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	01/13/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to start a medication timely for one resident (#1) of three residents sampled.Findings included: On 01/13/26 at 9:35 a.m. Resident #1 was observed sleeping with the head of the bed elevated. No odors were noted. A dressing was in place on her left cheek dated 01/12/2026. Her call light was within reach. Resident #1 was admitted on [DATE]. Review of the admission Record showed diagnoses included but not limited to CVA (Cerebrovascular Accident) with hemiplegia, diabetes, stage III chronic kidney disease, hypertension and Alzheimer's disease. Review of the quarterly Minimum Data Set (MDS) dated [DATE] showed a blank Brief Interview for Mental Status (BIMS) score. Section C-Memory- showed resident is rarely/never understood. Section GG showed the resident required substantial / maximal assistance for toileting and bathing/ and partial / moderate assistance for transferring. Review of a progress note dated 12/12/25 at 11:54 a.m. showed the orthopedic office called to give report on resident's status and new treatment orders post-surgery.New order for Tramadol 50mg every 8 hours as needed, Keflex [Cephalexin] 500 mg 4x daily x 10 days. [Family Member] escorted resident to appointment and has been notified of post-surgery orders. Awaiting resident's return. Signed by Staff A, Licensed Practical Nurse, Unit Manager (LPN/UM)Review of the physician orders showed Cephalexin 500 mg (milligrams) to be given 4 times a day (QID) starting 12/13/2025. Review of the December Medication Administration Record (MAR) showed Cephalexin 500 mg give 4 times a day was started on 12/13/2025 with the 5 p.m. and 9 p.m. doses administered. The review showed the Cephalexin 500 mg was not entered in Resident #1's physician orders on 12/12/2025, resulting in Resident #1 missing two doses. The review further showed on 12/14/25 the 9:00 a.m. dose was held, resulting in a delay of 4 doses and one more dose not administered on 2/14/25 at 9 a.m., a total of five missed doses. Review of the progress notes showed on 12/13/25, at 2:29 p.m. Cephalexin 500 mg entered give QID post- surgical for 10 daysReview of the progress notes showed on 12/14/25, at 8:16 a.m. Cephalexin, awaiting on MD approval to administer due to allergies to penicillin. Resident #1 did not receive the 9 a.m. dose. Review of the care plans showed the resident at risk and / or have actual impaired cognitive function/impaired thought processes related to CVA as of 04/23/2025. Interventions included but not limited to administer medications as ordered. During an interview on 01/13/2026 at 1:48 p.m. Staff A, LPN/UM, nurse for Resident #1 stated the resident usually goes with the family for her procedures. She stated the transportation person would give the paperwork to our staff if it was given to her. Staff A stated they had been unable to find any paperwork from the resident's ortho doctor. Staff A stated, You are correct, we should be getting the orders from the doctor not depending on the family to give them to us. Staff A stated she wrote the note about the antibiotic order on 12/12/2025. Staff A stated she gave the orders to the floor nurse on 12/12/2025. Staff A stated, My bad, it may not have been put in until the next day by the resident's nurse. I should have put the orders in myself. Staff A verified the resident had a delay (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of 4 doses. Staff A stated they may have been able to get the medication out of the emergency medications kit. Review of the facility's policy titled, Physician Orders, revised 01/2024, showed orders and administration of medications and treatments will be consistent with principles of safe and effective order writing. Procedure:1. Medications shall be administered upon the written order of a person duly licensed and authorized to prescribe such medications in this state as soon as practicable.2. Authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record.3. Drug and biological orders must be recorded on the physician's order sheet in the residence electronic chart.5. Verbal orders should be recorded in the resident's chart by the authorized person receiving the order and should include the prescriber's name credentials, the date and the time of the order.6. Orders should be transcribed by the authorized person receiving the order and recorded in the resident's medical record.7. The entry should contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information.9. Physician order should be followed as prescribed, and if not followed, this should be recorded in the resident's medical record during that shift. The physician should be notified and the responsible party if indicated. Review of the facility's policy titled, Medication Administration, revised 01/2024 showed medications are ordered and administered safely and as prescribed.3. Medications are administered in accordance with prescribing orders, including any required time limit.5. Medication errors are documented, reported, and reviewed by the QAPI (Quality Assurance and Performance Improvement) committee to inform process changes and or need for additional staff training.7. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss the concerns.