plan] where we would have a meeting and train as much staff as possible and involve restorative CNA. For [Resident #26's name], we did not find it necessary to do a FMP. Some of the residents are on the edge and it was really more of a precaution than anything. Review of Resident #26's Fiberoptic Endoscopic Evaluation of Swallowing [FEES] dated 5/30/2024, read, Consistencies Administered: Thin liquids- cup, straw . Aspiration: no aspiration visualized w/ thin liquids, mech soft, regular or mixed consistencies. During an interview on 6/26/2024 at 3:20 PM, the Director of Nursing (DON) stated, Therapy communication goes to the unit manager and the unit manager updates the care plan within a couple of days. If it is serious, we put it on the resident care manager [section of the electronic medical record] for the CNAs. There is an order in the system [regarding Resident #26]. During an interview on 6/27/2024 at 9:25 AM, the DON stated, The order [for Resident #26 not to have straws] goes to dietary and it goes on the [meal] ticket. They [the CNAs] need to check the tickets when they are passing trays.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105321	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocala Health and Rehabilitation Center	1201 SE 24th Rd Ocala, FL 34471

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 15234 Based on observation, interview, and record review, the facility failed to ensure foods were stored in a safe manner in 3 of 3 nourishment rooms. Findings include: During a tour of the East Hall nourishment room on 6/24/2024 beginning at 9:30 AM with the Certified Dietary Manager, there was no thermometer in the freezer compartment of the refrigerator. There was an ice buildup in the freezer compartment and there was a wire dangling from the ice. During a tour of the North Hall nourishment room on 6/24/2024 beginning at 9:35 AM with the Certified Dietary Manager, there was no thermometer in the freezer compartment of the refrigerator. During a tour of the South Hall nourishment room on 6/24/2024 beginning at 9:38 AM with the Certified Dietary Manager, there was no thermometer in the freezer compartment of the refrigerator. There was an ice buildup in the freezer compartment. There was one undated individual pizza serving in the freezer. There was no thermometer in the cooling compartment of the refrigerator. During an interview on 6/24/2024 beginning at 9:30 AM, the Certified Dietary Manager confirmed there should be thermometers in the nourishment room refrigerators. He acknowledged the freezer compartments of the refrigerators in the East and South Hall needed defrosting. He indicated the individual serving of pizza stored in the freezer compartment of the South Hall refrigerator was undated. Review of the facility policy and procedure titled Leftover Food Storage and Use last reviewed on 1/18/2024, showed the policy read, Process . b. Leftover foods should be covered, labeled and dated. c. Refrigerated leftover foods should be used within 72 hours (three days). If not used within 72 hours, refrigerated foods should be discarded. These foods should be monitored for proper cooling, with times and temperatures recorded on a cooling log. Review of the facility policy and procedure titled Food Storage Temperature Logs last reviewed on 1/18/2024, showed the policy read, Process: In order to prevent food borne illnesses, foods should be stored at proper temperatures. Standard . Temperatures should be monitored and recorded on a food temperature log.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105321	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocala Health and Rehabilitation Center	1201 SE 24th Rd Ocala, FL 34471

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 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** 46523 Based on observation, interview, and record review, the facility failed to ensure medical records were accurate for 2 of 10 residents reviewed for medication administration, Residents #12, and #39. Findings include: 1. Review of Resident #12's admission record showed the resident was admitted on [DATE] with diagnosis including but not limited to chronic pain syndrome. During an interview on 6/24/2024 at 9:46 AM, Resident #12 stated, I have pain in my legs and take pain medication for the pain. Review of Resident #12's physician order dated 5/13/2024 read, Acetaminophen 325 mg [milligrams] tablet: Administer 2 tablet(s) to equal 650 mg by mouth every 4 hours as needed As Needed, for mild pain. Review of Resident #12's physician order dated 5/13/2024 read, Morphine 20 mg/1 ml [milliliters] syringe administer 0.5 ml by mouth once every 4 hours as needed for pain management. Review of Resident #12's physician order dated 5/13/2024 read, Pain Assessment chart highest degree of pain by scale 0-10 for your shift. Chart q [every] shift. Review of Resident #12's Medication Administration Record (MAR) for Acetaminophen 325 mg for June 2024 showed the resident received the medication on 6/18/2024 at 8:26 PM. Review of Resident #12's MAR for administration of Morphine 0.5 ml for June 2024 documented the resident received the medication on 6/1/2024 at 3:05 AM, 9:32 AM, and 4:56 PM, on 6/2/2024 at 9:38 AM and 4:55 PM, on 6/7/2024 at 6:44 PM, on 6/10/2024 at 1:27 PM and 5:42 PM, on 6/11/2024 at 6:09 AM, on 6/12/2024 at 10:36 AM, on 6/13/2024 at 4:35 AM, on 6/14/2024 at 4:58 AM, on 6/15/2024 at 11:11 AM, on 6/16/2024 at 9:10 AM and 9:16 PM, 6/17/2024 at 4:42 AM, on 6/18/2024 at 8:26 PM, on 6/19/2024 at 5:36 AM, on 6/20/2024 at 11:48 AM and 7:28 PM, and on 6/24/2024 at 1:01 PM. Review of Resident #12's MAR for pain assessment for June 2024 showed the resident's pain level was documented as zero on 6/1/2024 through 6/25/2024 at 6:30 AM and 2:30 PM. Review of Resident #12's progress note dated 6/10/2024 read, Res [resident] on hospice, c/o [complain of] pain in afternoon, morphine given prn [as needed] per MAR and was effective. CNA [certified nursing assistant] attempted 2 times to go RES OOB [out of bed] and RES refused, this nurse attempted 1x [times] and RES refused, PT [Physical Therapist] attempted and RES refused. During an interview on 6/26/2024 at 3:55 PM, the Director of Nursing stated, The nursing staff should chart the pain level at the end of shift and follow what the order says. The staff should accurately document the highest level of pain at the end of the shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105321	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocala Health and Rehabilitation Center	1201 SE 24th Rd Ocala, FL 34471

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedure titled Pain Management and Assessment with the last review date of 1/18/2024 read, Purpose: The detection of the presence of pain, determining the frequency and intensity of pain, and identification of effective pain management interventions can help to avoid adverse outcomes that impact the resident/guest(s) functional status and quality of life. Standard . An on-going assessment of pain utilizing either a numeric scale of 0-10 or a verbal descriptor scale will be conducted daily and with evidence of new or worsening pain . Process . II. On-going Pain Assessment . e. Document Pain (1-10), or use verbal descriptors scale, or staff observation for documentation on MAR. 49289 2. Review of Resident #39's admission record showed the resident was most recently admitted on [DATE] with diagnoses including type 2 diabetes mellitus, chronic kidney disease (stage 4), hypokalemia, hypothyroidism, and adult failure to thrive. Review Resident #39's physician order dated 2/13/2024 read, Accu-checks [Blood glucose testing] AC/HS [before meals and at bedtime] cover w/ [with] Novolog [short acting insulin] 100 unit/ml vial . > [greater than] 399 mg /DL [deciliter] 7 U [units] & Call MD [medical doctor]. Special Requirement Brief Instructions . Notify MD for BG [blood glucose] less than 60 mg/dl or greater than 399 mg/dl. Review of Resident #39's physician order dated 5/22/2024 read, Novolin R [regular, human short acting insulin] 100 unit/ml vial. Administer 12 U subcutaneous if BS is > 399. Review of Resident #39's MAR for May and June 2024 for subcutaneous administration of 12 units of Novolin R of blood sugar is greater than 399 showed the resident received the medication on 5/25/2024 at 8:03 PM, on 5/27/2024 at 10:57 AM, on 5/28/2024 at 11:01 AM, on 5/29/2024 at 11:44 AM, on 5/31/2024 at 11:45 AM and 5:04 PM, on 6/1/2024 at 7:50 PM, on 6/2/2024 at 1:31 PM, on 6/4/2024 at 12:55 PM, on 6/11/2024 at 11:33 AM, on 6/12/2024 at 3:07 PM, on 6/14/2024 at 12:59 PM and 3:07 PM, on 6/15/2024 at 10:53 AM, on 6/16/2024 at 12:00 PM, on 6/17/2024 at 3:58 PM and 9:28 PM, on 6/18/2024 at 12:32 PM and 4:33 PM, on 6/19/2024 at 3:12 PM, on 6/20/2024 at 12:47 PM, on 6/22/2024 at 3:12 PM and 7:56 PM, on 6/24/2024 at 11:35 AM, on 6/25/2024 at 10:41 AM, and on 6/26/2024 at 11:07 AM, with no documentation of the blood glucose reading. Review of Resident #39's MAR for May and June 2024 for the order Accu-checks AC/HS cover w/ Novolog 100 unit/ml vial . > 399 mg/DL 7 U & Call MD showed N (Not Administered) documented for 5/25/2024 at 11:30 AM with no BG reading documented, on 5/25/24 at 9:00 PM with BG of 425, on 5/27/2024 at 11:30 AM with BG of 426, on 5/28/2024 at 11:30 AM with BG of 451, on 5/29/2024 at 11:30 AM with BG of 433, on 5/31/2024 at 11:30 AM with BG of 439, on 5/31/2024 at 4:30 PM with BG of 450, on 6/1/2024 with BG of 408, on 6/2/2024 at 11:30 AM with BG of 514, on 6/14/2024 at 11:30 AM with BG of 453, on 6/15/2024 at 11:30 AM with BG of 466, on 6/16/2024 at 11:30 AM with BG of 464, on 6/17/2024 at 4:30 PM with BG of 571 and at 9:00 PM with BG of 412, on 6/18/2024 at 11:30 AM with BG documented as high and at 4:30 PM with BG of 421, on 6/19/2024 at 4:30 PM with BG of 492, on 6/20/2024 at 11:30 AM with BG documented as high, on 6/21/2024 at 4:30 PM with BG of 463, on 6/22/2024 at 4:30 PM with BG of 486 and at 9:00 PM with BG of 500, on 6/24/2024 at 11:30 AM with BG of 433, and on 6/25/2024 at 11:30 AM with BG of 400. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105321	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocala Health and Rehabilitation Center	1201 SE 24th Rd Ocala, FL 34471

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #39's progress notes showed no documentation from the nurses or the Advanced Practice Registered Nurse (APRN) #1 to defer from the active order for administration of 7 units of Novolog for blood glucose over 399 and call MD to the active order for administration of 12 units of Novolin R for blood glucose over 399 and not call the MD. Review of Resident #39's progress note dated 5/29/2024 showed the APRN #1 documented, History of present illness . Has been eating more lately with multiple hyperglycemic episodes reported and blood sugars as high as 451 . Plan . Continue medication, MAR reviewed. Review of Resident #39's progress note dated 6/20/2024 showed the APRN #1 documented, History of present illness . Unfortunately continues with hyperglycemic episodes and blood sugars trending between 154 and high will increase with multiple readings in the 400s . Plan . Continue medication, MAR reviewed. During an interview on 6/25/2024 at 2:51 PM while reviewing the two insulin orders on the MAR for June 2024 with the Director of Nursing (DON), the DON stated, The doctor was sick of the nurses calling so they put that order (referring to the Novolin R insulin order to give 12 units of insulin for blood sugars over 399). The nurses will put 'N' [Not administered] for the Novolog sliding scale order if the BS is over 399 and defer to the Novolin R order. Right now, it's confusing and the orders need to be more clear. During an interview on 6/27/2024 at 9:46 AM, the APRN #1 stated, The resident [Resident #39] is very hard to manage for her blood sugars. She will either be hypoglycemic or hyperglycemic. She is very fragile. She is not supposed to be on two insulin orders. I don't know why the pharmacy did that. I have so many medication orders for reconciliation. It's hard to keep up with. The staff communicates her elevated blood sugars with me every day, throughout the day. I am there [at the facility] five days a week. We communicate verbally throughout the day and there is a communication log at the desk that the nursing staff use if I'm not there for any non-critical blood sugar concerns and actions. The nurses and I have agreed that they should follow the orders for insulin and do not need to call me unless the blood sugar is over 450. During an interview on 6/27/2024 at 10:38 AM, Staff H, Licensed Practical Nurse (LPN), stated, I am familiar with the resident [Resident #39] and have administered insulin to her. It's kind of common knowledge to give 12 units of insulin if the blood sugar is over 399. Typically, we use the sliding scale for blood sugars and give the insulin dose according to the blood sugar range. We usually will give 7 units and call the doctor for blood sugars over 399, and then the doctor may order an additional 5 units. We never go over 12 units. There is a separate PRN [as needed] order for this resident to just give the 12 units due to her labile sugars. I don't know why there are to orders, but we just know to go to the PRN order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105321	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocala Health and Rehabilitation Center	1201 SE 24th Rd Ocala, FL 34471

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/27/2024 at 10:55 AM, Staff I, LPN, stated, I am here each day and am the rounding nurse. I work directly with [the APRN #1's name] and gather the resident information from the communication call log printed sheets in the book here at the nursing station [pointing to the empty call book on the desk]. I am very familiar with the resident [Resident #39] and her labile blood sugars. I don't know why she has two insulin orders. Typically the standard order is to give 7 units of insulin for blood sugars over 399. I think the insulin order to give her 12 units of insulin was supposed to be a one-time order as needed. I am here Monday through Friday, and the nurses communicate her blood sugars to either me or [the APRN #1's name] throughout the day if there are concerns. At night, they would call the on-call provider. During an interview on 6/27/2024 at 11:05 AM, Staff J, Registered Nurse (RN), stated, I am very familiar with the resident [Resident #39]. If the nurses have questions about the elevated blood sugars during the day, [the APRN #1's name] is here every day, but if she is not here, we call the on-call doctor. It's a standard for this resident to give her 12 units of insulin if her blood sugar levels are over 399. It is confusing, it's common knowledge for the nurses caring for her. It could be confusing for a new nurse or a nurse not familiar with her to have two orders. Review of the facility policy and procedure titled Charting and Documentation Guidelines with the last review date of 1/18/2024 read, Purpose: Documentation in medical records of residents, by the interdisciplinary team, should provide: Communication of the resident's care, treatment, response to care, signs, symptoms and progress of the resident to providers of care . Process: I. Rules for charting and documentation: a) Chart all pertinent changes in the resident's condition, reaction to treatments, medications, as well as routine observations . IX. Miscellaneous Documentation: Documentation of various events occurs in the nursing notes and may include . e) Whenever a prn medication is given; the reasons for its use along with the resident's response.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105321	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocala Health and Rehabilitation Center	1201 SE 24th Rd Ocala, FL 34471

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49289 Based on observation, interview, and record review, the facility failed to ensure staff used appropriate personal protective equipment (PPE) while providing direct care for 2 of 5 residents on transmission-based precautions, Residents #154 and #96, and failed to ensure staff followed infection control standards by not cleaning the multi-use medical equipment in between resident use, not sanitizing the surface area during medication administration and not cleaning the medication syringe after enteral medication administration to prevent the possible spread of infection and communicable diseases. Findings include: 1. During an observation on 6/26/2024 at 8:45 AM, Residents #154 and #96's room had a sign posted on the door that read, STOP: Special Droplet/Contact Precautions . Everyone must: including visitors, doctors & staff: Clean hands when entering or leaving a room, Wear face mask, Wear eye protection (face shield or goggles), Gown and glove at the door. During an observation on 6/26/2024 at 8:46 AM, Staff G, Certified Nursing Assistant (CNA), opened the door from inside the room of Residents #154 and #96. Staff G was not wearing eye protection (a face shield or goggles). Staff G handed a tied bag of trash to the housekeeper and closed the door from inside the room. During an observation on 6/26/2024 at 8:47 AM, Staff G, CNA, opened the door from inside the room of Residents #154 and #96 and took a roll of clear bags from the housekeeper standing outside the room and closed the door from inside the room. Staff G was not wearing eye protection (a face shield or goggles). During an interview on 6/26/2024 at 8:48 AM, Staff G, CNA, stated, I should have had a face shield on. Both residents are on transmission-based precautions. They are both positive for COVID-19. During an interview on 6/26/2024 at 10:05 AM, the Director of Nursing stated, They [the staff] should be wearing goggles or a face shield when entering the COVID positive room. Review of Resident #154's medical record showed the resident was admitted on [DATE] with diagnoses including acute embolism and thrombosis of unspecified deep veins of the right extremity, dementia, mood disorder, and depression. Further review of the medical record showed Resident #154 tested positive for COVID-19 on 6/24/2024. Review of Resident #154's physician order dated 6/24/2024 read, Respiratory and droplet isolation r/t [related to] positive COVID 19 status. Review of Resident #96's medical record showed the resident was admitted on [DATE] with diagnoses including cognitive communication deficit, shortness of breath, history of falling, dependence on supplemental oxygen, anxiety disorder, major depressive disorder, and dementia. Further review of the medical record showed Resident #96 tested positive for COVID-19 on 6/23/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105321	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocala Health and Rehabilitation Center	1201 SE 24th Rd Ocala, FL 34471

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #96 physician order dated 6/23/2024 read, Droplet isolation r/t COVID. Review of the facility policy and procedure titled Response Phase Protocol for COVID-19 with an effective date of 3/13/2020 and last review date of 1/18/2024 read, d. Before entering resident room with an active case (or susceptive case), wear: 1. Gown (fluid resistant or impermeable), 2. Facemask, 3. Eye protection (goggles or face shield), 4. Gloves. 46523 2. During an observation on 6/26/2024 at 8:10 AM, Staff K, Licensed Practical Nurse (LPN), prepared Resident #110's medications and entered the resident's room. Resident #110 was lying in bed. Staff K took Resident #110's blood pressure. Staff K stated she would hold Resident #110's blood pressure medication due to the blood pressure parameters and placed blood pressure cuff on top of Resident #110's bedside table. Staff K gave Resident #110 a cup with water and administered the medications. Staff K placed blood pressure cuff in her pocket and exited the resident room. Staff K performed hand hygiene and began to pour Resident #133's medication. Staff K entered Resident #133's room. Without sanitizing the blood pressure cuff, Staff K used the medical device to take Resident #133's blood pressure. Staff K provided a cup with water to Resident #133 and administered medications. During an interview on 6/26/2024 at 8:30 AM, Staff K, LPN, stated, I should have sanitized the blood pressure cuff in between each resident use. I did not have wipes in my medication cart. During an observation on 6/26/2024 at 8:37 AM, Staff L, LPN, performed hand hygiene and poured all medications and removed a bottle of eye drops for Resident #101. Staff L donned gloves and grabbed two tissues. Staff L entered Resident #101's room and placed both tissues on top of the bedside table without sanitizing or placing a barrier on table. Table surface had areas of shining substance. Staff L moved tissues on top of the bedside table. Both pieces of tissue were in contact with the table surface. Staff L placed the medication cup on the table. Staff L applied eye drops into Resident #101's right eye and handed the resident the tissues resting on the bedside table to clean his eye. During an interview on 6/26/2024 at 8:44 AM, Staff L, LPN, stated, I should have handed the tissues to [Resident #101's name] or have sanitized the bedside table or placed a barrier on the table before placing the tissues down. During an observation on 6/26/2024 at 9:21 AM, Staff H, LPN, poured and crushed all of Resident #69's medications individually. Staff H donned gloves and gown to enter Resident #69's room. Staff H was administering medication and medication syringe fell on the floor. Staff H removed gloves and stood at the door and asked another staff member to bring her another syringe from her medication cart, giving them the medication cart keys. Staff H performed hand hygiene and donned a new pair of gloves. The staff member returned, gave Staff H the new syringe and the cart keys. Staff H put the keys into her pocket and returned to administer Resident #69's medications via gastric tube. Staff finished administering medications and placed medication syringe into a cup without cleaning syringe after administration. Staff H performed hand hygiene and proceeded to go assist another resident. During an interview on 6/26/2024 at 10:14 AM, Staff H, LPN, stated, I should have removed my gloves and performed hang hygiene after I was given the medication cart keys. I did not clean the syringe after I was done. I should have cleaned it. I was going to do that after going to get a zip lock bag for the syringe. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105321	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocala Health and Rehabilitation Center	1201 SE 24th Rd Ocala, FL 34471

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/2024 at 3:46 PM, the DON stated, Staff should run down with a wipe for all reusable medical equipment in between each resident use. If the bedside table is soiled, then staff should clean the surface of the table before placing the tissue on the table. The nursing staff should be cleaning the medication syringe after using them for medication administration. Review of the facility policy and procedure titled Blood Pressure Measurements with the last review date of 1/18/2024 read, Equipment Care: Clean the stethoscope and blood pressure cuff with a clean dampened cloth with disinfectant and water. Review of the facility policy and procedure titled General Dose Preparation and Medication Administration with the last review date of 1/18/2024 read, Procedure . 6. After medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following . 6.4: Clean any reusable equipment or supplies. Review of the facility policy and procedure titled Medication Administered through an Enteral Tube with the last review date of 1/18/2024 read, Procedure . 19. Clean medication syringe and return to bedside.