STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105442	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haines City Rehabilitation and Nursing Center	409 S 10th St Haines City, FL 33844

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 50732 Based on observation and interview, the facility failed to ensure a clean and comfortable environment by not maintaining and cleaning one (B Hall) of two community shower rooms. Findings included: On 11/18/2024 at 9:40 a.m., an observation was made of the B Hall community shower room. Upon entering the shower room, it was observed to be cluttered and disorganized. Located on the left-hand side just after entry was a restroom with a toilet and sink. Next to the room with the toilet, there was a shower with a curtain. On the other side of the room there were two sinks. The clutter of the room made it hard to get to the other two sinks. The clutter observed included a privacy curtain, various wheelchair parts, Hoyer lift, bedside commode and a walker. (Photographic evidence obtained). The observation of the shower room also included: 1. The foam mat laying on the top of the shower bed had a dried brown substance on the top. 2. On the shower bed underneath the foam mat and on the mesh part of the bed, there were dried brown and black objects as well as hair. 3. In a corner of the room there was a trash bucket; the lid was sitting on the floor next to the trash bucket; inside the trash bucket there were soiled gloves. The lining of the trash bucket was soiled with a brown substance. 4. The Hoyer lift pad, which was placed on the Hoyer lift, was soiled with a brown substance. 5. The grout in the shower was dirty with a black-brown substance. 6. Next to the entry door of the shower room there was a clump of hair on the wall. 7. The Hoyer lift itself had dirt, dust and a dried brown substance on it. 8. Trash and wheelchair attachments were on the floor. 9. A dirty band aid on the floor of the shower. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10. Hair on the shower floor. 11. Ripped and stained shower curtains. On 11/19/2024 at 9:33 a.m., an observation was made of the B Hall community shower. The observation was the same as the previous day's observation with no cleaning or organizing having been done. An interview was conducted on 11/20/2024 at 3:00 p.m. with Staff H, Director of Environmental Services. The Environmental Services Department includes the Housekeeping Department. He said a housekeeper starts the day at 7:00 a.m. cleaning the front lobby and the offices. The other housekeeping staff work from 9:00 a.m.-5:30 p.m. Staff H, Director of Environmental Services, said the housekeepers were assigned unit halls and were expected to clean the hallways, resident rooms, nurses' stations, and shower rooms. He said the shower rooms were cleaned once per day. Before entering the shower room Staff H, Director of Environmental Services, said he had not seen the current condition of the room. He said housekeeping responsibilities for cleaning the shower rooms include cleaning the floors, walls, toilets and sinks. He said he expected the shower rooms should be cleaned by 10:00 a.m. every day. He said curtains, which include resident rooms and the shower rooms, were checked one unit hall per week and replaced or cleaned if they are dirty. He agreed the curtains in the shower room needed to be changed. He also agreed the shower room did not look clean, appealing or organized. He said in the shower rooms the Certified Nursing Assistants who gave resident showers were responsible for picking up any dirty linen, cleaning up any bodily fluids, cleaning the equipment, and disinfecting the area(s) used while giving resident showers. During an interview on 11/21/2024 at 2:47 p.m., Staff W, CNA said it was the CNA's responsibility in the shower room to clean up after themselves after showering a resident. She said the CNA's were to pick up any dirty linen or towels, clean the shower area, disinfect and clean any equipment that was used during the resident's shower. Staff W said they were really busy and did the best they could to clean everything up as fast as possible. She said if another CNA did not clean up after showering a resident, she would tell the other CNA to clean it up and if it did not get done she could report it to the manager. During an interview on 11/21/2024 at 3:00 p.m. with the Nursing Home Administrator (NHA), he said he was not aware of the issues in the shower room. He said he had not been in the shower rooms lately. The NHA said he would talk to Staff H, Director of Environmental Services and get the shower rooms cleaned and organized. Review of the General Cleaning Policies and Procedures Resident Room - Clean, which was not dated, was provided by the Staff H, Director of Environmental Services, did not reveal specific guidance for cleaning the community shower rooms.

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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. 20536 Based on observation, interview, and record review, the facility failed to ensure one (#61) of forty-eight sampled residents, was provided with personal hygiene fingernail care during at least three of four days observed (11/18/2024, 11/19/2024, 11/20/2024). It was observed all ten of the fingernails were found with dark debris and were long, cracked/chipped and leaving sharp edges. Findings included: On 11/18/2024 at 2:10 p.m., Resident #61 was visited while in her room. She was observed residing in a private room and was noted in her bed lying flat with the Head of Bed (HOB) approximately 30 degrees. Resident #61 was further observed with her hands placed on her lap, over the bed linen. All ten fingernails were observed elongated approximately 1/2 inch to 3/4 inches, cracked and chipped with sharp edges. Further, the under nails were observed with build up of dark debris/matter. An interview with Resident #61 revealed she had impaired cognition, but was able to speak with regards to her daily routines and she was able to speak related to her personal hygiene and nail care. Resident #61 confirmed her nails were too long and that they had sharp edges. She did not know what all the debris was, which was packed under her finger nails. She confirmed she did not like her nails long, did not like them chipped and did not like having debris/matter under her fingernails. Resident #61 revealed she had asked staff to clip her fingernails in the past and at least three times since her admission. She could not remember which Certified Nursing Assistant (CNA) she told, but she remembered she had spoken to several of them. Resident #61 revealed that each time she had asked for nail care in the past, the CNA's would just tell her they would get to it, but they never did. Resident #61 revealed she did receive showers during her scheduled shower days, and she did not refuse showers or personal hygiene care. On 11/19/2024 at 8:10 a.m., 3:20 p.m., 11/20/2024 at 8:02 a.m., 9:52 a.m., 2:00 p.m., Resident #61 was visited in her room. She presented both of her hands for observation and it was revealed all ten fingernails were still elongated, cracked, chipped and still with dark debris under her nails. Resident #61 revealed she did ask about nail care during the evening shift on 11/20/2024 but staff never came back to do it. She could not remember what staff member she spoke with. .On 11/20 at 9:55 a.m Staff A, who was Resident #61's assigned CNA, was interviewed with relation to personal hygiene and nail care. Staff A revealed Resident #61 required full staff assistance with personal hygiene including showers/baths and nail care. Staff A, also revealed the resident was provided with a bed bath yesterday and she would typically want bed baths. Staff A revealed she usually would scrub the resident's fingers and finger nails to get debris out but was unaware her finger nails were long, cracked and chipped and with debris under the nails. Staff A went in Resident #61's room and confirmed the nails needed care to include clipping and cleaning. Staff A confirmed that as part of their routine daily assignment, they were to look at the resident's personal hygiene to include fingernails. She revealed staff should recognize if nails needed to be clipped and cleaned. Staff A revealed if a resident was diabetic, usually the nurse would be the one to clip the nails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/2024 at 10:03 a.m., an interview with Staff B., who was the Station 1 Unit Manager, revealed Resident #61 was a newer admission and at the facility less than one month. Staff B was aware the resident required maximal assistance with her Activities of Daily Living (ADLs) to include shower/bath and personal hygiene. Staff B explained that she was not aware the resident wanted nail care, but at the very least CNAs should have observed her for the need of nail care and/or cleaning. Review of the current Physician's Order Sheet for the month 11/2024 showed the following but not limited to: a. Weekly skin checks every Tuesday during day shift with an order date of 10/22/2024. Review of the nurse progress notes dated from 10/17/2024 to current 11/20/2024 showed no behaviors of refusing personal hygiene to include nail care. Review of the Admission Minimum Data Set (MDS) assessment and dated 10/24/2024, showed Cognition/Brief Interview Mental Status or BIMS score - 5 which indicted severe cognitive impairment; Mood - none documented as observed during the assessment timeframe; Behavior - None documented as observed during the assessment timeframe; ADL - Shower/Bathing including washing, rinsing, and drying self - Substantial/Maximal assistance; Personal Hygiene the ability to maintain personal hygiene including combing hair, shaving, apply make up, washing/drying hands - Substantial/Maximal assistance. Review of the Restorative Nursing Program Initial Evaluation dated 11/11/2024 revealed: Section#1 Assessment/Evaluation diagnosis - Need for Assistance with Personal Care, Weakness. A. Restorative Nursing Program for bed mobility and goal to include: Static and dynamic sitting and standing balance for carryover with ADL tasks to prevent contracture. Review of the current Care Plans with a next review date 1/18/2025 showed the following areas: (a) ADL self care deficit related to activity tolerance ADL needs and participation vary, Limited Mobility with interventions in place to include but not limited to: Extensive Assist for ADL care this may fluctuate with weakness, fatigue and weight bearing status; On 11/21/2024 at 9:47 a.m., the Director of Nursing (DON) was interviewed. She was knowledgeable with regards to Resident #61 and with her daily care and services. The DON revealed the resident had cognition deficits and required maximum assistance with all her Activities of Daily Living (ADL) to include personal hygiene. The DON revealed she was made aware yesterday, 11/20/2024, the resident required finger nail cleaning and trimming and made sure it was completed. The DON revealed it was the expectation of the aide and nurse who were assigned to the resident to look for personal hygiene needs to include nail care, on a daily basis. Review of the ADL Care and Services policy and procedure, with a last revision date of 1/2024 showed the following. The Policy Standard revealed; Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Guidelines section of this policy revealed; Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. The Procedure section of this policy revealed; 1. Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) are met. 4. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, nail care and oral care); 6. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observation, record review and interview the facility failed to ensure a hazarded free room environment, with (brand name) Air Freshener Spray found in one resident room, Resident (#99) out of eight residents sampled. Findings include: During an observation on 11/18/2024 at 10:00 a.m., and 12:41p.m., Resident #99's room was observed with the door open, where other residents were able to enter the room. Her dresser was observed with two air freshener sprays. The bathroom was observed with one additional air freshener spray on the bathroom rail over the toilet. During an interview on 11/19/2024 at 10:00 a.m., with Resident #99. She stated the staff took away her air fresheners today. She stated she has had her sprays on her dresser for about a month but was told by staff today they had to take it away because she is not allowed to have air freshener sprays in her room. Review of an Admission Record dated 11/21/2024 showed Resident #99 was admitted to the facility originally on 6/4/2024 and readmitted on [DATE] with diagnoses to include but not limited to Dysarthria Following Cerebral Infractions, Type 2 Diabetes Mellitus Without Complications, Unspecified Asthma, Uncomplicated. Review of Quarterly Minimum Data Set (MDS) dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 9 which indicated moderate cognitive impairment. During an interview conducted on 11/21/2024 at 2:00 p.m., with the Nursing Home Administrator, (NHA), the NHA stated when a resident is admitted to the facility, they conduct a 24-hour meeting to discuss the facility's guidelines with the resident. They also conduct a follow-up discussion during the care plan meeting in which they go over the facility do's and don'ts. If a resident has air freshener in the room, they find out if the resident is alert. If the resident is alert the facility would provide the resident with a lock, and they are allowed to have items locked up in their rooms. If they can't use the lock, they would have the discussion with the resident's family to tell them not to bring in air freshener. During an interview conducted on 11/21/2024 at 2:30 p.m., with the Director of Nurses (DON) the DON stated she was not aware that Resident #99 had air freshener spray in her room. She stated the resident orders a lot of items that are delivered to the facility. She stated that Aerosol sprays are not allowed in the facility, so staff should have taken the spray out of the resident room and educated her about the facility process. She stated she will have to do further training with her staff and residents about the use of Aerosol spray. (Photographic Evidence obtained) The facility did not have a policy to provide related to the prohibited use of Aerosol Sprays.