STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105482	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Breezy Hills Rehab and Care Center	5245 N Socrum Loop Rd Lakeland, FL 33809

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40775 43453 Based on observation, interviews, and record review, the facility, 1. failed to ensure allegations of neglect were investigated for one (#8) of two residents reviewed for neglect and 2. failed to have evidence that alleged violations were thoroughly investigated for two (#2 and #7) of five residents sampled for alleged violations. Findings included: On 07/02/24 at 12:30 p.m., an observation and interview was conducted with Resident #8. She was observed in her room laying on her bed. Her Right leg was observed in a cast and was elevated. She stated she was in pain. The resident stated she was involved in a [mechanical lift] accident. She stated she remembered the incident very well. She said two CNAs (Certified Nursing Assistants) were transferring her from the bed to her wheelchair. During the transfer, the [mechanical lift] tipped when she was in mid-air. She stated the staff put her to the ground, but the metal part of the side table caught her ankle. She said, One of the CNAs was standing away from the lift holding on to the wheelchair. One CNA was operating the lift. She stated the side table was very close to the lift and it caught the leg of the lift, causing the lift to tip. The resident stated she broke her ankle. She stated she was frustrated because she could not get out of bed any longer and she probably would not for a very long time. She stated she was struggling with pain and realizing her recovery had been a set back. The resident said, I am a big girl, I think the CNA who was moving me could not do it without help. The resident stated there were two CNAs in the room. She stated when the tray table fell , everything fell over her and the aide had to lower her down. She stated they were calling for help and no one was answering. Review of the Admission Record for Resident #8 showed the resident was originally admitted to the facility on [DATE] and readmitted on [DATE]. Review of a quarterly Minimum Data Set (MDS) dated [DATE], showed Resident #8 had a BIMS (Brief Interview for Mental Status Score) of 15, which indicated the resident was cognitively intact. Review of section GG - functional abilities showed Resident #8 was dependent, which indicated a helper provided all effort to transfer to and from bed to wheelchair. Review of a progress note dated 06/27/24 at 11:26 p.m., showed Resident #8 returned from [name of hospital] via stretcher . Resident with right fracture of ankle and placed in a cast. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105482	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Breezy Hills Rehab and Care Center	5245 N Socrum Loop Rd Lakeland, FL 33809

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Advanced Registered Nurse Practitioner (ARNP) progress note dated 06/27/24 showed, Resident was seen today in facility after receiving a call the resident was being transferred from bed to wheelchair with [mechanical lift] and 2 Staff members when the [mechanical lift] began to tilt, staff were able to keep her from further tilting. Her right ankle/foot hit the bedside table and multiple staff eased her down to the floor to prevent the [mechanical lift] from tilting further over. She is seen with soft tissue swelling over her right ankle and mild ecchymosis. X-rays of her right ankle were ordered and returned showing, age -indeterminate tib-fib fracture by 2 views. Review of a hospital discharge summary dated 06/27/24, showed Resident #8 was discharged with a diagnosis of distal end of fibula, Fracture of distal end of tibia. Review of a CNA task log as of 7/2/24, showed for transferring, the resident required a Mechanical lift with 2-plus assistance. Review of a care plan for Resident #8 with a transfer goal initiated on 04/14/22, showed the resident required a mechanical lift for transfers, with 2 plus assistance. On 07/02/24 at 2:30 p.m., an interview was conducted with the Nursing Home Administrator (NHA). She stated she went to see Resident #8 after the fall. She said the resident reported she had an accident with a [mechanical lift]. The NHA said, This resident normally likes to get up. She said she was afraid of transfers. I told her not to let this hold her back. The NHA stated both CNAs walked them through the process. They said the lift legs were open. The CNAs reported during the transfer, the lift started to tilt, and they lowered the resident to the floor. The NHA stated they did not investigate the incident any further because the CNAs were following the right process. She said, I spoke to both CNAs briefly that day. I asked if the [mechanical lift] could accommodate her weight. We ruled that out. The Director of Maintenance confirmed the lift was functioning properly. I believe the CNAs wrote statements. I have to check with the Unit Manager. She was leading the investigation. The NHA stated there were two staff members in the room and she went by that. She stated she would have expected them to write statements. An incident report should have been documented. She stated she was glad there were two staff members in the room. She stated that was her main focus. The NHA said, I don't have any documentation on any interviews. We did not think we had a problem. We did not get to the bottom of how the injury occurred. We did not conclude anything other than there were two staff members in the room. On 07/02/24 at 4:15 p.m., an interview was conducted with the Director of Nursing (DON). She said, Looking back, I feel bad. I think we failed that resident. I should have conducted the investigation myself. I now know better. On 07/02/24 at 5:13 p.m., a follow-up was conducted with the Regional Nurse Consultant (RNC). She stated she did not think the fall should have been reported. She said, Based on our initial investigation, we did not find a reason to report. She stated, a thorough investigation should have been conducted. 2. A review of Resident #2's medical record revealed Resident #2 was admitted to the facility on [DATE]. Resident #2 was discharged from the facility to the hospital on 2/4/2024. A review of the facility's reportable incidents log revealed an allegation of neglect was reported for Resident #2 on 2/13/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105482	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Breezy Hills Rehab and Care Center	5245 N Socrum Loop Rd Lakeland, FL 33809

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/2024 at 3:00 p.m. during an interview with the NHA, she stated an allegation of neglect was reported to her on 2/13/2024, which involved Resident #2 being sent to the hospital on 2/4/2023 and not wishing to return to the facility due to the facility causing pressure injuries. The NHA also stated during the investigation of the allegation of neglect for Resident #2 other alert and oriented residents in the same hallway where Resident #2 resided were interviewed and expressed no concerns with the care they received. The NHA was not able to provide a list of residents who were interviewed and was not able to provide evidence the interviews were conducted with the residents during the investigation. The NHA left the room and attempted to locate the investigation file. The NHA returned to the room at 4:32 p.m. and stated she was not able to locate the investigation file for the allegation of neglect for Resident #2 on 2/13/2024. The NHA also stated the investigation files were transferred between herself and the DON because she also conducted parts of the investigation. The NHA stated the facility interviewed the facility staff as part of the investigation, but was not able to provide a list of staff who were interviewed or evidence of the interviews being conducted at the time. A review of Resident #7's medical record revealed Resident #7 was admitted to the facility on [DATE]. A review of the facility's reportable incidents log revealed an allegation of abuse was reported for Resident #7 on 4/24/2023. An interview was conducted on 7/2/2024 at 5:11 p.m. with the NHA regarding the allegation of abuse for Resident #7 on 4/24/2023. The NHA stated an allegation of abuse was reported to her on 4/24/2023 by another staff member involving a verbal argument between Resident #7 and the resident's nurse on 4/24/2023. The NHA also stated during the investigation of the allegation of abuse other alert and oriented residents in the same hallway where Resident #7 resided were interviewed and expressed no concerns related to abuse. The NHA was not able to provide a list of residents who were interviewed and was not able to provide evidence the interviews were conducted with the residents during the investigation. The NHA stated she was not able to locate the investigation file for the allegation of abuse for Resident #7 on 4/24/2023 and was not able to provide evidence of the investigation being conducted. Review of a facility policy titled, Abuse, Neglect, exploitation, Misappropriation, Mistreatment, injury of unknown source and investigations, dated 4/01/22, showed it will be the policy of this facility to honor resident's rights and to address with employees the seven (7) components regarding mistreatment, abuse, neglect . Under Investigation, The facility shall conduct their own internal investigation including, but not limited to staff(work history and background screening), resident, and family/resident representative interviews, medical record reviews, 24-hour reports reviews, full body skin exam, etc. The resident/representative and physician should be notified that there is an on-going investigation regarding the alleged incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105482	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Breezy Hills Rehab and Care Center	5245 N Socrum Loop Rd Lakeland, FL 33809

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 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** 43453 Based on observations interviews, and record review the facility failed to prevent a fall with injury for one (#8) of two residents reviewed for falls. Findings included: On 07/02/24 at 12:30 p.m., an observation and interview was conducted with Resident #8. She was observed in her room laying on her bed. Her Right leg was observed in a cast and was elevated. She stated she was in pain. The resident stated she was involved in a [mechanical lift] accident. She stated she remembered the incident very well. She said two CNAs (Certified Nursing Assistants) were transferring her from the bed to her wheelchair. During the transfer, the [mechanical lift] tipped when she was in mid-air. She stated the staff put her to the ground, but the metal part of the side table caught her ankle. She said, One of the CNAs was standing away from the lift holding on to the wheelchair. One CNA was operating the lift. She stated the side table was very close to the lift and it caught the leg of the lift, causing the lift to tip. The resident stated she broke her ankle. She stated she was frustrated because she could not get out of bed any longer and she probably would not for a very long time. She stated she was struggling with pain and realizing her recovery had been set back. The resident said, I am a big girl, I think the CNA who was moving me could not do it without help. The resident stated there were two CNAs in the room. She stated when the tray table fell , everything fell over her and the aide had to lower her down. She stated they were calling for help and no one was answering. Review of the Admission Record for Resident #8 showed the resident was originally admitted to the facility on [DATE] and readmitted on [DATE]. Review of a quarterly MDS dated [DATE], showed Resident #8 had a BIMS (Brief Interview for Mental Status Score) of 15, meaning the resident was cognitively intact. Review of section GG - functional abilities showed Resident #8 was dependent, meaning a helper provided all effort to transfer to and from bed to wheelchair. Review of June 2024 Active Physician Orders for Resident #8 showed an order to send the resident out for imaging to Right foot and ankle on 06/27/24, one time only related to acute pain due to trauma. Review of a Hospital Transfer Form dated 06/27/24 showed Resident #8 was transferred to a local hospital for a possible fracture. Review of a Change in Condition form dated 06/27/24 showed Resident #8 had a fall. The form showed the resident was her own person. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105482	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Breezy Hills Rehab and Care Center	5245 N Socrum Loop Rd Lakeland, FL 33809

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Physical Therapy evaluation and plan of treatment dated 06/28/24 -07/27/24 showed the resident was referred by nursing staff to PT (Physical Therapy) services, after sustaining a (R) ankle fracture during a [mechanical lift] transfer from the bed to wheelchair as patient was being lowered into wheelchair by nursing staff. Patient stated her table somehow tilted hitting her (R) ankle. Patient went to the hospital and returned with (R) ankle fracture with a soft cast in place. Review of a progress note dated 06/27/24 showed the resident was in the process of being transferred by 2 staff members via [mechanical lift] from bed to chair when she experienced a fall. In the process of transfer, the [mechanical lift] tilted in a way that was uncomfortable for staff and for safety purposes staff decided to lower resident to the floor . Upon reassessing resident had an abrasion 3 inches long on her lower leg. There were no open areas or further skin tears noted at the time. Review of a progress note dated 06/27/24 at 11:26 p.m., showed Resident #8 returned from [name of hospital] via stretcher . Resident with right fracture of ankle and placed in a cast. Review of an Advanced Registered Nurse Practitioner (ARNP) progress note dated 06/27/24 showed, Resident was seen today in facility after receiving a call the resident was being transferred from bed to wheelchair with [mechanical lift] and 2 Staff members when the [mechanical lift] began to tilt, staff were able to keep her from further tilting. Her right ankle/foot hit the bedside table and multiple staff eased her down to the floor to prevent the [mechanical lift] from tilting further over. She is seen with soft tissue swelling over her right ankle and mild chamois. X-rays of her right ankle were ordered and returned showing, age -indeterminate tib-fib fracture by 2 views. Review of a hospital discharge summary dated 06/27/24, showed Resident #8 was discharged with a diagnosis of distal end of fibula, Fracture of distal end of tibia. Review of a CNA task log as of 7/2/24 showed for transferring, the resident required Mechanical lift with 2-plus assistance. Review of a care plan for Resident #8 with a transfer goal initiated on 04/14/22 showed the resident required a mechanical lift for transfers, with 2 plus assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105482	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Breezy Hills Rehab and Care Center	5245 N Socrum Loop Rd Lakeland, FL 33809

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 07/02/24 at 12:43 p.m. with Staff B, CNA. She stated Staff C, CNA was assigned to the resident but had asked her for help with the transfer. She said, The resident was in bed and was being transferred to her wheelchair. I was the one in control of the [mechanical lift]. [Staff C] was standing behind the chair, guiding her as I was turning the lift. Once she was over the chair, she was leaning a bit and was tipping to her right. The problem started when Staff B went to pull her to the chair, the lift was tipping and I called her, I said '[Staff B], she is about to fall!' We could not pull her. She was heavy. We were calling for help. We were both holding her, and her body was on top of the bedside table. We should have moved that out of the way. We were holding her, she is not particularly small, her feet were in a dangling position. I raised the lift all the way up. We were calling for help. Another resident went and got Staff D, CNA and another staff member, I don't remember her name. They came as we were lowering her down. She was all the way down when they got to the room. The nurse [Staff E, Licensed Practical Nurse (LPN)] came. She was kind of guiding us to position her. She told us to wait for EMS (Emergency Medical Service). It happened so fast we were trying to get her to the floor. We got her down to the floor and called 911. They came and helped lift her up. When we got her to bed, I saw she had an abrasion on the opposite leg, her left I believe. I notified the nurse. Later, the resident reported to Staff B that she had pain to her ankle. Staff B stated they talked about the incident later. Staff C was supposed to have had the resident ready. Her role was to help. Staff C was standing behind the chair the whole time. She was ready to pull her and guide her behind the chair. We used the lift that was in the room. The [mechanical lift] limit was 450 lbs. She stated the resident was already hooked up when she entered the room. She did not remember what sling size she had on. She said, it should have been the new bigger size. They just ordered new ones since the incident. She has one designated for her now. Staff B stated after the incident, the Nursing Home Administrator (NHA) and the Assistant Director of Nursing (ADON) asked what had happened. Staff B said, I told them there were two of us in the room. They did not ask about the sling or the lift. They asked if the lift legs were open. I told them they were, but the table was in the way a little bit. They did not ask me to write a statement. No one followed up with me after that. On 07/02/24 at 1:04 p.m., an interview was conducted with the ADON. She said, We were in a meeting when we were told [Resident #8] was on the floor. They were trying to put her in a chair before lunch. The Unit Manager Staff F, Registered Nurse (RN) went to the room and was told there were two CNAs in the room. The resident was on the floor. They said the lift was tilted and they lowered the resident to the floor. We asked if the lift base was open. That's what should have happened. We would want the base to be open to balance the weight. They said she was positioned correctly. At that moment we got the Director of Maintenance to inspect the lift. It had no faults. The ADON stated she could not speak to anything else. She stated she was not present. The ADON stated they concluded they had two staff in the room, and they followed the care plan. The ADON stated she did not confirm the size of the sling. She stated the resident went out and the X-rays came back positive for a fracture. The ADON stated in response they started the in-service about the transfers, use of the [mechanical lift] and demonstrations. The ADON stated they did not conduct any further investigation. She stated they had not educated all CNAs, but they were in the process. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105482	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Breezy Hills Rehab and Care Center	5245 N Socrum Loop Rd Lakeland, FL 33809

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/02/24 at 1:28 p.m., an interview was conducted with Staff F, RN. She stated she was made aware by the floor nurse Resident #8 had a fall. Staff F, RN said, there was a malfunction of the equipment at the start. The floor nurse said the lift tilted over during the transfer and they lowered the resident to the ground. Upon investigation, I asked the resident what happened. She said she hit her leg on the bedside table. Staff F stated she removed that particular [mechanical lift] from the room and tagged it so no one could use it. She stated she did not remember the weight limit. She said, That was not a question we asked. We were trying to figure out if the [mechanical lift] was functioning properly. Staff F stated she did not ask the nurse what she meant by the lift was the problem. Staff F said she did not have her write a statement. I asked the two CNAs what happened, and their stories lined up. I did not ask how the injury happened. I did not collect any statements. I did not investigate it further. On 07/02/24 at 2:04 p.m., an interview was conducted with the Director of Maintenance (DOM). He stated after the incident, he inspected the [mechanical lift] that was used to transfer the resident. He stated the [mechanical lift] was fully operational. He said, I would not know the weight limit. All I know was that there was nothing wrong with the lift. That should be something the CNA should now. On 07/02/24 at 2:30 p.m., an interview was conducted with the Nursing Home Administrator (NHA). She stated she went to see Resident #8 after the fall. She said the resident reported she had an accident with a [mechanical lift]. The NHA said, This resident normally likes to get up. She said she was afraid of transfers. I told her not to let this hold her back. The NHA stated both CNAs walked them through the process. They said the lift legs were open. The CNAs reported during the transfer, the lift started to tilt, and they lowered the resident to the floor. The NHA stated they did not investigate the incident any further because the CNAs were following the right process. She said, I spoke to both CNAs briefly that day. I asked if the [mechanical lift] could accommodate her weight. The DOM confirmed the lift was functioning properly. I believe the CNAs wrote statements. I have to check with the Unit Manager. She was leading the investigation. The NHA stated there were two staff members in the room and she went by that. She stated she would have expected them to write statements. An incident report should have been documented. She stated she was glad there were two staff members in the room. She stated that was her main focus. The NHA said, I don't have any documentation on any interviews. We did not think we had a problem. We did not get to the bottom of how the injury occurred. We did not conclude anything other than there were two staff members in the room. On 07/02/24 at 3:20 p.m. an interview was conducted with the Regional Nurse consultant (RNC). She stated the day the fall happened she was in the building. She remembered them going over the fall and they mentioned there were two staff in the room because she was a 2-person transfer. She said, I asked if the equipment was okay, and they said the DOM inspected the lift and determined there was nothing wrong with it. I understand nothing is documented but we asked those questions. On 07/02/24 at 4:15 p.m., an interview was conducted with the DON. She said, Looking back, I feel bad. I think we failed that resident. I should have conducted the investigation myself. I now know better. On 07/02/24 at 5:13 p.m., a follow -up was conducted with the RNC. She stated she did not think the fall should have been reported. She said, Based on our initial investigation, we did not find a reason to report. She stated a thorough investigation should have been conducted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105482	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Breezy Hills Rehab and Care Center	5245 N Socrum Loop Rd Lakeland, FL 33809

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled, Falls and Fall risk-managing, dated 04/01/22, showed based on previous evaluations and current data the staff should identify interventions related to the residents specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Per the MDS (minimum data set) a fall is defined as unintentionally coming to rest on the ground, floor or other lower level but not as a result of an overwhelming external force (e.g. A resident pushes another resident). Fall risk factors include (d). Obstacles in the footpath. Under resident's centered approaches to managing falls and fall risk, (1.) The staff, with the input of the attending physician, should implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk with the history of falls. (7.) In conjunction with the attending physician, staff should identify and implement relevant interventions . to try to minimize serious consequences of falling. Under monitoring subsequent falls and fall risk (1.) The staff should monitor and document each resident's response to interventions intended to reduce falling or the risk of falling. (3.) If the resident continues to fall, staff should reevaluate the situation and whether it is appropriate to continue or change current interventions. (4.) The staff and all physician should document the basis of conclusions that specific irreversible risk factors exist that continue to present a risk or injury due to falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105482	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Breezy Hills Rehab and Care Center	5245 N Socrum Loop Rd Lakeland, FL 33809

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50570 Based on observations, interviews, and record review, the facility failed to assess, care plan and identify triggers related to trauma for one (#10) of two residents reviewed. Findings included: On 7/1/24 at 10:10 a.m., an observation of Resident #10 revealed she was lying in bed watching television. An interview with Resident #10 revealed she was upset by an experience she had on 6/21/24. She stated a nurse, who she could not recall her name, and [Staff A, Certified Nursing Assistant (CNA)] were providing catheter care. Resident #10 stated the door was closed. She stated a female resident entered her room and saw Resident #10 exposed from the waist down. Resident #10 stated, I was spread eagle and she saw me. An observation of Resident #10 revealed she was tearful and stated, I felt violated. She stated the nurse assisting Resident #10 escorted the female resident out of the room and closed the door. Resident #10 stated she reported the experience to another nurse, but she could not recall her name, and the Physician Assistant (PA) who followed her for catheter care at the facility. Resident #10 stated the second nurse who she told about the experience stated, The resident is demented and there's not much they can do as the resident is allowed to be in the halls. She stated the Administrator was supposed to see her regarding the experience, however, Resident #10 stated she has not. Further interview and observation of Resident #10 revealed she was tearful while describing an incident at a previous facility. She stated, I was raped by a female staff. She stated the previous facility was aware of the assault and she was sent to the hospital for examination. Resident #10 was visibly upset and crying while communicating about the sexual assault. A review of Resident #10's Admission Record revealed an original admitted [DATE] and a readmitted [DATE]. Further review of the Admission Record revealed no diagnosis related to trauma. A review of Resident #10's active physician orders revealed, Psychiatry as needed, and, Psychology as needed, both dated 11/17/23. A review of Resident #10's psych notes, dated 6/10/24, revealed for abuse and neglect, There is no known history of physical, sexual, emotional abuse, or emotional neglect. Further review of psych notes revealed, Patient denies symptoms of PTSD [Post Traumatic Stress Disorder]. Denies experiencing traumatic events that involved actual or threatened death or serious injury. An initial review of Resident #10's current care plan revealed a focus related to a mood problem which revealed, r/t [related to] feeling tired and poor appetite at times. Interventions related to the mood problem focus revealed, Monitor/record/report to MD prn [as needed] acute episode feelings or sadness, and Monitor/record/report to MD prn mood patterns s/sx [signs and symptoms] of depression. Further review of the current care plan revealed no evidence of a focus associated with Resident #10's trauma history or interventions related to identified triggers. A review of Resident #10's progress notes revealed no notes related to the incident on 6/21/24. A review of a nursing progress note dated 6/21/24 revealed, resident c/o [complaint of] abdominal pain catheter irrigated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105482	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Breezy Hills Rehab and Care Center	5245 N Socrum Loop Rd Lakeland, FL 33809

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Grievance Logs, dated January 20224 to May 2024, revealed no evidence regarding the resident's grievance/concern on 6/21/24. A review of the facility's matrix revealed the response regarding PTSD/Trauma was blank for Resident #10. On 7/1/24 at 1:02 p.m., an interview was conducted with the Director of Social Services and the Nursing Home Administrator. The Regional Nurse (RN) Consultant was present during the interview. The Director of Social Services initially stated the resident had a care plan for PTSD. She stated, The resident came to us from another facility with a statement that she'd been sexually assaulted. She stated the statement, regarding Resident #10 being sexually assaulted, was in paperwork from the other facility. The Director of Social Services reviewed the current plan and stated, I don't see a trauma care plan. She stated Resident #10 was assessed by her and she received psych services. The Director of Social Services stated she could not recall if Resident #10 was assessed for triggers. She confirmed Resident #10 should have been assessed for trauma. She stated if a resident had a past or current trauma, she assessed the resident, and a care plan was put in place. The Director of Social Services revealed the incident that occurred on 6/21/24 during catheter care with Resident #10 was not reported to her. The Nursing Home Administrator revealed she was not aware Resident #10 had a history of sexual abuse and she stated the incident on 6/21/24 was not reported to her. On 7/1/24 at 2:29 p.m. an interview with the Director of Social Services revealed when a resident was identified with trauma, a care plan was put in place. She stated she reviewed previous trauma assessments for Resident #10, which revealed no documentation of trauma. A review of the facility's policy titled, Social Services - Trauma Informed Care, with a revised date of 4/1/22, revealed the following: Purpose: It is the policy of this facility to provide care and services, which in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Procedure: . 2. The facility should use a multi-pronged approach to identifying a resident's history of trauma . This should include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), Admission Assessment, the history and physical, the social history/assessment and others. Further review of the facility's policy, under procedure, revealed the following, 7. Trauma-specific care plan interventions should recognize the interrelation between trauma and symptoms of trauma .