

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105599	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2026
NAME OF PROVIDER OR SUPPLIER Hillside Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** Based on observations, interviews, and record review the facility did not ensure medications were stored in accordance with current professional standards in four medication carts (100, 200, 300, and 400) of four observed. Findings included: An observation on [DATE] at 2:30 P.M. of the 400 Hall medication cart revealed the following: A box of micro kill wipes stored next to 2 boxes of cholestyramine power packets and a box of ProAir RespiClick inhaler A fluticasone inhaler with no open or expiration date. The instructions indicated medication to be discarded 30 days after opening An interview on [DATE] at 2:36 P.M. with Staff E, Licensed Practical Nurse (LPN) was conducted. Staff E, LPN said the micro kills wipes should not have been stored with the medications. Staff E, LPN said the inhaler should have an opened date. An observation on [DATE] at 2:45 P.M. of the 200 Hall medication cart revealed: A bottle labeled drug buster stored next to a bottle of powdered fiber, 2 bottles of liquid protein, and 1 bottle of liquid valproic acid. Three boxes of fluticasone inhalers with no open or expiration date. The instruction indicated medication to be discarded 30 days after opening. Two vials of unopened Lispro Insulin in the top drawer of the medication cart. The instruction indicated refrigerate until opening Four vials of opened Lispro Insulin in the top drawer of the medication cart did not indicate the date the vial was opened. One vial of opened Lispro Insulin with no open or expiration date. The vial resident label did not match the label on the box the vial was stored in. One vial of opened Lyumjev Lispro Insulin with no open or expiration date. Three unopened Insulin pens in the top drawer of the medication cart. The instruction indicated refrigerate until opening. An interview on [DATE] at 2:57 P.M. with Staff F, LPN was conducted. Staff F, LPN said he does not know why the insulins are not dated. Staff F, LPN said he does not know who was responsible for discarding medications or maintaining the medication carts. An interview was conducted on [DATE] at 3:00 P.M. with the Assistant Director of Nursing (ADON). The ADON said the unit managers were responsible for maintaining the medication carts. The ADON said the facility does not have unit managers at this time. The ADON said the floor nurses are responsible. The ADON said medications should be labeled with the date they are opened and discarded when expired. An observation on [DATE] at 3:11 P.M. of the 100 Hall Medication Cart revealed the following: A prefilled syringe of Repatha in the top drawer of the medication cart. The instruction indicated refrigerate until opening One box of an Ellipta inhaler with no open or expiration date. The instruction indicated medication to be discarded 30 days after opening. One box of a Budesonide inhaler with no open or expiration date. The instruction indicated medication to be discarded within 2 weeks of opening. Arformoterol Tartrate inhaled solution located in the third drawer. The medication required refrigeration. One medication card located in the bottom drawer of the medication cart. The resident's names were marked out with a pen, and the cards were stored with other residents medications. An interview on [DATE] at 3:18 P.M. with Staff G, LPN, was conducted. Staff G, LPN said the Repatha and Arformoterol Tartrate should have been refrigerated. Staff G, LPN said she does not know why the medication cards have the residents' names scratched out. Staff G, LPN said the inhalers should have been dated. An observation on [DATE] at 3:53 P.M. of (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the 300 Hall medication cart revealed the following:One card of Lorazepam 0.5mg expired on [DATE]One box of fluticasone inhalers with an open date of [DATE] or expiration date. The instruction indicated medication to be discarded 30 days after opening.Two vials of lidocaine with no open date or expiration date. An interview on [DATE] at 4:00 P.M. with Staff H, LPN was conducted. Staff H, LPN said the medication card expired one year after the issued date. Staff H, LPN said she follows the date on the medication boxes and not the date issued by pharmacy. An interview on [DATE] at 9:26 A.M. with the Director of Nursing (DON) was conducted. The DON said the expectation and facility policy was for the medications to be dated at the time the medication was opened. The DON said all the medications should have been dated with an opened date and an expiration date. The DON said the nurses were not following the facility policy. The DON said unopened insulins should have been stored in the refrigerator, not in the medication carts. The DON said chemicals should have been stored away from the medications or oral supplements. The DON said the lidocaine should not have been in the medication cart, the medication was discontinued. A review of the policy revised on 1/2024 titled; Medication Storage and Labeling guideline was the facility stores all drugs and biologicals in a safe, secure, and orderly manner. 3: The nursing staff is responsible for maintaining medication storage areas; 5: Hazardous drugs are clearly marked and stored separately from other medications; 7: The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened/expiration date is recorded on the container; 8: Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure informed consent was documented for psychotropic medications, as indicated, for three of three residents (#7, #25, #73) out of five residents sampled for unnecessary medications. Findings included: Review of Resident #7's electronic chart revealed an initial admission of 4/26/24, a readmission on [DATE], and a primary diagnosis of unspecified fracture of lower end of left femur, subsequent encounter for closed fracture with routine healing. Her additional diagnoses included post-traumatic stress disorder, unspecified; major depressive disorder, recurrent, moderate; insomnia due to other mental disorder; and adjustment disorder with anxiety. Review of Resident #7's MDS from 4/28/26 showed a brief interview for mental status (BIMS) score of 14 indicating minimal to no impairment with thinking or memory. Review of Resident #7's orders included:- Sertraline hydrochloride 100mg (milligram), give one tablet by mouth one time a day for depression; started 3/11/26- Sertraline hydrochloride 100mg, give 1.5 tablets by mouth one time a day for depression; started 4/14/26- Trazodone hydrochloride 50mg, give 3 tablets by mouth at bedtime for depression/insomnia; started 3/11/26 Review of Resident #7's psychoactive medication informed consents revealed:- Sertraline hydrochloride 100mg for depression, Resident #7 verbally consent and two staff signatures documented, dated 3/11/26 The review showed there was no consent from the resident for the increase in sertraline dose from 100mg to 150mg on 4/14/26.- Trazodone hydrochloride 50mg for depression and insomnia, Resident #7 verbally consented and two staff signatures documented, dated 3/11/26; Resident was prescribed 150mg Review of Resident #25's electronic medical chart revealed an admission date of 2/16/26 and a primary diagnosis of Alzheimer's disease, unspecified. Her additional diagnoses included depression, unspecified. Review of Resident #25's MDS from 2/22/26 showed a BIMS score of 3 out of 15, indicating severe problems with thinking or memory. Her proxy was listed as her family member. Review of Resident #25's orders included:- Sertraline hydrochloride 100mg for depression; give one tablet by mouth one time a day for depression; started 2/17/26- Lorazepam oral tablet 0.5mg; give one tablet by mouth every six hours as needed for anxiety for 14 days; started 2/19/26- ABHR (Ativan, Benadryl, Haldol, Reglan) 0.5-25-2-10 mg /1ml (milliliter) gel; apply to skin topically every eight hours as needed for anxiety for 12 days; started 3/16/26- Sertraline hydrochloride 100mg for depression; give 1.5 tablets by mouth one time a day for depression; started 3/17/26 Review of Resident #25's psychoactive medication informed consents revealed:- Sertraline hydrochloride 100mg for depression, verbal consent from Resident #25's family member with two staff signatures documented, dated 2/16/26 There was no consent for initiation of lorazepam 0.5mg on 2/19/26 There was no consent for initiation of ABHR 0.5-25-2-10 mg /1ml gel on 3/16/26 There was no consent for increase in sertraline dose from 100mg to 150mg on 3/17/26 Review of Resident #73's electronic medical chart revealed an admission date of 3/15/26 with a primary diagnosis of myocardial infarction [heart attack]. His additional diagnoses included alcohol use, unspecified with alcohol-induced persisting amnesic disorder and mild cognitive impairment of uncertain or unknown etiology. Review of Resident #73's history and physical dated 3/16/26 and psychiatry admission note from 3/21/26 revealed a diagnosis of bipolar disorder. Review of Resident #73's MDS from 3/21/26 showed a BIMS score of 11 indicating moderate problems with thinking or memory. Review of Resident #73's orders included:- Quetiapine fumarate extended release (ER) 24-hour 50mg oral tablet; give one tablet by mouth at bedtime for mood disorder; started 3/17/26- Quetiapine fumarate ER 24-hour 50mg oral tablet; give two tablets by mouth at bedtime for mood disorder; started 3/24/26- Quetiapine fumarate ER 24-hour 50mg oral tablet; give three tablets by mouth at bedtime for mood disorder; started 3/30/26- Risperidone 0.5mg oral tablet; give one tablet by mouth two times a day for bipolar; started 4/23/26 Review of Resident #73's psychoactive medication informed consents revealed:- Quetiapine ER 50mg for mood disorder; verbal consent with two staff signatures; dated 3/17/26 There was no consent for increase in quetiapine ER dose from (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50mg (1 tablet) to 100mg (2 tablets) on 3/24/26 or from 100mg (two tablets) to 150mg (three tablets) on 3/30/26There was no consent for initiation of risperidone 0.5mg on 4/23/26An interview was conducted on 5/20/26 at 10:54 a.m. with Staff D, Registered Nurse (RN). She stated psychotropic medication consents are obtained when residents are admitted for continuation of psychotropic medications, when new psychotropic medications are initiated, or when there is a change in the psychotropic medication dosage. She verified that psychotropic consents are the responsibility of the unit manager, the Assistant Director of Nursing (ADON), and the Director of Nursing (DON). She stated there has been no unit manager for 1.5 weeks.An interview was conducted on 5/20/26 at 11:20 a.m. with the DON. She verified the ADON and the DON are responsible for ensuring that psychotropic consents are obtained and accurate. She reported that obtaining the consents is part of the facility admission checklist. She verified the expectation that psychotropic consents should be obtained on admission, when new psychotropic medications are ordered, and for changes in dose. She confirmed that psychotropic consents are uploaded to residents' electronic medical records.An interview was conducted on 05/20/2026 at 12:41 p.m. with the facility's Medical Records. She reviewed Resident #25 and Resident #73 for any psychotropic consents that have not been uploaded to the electronic medical record. She verified all consents have been scanned. She reported she scans everything as soon as possible. Facility failed to provide a policy related to psychotropic medication consents as requested.Review of Facility policy title Medication Utilization and Prescribing - Clinical Protocol, revised January 2024, included:Guideline: The facility will comply with the requirements specified in accordance with State and Federal regulations as they pertain to Medications Utilization and PrescribingProcedure:5. Consent for medications including but not limited to psychotropic medications, OTC, narcotics, and any other physician-prescribed medications are included in the consent to treat.6. Risks and benefits of utilization of psychotropic medications will be reviewed with resident and/or responsible party prior to initiation or increase of dose as indicated.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observations and interviews the facility failed to provide a clean, sanitary, and homelike environment in three units (200, 300, and 400) out of four units, affecting six resident rooms (207, 203, 201, 405, 305 and 307) and failed to ensure one laundry room out of one observed was maintained in a sanitary manner. Findings included: On 5/20/26 at 3:46 p.m. observations of resident rooms and laundry room were conducted with the Director of Maintenance (DOM). The DOM reported doing monthly walkthroughs for the facility and resident rooms and stated staff can submit maintenance tickets electronically which are received by the DOM by text notifications. During this tour with the DOM, the following areas were observed: The DOM observed room [ROOM NUMBER] and noted the staining in toilet, large area of unpainted plaster in the bathroom, baseboards which were peeling, and ill-fitting linoleum. The DOM stated the bathroom had had a large leak which had needed repairing and had ordered a pumice stone to work on the stains in toilet. The DOM stated the facility was planning to paint and replace the flooring but was unable to provide timeline for completion. The DOM denied being aware of any issues with room [ROOM NUMBER]. The DOM reported the facility had identified painting and flooring concerns and had initiated project plans 2.5 months ago but was unable to provide a tentative date for completion. The bathroom was observed in room [ROOM NUMBER]. The DOM confirmed bathroom flooring issues and toilet staining. The DOM stated he was not sure how long it had been this way but was on a project list. room [ROOM NUMBER] was observed without a flooring transition strip. The DOM stated the flooring transition strip had been ordered for room [ROOM NUMBER]. The area surrounding room [ROOM NUMBER]'s Packaged Terminal Air Conditioner (PTAC) was observed, where outside light could be seen entering the room and uneven wall patching was evident. The DOM agreed there was a hole next to the unit and it was missing anchor screws before shoving it back into wall. The DOM verified the gap could allow for pest entry. The DOM viewed the bathroom of room [ROOM NUMBER] confirming floor defects in the transition area between room tiles and the bathroom rolled linoleum, sections of unpainted plaster in the bathroom and peeling baseboards. The DOM was unable to comment on how long the issues had been present. Review of the facility's maintenance report from 4/3/26 to 5/19/26 revealed there were no maintenance reports documented for room [ROOM NUMBER]. An observation on 5/20/26 at 3:46 p.m. was conducted of the facility laundry services with the Director of Maintenance (DOM). The observation revealed a square air vent above the folding table in room with dryers covered with a gray fuzzy material. A piece of the gray fuzzy material hung from the vent and moved in the air. An area of hanging unattached pieces of ceiling paint and gray fuzzy material attached to piping was observed in the washer room. The DOM acknowledged the ceiling vent and stated the pieces of paint were not falling. On 05/17/2026 at 10:25 AM, an observation in room [ROOM NUMBER] revealed the resident's wall (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	closest to the door was stained with unknown substances that were brown and yellow. The wall was also observed to have a hole in it near the baseboard. On 05/19/2026 at 3:02 PM, an observation in room [ROOM NUMBER] revealed the residents' privacy curtain was stained with a brown substance on the bottom of the curtain in various places. An interview was conducted on 05/19/2026 at 12:45 PM with Staff I, Certified Nursing Assistant (CNA). The interview revealed if a CNA observes a hole in a resident's room wall or any maintenance needs in resident care areas, they should report the observation to maintenance. Staff I observed the hole in the wall in room [ROOM NUMBER] and was unsure of the length of time the hole has been in the wall. Staff I also observed the privacy curtain in room [ROOM NUMBER] and was unsure of the process for privacy curtains to be replaced. Staff I stated someone should come to replace stained privacy curtains. An interview was conducted on 05/19/2026 at 1:38 PM with theedom. The interview revealed that maintenance is responsible for building repairs including a hole in the wall. The DOM said the process for maintenance repairs begins with staff; a CNA, a nurse, or housekeeping inputting the maintenance request into the facility's online maintenance request system. After the request is submitted, the Maintenance Director reviews the online maintenance requests every morning, makes an observation of the needed repairs, and begins the process to resolve the maintenance request. Review of the facility's maintenance requests within the previous 30 days revealed there was not a request to repair the hole in the wall for room [ROOM NUMBER]. An interview was conducted on 05/19/2026 at 1:40 PM with the Housekeeping and Laundry Supervisor. The interview revealed housekeeping is responsible to maintaining the cleanliness of privacy curtains. The Housekeeping and Laundry supervisor said the privacy curtains in resident rooms are washed in the facility's laundry facility in order to maintain cleanliness in addition to washing privacy curtains during monthly facility deep cleaning. A job description titled housekeeping/laundry aide provided by the facility revealed responsibilities of maintaining a clean atmosphere throughout the facility. The facility did not provide a policy related to repairs in resident rooms or a policy related to the cleanliness of privacy curtains. (Photographic Evidence Obtained)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interview, the facility failed to ensure accurate Level I Preadmission Screening and Resident Review (PASARR) for three residents (#26, #25, #73) out of four residents sampled for PASARRs. Findings included: Record review for Resident #26 revealed an admission date of 06/26/2025 with diagnoses to include epilepsy. A review of a physician encounter note dated 3/2/26 revealed chief complaint, history mood disorder and dementia among other medical diagnoses. A review of the Level I PASARR dated 06/27/2025 for Resident #26 did not reveal a mental illness or suspected mental illness based on documented history and medications. The Level I PASARR for Resident #26 revealed epilepsy was checked and no other diagnoses were indicated. Review of Resident #25's electronic medical chart revealed an admission date of 2/16/26 and a primary diagnosis of Alzheimer's disease, unspecified. Her additional diagnoses included depression, unspecified. Review of Resident #25's preadmission screening and resident review (PASARR) level 1 screen dated 2/2/26 revealed no diagnoses marked for section A. Additionally, the screen was marked no for both questions in #5 related to dementia and a diagnosis of Alzheimer's disease. Review of Resident #73's electronic medical chart revealed an admission date of 3/15/26 with diagnoses to include alcohol use, unspecified with alcohol-induced persisting amnesic disorder and mild cognitive impairment of uncertain or unknown etiology. Review of Resident #73's history and physical dated 3/16/26 and psychiatry admission note from 3/21/26 revealed a diagnosis of bipolar disorder and alcohol use disorder. Review of Resident #73's PASARR level 1 screen dated 3/15/26 revealed no diagnoses marked for section A. An interview was conducted on 5/20/26 at 11:06 a.m. with Director of Social Services (DSS) and Social Worker Assistant (SWA). DSS stated Director of Nursing (DON) completes a new PASARR when identified by social services. She stated that she reviews the level I screens on residents' admission and then would notify DON as needed. She stated, I have to admit, I'm behind. She reported MDS (Minimum Data Set) Coordinator, DON, and the Nursing Home Administrator (NHA) have informed her to review level 1 PASARRs with the diagnoses listed from the MDS assessment. She stated, My previous building we sat down as a team and would review physician medication orders, psychiatry notes, and psychology notes and MDS would update the diagnoses. Regarding the current process in this facility, she stated, Something I'm working on at the moment. She reviewed Resident #73's MDS medical diagnoses and verified no psychiatric diagnoses were listed. She reviewed Resident #73's PASARR level 1 screen and verified that it was not correct. She verified Resident #73's level 1 screen should have been identified on admission and revised. She reviewed Resident #25's level 1 and confirmed that it was completed incorrectly and would need to be revised. She stated Resident #25's diagnosis of Alzheimer's disease would automatically require a referral for level 2. An interview was conducted on 5/20/26 at 11:10 a.m. with MDS Coordinator and Regional Director of (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical Reimbursement (RDCR). MDS Coordinator stated, I don't know when asked how she is notified to update resident diagnoses. MDS Coordinator was unable to outline a current process to ensure an accurate list of diagnoses. RDCR stated, It would be updated during your weekly team meetings. MDS coordinator reviewed Resident #73's MDS active diagnoses and confirmed bipolar disorder and alcohol use disorder were not listed. MDS coordinator reviewed Resident #73's admission psychiatry note on 3/21/26 and verified diagnoses of bipolar disorder and alcohol use disorder were documented. MDS Coordinator and RDCR confirmed Resident #72's diagnoses should have been updated to reflect the former findings. An interview was conducted on 5/20/26 at 11:17 a.m. with DON. She verified that she completes a new PASARR level I when notified by social services. The facility did not provide a policy in relation to PASARRs as requested.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure food, and food storage areas were maintained in a sanitary manner in the one out of one kitchen (main) and in two out of two nourishment rooms observed. During a kitchen tour conducted on 05/17/2026 at 9:24 AM, observations were made of employee food and beverages being stored in food preparation areas. Employees food was observed on a table next to the dessert cooler. A beverage was observed to be stored next to the juice dispenser on top of a table. Food to be discarded from resident breakfast was observed to be on top of the steam table used to hold hot foods. There was a sealed bag containing an unknown food item that was green and red in the freezer without a label or a date of expiration or preparation. The refrigerator was observed to have a sealed bag of a yellow block like food item without a food item label, a preparation date, or expiration date. The refrigerator was also observed to contain a sealed bag with a round, brown food item that was not observed to have a label of what the food item was, a preparation date, or an expiration date. During the same tour, two out of two nourishment rooms were observed to contain food resident and staff food items that did not have resident or staff names nor labeled with the date of procurement. The ice machine in the kitchen was observed to have black biological growth underneath the water spout in addition to brown staining in the container beneath the water spout. An interview conducted with the Dietary Manager and Regional Food Service Manager on 05/20/2026 at 12:30 PM revealed that all items being stored in the kitchen and nourishment rooms should be labeled and dated with use by dates on the food items. The Dietary Manager said when deficiencies are observed, the facility begins corrective action with verbal education, an in-service, and then modeling the correct practice. The dietary manager said department managers, nurses, and dietary staff are responsible for maintain clean and sanitary nourishment rooms. The dietary manager said the ice machine is serviced by maintenance once a month, by taking the machine apart and cleaning the inside. Dietary staff performs a general cleaning of the ice machine once a day or weekly, cleaning the outside of the machine and spills on or near the ice machine. The dietary manager said that staff personal items should not be stored in work areas and said they may be stored in the Dietary Manager's office or the staff lockers located in the staff area of the facility. The Dietary Manager said after each meal, the kitchen area should be cleaned thoroughly, which includes discarding resident meals promptly, and not storing discarded meals on top of food preparation areas. Review of a facility policy titled Outside Foods issued 01/2019, revised 04/30/2024, revealed that food and beverages without a name or date, past package expiration dates, all perishable items will be discarded after 3 days. Review of a facility policy titled Food Safety: Labeling & Dating revealed All foods that require time and temperature control (TCS) should be labeled with the following: Common name of the food (example: macaroni and cheese), date the food was made, use by date. A policy for maintain the cleanliness of the ice machine was requested and not received. (Photographic evidence obtained).		

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observations, interviews and record review, the facility failed to ensure the physician was notified regarding changes in a catheter output for one resident (#132) of one observed. Findings included: On 5/18/26 at 9:56 a.m., an observation and interview were conducted with Resident #132. During the interview Resident #132 was grimacing in pain and was saying they feel horrible from the pain due to having a recent surgery on their coccyx. Resident #132 further mentioned they are very thirsty and feel so weak. Resident #132's catheter was observed with a dark orange-red colored urine in the tubing. Resident #132 stated they were not aware of the condition of their catheter, but believes it was because the staff never checks it. The resident stated the staff never tell her what is going on. Resident #132 stated she did not have a catheter before going into the hospital and received it once they got to the nursing-home facility. Photographic Evidence Obtained On 5/19/26 at 11:24 a.m., an interview was conducted with Staff F, Licensed Practical Nurse (LPN). Staff F, LPN observed Resident #132's urine and confirmed it was concentrated and miscolored. Staff F, LPN stated having worked 2/3 days in this assignment and stated not having seen the catheter condition. Staff F, LPN stated they had been off, so they were not aware of the coloring of the urine output since they returned from their off days. Staff F, LPN stated they will notify the physician and document a change in condition (CIC). On 5/19/26 at 1:50 p.m., an interview was conducted with Staff K, Certified Nursing Assistant (CNA). Staff K, CNA stated they do not remember having any catheter training off the top of their head from the facility, but they do know if any kind of changes are observed to report the findings to the nurse right away. Staff K, CNA was unaware if they document or who documents the change in condition. On 5/20/26 at 10:15 a.m., an observation of Resident #132's catheter was made. The resident's urine still appeared to be dark orange in color with cloudiness present. Resident #132 stated the staff has yet to do anything about their catheter, and the Resident had not seen a physician yet. On 5/20/26 at 2:45 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated when a resident has an abnormality with their catheter, the CNA should advise the nurse, and once the nurse is aware, they should go and assess the catheter by evaluating the urine color in the bag. The DON said if the resident was experiencing any pain, the nurse should check the resident's abdomen. The DON said if the nurse observes an issue with the catheter, then the doctor should be contacted as soon as possible during the nurses' shift, and a CIC should be made. The DON stated the orders from the doctor would be reviewed as they come in and acted upon immediately. The DON explained a progress note should be made by the care staff detailing the condition of the abnormal urine and what was done to help relieve the issue. A review of Resident #132's admission record revealed an admission date of 5/7/26, with diagnoses to pressure ulcer of sacral region, chronic pain syndrome, and depression. A review of Resident #132's Quarterly Minimum Data Set (MDS) assessment, dated 5/13/26, revealed a BIMS of 14 out of 15, indicating Resident #132 is cognitively intact. A review of Resident #132's current Care Plan revealed the resident will be free of symptoms of dehydration and fluid imbalance by monitoring and documenting/reporting any signs and symptoms of dehydration including: decreased or no urine output, concentrated urine, fatigue/weakness, and thirst. Further review revealed Resident #132 will be free of any complications and infections related to catheter use and cystitis. The resident is to be monitored for any signs or symptoms of bacteriuria such as pain, blood-tinged urine, cloudiness, deepening of urine color and discomfort related to the use of a catheter. Any findings should be reported to the physician. Review of Resident #132's chart did not reveal any change in conditions (CIC) made for the resident related to catheter/urine output and coloring during the duration of the resident's stay. A review of Resident #132's progress notes revealed no documentation regarding the resident's urine output/coloring. On 5/20/26 at 3:14 p.m., the DON observed Resident #132's catheter bag noting the discoloration. Resident #132 stated to the DON they were having abdominal pain. The (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON stated the physician should have been notified of the condition of the resident's urine, and confirmed that Staff F, LPN did not put in a CIC for Resident #132 on 5/19/26 as stated. The DON stated the resident's urine is not a normal color and needs to be evaluated as soon as possible. A review of the facility's Catheter Care- Quality of Care Policy revealed the following: The facility will maintain infection control guidelines related to catheter use and catheter care to minimize catheter associated infections. Observe the resident routinely for complications related to catheter use. Report new complications to the provider per the change in condition policy. A review of the facility's Change in Resident Condition or Status-Resident Rights Policy revealed the following: Facility shall notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) . To ensure the facility provides timely notification in accordance with State and Federal Regulations as it pertains to residents' rights. The Nurse will notify the resident's Attending Physician or physician on call when there has been a (an): Significant change in the resident's physical/emotional/mental condition Need to alter the resident's medical treatment significantly Specific instructions to notify the Physician of changes in the resident's condition. A 'significant change' of condition is a major decline or improvement in the resident's status that: Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not 'self-limiting') Impacts more than one area of the resident's health status Requires interdisciplinary review and/or revision to the care plan A nurse will notify the resident's representative when: There is a significant change in the resident's physical, mental, or psychosocial status		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that the Minimum Data Set (MDS) accurately reflected active diagnoses for one resident (#73) of three residents sampled. Cross-reference F645. Findings included: Review of Resident #73's electronic medical chart revealed an admission date of 3/15/26 with a primary diagnosis of myocardial infarction [heart attack]. His additional diagnoses included alcohol use, unspecified with alcohol-induced persisting amnesic disorder and mild cognitive impairment of uncertain or unknown etiology. Review of Resident #73's history and physical dated 3/16/26 and psychiatry admission note from 3/21/26 revealed bipolar disorder and alcohol use disorder diagnoses. Review of Resident #73's Minimum Data Set (MDS), dated [DATE], revealed: Section I: Active Diagnoses: no psychiatric/mood disorder diagnoses Section N: Medications: is taking antipsychotic and antidepressant with indication noted. An interview was conducted on 5/20/26 at 11:06 a.m. with Director of Social Services (DSS) and Social Worker Assistant (SWA). Regarding the facility process to keep MDS updated, she stated, My previous building we sat down as a team and would review physician medication orders, psychiatry notes, and psychology notes and MDS updated the diagnoses. Regarding the current process in this facility, she stated, Something I'm working on at the moment. She reviewed Resident #73's MDS medical diagnoses and verified bipolar disorder and alcohol use disorder were not listed. An interview was conducted on 5/20/26 at 11:10 a.m. with MDS Coordinator and Regional Director of Clinical Reimbursement (RDCR). MDS Coordinator stated, I don't know when asked how she is notified to update resident diagnoses. MDS Coordinator was unable to outline a current process to ensure an accurate list of diagnoses. RDCR stated, It would be updated during your weekly team meetings. MDS coordinator reviewed Resident #73's MDS active diagnoses and confirmed bipolar disorder and alcohol use disorder were not listed. MDS coordinator reviewed Resident #73's admission psychiatry note on 3/21/26 and verified diagnoses of bipolar disorder and alcohol use disorder were documented. MDS Coordinator and RDCR confirmed Resident #73's diagnoses should have been updated to reflect the former findings. Facility did not provide a policy in relation to MDS and/or comprehensive assessments.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and interview, the facility failed to ensure resident referral for a Level II Preadmission Screening and Resident Review (PASARR) review following qualifying diagnosis for one resident (51) out of four residents sampled for PASARRs. Record review for Resident #51 revealed a diagnosis of Post-Traumatic Stress Disorder (PTSD), unspecified, with an admission date of 08/09/2025. Further review of Resident #51's psychiatry progress notes dated 3/9/2026 and 4/10/2026 revealed an assessment treatment plan for diagnoses to include Major depressive disorder, generalized anxiety disorder, insomnia due to other mental disorder, mood lability, borderline personality disorder and psychotic disorder with delusions due to a known physiological condition. Review of the Level I PASARR for Resident #51 dated 08/13/2025 revealed under mental illness diagnoses of PTSD, unspecified and anxiety disorder were checked. The facility did not provide evidence of a level II consideration following qualifying diagnoses. An interview was conducted on 5/20/26 at 11:06 a.m. with Director of Social Services (DSS) and Social Worker Assistant (SWA). The DSS stated the Director of Nursing (DON) completes a new PASARR when identified by social services. She stated that she reviews the level I screens on residents' admission and then would notify the DON as needed. She stated, I have to admit, I'm behind. She reported the MDS (Minimum Data Set) Coordinator, DON, and Nursing Home Administrator (NHA) have informed her to review level I PASARRs with the diagnoses listed from the MDS assessment. She stated, In my previous building we sat down as a team and would review physician medication orders, psychiatry notes, and psychology notes and MDS updated the diagnoses. Regarding the current process in this facility, she stated, Something I'm working on at the moment. An interview was conducted on 5/20/26 at 11:10 a.m. with the MDS Coordinator and Regional Director of Clinical Reimbursement (RDCR). The MDS Coordinator stated, I don't know when asked how she is notified to update resident diagnoses. MDS Coordinator was unable to outline a current process to ensure an accurate list of diagnoses. RDCR stated, It would be updated during your weekly team meetings. An interview was conducted on 5/20/26 at 11:17 a.m. with DON. She verified that she completes a new PASARR level I when notified by social services. The facility did not provide a PASARR policy as requested.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observations, interviews and record review, the facility failed to ensure bedfast residents with limited mobilities received activities to meet the interests and support the physical, mental and psychosocial well - being for one resident (#83) of one resident reviewed. Findings included: On 5/17/26 at 2:00 p.m., an observation and interview occurred with Resident #83 and a family member. Resident #83's family member stated they were unhappy with the care Resident #83 was receiving and felt the care staff does not know how to care for stroke residents. The family member stated the facility does not do anything with Resident #83 and just leave him in his room watching TV most of the day. The family member stated they visit the resident for multiple hours at a time and have not seen staff trying to take the resident to any activities. On 5/17/26 at 3:20 p.m., an interview occurred with Resident #83's family member who stated Resident #83 is confined to their room and needs to be able to get outside and do activities the resident prefers to make their stay at the facility more enjoyable. Resident #83's family member stated they felt the resident is forgotten due to his abilities as he does not take part in activities and 1:1 activities were not offered. The family member stated staff just puts the resident in front of the TV (television). On 5/19/26 at 1:07 p.m., an interview was conducted with the Social Services Assistant (SSA). The SSA explained for bedridden residents, they are provided with reading materials and music. The SSA stated the new Director of Activities (DOA) is starting a new process for these residents. The SSA stated being unaware of how often bedridden residents were getting activities. The SSA said for each resident the activities are to be documented in the progress notes daily, and a completed assessments for the activity the resident is participating in. If the resident is unable to verbalize their activity preferences, then the SSA stated they will get preferences from the resident's guardian/family member. On 5/19/26 at 1:23 p.m., an interview was conducted with the Director of Activities (DOA). The DOA stated they had been doing assessments of residents' interests and do 1:1 activities with those who are unable to leave their bed, such as word searches, crossword puzzles, reading materials, chess, checkers, provide music and read stories. The DOA stated activities provided to residents are to be documented in the resident's portal system daily. The DOA said activities are to be provided at least once a day to bedridden and nonverbal residents, and for residents who are unable to vocalize their preferences, the family or representative is contacted for the residents' activities of choice. The DOA stated they just met Resident #83 yesterday (5/18/26). The DOA said prior to the activities director coming on board the activity's assistant had been providing activities. Documentation of activities being provided to Resident #83 was requested and not provided by the facility. On 5/19/26 at 3:08 p.m., the DOA and SSA provided a performance improvement plan (PIP) with a start date of 4/20/26 revealing the facility is completing ongoing audits on random residents one time weekly for 4 weeks and then every 2 weeks for 2 months to ensure compliance by the Activities Director (AD). The document revealed on 4/21/26 the facility's calendar was reviewed to ensure adequate time was designated for visits and documentation. They educated activities staff on the correct documentation for all activities. By 4/25/26 a quality review of activity participation was completed, and all residents without any documentation received a visit from the activities staff for support and stimulation. On 5/20/26 at 12:28 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated the expectation of the facility is to encourage Resident #83 to attend any and all activities he is able. The DON sighed when presented Resident #83's activity log and stated there was no documentation of activities being provided so they are unable to determine if the resident received activities. On 5/20/26 at 1:06 p.m., an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated residents who are bed bound or require 1:1 activities should be offered activities. The NHA stated TV is okay to provide as an activity to residents if they are care planned for enjoying watching TV. The NHA explained the activities department does an assessment on all residents to reveal their preferences and what residents would like to participate in. The NHA stated all activities (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided or not are to be documented in the resident's activity task. The NHA said they were unaware of the resident not getting any type of activities. The NHA reviewed Resident #83's activity documentation and confirmed the resident only had two activities documented from April 20th-30th. The NHA stated this is not the documentation expectation. The NHA confirmed Resident #83 did not have documentation for group activities, music, group activities or outdoor activities, and religious activities for months March-May 2026. The NHA stated they are unable to determine if Resident #83 received activities on days notated as N/A. A review of Resident #83's admission record revealed an initial admission date of 2/19/2026, and a readmission date of 3/11/26 with diagnoses to include frontal lobe and executive function deficit following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and arteritis. A review of Resident #83's Quarterly Minimum Data Set (MDS) assessment, dated 3/17/26, revealed a Brief Interview Mental Status (BIMS) score was not completed due to the resident being rarely/never understood. Further review of Resident #83's cognitive patterns revealed the resident has a short and long-term memory problem, no recall ability, and is severely impaired for cognitive skills for daily decision making. Review of Resident #83's assessment of hearing, speech, and vision revealed the resident had adequate hearing and vision and is unable to be verbally understood. For Resident #83's activity and routine preferences, the resident had indicated the following: Family or significant other involvement in care decisions, listening to music, keeping up with the news, doing things with groups of people, participating in favorite activities, spending time outdoors, and participating in religious activities or practices. A review of Resident #83's Activities task dates 3/11/26-5/18/26 revealed the following: From March 12th-31st: (20/20 days the resident did not receive activities, either blank or marked as Not Applicable (N/A)) From April 1st- 30th: 29/30 days the resident did not receive activities, either blank or marked as Not Applicable (N/A). From May 1st-18th: 7/18 days the resident did not receive activities, either blank or marked as Not Applicable (N/A) A review of Resident #83's current Care Plan revealed staff is to facilitate assistance and encouragement to the resident to participate in preferred leisure pastimes, have community involvement, and introduce Resident #83 to other residents with similar interests and backgrounds. A review of Resident #83's progress notes revealed there was no documentation regarding activities being provided to the resident. A review of the facility's Activity Assistant Job Description revealed the following: Assist in scheduling, organizing and facilitating activities to meet the residents' creative, social, physical, spiritual, and emotional needs. Adapts activities to suit resident and incorporate them into overall resident care routines and objectives. Responsibilities: Planning and facilitating daily, weekly, and monthly events to encourage socialization, relaxation, and recreation. Implementing activities that accommodate those with special needs. Keeping records regarding event planning resources, participation interest, and other notable information, such as injuries or behavioral incidents.		

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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. Based on observations interviews and record review the facility failed to provide timely care and assistance for residents needing staff's help for two residents (#132 and #109) of two residents reviewed. Resident #132 waited for one hour to be repositioned resulting in on-going pain, and Resident #109 waited for assistance off the floor for 45 minutes post fall. Findings included: 1. On 5/18/26 at 9:56 a.m., an interview occurred with Resident #132 while they were lying in bed. During the interview Resident #132 was grimacing in pain and was saying they feel horrible from the pain due to having a recent surgery on their coccyx. Resident #132 further mentioned they are very thirsty and feel so weak they are unable to reposition themselves on the bed. Resident #132 stated if they hit their call light the care staff will not answer and will take hours to come help her. Resident #132 said, Watch and you will see. On 5/18/26 at 9:58 a.m., Resident #132 hit their call-light and Staff L, Occupational Therapist Assistant (OTA) came in and turned off the resident's call light while asking what they needed. Resident #132 told Staff L, OTA they would like to be repositioned because they are in pain in their coccyx area due to having a recent surgery in that area. Staff L, OTA advised Resident #132 they will let the resident's care staff know and to assist the resident. When Staff L, OTA left the room, Resident #132 continued to grimace and moan in discomfort while waiting for assistance to be repositioned. On 5/18/26 at 10:20 a.m., care staff were observed answering call lights and providing care to residents across the hall but did not come to assist Resident #132. On 5/18/26 at 10:34 a.m., care staff were observed answering call lights and providing care to residents next door to Resident #132 but did not come to assist the resident. On 5/18/26 at 10:50 a.m., Staff M, Certified Nursing Assistant (CNA) came to Resident #132's room to take them to therapy, not to assist with repositioning in bed. Staff M, CNA stated they were unaware that Resident #132 needed to be repositioned. Resident #132 did not go to therapy due to stating they are in too much pain in their coccyx region. At 10:52 a.m., another CNA entered Resident #132's room to ask Staff M, CNA for assistance on getting another resident off of the toilet. Staff M, CNA left to go assist with another resident telling Resident #132 they will be right back to assist with repositioning. At 10:57 a.m., Staff M, CNA returned with another aide and repositioned Resident #132, having waited approximately one hour. On 5/18/26 at 11:00 a.m., an interview was conducted with Staff L, OTA. Staff L, OTA stated they assist residents with call light concerns if they have the time and are able to assist them independently with a task, otherwise they let the resident's aide or nurse know of the need. Staff L, OTA explained they turn off a call light even if a task is not completed because they already let the nurse or aide know. Staff L, OTA said they advised the resident's nurse, Staff F, LPN about Resident #132 needing to be repositioned. On 5/18/26 at 11:07 a.m., an interview was conducted with Staff F, LPN regarding being notified Resident #132 needed assistance. Staff F asked, what was it they needed again? After Staff F, LPN then remembered Resident #132 needed to be repositioned and said, Oh yeah, I will let the aide know. On 5/20/26 at 5:37 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated call lights should be answered timely, and the residents' needs should be addressed timely as well. The DON stated any care, or rehabilitation staff is able to help assist a resident with repositioning, so she is unsure as to why Staff L, OTA did not help assist Resident #132 in being repositioned. The DON stated it is not proper procedure to turn off the call light if the resident's need is not able to be met at the time it is answered. The DON said staff is to leave the light on, to prevent a resident being left unattended for an hour after already making their needs known. A review of Resident #132's admission record revealed an admission date of 5/7/26, with diagnoses to pressure ulcer of sacral region, chronic pain syndrome, the presence of right artificial hip joint, and multiple fractures of the right-side ribs. A review of Resident #132's Quarterly Minimum Data Set (MDS) assessment, dated 5/13/26, revealed a BIMS of 14 out of 15, indicating Resident #132 is cognitively intact. Resident #132 required Partial/Moderate assistance. Further review of the MDS revealed Resident #132 has a pressure ulcer/injury and is at further risk for developing additional (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure ulcers/injuries. Resident #132 has one Stage 3 pressure ulcer and one Stage 4 pressure ulcers that were present before being admitted to the nursing home facility. A review of Resident #132's current Care Plan revealed the resident has a communication problem and should be monitored and followed up on for any physical/nonverbal indicators of discomfort or distress. Resident #132 also has and is at risk of pain, and unsuccessful interventions should be reported to the physician. Resident #132 has nonpharmacological interventions for pain include: repositioning for comfort. Any findings should be reported to the physician. Resident #132 should be free from any new skin impairments or worsening of current conditions by being provided with preventative skin treatments as ordered and tolerated by the resident. Resident #132 is to be free from pain or discomfort by being encouraged and assisted with repositioning to prevent skin breakdown, and responding promptly to requests for assistance. A review of Resident #132's progress notes revealed a Physician Note from 5/18/26 mentioning due to the resident's multiple medical issues, this places them at high risk for readmission without proper care. Neglecting regular monitoring and management can result in symptom exacerbation and complications leading to rehospitalization. Review of a physician Note from 5/14/26 revealed Resident #132, has the most pain from her wound to her buttocks. Further review of the note showed the resident has fragile skin, scattered bruising and multiple wounds making Resident #132 at high risk for pressure ulcers and poor healing if not receiving adequate therapy and pain control. A psychiatric note from 5/11/26 revealed the resident has reported painful chronic wounds on her buttocks, expressing their current pain medication is not providing relief. A review of the facility's CNA job description revealed the following: Provide quality nursing care to residents in a long-term care environment which promotes their rights, dignity, freedom of choice, and their individuality under the supervision of a Registered Nurse. Provide individualized attention which encourages each resident's ability to maintain or attain the highest practical physical, mental, and psychosocial wellbeing. Maintain the comfort, privacy, and dignity of each resident in the delivery of services to them. Provide care that maintains each resident's skin integrity to prevent pressure ulcers, skin tears, and other damage by changing incontinent residents, turning, repositioning immobile residents. 2. On 5/17/26 at 9:26 a.m., an interview was conducted with Resident #109. Resident #109 stated they had an unwitnessed fall off of their bed a few months ago around 9 or 10 p.m. The resident stated they were yelling for someone to come help them as the call light was not within reach after they had fallen. Resident #109 stated they had to call their family member who lives about seven minutes away, and their family member had arrived to the room before a member of the care staff came to help get them back in bed. On 5/18/26 at 2:26 p.m., an interview was conducted with Resident #109's family member. The resident's family member stated Resident #109 had gotten close to the edge of their bed then fell off. The family member stated Resident #109 was on their knees and could not find their call light. The family member stated Resident #109 was on the side of the bed for about 45 minutes before help came and was yelling for help to get back up. The family member stated they saw Staff O, Certified Nursing Assistant (CNA) down the hall, and got the staff member to assist putting Resident #109 back into bed. On 5/19/26 at 4:21 p.m., an interview was conducted with Staff O, CNA. Staff O, CNA stated they were not working with Resident #109 the night of the 3/13/26 fall, but they were down the 100 hall due to looking for a Hoyer lift for another resident. Staff O, CNA, stated they heard the resident calling for help, and saw the family member coming to get them for help. When Staff O, CNA entered the room they saw Resident #109 on the floor and their family member in the room. Staff O, CNA stated they went and got another care staff member to help Resident #109 back into bed. Staff O, CNA said Resident #109's call light was not within reach from where the resident fell. On 5/20/26 at 11:51 a.m., an interview was conducted with Staff Q, CNA. Staff Q, CNA stated they were working on the assignment for Resident #109 on the night of 3/13/26 and were taking care of another resident at the time when the fall occurred. When Staff Q, CNA came out of the room they saw Staff O, CNA, calling for help. When Staff Q, CNA entered Resident #109's room they saw the resident on the floor at bedside with their family member in the (continued on next page)		

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Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105599	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2026
NAME OF PROVIDER OR SUPPLIER Hillside Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room. Staff Q, CNA stated Staff O, CNA and Staff N, LPN helped Resident #109 get back into bed. On 5/19/26 at 6:46 p.m., an interview was conducted with Staff N, LPN. Staff N, LPN stated they were on the other end of the hall at the time of the fall passing medications to other residents. Staff N, LPN stated Staff O, CNA told her Resident #109 was on the floor and they both helped Resident #109 back into bed. Resident #109's family member was in the room at the time but was not sure if he was there when the fall occurred as he is not usually at the facility around nighttime. Staff N, LPN stated they assessed the resident and initiated a skin and vital check. Staff N, LPN stated the resident told them they slowly lowered themselves to the floor. Staff N, LPN stated they did not document the fall or initiate timely assessments because they were busy having to do 3 admissions, so they were going to do the evaluation when they got a chance but forgot. Staff N, LPN stated they also notified the physician and NP (Nurse Practitioner) of the resident's fall. Staff N, LPN said they did not notify the DON in a timely manner. Staff N, LPN said they did not hear Resident #109 calling out for help due to them being all the way at the end of the hall. Staff N, LPN stated the DON found out about Resident #109's fall after the late entry CIC (Change in condition) was put in. Staff N, LPN stated they checked on the resident the remainder of their shift. Staff N, LPN stated Resident #109 was confused at times but was alert. Staff N, LPN stated they did not document timely. On 5/19/26 at 5:41 p.m., an interview was conducted with the DON and the Nursing Home Administrator (NHA). The DON and NHA stated on 3/13/26 at 9:30 p.m. the CNA notified the nurse of Resident #109 being on the floor in a sitting position. The DON and NHA stated the nurse helped Resident #109 back into bed with the resident's family member present in the room. The DON stated regarding neuro checks the patient denied hitting their head on the floor while trying to transfer from their bed to their wheelchair and eased themselves to the floor. The NHA stated Resident #109 had a skin assessment initiated and had no visible injuries with their consciousness remaining the same. The NHA stated the on-call practitioner was notified with no new orders put into place. The DON stated Resident #109's family member was present at the time of the event but was not interviewed on what happened. The DON stated they were not notified of the fall initially and were notified on 3/19/26, six-days after the fall occurred because Staff N, LPN forgot to document what happened regarding the fall. The DON stated the process for when a resident fall includes the following: The nurse is to assess the resident for any pain or skin tears/bruising. A CIC is then to be put in when the event occurs, not days later. When the CIC is put into place, the physician, family and DON are to be notified of the incident. When a fall occurs all incident assessments are to be completed timely and within the same shift that the event occurred. If a resident is to have an unwitnessed fall, all assessments are to be completed as well as neurological checks which are documented on the neuro-checks form and are uploaded by medical records. Once the DON is notified of a fall, they are to ask all parties involved what happened during the event and find out when the last time someone was with the resident and where staff was at the time of the incident, and to document the findings. The DON stated vitals taken hours after a fall are not an accurate representation of data for the fall at the time it occurred. The DON and NHA stated they did not have documentation of their interviews and education regarding this file. A review of Resident #109's admission record revealed an initial admission date of 9/9/25 and a readmission date of 2/6/26, with diagnoses to include unspecified dementia, and a personal history of a traumatic brain injury. A review of Resident #109's Quarterly Minimum Data Set (MDS) assessment, dated 5/4/26, revealed a BIMS of 12/15, indicating Resident #109 is moderately impaired. A review of Resident #109's current Care Plan revealed the resident will be free of falls with interventions to include providing the resident with frequent reminders to use the call light for transfers and ambulation. A review of Resident #109's progress notes revealed on 3/16/26 a physician encounter note revealing the following: 3/16/26 patient is seen up in the wheelchair, no distress, denies pain at this time. She apparently had an unwitnessed fall yesterday, denies injury. A Late Entry Interdisciplinary Team (IDT) note entered on 3/17/26 revealed: IDT meeting held to review patient fall on the floor in her room on 3/13/26. At approximately 21:30 patient seen on the floor by staff member. No injuries noted. Patient (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not wet or soiled. She was wearing non-skid footwear. Call light was not on. A review of the facility's Incident Management Policy revealed the following: The licensed nurse will: Document the facts of the incident in the resident chart, document notification of responsible party and physician, new orders and new interventions implemented. Begin alert charting (a note specific to event/resident response to event every shift for a specific duration) Complete appropriate risk assessment as indicated (e.g. Fall Risk Assessment, Elopement Assessment, Smoking Assessment etc.) The Director of Nurses/Designee will: Participate in investigations and risk analysis. Provide and document clinical team education/training/competencies as indicated. Provide and document clinical team performance discipline as indicated. The Nursing Home Administrator will: Review and sign off on completed investigations and Incident Reports. Initiate, participate, review, approve, and close investigations. A review of the facility's policy, Falls- Managing, Preventing, and Documentation revealed the following: 'Fall' refers to unintentionally coming to rest on the ground, floor, or other lower level, OR as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. If there is a loss of balance during supervised therapeutic interventions and the resident comes to rest on the ground floor or next lower surface despite the clinician's effort to intercept the loss of balance, it is considered a fall.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews the facility failed to provide enteral nutrition as ordered by the physician for one resident (#34) out of two sampled. Findings included: An observation on 05/17/2026 at 1:44 p.m. of Resident #34 revealed her tube feeding was connected; the pump was off and not running. Resident #34's nutrition feed bottle was dated 5/16/2026 at 2:00 P.M.; also written on the bottle was 65 mL/hr. There was 375 mL of nourishment left in the bottle as indicated by the measurement markings on the side of the bottle. Hanging beside the bottle was a clear bag with 400 mL of water remaining. The clear bag was also connected to the pump and Resident #34. At the time of this observation, the pump was off and not running. Review of Resident #34's admission Record showed the resident was admitted on [DATE]. The record included diagnoses not limited to dysphagia following non traumatic intracerebral hemorrhage, encounter for surgical aftercare following surgery on the digestive system, gastrostomy status, and oropharyngeal phase dysphagia. Review of Resident #34's May 2026 Medication Administration Record (MAR) showed an order dated 5/6/26 at 1:00 p.m. showing the resident was to receive liquid nutrition at 65 milliliter (mL)/hour for 20 hours or until 1300 mL total volume reached with water flush of 60 mL/hour every 1 hour/day for nothing by mouth (NPO). The MAR revealed a scheduled time of 24h. The MAR revealed one daily administration entry for the scheduled 24hr time frame. The MAR revealed the resident's nutrition had been administered on 5/16/26 at 2:16 p.m. Review of the liquid nutrition prescribed to Resident #34 showed the Ready-to-Hang bottle contained 1 liter (1000 mL) of nourishment (located at https://athome.medline.com , retrieved on 5/18/2026). The amount of liquid in the bottle (1000 mL) showed the resident was to receive approximately 1.3 bottles of nutrition per the ordered volume of 1300 mLs. One bottle of nourishment would run for approximately 15.38 hours if ran continuously at 65 mL/hr., showing the bottle hung on 5/16/26 (Saturday) at 2:16 p.m., would have had to be changed to a second bottle on 5/17/26 at approximately 5:40 a.m. The resident would receive 300 mLs from the second bottle, leaving a volume of 700 mLs. The MAR showed the resident's nourishment was administered on 5/17/26 at 1:07 p.m., 37 minutes prior to the observation of the bottle at 1:44 p.m., containing 375 mLs, dated 5/16/26 at 2:00 p.m. and the pump was not running. Review of Resident #34's Nutrition Evaluation, dated 3/26/26, showed the resident's BMI (body mass index) was 25.3 and was overweight. The resident had received enteral nourishment and fluids, continuously with liquid nourishment delivered at 65 milliliter (mL) / hour for 20 hours to equal 1300 mLs. A water flush of 60 mLs every hour to be delivered for 1200 mLs and 761 free fluid for a volume of 1961 mLs. The evaluation showed the resident was dependent upon feeding assistance. The summary revealed the mini nutritional assessment score showed malnutrition which the resident had received nutritional needs via tube feedings at 65 mL/hour for 20 hours for a total of 1300 mLs/day. An interview was conducted on 5/20/26 at 1:51 p.m. with the Registered Dietitian (RD). The RD (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported Resident #34 was to review 1300 mLs (of nutrition) at 65 mL/hour, staff were to hang at 2:00 p.m. and remove at 10 a.m. The RD reported sometimes a resident would be taken off the nutrition when going to therapy and that was why the RD ordered volume of 1300 mLs to be given. The RD confirmed the resident was to receive 2 bottles of nutrition (to deliver 1300 mL's) and if the observed bottle was the same bottle (hung at 2:00 p.m. on 5/16/26) it did appear the resident received 675 mL's (625 mL's). An interview was conducted on 5/20/26 at 3:15 p.m. with the Director of Nursing (DON) and the Regional Nurse Consultant (RNC). The DON stated a bottle of (brand name) liquid nutrition contained 1000 mLs. The staff members had to think about how many bottles of nutrition it took to deliver Resident #34's volume of 1300 mL's. The staff stated the preference was to hang the nutrition bottles with the date and time it was hung. An interview was conducted on 5/20/26 at 3:20 p.m. with Staff G, Registered Nurse (RN). The staff member reported not knowing if another bottle was there and another was hung. Staff G stated the family does request Resident #34 to come off the nutrition to go outside at times. The staff member stated if the nutrition is off for a couple of hours then staff need a physician order and document the incident. Staff G stated that two bottles of nutrition are necessary for a volume of 1300 mLs and the bottles should be dated and timed as to when they were applied. Review of the policy &dash; Enteral Nutrition, revised 9/2024, revealed Adequate nutritional support through enteral nutrition is provided to residents as ordered. 2. Enteral nutrition is ordered by the provider based on the recommendations of the dietitian. If a feeding tube is ordered, the provider and interdisciplinary team document why enteral nutrition is medically necessary. 6. Enteral feedings are scheduled to try to optimize resident independence whenever possible (e.g., at night or during hours that do not interfere with the residents ability to participate in facility activities). 8. Staff caring for residents with feeding tubes are trained on managing enteral tubes and		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility did not ensure medications were correctly reconciled upon admission to the facility for one resident (#131) of one resident sampled, resulting in delayed medical intervention and pain. Findings included: An interview on 5/19/2026 at 3:02 P.M. with Resident #131 was conducted. Resident #131 said she did not receive any medication on 5/15/2026 after she arrived at the facility. Resident #131 said she experienced excruciating pain on 5/15/2026 and 5/16/2026. Resident #131 said she explained to the staff that she was supposed to receive 200mg of Gabapentin three times a day and not 100mg three times a day. A record review of Resident #131's admission record showed he was admitted to the facility on [DATE] with diagnoses including but not limited to open wound left ankle, polyneuropathy, and spinal stenosis. A review of Resident #131's admission assessment, dated 5/18/2026 revealed a brief interview for mental status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment. An interview on 5/19/2026 at 2:56 P.M. with the Power of Attorney (POA)/Health Care Surrogate (HCS) for Resident #131 was conducted. The HCS said Resident #131 was having excruciating pain after arriving at the facility on 5/15/2026. The HCS said Resident #131 did not receive the correct dose of Gabapentin on 5/16/2026 and did not receive any pain medication on 5/15/2026. A review of Resident #131 documented pain levels revealed the following: 5/15/2026 at 11:18 P.M. - Pain Level of 9/10 5/16/2026 at 3:27 A.M. - Pain Level of 9/10 5/16/2026 at 5:49 A.M. - Pain Level of 9/10 5/16/2026 at 7:49 A.M. - Pain Level of 5/10 5/16/2026 at 1:37 P.M. - Pain Level of 5/10 A review of Resident #131 progress note on 5/15/2026 at 6:44 P.M. revealed the following entry, [AGE] year-old female arrived at facility via stretcher. DX (diagnosis): Post surgery for leg ulcers and heel debridement .MD (medical Doctor) notified and medications confirmed. A review of the ordered hospital discharge medication list revealed the following medication was ordered to be continued:- Gabapentin 100 MG capsule; Commonly known as: Neurontin; Take 2 capsules (200 mg total) by mouth in the morning and 2 capsules (200 mg total) at noon and 2 capsules (200 mg total) before bedtime. A review of the physician orders revealed the following order was transcribed:- Gabapentin Oral Tablet 100 MG Give 1 tablet by mouth three times a day for neuropathy. The review of records revealed Resident #131's Gabapentin was reconciled incorrectly resulting in excruciating pain. An interview was conducted on 5/20/2026 at 3:40 P.M. with the Director of Nursing (DON). The DON confirmed Resident #131's medications were not reconciled correctly upon arriving at the facility. The DON said Resident #131 should have received pain medication after arriving at the facility and said the nurse should have pulled the medication from the pyxis (An automated medication dispensing cabinet used in healthcare facilities). A review of a policy revised on 2/2023, titled, Medication Reconciliation Admission/Re-Admission revealed the purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications upon admission or readmission to the facility. The guideline was 1: Medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications for the purpose of preventing unintended changes or omissions at transition points of care. The procedure was 2: All medications from the medication history, the discharge summary, should be prescribed to the resident after approved by the facility physician. 4: Review the list carefully to determine if there are discrepancies/conflicts.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and record review, the facility did not ensure the medication error rate was below 5% for two residents (#6 and #68) out of five residents sampled for medication administration. This resulted in 2 errors out of 29 medication administration opportunities for a medication error rate of 6.9%. Findings included: An observation was conducted on 5/18/2026 at 8:20 A.M. of medication administration with Staff E, Licensed Practical Nurse (LPN). Staff E, LPN was observed preparing and administering the following medications for Resident #6: Lorazepam 0.5mg x 1 tablet. Reconciliation of Resident #6's physician orders showed the following orders: - Lorazepam Oral Tablet 0.5mg; Give 1 tablet by mouth every 6 hours for anxiety-agitation-restlessness. A review of the medication audit report for Resident #6 on 5/18/2026 at 11:40 A.M. revealed the last documented dose for lorazepam was administered on 5/18/2026 at 5:16 A.M. An interview on 5/18/2026 at 1:10 P.M. with Staff E, LPN was conducted. Staff E, LPN was unable to locate any administration in the electronic medical record for the 8:20 A.M. administration observed. Staff E, LPN said she could not document the dose given at 8:20 A.M. because the medication administration record would not allow documentation at that time. Staff E, LPN said she documented the medication was given around 12:00 P.M. An observation was conducted on 5/18/2026 at 9:08 A.M. of medication administration with Staff G, LPN. Staff G, LPN was observed preparing and administering the following medications for Resident #68: Metoprolol 50mg x 1/2 tablet. Reconciliation of Resident #68's physician orders showed the following orders: - Metoprolol Tartrate Oral Tablet 12.5mg; Give 1 tablet by mouth one time a day for Hypertension; Give in evening. An interview was conducted on 5/20/2026 at 9:18 A.M. with the Director of Nursing (DON). The DON said the lorazepam should have been documented at the time the medication was administered. The DON said the metoprolol dose should have been 12.5mg and not 25mg. The DON said the doctor should have been notified of Resident #68 receiving the wrong dose. The DON said she did not see documentation where the doctor had been notified of Resident #68 receiving the wrong dose. The DON said the expectation was for the nurses to document on the medication administration record at the time the medication was administered. A review of a policy revised on 1/2024 titled, Medication Administration revealed the standard Medications are ordered and administered safely and as prescribed. The procedure Medications are administered in accordance with prescriber orders.; 5: Medications errors are documented, reported.; 6: Medications are administered within one hour before or after the prescribed time.; 9: The individual administering the medication checks the label to verify the right resident, right medication, right dose, right time. before giving the medication.; 17: As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a: The date and time the medication was administered.		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility did not ensure therapy or restorative service were provided for two residents (#68, and #83) of two residents sampled. Findings included: 1. An observation and interview on 05/17/2026 12:48 PM with Resident #68 was conducted. Resident #68 was observed lying in bed and had bilateral upper arm contractures. Resident #68 said he was not receiving therapy services and had not received therapy since he was admitted . Resident #68 said he would like to be receiving therapy; Resident #68 said he does not have any braces or splints. A record review of Resident #68's admission record showed he was admitted to the facility on [DATE] with diagnoses including but not limited to early-onset cerebellar ataxia, Friedreich ataxia, and major depressive disorder. A review of Resident #68's minimum data set (MDS), section C, dated 4/5/2026 revealed a brief interview for mental status (BIMS) score of 15 out of 15 indicating cognitively intact. A review of Resident #68's physician orders revealed the following order dated 4/1/2026: Therapy: Resident may be screened or evaluated by Physical, Occupational, and/or Speech Therapies as needed. No directions specified for order. A review of Resident #68's care plan initiated on 4/2/2026 revealed a focus of: Resident has a potential for ADL (activities of daily living) selfcare deficit r/t (related to) ADL needs and participation may vary, fatigue, chronic medical conditions; with interventions included: PT/OT evaluation/treatment/screen as indicated and/or as ordered. A review of Resident #68's MDS Section O, O0390. dated 4/4/2026 revealed no therapy services (PT, OT, ST, RT) were being utilized. An interview on 5/19/2026 at 12:50 P.M. with the Physical Therapy Assistant (PTA) was conducted. The PTA said there were no therapy notes because Resident #68 was not evaluated. The PTA said Resident #68 was admitted with Medicaid services and was not evaluated due to not having a payor source. The PTA said if Resident #68 had Medicare A services, then he would have been evaluated for therapy services. An interview on 5/19/2026 at 2:45 P.M. with Nursing Home Administrator (NHA) was conducted. The NHA said Resident #68 was not screened by therapy due to being admitted to the facility for Long Term Care services. The NHA said Resident #68 was admitted to the facility from another skilled nursing facility. The NHA stated, Ideally therapy would go in and at least assess the resident to see if they need therapy services. The NHA said Resident #68 was not evaluated or assessed upon admission. An interview on 5/20/2026 at 10:01 A.M. with the Director of Nursing (DON) was conducted. The DON said she does not know if Resident #68 was evaluated, but the therapy department would know better than she would. (continued on next page)		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 5/20/2026 at 10:35 A.M. with the Director of Therapy (DOT) was conducted. The DOT said Resident #68 was not screened by physical or occupational therapy. A review of a policy revised 1/2024, titled, Therapy Services revealed the guideline was: 1: The physician, in coordination with facility staff will determine the resident/patient's function along with their physical condition to determine if therapy services are needed upon admission. 2. On 5/17/26 at 3:20 p.m., an interview occurred with Resident #83's family member. Resident #83's family member stated Resident #83 never gets any kind of restorative exercise ever since they were discharged from physical and occupational therapy. Resident #83's family member stated they feel the resident is forgotten due to his abilities. They said staff does not exercise the resident's arms, legs, or hands. Resident #83's family member said they have not seen staff come and do any kind of exercises with the resident, despite bringing in one-pound weights for the Resident to use at bedside. Resident #83's family member stated they would feel better if they knew the resident was getting restorative care to become stronger and independent. On 5/19/26 at 2:14 p.m., an interview was conducted with Staff F, LPN. Staff F, LPN stated they assume most bedridden or contracture residents are getting the proper range of motion (ROM) evaluations as ordered. Staff F, LPN stated they have not seen anyone do any type of towel rolling, palm guards or ROM (range of motion) therapy for Resident #83 for as long as the resident has been at the facility. On 5/20/26 at 10:22 a.m., an interview was conducted with the Director of Rehab (DOR). The DOR stated Resident #83 was discharged from physical, occupational, and speech therapies by the physician due to the resident not having much potential of rehabilitation from the massive stroke the resident endured. The DOR stated Resident #83 was ordered to receive restorative care for ROM and to use palm guards as tolerated. The DOR said Resident #83's hands are very tight, so the restorative team is to do ROM with the resident's arms and legs while having the palm guards on. The DOR stated they do not monitor the restorative care team but knows they are supposed to document when the care is provided to the resident. The DOR stated they educated the restorative nurse on the resident needing the care and what is to be provided. On 5/20/26 at 12:28 p.m., an interview was conducted with the Director of Nursing (DON). The DON reviewed Resident #83's record and stated they do not see any documentation regarding restorative care in the residents' portal. The DON said what normally happens is when restorative care is ordered, there will be an assessment that pops up for the restorative nurse to initiate the evaluation. The DON described the process for residents who have ordered restorative care begins at interdisciplinary team (IDT) meetings where the DOR notifies the rest of the team who is being ordered for the restorative program. After the IDT meeting nursing will be notified in the portal system to initiate the evaluation for the resident, a copy of the evaluation request is printed and put into a physical binder for the Restorative Aid to pick up and begin any evaluations and orders at the start of each shift. The DON said restorative orders are to begin the day or next day they are ordered. Once the restorative evaluation is completed, the restorative aid will receive a new task for the resident in the portal system where they can indicate the restorative care provided. The DON stated Resident #83 had a restorative evaluation ordered but does not see one completed for the resident. The DON confirmed Resident #83 should have an active ROM or Restorative care task, but it was not found in their task list for the resident. The DON said the task is not put in for Resident #83 because the evaluation was never initiated or completed. (continued on next page)		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/26 at 4:00 p.m., an interview was conducted with Staff R, Certified Nursing Assistant Restorative Aid (CNARA). Staff R, CNARA explained therapy will let the restorative nurse know they added a new resident and will inform the restorative team what needs to be done with the resident. Staff R, CNARA stated they are provided with a printout each day that includes a list of residents, their information and what needs to be done for each resident. Staff R, CNARA said restorative care is provided to residents at least three times a week but can be more if the resident prefers it. Staff R, CNARA stated management is to put the task into the resident's profile so they can chart what restorative care was provided, but the unit manager who managed restorative care no longer works at the facility. Staff R, CNARA stated Resident #83 does not have a task in their profile for restorative and ROM care to be provided. Staff R, CNARA stated there was no way for them to document Resident #83's restorative/ROM care due to the task not being in their system. A review of Resident #83's admission record revealed an initial admission date of 2/19/26 and a re-admission date of 3/11/26, with diagnoses to include frontal lobe and executive function deficit following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side, and arteritis. A review of Resident #83's Quarterly Minimum Data Set (MDS) assessment, dated 3/17/26, revealed a Brief Interview Mental Score (BIMS) was not provided for Resident #83 due to the resident being rarely/never understood. Further review of Resident #83's cognitive patterns revealed the resident has a short and long-term memory problem, no recall ability, and is severely impaired for cognitive skills for daily decision making. Review of Resident #83's hearing, speech, and vision revealed the resident has adequate hearing and vision and is unable to be verbally understood. Functional abilities range of motion (ROM) revealed Resident #83 is impaired on both upper and lower extremities and uses a manual wheelchair, requiring Dependent assistant where helper does ALL of the effort, resident does none of the effort to complete an activity, and an assist of 2 helpers is required. A review of Resident #83's current Care Plan revealed the resident has a cognitive deficit communication problem. Resident #83 is to be free from ADL and self-care deficits through treatments being provided as ordered. Resident #83 is to wear palm protectors on both hands Review of Resident #83's chart did not reveal any documentation regarding restorative care therapy. A review of Resident #83's progress notes revealed no documentation regarding restorative care therapy once it was ordered. A review of Resident #83's occupational therapy (OT) evaluation and plan of treatment revealed the residents exercise prescription's purpose is for ROM as the resident will benefit from co-treatment modes of therapy as an adjunct to individual therapy. A review of Resident #83's OT Discharge (DC) summary dated 4/2/26 had DC recommendations for the restorative and functional maintenance program to be established for the resident. A review of Resident #83's Restorative Nursing Program Initial Assessment revealed the assessment was ordered on 4/3/26 by physical therapy (PT) and not completed by the restorative staff. A review of Resident #83's tasks revealed no Restorative Care task implemented for the resident. A review of the facility's Restorative Nursing Services Policy revealed the following: To promote the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105599	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2026
NAME OF PROVIDER OR SUPPLIER Hillside Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's optimum function a restorative nursing program may be developed by proactively identifying, care planning, and monitoring of a resident's assessments and indicators. Restorative nursing program refers to interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. The concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. Restorative programs may be initiated by nursing and/or therapy. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g., physical, occupational, or speech therapies). Residents may be started on a restorative nursing program upon admission during the course of stay or when discharged from rehabilitative care. Restorative indicators may be identified by multiple disciplines utilizing various assessments, physician orders, progress notes, environmental factors, caregiver conversations, and any other means of communication. Restorative nursing functions can be within one of the following categories: Range of Motions (Active or Passing) Splint or brace assistance Restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care. The resident or representative will be included in determining goals and plan of care. Communicate the restorative care plan and care directives to other members of the interdisciplinary team. Nursing assistants/aides/other staff who are trained will document provided techniques per the restorative care plan in the medical record. The registered nurse or licensed practical nurse will conduct an evaluation on a routine basis to include progress towards goals and response to the program. Any changes will be documented in the medical record. The restorative care plan and care directive will be reviewed/revised as indicated. Restorative goals may include, but are not limited to supporting and assisting the resident in: Adjusting or adapting to life-changing abilities Developing, maintaining or strengthening his/her physiological and psychological resources Maintaining his/her dignity, independence and self-esteem Participating in the development and implementation of his/her plan of care.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105599	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2026
NAME OF PROVIDER OR SUPPLIER Hillside Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to maintain an effective infection prevention program related to accurate signage posting for one resident (#18) out of one resident sampled for contact precautions. Findings included: An observation on 05/18/2026 at 10:53 AM, revealed a sign posted outside of Resident #18's room door reading, Enhanced Barrier Precautions. Record review for Resident #18 revealed an order for contact precautions as follows: encourage and assist resident to maintain contact precautions for Extended-Spectrum Beta-Lactamase (ESBL) in urine. The order start date was 05/09/2026, with an end date of 05/19/2026. An interview with Staff I, Certified Nursing Assistant (CNA), on 05/19/2026 at 12:45 PM revealed the most recent education for transmission-based precautions (TBP) was completed in the prior week. Staff I said the staff was educated to ask a nurse questions if they do not understand a particular precaution. Staff I stated staff had been educated to observe door signage of resident rooms in order to determine the proper protocol to follow prior to entering a resident's room. Staff I said the facility assumes that if a training has been completed, then the staff is knowledgeable about the information presented during education. An interview with Staff A, CNA, on 05/19/2026 at 1:12 PM revealed the education presented during the previous week on contact-based precautions informed staff to put on a gown and gloves prior to entering a resident's room under any circumstances. The staff member said the gown and gloves must be removed and discarded prior to exiting the resident's room. An interview was conducted with Staff G, Licensed Practical Nurse (LPN), on 05/19/2026 at 1:47 PM revealing that nurses bear the responsibility of assigning accurate TBP signage to residents. Staff G said ESBL in urine would require a resident to be placed under contact precautions. Staff G stated having received education on TBP in the previous month. Staff G said the nurses familiarize themselves with residents on their assignments from the report of the previous nurse. Staff G stated if a resident has a new diagnosis of ESBL in their urine, the nurse is responsible for ensuring signage is posted on the resident's door to reflect the contact precautions. An interview with Staff C, LPN on 05/19/2026 at 2:23 PM revealed previous education on TBP, although unsure of the most recent education. Staff C said contact precautions are assigned to a resident with a positive test for ESBL in urine. Staff C said nurses are responsible for ensuring accurate TBP signage is posted outside of resident room doors. Staff C recalled last being assigned to Resident #18 on 05/15/2026, during which contact precautions were assigned to the resident due to confirmation of ESBL in urine. An interview was conducted with Staff J, LPN/ Minimum Data Set (MDS) coordinator on 05/19/2026 at 3:18 PM. The interview revealed staff is education on TBP at least one time per month. Staff J said it is the role of the MDS coordinator to review a resident's medical record upon admission which includes noting isolation indicators. Staff J said the Assistant Director of Nursing (ADON) is the infection control preventionist and is ultimately responsible for the correct isolation being assigned to a resident in addition to the correct signage being posted. Staff J said the ADON can delegate other staff to post proper TBP signs on resident rooms. An interview conducted with the Director of Nursing (DON) on 05/20/2026 at 2:09 PM, revealed if a resident is on contact precautions, staff should perform hand hygiene prior to putting on a gown and gloves, then staff should enter the room after putting on appropriate personal protective equipment. The DON said when the facility receives a new admission on the floor, the assigned nurse enters orders for appropriate TBP. If the assigned nurse does not enter the appropriate orders, the clinical team will review the resident's medical record during a morning meeting and assign the resident to the proper TBP. The DON said Resident #18 was on contact based precautions due to a positive result of ESBL in urine from 05/09/2026 - 05/19/2026. Review of a facility policy titled, Infection Control-Infection, Prevention and Control Program, issued 10/2018, revised 06/2023 did not reveal a policy for contact-based precautions or enhanced barrier precautions. (Photographic evidence obtained)		