STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105470	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fernandina Beach Rehabilitation and Nursing Center	1625 Lime Street Fernandina Beach, FL 32034

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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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 43857 Based on record review and interviews, the facility failed to provide form CMS-10055 (Skilled Nursing Facility Advance Beneficiary Notices) to two (Residents #55 and #456) of three residents sampled for review of beneficiary notices. The findings include: A review of Resident #55's medical record revealed that her Medicare Part A Skilled services began on 1/5/24 and ended on 2/28/24. Resident #55's CMS 10055 form was not provided. A review of Resident #456's medical record revealed that his Medicare Part A Skilled services began on 3/9/24 and ended on 4/15/24. Resident #456's CMS 10055 form was not provided. On 6/26/24 at 2:35 PM, an interview was conducted with Regional Field Analyst U. She stated the Social Services Department was responsible for filling out and providing the forms. She further stated the CMS 10055 forms were not completed because the Social Services Department was not aware of it. On 6/26/24 at 2:36 PM, an interview was conducted with Social Services Director P. She stated she was not aware that she had to complete the CMS 10055 forms. She further stated she would complete and provide those forms from now on.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43857 Based on observations and interviews, the facility failed to maintain a clean and home-like environment in four (Rooms 106, 114, 163, and 166) of 62 occupied rooms. The findings include: On 6/25/24 from 9:00 AM to 1:00 PM, the following observations revealed environmental concerns: room [ROOM NUMBER] had bubbled paint around the air conditioner unit, built-up dust and debris on the air conditioner vent, and the air conditioner unit was detached from the wall. room [ROOM NUMBER] had black-colored markings on the air conditioner unit's front panel (resembling biological growth), built-up dust and debris on the air conditioner vent, and the air conditioner was detached from the wall. room [ROOM NUMBER]-A had trim falling off the wall behind the bed's headboard. room [ROOM NUMBER]-A had trim behind the bed's headboard that was detached from the wall and the dresser's top drawer was broken. (Photographic evidence obtained) On 6/27/24 at 9:12 AM, a follow-up tour was conducted with Environmental Director/Plant Operation Director V, who observed room [ROOM NUMBER]'s bubbled paint around the air conditioner unit and stated the facility would repaint and properly seal the air conditioner unit to the wall. He observed room [ROOM NUMBER]'s air conditioning unit and stated it would be cleaned and reattached to the wall. He observed room [ROOM NUMBER]-A's trim behind headboard that was falling off the wall and stated he was planning to place a skinny board there and get rid of the trim. He observed room [ROOM NUMBER]-A's trim behind the bed and the broken top drawer of the dresser and stated both would be fixed. Upon completing the tour, he stated the facility had a plan to conduct room audits next week and get everything fixed. He further stated sometimes it was good to have State in the building because things would get done.

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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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 50783 Based on medical record review and interviews, the facility failed to protect, in a timely manner, the resident's right to be free from verbal abuse/threat to deprive the resident of services by a staff member for one (Resident #79) of a total of 42 residents in the sample. The findings include: During an interview with Resident #79 on 06/25/24 at 1:20 PM, she stated, Staff ignore me. No one will answer my call light. The staff are always outside my door laughing at me in the hallway since the other day. She stated on Sunday (06/23/24) she reported the following incident to Social Services Director (SSD) P, stating, [Certified Nursing Assistant (CNA) M] told me that I could not go back to bed after my therapy session, and I had to stay up for two hours. I was in a lot of pain, and I asked for pain medication, but the nurse did not bring it. I told the other CNA that [CNA M] should not keep doing this to me. I did call her (CNA M) a bitch when I said that. [CNA M] came back into my room and told me her name was not bitch. She grabbed her name badge and pulled it down and said, My name badge does not have bitch on it. From now on when you press your call light, I will not answer it anymore. Resident #79 began to cry and placed her forehead in her hands. Resident #79 stated, I have tried apologizing several times and explained that I was in pain and very tired. I wanted to go lie down. I didn't mean to call her a bitch, but now no one answers my call light when I need something. A review of the resident's Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 06/03/24, revealed a brief interview for mental status (BIMS) score of 15 out of 15 possible points, indicating intact cognition. Section C (Mood) and Section D (Behaviors) revealed no indicators of mood changes or behavioral issues. During an interview with SSD P on 06/25/24 at 1:40 PM, she stated, Once a complaint, concern, or grievance is reported, I immediately write it down on the grievance form. If I can handle or resolve the concern, I will go ahead and complete it. If the concern involves a resident and a staff member, I will take the grievance to the appropriate nursing supervisor, usually the Director of Nursing (DON) or the Administrator. When she was asked whether she had received any concerns or grievances from or related to Resident #79, she stated she would need to review her grievance log. Upon review of the facility's grievances with SSD P, it was noted that there were two grievances that Resident #79 had filed with SSD P, one on 05/30/24 and the other on 06/24/24 as follows: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A grievance dated 05/30/24 read: [Resident #79] is missing her purse/wallet, items in her wallet and $50.00. (Photographic evidence obtained) The investigation section of the grievance form, documented by SSD P, revealed that all the resident's items had been located and returned to her. The grievance form indicated that the investigation was completed and resolved on 06/03/24. When SSD P was asked if she was aware that Resident #79 was stating that the fifty dollars from her wallet was still missing, SSD P replied, No, everything was returned to her. SSD P was asked if she recalled a grievance having been filed by Resident #79 on Sunday, 06/23/24, regarding CNA M. SSD P stated, I vaguely remember the resident saying something about that. When she was asked to produce the grievance from 06/23/24, she replied, It's in my other book. I will have to go get it. When asked what other book she was referring to, she stated, These grievances are all resolved and the ones that are still being investigated are on my desk in another book. A grievance dated 06/24/24 read: Call light response is not timely, and resident would like her care service needs to be addressed faster. (Photographic evidence obtained) There was no documentation in the grievance investigation section verifying that the investigation was initiated or completed. When SSD P was asked if this grievance had been resolved, she stated nursing education was started and nursing management (DON and Assistant DON (ADON) were responsible for providing that education. I write out the training and then give it to the nursing staff to complete the training; however, the facility has not had an ADON or a DON consistently since I have been here, and I have been here since December (2023). When she was asked to provide a copy of the training, she replied, I will have to get it. It's on my desk in a folder; however, like I said, we haven't had anyone to do the nursing staff education for the last five to six weeks. She left the room to get the other grievance book and staff education from her office, but never produced the book or education for review. On 06/26/24 at 11:46 AM, an interview was conducted with the Administrator who had three grievances in hand. She stated, I understand you wanted to see these forms. One of the three grievances was filed by Resident #79 on 06/24/24. The Administrator was asked when she received this grievance and she stated, today or late yesterday evening (06/25/24). (Photographic evidence obtained) A review of the grievance with the Administrator (also Abuse Coordinator), revealed that a CNA had not gotten the resident to bed right away and she had soiled herself. Upon further review and interview, the Administrator was not aware of the details of the grievance. She stated, I will go talk with the resident now and start the investigation immediately. On 06/26/24 at 5:37 PM, the Administrator stated another Administrator from a sister facility (Administrator O) had conducted an interview with Resident #79 and an investigation was ongoing. The incident would be reported immediately. A review of the facility's policy for Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, and Injury of Unknown Origin (Issued: 8/2022, Revised: 1/2024), revealed that residents had the right to be free from abuse. Abuse was defined as a willful infliction of injury, unreasonable confinement, intimidation, or punishment that resulted in physical harm, pain, or mental anguish. Verbal abuse consisted of written, oral, or gestured language that included disparaging or derogatory comments to the resident within hearing distance. The center would train all new employees and existing employees about the prevention and response to abuse. The center would seek and accept concerns, complaints, and/or grievances from residents and resident family members. An employee having any direct or indirect knowledge that might be considered abuse was expected to report the event promptly within two hours after the allegation was made.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 50783 Based on medical record review and interviews, the facility failed to ensure that all alleged violations involving abuse/mistreatment and misappropriation of resident property, were reported no later than two hours after the allegation was made, if the events that caused the allegation involved abuse, to the Administrator and to other officials, including the State Survey Agency, for one (Resident #79) of 42 residents in the survey sample. The findings include: During an interview with Resident #79 on 06/25/24 at 1:20 PM, she stated, Staff ignore me. No one will answer my call light. The staff are always outside my door laughing at me in the hallway since the other day. She stated on Sunday (06/23/24) she reported the following incident to Social Services Director (SSD) P, stating, [Certified Nursing Assistant (CNA) M] told me that I could not go back to bed after my therapy session, and I had to stay up for two hours. I was in a lot of pain, and I asked for pain medication, but the nurse did not bring it. I told the other CNA that [CNA M] should not keep doing this to me. I did call her (CNA M) a bitch when I said that. [CNA M] came back into my room and told me her name was not bitch. She grabbed her name badge and pulled it down and said, My name badge does not have bitch on it. From now on when you press your call light, I will not answer it anymore. Resident #79 began to cry and placed her forehead in her hands. Resident #79 stated, I have tried apologizing several times and explained that I was in pain and very tired. I wanted to go lie down. I didn't mean to call her a bitch, but now no one answers my call light when I need something. A review of the resident's Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 06/03/24, revealed a brief interview for mental status (BIMS) score of 15 out of 15 possible points, indicating intact cognition. Section C (Mood) and Section D (Behaviors) revealed no indicators of mood changes or behavioral issues. During an interview with SSD P on 06/25/24 at 1:40 PM, she stated, Once a complaint, concern, or grievance is reported, I immediately write it down on the grievance form. If I can handle or resolve the concern, I will go ahead and complete it. If the concern involves a resident and a staff member, I will take the grievance to the appropriate nursing supervisor, usually the Director of Nursing (DON) or the Administrator. When she was asked whether she had received any concerns or grievances from or related to Resident #79, she stated she would need to review her grievance log. Upon review of the facility's grievances with SSD P, it was noted that there were two grievances that Resident #79 had filed with SSD P, one on 05/30/24 and the other on 06/24/24 as follows: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A grievance dated 05/30/24 read: [Resident #79] is missing her purse/wallet, items in her wallet and $50.00. (Photographic evidence obtained) The investigation section of the grievance form, documented by SSD P, revealed that all the resident's items had been located and returned to her. The grievance form indicated that the investigation was completed and resolved on 06/03/24. When SSD P was asked if she was aware that Resident #79 was stating that the fifty dollars from her wallet was still missing, SSD P replied, No, everything was returned to her. SSD P was asked if she recalled a grievance having been filed by Resident #79 on Sunday, 06/23/24, regarding CNA M. SSD P stated, I vaguely remember the resident saying something about that. When she was asked to produce the grievance from 06/23/24, she replied, It's in my other book. I will have to go get it. When asked what other book she was referring to, she stated, These grievances are all resolved and the ones that are still being investigated are on my desk in another book. A grievance dated 06/24/24 read: Call light response is not timely, and resident would like her care service needs to be addressed faster. (Photographic evidence obtained) There was no documentation in the grievance investigation section verifying that the investigation was initiated or completed. When SSD P was asked if this grievance had been resolved, she stated nursing education was started and nursing management (DON and Assistant DON (ADON) were responsible for providing that education. I write out the training and then give it to the nursing staff to complete the training; however, the facility has not had an ADON or a DON consistently since I have been here, and I have been here since December (2023). When she was asked to provide a copy of the training, she replied, I will have to get it. It's on my desk in a folder; however, like I said, we haven't had anyone to do the nursing staff education for the last five to six weeks. She left the room to get the other grievance book and staff education from her office, but never produced the book or education for review. On 06/26/24 at 10:34 AM, Resident #79 was interviewed again regarding the missing items from the grievance she filed on 05/30/24. When she was asked if the facility had found her missing purse/wallet, items in her wallet, and the missing fifty dollars, she stated, Yes, they brought my wallet and items back to me, but I never got my fifty dollars back. It is still missing. On 06/26/24 at 11:46 AM, an interview was conducted with the Administrator who had three grievances in hand. She stated, I understand you wanted to see these forms. One of the three grievances was filed by Resident #79 on 06/24/24. The Administrator was asked when she received this grievance and she stated, today or late yesterday evening (06/25/24). (Photographic evidence obtained) A review of the grievance with the Administrator (also Abuse Coordinator), revealed that a CNA had not gotten the resident to bed right away and she had soiled herself. Upon further review and interview, the Administrator was not aware of the details of the grievance. She stated, I will go talk with the resident now and start the investigation immediately. On 06/26/24 at 5:37 PM, the Administrator stated another Administrator from a sister facility (Administrator O) had conducted an interview with Resident #79 and an investigation was ongoing. The incident would be reported immediately. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy for Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, and Injury of Unknown Origin (ANEMMI - Issued: 8/2022, Revised: 1/2024), revealed that residents had the right to be free from abuse. Abuse was defined as a willful infliction of injury, unreasonable confinement, intimidation, or punishment that resulted in physical harm, pain, or mental anguish. Verbal abuse consisted of written, oral, or gestured language that included disparaging or derogatory comments to the resident within hearing distance. An employee having any direct or indirect knowledge that might be considered abuse was expected to report the event immediately to the Administrator, their immediate supervisor, and either the Director of Nursing, Abuse Prevention Coordinator, or Risk Manager after the allegation was made. Any employee was empowered to call the Abuse Hotline if they suspected such an event occurred; however, they were also responsible for notifying management as previously mentioned. All allegations of ANEMMI would be immediately reported to the Abuse Hotline by the Administrator. With regard to Immediate and 5-Day reports, the policy reflected the verbiage in the Federal regulation at F609.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47306 Based on record review and staff interview, the facility failed to 1) Provide the appropriate transfer/discharge notice to the resident and their responsible party, and 2) Notify the Office of the State Long-Term Care Ombudsman in writing of a resident transfer to the hospital for one (Resident #70) of two residents reviewed for transfer/discharge and hospitalization , from a total sample of 42 residents. The findings include: A review of Resident #70's medical record revealed that she was transported to the hospital on 4/30/24 for right foot pain, fever, and nausea. A progress note dated 5/3/24 revealed that she was transferred back/readmitted to the facility on [DATE] from the hospital with a diagnosis of cellulitis to the right lower extremity. On 6/26/24 at 3:30 PM, an interview was conducted with the Administrator, who was informed that Resident #70's medical record contained no notification in writing to the resident's representative or the local Ombudsman of the resident's transfer to the hospital on 4/30/24. On 6/27/24, emails provided by the Administrator and addressed to the local Ombudsman notifying the Ombudsman of resident transfers and discharges were reviewed. The emails were dated 2/5/24, 3/6/24, and 4/10/24. There were no emails dated for the month of May 2024. Resident #70's name did not appear in any of the emails. On 6/27/24 at 10:07 AM, a follow-up interview was conducted with the Administrator regarding the emails to the local Ombudsman. The Administrator was asked if she had additional emails for the month of May 2024 that would verify notification of Resident #70's transfer to the hospital on 4/30/24. The Administrator replied no, the emails she provided were all she had. The Administrator was asked if she had documentation verifying notification of Resident #70's representative in writing of the transfer to the hospital on 4/30/24. The Administrator stated she did not. The Administrator stated she was not aware of a facility policy regarding notification of the local Ombudsman.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 47306 Based on record review, interview, and facility policy review, the facility failed to provide a Bed Hold notice to one (Resident #70) of two residents reviewed for transfer/discharge to acute care settings, from a total sample of 42 residents. The findings include: A review of Resident #70's medical record revealed a progress note dated 4/30/24 indicating that the resident was transported to an acute care hospital on 4/30/24. The record did not contain a Bed Hold notice for the transfer. On 6/27/24 at 10:07AM, an interview was conducted with the Administrator. The Administrator stated no Bed Hold notice was issued for the resident regarding her transfer to the hospital on 4/30/24. A review of the facility's policy titled Attachment A, Bed Hold Policy and Notification (Undated), revealed that it was facility policy to inform residents/legal representatives upon admission and after leaving the facility for hospitalization , observation, or therapeutic leave, of the facility's Bed Hold Policy and Notification. The policy indicated each resident/legal representative would be informed by staff of the facility's Bed Hold Policy and Notification upon admission to the facility and/or when a resident left for hospitalization , observation, or therapeutic leave.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45951 Based on observation, interview, and record review, the facility failed to ensure the maintenance of acceptable parameters of nutritional status, by failing to provide nutritional interventions in a timely manner to prevent significant weight loss for two (Residents #57 and #34) of five residents reviewed for nutrition, from a total sample of 42 residents. The findings include: 1. During a tour of the facility on 06/25/24 at 9:38 AM, Resident #57 was observed lying in her bed. She appeared thin. A review of the resident's medical record revealed she had suffered weight loss. On 12/23/23, Resident #57 weighed 108 pounds, and on 06/18/24, she weighed 84.7 pounds. This indicated the resident lost 21.57% of her body weight within six months. She was admitted to the facility on [DATE] with a medical history significant for dementia, anxiety, depression, weakness, transient ischemic attack (TIA), and osteoarthritis. A review of the Quarterly Minimum Data Set (MDS) assessment, completed on 04/12/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 possible points, indicating severe cognitive impairment. She required staff assistance to set up her meal trays, and it was documented that she had suffered unintentional weight loss. A Care Plan was revised during the survey week regarding Resident #57's weight loss. Review of the resident's active physician's orders revealed she was ordered to receive a regular diet with regular textured foods and thin consistency liquids. An order was written on 03/15/24 for Ensure chocolate nutritional supplement to be given three times a day. An observation was made on 06/25/24 at 12:45 AM of Resident #57 in her bed with her lunch meal tray. A staff member set her tray up for her. Continued observation revealed that she consumed approximately 25% of her meal. There was no Ensure supplement present on her tray. A review of her nutritional intake records revealed she had consumed zero percent of her Ensure supplement 41 times between 06/01/24 and 06/26/24. A 30-day look back of meal consumption revealed she consumed 50% or less of 48 of her documented meals. A review of progress notes regarding Resident #57's weight status, revealed that on 01/18/24, an Interdisciplinary Team (IDT) meeting discussed the weight loss, stating Overall decline and generalized weakness. Has had a significant weight loss recently. PO [oral] intake is poor. Doesn't go to the dining room anymore. Will try and bring her to the dining room to see if the environment during meals helps cue her to eat. Further review of progress notes revealed that on 01/31/24, an IDT meeting discussed the weight loss again, stating Can add Ensure Clear [supplement] TID [three times per day]. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An additional IDT meeting note was written on 02/15/24, stating, Eating in the dining room infrequently. Getting Ensure TID. Weight continues to trend down. Need to bring her to the dining room more frequently/consistently. A Quality of Care note written on 03/14/24, revealed, Reviewed for weight loss. Trending down overall. Poor PO intake. Getting Ensure Clear, dislikes. MD declined appetite stimulant. Can change to Ensure Chocolate TID. An observation was made on 06/26/24 at 1:18 PM of Resident #57 in her bed with her lunch meal tray. She consumed 0% of her meal. There was no Ensure supplement present on her tray. An interview was conducted with the facility's Dietitian on 06/26/24 at 3:58 PM. He stated he had been following Resident #57 for the last few months and that the IDT met weekly to discuss any residents with weight loss. He stated Resident #57 had been receiving Ensure supplements since February. He further stated they had started with Ensure Clear, but she did not like that supplement, so they changed to Ensure chocolate. He recalled speaking to Resident #57's physician about ordering an appetite stimulant, but the physician did not agree with that course of action. When asked what other interventions were considered to assist in stopping Resident #57's weight loss, the Dietitian stated the staff were instructed to encourage Resident #57 to go to the restorative dining room for her meals. When asked which meals she should be eating in the dining room, he stated the staff should be encouraging her at all meals to go to the dining room. When asked who was responsible for providing the Ensure supplements to the residents, he stated it was Nursing's responsibility to make sure the Ensure supplements were distributed to the residents at mealtimes. He further stated the kitchen was responsible for ordering the Ensure. When asked if any other interventions were considered for Resident #57's weight loss, he stated he felt the established interventions were having a positive effect, so he did not feel there was a need for additional interventions. An observation was made on 06/26/24 at 6:08 PM of Resident #57 in her bed with her dinner tray. There was no Ensure supplement present on her tray. Certified Nursing Assistant (CNA) A was observed assisting her with her meal. An interview was conducted with CNA A at this time. She stated she did not work for the facility but rather worked for a nurse staffing agency. She stated she was familiar with Resident #57 and had worked with her before. When asked if the resident required assistance with dining, CNA A stated she ate well with assistance. When asked what she had consumed at her other meals that day, CNA A stated the resident had not eaten her breakfast and that she had slept through her lunch. When asked if she had assisted Resident #57 with Ensure supplements that day or before, the CNA stated she had never helped her with Ensure. An interview was conducted with CNA B on 06/26/24 at 6:12 PM. She stated she worked for the facility, and she was familiar with Resident #57. When asked how residents received Ensure supplements, she stated the CNAs did not provide Ensure to the residents but maybe the nurses do. She stated, All I know is that the Ensures do not come from the kitchen on the trays. When asked if she recalled assisting Resident #57 with Ensure supplements, she stated she did not. (continued on next page)

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	105470	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fernandina Beach Rehabilitation and Nursing Center	1625 Lime Street Fernandina Beach, FL 32034

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Licensed Practical Nurse (LPN) C on 06/26/24 at 6:18 PM. She confirmed that the nurses kept the Ensure supplement bottles in their medication carts, and that they were responsible for providing them to the residents. When asked if she had been providing Resident #57 with her Ensure supplements, she stated she had not because Resident #57 did not like Ensure Clear. She said she had spoken to the Dietitian about changing her to chocolate, but that they had not. When told that the Ensure order had been changed in March to the chocolate, she stated she was not aware of that change. This indicated that Resident #57 was not receiving her physician-ordered supplement. An observation was attempted on 06/27/24 at 9:16 AM of Resident #57's breakfast tray. Resident #57 was in bed at the time of this observation, but the tray had been removed from the bedside. A staff member stated Resident #57 had consumed approximately 10% of her meal. A strawberry flavored Ensure was present on her bedside table and was approximately half consumed. An observation was made on 06/27/24 at 12:44 PM of Resident #57 in her bed with her lunch meal tray. Resident #57 had consumed 0% of her meal. There were two Ensure cartons present on her tray - one was the leftover strawberry flavor from her breakfast tray and was approximately 70% consumed. The other was chocolate and was unopened. 2. During a tour of the facility on 06/25/24 at 10:10 AM, Resident #34 was observed sitting up in her wheelchair. She appeared thin. A record review revealed that Resident #34 had suffered weight loss. On 12/03/23, she weighed 157 pounds, and on 06/17/24 she weighed 115.8 pounds. This indicated that Resident #34 lost 26.24% of her body weight in six months. Resident #34 was last admitted to the facility on [DATE] with a medical history significant for dementia, agitation, anxiety, schizoaffective disorder, depressive type, and malnutrition. A review of the resident's Quarterly MDS assessment, completed on 04/25/24, revealed she had a BIMS score of 8 out of 15 possible points, indicating a moderate cognitive impairment. Weight loss was documented as unknown. A Care Plan was revised during the survey week regarding Resident #34's weight loss. A review of the resident's active physician's orders revealed she was ordered to receive a regular diet with mechanical soft textured foods and thin consistency liquids. An observation was made on 06/26/24 at 9:13 AM of Resident #34 in her room with her breakfast tray. She had consumed 0% of her meal. A review of a 30-day look back of meal consumption revealed she had consumed 50% or less of 34 of her documented meals. A review of the Quality of Care notes written in March, April, and June 2024 revealed the staff were aware of unplanned weight loss. It was also documented that her oral intake was variable, and her diet had required a downgrade in April 2024 from regular texture to mechanical soft. No notes were found regarding weight loss interventions. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation was made on 06/26/24 at 1:19 PM of Resident #34 in her room with her lunch meal tray. She consumed 0% of her meal. When she was asked if she was going to eat her food, she said no. An interview was conducted with the facility's Dietitian on 06/26/24 at 4:13 PM. He stated he had been following Resident #34. He said she had triggered in the computer system for significant weight loss in March. He recalled, She used to be sprightly, but now not so much. He stated as a result of the weight loss, they initiated encouraging Resident #34 to go to the restorative dining room for her meals. He said the kitchen followed up with her regarding her food preferences and the Psychiatry team saw her due to her change in mood. When asked if any other interventions were considered for Resident #34's weight loss, he stated he felt the established interventions were having a positive effect, so he did not feel there was a need for additional interventions. An interview was conducted with CNA B on 06/26/24 at 6:13 PM. She stated she worked for the facility, and she was familiar with Resident #34. She stated Resident #34 was in the dining room for her dinner, but that she often ate in her room. She said depending on the day, Resident #34 decided where to eat her meals. Resident #34 had not eaten any of her breakfast or lunch that day, so she was hopeful that she would eat a good dinner. An observation was made on 06/27/24 at 9:15 AM of Resident #34 in her room with her breakfast tray. She had consumed 25% of her meal. An observation was made on 06/27/24 at 12:46 PM of Resident #34 in her room with her lunch meal tray. She had consumed 0% of her meal. When she was asked if she was going to eat her food, she said no.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50783 Based on observations, record reviews, and interviews, the facility failed to 1) Provide meals for one (Resident #23) of four residents receiving hemodialysis, and 2) Complete communication information forms for three (Residents #55, #413, and #13) of four residents receiving hemodialysis. The findings include: 1. On 6/25/24 at 10:30 AM, Resident #23 left for her dialysis appointment and did not receive a lunch or snack to take with her. Upon her return at 4:00 PM, she stated she was supposed to take a lunch with her; however, none was provided to her. This happens all the time. She said she had not had anything to eat since breakfast and was now having to wait until dinner time to eat. She confirmed that the facility was supposed to provide a snack or a lunch to take with her, but they never do. The resident's sister, present during this interview, stated, I am here every day, and they have not provided a lunch for her since her admission that I know of. (admitted on [DATE]) I usually buy her snacks to have when she gets back from dialysis. I have had to buy her lunch and take it to her at the dialysis center at times. During an observation of Resident #23's room on 6/25/24, her lunch was served in her room at 12:45 PM while she was out of the facility at dialysis. At 2:30 PM on 6/25/24, the lunch tray was no longer observed in the resident's room. An interview was conducted with Certified Nursing Assistant (CNA) S on 06/26/24 at 2:14 PM. She stated lunch trays were usually served around 1:00 PM on the units, but if staff knew that a resident had an appointment prior to that, they could request an early lunch tray or have a sack lunch provided for the resident to take with them. An interview was conducted on 6/26/24 at 2:06 PM with Registered Dietician (RD) Q. He stated the kitchen prepared and provided a lunch for all dialysis residents to take with them during their appointments. A communication form was filled out by the facility with any concerns or pertinent information. The residents took those with them to their dialysis appointments and the dialysis nurse used the forms to communicate any lab work, medications, resident vital signs, and/or weights prior to treatment and again post treatment. Upon the residents' return to the facility, the communication forms were kept in a binder at the nurses' station for the staff and the RD to review for information that may be needed to complete resident assessments. On 6/26/24 at 2:47 PM, an interview was conducted with Dietary Manager J who stated lunch trays were served on the units around 12:50 PM. For residents with an appointment before then, staff could request an early tray to be delivered to them before their appointment or take a sack lunch with them while they were out of the facility. She also stated for residents going to dialysis centers, the transportation driver would pick up the resident's lunch from the kitchen prior to them leaving for the appointment. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 6/26/24 at 11:45 AM, an interview was conducted with Licensed Practical Nurse (LPN) F, who stated all dialysis communication information was kept in a binder at the nurses' station. Further review of progress notes and dialysis communication forms located in a binder at the nurses' station and labeled Dialysis Communication Binder, revealed there was no documentation present for three of four residents receiving dialysis. (Residents #55, #413, and #13) On 6/26/24 at 12:00 PM, Corporate Nurse G was asked to provide dialysis communication forms for the residents receiving dialysis. On 6/26/24 at 4:31 PM, a second request was made to Corporate Nurse G for the dialysis communication forms for the residents receiving dialysis. A review of the dialysis communication forms provided by the facility, revealed that either section one was not completed by nursing facility staff prior to dialysis appointments, and/or section three was not completed by nursing facility staff upon the residents' return from dialysis. A review of the four dialysis residents' medical records revealed that the dialysis communication forms for all four were incomplete. Resident #55's dialysis communication forms were incomplete on 4/6/24, 6/20/24, 6/22/24, and 6/25/24. (Photographic evidence obtained) Resident #413's dialysis communication forms were incomplete on 6/20/24, 6/22/24, and 6/25/24. (Photographic evidence obtained) Resident #13's dialysis communication forms were incomplete on 6/6/24, 6/11/24, 6/13/24, and 6/18/24. (Photographic evidence obtained) On 6/26/24 at 6:06 PM, an interview was conducted with the Director of Nursing (DON). She stated communication between the facility and the dialysis center was conducted via a communication form that listed pertinent information about the resident such as lab work, nutritional status, vital signs, and the residents' status. The form was sent with the resident to the dialysis center on the days of their appointments. Upon their return, the form was checked to see if any concerns were addressed at the center during treatment, or if there were any recommendations that the facility should follow up on prior to the next treatment. The DON denied having any knowledge of a binder to keep the communication sheets in and further stated, Those sheets should go to medical records and then be uploaded in the computer. On 6/26/24 at 6:30 PM, an interview was conducted with LPN H at the nurses' station on Unit Two. She was asked to provide the dialysis binder used for communication with the dialysis center. She picked up the binder that was sitting directly in front of her and opened it, revealing only one communication form, dated 6/15/24. The nurse then stated, with Corporate Nurse G present, Oh no, the communication sheets are sent to medical records when the resident returns. We don't keep them in here anymore. On 6/26/24 at 7:10 PM, Corporate Nurse G stated the medical records office was locked, no one had access to the room, and the communication forms could not be obtained until the following morning. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/24 at 10:32 AM, Resident #23 was observed preparing to leave for her dialysis appointment. She was being assisted by staff into the transport van and was leaving the facility for her appointment. Further observation revealed that Dietary Manager J was standing at the front lobby desk holding a bagged lunch for Resident #23. When she was asked whether Resident #23 got her lunch, Dietary Manager J stated, No, she didn't get it. On 6/27/24 at 11:00 AM, an interview was conducted with Transportation Driver T. He stated it was his responsibility to ensure the resident's lunch was picked up from the kitchen to take with her, and to communicate with any outside transportation any care needs the resident may have during transport; however, the dialysis center did not allow them to eat while they were there. On 6/27/24 at 11:30 AM, the Regional Director of Clinical Practice stated she spoke with a nurse at the dialysis center and was told that the facility did not allow the residents to eat while being administered their treatment; however, they were more than welcome to eat prior to their treatment or after their treatment was completed while waiting for transportation back to the facility. She further stated the dialysis center encouraged the facility to supply their lunch to bring with the resident to the center. A review of the facility's policy titled Standards and Guidelines for Dialysis Care (Issued: 10/2014, Revised: 1/2024) revealed: The facility staff will provide information that is useful or necessary for the care of residents to the dialysis center. The facility will communicate with the dialysis center related to the resident's tolerance of treatment. The facility will provide a snack/meal to the resident per request, prior to or after dialysis appointments.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44730 Based on observations, interviews, and record review, the facility failed to maintain proper storage of medications for three (Residents # 51, #65, and #6) of 112 residents observed during the initial tour of the facility, one resident (#41) during an observation at one nurses' station (Station 2), and in one medication cart (Station 2 - C Hall) during a medication storage observation. The findings include: 1. On [DATE] at 9:29 AM, an observation was made of Resident #51's over-the-bed table, which revealed a clear medication cup sitting there with two orange-colored pills in the cup. Resident #51 stated the medication was her Vitamin C chewable tablets, and she liked to suck on them after she took her other medications because she did not have any teeth. (Photographic evidence obtained) On [DATE] at 10:29 AM, an interview was conducted with Licensed Practical Nurse (LPN) H. When shown a photograph of the medication observed on Resident #51's over-the-bed table the previous day, LPN H stated the medication was indeed Resident #51's Vitamin C, and she confirmed that she should not have left the medication at the resident's bedside. She stated she should have stayed with the resident until she took the medication. On [DATE] at 5:33 PM, an interview was conducted with the Director of Nursing (DON), who stated it was her expectation that all nurses remain with the residents until their medications had been taken. 45951 2. On [DATE] at 9:42 AM, an observation was made of Resident #65's room. A Budesonide inhaler (asthma medication) was on his bedside table. (Photographic evidence obtained) When asked if the staff always left this inhaler in his room for him, Resident #65 replied, sometimes. A review of the resident's medical record revealed he had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 possible points, indicating that he was cognitively intact. Further review of the medical record revealed he did not have an assessment present for safe self-administration of medication. An interview was conducted with the Director of Nursing on [DATE] at 4:28 PM. She confirmed she knew the inhaler had been left at Resident #65's bedside and that it had since been removed and properly stored in the medication cart. 3. On [DATE] at 10:07 AM, an observation was made of Resident #6's room. A box of Artificial Tears (eye drops), a Budesonide inhaler, and an Incruse Ellipta inhaler (treats chronic obstructive pulmonary disease including emphysema) were observed on her bedside table. (Photographic evidence obtained) When asked if the staff always left these medications in her room, Resident #6 replied, yes, always. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's medical record revealed she had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 possible points, indicating she was cognitively intact. Further review of the medical record revealed there were two assessments completed regarding safe self-administration of medication. The first was completed on [DATE] for eye drops and oral inhaler-Albuterol 0.83%, and the second was completed on [DATE] for Fluticasone nasal spray. Both assessments noted that the resident was safe to self-administer these medications. An interview was conducted with the Director of Nursing on [DATE] at 4:30 PM. She stated she was unaware of the medications found at Resident #6's bedside. She was pleased to hear that the assessments had been done but agreed that since they were more than three years old and did not match the current medications, new assessments should be completed. When she was asked if there was a policy regarding medication self-administration assessments, she replied that there was not. 4. On [DATE] at 12:40 PM, an observation was made at the Station 2 nurses' station of a stack of medication cards containing medications that was left unattended. (Photographic evidence obtained) Closer observation revealed the medication cards were labeled with Resident #41's information. Continued observation revealed that LPN C returned to the nurses' station at 1:18 PM. When she saw the medication cards, she asked, Did you take a picture of those? She was asked why the medication cards had been left unattended at the nurses' station for so long. She stated Resident #41 had been transferred from another hall to her hall just before lunch, and the person who brought him over had handed her the medication cards. She said she placed them at the nurses' station because she wanted to check and organize them before placing them in her medication cart. She stated she knew she shouldn't have left them out of the cart and loose on the desk where they could be seen and accessed by others. Corporate Nurse G was present during this interview. An interview was conducted with the Director of Nursing on [DATE] at 4:34 PM. She stated she was unaware of the medications/cards that had been found at the nurses' station. A medication room observation was made on [DATE] at 5:53 PM with LPN D at the Station 1 nurses' station medication room. Upon entering the room, LPN D asked if she could leave to continue her charting. She was made aware that she needed to stay in the room during the observation. Three personal drinks and a to-go container of fried chicken were observed in an upper cabinet of the medication room. (Photographic evidence obtained) When LPN D was asked if she knew who the drinks and food belonged to, she threw her hands up and said, I swear I was doing my work down the hall! I just came to the nurses' station to do my charting. She then called Nurse Manager F and LPN E for assistance. When they arrived at the medication room, LPN D promptly left. Nurse Manager F and LPN E removed the drinks and food from the medication room immediately. A medication cart observation was made on [DATE] at 6:09 PM with LPN C and Corporate Nurse G on the Station 2 C Hall. While reviewing the medication cart, one box containing five Acetaminophen Suppositories with an expiration date of ,d+[DATE] was found. (Photographic evidence obtained) LPN C and Corporate Nurse G stated they would dispose of the expired medication immediately. A review of the facility's policy titled Medication Administration (Revised ,d+[DATE]) revealed: Only persons licensed or permitted by this state to administer medications may do so. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled Medication Storage and Labeling (Revised ,d+[DATE]) revealed: Drugs used in the facility are stored in locked compartments. Only persons authorized to prepare and administer medications have access to locked medications; Drugs are stored in the packaging in which they are received; The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner; Outdated drugs are returned to the dispensing pharmacy or destroyed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 50783 Based on observations, record review, and interviews, the facility failed to maintain and document accurately on medication administration records for one (Resident #406) of 42 residents in the total sample. The findings include: A review of Resident #406's physician's orders revealed that the resident had an order for oxycodone HCl (narcotic pain medication) 10 mg (milligrams) every 4 hours as needed, ordered 6/18/24. A review of the June 2024 electronic Medication Administration Record (eMAR) revealed that Resident #406's Oxycodone 10 mg was documented as having been administered on 6/24/24 at 4:27 AM, 8:48 AM, and 1:53 PM. On the resident's narcotic sign-out sheet for Oxycodone 10 mg, the medication was signed out as having been administered on 6/24/24 at 4:27 AM and 1:53 PM. On the narcotic sign-out sheet, this medication was also signed out as having been administered on 6/24/24 at 8:26 PM, but it was not documented on the eMAR for this date and time. On 6/25/24, Oxycodone 10 mg was documented on the eMAR as having been administered at 9:39 PM, but the narcotic sign-out sheet showed the medication was administered at 7:40 AM, 11:17 AM, 3:22 PM, and at 10:00 PM. On 6/26/24, Oxycodone 10 mg was documented in the eMAR as having been administered at 11:20 AM and at 4:12 PM. The narcotic medication sign-out sheet for the same date indicated that this medication was administered at 11:20 AM, 4:12 PM, and at 11:00 PM. (Photographic evidence obtained) An interview with the Director of Nursing (DON) was conducted on 6/27/24 at 12:21 PM. The above-mentioned concern was discussed. The DON stated the medication, once administered, would be and should be documented in the eMAR. Once the medication was documented as having been administered, the eMAR would automatically flag for thirty minutes to an hour for the nurse to document the effectiveness or ineffectiveness of the medication that was administered. On 6/27/24 at 2:06 PM, Resident #406 was interviewed. She stated nursing staff did not administer her pain medication as she requested, stating, Sometimes it takes hours to get it. I started to write it down when I asked for pain medication. Yesterday, I requested my pain medication at 4:00 PM and the nurse brought it to me at 4:10 PM. I can get it every 4 hours as needed. I asked for it again at 8:00 PM and the nurse said she would bring it, but she never did. I asked for it again at approximately 9:00 PM and I never got it. I asked for it again at approximately 10:00 PM and still I did not get it. I finally got my pain pill at 11:10 PM. A review of the facility's policy titled Standards and Guidelines of Medication Administration (Issued: 10/2020, Revised: 1/2024) revealed: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	As required, or indicated for a medication, the individual administering the medication records in the resident's medical record: The date and time the medication was administered; the dosage; the route of administration; the injection site (if applicable); any complaints or symptoms for which the drug was administered (if applicable); any results achieved and when those results were observed; and the signature and title of the person administering the drug. Medication administration times are determined by resident need, preference, and benefit, not staff convenience.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105470	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fernandina Beach Rehabilitation and Nursing Center	1625 Lime Street Fernandina Beach, FL 32034

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50783 Based on a review of medical records and facility policy, and observations made during medication administration, the facility failed to implement infection control measures to prevent the spread of infection. Standard of practice hand hygiene procedures were not implemented during provision of care for two (Residents #406 and #72) of four residents observed during medication administration. The findings include: On 6/27/24 at 8:28 AM during a medication administration observation with LPN R, she was observed walking up to the medication cart, unlocking the cart, removing a medicine cup from the top drawer, locking the medication cart, and taking the medicine cup to Resident #406's room to administer the medication in the cup. LPN R did not perform hand hygiene before or after administering medications to the resident. When LPN R returned to the medication cart, she unlocked the cart, pulled medication cards from the drawer, reviewed orders for each medication, placed medication that was to be administered in a medicine cup, locked the cart and entered Resident #72's room to administer the medications. She did not perform hand hygiene before removing medications from the medication cards, before administering the medications to Resident #72, or after medication administration was complete. LPN R returned to her medication cart and proceeded to review the Medication Administration Record for the next medication administration. A review of the facility's policy titled Standards and Guidelines of Medication Administration (Issued: 10/2020, Revised: 1/2024), revealed that staff were to follow established facility infection control procedures, including handwashing, antiseptic technique, gloves, isolation precautions, etc., for the administration of medications, as applicable.

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45951 Based on record review and interview, the facility failed to assess residents' pneumococcal vaccination status in a timely manner for two (Residents #454 and #406) of five residents reviewed for vaccination status, from a total sample of 42 residents. The findings include: A record review for Resident #454, revealed that she was admitted to the facility on [DATE], and her assessment for pneumococcal vaccination status was due by 6/10/24. A record review for Resident #406, revealed that she was admitted to the facility on [DATE] and her assessment for pneumococcal vaccination status was due by 6/21/24. A review of residents' pneumococcal vaccination status was conducted on 6/27/24 at 2:30 PM with the Director of Nursing (DON), who confirmed that she was the acting Infection Preventionist for the facility. Five residents were selected for review regarding their pneumococcal vaccination status. The DON stated she was new to the role of Infection Preventionist and she was not in this role when Residents #454 and 406 were admitted to the facility. She reviewed Residents #454 and 406's records and confirmed that she could not find pneumococcal vaccination status records for either resident. She stated in her new role, she planned to conduct a whole-house audit beginning on 7/1/24 to review the pneumococcal vaccination status of each resident, but that she had not begun reviewing the records of the facility's newly admitted residents, which included Residents #454 and 406. A review of the facility's policy titled Immunizations-Pneumonia (Issued: 7/2020, Revised 2/2024), revealed that residents with no medical contraindications would be offered the pneumococcal vaccine to encourage and promote benefits associated with vaccinations. Assessments of pneumococcal vaccination status would be conducted within five (5) working days of the resident's admission if not conducted prior to admission.