STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105343	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heather Hill Healthcare Center	6630 Kentucky Ave New Port Richey, FL 34653

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 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** 46234 Based on observation, interview, and policy review, the facility did not ensure dignity was maintained for residents in one (400) out of two dining rooms and on one (200) out of four units related to staff standing while assisting residents with eating, not serving residents at a single table their meals at the same time, and having residents eat in the hallway. Findings included: An observation was conducted on 6/4/24 at 5:16 p.m. in the 400-unit dining room of a table with four residents seated. Three of the residents had their meals and were eating while the fourth resident (#79) did not have any food. At 5:21 p.m. Resident #79 was observed walking to the tray cart and asked why everyone had food but her. She said, I am having to wait. Staff A, Licensed Practical Nurse (LPN) walked up to the resident and the resident told Staff A she wanted her food. Staff A told Resident #79 someone would bring it to her in a minute. Staff A proceeded to leave the unit and stand in the hall talking with other staff members. Resident #79 said, She just left. She could have given me my food. At 5:23 p.m. Resident #79 walked across the dining room to an aide and asked for her food; the aide's response was not heard. Resident #79 then walked back to the tray cart, pulled her own tray out and carried it to her table. Review of Admission Record showed Resident #79 was admitted on [DATE] with diagnoses including dementia and anxiety. Review of Resident #79's Minimum Data Set (MDS), dated [DATE], Section C, Cognitive Patterns, showed her Brief Interview for Mental Status (BIMS) score is 9, indicating moderately impaired cognition. Review of Resident #79's Activities of Daily Living (ADL) care plan, revised 1/31/24, showed she needed assistance setting up her tray for eating. An observation was conducted on 6/4/24 at 5:27 p.m. in the 400-unit dining room of a table with three residents seated. Two of the residents had their meals and were eating while the third resident did not have any food. The third resident proceeded to grab a yogurt container from one of the residents with food and started eating. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was conducted on 6/4/24 at 5:20 p.m. in the 400-unit dining room of an aide assisting a resident with eating. The aide was standing beside the resident throughout the process, never sitting down and interacting with the resident. An interview was conducted on 6/6/24 at 12:33 p.m. with Staff J, Registered Nurse (RN.) She said staff should be sitting when helping feed a resident. She said, It's a dignity issues, we shouldn't tower over them. She said sometimes the aides must go table to table when they do not have enough help. An interview was conducted on 6/6/24 at 1:06 p.m. with the Director of Nursing (DON.) She said when staff are assisting a resident with their meal, they should wash their hands, set the food up, talk to the resident, then sit down and assist them. She said they should always be sitting, not standing. 50570 2. An observation on 6/3/24 at 4:00 p.m. revealed three residents in the 200-unit hallway sitting in their wheelchairs with their bedside table in front of them. An observation on 6/4/24 from 12:35 p.m. to 1:24 p.m. revealed Resident #60 sitting in her wheelchair in the hallway, outside of room [ROOM NUMBER], with the bedside table in front of her. At the time of the observation, the bedside table in front of her did not have any activities present. Further observation at 12:48 p.m. revealed another resident sitting in her wheelchair in the hallway, outside room [ROOM NUMBER], with the bedside table in front of her. At the time of the observation, the bedside table in front of her did not have any activities present. The same observation revealed a third resident sitting behind the second resident. The third resident was observed sitting in her wheelchair with the bedside table in front of her. The third resident was observed with no activities present on the bedside table in front of her. An observation of the 200-unit hallway on 6/4/24 at 4:22 p.m. revealed two residents, one of them being Resident #60, sitting in their wheelchair with the bedside table in front of them. An interview on 6/4/24 at 4:25 p.m. with the Activities Director revealed the residents who are sitting in the 200s hall hallway, with the bedside tables in front of them, are considered a fall risk. She stated the residents are provided meals there. The Activities Director stated after the residents are toileted by staff, they wait there to go to activities. She stated sometimes she picks residents up from the hallway or the staff takes residents themselves to activities. An observation on 6/4/24 at 5:15 p.m., in the 200s hallway, revealed three residents (#60, #62 and an unidentified resident) were sitting in their wheelchairs with the bedside table in front of them. The residents were waiting for their dinner meal to arrive. An observation at 5:53 p.m. of the 200s hallway revealed the same three residents were eating their dinner. On 6/5/24 at 10:53 a.m. Resident #60 was observed sitting in her wheelchair in the hallway, outside of room [ROOM NUMBER], with the bedside table in front of her. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 6/5/24 at 10:53 a.m. with Staff W, Certified Nursing Assistant (CNA) revealed the residents sitting in the hallway are there for supervision. Staff W stated it is the resident's choice to sit and eat in the hallway. Staff X, CNA stated that Resident #60 likes to see people and, Say hi. She stated that Resident #60 prefers to be in the hallway. A review of Resident #60's Admission Record revealed an original admitted [DATE] and a re-entry date of 5/13/23. Further review of the Admission Record revealed diagnoses to include unspecified dementia, generalized anxiety disorder, and history of falling. A review of Resident #60's Minimum Data Set (MDS) assessment, Section C - Cognitive Patterns, dated 5/23/24, revealed a Brief Interview for Mental Status (BIMS) score of 3, severely impaired. A review of Resident #60's active orders, with a date of 6/5/24, revealed medications to include: Remeron 15 mg (milligrams) for depression. Start date 11/17/2023. A review of Resident #60's current care plan to include a focus related to nutritional risk and activities of daily living (ADLs) showed no evidence of interventions/tasks regarding sitting or eating in the hallway. An interview on 6/6/24 at 11:10 a.m. with the Director of Nursing (DON) revealed: It is the resident's preference to sit in the hallway due to their disease process. In reference to Resident #60, the DON she said the dining room overstimulates her. She stated, The dining room is busy and sitting with other residents is a big distraction for her. The DON stated, If she's dining the resident gets elevated, won't eat and is more interested in people at the table. She stated the resident getting distracted by other residents at the dining table and would interfere with Resident #60's intake. The DON stated having the residents sit in the hallway is, Not practice and I don't encourage this. She stated staff tries to accommodate what the resident wants and what is best for them. The DON stated the resident's sitting in the hallway depends on their behaviors. She stated Resident #60 is a fall risk and likes social interaction. The DON stated when residents have poor cognition, staff have to judge their behaviors and expressions. She stated the intervention of having the resident eat in the hallway should be in their care plan. The DON stated care plans are reviewed every three months and falls are reviewed every time they occur. She stated the resident has the choice to be in bed if they want to, however, if they display behaviors of getting out bed then the resident being in the hallway is more about safety. The DON stated the facility is scrutinized about safety. 3. An observation on 6/4/24 at 5:55 p.m. of the 100s hallway, during the dinner mealtime, revealed Staff R, Admission Director, referring to a resident as a feed. Further observations revealed Staff R and Staff T, CNA conversing about which residents need assistance with feeding and referring to the residents as a, feed. An interview on 6/5/24 at 10:04 a.m. with the DON revealed her expectation is that staff would refer to residents as, Residents who need assistance, not a feed. An interview on 6/6/24 at 11:12 a.m. with Staff S, CNA revealed she would refer to residents who need assistance with feeding as a, Feeding resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 6/6/24 at 11:15 a.m. with a CNA, on the 100s hall, revealed she would refer to residents who need assistance with feeding as a, Dependent diner. An interview on 6/6/24 at 12:21 p.m. with the DON revealed she would identify residents as, Needs assistance with feeding. She stated she would not refer to a resident as a feed, feeder or feeding assistant, and wouldn't expect staff to use those terms. She stated the staff may have been referring to the residents that way in relation to their dining assignments. The DON stated the staff should not have been saying, Feed, out loud in the hallway. 48223 4. On 6/3/2024 at 12:25 PM an observation occurred of the memory unit's lunch meal. Twenty-Four (24) residents were observed in this dining room. Three (3) staff members were passing the lunch trays to the residents. A group of three (3) residents were sitting in chairs at the table closest to the window of the courtyard. Two (2) of the residents were served their meal at 12:32 PM. The third (3) resident at the table did not receive their tray until 12:48 PM. On 6/3/2024 at 12: 35 PM an observation occurred of the memory unit's lunch meal. A resident was sitting at a table, under the TV. A staff member placed the resident's meal tray in front of the resident. The staff member continued to assist the resident with eating, the staff member stood over the resident while assisting with the meal to completion. On 6/4/2024 at 5:18 PM an observation occurred of the memory unit's dinner meal. Two residents were seated at the table closest to the courtyard door, against the wall with the TV, both residents received their meal trays. One resident needed assistance with eating and the staff member was observed standing while assisting the resident with the meal. During an interview on 6/6/2024 at 12:30 PM, Staff K, Certified Nursing Assistant (CNA) stated there is no rule on if you should stand or sit when assisting a resident with their meal. You can stand or sit, whichever is more comfortable. During an interview on 6/6/2024 at 12:42 PM, Staff L, CNA stated, we should sit down, it's not nice to stand over the resident when assisting them with their meal. Staff L, CNA continued to state it is hard to sit down in the memory unit's dining room as most of the time there are not enough chairs. During an interview on 6/6/2024 at 1:12 PM, the Nursing Home Administrator (NHA) stated staff are supposed to sit while assisting residents with meals. The NHA also stated she wasn't sure why the staff were not sitting with the resident to assist them with their meal. Review of the policy and procedure titled Quality of Life - Dignity, with a revised date of August 2009 revealed: Policy Statement - Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Policy Interpretation and Implementation: 1. Residents shall be treated with dignity and respect at all times. 11. Demeaning practices and standards of care that compromise dignity are prohibited. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy and procedure titled Assistance with Meals, with a revised date of March 2022 revealed: Policy Statement - Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Policy Interpretation and Implementation: Dining Room Residents: 1. All residents will be encouraged to eat in the dining room. 2. Facility staff will serve resident trays and will help residents who require assistance with eating. 3. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. Not standing over residents while assisting them with meals; b. Keeping interactions with other staff to a minimum while assisting residents with their meals; c. Avoiding the use of labels when referring to residents (e.g., feeders); and d. Avoiding the use of bibs or clothing protectors instead of napkins, unless requested by the resident.

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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. 48223 Based on observation, interview and record review, the facility failed to ensure prompt efforts were made to resolve grievance for one (Resident #30) out of three (3) residents sampled. Findings included: During an interview and observation on 6/4/2024 at 5:48 PM the Responsible Party (RP) of Resident #30 stated visiting the resident daily and assists with dinner and gets the resident ready for bed. The RP showed the brief that had just been taken off of Resident #30. The incontinent product appeared saturated with yellow liquid. The RP stated approximately 4 days out of the week when arriving Resident #30 has not been changed and the incontinent product is saturated. The RP stated, they [the facility] do not have enough staff to help with the population of residents on the 400 [memory care] unit. The RP states reporting these events to the nurse on multiple occasions. The RP states telling Staff A, Licensed Practical Nurse (LPN) multiple times including tonight. The RP continued to state staffing is probably the problem, as the unit (memory care unit) usually only has 1 Certified Nursing Assistant (CNA) on the hallway and this leaves 1 CNA to assist with meals and 1 CNA for toileting. A review of the Grievance Logs from November 2023 to May 2024, revealed an absence of grievance concern for Resident #30. Review of the grievance log for June revealed a grievance written for Resident #30 on 6/5/2024. During an interview on 6/5/2024 at 4:31 PM Staff A, Licensed Practical Nurse (LPN) confirmed the RP of Resident #30 had complained multiple times regarding the issue with Resident #30 being saturated on a regular basis upon the RP's arrival. Staff A, LPN stated I did not think much of it, I would have the Certified Nursing Assistant (CNA) change her right away. I try to make sure one of the regular staff members care for Resident #30 so this doesn't happen, as you know some staff better than others. During an interview on 6/5/2024 at 4:45 PM Staff O, Interim Social Service Director (ISSD) and Staff U, Social Service Director (SSD), explained the grievance process. Staff U, SSD stated anyone can complete grievance also known as a concern; the grievance will be logged by social services; the SSD will give to the respective department(s) for correction; the SSD will track and ensure the grievance is completed within 5 days; the SSD will then follow up with the resident/resident family to ensure satisfaction. Staff U, SSD stated if a nurse received a complaint/concern/grievance the nurse should have completed a grievance form, this would allow for tracking and trend for issues. During an interview on 6/6/2024 at 1:15 PM the Nursing Home Administrator (NHA) stated the expectation is for any staff the receives a concern/grievance to complete a form for documentation. (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 policies and procedures titled Grievance Policy, with a revision date of 08/2023 revealed: All persons are encouraged to make requests, share concerns, and file grievances regarding care and/or services without fear of retribution or negative treatment. Customer service/Grievance forms are provided on admission and are available throughout the facility in lobbies and nursing units. A concern or grievance may be given orally or in writing. You also have the right to file a grievance anonymously. every attempt will be made to resolve the issue within five business days period's contact should be made with the persons involved by the 5th day if indicated, to make them aware of the results and/or status of the investigation and/or follow up. Complex issues may require more time beyond the five days. Contact will continue with the parties involved. You also have the right to obtain a written decision regarding your concern or grievance. One will be provided to you upon request. Procedures: 1. Notify the grievance officer, identified above, of your concern/grievance. This individual is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion; Leading any necessary investigations by the facility; Maintaining the confidentiality of all information associated with grievances; And coordinating with state and federal agencies as necessary in light of specific allegations.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on record review, interview, and policy review facility did not ensure Preadmission Screening and Resident Review (PASRR) Level 1 Screen was updated when new diagnoses were added for three residents (#9, #11, and #17) out of twenty-six reviewed for PASRR screening. Findings included: Review of Admission Records for Resident #17 showed she was admitted on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction, symptoms and signs involving cognitive functions. Review of Resident #17's PASRR Level 1 Screen, dated 12/23/22, showed no diagnoses or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR not required. No mental illness or suspected mental illness were checked in Section I and dementia was indicated as No in Section II. Review of Admission Records for Resident #17 showed during her stay a diagnosis of dementia was added on 10/1/22, anxiety disorder was added on 4/11/24, and persistent mood disorders was added on 4/11/24. No updated PASRR Level I screen was completed for Resident #17 with the added diagnoses. 50570 2. A review of Resident #9's Admission Record revealed an original admitted [DATE] and a re-entry date of 3/18/23. Further review of the Admission Record revealed diagnoses to include other generalized epilepsy and epileptic syndromes, major depressive disorder, obsessive-compulsive disorder, and attention deficit disorder, combined type. A review of Resident #9's Preadmission Screening and Resident Review (PASRR) Level 1 dated 4/16/12 revealed a diagnosis of bipolar disorder. The PASSR Level 1 indicated the resident has a serious mental illness (MI) and a PASRR Level II was required. A referral for Level II was indicated. A review of Resident #9's Level II PASRR revealed diagnoses to include bipolar disorder and anxiety disorder. A review of Resident #9's quarterly Minimum Data Set (MDS), Section I - Active Diagnoses, with an Assessment Reference Date (ARD) of 5/12/24 revealed diagnoses to include seizure disorder or epilepsy, depression, and obsessive-compulsive disorder. A review of Resident #9's electronic medical record revealed no evidence of an updated Level I PASSR with new diagnoses. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. A review of Resident #11's Admission Record revealed an original admitted [DATE], an initial admitted [DATE] and a re-entry date of 4/17/24. Further review of the Admission Record revealed diagnoses to include vascular dementia, bipolar disorder, schizoaffective disorder, bipolar type, anxiety disorder, and major depressive disorder. A review of Resident #11's PASRR Level 1 dated 4/14/11 revealed a diagnosis to include a major MI. A review of documentation revealed a request for Level II PASSR evaluation and determination, dated 4/14/11. A review of Resident #11's Level II PASRR dated 4/21/11 revealed a psychiatric history of psychosis and depression. A review of Resident #11's Level II PASRR dated 12/20/16 revealed diagnoses to include bipolar disorder, anxiety disorder, depression, and psychotic disorder. A review of Resident #11's significant change in status MDS, Section I - Active Diagnoses, with an ARD of 4/30/24 revealed diagnoses to include non-Alzheimer's dementia, anxiety disorder, depression, bipolar disorder, and schizophrenia. A review of Resident #11's significant change in status MDS, Section N - Medications, with an ARD of 2/15/24 revealed medications to include antianxiety and antidepressant. A review of Resident #11's electronic medical record revealed no evidence of an updated Level I PASSR with a new diagnosis. On 6/5/24 at 3:22 p.m., an interview with Staff O, Social Worker (SW), Interim stated she was aware there are issues with the PASRRs. During the interview Staff U, the new Social Service staff member, was present. The SW, Interim stated Staff U was going to assist with the PASRR issue. The SW, Interim stated, I told the Administrator we are probably going to get tagged but all we can do is move on. She stated she expected Medical Records and the new Social Service staff member to collaborate and communicate if there's a new diagnosis for a resident. A review of the facility's policy titled, Admission Criteria, with a revised date of March 2019, revealed in the Policy Interpretation and Implementation: .9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID, or RD. b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223 Based on interviews and record reviews, the facility failed to complete the Preadmission Screening and Resident Review (PASRR) Level II upon having a qualifying mental health diagnosis for 7 of 20 residents sampled (Residents #80, #54, #19, #62, #22, #52, and #33). Findings included: 1. Review of the Admission Record showed Resident #54 was admitted on [DATE] with diagnoses of Major Depressive Disorder, Dementia, psychosis, anxiety, pseudobulbar affect, and other comorbidities. Review of Resident #54's PASRR Level I Assessment, dated 4/30/2021 did not reveal a qualifying mental health diagnosis marked in section I A. Section 6 was marked yes for dementia with a suspected mental illness although a level II PASRR was not completed. Due to the diagnosis' Resident #54 should have a Level II PASRR requested. Review of the Admission Record showed Resident #38 was admitted on [DATE] with diagnoses of Dementia, Parkinson's, Schizoaffective Disorder of the bipolar type; Mood Disorder, and other comorbidities. Review of Resident #38's PASRR Level I Assessment, dated 1/5/2021 did not reveal diagnosis of Dementia or schizoaffective disorder. A level II PASRR should be completed due to the qualifying diagnoses. 50570 2 Review of Resident #80's Admission Record revealed an admitted [DATE]. Further review of Resident #80's Admission Record revealed diagnoses to include unspecified dementia with an onset date of 4/9/24 and classified upon admission. Further review of diagnoses revealed adjustment disorder with depressed mood with an onset date of 4/17/24 and classified during stay. Review of the admission Minimum Data Set (MDS), Section I - Active Diagnoses, with an Assessment Reference Date (ARD) of 4/13/24 revealed a neurological diagnosis to include non-Alzheimer's dementia. Review of the MDS, Section N - Medications, with an ARD of 4/13/24 revealed medications to include antipsychotic and antidepressant. Review of Resident #80's active physician orders as of 6/6/24 revealed medications to include: Topiramate 25 milligrams (mg) related to unspecified dementia. Start date 4/9/24. Trazodone HCl (hydrochloride) 50 mg related to depression. Start date 4/11/24. Review of Resident #80's Preadmission Screening and Resident Review (PASRR), Level 1 Screen dated 2/2/24 revealed no qualifying mental health diagnosis. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record revealed no evidence of an updated PASRR, Level 1 to include a qualifying mental health diagnosis. 3. Review of Resident #52's Admission Record revealed an original admitted [DATE] and a re-entry date of 1/23/24. Further review of Resident #52's Admission Record revealed diagnoses to include unspecified dementia with an onset date of 2/22/24 and classified upon admission. Review of the significant change in status MDS, Section I - Active Diagnoses, with an ARD of 4/3/24 revealed a neurological diagnosis to include non-Alzheimer's dementia. Review of Resident #52's active physician orders as of 6/5/24 revealed medication to include: Lorazepam 0.5 mg for anxiety/agitation. Start date 5/25/24. Review of Resident #52's PASRR, Level 1 Screen dated 9/15/22 revealed no qualifying mental health diagnosis. Review of the medical record revealed no evidence of an updated PASRR, Level 1 to include a qualifying mental health diagnosis. 4. Review of Resident #19's Admission Record revealed an admitted [DATE]. Further review of Resident #19's Admission Record revealed diagnoses to include Alzheimer's disease, unspecified with an onset date of 5/1/24 and classified upon admission. Further review of diagnoses revealed dementia with an onset date of 5/1/24 and classified upon admission. Review of the MDS Section, I - Active Diagnoses with an ARD of 5/5/24, revealed a neurological diagnosis to include Alzheimer's disease. Review of the MDS, Section N - Medications, with an ARD of 5/5/24 revealed medications to include antidepressant. Review of Resident #19's PASRR, Level 1 Screen dated 5/1/24 revealed no qualifying mental health diagnosis. Review of the medical record revealed no evidence of an updated PASRR, Level 1 to include a qualifying mental health diagnosis. On 6/05/24 at 3:22 p.m., an interview with Staff O, Social Worker (SW), Interim stated she was aware there are issues with the PASRRs. During the interview Staff U, the new Social Service staff member, was present. The SW, Interim stated Staff U was going to assist with the PASRR issue. The SW, Interim stated, I told the Administrator we are probably going to get tagged but all we can do is move on. She stated she expected Medical Records and the new Social Service staff member to collaborate and communicate if there's a new diagnosis for a resident. 41015 5. Review of the Admission Record showed Resident #22 was admitted to the facility on [DATE] with diagnoses that included but limited to displaced intertrochanteric fracture on left femur, subsequent encounter for closed fracture with routine healing, Type 2 Diabetes mellitus with other complications, Fibromyalgia, Depression and Anxiety disorder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105343	A. Building B. Wing	06/06/2024

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #42's Preadmission Screening and Resident Review (PASARR) assessment, dated 05/09/24 revealed, under the section titled A. MI (Mental Illness) or suspected MI (check all that apply), the checkbox for the selection Anxiety Disorder and Depressive Disorder was not checked. Review of Resident #22's Admission Minimum Data Set (MDS) dated [DATE] Section I-Active Diagnoses showed Resident #22 had diagnoses of Anxiety disorder and Depression. During an interview on 06/05/24 at 3:22 p.m., Staff O Social Worker Interim (SW) stated, she was aware there was a lot of stuff missing on the PASARRs. Staff O SW stated Resident #22's PASARR was wrong and should have been updated to reflect Resident #22's current diagnoses. Staff O SW stated, I told the Administrator we are probably going to get tagged on PASARRs but all we can do is move on. 43453 6. Review of Resident #33's admission record revealed an admitted [DATE] with diagnoses to include vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, generalized anxiety disorder, major depressive disorder, single episode, unspecified convulsions, Narcolepsy other specified persistent mood disorders. Review of a quarterly Minimum Data Set (MDS) dated [DATE] section I showed, Resident #33 had the following diagnoses listed, Non-Alzheimer's Dementia, Seizure disorder or epilepsy, Anxiety disorder, Depression and Post Traumatic Stress Disorder (PTSD). Review of a level I PASARR for Resident #33 dated 01/12/18 revealed the qualifying diagnoses were not checked and recommendations for a level II PASARR were not acted upon. 7. The admission record for Resident #62 revealed the resident was admitted to the facility on [DATE] with diagnoses to include unspecified dementia unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, major depressive disorder, recurrent, mild and generalized anxiety disorder. Review of a level I PASARR for Resident #62 dated 08/18/23 revealed a blank PASARR without any diagnosis checked. On 06/05/24 at 11:35 a.m., an interview was conducted with the Director of Nursing (DON). She stated they had a previous social worker who was in the process of updating PASARRs. The DON stated she did not get very far. The DON reviewed the PASARR's with the surveyor and said, Yes, I see the PASARR is blank. All the diagnoses should be checked for qualifying diagnosis. The DON stated their expectation was for the Social Services Director (SSD) to check PASARRs to see if they were accurate. She stated if they identified inaccurate PASARRs, they should have let her know so she could update them. She stated the previous SSD had started the Resident Review Requests for some residents requiring a level II. The DON said, I don't know if the referral was sent to the state agency for review. I will check. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/05/24 at 11:48 a.m., an interview was conducted with Staff O, interim SSD and Staff E, SSD. Staff O stated she had stepped in briefly to assist while they were in the hiring process. She stated she was only putting out fires. She stated the previous SSD did not follow -up with providing documentation for the paperwork requested for level II PASARRs. She said, It should have been done. Staff E, SSD stated she had received training and would start reviewing PASARRs to make sure they were updated. She confirmed the PASARRs that were reviewed were missing diagnoses. Review of a document titled, Admission Criteria, Revised March 2019, showed: (9.) All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID), all related disorders (RD), pause the Medicaid pre admission screening and resident review (PASARR) process. a.) The facility conducts A level one PASARR screen for all potential admissions, regardless of payor source to determine if the individual meets the criteria for a MD, ID or RD. b.) If the level one screen indicates that the individual may meet the criteria for a MD, ID or RD, he or she is referred to the state PASARR representative for the level II (evaluation and determination) screening process. (1) the admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID or RD. (2) the social worker is responsible for making referrals to the appropriate state designated authority.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on record review, interview and review of the facility's policies Care Plans, Comprehensive Person-Centered and Pain Assessment and Management, the facility failed to develop a care plan for pain management for one Resident (Resident #22) and diabetic management with insulin use for one Resident (Resident #80) out of twenty sampled residents reviewed for development of care plans. Findings included: During an interview on 06/03/24 at 9:48 a.m., Resident #22 stated, I had fallen prior to coming to the facility and broke my leg. Resident #22 stated her leg began to heal but was set wrong, so the hospital had to go in and rebreak it and set it correctly. Resident #22 stated after the procedure she came to the facility but stated she was in pain. Resident #22 stated the facility gave her something for pain but felt as though that pain medication did not help much. Resident #22 stated the facility offered her morphine, but she declined as she felt that was too strong and would prefer something stronger than what she was getting but not as strong as morphine. Review of the Admission Record showed Resident #22 was admitted to the facility on [DATE] with diagnoses that included but limited to displaced intertrochanteric fracture on left femur, subsequent encounter for closed fracture with routine healing, Type 2 Diabetes mellitus with other complications, Fibromyalgia, Depression and Anxiety disorder. Review of the Order Summary Report showed Resident #22 had a pain regimen that consisted of the following orders: -Percocet Oral Tablet 5-325 [milligrams] MG (Oxycodone w/ Acetaminophen) *Controlled Drug*- Give 2 tablet by mouth every 4 hours as needed for non-acute pain. -Pregabalin Oral Capsule 100 MG (Pregabalin) *Controlled Drug*-Give 1 capsule by mouth two times a day for pain related to Fibromyalgia Review of Resident #22's Admission Minimum Data Set (MDS) dated [DATE] Section I-Active Diagnoses showed Resident #22 had diagnoses of anxiety disorder and Depression. Section J- Health Conditions showed Resident #22 had received scheduled pain medication regimen and received PRN pain medications. Section N-Medications showed Resident #22 received a drug regimen of Opioid. Review of the Care Plan showed no care plan development for non-acute pain, fibromyalgia or any pain management area of focus. During an interview on 06/05/24 11:31 a.m., Staff P, Registered Nurse (RN) Minimum Data Set (MDS) Coordinator stated any Resident with pain should be care planned for it. Staff P RN, MDS Coordinator reviewed Resident #22's MDS and stated that she was assessed for pain and received pain medications on the Admission MDS dated [DATE] but was not triggered for pain to go on the care plan. Staff P RN, MDS Coordinator stated that pain management for non-acute pain and fibromyalgia should be included on Resident #22's care plan but was missing. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Facility's Policy Pain Assessment and Management Revised date March 2020 revealed, Purpose: The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. General Guidelines: 1. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan and the resident's choices related to pain management. 2. Pain Management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. 50570 2. A review of Resident #80's Admission Record revealed an admitted [DATE]. Further review of the Admission Record revealed a diagnosis to include type 2 diabetes mellitus with diabetic neuropathy, unspecified. A review of Resident #80's active physician orders dated 6/6/24 revealed Accucheck two times a day (start date 5/25/24), observations for hypoglycemia and hyperglycemia signs/symptoms (start date 4/9/24), glucagon injection 1 milligram (mg) (start date 5/26/24), Humulin 70/30 100 unit/milliliter (ML) (start date 5/15/24), and metformin HCl (hydrochloride) 500 mg (start date 5/30/24). A review of Resident #80's current care plan revealed no evidence of focus, goals or interventions/tasks related to physician's orders specific to insulin for diabetes management or observations for hypoglycemia and hyperglycemia signs/symptoms. Review of the admission Minimum Data Set (MDS), Section I - Active Diagnoses, with an Assessment Reference Date (ARD) of 4/13/24 revealed a metabolic diagnosis to include Diabetes mellitus (DM). Review of the MDS, Section N - Medications, with an ARD of 4/13/24 revealed medications to include insulin injections and a hypoglycemic. An interview on 6/6/24 at 10:59 a.m. with Staff P, MDS coordinator, Registered Nurse (RN) revealed Resident #80 does have a care plan for diabetes management. An observation of the MDS coordinator/RN reviewing Resident #80's current care plan revealed he has a care plan for pressure ulcers, nutritional risk, and potential oral/dental health concerns related to diabetes. After reviewing the current care plan further, she stated he doesn't have a diabetes care plan related to insulin use. She stated, I will add it now. An observation of the MDS Coordinator/RN revealed she started creating a care plan for insulin use related to diabetes. An interview on 6/6/24 at 12:21 p.m. with the Director of Nursing (DON) revealed she expects care plans to follow physician orders. She stated the care plan typically includes, Medication or treatments as ordered by physician. The DON stated she is okay with this in Resident #80's care plan related to diabetes and insulin use. She stated she would expect a change to the care plan as the resident's disease process changes. The DON stated, Our residents change frequently. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Facility's Policy Care Plans, Comprehensive Person-Centered Revised date March 2022 revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .2. The comprehensive, person-centered care plan is developed within seven days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status) and no more than 21 days after admission .7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practical physical, mental and psychosocial well-being. e. reflects currently recognized standards of practice for problem areas and conditions.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observations, interviews and record reviews, the facility did not ensure care was provided in accordance with professional standards by failing to ensure Hospice care coordination was in place for 2 (#12 and #52) of 4 residents with a Hospice diagnosis and did not ensure one resident (#5) out of 5 residents received appropriate care and services related to behaviors. Findings included: 1. On 06/03/24 at 01:32 p.m., Resident #12 was observed in bed sleeping. The resident did not respond to the interview. An immediate interview was conducted with the Responsible Party who was visiting. She stated the resident was on Hospice. She stated the resident had declined significantly and she occasionally expressed pain. Review of the admission record for Resident #12 revealed an admitted [DATE] with a primary diagnosis of hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 kidney disease. Review of June 2024 physician orders for Resident #12 showed the resident was followed by [Name of Hospice] for palliative care, resident under care of [Name of Hospice] and a phone number was listed effective 04/28/23. Review of Resident #12's care plan, dated 05/17/23 showed a focus, the resident has terminal prognosis related to disease. Interventions included working cooperatively with hospice team to ensure the resident's spiritual, intellectual, physical and social needs are met. A second focus initiated on 03/14/23 showed the resident had advanced directives . Palliative care through Hospice. Interventions initiated on 04/28/23 showed the resident was receiving hospice services with [name of Hospice]. Review of Resident #12's electronic record showed the resident did not have a specific Hospice care plan and did not have a Plan of Care related to contracted Hospice services from the provider's end. Review of the electronic record showed there were no care notes related to collaboration of care between the facility and the Hospice provider. 41015 2. An observation on 06/03/24 at 9:13 a.m. revealed Resident #5 laid in bed with a bloody forehead. Further observation showed Resident #5 had a bloody area on the left side of her chest area. Resident #5 was non-verbal and did not response to Surveyor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/03/24 at 9:13 a.m., Staff N Certified Nursing Assistant (CNA) stated Resident # 5 was known to pick her skin and she must have been picking this weekend as she had new picking spots especially on her chest. Review of the Admission Record showed Resident #5 was initially admitted to the facility on [DATE] with diagnoses that included but not limited to Alzheimer's Disease, Dementia in other diseases classified elsewhere unspecified severity with behavioral disturbances, disorganized Schizophrenia and generalized anxiety disorder. Review of the Order Summary Report showed Resident #5 had the following orders: -Geodon Oral Capsule 40 [milligrams] mg (Ziprasidone HCl)- Give 1 capsule by mouth one time a day for schizoaffective disorder. Give with 20 mg = 60 mg -Observation: Behaviors. Observe for the following: 1. itching, picking at skin; 2. restlessness, agitation; 3. hitting, kicking, physical aggression; 4. spitting, biting; 5. cussing, yelling; 6. delusions, hallucinations, psychosis; 7. refusing care; 8. isolation, withdrawn, depression; 9. wandering, pacing; 10. insomnia; 11. disorganized thinking; 12. abnormal motor behaviors; 13. negative symptoms (neglect personal hygiene, avoids eye contact, lacks facial expression, monotone speech); 0. NO Behaviors.- every shift Non-pharmacological interventions: 1. diversion, re-direction; 2. activities,music; 3. resident expressed feelings, 1-to-1 interaction; 4. snack, drink; 5. calming environment, relaxation techniques, aromatherapy; 6. alternate staff member; 0. NO Behavior. Review of Resident #5's Care Plan showed, Focus- Behavior: [Resident #5] has a behavior problem. She has scabs on her face that she picks at and then places in her mouth. Yells out despite needs being met. Expresses delusional thoughts and ideas. Goal- [Resident #5] will have fewer episodes of picking the scabs on her face by review date. Decreased episodes of yelling out and delusional expressions. The Interventions included: -Administer medications as ordered. Monitor/document for side effects and effectiveness. - Anticipate and meet the resident's needs. - Assist the resident to develop more appropriate methods of coping and interacting. Encourage the resident to express feelings appropriately. - Caregivers provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. - Explain all procedures to the resident before starting and allow the resident adequate time to adjust to changes. - If reasonable, discuss with [NAME] her behavior. Explain/reinforce why behavior is inappropriate. - Offer white gloves as needed to assist in picking - Praise any indication of the resident's progress/improvement in behavior. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Provide a program of activities that is of interest and accommodates the resident's status. Rolling yarn. Review of the May 2024 Treatment Administration Record (TAR) showed Resident #5 had no behaviors observed between the dates of 05/01/24 through 05/31/24. Review of the June 2024 Treatment Administration Record (TAR) showed Resident #5 had no behaviors observed between the dates of 06/01/24 through 06/04/24. Review of Resident #5's skin assessments showed the following: A Skin Observation dated 06/1/24 revealed Skin intact, no new skin issues noted. A Skin Observation dated 05/25/24 revealed Skin intact, no new skin issues noted. A Skin Observation dated 05/18/24 revealed Skin intact, no new skin issues noted. A Skin Observation dated 05/11/24 revealed Skin intact, no new skin issues noted. A Skin Observation dated 05/04/24 revealed Skin intact, no new skin issues noted. A review of Progress Notes showed Resident #5 had no notes that discussed any picking behavior or any change of condition to show increased picking behavior. An observation on 06/05/24 at 10:00 a.m., revealed Resident #5 was in bed with multiple scabs visible on her forehead. During an interview on 06/05/24 at 10:11 a.m., the Director of Nursing (DON) stated Resident # 5 just had a gradual dose reduction (GDR) on Geodon medication that she had received for years, and the picking behavior may have started again because of the GDR. The DON went immediately to assess Resident #5 and confirmed Resident #5 had active scabs from picking. The DON stated she would have expected her staff to have identified the behavior, completed a change of condition and documented the behavior on the behavior monitoring section of the Treatment Administration Record TAR. Review of the Facility's policy Change in Resident's Condition or Status revised date February 2021 revealed 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information or the provider, including (for example) information prompted by the Interact SBAR Communication Form. 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. 50570 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the Admission Record revealed an original admitted [DATE] and a re-entry date of 1/23/24. Further review of the Admission Record revealed diagnoses to include hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, acute on chronic systolic (congestive) heart failure, chronic kidney disease, stage 3B, unspecified severe protein-calorie malnutrition, and unspecified dementia. Further review of Resident #52's Admission Record revealed an advanced directive to include, . Comfort Measures Only [vendor name] . for Palliative care. Review of Resident #52's active physician orders revealed [vendor name] for palliative care with an order date of 5/23/2024. Review of Resident #52's current care plan revealed a focus, with an initiation date of 11/04/2022, for advanced directives. The focus for advanced directives in Resident #52's current care plan revealed he receives palliative care through [vendor name]. Review of Resident #52's Minimum Data Set (MDS) Section O - Special Treatments, Procedures, and Programs, dated 4/3/24, revealed treatments to include hospice care. Review of Resident #52's electronic medical record to include progress notes from 5/6/2024 to 6/6/2024, miscellaneous documents, and assessments showed no evidence of plan of care or notes from hospice services. An interview on 6/5/24 at 11:38 a.m. with the Director of Nursing (DON) revealed the facility does not have hard charts. She stated, Everything is electronic. An interview on 6/5/24 at 1:55 p.m. with Staff J, Registered Nurse (RN) Supervisor, revealed hospice notes are not in the resident's medical record. She stated the hospice nurse and doctor have access to the facility's electronic medical record. The RN Supervisor stated, The hospice progress notes don't go into our medical record. The RN Supervisor suggested asking the medical records staff member to see if they have hospice notes. An interview on 6/5/24 at 2:18 p.m. with Staff V, Medical Records, stated if the hospice progress notes or plan of care are not in the resident's electronic medical record then, We don't have it. She stated she doesn't have hospice notes that haven't been scanned into the residents' charts. An interview on 6/5/24 at 2:18 p.m. with Staff P, MDS coordinator/RN, stated she was never told the resident's medical record had to have hospice progress notes or plan of care. She stated the process for communicating with hospice is that nursing staff consults hospice. The MDS coordinator/RN stated hospice will accept the resident or not depending on their assessment. She stated the hospice nurse gives the facility her orders. She stated the hospice nurse sees their residents, On a regular basis, or as often as the resident needs. The MDS coordinator/RN stated if there's any changes to include medications or plan of care, the hospice nurse or doctor will let the facility staff know. She stated if hospice changes orders or discontinues orders then it'll be under medication records. The MDS Coordinator/RN stated, The hospice staff tells the nursing staff what they did with the resident. She states the process is that hospice staff notifies the facility nurse, and then the facility nurse puts a note in the system. (continued on next page)

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	105343	A. Building B. Wing	06/06/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 6/5/24 at 2:25 p.m. with the DON revealed hospice has a new system and portal. She stated the facility staff have access to the hospice system to see their notes. The DON confirmed there should be documentation of hospice's plan of care in the residents' medical record to coordinate care with the facility. She stated if the facility gets orders from hospice, then they send them over through fax. The DON stated the faxed orders are printed and the orders are implemented. On 6/5/24 at 2:28 p.m. the MDS coordinator/RN brought the hospice resource binder. Review of the binder did not show evidence of progress notes from hospice. Review of the facility's policy titled, Hospice Program, with a revised date of July 2017 revealed the following in the Policy Interpretation and Implementation: . 13. Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental and psychosocial well-being.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46234 Based on observations and interview, the facility failed to ensure sufficient staff to meet the needs of 30 residents on one (400 - secure) of four units during mealtime and for 30 residents on one (400 - secure) of four units for activities over three (06/03/2024, 06/04/2024 and 06/06/2024) out of four days observed. Findings included: An observation was conducted on 6/3/24 at 10:50 a.m. of Resident #17 sitting in the dining room on the 400 unit. No staff were interacting with the resident, she had nothing at the table to do, and there were no activities going on. The resident remained in the same spot at 1:48 p.m. No staff interacted with the resident or provided any stimulation. No activities were observed throughout the day on 6/3/24. An observation was conducted on 6/3/24 at 11:59 a.m. during lunch service in the 400-unit dining room. Lunch trays were being set up for residents. There were only two staff members in the dining area to pass trays, set up food, and assist residents. Twenty-three residents were present in the dining area. One resident was wandering around the dining area going up to other tables and residents. Resident #64 was sitting at a table in the dining room with her lunch in front of her. The resident had her hands in her food and was putting her canned drink in the food as well. No one was assisting or cueing Resident #64. At 12:06 p.m. Resident #64 continued playing in her food, no staff member had noticed or spoken to the resident. At 12:17 p.m. the resident remained seated at the table with food spilled in her lap and on the table. She was continuing to play with her drink which had been poured into the plate. The resident also began chewing on her napkin. There had been no staff interaction with the resident. The two staff members present in the dining room were assisting other residents and setting up food. (Photographic evidence obtained) An interview was conducted on 6/6/24 at 10:05 a.m. with Staff Y, Registered Nurse (RN). She said she knows Resident #64 well. She said the resident can feed herself if it is finger food. She said the resident plays in her food and makes a mess. She said the resident had done that since admission. She said the resident needs to be redirected or assisted when she starts making a mess. When asked about only having two staff members assisting in the 400-unit dining room she said they get swamped in there. At 11:59 a.m. Resident #10 was observed to already have her food set up in front of her but was not receiving assistance. At 12:27 p.m. the resident remained sitting in the same position with her food relatively untouched. No staff member had spoken to the resident during this time to ask if she needed assistance or if she would like something else and the resident received no cueing. At 1:34 p.m., after lunch services had been completed, Resident #10 was still sitting at the dining room table with a partially eaten plate of food in front of her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105343	A. Building B. Wing	06/06/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:59 a.m. Resident #17 was observed to be sitting in a high back wheelchair pushed up to the table. Her food had been set up in front of her, but she had not eaten. At 12:29 Staff G, Certified Nursing Assistant (CNA), approached the resident to assist her with eating. Staff G then got up and took Resident #17's meal to the supply room and microwaved it. When Staff G returned to the table, she assisted the resident, and the resident began to help feed herself. An interview was conducted with Staff G at that time. She said she had to heat Resident #17's meal because it was ice cold from just sitting there. She said the resident wants Staff G to sit and assist her with eating every day. Staff G said if she assists to begin with, the resident will start eating some on her own. An interview was conducted on 6/3/24 at 12:14 p.m. with Staff D, CNA. He said there are several residents in the dining room that need assistance and are not getting it. He was observed going from table to table trying to assist multiple residents at a time. Observations conducted on the 400-unit throughout the day on 6/4/24 showed very little interaction with residents. Staff were moving around the facility and residents were left sitting in the dining room/activities area all day. Occasionally a resident was observed to have a toy sitting on the table in front of them. An observation was conducted on 6/4/24 at 5:14 p.m. during dinner service on the 400 unit. At 5:14 p.m. dinner trays were being passed to residents. At 5:30 p.m. staff continued to pass and set up food for residents in the dining room. A CNA was observed setting up a tray for a resident while the resident across the table was trying to grab that resident's food. The first resident was getting upset and yelling at the second resident to stop grabbing her food. The CNA did not interact with the resident across the table, he quickly set up the first resident's food and walked off to continue passing more trays. The second resident continued to reach for the first resident's food and the first resident was getting more and more upset. No staff were paying attention or trying to redirect the resident to stop the situation from escalating. As it continued the first resident stood up and threw a cup of juice on the second resident. Only then did staff come over and try to redirect the second resident. An interview was conducted on 6/3/24 at 11:05 a.m. with a family member of Resident #75. She said she comes almost daily and assist with Resident #75's care, including feeding him lunch. She said they do not have enough staff on the 400-unit to care for that population. She said it is a struggle to get them to give her family member a shower and not just a quick bed bath. An interview was conducted on 6/4/24 at 5:48 p.m. with a family member of Resident #30. Resident #30 resides on the 400 unit. She said she comes to the facility daily to assist her mother with dinner and to get her ready for bed. She said at least four days a week her mother had not had her brief changed for hours. She said at dinner there is usually only 1 CNA in the dining room assisting with meals. She said there is not enough staff on the 400 unit to care for the residents. Observations conducted on the 400-unit throughout the day on 6/5/24 showed very little interaction with residents. At 11:05 a.m. 11 residents were sleeping sitting up in the dining room/activities area and 3 residents were flipping through/playing with magazines, and 5 residents were sitting at tables awake with no staff interaction or activities. (continued on next page)

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	105343	A. Building B. Wing	06/06/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Throughout the days on 6/3, 6/4, and 6/5/24, residents in the 400 unit were placed in the dining room/activities area and left there all day, apart from the residents that can ambulate or self-propel. The residents were not taken back to their rooms to rest and had very little interaction/activities while in the dining room/activities area. The dining room/activities area is at the center of the facility and is a bright, noisy environment. An interview was conducted on 6/6/24 at 12:54 p.m. with the Director of Nursing (DON)/Staff Coordinator. She said the 400 unit is typically staffed with 1 nurse and 4 CNAs during the day, two stay in the dining room/activities area to engage residents and 2 work on the hall. The DON said the residents on the 400 unit need more attention and assistance and always need to be redirected. She said the two CNAs in the dining room/activities area should have been doing activities with residents and made sure residents were engaged. She said the activities director puts together programming for the unit and the CNAs should follow the activities programming. She said during meals an additional CNA from the hall should have been in the dining room and the nurse should have been in there assisting as well. The DON said it is absolutely not ok for a resident to be playing in their food and receiving no redirection or cueing from staff. An interview was conducted on 6/5/24 at 2:52 p.m. with the Activities Director. She said she is the only activities person for the facility. She said she plans and activities program for the 400-unit and posts it on the board in the dining room/activities area daily. She said the CNAs that work on the unit are supposed to follow through with the activities on the board. She said she tries to keep it consistent for the residents. The Activities Director said she does art expressions and music in the mornings and works with the residents on the 400 unit from 6:00-8:00 in the morning. She said she then does activities for the rest of the facility and depends on the CNAs to do the activities on the 400 unit. She said she thinks the staff are trying the best they can, but said the residents do need to be engaged and also need time to rest. 48223 On 6/3/2024 at 10:00 AM an observation occurred in the memory unit's dining/activity room. The activity room had 10 residents sitting around tables and 4 residents wandering around the room. One Certified Nursing Assistant (CNA) Staff G was observed sitting at the table closest to the door to the hallway, with the staff members back to the resident's entrance to the activity/dining room. A resident was observed near the Resident entrance, trying to pull out a chair from the table. The resident was not having success and became agitated. Another resident was in a wheelchair at this table and went to assist the resident. The resident standing did not want assistance and swatted at the other resident. On 6/3/2024 at 11: 35 AM an observation occurred in the memory unit's dining/activity room. Resident #49 started to yell at Resident #46 for wandering near. Resident #49 continued to escalate and reached out for Resident #46's wrist. Resident #46 pulled away but was corned by Resident #49. Staff B, Licensed Practical Nurse (LPN) came of the office and separated the residents. On 6/4/2024 at 5:18 PM an observation occurred of the memory unit's dinner meal. 24 residents were observed in the dining/activity room with 3 CNAs passing trays. Residents were wandering around the activity/dining room reaching onto other resident's trays for food, wandering over to the discarded plates and taking food off the plates and ingesting, and some residents were sitting in front of their trays not eating. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/4/2024 at 11:30 AM Staff D, CNA stated the activity/dining room is usually like this, chaotic, there is a lot going on, too much not enough staff to watch and assist with all elements of our jobs. During an interview on 6/4/2024 at 5:30 PM Staff C, CNA stated not enough staff - cannot get our job done and too much going on. During an interview on 6/4/2024 at 5:40 PM Staff F, CNA stated there looks like 4 staff members should ok, but 2 staff members are activities. These activities staff are CNAs but don't assist with any care, not really sure of their purpose. During an interview on 6/5/2024 at 1:15 PM Staff E, CNA stated struggling to get the job done, no extra time for anything. During an interview on 6/5/2024 at 1:30 PM Staff B, Licensed Practical Nurse (LPN) stated the activity/dining room is usually very hectic. The atmosphere is loud, not calming as usually the two TVs are on different channels competing. The lighting is always on with the bright white, fluorescent light bulbs. The residents don't get any time to rest or be calm they are always being over stimulated with loud noise. The residents need small, short group activities. Mostly only activities occur in the early morning hours with the Activity Director. The remainder of the day the residents are just left to wander. During an interview on 6/5/2024 at 4:45 PM Staff A, LPN stated the (memory care) unit is quite lively not necessarily in a good way. Usually there are 2 CNAs on the floor to assist residents and one in the dining/activity room. After dinner the residents need to be assisted with getting ready for bed, provide calming routines, we just don't have time for that. During an interview on 6/6/2024 at 12:54 PM the Nursing Home Administrator (NHA) and Director of Nursing (DON) stated they base the staffing on acuity. The NHA works with the DON to determine the acuity on level of assist, cognition. If need 1:1 need an extra person. A policy and procedure was requested for staffing in the memory unit; however, one was not provided.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on interviews and record review, the facility did not ensure residents who entered arbitration agreements understood the contract contents for three residents (#342, #22 and #87) of three residents sampled. Findings included: 1. During an observation and interview conducted on 06/05/24 at 03:03 p.m., Resident #342 stated she had signed the arbitration agreement during orientation. She stated a young man came to the room the other day with a stack of papers and had her sign all kinds of paperwork. She said, To be honest I don't know what that is. Everything was mumbo jumbo (meaning confusing or meaningless). I told my husband to listen to him. The resident and surveyor reviewed the Arbitration Agreement with her signature dated 06/03/24. She said, Yes that is my signature. I don't remember him saying anything about waiving my rights. The resident stated the staff member may have explained those things. I just was not in my right mind. The resident stated I still do not understand it. The resident asked, why should I waive my right to an attorney? The resident stated she did not remember anything said about revoking the arbitration agreement within 30 days. Review of the admission record for Resident #342 revealed an admitted [DATE]. An admission Minimum Data Set (MDS) dated [DATE] showed Resident #342 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, meaning intact cognition. The record showed Resident #342 was her own person. On 06/06/24 at 01:27 p.m., an interview was conducted with Resident #342's family member. He stated he was present when the resident signed the paperwork. He stated the Admissions Coordinator explained the arbitration paperwork but, it was over her head. He said, I stepped in and asked questions. I did not sign it. They did not ask me to sign. She definitely did not understand it, but I did. The family member stated the resident was her own person. 2. Review of the Admission Record for Resident #22 revealed an admitted [DATE]. Review of an Admission Minimum Data Set (MDS), dated [DATE], showed Resident #22 had a BIMS score of 05 out of 15, meaning severe impairment. On 06/06/24 at 09:48 a.m., an interview was conducted with care conference contact/next of kin who signed Resident #22's admission paperwork on 05/10/24. The next of kin stated she was not Resident #22's healthcare surrogate nor her POA (Power of Attorney). She stated she did not know if she had signed an arbitration agreement. She said, I don't know what an arbitration agreement is. The next of kin asked the surveyor to explain what that meant. She stated, I was reeling about the paperwork they gave me to sign. It was a lot. I don't want to be held responsible for her decisions legally. I don't know if I signed it. I may have signed it among all the other papers. 3. Review of the Admission Record for Resident #87 revealed an admitted [DATE]. Review of an Admission Minimum Data Set (MDS), dated [DATE], showed Resident #87 had a BIMS score of 12 out of 15, meaning intact cognition. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 06/06/24 at 10:07 a.m. with Resident #87's Responsible Party. The Responsible Party stated she did not remember signing anything about a dispute resolution procedure. She stated she had signed a lot of paperwork that day. She said, I would not have waived my rights to go to court. Why would anyone do that? No, they did not say I could revoke it either. The Responsible Party stated she did not really understand the legal stuff. She stated she signed a bunch of paperwork. She said, I do not remember anyone explaining what that meant. I still don't know what that means. On 06/05/24 at 11:58 a.m., an interview was conducted with Staff Y, Admissions Coordinator. He stated he assisted with admissions paperwork to include reviewing their Dispute Resolution Procedure. He states he takes the time to explain the paperwork to the residents and/or their representatives. He states he confirms the resident's cognition and also assesses their ability to comprehend at the time of admission. He stated he asks family members who are present to participate. He stated some of the residents have high BIMS bust still would not understand the Arbitration Agreement. He stated the language can be somewhat legal. He said, In that case, I ask the family members to participate but the resident still signs if they are their own person. If they can't, I ask the family to help. An interview was conducted on 06/06/24 at 10:45 a.m. with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). They stated the expectation was to make sure the residents/representatives understood it was not a condition for admission. The NHA stated, We explain it to them. I can understand how the admission paperwork can be overwhelming. On 06/06/24 at 11:36 a.m., an interview was conducted with Staff R, Admissions Coordinator. She stated the first thing they do is to assess if the resident was incapacitated and if they had a next of kin. She stated they present the Arbitration Agreement along with the other orientation paperwork. She stated the residents go to nursing staff first and sign medical authorizations and then admissions department follows with the rest of the intake paperwork. She stated some of the authorizations are duplicated and the residents find it repetitive. She said, I can understand how the process can be overwhelming. We do our best to make sure they know what they are signing. On 06/06/24 at 11:30 a.m., Staff R stated they did not have a specific policy on arbitration agreements.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on observations, interview, and policy review, the facility failed to ensure proper infection control practices during medication pass for three out of three observations, for one of one CPR backboard, and during dining on one (100) out of four hallways. Findings included: An observation was conducted on [DATE] at 9:09 a.m. of Staff H, Licensed Practical Nurse (LPN) during medication pass. Staff H was observed preparing medication for a resident, she then administered the medication, took two bottles of body cleanser another resident handed her, then returned to the medication cart and documented on the computer. During this process Staff H did not perform any hand hygiene. At 9:19 a.m. Staff H began pulling medication for a second resident. She left to get medication from the medication room and performed hand hygiene upon returning to the cart. Staff H continued preparing medication for the second resident, put on gloves and crushed/opened medication and placed in pudding, removed gloves, then administered the pudding with medication to the second resident. The nurse returned to the medication cart without performing hand hygiene and proceeded to document in the computer. An interview was conducted on [DATE] at 9:25 p.m. with Staff H, LPN. The nurse acknowledged that she did not do proper hand hygiene and said she should have cleaned her hands before and after each medication administration. An observation was conducted on ,d+[DATE] at 9:50 a.m. with Staff I, Registered Nurse (RN). Staff I was noted to have artificial nails that extended ,d+[DATE] inch passed the end of her finger. While preparing medication for a resident, Staff I used her fingernail to pull a pill out of the bottle. While preparing another medication, the proper dose was not available in the medication cart so Staff I said she would break a pill in half. Staff I did not perform hand hygiene, she picked up the pill with her bare hands and broke the pill in half. Staff I entered the resident's room, prepped and hung an IV medication, put gloves on to administer a nose spray, removed gloves, took the resident's blood pressure, administered oral medication, then returned the nose spray to the medication cart and placed the used blood pressure cuff on top of the medication cart. Staff I never performed hand hygiene throughout this process and the blood pressure cuff was not cleaned prior to returning it to the medication cart. An interview was conducted on [DATE] at 2:48 p.m. with Staff I, RN. Staff I confirmed she did not do hand hygiene during medication pass. She said she thought about it after she was finished and realized she forgot. Staff I also confirmed she broke a pill with her hands without using gloves. She said she knows she shouldn't touch pills when she takes them out of the container. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on [DATE] at 4:28 p.m. with the Director of Nursing (DON)/Infection Preventionist (IP). She stated staff should wash their hands between each resident and be cautious of what they touch while in the resident rooms, being careful not to touch items their lips might touch. The DON/IP said if a nurse needed to break a pill, she would expect them to put gloves on or use the plastic packets intended for crushing pills. She said she would never recommend breaking a pill with your hands. The DON/IP also said blood pressure cuffs should be cleaned between each resident and should not be placed on the medication cart without being cleaned. An observation was conducted during a tour on [DATE] at 10:28 a.m. of the code cart in the hallway with a piece of wood on top with unfinished edges and cracks in the wood. On [DATE] at 12:10 p.m. the piece of wood remained on top of the code cart. An interview was conducted with Staff J, RN. She confirmed the piece of wood on the code cart was the back board used on residents during cardiopulmonary resuscitation (CPR). When asked how the board is sanitized after use, she said she guessed bleach wipes were used but she didn't know if they worked on wood. (Photographic evidence obtained.) During the tour on [DATE] at 10:28 a.m. bedside tray tables were also observed in rooms [ROOM NUMBERS] with unfinished edges/top causing particle board to being exposed creating an uncleanable surface. An interview was conducted on [DATE] at 1:40 p.m. with the DON. She was observed inspecting the CPR back board and confirmed it is a porous surface and agreed it could be an infection risk. She said the board typically gets cleaned with sanitizing wipes and she would order a new one. The DON was also shown the exposed particle board on the tray tables and said those should have been reported by staff in the maintenance request system. She said the tables should have been replaced and said the cork surface would be an infection risk. 48223 41015 An observation on [DATE] between 5:33 p.m. to 6:00 p.m. on 100-hallway for dinner tray pass revealed Staff M Certified Nursing Assistant (CNA) not hand sanitizing between tray delivery. At approximately 5:41 p.m. Staff M CNA was observed picking up a cup that had fallen on the floor in room [ROOM NUMBER]. Staff M CNA was then observed walking across the hall to room [ROOM NUMBER] bathroom and State Agency (SA) Surveyor heard the toilet flush. Staff M CNA then walked across the hallway to room [ROOM NUMBER] bathroom where he came out with paper towels and back into room [ROOM NUMBER] to clean up the spill off the floor. Staff M CNA was then observed completing tray pass without hand hygiene. During an interview on [DATE] at 6:00 p.m. Staff M CNA stated questionably you want me to wash my hands between each room? State Agency (SA) Surveyor asked Staff M CNA about his hand hygiene practices in which the CNA M aggressively responded I wash my hands and complete tray pass and proceeded to walk away from the State Agency (SA) Surveyor. During an interview on [DATE] at 8:35 a.m., the Administrator stated that she expected Staff M CNA to hand sanitize between trays and when discussed with Staff M CNA he informed her that he just forgot. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy, Handwashing/Hand Hygiene revised date [DATE] revealed., 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .o. Before and after eating or handling food; p. Before and after assisting a resident with meals. Review of the facility's policy, Infection Prevention and Control Program revised date [DATE] showed, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Review of the facility's policy, Cleaning and Disinfection of Resident-Care Items and Equipment revised date [DATE] showed, Resident- care equipment, including reusable and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfecting and the OSHA Bloodborne Pathogens Standards. Review of the facility's policy, Medication and Administration General Guidelines revised date [DATE] showed, .2. Handwashing and Hand Sanitization: The person administering medications adheres to good hand hygiene, which includes washing hands thoroughly before beginning a medication pass, prior to handling any medication, after coming in direct contact with a resident, before and after administration of ophthalmic topical, vaginal, rectal and parenteral preparations, and before and after administration of medications. A. Examination gloves are worn when necessary. B. Hand Sanitation is done with an approved sanitizer, between handwashing, when returning to the medication cart or preparation area (assuming hands have not touched a resident or potentially contaminated surface and at regular intervals during the medication pass such as after each room, again assuming handwashing is not indicted. C. Sanitation is not a substitute for proper handwashing, and washing should be done if there is any question.