STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105599	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Health and Rehabilitation Center	38220 Henry Dr Zephyrhills, FL 33540

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Based on observation, interview, and record review, the facility failed to ensure Activities of Daily Living (ADLs) were performed for one (#3) three sampled residents related to incontinence care. Findings included: On 01/23/2025 at 9:55 a.m., an interview was conducted with Staff A Licensed Practical Nurse (LPN) and Staff C, Certified Nursing Assistant (CNA) with Resident #3. The resident was sitting in a wheelchair in her room. The resident was dressed and groomed for the day. She had no noted odors. The resident was sitting on a cushion in her wheelchair. Requested Staff A and Staff C contact the surveyor when the resident was due and needed incontinence care. On 01/23/2025 at 1:00 p.m., an observation of Resident #3 with Staff A and Staff C was conducted during the transfer of the resident to the bed from her wheelchair. They both applied gloves and transferred the resident to the bed using the sit to stand lift onto the bed. The resident was placed on her right side. Her legs had a straight line across the lower back of her thighs, her upper thighs were a deep red/purple color. The shape of the color was the shape of the wheelchair cushion. Staff C, with her gloves on, cleaned the resident's peri area. She moved the trash can to the bedside and continued to use those gloves to finish the peri-care. Staff C stated she had been trying to change her since 11:00 a.m. but could not because the trays came out and she had to pass trays. Staff C stated she was pulled to take a floor assignment because the aide scheduled to work left after she heard she was scheduled for 18 residents. Staff C stated they usually have 4 aides on the 300 / 400 halls and they only had 3 today. Staff C stated no one was doing her job (restorative) today, because they pulled her. Staff C stated when she came over at around 9:00 a.m., the resident was already up and in her wheelchair. She did not know how long the resident had been up in her wheelchair. Staff C stated she did not know when the resident was last changed, it was already done when she came on shift. Staff C changed her gloves and replaced her gloves without hand sanitizing. Resident #3's brief was removed, and an old dressing was observed on her buttocks dated 01/22/25. The dressing appeared saturated with blood-tinged drainage. After wound care was performed Staff A and Staff C replaced the brief on the resident. The resident's legs appeared to be lightening in color. Staff C removed the sit to stand lift and placed it in the hallway. Both Staff A and Staff C hand sanitized post removing their gloves. Resident #3 was admitted on [DATE] and readmitted on [DATE]. Review of the admission record showed diagnoses included but not limited to atrial fibrillation, morbid obesity, dementia, hypertension, osteoarthritis, and disorder of kidney and ureter. (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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Health and Rehabilitation Center	38220 Henry Dr Zephyrhills, FL 33540

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders and January 2025 Treatment Administration Record (TAR) showed: Treatment as follows: Left buttock. Cleanse with wound cleanser, pat dry, apply antifungal powder and cover with bordered gauze dressing daily and as needed as of 01/09/2025 Treatment as follows: Right buttock. Cleanse with wound cleanser, pat dry, apply antifungal powder and cover with bordered gauze dressing daily and as needed as of 01/09/2025 Treatment as follows: Coccyx. Cleanse with wound cleanser, pat dry, apply antifungal powder and cover with bordered gauze dressing daily and as needed as of 01/09/2025 Review of the Wound APRN (Advanced Practice Registered Nurse) specialist notes showed: On 01/01/2025, Follow up of multiple wounds, the patient is a readmit due to MASD (Moisture Associated Skin Damage). Nursing staff educated on the importance of keeping the patient dry at all times. Significant contributors for impaired wound healing include generalized muscle weakness, underlying comorbidities, impaired mobility, and inevitable effects of aging. Frequent offloading and repositioning, pressure relief, and all due care have been rendered prior to today's assessment. Treatment initiated this visit, will re-assess on next provider visit. Review of the care plans showed: Resident needs assist with ADL care related to multiple factors including weakness/decreased mobility, ADL assist may vary as of 11/10/2023 and revised on 02/05/2024. Interventions included but not limited to toileting: the resident will need the extensive help of one or two staff to stand and transfer on and off he commode or bed pan the resident will probably need you to wipe, redress, and wash their hands, but allow the resident to do any part of the activity they can to promote independence Be prepared with 2 people to assist for resident safety during transfer on 0/21/2024. Transfer: the resident dependent is unable to assist with a transfer and will need assistance x 2 staff and a mechanical lift to move from bed to chair and back as of 05/21/2024. Resident is at risk for skin impairment related to fragile skin, incontinence, weakness/decreased mobility as of 05/20/2024. Goal was to keep resident free from any new skin impairment through 05/20/2024. Interventions included but not limited to encourage and assist resident to turn and reposition as tolerated as of 05/20/2024; Preventative skin treatments as ordered/indicated, as tolerated by resident as of 05/20/2024; Provide incontinence care promptly should any episode of incontinence occur as of 05/20/2024. The resident is at risk for complications related to bowel and bladder incontinence related to diverticulosis as of 05/16/2024. Goal was the resident will have no complications related to incontinence. Interventions included but not limited to administer medications as ordered by MD; provide incontinence care with each incontinence episode are tolerated. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/23/2025 at 2:21 p.m., an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). The NHA stated they staff the residents per the census, it was adjusted based on the census. The NHA stated if an aide called off, we fill the shift. The NHA stated it would depend; we would call someone in or use someone here for the shift. The NHA stated an aide called off for the 7:00 a.m. - 3:00 p.m. shift on 01/23/2025. The NHA stated normally they had 4 to 5 aides on each side of the building. The NHA and the DON verified they only had three aides covering the 300 and 400 hallways and one aide which was on orientation and could not take a schedule. The NHA stated the Transport aide, Staff D, CNA was working the floor because they did not have anyone needing transportation today. The NHA stated the Restorative aide Staff C, CNA, was working the floor today. The NHA stated Staff C was working in the place of the aide that called off. The NHA stated they had used agency staff in the past. The NHA stated normally the aides had 10-15 residents per each aide. The DON stated the residents were changed (incontinence care) every 2 hours. The DON stated Resident #3 should have been checked (incontinence care) before going into the dining room. The DON stated Resident #3 should have been checked (incontinence care) after dining when getting ready to lay her down. The DON stated they would have changed Resident #3 when they got her up for breakfast. The DON stated breakfast came around 8:00 a.m. The DON stated the expectation was to change Resident #3 before 4 1/2 -5 hours Review of the facility's policy, ADL Care and Services, revised 01/2024 showed Standard: resident will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Guideline: Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Procedure: 1. Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) are met. 4. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: C. Elimination toileting.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Based on observation, interview, and record review, the facility failed to ensure Quality of Care was provided related to wound care and following Infection Control Practices for one (#3) of one sampled resident. Findings included: Review of the admission record showed Resident #3 was admitted on [DATE] and readmitted on [DATE]. Her diagnoses included but not limited to atrial fibrillation, morbid obesity, dementia, hypertension, osteoarthritis, and disorder of kidney and ureter. On 01/23/2025 at 1:20 p.m., wound care was observed for Resident #3. Staff B, Licensed Practical Nurse (LPN) brought dressing supplies, normal saline in syringes, and the resident's [Antifungal] powder bottle and sat them on the overbed table. Staff B did not clean the overbed table nor place a barrier down. Staff B went into the bathroom and washed her hands. Staff B removed the old dressing and stated, that looks like calcium alginate, that was not ordered for her. Staff B stated the resident was supposed to be on [Antifungal] powder only. The affected buttocks area was a deep red beefy color and was about the size of a grapefruit. The resident had 3 approximately dime size open areas on the left side of the buttocks and 1 approximately the size of a quarter on the right side of the buttocks. Staff B removed her gloves and re-gloved. Staff B opened the normal saline syringe package and cleaned the right side or bottom area of the buttocks first. Staff B dried the area with a gauze pad. Staff B removed her gloves and replaced her gloves. Staff B squirted the normal saline on the left buttocks or top and then dried the area. Staff B removed her gloves and replaced her gloves. The [Antifungal] bottle lid fell on to the floor, she picked it up with her left hand and placed it back onto the bottle. Staff B did not change her gloves or hand sanitize. Staff B stated she would use the [Antifungal] powder since that was the order but would call the wound nurse and/or wound doctor with an update. Staff B shook the [Antifungal] powder on the right side or bottom area and placed the border dressing on. Staff B removed her gloves and re-gloved. Staff B shook the [Antifungal] powder on the left side or top area, she had a difficult time shaking the powder onto that site. Staff B removed her gloves and replaced her gloves. Staff B placed the border dressing on the left side or top. Staff B stated she had never cared for the resident before. Staff B removed her gloves and replaced them. Staff B dated both border dressings with the date and time with a red pen. Staff B closed the [Antifungal] powder and removed her gloves and replaced her gloves. Staff B gathered the used supplies and used gloves and placed them in the trash can. Staff B removed her gloves and washed her hands. Staff B left the room with the unused border dressing, the [Antifungal] powder, and the used normal saline syringes. Staff A, LPN and Staff C, Certified Nursing Assistant (CNA) replaced the brief on the resident. Both Staff A and Staff C hand sanitized post removing their gloves. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Staff A, LPN and Staff B, LPN after the wound care, they stated that the resident was not on Enhanced Barrier Precautions (EBP). They stated EBP was used if a resident had wound care, urinary catheters, was on IV therapy, ostomies. They stated you were supposed to wear gowns and gloves when providing care. Staff A and Staff B verified the resident was not on EBP because the area was not considered a wound, just MASD or Moisture -Associated Skin Damage. Staff B verified she had not hand sanitized between glove changes. Staff B stated the hand sanitizer is only on the hallway walls and was too far to come out here and sanitize. Staff B stated she could not leave the resident to wash her hands between glove changes. Staff B stated she did not have any hand sanitizer on her cart or with her. Staff A stated they were supposed to have it (hand sanitizer) in our pockets. Staff B stated she did take the [Antifungal] powder into the resident's room. Staff B stated she did not place any of the supplies on a barrier. Staff B stated she took the [Antifungal] powder out of the bag from the wound cart and brought it to the room. Staff B stated the [Antifungal] powder was labeled with the resident's name. Staff B stated she placed it back into the bag and into the wound care cart and placed the unused border dressing back into the wound cart. Staff B stated she did not remember picking the [Antifungal] powder cap up off the floor. Staff A stated the [Antifungal] container would be considered contaminated after going into the resident's room as well as the border dressing. Review of the physician orders and January 2025 Treatment Administration Record (TAR) showed Treatment as follows: Left buttock. Cleanse with wound cleanser, pat dry, apply antifungal powder and cover with bordered gauze dressing daily and as needed as of 01/09/2025 Treatment as follows: Right buttock. Cleanse with wound cleanser, pat dry, apply antifungal powder and cover with bordered gauze dressing daily and as needed as of 01/09/2025 Treatment as follows: Coccyx. Cleanse with wound cleanser, pat dry, apply antifungal powder and cover with bordered gauze dressing daily and as needed as of 01/09/2025 Review of the Wound APRN (Advanced Practice Registered Nurse) specialist notes showed On 01/01/2025, Follow up of multiple wounds, the patient is a readmit due to MASD (Moisture Associated Skin Damage). Nursing staff educated on the importance of keeping the patient the patient dry at all times. Significant contributors for impaired wound healing include generalized muscle weakness, underlying comorbidities, impaired mobility, and inevitable effects of aging. Frequent offloading and repositioning, pressure relief, and all due care have been rendered prior to today's assessment. Treatment initiated this visit, will re-assess on next provider visit. Wound #9 Left Buttock is a Partial Thickness Moisture Associated Skin Damage and has received a status of Not Healed. Initial wound encounter measurements are 8 cm (centimeter) length x 4 cm width x 0.1 cm depth, with an area of 32 sq cm and a volume of 3.2 cubic cm. There is a Moderate amount of sero-sanguineous drainage noted which has no odor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wound #10 Right Buttock is a Partial Thickness Moisture Associated Skin Damage and has received a status of Not Healed. Initial wound encounter measurements are 4 cm length x 2 cm width x 0.1 cm depth, with an area of 8 sq cm and a volume of 0.8 cubic cm. There is a Moderate amount of sero-sanguineous drainage noted which has no odor. Wound #11 Coccyx is a Full Thickness Moisture Associated Skin Damage and has received a status of Not Healed. Initial wound encounter measurements are 2 cm length x 0.5 cm width x 0.1 cm depth, with an area of 1 sq cm and a volume of 0.1 cubic cm. There is a Moderate amount of drainage noted which has no odor. Treatment Goals: Healing is expected to be delayed de to identified barriers to healing: impaired mobility and incontinence. On 01/08/2025 The patient is seen for a follows up of multiple wounds. Changes made to facilitate wound healing. Wound #9 Left Buttock is a Partial Thickness Moisture Associated Skin Damage and has received a status of Not Healed. Subsequent wound encounter measurements are 8 cm length x 3 cm width x 0.1 cm depth, with an area of 24 sq cm and a volume of 2.4 cubic cm. Moderate amount of sero-sanguineous drainage noted, which has no odor. The wound is improving. Wound #10 Right Buttock is a Partial Thickness Moisture Associated Skin Damage and has received a status of Not Healed. Subsequent wound encounter measurements are 5.5 cm length x 3 cm width x 0.1 cm depth, with an area of 16.5 sq cm and a volume of 1.65 cubic cm. Moderate amount of sero-sanguineous drainage noted, which has no odor. The wound is deteriorating. Wound #11 Coccyx is a Full Thickness Moisture Associated Skin Damage and has received a status of Not Healed. Subsequent wound encounter measurements are 2.5 cm length x 1 cm width with no measurable depth, with an area of 2.5 sq cm. Moderate amount of sero-sanguineous drainage noted, which has no odor. The wound is deteriorating. On 01/15/2024, Follow up multiple wounds on assessment the wounds are improving. Continue current treatment recommendations. Wound #9 Left Buttock is a Partial Thickness Moisture Associated Skin Damage and has received a status of Not Healed. Subsequent wound encounter measurements are 4 cm length x 1 cm width x 0.1 cm depth, with an area of 4 sq cm and a volume of 0.4 cubic cm. There is a small amount of sero-sanguineous drainage noted which has no odor. The wound is improving. Wound #10 Right Buttock is a Partial Thickness Moisture Associated Skin Damage and has received a status of Not Healed. Subsequent wound encounter measurements are 4.5 cm length x 1 cm width x 0.1 cm depth, with an area of 4.5 sq cm and a volume of 0.45 cubic cm. There is a small amount of sero-sanguineous drainage noted which has no odor. The wound is deteriorating. Wound #11 Coccyx is a Full Thickness Moisture Associated Skin Damage and has received a status of Not Healed. Subsequent wound encounter measurements are 1 cm length x 0.5 cm width x 0.1 cm depth, with an area of 0.5 sq cm and a volume of 0.05 cubic cm. There is a small amount of sero-sanguineous drainage noted which has no odor. The wound is deteriorating. (continued on next page)

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Hillside Health and Rehabilitation Center	38220 Henry Dr Zephyrhills, FL 33540

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Same wound care. On 01/22/2025, resident was visited by Wound APRN, the documentation had not been submitted. Review of the Wound Care form showed Left Buttock, MASD, current size, 4.0 cm x 1.0 cm x 0.1 cm. Medium sero-sanguineous drainage. Continue Nystatin powder daily and as needed. Right Buttock, MASD, current size, 4.5 cm x 1.0 cm x 0.1 cm. Medium sero-sanguineous drainage. Continue Nystatin powder daily and as needed. Coccyx was resolved. Review of the care plans showed: Resident was risk for skin impairment related to fragile skin, incontinence, weakness/decreased mobility as of 05/20/2024. Goal was to keep resident free from any new skin impairment through 05/20/2024. Interventions included but not limited to encourage and assist resident to turn and reposition as tolerated as of 05/20/2024; Preventative skin treatments as ordered/indicated, as tolerated by resident as of 05/20/2024; Provide incontinence care promptly should any episode of incontinence occur as of 05/20/2024. The resident has MASD to coccyx, left buttock, right buttock as of 01/03/2025 and revised on 01/13/2025. Goal was the resident will have no complications from rash through the review date. Interventions included but not limited to administer medication as ordered by the MD; avoid scratching and keep hands and body parts from excessive moisture; increase out of bed activity as tolerated; monitor skin rashes for increased spread or signs of infection; seek medical attention if skin becomes bloody or infected. The resident is at risk for complications related to bowel and bladder incontinence related to diverticulosis as of 05/16/2024. Goal was the resident will have no complications related to incontinence. Interventions included but not limited to administer medications as ordered by MD; provide incontinence care with each incontinence episode are tolerated. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/23/2025 at 2:21 p.m., an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). The DON stated the residents were changed (incontinence care) every 2 hours. The DON stated Resident #3 should have checked (incontinence care) before going into the dining room. The DON stated Resident #3 should have been checked (incontinence care) after dining when getting ready to lay her down. The DON stated they would have changed Resident #3 when they got her up for breakfast. The DON stated breakfast came around 8:00 a.m. The DON stated the expectation was to change Resident #3 before 4 1/2 -5 hours. The DON stated Resident #3 would not be on Enhanced Barrier Precautions with MASD, that was not considered a wound. The DON stated Resident #3's wound care was done by the wound practitioner and wound manager on 01/23/2024. The DON stated they were supposed to follow the wound care orders, or the wound practitioner should have put in a change in wound care orders. The DON stated based on the verbal report and Wound Care form that was given to her Resident #3 had MASD and no change in wound care. The DON stated hand hygiene was to be done before touching a resident, after touching a resident, after touching an object, before putting on gloves, and between glove changes. The DON stated if the antifungal powder bottle goes into the resident's room it was contaminated. The DON stated that they have little cups they can dump some of the powder into to take to the room. The DON stated all supplies should be placed on a barrier after the overbed table was cleaned. The DON stated the supplies needed to be on a barrier due to infection control: clean the table, barrier down, lay supplies down. The DON stated any supplies not used during the care that have been taken into a resident's room need to be trashed or left in that resident's room in a drawer. The supplies should not be taken out of the room and placed back in the wound cart; they are contaminated. The DON stated if a antifungal powder bottle lid falls on the floor, she would throw the lid away. The DON stated once the lid was picked up with the gloved hands, the gloves were contaminated. The gloves needed to be removed, hands sanitize and re-glove. The DON stated she would date the dressing prior to putting it on the resident, not after it was on the resident's buttocks. Review of the facility's policy, Clean Dressing Change, revised 01/2025 showed the purpose of this procedure is to provide guidelines for the application of dry, clean dressing. Procedure: 1. verify that that there is a physician's order for the procedure 2. review the residence care plan, current orders, and diagnosis to determine if there are special resident needs. 3. appeared assembled the equipment and supplies as needed per physician orders or facility protocol. 5. Perform hand hygiene as indicated throughout procedure 6. Position and prep resident and supplies for the procedure. 7. Remove all dressing of applicable per physician orders and dispose of as indicated. 8. Performed clean dressing change procedure as indicated per physician orders. 9. Document completion of procedure and the resident record. Review of the Clinical Safety: Hand Hygiene for Healthcare Workers, https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html on 01/24/2024 showed hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with hand washing antiseptic hand rub. Cleaning your hands reduces: the potential spread of deadly germs to patients. Recommendations when to clean your hands: immediately before touching a patient, before moving from work on a soiled body site to a clean body site on the same patient. After touching a patient or patient's surroundings. After contact with blood, body fluids, or contaminated surfaces. Immediately after glove removal. Review of the facility's policy, Enhanced Barrier Precautions, 05/28/2024 showed the facility will decrease the transmission of multidrug-resistant organisms by maintaining infection control standards. Enhanced Barriers precautions (EBP) refers to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs targeted gown and glove use during high contact resident care activities.