STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105325	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedrock Rehabilitation and Nursing Center at Islan	125 Alma Blvd Merritt Island, FL 32953

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39943 Based on observation, interview, and record review, the facility failed to ensure that dignity was maintained for 2 of 2 residents reviewed for dining, of a total sample of 59 residents, (#13, and #88). Findings: 1. Resident #13 was admitted to the facility on [DATE] with diagnoses that included dementia, stroke, history of traumatic brain injury, and history of falls. The resident's Significant Change Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 11/23/24 revealed the resident's cognition was severely impaired. The assessment noted she was dependent for all Activities of Daily Living (ADLs). The assessment noted the resident did not have any documented behaviors during the lookback period. On 1/13/25 at approximately 12:45 PM, the resident was observed eating lunch in the B wing dining room. She used a built-up spoon to assist with her meal. When she began to eat her dessert, instead of using the spoon she picked up the bowl of pudding and held it in both hands and licked the pudding out of the bowl. She also had a frozen treat cup and held it in both hands and licked the ice cream until it was gone. On 1/16/25 at 1:50 PM, the resident was observed eating her frozen treat cup and then pudding by holding the container and licking the food out of it. Further observation revealed the built-up spoon was too big to fit in the dessert cups she was given. No staff were present in the dining room at that time to observe resident #13 licking the food out of the container. 2. Resident #88 was admitted to the facility on [DATE] with diagnoses that included wedge compression fracture, dementia, and need for assistance with personal care. The resident's Quarterly MDS assessment with ARD of 12/18/24 revealed the resident's cognition was severely impaired. On 1/13/25 at approximately 12:45 PM, the resident was sitting at a table in the B wing dining room with another resident who was eating her lunch. Resident #88 sat at the table watching resident #13 eat her lunch for 45 minutes before staff served her lunch. (continued on next page)

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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/13/25 at 1:05 PM, Certified Nursing Assistant (CNA) G took a box of wipes to resident #88 and told her to wipe her mouth and hands. She was informed that resident #88 had not received her lunch yet. She stated she thought the resident had finished eating and said she would go to the kitchen and get her a tray. There were no staff in the dining area while the residents were eating. On 1/13/25 at 1:15 PM, CNA J served resident #88's lunch tray she stated the kitchen had run out of food. On 1/15/25 at 1:40 PM, the Certified Dietary Manager stated on Monday they had to cook a 2nd portion of meals and were having trouble with the oven. She said she was not sure if the intern expressed to the staff that the trays would be late. On 1/16/24 at 3:30 PM, the Director Of Nursing (DON) stated her expectation was for staff to observe residents in the B Wing dining area while they were dining. She acknowledged resident #13 should not have to lick her food from the bowl and should have utensils to accommodate the food being eaten. The DON also acknowledged that residents seated at a table should receive their meals at approximately the same time.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on observation, interview, and record review, the facility failed to ensure 2 of 2 residents were evaluated for safe self-administration of medications and failed to obtain a physician order for self-administration of medication for 2 of 9 residents reviewed for choices, of a total sample of 59 residents, (#37, #95). Findings: 1. Resident # 37, a [AGE] year-old female was admitted to the facility initially on 11/18/19, with her most recent readmission on 4/24/23. Her diagnoses included diabetes type II, generalized muscle weakness, hypertension, chronic obstructive pulmonary disease, and age-related osteoporosis. Review of the resident's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's Brief Interview For Mental Status (BIMS) score was 15/15 indicating the resident's cognition was intact. On 1/13/25 at 11:44 AM, resident #37 was lying in bed in the supine position. A bottle of nasal spray was noted on the resident's tray table. On 1/15/25 at 9:57 AM, the resident was sitting up in bed, and a bottle of nasal spray was on her tray table. Resident #37 stated the nurses were aware she had the nasal spray, and she self-administered the nasal spray. She said she was tested and passed the test to be able to self-administer the nasal spray. Clinical record review revealed no assessment for self-administration of medications, and a physician's order for the nasal spray, or for self-administration of the spray could not be identified. On 1/15/25 at 10:41 AM, Licensed Practical Nurse (LPN) A explained that if a resident would like to self-administer medication, the resident had to be assessed, and a physician's order for self-administration of the medication would be obtained. On 1/15/25 at 11:06 AM, observation of the nasal spray was conducted with LPN A. She acknowledged that a bottle of nasal spray was observed on the resident's tray table. The resident reiterated that nurses knew she had the nasal spray, and she was tested to be competent. Resident #37 said sometimes her nostrils got clogged up, and she had to use the nasal spray, otherwise she got very anxious. LPN A said the nasal spray should be kept on the medication cart. Review of the physician's orders conducted with LPN A revealed no orders for the nasal spray, or for self-administration of the medication. The findings were acknowledged by the LPN. 2. Resident #95, a [AGE] year-old female was admitted to the facility on [DATE]. Her diagnoses included fracture of the right femur, dementia, and essential hypertension. Review of the resident's Medicare-5-day MDS dated [DATE], revealed the resident's cognition was intact, with a BIMS score of 13 of 15. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/13/25 at 10:57 AM, resident # 95 was observed sitting on the side of her bed, with the top drawer of her bedside table open. In the drawer a bottle of Vitamin B-12, and a pharmacy container labeled Rosuvastatin was noted. The resident said she gave herself the Vitamin B-12, and did not consider it a medication. She said she was not sure if the nurses documented or knew about the Vitamin B-12. Vitamin B-12 (cobalamin) plays an essential role in red blood cell formation, cell metabolism, nerve function and the production of DNA, (retrieved on 2/03/2025 from mayoclinic.org). Rosuvastatin (Crestor) is commonly used to lower bad cholesterol levels . and fats (triglycerides) in the blood. It also increases good cholesterol levels (HDL), (retrieved on 2/03/2025 from webmd.com). In a review of the resident's clinical records, an order for self-administration of Vitamin B-12, and an assessment for self-administration of medication could not be identified. On 1/15/25 at 10:41 AM, LPN A stated Vitamin B-12 was an over-the-counter medication that was provided on the medication cart, and any medications taken by the resident should have a physician's order to prevent drug interaction with other medications. The LPN said nurses needed to know what medications a resident took, and the medications should be documented. On 1/15/25 at 11:17 AM, LPN A reviewed the resident's clinical records, and shared that a physician's order for vitamin B-12, nor an order for the resident to self-administer the medication could not be found. On 1/15/25 at 11:23 AM, an observation conducted in the resident's room with LPN A revealed two bottles of vitamin B-12, 1000 microgram (mcg), and an empty pharmacy container labeled for Rosuvastatin in the top drawer of the resident's bedside table. Resident #95 stated she took the Vitamin B-12 every day. On 1/15/25 at 11:24 AM, LPN A notified the Director of Nursing (DON) of the nasal spray retrieved from resident #37's room, the two bottles of Vitamin B-12, and the empty pharmacy container labeled for Rosuvastatin retrieved from resident #95's room. The DON stated that for residents to self-administer medications, the resident(s) had to have an assessment for self-administration of medications, and a physician's order had to be obtained. She stated if the medications were to be stored at bedside, a lock box should be in place to secure the medications. The DON acknowledged that resident #37 and resident #95 did not have a physician's order for self-administration of the nasal spray, or Vitamin B- 12, and an assessment for self-administration was not conducted for the residents as required. The facility's policy Nursing-Self Administration Medication Program with an effective date of 4/01/22 read, If a resident requests to self -administer drugs, it is the responsibility of the IDT (Interdisciplinary Team) to determine that it is safe for the resident to self-administer drugs, before the resident may exercise that right . The nurse or designee should complete a Self-Administration of Medication Evaluation and report the findings to the Unit Manager or designee .Once the resident has been deemed safe by the IDT an order should be obtained from the resident's physician . listing the medication(s) that may be self-administered.

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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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on interview, and record review, the facility failed to follow generally accepted accounting principles to handle residents' funds for 2 of 2 residents reviewed for personal funds, of a total sample of 59 residents, (#32, and #47). Findings: 1. Review of resident #32's medical record revealed he was readmitted to the facility on [DATE]. His diagnoses included type 2 diabetes, absence of right and left leg above the knee, and glaucoma. Review of the Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date (ARD) of 10/19/24 revealed resident #32 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated he was cognitively intact. On 1/13/25 at 11:31 AM, resident #32 said, They hardly have money in here. He explained last week he attempted to access his money three or four times and every time he was told they did not have any money available. He spoke with Receptionist K, who handed out the money. He indicated he needed to buy phone cards which the Activities Director purchased for him. Resident #32 stated he placed the request approximately 2 weeks ago and he still did not receive them. He mentioned the Administrator was aware and has done nothing to fix it. Resident #32 shared he had not received his quarterly statements in at least six months. He said he was, tired of not having money. The next day, 1/14/25 at 12:37 PM, resident #32 stated the Activities Director told him he may not have access to the money, until God knows when. He mentioned it was not right for him not to have access to the money in his account to recharge his calling cards. Review of a Grievance Report dated 5/13/24 filed by resident #32 read, not being able to get our money for a while and we are suppose [sic] to be able to get money daily. The follow-up comment added by the Business Office Manager (BOM) on 5/17/24 read, New company that issues checks for us to deposit in our accounts. Once check clears we withdraw the funds and place them in the petty cash box. The form did not show resident #32 was notified of the resolution. Review of resident #32's Resident Trust statement from 3/01/24 thru 1/17/25 revealed a balance of $6,901. 43. The statement showed 2 transactions posted on 12/10/24 for cash withdrawals dated from August to September 2024 as follows: 8/15/24 cash withdrawal $112.94 9/12/24 cash withdrawal $92.28 2. Review of resident #47's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included atherosclerotic heart disease, type 2 diabetes, and polyarthritis. Review of the MDS quarterly assessment with ARD of 9/28/24 revealed resident #47 had a BIMS score of 13 out of 15 which indicated she was cognitively intact. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/13/25 at 10:46 AM, resident #47 stated she used to get $50.00 approximately three times a month but was recently told she did not have any money in her account. She indicated she was getting money and now she owed them about $400.00, so the facility would keep the new deposits until her negative balance was paid off. She indicated she did not sign anything and was just told she had to pay for it. Review of resident #47's Resident Trust statement from 3/01/24 thru 1/17/25 revealed a balance of negative $370.33. The statement showed 8 transactions posted on 12/10/24 for cash withdrawals dated from April to September 2024 as follows: 8/15/24 cash withdrawal $18.45 4/05/24 cash withdrawal $50.00 5/16/24 cash withdrawal $50.00 5/16/24 cash withdrawal $20.12 9/03/24 cash withdrawal $50.00 6/11/24 cash withdrawal $50.00 6/13/24 cash withdrawal $16.88 6/06/24 cash withdrawal $50.00 (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/16/25 at 8:58 AM, the BOM explained her responsibilities included handling the resident trust accounts. She stated residents' quarterly statements were mailed out by a third-party company since April 2024. She indicated prior to April 2024 they hand delivered the statements to the residents and obtained their signature on a copy as proof of delivery. She mentioned now she had no way to confirm if residents received their quarterly statements. The BOM explained residents could get up to $50.00 daily from their petty cash. She added if more than $50.00 was needed, they could cut a check to the resident, responsible party or a vendor. She repeated if cash was needed, residents could get $50.00 every day from 9 AM to 4 PM. She shared when the box ran low of cash, she requested a replenishment check, so there could be a day or so when the box was empty. She indicated they had experienced this in the last couple of months since the transition to the new company. She explained when they had about 60 of them trying to all get money at the same time they could run out of money, and this was mostly an issue during the holidays. She stated residents shared their concerns about access to their funds with her, and once she explained the process they were okay. She mentioned she had never written any grievances if they left upset about it although she was aware of the grievance process. She indicated there were concerns with Activities purchasing debit cards with resident trust account for resident #32. The BOM stated the last purchase of items for resident #32 was in November 2024 and did not include calling cards. She mentioned they were now waiting for the check to clear, which usually took two days, but the money would be available to residents today. She indicated resident #32's calling cards would be purchased through the resident shopping done by Activities. She explained last November, she requested three months of statements from their third-party company and performed a house audit and noticed there were transactions not posted into several resident accounts. She stated she identified four residents whose accounts were negative. She shared resident #47's account was negative $370.00. She stated she questioned how this was possible because she emailed the third-party billing company daily all transactions to be posted into the resident trust accounts. She indicated resident #47 did not come to get money very often. She explained they noticed account balances were not what she anticipated them to be, account balances were off, and she explained to the residents they were completing an audit. She stated when they confirmed account discrepancies, she informed the four residents affected by a negative balance and they were understanding of it but it still does not make it right though. She mentioned they received their monthly $160.00 allowance into their account but since they overdrew the account, they kept the money to cover the negative balance. She stated she did not have them sign anything because they understood why their accounts were overdrawn. She validated this was their billing error, and not the residents fault. She indicated the Administrator was aware of the issue. Later at 1:20 PM, the BOM explained the decision was made in December to post back transactions and deduct the money from the residents' accounts. On 1/16/25 at 9:45 AM, the Activities Director confirmed he purchased the minutes cards for resident #32 when he ordered them. He explained each card cost approximately $30.00 to $35.00. He indicated resident #32 may have called Receptionist K and added his name to the shopping list. He explained he went every two weeks but, It has not been obviously done because of the transfer [from current facility name to the new one]. He indicated it had been a while since he last purchased the cards for resident #32 and he handed the receipts to the business office. On 1/16/25 at 9:47 AM, Receptionist K confirmed resident #32 called to request money a couple of days ago and was told they did not have it. She explained to him the money was not available but should be soon. She indicated there were a lot of times the box was empty because they could not get a new check to replenish it until the box was low. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Resident Trust Fund (RTF) Policy - Florida dated 4/24/24 revealed the purpose was, To ensure that the facility residents have access to, and are able to manage, their personal funds. The document included, . the facility must provide cash within one day of request or a check within 3 days. The policy read, The facility acts as a fiduciary of its resident's funds and has established and maintains a system that assures fill sand [sic] complete and separate accounting, according to generally accepted accounting principles, of each residents' personal funds entrusted to the facility on the resident's behalf in a clear and understandable manner. The document revealed proper bookkeeping techniques were to be employed, by which staff could determine, upon request, the amount of individual resident funds.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 32131 Based on observation, interview, and record review the facility failed to ensure the privacy, and confidentiality of resident records was maintained for 1 resident, of a total sample of 59 residents, (#519). Findings: On 1/16/25 at 10:20 AM, the computer on medication cart #1 located to the left of the nurses' station on the A Wing was noted with the screen open, facing the hallway. Pertinent information regarding resident #519 was visible to other staff, residents, and any visitors walking by the medication cart. On 1/16/25 at 10:24 AM, Registered Nurse (RN) F was standing at medication cart #1. She verbalized that she had previously locked her computer screen when she walked away from the medication cart. On 1/16/25 at 10:29 AM, the Assistant Director of Nursing (ADON) confirmed the computer screen on medication cart #1 was locked by RN F. The ADON stated she logged on to the computer at medication cart #1 to ascertain the correct spelling of resident #519's name and forgot to lock the screen when she walked away. She acknowledged that leaving the computer screen open was a Health Insurance Portability and Accountability Act (HIPAA) violation. The policy Health Information Privacy And Accountability Act with effective date of 4/01/22, and revision date of 2/21/23 read, The Center shall protect the privacy of our residents .as related to their personal health information and maintain compliance with HIPAA laws in order to protect the privacy of health care information and privacy of the resident . Staff should lock/log off computers or tablets when not in use.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 39943 Based on observation, interview, and record review, the facility failed to provide a homelike environment for residents who ate their meals in the B Wing dining room to ensure resident dining did not resemble an instutional experience. Findings: On 1/13/25 at 12:50 PM, during meal observation in the B wing day/dining room, seven residents were observed seated at three tables that had been prepared for lunch. There were no tablecloths or centerpieces on any of the tables, the walls of the room were bare, with no pictures, or posters. There was no music, leaving the room very quiet. Each resident had a serving tray on the table in front of them which contained their lunch. The plates, cups, bowls and eating utensils were not removed from the trays and placed on the table. When the trays were served, the staff left the room. On 1/14/25 at 12:45 PM, the lunch meal observation revealed the same observations. The dining area was lacking decorations, tablecloths, centerpieces, and/or music. The residents had their serving tray in front of them with the utensils and dishware on top. Once the trays were served the staff left the room. On 1/14/25 at 1:30 PM, Certified Nursing Assistant (CNA) J was in the dining room collecting trays. She acknowledged the residents' meals arrived on the floor in a cart full of trays, and each resident was served their meal on a tray in the dining room. She acknowledged there were no tablecloths on the table and the room was usually silent. On 1/16/25 at 8:56 AM, the Administrator observed the B wing dining room and acknowledged it was not home-like and needed some work. The Policy and Procedure, Guideline: Resident Rights-Safe/Clean/Comfortable Homelike Environment with effective date 4/02/22, read, It is the policy of this facility to provide the residents with a safe, clean, comfortable home-like environment in such a way that it acknowledges and respects the residents' rights.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on interview, and record review, the facility failed to follow the grievance process to make a prompt effort to resolve the grievance and keep the resident apprised of the progress toward resolution for 1 of 5 residents reviewed for personal property, of a total sample of 59 residents, (#56). Findings: Review of resident #56's medical record revealed she was admitted to the facility on [DATE] with diagnoses including atherosclerotic heart disease, type 2 diabetes, and osteoarthritis. Review of the Minimum Data Set significant change in status assessment with Assessment Reference Date of 11/12/24 revealed resident #56 had a Brief Interview for Mental Status score of 15 out of 15 which indicated she was cognitively intact. On 1/13/25 at 1:42 PM, resident #56 shared she lost her cell phone in her previous room, a few weeks ago. She explained she reported it to staff, they searched for it, but it was not found, and the facility did not replace it. She indicated she had to buy a new phone. She recalled she had to borrow her roommate's cell phone to contact her cell phone company to report it lost. She mentioned her daughter lived in England and she had not spoken to her in a month because of her missing phone. She recounted she could not speak with her daughter on Christmas or on her daughter's birthday at the beginning of January. She stated she reported the phone lost but it was hard to get someone from the facility for a follow-up discussion. Later, on 1/15/25 at 10:19 AM, resident #56 stated she should not have to pay the almost $80.00 she spent on the new phone for which she indicated she could hardly afford. She mentioned she had been without a phone for almost a month and both the charger and phone disappeared. She could not recall the staff she informed about her missing phone but recalled her assigned Certified Nursing Assistant (CNA) along with several CNAs and her assigned nurse at the time searched her room for the phone but did not locate it. She said, All they said was they could not find it. She stated when she spoke with the Social Services Director requesting a room change, she told the Social Services Director about her missing phone and she made sure everyone knew about the missing phone. Review of the medical record census revealed resident #56 was moved to her current room on 1/01/25. Review of the Grievance Log from December 2023 to January 13th, 2025 did not reveal any grievances for resident #56. Review of resident #56's Inventory of Personal Effects dated 10/17/24 included 1 cell phone, and 1 charger. (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	On 1/16/25 at 2:05 PM, the Social Services Director confirmed she was the Grievance Officer. She explained Grievance forms were located on both nursing units, and anyone could complete the form, including residents, families, or any staff. She indicated grievances were discussed during management morning meetings and given to the appropriate department for investigation and resolution. Later at 3:13 PM, the Social Services Director indicated resident #56 had come to her office today about her missing phone. The Social Services Director stated she would write up a grievance form tomorrow when resident #56 provided the copy of the receipt showing purchase of her new phone. She indicated the resident had to return to her room so she could not complete it at that time. The Social Services Director explained resident #56 told her she had informed the CNAs about the missing phone, and she responded that the CNAs sometimes forgot to tell her because they got busy. She indicated she would request a refund because she looked on the inventory sheet and confirmed resident #56 had a cell phone and the charging cable. She explained the expectation was for staff to write up a grievance form or personally let her know when residents reported missing items or shared any concerns. She indicated she or her assistant attended the care plan meetings. The Social Services Assistant, who was present, showed a notebook where she had taken notes during care plan meetings. The Assistant mentioned she had an entry in her notebook during the last care plan meeting on 12/03/24 that resident #56 requested bed rails and shared a concern about call light response on the 3:00 PM to 11:00 PM shift. She indicated resident #56 did not mention the missing phone at that time. When asked why a grievance form was not completed for those concerns shared on 12/03/24 during the care plan meeting, she answered she was hoping nursing would document it. She looked in resident #56's progress notes and confirmed she did not see any notes from nursing addressing the bed rails request. On 1/17/25 at 10:50 AM, CNA L recalled resident #56's assigned CNA informed the B-Wing Unit Manager (UM) the resident had lost her cell phone. She explained she was not her assigned CNA, but was sitting by the nurses' station and overheard the conversation. She stated this incident happened before resident #56 was transferred to her new room. CNA L stated the UM instructed that CNA to fill out a witness statement, to cover everyone. She confirmed she had assisted on the search for the phone but it was not found. She recalled when resident #56 moved rooms, the CNA who moved her room emptied all of her things and her cell phone was not there. CNA L mentioned resident #56 told her since losing her cell phone, she could not communicate with her daughter, and she was ordering a new one. On 1/17/25 at 11:03 AM, the B-Wing UM stated she learned resident #56 lost her phone sometime in December when a CNA brought it to her attention at the nurses' station. She mentioned that it occurred over a weekend and the CNA had searched her room trying to find it. The B-Wing UM indicated she also tried looking for the cell phone herself. She confirmed she asked the CNA to write a statement and brought it to the Social Services Director, then it was discussed during the morning meeting. She stated she did not keep a copy of the statement she gave to the SSD and confirmed she collected a witness statement from the CNA who informed her and searched for the phone. The UM said, Apparently I should have gotten a different form, it should had been a grievance form, but the Social Services Director received the witness statement. On 1/17/25 at 11:13 AM, the Social Services Director stated the UM told her she had a witness statement, and she instructed the UM to complete a grievance form. She remembered during the morning meeting the UM said something about the phone, and she told her to write it up on a grievance form. The Social Services Director stated since she did not receive the grievance form, she figured they had found the phone. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy, Social Services - Grievance Process revised on 2/21/23 revealed the Grievance Coordinator was responsible for overseeing and implementing the grievance procedure; receiving and tracking grievances through to their conclusion; and leading any necessary investigations by the facility. The document included grievances could be voiced as verbal or written complaints to a staff member or the Grievance Coordinator. The procedure listed grievances would be documented on the facility Grievance Report, listed on the facility's Grievance Tracking Log, investigated accordingly, and the facility should make prompt efforts to resolve the grievances.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39943 Based on observation, interview, and record review, the facility failed to provide nail care and removal of chin hair for 3 of 3 residents observed for Activities of Daily Living (ADL) care of a total sample of 59 residents, (#13, #87, and #88). Findings: 1. Resident #13 was admitted to the facility on [DATE] with diagnoses to include dementia, stroke, history of traumatic brain injury, history of falls. The resident's Significant Change Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 11/23/24 revealed the resident's cognition was severely impaired. The assessment noted she was dependent on staff for all ADLs. The assessment noted the resident did not have any behaviors toward herself or others. On 1/13/25 at approximately 12:45 PM, the resident was eating lunch in the B wing dining room, and was seen picking up food with her hands. Her nails were long and had a dark substance under each nail. Resident #13 had an ADL care plan dated 10/03/24, which directed staff to, Check nail length and trim and clean on bath day and as necessary. On 1/15/25 at 11:12 AM, Registered Nurse (RN) I acknowledged resident #13 had long, dirty nails on both hands and stated the Certified Nursing Assistants (CNAs) knew they were supposed to clean and trim the resident's nails on shower days and as needed. She stated they should have been looking at the resident's nails every day. 2. Resident #88 was admitted to the facility on [DATE] with diagnoses that included wedge compression fracture, dementia, and need for assistance with personal care. The resident's Quarterly MDS assessment with ARD of 12/18/24 revealed the resident's cognition was severely impaired. The assessment noted she required substantial maximum assistance for personal hygiene (which included shaving). The assessment noted the resident did not have any behaviors toward herself or others. On 1/13/25 at approximately 12:45 PM, the resident was sitting at a table in the B wing dining room for lunch. She had long facial hair on her chin. The resident was observed several times over the next two days with the facial hair present on her chin. On 1/15/25 at 11:09 AM, RN I acknowledged the hair on the resident's chin and stated the CNAs know they were supposed to remove facial hair from the female residents' faces unless told not to do so. She stated the hair should have been removed on the resident's shower day or anytime it was noticed. She also stated the resident did not refuse care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 the Director of Nursing (DON) stated her expectation was for the CNA to ensure the residents' nails were kept clean and trimmed. She also stated the female residents should not have facial hair and it should be removed on shower days and when seen. She said the CNAs had all received education regarding ADL care for residents. The Activities of Daily Living policy implemented on 4/01/22, revealed, The facility shall provide care and services for the following activities of daily living as needed based on the individual care plan of each resident. Hygiene- bathing, dressing, grooming, and oral care. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 32131 3. Resident # 87, a [AGE] year-old male was admitted to the facility on [DATE]. His diagnoses included heart failure, need for assistance with personal care, atrial fibrillation, cardiac pacemaker, anxiety disorder, and psychotic disorder. Review of the resident's significant change MDS assessment dated [DATE] revealed the resident's cognition was moderately impaired with a Brief Interview For Mental Status score of 11 of 15. The assessment revealed the resident had functional limitation in range of motion on both sides of his lower extremities and was dependent on the assistance of one staff for toileting hygiene, and personal hygiene. A care plan for ADL self-care performance deficit related to activity intolerance was initiated on 6/14/24, with revision on 7/02/24. An intervention initiated on 6/17/24 was to, check nail length and trim and clean on bath days and as necessary. Observations on 1/13/25 at 10:30 AM, 1/14/25 at 10:33 AM, and on 1/15/25 at 9:05 AM, showed resident #87's fingernails on his bilateral hands were untrimmed, with a dark substance underneath the fingernails of the resident's left hand. Resident #87 stated his fingernails were trimmed approximately one month ago. On 1/15/25 at 9:17 AM, CNA C stated nail care was provided for residents on shower days, and during ADL care. The CNA acknowledged that resident #87 was included in her assignment, and verbalized he was assigned to her also on 1/13/25, but she did not provide nail care. The resident's fingernails were observed with the CNA. She acknowledged that the resident's fingernails on bilateral hands were untrimmed, with a dark substance underneath the nails. The CNA stated nail care should have been provided for the resident. On 1/15/25 at 9:57 AM, the A Wing Unit Manager (UM) stated nail care was provided by the CNAs, who should clean and file the residents' nails on shower days and as needed. The observations of the resident's fingernails on 1/13/25, 1/14/25, and 1/15/25 were discussed with the UM, who stated she would address the resident's nail care. The facility's policy Nursing-Activities of Daily Living with effective date of 04/01/22 read, A resident who is unable to carry out activities of daily living shall receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39943 Based on observation, interview, and record review the facility failed to provide an on-going program of activities to meet the needs and preferences for 3 of 4 residents reviewed for activities, of a total sample of 59 residents, (#13, #40, and #88). Findings: 1. Resident #13 was admitted to the facility on [DATE] with diagnoses to include dementia, stroke, history of traumatic brain injury, history of falls. The resident's Significant Change Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 11/23/24 revealed the resident's cognition was severely impaired. The assessment noted she was dependent on staff for all Activities of Daily Living (ADLs). The assessment noted the resident did not have any behaviors toward themselves or others. Section F (Activities) indicated the following to be very important to the resident: music that she liked, going outside when the weather is good, activities that she enjoys with a group, reading magazines, newspapers and hearing the news. The resident's care plan dated 11/07/18 and revised on 8/24/21 indicated the resident was dependent on staff for social needs. On 1/13/24 at 10:50 AM, resident #13 was observed in the day room sitting in her wheelchair looking out the window. On 1/14/25 at 12:55 PM, the resident was observed sitting in the day room at a table, with no activities. On 1/15/25 at 12:45 PM, the resident was observed in the day room sitting at a table with the TV on, but the resident was not watching television. On 1/15/25 at 4:15 PM, observed the resident in the day room sitting at a table with no activities available. On 1/16/25 at 8:30 AM, the resident was observed lying in bed with her eyes open. She stated she ate her breakfast. There was no television on in her room. On 1/16/25 at 11:00 AM, the resident was observed lying in bed with no television on and no radio seen or heard in the room. On 1/16/25 at 3:00 PM, the resident was observed lying in bed, staring at the wall. Review of the resident's record revealed no notes from Activity staff that indicated resident #13 was offered activities and declined. 2. Resident #40 was admitted to the facility on [DATE] with diagnoses including adjustment disorder, respiratory failure, contractures, and abnormal posture. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's Quarterly MDS assessment with ARD of 11/19/24 revealed the resident's cognition was moderately impaired. The assessment noted the resident was dependent on staff for all ADL activities. Section F (Activities) indicated reading books, magazines, newspapers; listening to music he liked; keeping up with the news; doing things with a group, and participating in his favorite activities to be somewhat important to the resident. Review of the resident's care plan dated 10/26/23, indicated when the resident chose not to participate in organized activities, the resident preferred to watch television or go outside for social and sensory stimulation. On 1/13/25 at 10:30 AM, and 2:00 PM, the resident was lying in bed with his eyes closed and the television was off. On 1/14/25 at 8:35 AM, and 1:39 PM, the resident was lying in bed with his eyes closed and the television was off. On 1/15/25 at 8:43 AM, and 11:40 AM, the resident was lying in bed with his eyes closed and the television was off. On 1/16/25 at 8:32 AM, the resident was lying in bed with his eyes open and the television was off. The resident asked staff for his breakfast. Review of the resident's medical record revealed no notes from Activity Staff which indicated the resident was offered activities and declined. 3. Resident #88 was admitted to the facility on [DATE] with diagnoses that included wedge compression fracture, dementia, and need for assistance with personal care. The resident's Quarterly MDS assessment with ARD of 12/18/24 revealed the resident's cognition was severely impaired. The assessment noted the resident did not have any behaviors toward themselves or others. Section F (Activities) indicated doing favorite activities, going outside, doing things with groups of people, being around pets, and listening to music was important to her. The residents' Activity Care Plan dated 10/01/24, indicated the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs. On 1/13/25 at 10:50 AM, resident #88 was observed in the day room sitting at a table with her hands folded, with no activities observed, On 1/14/25 at 8:40 AM, observed the resident in the day room sitting at a table, with no activities noted. On 1/14/25 at 11:15 AM, observed the resident was sitting in the day room with her head on the table. No activity was seen. On 1/14/25 at 1:49 PM, the resident was observed sitting in the day room rocking back and forth in her wheelchair, no activities were observed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 11:30 AM, observed the resident sitting in the day room in her wheel chair at a table. No activity. On 1/15/25 at 2:10 PM, the resident was observed in the day room looking around the room with no activity. On 1/16/25 at 8:30 AM, the resident was observed lying in bed in her room. She was staring at the curtains, with no television or radio playing. On 1/16/25 at 11:30 AM, the resident was observed lying in bed with her eyes closed. On 1/16/25 at 2:10 PM, the resident was observed lying in bed with her eyes open. There was no activity occurring in the room, including the television or radio. Review of the resident's record revealed no notes from Activity Staff that indicated the resident was offered activities and declined. On 1/17/25 at 2:26 PM, the Activity Director stated all the activities were done in the main dining room. He stated if the residents self-isolated they usually did not come to activities. When asked about the residents who were cognitively impaired, he said, the families will do things with them, or they don't want to do anything. He said his department did room rounds for the residents who did not get out of bed. He said he had three assistants, and they did 1:1 activities for about 30 residents a month. He stated they usually did their documentation at the end of month. The Activity Director was asked for written documentation of the 1:1 interactions with those residents and he provided a handwritten paper he said was completed during a 1:1 activity. The paper read: Bedrock Activities One-On-One. The paper was a questionnaire with a series of questions including: resident name, room number, how did the resident feel about the care they received, how was the meals/food, was there anything they would like to report/ any issues, brief summary of the conversation during the one-on-one. The paper did not indicate any actual activity being provided to the residents. Review of the records did not provide any documentation of activities provided to the residents. The Community Life Program Policy, dated 4/01/22 read: The Community Life Department as part of the Multidisciplinary care team, provides comprehensive leisure programming geared to the enhancement of the social, emotional, intellectual, physical, creative and spiritual well-being of our resident population. The Community Life Program should be made available to all members of the resident population through service delivery in different areas: large group programs, small groups, special interest groups, special events, outside community trips, and individual intervention.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on interview, and record review, the facility failed to ensure a resident received proper and timely treatment to maintain his vision for 1 of 3 residents reviewed for vision and hearing, of a total sample of 59 residents, (#32). Findings: Review of resident #32's medical record revealed he was readmitted to the facility on [DATE]. His diagnoses included type 2 diabetes, absence of right and left leg above the knee, and glaucoma. Review of the Minimum Data Set quarterly assessment with Assessment Reference Date of [DATE] revealed resident #32 had a Brief Interview for Mental Status score of 15 out of 15 which indicated he was cognitively intact. On [DATE] at 11:45 AM, resident #32 stated he was told by his optometrist he had bleeding behind his left eye and needed to see a specialist. He explained she wrote it on her visit note last year but the facility did not follow up timely. He indicated when he finally saw the specialist, a treatment of injections was started but he was told the bleeding might not stop because he should have been seen sooner. Review of resident #32's optometrist Eye Exam Report dated [DATE] read, Set up external retinal consult in , d+[DATE] weeks. Review of resident #32's optometrist Eye Exam Report dated [DATE] read, Still haven't had OMD (Ophthalmologist) consult yet. Rewrite TO (telephone order) to set up external retinal consult ,d+[DATE] weeks . Will discuss with Social Service. Review of resident #32's optometrist Eye Exam Report dated [DATE] read, Still haven't had OMD consult yet. Rewrite TO for the 3rd time to set up external retinal consult in ,d+[DATE] weeks . Will email and discuss with social service and DON (Director of Nursing). Review of resident #32's physician orders revealed the following orders: Set up appointment with retina specialist for diabetic retinopathy was entered on [DATE]. The order was discontinued on [DATE] and entered as prescriber written. Set up appointment with retina specialist for diabetic retinopathy was entered on [DATE]. The order was entered as verbal order. Consult external Ophthalmology for diabetic retinopathy and glaucoma eval (evaluation). Please schedule appointment and arrange transportation. The order was entered on [DATE]. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #32's care plan revised on [DATE] revealed a focus for impaired visual function related to risks for diabetic retinopathy, retinal hemorrhage, severe diabetic retinopathy with macular edema, and glaucoma. The interventions included, Appointment for eye exam as ordered initiated on [DATE], Arrange consultation with eye care practitioner as required and Consult Retina specialist as ordered initiated on [DATE]. Another intervention initiated on [DATE] read, Ophthalmologist/retinal consult ASAP (as soon as possible) as ordered. On [DATE] at 7:46 AM, the Social Services Director stated she did not find any email messages from the Ophthalmologist except for the notes already uploaded into his medical record. On [DATE] at 9:12 AM, the DON stated she did not recall any details of resident #32's eye consultation. On [DATE] at 9:46 AM, the transportation and scheduler for residents' appointments explained she was responsible for setting up outside specialty physician's appointments. She explained the process included the clinical team entered the order and she pulled a daily report to identify and schedule the appointment. She indicated after the appointment was set up, she entered the information on a calendar she placed in a scheduling binder located on each nursing unit and shared a digital calendar among the clinical team so they could see residents' upcoming appointments. She explained for the order to show up in her report it must be entered as a verbal or telephone order. She indicated any order entered as prescriber written did not come across on her consults report. She stated she had communicated this to the clinical team more than once. She verified her report dated [DATE] and stated resident #32's order for the retina specialist was not included. She indicated that order was entered on [DATE] as prescriber written so it did not show in the report. She explained the second order entered on [DATE] was entered as verbal with an expiration of 3 days and the order expired on [DATE] at 8:59 AM. She stated she pulled the report on [DATE] at 3:25 PM, and the order was not there, even though she used a range of dates from [DATE] to [DATE]. She indicated the third order was entered by the primary physician and confirmed by a nurse on [DATE] as prescriber entered so it did not show on her report. She stated when she ran her report on [DATE], she saw the consult order, and she worked on it. She indicated she made the specialist appointment and set up transportation for [DATE] and resident #32 went by himself. She explained she communicated to the clinical team to let all the providers who entered orders know that a telephone or verbal order was needed or the clinical team needed to ensure it was entered correctly so she did not miss setting those appointments as ordered. Review of the Progress Notes from the Ophthalmologist consult on [DATE] revealed, significant evidence of advanced diabetic retinopathy on today's exam. The patient was explained that diabetic retinopathy is the most common diabetic eye disease and a leading cause of blindness around the world. Frequent examinations are important . Review of the Facility Assessment updated on [DATE] revealed they work with the current clinical professionals to ensure they retained medical practitioners who were adequately trained and knowledgeable in the care of residents. The document read, The Medical Director and Director of Nurses works closely to ensure that care and services rendered legally and appropriately.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45646 Based on observation, interview, and record review, the facility failed to ensure an intravenous (IV) dressing was changed as ordered for 1 of 2 residents reviewed for IV therapy, of a total sample of 59 residents, (#513). Findings: Resident #513 was admitted to the facility on [DATE] with diagnoses including encounter for surgical aftercare following surgery on the skin and subcutaneous tissue, other staphylococcus as the cause of diseases classified elsewhere, local infection of the skin and subcutaneous tissue, personal history of methicillin resistant staphylococcus aureus (MRSA) infection. MRSA is a type of bacteria that is resistant to several antibiotics. The risk is increased for people in nursing homes or exposure to crowded, unhygienic places. If left untreated MRSA infections can cause sepsis or death, (retrieved from cdc.gov/mrsa on 2/03/25). Review of the Minimum Data Set admission assessment with assessment reference date of 1/01/25 revealed resident #513 had a Brief Interview for Mental Status score of 14/15 which indicated she was cognitively intact. She did not exhibit any behavioral symptoms and did not reject care that was necessary to achieve her goals for health and well-being. The document revealed resident #513 had a diagnosis of wound infection and received IV antibiotics. A care plan for IV Medications was initiated on 1/06/25. The care plan indicated resident #513 received IV antibiotics related to a wound infection. Interventions included to observe IV dressing to left upper arm, change dressing and record observations per physician order and facility protocol. Review of resident #513's electronic medical record (EMR) revealed a physician order dated 12/27/24 which instructed licensed nurses to measure upper arm circumference and external catheter length on admission, with each dressing change and as needed one time a day every 7 days. A second order directed licensed nurses to change dressing on admission or 24 hours after insertion and weekly thereafter and as needed. Review of the Medication Administration Record (MAR) for January 2025 revealed documentation the IV dressing was changed on 1/03/25. The MAR had no documentation for dressing change on 1/10/25 and was next scheduled to be changed on 1/17/25 and 1/24/25. There was no documentation on the MAR to show where an as needed dressing change was performed on 1/07/25. On 1/13/25 at 11:02 AM, resident #513 was observed in bed with head of bed elevated, watching television. An IV medication bag was hanging from the IV pole but not connected. Resident #513 stated she received antibiotics through the IV site once a day. The IV site was covered by the resident's clothing and she was unable to pull the sleeve up far enough to be observed. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 10:39 AM, resident #513 was observed supine in bed with staff at bedside. Licensed Practical Nurse (LPN) E lifted resident's sleeve. She verified the IV site was covered with a transparent dressing dated 1/07/25. She reviewed resident #513's EMR and reported the dressing was scheduled to have been changed every 7 days. LPN E stated the dressing should have been changed on 1/14/25. On 1/15/25 at 10:52 AM, the Director of Nursing (DON) stated the 7 AM-3 PM shift usually changed IV dressings. She reviewed resident #513's EMR and reported Registered Nurse (RN) F changed the IV dressing on 1/03/25. She was unable to locate documentation on the MAR or in the progress notes for the IV dressing change per the IV site for 1/07/25. She verified the possibility a nurse would likely not change the IV dressing on 1/10/25 if he or she saw a date of 1/07/25 on the dressing. The DON acknowledged the MAR would not show the need for another dressing change until 1/17/25 which would be a total of 10 days since the bandage was changed last if an as needed dressing change was not performed prior to then. On 1/15/25 at 2:14 PM, the Regional Nurse Consultant (RNC) stated she looked at the as needed order for the IV dressing change and realized it was not set up correctly. She explained the way it was set up would not allow anyone to document an as needed dressing change. The RNC reported resident #513's IV dressing was changed on 1/15/25 and the as needed order was adjusted to enable documentation for as needed IV dressing changes. The facility's policy and procedure for midline dressing changes revised 1/17/19 indicated the IV dressings would be changed at specified intervals, or when needed, to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings. The document contained components of documentation which included date and time dressing was changed, location and objective description of insertion site, type of dressing placed and signature and title of the person recording the data.

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	105325	A. Building B. Wing	01/17/2025

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Bedrock Rehabilitation and Nursing Center at Islan	125 Alma Blvd Merritt Island, FL 32953

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39943 Based on interview, and record review, the facility failed to implement pharmacy recommendations and physician orders and failed to document a physician rationale for not following pharmacy recommendations for 3 of 5 residents reviewed for Medication Regimen Review (MRR), of a total sample of 59 residents, (#61, #11, and #34). Findings: 1. Resident #61 was admitted to the facility on [DATE] with diagnoses to include dementia, breast cancer, anxiety, delusional disorders, anemia, hypertension, and pain. The Order Summary Report revealed the resident had active medication orders included, Remeron 15 milligrams (mg) for insomnia, Lorazepam 0.5 mg daily for agitation, Norco 5/325 mg for pain, Pantoprazole 40 mg for acid reflux, Risperdal 0.25mg for adjustment disorder, Senna tab 8.6 mg for constipation, Singular 10 mg for asthma, Zoloft 50 mg for depression, and Melatonin 5 mg at bedtime for insomnia. Review of the Medication Regimen Review (MRR) recommendations for resident #61 included: In July 2023 resident #61 received Temazepam 15 milligrams (mg) at bedtime. Please attempt a gradual dose reduction of Temazepam to 7.5 mg at bedtime. There was no response from the physician. For September 2023, the pharmacist wrote, Currently receiving Lorazepam which can increase falls. Medical record with recent falls. Consider tapering dose or implementing alternative treatment if necessary. There was no decreased dose noted in the medical record and no response noted from the physician. In July 2024, the pharmacist indicated, Currently with active order for hemmorrhoidal cream 5% which has not been used in over 30 days. Please evaluate current need and discontinue if appropriate. The response from the physician was disagreed. No rationale was provided for the response. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In September 2024 the pharmacist documented, Currently receiving Pantoprazole 40 mg daily with order to crush med. Pantoprazole is enteric coated and cannot be crushed. Consider switching to Famotidine 40 mg at bedtime. The response was agreed by the physician but, there was no change to the order noted in the medical record. The pharmacist also indicated, Currently receiving Senna 1 tablet twice daily. Consider switching to Senna 2 tablets at bedtime for equal efficacy. The response was agreed to by the physician, but there was no change to the order noted in the medical record. Next the pharmacist reviewed, Receiving Bisacodyl which cannot be crushed. Please evaluate and discontinue (d/c) if appropriate. The response by the physician was to d/c on 9/18/24. The medication order was not discontinued in the medical record. The pharmacist also documented, Currently with active order for hemmorrhoidal cream which has not been used in over 30 days. Please evaluate current need and discontinue if appropriate. The physican response was to d/c the medication on 9/18/24. The medication order was not discontinued in the record. Finally, the pharmacist recommended, Receiving as needed (PRN) Guaifenesin tablets which cannot be crushed. Consider switching to Guaifenesin liquid if appropriate. The physician response was d/c this order on 9/18/24. The medication was not discontinued until 11/08/24. In October 2024 the consulting pharmacist documented, Currently receiving Montelukast which has been associated with mood and behavior changes including insomnia, agitation, anxiety, depression, and similar problems. Please evaluate risk vs (versus) benefit. Consider trial discontinue if appropriate. The physician response was disagreed, with no rationale given. In November 2024 the consulting pharmacist indicated, Receiving Risperidone (Reisperdal) which can increase risk for falls. Resident with recent falls, please evaluate, consider tapering dose or implementing alternative treatment, if appropriate. Response was disagreed by the physician with no rationale given. On 1/17/25 at approximately 3:30 PM, The Director of Nursing (DON) stated she was aware of the problems with the MRR, and said she would be addressing them with the physicians and nurses. 45646 2. Resident #34 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, acquired absence of left leg below knee, acquired absence of right leg below knee, anxiety disorder, depression, insomnia and unspecified pain. Review of the Minimum Data Set (MDS) quarterly assessment with assessment reference date of 11/05/24 revealed resident #34 had a Brief Interview for Mental Status score of 15/15 which indicated he was cognitively intact. He had impairments to both sides of his lower extremities. The assessment revealed resident #34 had two or more falls in the last three months; experienced pain frequently; and received antidepressant, hypnotic, hypoglycemic and scheduled and as needed (prn) pain medications. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the consulting pharmacist Medication Regimen Review reports for March 2024 revealed recommendations for added stop date for use of prn Oxycodone, tapered dosage of scheduled Oxycodone due to increased risk of falls and increased dosage of basal insulin with eventual discontinuance of sliding scale insulin; September 2024 contained recommendations for tapered dosages of Trazodone and Sertraline due to increased risk of falls; October 2024 contained a recommendation to evaluate risk versus benefits for the use of Zolpidem (Ambien) due to increased risk for falls; and November 2024 contained a recommendation for increased the dosage of basal insulin to Glargine at bed time. The physician disagreed with each recommendation but did not supply a rationale for the decision on the Medication Regimen Review report or in resident #34's medical record. On 1/17/25 at 9:21 AM, the DON reviewed the Medication Regimen Review reports for resident #34 and acknowledged the physician had not provided a rationale for times when she disagreed with pharmacy recommendations. 43192 3. Review of the medical record revealed resident #11 was readmitted to the facility on [DATE] with diagnoses including bipolar disorder, osteoarthritis, congestive heart failure and type 2 diabetes. Review of the Medication Regimen Review form dated 9/17/24 included the following pharmacist recommendation, Currently receiving Psyllium (Metamucil). Please consider adding instructions to mix with 8 ounces of water to ensure proper administration. The physician checked the Agree; Will do box and signed the form on 9/18/24. Review of the Medication Regimen Review form dated 10/15/24 included the following pharmacist recommendation, Currently with active order for sliding scale insulin coverage with has mostly not been used this month. Please evaluate current need. Consider discontinue insulin coverage and taper fingerstick order to two times a week, AM and PM, notify MD (physician) if below 70 or above 50, if appropriate. The physician checked the Agree; Will do box and signed the form on 10/17/24. Review of resident #11's active physician orders revealed the following: An order dated 9/04/24 for Insulin Aspart to inject subcutaneously per the sliding scale before meals and at bedtime. The physician approved changes to the insulin order from 10/17/24 were not found. An order dated 9/06/24 for Psyllium Husk Powder to give 2.4 gram by mouth one time a day for hard stools. The order did not contain the added instructions suggested by the pharmacist and approved by the physician. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/17/25 at 7:58 AM, the DON explained when she received the pharmacist recommendations they were handed out to the physicians for review. She indicated they implemented the changes as ordered once the form was returned signed from the physicians. She indicated the process generally took around seven days. She explained due to a high turnover with Unit Managers, the Assistant DON and herself handled this process. The DON stated she noticed not all physicians included a rationale when disagreeing with the recommendations and she would address them. The DON reviewed the recommendations for resident #11 and confirmed the physician's orders were not followed. She validated recommendations for Psyllium and insulin were not implemented. Review of the Administering Medications policy revised on 2/21/23 revealed a purpose to ensure medications were administered in a safe and timely manner, and as prescribed. The General Guidelines included, Medications are administered in accordance with prescriber orders, and current standards of practice.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on interview, and record review, the facility failed to ensure an as needed (PRN) order for a psychotropic drug was limited to fourteen (14) days for 1 of a total sample of 59 residents reviewed, (#30). Findings: Resident #30, a [AGE] year-old male was initially admitted to the facility on [DATE], with his most recent readmission on 2/01/24. His diagnoses included schizophrenia, psychosis, dementia, depression, seizures, and chronic kidney disease. Review of the medical record revealed a physician order dated 10/01/24 for Xanax 1 milligram (mg) every 12 hours as needed for agitation. The order did not have a stop date. Xanax is used to treat anxiety disorders and anxiety caused by depression, (retrieved on 2/03/25 from www.drugs.com). On 1/16/25 at 9:05 AM, the A Wing Registered Nurse/Unit Manager (RN/UM) stated PRN Xanax was normally prescribed for 14 days. She stated that if the medication was used occasionally, it could be continued for 30 days, and if not used the medication should be discontinued. On 1/16/25 at 11:05 AM, the Director of Nursing (DON) stated that PRN psychotropic medications had a 14 day stop date and then had to be reevaluated. Record review of the resident's physician's orders were conducted with the DON. She acknowledged that resident #30 had an order for PRN Xanax which was dated 10/01/24, and a stop date was not noted. A review of the resident's progress notes conducted by the DON from October 2024 to current date did not reveal any documentation regarding a stop date for the Xanax. The DON stated the medication should have been re-evaluated for continuation, and a stop date should have been included. The facility's policy, Administering Medications with effective date of 4/01/22, and revision date of 2/21/23 did not address a stop date protocol for PRN psychotropic medications, but instructions were that if a resident uses PRN medications frequently, the Attending Physician and the Interdisciplinary Care Team .shall reevaluate .examine the individual as needed, determine if there is a clinical reason for the frequent PRN use, and consider whether a standing dose of medication is clinically indicated.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 45646 Based on observation, interview, and record review, the facility failed to ensure waste was disposed of in a sanitary manner. Findings: During Kitchen observation on Monday 1/13/25 at 9:45 AM, an uncovered dumpster was observed located at the back of the facility. The dumpster was designed to have two parallel lids to cover the container. One lid was noted to be missing, and the other lid was warped and half torn from the hinge preventing it from sealing the dumpster. Two adult briefs were observed on the ground in front of the dumpster. The Certified Dietary Manager (CDM) acknowledged the container should have lids that closed to prevent pests and rodents from getting inside the container. She stated the maintenance department was responsible for maintaining the dumpsters. On 1/13/25 at 9:48 AM, the Maintenance Director acknowledged the dumpster did not have lids that closed and fit securely which could attract rodents and insects. He stated the dumpster had been in this condition for about 2 months. He explained the regional maintenance consultant was aware the dumpster needed to be replaced. On 1/13/25 at 09:54 AM, the Administrator stated he had not been informed the dumpster was in disrepair and needed to be replaced. He stated he would call the garbage collection company to have it replaced. On 1/14/25 at 10:20 AM, the broken dumpster was observed with garbage bags and boxes inside. The garbage bags contained food items, drink cans, plastic utensils, paper products and adult briefs. One bag was noted to be torn open. On 1/16/25 at 11:22 AM, the Administrator verified the facility continued to use the dumpster despite the missing and warped lids as they did not have anywhere else to dispose of the refuse. He stated a new dumpster was scheduled for delivered next week but the facility would have to use the dumpster until then. The Food and Drug Administration's 2017 Food Code referred to the use of outside receptacles for waste in chapter 5-501.15(A). Receptacles and waste handling units for refuse, recyclables and returnables used with materials containing food residue and use outside the food establishment shall be designed and constructed to have tight-fitting lids, doors, or covers.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 45646 Based on interview, and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee conducted performance improvement activities to ensure prior improvement measures were sustained. Findings: Review of the facility's policy and procedure for Quality Assurance and Performance Improvement revised 3/10/23 revealed the QAPI program included comprehensive data-driven activities that focused on indicators of the outcomes of care and quality of life. The policy indicated the QAPI program took a systematic, interdisciplinary, comprehensive and data-driven approach to maintain and improve safety and quality. The facility had deficiency cited at F584, F585, F694 and F814 during the previous recertification survey conducted 5/15/23 through 5/19/23. During the current survey, the facility was found to be in noncompliance with F584, F585, F694 and F814. As a result of the repeat deficiencies, it was identified there was insufficient auditing and oversight to correct the deficiencies. On 1/17/25 at 3:54 PM, the Administrator stated the QAPI committee met monthly and included staff from various departments. He explained the committee reviewed and discussed the previous month's data gathered by departments. The committee determined what Performance Improvement Plans (PIPs) to put in place to address the identified areas. The Administrator clarified audits were a part of PIP monitoring and were brought to QAPI to evaluate the effectives of the plan. He explained PIPs continued to be addressed until the committee determined the facility had reached a level of substantial compliance. The Administrator verified PIPs were developed and implemented based on survey outcomes. He explained the goal of QAPI activities was to make and sustain improvements in identified areas. The Administrator acknowledged repeat citations were identified during the current survey. He stated there was no excuse and acknowledged there was obvious system breakdown which needed to be addressed.

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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. 32131 Based on observation, interview, and record review, the facility failed to ensure correct signage was posted for Enhance Barrier Precaution (EBP), failed to ensure Personal Protective equipment (PPE) was readily available for residents on EBP, and failed to ensure proper infection control measures were practiced, by failing to store residents' equipment in a sanitary manner on 1 of 2 Wings, (A wing). Findings: On 1/14/25 at 9:23 AM, observation showed signage on resident #5's room door for contact Isolation, a container with the appropriate PPE was not noted. Certified Nursing Assistant (CNA) D was sitting in the resident's room, and stated the contact isolation was for resident #5 due to wounds and explained she was providing one-on-one observation to the resident for safety. The CNA stated that gloves were in the room, but no other PPE was in place. On 1/14/25 at 9:27 AM, Licensed Practical Nurse (LPN) A stated resident #5 was on contact isolation due to a wound. On 1/14/25 at 9:30 AM, the Infection Preventionist (IP) who explained she was also the Assistant Director of Nursing. She stated resident #5 was on EBP due to a wound. The signage posted on the resident's door was observed with the IP. She acknowledged the signage was incorrect, and should have been for EBP, not contact isolation, and acknowledged that the appropriate PPE was not in place. The IP stated EBP was initiated for residents with wounds, gastrostomy tubes (GT), and indwelling catheters. However, resident #31 was currently receiving GT feed, and had no signage in place regarding EBP, and PPE was not readily available. This was acknowledged by the IP. She verbalized that a total of thirty (30) residents were currently on EBP but was unable to say if signage was posted for them. She shared that prior to 1/01/25 signage was posted, and caddies with PPE were outside of the resident doors in the hallways, but the caddies were removed from the hallways due to pillage'. The IP stated PPE were available in the CNA's supply room at the nurses' station. On 1/16/25 at 8:52 AM, CNA B stated that when providing care for residents on EBP, she had to retrieve PPE from the CNA supply room by the nurses' station, prior to going into the resident's room. She said it was a lengthy process. On 1/16/25 at 9:00 AM, Licensed Practical Nurse (LPN) E stated signage for EBP was posted on the walls in the resident's room, and PPE would be in a container at the resident's door. LPN E stated she had some residents on EBP, and signage was posted on the wall in the resident's room, but PPE was not available at the doors, or in the residents' rooms. The LPN stated if she had to do catheter care she would need PPE and would have to go to the CNAs supply room at the nurses' station instead of having it readily available at the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/16/25 at 9:29 AM, the IP stated that a Quality Assurance and Performance Improvement (QAPI) meeting was held on 1/15/25 for implementing that EBP signs would be placed above the residents' bed in a sleeve. PPE would be made available in the supply room at the nurses' station, and she considered that as being readily available. She shared that prior to the QAPI, Transmission Based Precaution signage was posted on the residents' doors, and caddies with the appropriate PPE were outside the rooms. However, since 1/01/25, the caddies were removed from the hallways, gloves were available in each room, and gowns and other PPE had to be retrieved from the supply closet at the nurses' station. The policy Enhanced Barrier Precautions with effective date of 4/01/24, and revision date of 4/03/24 read, Make gown and gloves available inside of the resident's room .Signage indicating enhanced barrier precautions to be placed inside of resident room. PPE to be kept inside resident room and easily accessible for use. 2. On 1/13/25 at 10:48 AM, and on 1/16/25 at 1:20 PM, observations showed two basins on the floor in the bathroom of room #A-17. The basins were not labeled with the individual resident's name and were not stored in a plastic bag. On 1/16/25 at 1:23 PM, Registered Nurse (RN) F stated that in a perfect world resident's equipment/ basin should be labeled, placed in a plastic bag, and stored in the resident's closet, not stored on the floor. On 1/16/25 at 1:25 PM, an observation of the basins on the bathroom floor was conducted with the IP. She acknowledged the findings, and stated for proper infection control practices, the basins should not be stored on the floor, they should be labeled and placed in the individual residents' closet/drawer to prevent cross contamination. On 1/16/25 at 1:38 PM, CNA M stated bed pans, and basins for residents should be placed in a plastic bag, labeled, and stored in the resident's closet or empty drawer. The facility's policy Nursing-Infection Control Prevention and Control Program with effective date 2/21/23 did not address storage of resident equipment.