STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105603	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riviera Palms Rehabilitation Center	926 Haben Blvd Palmetto, FL 34221

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to maintain a home-like environment for two rooms (124, 174) out of twenty-nine rooms sampled. Findings included: During a facility tour on 06/02/2025 at 9:30 a.m. room [ROOM NUMBER]'s bathroom was observed with a towel wrapped around the bottom of the toilet. During an interview on 6/2/2025 at 10:30 a.m. with Staff V, Certified Nursing Assistant (CNA), she stated she has to put a towel on the bathroom floor in room [ROOM NUMBER] for the resident's safety. She stated whenever the toilet is flushed, water leaks on the floor. She stated she had reported the problem to maintenance. During an interview 06/05/2025 at 10:37 a.m. with Staff X, Maintenance Assistant. Staff X stated he was notified about the toilet in room [ROOM NUMBER] a week ago, but he had to order a part to do the repair. He stated the parts came in last Thursday, but he did not have time to fix the toilet. During an interview on 06/05/2025 at 10:37 a.m. with Staff W, Regional Director of Maintenance (RDOM). He stated if a toilet has a leak, it should be fixed immediately. He stated if the repair involved a part that needed to be replaced, then his expectations was for someone in the maintenance department to go to the store to purchase the part and fix the problem immediately. 2. On 6/2/25 at 1:33 p.m., an observation of the bathroom in room [ROOM NUMBER] was conducted. Observations of the bottom right side of the shower revealed two tan colored tiles were missing, exposing a pipe with brown colorization on the pipe. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/25 at 10:15 a.m., an interview and tour was conducted with the Maintenance Technician and Staff W, Regional Director of Maintenace (RDOM). The RDOM stated, The CNAs [Certified Nursing Assistants] put in work orders. The Maintenance Technician stated staff tell him about issues verbally, but he encouraged them to put work orders in the system. The RDOM stated the facility staff have guardian angel rounds which included checking resident rooms every day. He said the findings from the guardian angel rounds are discussed in the daily morning meeting. The Regional Maintenance Director said himself and the Maintenance Technician have a notebook to document concerns when they complete their rounds. He stated staff are asked to put what needs to be repaired in the maintenance log but, That doesn't always happen. The Regional Maintenance Director stated, Our eyes are the CNAs and nurses as they go in the room daily. The Maintenance Technician confirmed he had a work order for room [ROOM NUMBER] but it was related to one of the residents' mattress. A tour of the bathroom with the Maintenance Technician revealed he did not know about the missing tiles in the shower. He confirmed he does check the bathroom during his rounds. He stated the previous residents in that room would use the shower as storage for equipment, therefore he did not see the missing tiles. On 6/5/25 at 10:36 a.m., an interview conducted with Staff F, Housekeeper revealed the hall including room [ROOM NUMBER] was typically her assignment. She confirmed she cleaned the bathroom in room [ROOM NUMBER] and said she was aware of the missing tiles. Staff F, Housekeeper said she did not report it. She said there was another room that also has the same missing tiles. She said she thought maintenance took care of that in their rounds. Staff F, Housekeeper stated she thought she had to report if there was something wrong with the toilets, walls, or anything under the area of housekeeping. On 6/5/25 at 11:08 a.m., an interview with Staff E, CNA revealed she had room [ROOM NUMBER] on her assignment. Staff E, CNA confirmed she goes into the bathroom because she assisted one of the residents with setting her up to use the sink. She said she had not looked at the shower and did not notice the tile was missing. On 6/5/25 at 12:47 p.m., Staff H, Regional Nurse Consultant (RNC) said the facility did not have a home-like environment policy. On 6/5/25 at 10:30 a.m., the RDOM stated the facility did not have a policy related to the environment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to protect the resident's right to be free from neglect for one resident (#59) out of two residents sampled for abuse/neglect. The facility neglected to properly report, assess, document, and intervene in a timely manner for Resident #59 related to an unwitnessed fall with major injury that occurred on [DATE]. This lack of intervention resulted in physical pain and suffering for the resident until his death on [DATE]. This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and or death to Resident #59 and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the severity and scope was reduced to a D after verification of removal of immediacy of harm. Findings included: Resident #59 was admitted to the facility on [DATE] with diagnoses to include: dementia, coronary artery disease, atrial fibrillation, hypertension, failure to thrive, major depression disorder, insomnia, and cardiac pacemaker. The resident was placed in Hospice care on [DATE]. A review of the Minimum Data Set (MDS), dated [DATE], revealed Resident #59 had a Brief Interview of Mental Status score of 00, indicating severe cognitive impairment. A review of the Order Summary Report, dated [DATE], for Resident #59 revealed the following: -Regular diet, soft and bite sized texture, thin liquids consistency -Alerting bracelet: located on left ankle, check for placement every shift -Do Not Resuscitate, Palliative Care -Hospice Diagnosis: Cerebral Atherosclerosis -May go on leave with supervision -Citalopram Hydrobromide oral tablet 40 milligram (mg) one time a day for depression -Depakote sprinkles 250 mg twice a day for depression -Morphine Sulphate 0.25 milliliter (ml) every 4 hours as needed (PRN) for pain 5-10/SOB (shortness of breath) order started on [DATE] -Trazodone Hydrochloride 25 mg daily at bedtime -STAT (Emergent) x-ray Right hip ordered [DATE] (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Lorazepam 0.5 mg every 8 hours for anxiety/agitation/restlessness/sob started [DATE] -Morphine Sulphate 0.25 ml every six hours for chronic pain and continue PRN Morphine started [DATE] -Release body to FH (funeral home) [DATE] A review of a radiology report, dated [DATE] revealed: X-ray Right Hip Acute intertrochanteric fracture of the right femur with varus angulation and mild displacement. Lesser trochanteric avulsion fragment is mildly displaced. No dislocation. No other fractures are identified. Moderate right and mild left hip arthrosis. Conclusion: Acute fracture of the right hip. A review of the Care Plan for Resident #59 revealed the following: Focus: Risk for falls--initiated [DATE] Interventions included: 1:1 supervision started on [DATE] and completed on [DATE] Family educated not to transfer resident [DATE] Post event skin check [DATE] Focus: Right Hip fracture-initiated [DATE] Interventions included: Monitor signs/symptoms complications related to mobility alteration; joint stiffness/pain, swelling, decline in mobility/self-care, contracture formation, creaking/clicking with joint movement, pain after exercise/weight bearing. A review of the Progress Notes for Resident #59 revealed the following: -[DATE] post fall review completed reads: 3/31 at 915 a.m. Therapy walking by room and saw resident become unsteady and fall. nonskid socks floor not wet. call light within reach. adequate lighting. -[DATE] Resident fall--no nursing notes indicating the event occurred at all -[DATE] Resident family is at bedside and reporting that resident is having pain to right hip. Resident does not verbalize pain but grimaces with movement. MD notified and stat X-ray ordered. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-[DATE] LATE ENTRY: IDT (Interdisciplinary team) note-for [DATE] at 1640 CNA (Certified Nursing Assistant) found resident on the floor and notify nurse. Nurse assessed resident and full ROM (range of motion) to all extremities. Nurse attempted to get resident off the floor and resident was being combative, kicking and hitting the staff. After giving resident some space making sure there was no items around resident that would harm him. Resident was able to assist with transfer and 2 other staff members helped. He was placed back on his w/c (wheelchair) and brought to the dining room. Snack given and resident ate it without discomfort. No complaints of pain or facial grimacing noted. He had a small skin tear to his elbow. Cleansed with NS (normal saline) and LOTA (left open to air). Hospice was notified with NNO (no new orders) at this time. Resident [family member] came in about an hour after incident . He was notified of incident, and he stayed to assist with dinner resident ate 100% of his dinner and [family member] stated he transferred his dad back to bed and he complained of pain. He stated, I hope I didn't hurt him. Nurse educated son on not transferring resident without staff assistance. Medications administered and resident is resting in bed . -[DATE] IDT note: CNA reported resident was on the floor on [DATE] at 1640 p.m. Nurse assessed resident and full ROM to all extremities. Son came in to assist resident with dinner and transferred resident to bed without waiting for assistance. He was educated by nurse on calling for assistance he stated, He complained of pain I hope I didn't hurt him. Resident was medicated at the time. Following day resident was not complaining of pain and continued his normal activities without difficulties .On [DATE] Resident [family member] took resident outside to the courtyard as usual without any concerns. She brought him back to his room and transferred him to bed without assistance. She then grabbed hospice nurse and told her that her dad was complaining of pain. Hospice ordered X-ray of right hip, and result obtained with right trochanteric fracture mild displaced . [DATE] Resident with family at bedside. No VS noted, pronounced by 2. MD notified, order to release body received. Spouse notified. Hospice notified. Resident passed at 1045 a.m. -[DATE] Minimally responsive to verbal/tactile stimulation. Per family report, no longer able to swallow and is not accepting fluids .lethargic. -[DATE] Resident with family at bedside. No vital signs noted., pronounced by 2 A review of the Narcotic Log for Resident #59 revealed a prn pain medication order for Morphine Sulphate was available since [DATE]. No pain medications were administered to the resident until after the unwitnessed fall on [DATE]. The first doses of Morphine were administered on [DATE] after an X-ray was taken and confirmed a fracture to the right hip. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:56 p.m. an interview was conducted with the Director of Nursing (DON). The DON stated Resident #59 had a fall on [DATE] but it was not reported to her until [DATE]. She stated the incident was reported by a family member to the hospice nurse and her at the same time. She stated she had no knowledge of the fall prior to [DATE] and she could find no notes related to the fall on [DATE] in the progress notes. The DON stated an investigation was started but no other reports were filed related to the incident. The DON stated the family member reported to the hospice nurse that an aide told her Resident #59 had a fall on [DATE]. The DON said during an interview with Staff D, CNA, she told her on [DATE] she saw Resident #59 on the floor by the roommates bed, and the door to the room, and he was laying on his right side. Staff D, CNA told the DON she notified Staff B, Registered Nurse (RN), and the nurse came to do an assessment. The DON stated this was an unwitnessed fall. The DON said she spoke with Staff B, RN to take a statement about the incident. The DON stated, Staff B, RN said she assumed this was a behavior problem because the resident would be on the floor occasionally. The DON stated Staff B, RN did not call the doctor, notify the DON, or report the incident as a fall. The DON said Staff D, CNA told her the resident did not complain of pain and was put in a wheelchair after being found on the floor. The DON said the aide told her a family member helped Resident #59 back to bed after dinner, and mentioned the resident had pain so she went to tell the nurse. The DON said the family member was unaware the resident was found on the floor at the time. The DON stated the nurse noted a scratch to the elbow at the time and said the resident had no obvious signs of pain. The DON stated the nurse said Resident #59 was combative when they tried to get him off the floor and it took three of them. The DON said she spoke with other nurses and aides who provided care to Resident #59 on [DATE] and they reported no pain was observed. The DON said hospice ordered an X-ray to be done stat on [DATE]. The DON stated the resident complained of pain when she went in to assess him after finding out about the fall. She stated, He definitely had pain when I moved his leg around. The DON stated the family member said the resident was complaining of pain. She said the X-ray results came back with confirmation of a fracture. She stated, she completed the investigation and determined the nurse did not follow policy and report the incident as an unwitnessed fall immediately. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:51 p.m. an interview was conducted with Staff B, RN. Staff B stated she was familiar with the resident and had cared for him intermittently because she was a float person. She stated she would provide care once or twice a week for Resident #59. Staff B, RN, stated on [DATE] she was coming on shift, and she had just finished counting narcotics. She said Staff D, CNA came to her to let her know Resident #59 was on the floor and she did not know what happened. She stated the resident would get on the floor sometimes and sometimes he would need help to get up. She stated she went to see the resident and noticed a scratch on his arm, and she called for help. She said Resident #59 was combative and it took three of them to get him up and put him in a wheelchair. Staff B, RN stated the resident was kicking them and, His range of motion seemed fine to me because he kicked me in the stomach, so I assumed it was one of his get down on the floor days. She said, I documented the incident somewhere, but I do not recall exactly where. The nurse stated the resident sat in his wheelchair until his family member came at dinner time around 6:00 p.m. The nurse stated the family member took the resident back to his room and the aide told her the family member put Resident #59 back to bed and said the resident was uncomfortable. The nurse stated it was time for the night medications, so she gave the resident some Lorazepam and Trazodone. She said she left around 11:00 p.m. after her shift and she did not do another assessment on Resident #59. Staff B, RN stated she found out two days later the resident was injured. She said she could not say it was a fall because the incident was unwitnessed. She stated for the residents that are care planned and get down on the floor she would not report the incident. She stated she did provide care for Resident #59 after the incident and he was always in bed, agitated, and receiving Morphine for the pain. She stated she was not aware if Resident #59 had a previous fall or if he was care planned for falls. An interview was conducted on [DATE] at 10:56 a.m. with Staff D, CNA. Staff D stated, On [DATE] I went down the hall to check on all my residents and I saw the resident on the floor by the roommates bed. I checked on him and he was ok, so I went and got the nurse, I did not touch him or move him. The nurse came down to see the resident. She took vitals and looked at his head. Then three of us picked him up off the floor. He was combative swinging, punching and kicking us so that is why we had three people. He was placed in his wheelchair. Staff D stated Resident #59 did not speak so he could not say he was in pain, and they would have to see if he had a grimace to know if he was in pain. She said she did not see the resident do that. She stated she wheeled the resident to the dining room and gave him a cookie. She said he sat in the chair and ate his cookie. She said she did not see him again until after dinner and he was in his room with a family member who had helped him back into bed. She said the family member told her the resident had pain and stated, I hope I did not hurt him. She said she informed the nurse what the family member told her. She said on [DATE] a family member told her she heard the resident had a fall and she asked me what happened. She stated she told the family member she had found the resident on the floor on [DATE]. She said they took x-rays and found out the resident had a fracture. She stated when she found the resident on the floor she did what she was supposed to do and notified the nurse. She stated she did not tell anyone else. The aide stated she had received education on reporting falls and had signed a paper yesterday. An interview was conducted on [DATE] at 11:16 a.m. with the NHA and the DON. The NHA stated she did not report the incident because she felt finding the resident on the floor was not the cause of the injury. She stated she felt after looking at all the information and doing the investigation the injury occurred when the family member admitted transferring the father to the bed and stated, I hope I did not hurt him. The DON and the NHA stated the nurse did not follow the proper policy and procedure required for a change of status, or unwitnessed fall and report it immediately to the DON. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on [DATE] at 3:51 p.m. with Staff C, Hospice RN. Staff C, RN stated she had taken care of Resident #59 the entire time he was in hospice care at the facility. She stated he was declining from dementia, and he was still eating some and was able to get out of bed and take walks with his family. She stated due to his dementia he was always combative, and he had a few falls while at the facility. She stated he did not speak, and he could be hard to handle but he had never hurt himself before. She stated he was never able to get up and walk or get into a wheelchair by himself, he always needed assistance. She stated prior to the fall he was having a slow decline due to dementia that was typical for the disease. She stated he had started to lose weight and was weak. She stated she was in to see the resident early in the morning of the 14th. She said they had him up in a wheelchair. She said she was seeing another patient when an aide told her the family member wanted to talk to her. Staff C, RN stated the family member told her there was something not right and informed me the facility had found him on the floor a few days before. She said that was the first time she had heard of a fall. She said she informed the DON, the nurse, and the unit manager and none of them appeared to know he was on the floor at all. She said she got an order for an X-ray, and they determined he had a fracture. She stated the family was very involved in the care of Resident #59 and spent many hours a day with him. She stated the family was able to properly assist the resident from a wheelchair to the bed. The hospice doctor gave orders for him to remain in bed and have pain medication around the clock as well as needed. The RN stated a meeting was held with the family and the decision was to allow the resident to just receive comfort measures and pain management for the fracture. She stated the family members were able to tell when the resident was in pain and they would call and let her know if he was comfortable or if he needed more. She stated Ativan was added for agitation as he got closer to death. She stated prior to the fracture he did not appear to be in a lot of pain and really did not require the Morphine that was ordered for him. She stated she was not aware that the resident would throw himself on the floor and it was not ever relayed to her he did so. A telephone interview was conducted on [DATE] at 4:24 p.m. with the Power of Attorney (POA) for Resident #59. The POA stated she was notified by another family member on [DATE] that the resident had a fracture, and he had been found on the floor a couple of days before. The POA stated a family member who was visiting on the 14th observed the resident during a transfer to the bed and the resident yelling in pain. The family member told her she went to the hospice nurse and asked the nurse to come and see the resident and informed her of the incident from [DATE] when he was found on the floor. The POA stated she was not informed of the resident being found on the floor and the nurse never even filed a report or told the doctor. The POA stated the family has been assisting the resident with all of his care and they were capable of assisting him in and out of bed. She stated they knew how to be careful, go slowly, and pivot him into the bed. The POA said on [DATE] when the family helped him at dinner and then took him back to his room he had pain when moving and it was reported by the family member to the facility nursing staff. The POA stated prior to the hip fracture they were getting him up in his chair and taking him to meals. She said they would take him outside for a walk and he never had pain. The POA stated they did have some type of normal routine prior to the fall. The POA stated the doctor said surgery was not an option, and he was too weak to be treated so the best thing we could do is keep him comfortable. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview was conducted on [DATE] at 9:09 a.m. with the Primary Care Provider (PCP) for Resident #59. The PCP stated he had taken care of Resident #59 for 40 years and knew the entire family well. He stated the resident suffered from bad dementia and was quite combative. The doctor stated the resident had trouble walking and had a history of falls. He stated he received a call from the family about a hip problem and told him the resident had a broken hip. The PCP stated after a discussion with the family it was decided Resident #59 had no quality of life and due to dementia he would not be a candidate for an operation. The PCP stated it was decided to just provide palliative care and pain medications for the fracture. The doctor stated he heard there was a fall, but no one had witnessed the fall so he was not aware of the details. He stated he was not notified on [DATE] of a fall and did not find out until [DATE] when the family called him. The doctor stated Resident #59 had a high tolerance for pain and when he went to see him he was on medications, and his pain was about a six. He stated the resident could withstand a lot of pain. A review of the facility policy entitled Abuse and Neglect Prohibition, revised 8/2023, revealed the following: Policy: Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, exploitation, and misappropriation of property. Fundamental information: Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Procedure: Training 1 The center will train each employee regarding these policies. Prevention 3 Staff will be instructed to report any signs of stress from family and other individuals involved with the resident that may lead to abuse, neglect, or misappropriation of resident property, and intervene as appropriate. 4 Residents identified by staff as being self-injurious or exhibiting abusive behavior, which requires professional services not provided in the center, will be reviewed by the physician and treatment plans modified as appropriate. A review of the facility policy entitled Procedural Guidelines: Change in Condition, revised 9/2023 revealed the following: Purpose: The center will inform the resident, consult with the resident's physician, and notify the resident's family member or legal representative when there is a change requiring such notification. Fundamental Information: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Situations requiring notification include: 1 An accident involving the resident which: -Resulting in injury. -Potential to require physician intervention. 2 A significant change in the resident's physical, mental, or psychosocial status that is , a deterioration in health, mental, or psychosocial status in life-threatening conditions or clinical complications. 6 Upon the identification of a change in condition in a resident, the nurse will complete an evaluation of the resident's status, and document findings on the SBAR Change in Condition in the resident's medical record. A review of the facility policy entitled Incident Reporting for Residents or Visitors, revised 8/2023, revealed the following: Policy: All accidents and unusual occurrences involving a resident or visitor will be documented and reported so as to meet all regulatory requirements. Fundamental Information: Adverse Event-An untoward, undesirable, and usually unanticipated event that causes death or serious injury to risk thereof. Procedure 1 When an unusual occurrence is discovered, the employee making the discovery will notify his or her immediate supervisor of the discovery. The supervisor will notify the Administrator and DON immediately. 8 The person discovering the event must complete the Incident/Accident Report prior to completing the shift. Facility immediate actions to remove the Immediate Jeopardy included: A. Reported to the Abuse Hotline. Completed on [DATE] B. The 1-day report was submitted to AHCA. Completed on [DATE] C. Review of facility staff for current background checks. Completed [DATE] D. Licensed staff will be re-educated on the centers policy on Change of Condition and AI\TE to include recognition, assessment, interventions, documentation, and reporting of a change in (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riviera Palms Rehabilitation Center	926 Haben Blvd Palmetto, FL 34221

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	condition or unwitnessed falls to determine if an injury exists in a timely manner. Completed 100% (16 RN's, 17 LPN's, and 53 CNA's) by 5 pm on [DATE]. E. All staff will be re-educated prior to working their next scheduled shift regarding abuse, neglect, exploitation allegations. Ongoing. F. New hire orientation will continue to have education to include Change of Condition and ANE to include recognition, assessment, interventions, documentation, and reporting of a change in condition or unwitnessed falls to determine if an injury exists in a timely manner. The facility does not utilize agency or temporary staff. G. Licensed and certified staff will have retention questions after education to gauge competency of timely recognition, notification, documentation, timely assessment and reporting a change in condition are completed. Verification of the facility's removal plan was conducted by the survey team on [DATE]. On [DATE] interviews with facility staff was conducted for 4 RN's, 12 CNA's, and 3 LPN's to verify education and training had been completed related to topics to include: change of status, abuse/neglect, reporting, unwitnessed falls, resident assessments, and documentation of all unusual occurrences. All staff were able to voice understanding of the policies and processes required to provide competent care to residents. The staff interviewed have worked across all shifts. A review of the sign in sheets was conducted to verify education and training was completed as outlined in the IJ removal plans. --In-service topic completed for nursing staff members to include Change in Condition, Stop and Watch Alerts, ANE and signed off for 102 employees and was completed on [DATE]. --In-service topic completed for nursing staff members to include Pain Evaluation and signed off for 90 employees and was completed on [DATE]. --In-service topic completed for all other employees to include Change in Condition, ANE, and Stop and Watch Alerts and signed off for 100% of staff was completed on [DATE]. Based on verification of the facility's Immediate Jeopardy removal plan the immediate jeopardy was determined to be removed on [DATE] and the non-compliance was reduced to a scope and severity of D.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to monitor side effects of Antipsychotic and Antidepressant medications for one (Resident #82) out of five residents sampled. Findings Included: During an observation on 06/02/2025 at 10:12 a.m., Resident #82 was observed sitting in a wheelchair in her room sleeping. During an observation on 06/02/2025 at 1:16 p.m., Resident #82 was observed sleeping in a wheelchair in the 2nd floor dining room. Review of Resident #82's admission record revealed an admission date of 03/24/2025. Resident #82 was admitted to the facility with diagnosis to include Major Depressive Disorder, Recurrent, Unspecified, Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, And Anxiety. Review of Resident #82 Medicare 5 Day Minimum Data Set (MDS) dated [DATE], revealed Section C. Cognitive Patterns, revealed a Brief Interview Mental Status (BIMS) of 03 out of 15 showing severe cognitive impairment. Review of Section N. Medications revealed Resident #82 is taking Antipsychotic and Antidepressant medications. Review of Resident #82's orders revealed: 03/24/2025 Fluoxetine HCl Capsule 10 milligram (MG) Give one capsule by mouth in the morning for depression. 04/03/2025 Mirtazapine Oral Tablet 7.5 MG (Mirtazapine) Give one tablet by mouth at bedtime for Depression. 03/24/2025 Quetiapine Fumarate Tablet 25 MG Give one tablet by mouth one time a day for mood disorder Medication should be administered as close to scheduled time as possible. 03/24/2025 Quetiapine Fumarate Tablet 50 MG Give 1 tablet by mouth at bedtime for mood disorder medication should be administered as close to scheduled time as possible. The review showed there were no orders for side effect monitoring of Antidepressant and Antipsychotic medications. Review of Resident #82's Treatment Administration Record (TAR) revealed no side effect monitoring for Antipsychotic and antidepressant medications. Review of Resident #82's Care Plan dated 03/24/2025 revealed: Focus: Resident #82 uses Psychotropic Medication Therapy related to Depression The goal showed Resident #82 will be maintained on the lowest effective dose of Antidepressant medication through the review date. Interventions included: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Consult with pharmacy, provider to consider dosage reduction when clinically appropriate; Educate family/caregivers about risks, benefits and the side effects of medications; Evaluate other factors potentially causing insomnia, for example: environment (excessive heat, cold, or noise), lighting, inadequate physical activity, facility routines, caffeine/medications; Monitor for side effects and adverse reactions of psychoactive medications: anticholinergic effects, irregular heartbeat, drowsiness, unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat difficulty swallowing, dry mouth, depression, suicidal idealizations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person; Monitor ongoing signs/symptoms of depression unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance; Psych consult as indicated. A second focus on the same care plan showed Resident #82 is taking an anticonvulsant related to Depression. Goal: Resident #82 will be maintained on the lowest effective dose of anticonvulsant medication. Interventions included: Cueing, reorientation as needed; Discuss with resident/family/caregivers any concerns, fears, issues regarding diagnosis or treatments; Encourage resident to engage in activities that will help improve co-ordination; Monitor for tremors, rigidity, dizziness, changes in level of consciousness, slurred speech, poor coordination, decline in range of motion, gait disturbances, insomnia, dysphasia, behavior changes, changes in motor responses; Psych services, as indicated. During an interview on 06/05/2025 at 10:49 a.m., Staff Q, Licensed Practical Nurse (LPN), stated residents on Antipsychotic or antidepressant medications may have any side effects so they need to be monitored. An order is put in by the unit manager for monitoring. When the order is put in it shows up on the TAR and that is where the nurse documents. She reviewed Resident #82's orders and stated Resident #82 does not have anything. Resident #82 has been refusing her medications so they would not need to monitor for side effect of the medication. During an interview on 06/05/2025 at 10:52 a.m., Staff U, LPN, Unit Manager (UM), stated Residents on Antipsychotic or antidepressant medications have an order for monitoring of side effects of those medications. The nurse's documents the side effects on the TAR. She reviewed Resident #82's orders and stated I do not see the stand-alone order. I am going to add the order now. During an interview on 06/05/2025 at 11:59 a.m., the Director of Nursing (DON) stated residents on antipsychotics/antidepressants should for be monitored for side effects. There is an order for side effect monitoring, which adds it to the TAR. The nurses document any side effects on the TAR. Nurses also document side effects in the progress notes. Resident #82 should have monitoring orders. During an interview on 06/05/2025 at 12:03 p.m., the Pharmacy Consultant stated there should be side effect monitoring for residents. He looks at the nurses notes or doctors notes for any side effect concerns. It's a good standard of practice to monitor the side effects for residents on any medication. He would assume that staff would just know to look for side effects and a stand-alone order for monitoring side effects would not be needed. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Psychotropic Medication Assessment and Monitoring, dated 08/2023 revealed: Purpose - That each resident's entire drug/medication regiment is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being. Procedure: (c). The interdisciplinary team assesses and monitors the appropriateness, effectiveness, and side effects associated with psychotropic medications for each resident via the MDS process. The resident, and when indicated the family or responsible person, will be included in this process. The consultant pharmacist reviews the use of the psychotropic medication order as part of each drug regimen review and monitors for: timely completion of reassessments; reassessment for trial reduction in dose as per acceptable standards of practice, if there is a change in behavior or clinical status; and (d). Monitoring of residents receiving antipsychotic medication will be completed by a licensed nurse as per acceptable standards of practice using the behavior of monitoring record.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to report an injury of unknown origin for one resident (#59) out of 40 sampled residents. Findings included: Resident #59 was admitted to the facility on [DATE] with diagnoses to include: dementia, coronary artery disease, atrial fibrillation, hypertension, failure to thrive, major depression disorder, insomnia, and cardiac pacemaker. The resident was placed in Hospice care on 2/7/2025. A review of the Minimum Data Set (MDS), dated [DATE], revealed Resident #59 had a Brief Interview of Mental Status score of 00, indicating severe cognitive impairment. A review of the Order Summary Report, dated May 2025, for Resident #59 revealed the following: -Regular diet, soft and bite sized texture, thin liquids consistency -Alerting bracelet: located on left ankle, check for placement every shift -Do Not Resuscitate, Palliative Care -Hospice Diagnosis: Cerebral Atherosclerosis -May go on leave with supervision -Citalopram Hydrobromide oral tablet 40 milligram (mg) one time a day for depression -Depakote sprinkles 250 mg twice a day for depression -Morphine Sulphate 0.25 milliliter (ml) every 4 hours as needed (PRN) for pain 5-10/SOB (shortness of breath) order started on 2/03/2025 -Trazodone Hydrochloride 25 mg daily at bedtime -STAT (Emergent) x-ray Right hip ordered 5/14/2025 -Lorazepam 0.5 mg every 8 hours for anxiety/agitation/restlessness/sob started 5/22/2025 -Morphine Sulphate 0.25 ml every six hours for chronic pain and continue PRN Morphine started 5/22/2025 -Release body to FH (funeral home) 5/26/2025 A review of a radiology report, dated 5/14/2025 revealed: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	X-ray Right Hip Acute intertrochanteric fracture of the right femur with varus angulation and mild displacement. Lesser trochanteric avulsion fragment is mildly displaced. No dislocation. No other fractures are identified. Moderate right and mild left hip arthrosis. Conclusion: Acute fracture of the right hip. A review of the Care Plan for Resident #59 revealed the following: Focus: Risk for falls--initiated 3/1/2025 Interventions included: 1:1 supervision started on 4/3/2025 and completed on 4/7/2025 Family educated not to transfer resident 5/16/2025 Post event skin check 4/3/2025 Focus: Right Hip fracture-initiated 5/15/2025 Interventions included: Monitor signs/symptoms complications related to mobility alteration; joint stiffness/pain, swelling, decline in mobility/self-care, contracture formation, creaking/clicking with joint movement, pain after exercise/weight bearing. A review of the Progress Notes for Resident #59 revealed the following: -5/12/25 Resident fall--no nursing notes indicating the event occurred at all -5/14/25 Resident family is at bedside and reporting that resident is having pain to right hip. Resident does not verbalize pain but grimaces with movement. MD notified and stat X-ray ordered. -5/14/25 LATE ENTRY: IDT (Interdisciplinary team) note-for 5/12/2025 at 1640 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA (Certified Nursing Assistant) found resident on the floor and notify nurse. Nurse assessed resident and full ROM (range of motion) to all extremities. Nurse attempted to get resident off the floor and resident was being combative, kicking and hitting the staff. After giving resident some space making sure there was no items around resident that would harm him. Resident was able to assist with transfer and 2 other staff members helped. He was placed back on his w/c (wheelchair) and brought to the dining room. Snack given and resident ate it without discomfort. No complaints of pain or facial grimacing noted. He had a small skin tear to his elbow. Cleansed with NS (normal saline) and LOTA (left open to air). Hospice was notified with NNO (no new orders) at this time. Resident [family member] came in about an hour after incident . He was notified of incident, and he stayed to assist with dinner resident ate 100% of his dinner and [family member] stated he transferred his dad back to bed and he complained of pain. He stated, I hope I didn't hurt him. Nurse educated son on not transferring resident without staff assistance. Medications administered and resident is resting in bed . -5/15/25 IDT note: CNA reported resident was on the floor on 5/12/25 at 1640 p.m. Nurse assessed resident and full ROM to all extremities. Son came in to assist resident with dinner and transferred resident to bed without waiting for assistance. He was educated by nurse on calling for assistance he stated, He complained of pain I hope I didn't hurt him. Resident was medicated at the time. Following day resident was not complaining of pain and continued his normal activities without difficulties .On 5/14/25 Resident [family member] took resident outside to the courtyard as usual without any concerns. She brought him back to his room and transferred him to bed without assistance. She then grabbed hospice nurse and told her that her dad was complaining of pain. Hospice ordered X-ray of right hip, and result obtained with right trochanteric fracture mild displaced . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/03/2025 at 2:56 p.m. an interview was conducted with the Director of Nursing (DON). The DON stated Resident #59 had a fall on 5/12/25 but it was not reported to her until 5/14/25. She stated the incident was reported by a family member to the hospice nurse and her at the same time. She stated she had no knowledge of the fall prior to 5/14/25 and she could find no notes related to the fall on 5/12/25 in the progress notes. The DON stated an investigation was started but no other reports were filed related to the incident. The DON stated the family member reported to the hospice nurse that an aide told her Resident #59 had a fall on 5/12/25. The DON said during an interview with Staff D, CNA, she told her on 5/12/25 she saw Resident #59 on the floor by the roommates bed, and the door to the room, and he was laying on his right side. Staff D, CNA told the DON she notified Staff B, Registered Nurse (RN), and the nurse came to do an assessment. The DON stated this was an unwitnessed fall. The DON said she spoke with Staff B, RN to take a statement about the incident. The DON stated, Staff B, RN said she assumed this was a behavior problem because the resident would be on the floor occasionally. The DON stated Staff B, RN did not call the doctor, notify the DON, or report the incident as a fall. The DON said Staff D, CNA told her the resident did not complain of pain and was put in a wheelchair after being found on the floor. The DON said the aide told her a family member helped Resident #59 back to bed after dinner, and mentioned the resident had pain so she went to tell the nurse. The DON said the family member was unaware the resident was found on the floor at the time. The DON stated the nurse noted a scratch to the elbow at the time and said the resident had no obvious signs of pain. The DON stated the nurse said Resident #59 was combative when they tried to get him off the floor and it took three of them. The DON said she spoke with other nurses and aides who provided care to Resident #59 on 5/13/25 and they reported no pain was observed. The DON said hospice ordered an X-ray to be done stat on 5/14/25. The DON stated the resident complained of pain when she went in to assess him after finding out about the fall. She stated, He definitely had pain when I moved his leg around. The DON stated the family member said the resident was complaining of pain. She said the X-ray results came back with confirmation of a fracture. She stated, she completed the investigation and determined the nurse did not follow policy and report the incident as an unwitnessed fall immediately. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/03/2025 at 4:51 p.m. an interview was conducted with Staff B, RN. Staff B stated she was familiar with the resident and had cared for him intermittently because she was a float person. She stated she would provide care once or twice a week for Resident #59. Staff B, RN, stated on 5/12/25 she was coming on shift, and she had just finished counting narcotics. She said Staff D, CNA came to her to let her know Resident #59 was on the floor and she did not know what happened. She stated the resident would get on the floor sometimes and sometimes he would need help to get up. She stated she went to see the resident and noticed a scratch on his arm, and she called for help. She said Resident #59 was combative and it took three of them to get him up and put him in a wheelchair. Staff B, RN stated the resident was kicking them and, His range of motion seemed fine to me because he kicked me in the stomach, so I assumed it was one of his get down on the floor days. She said, I documented the incident somewhere, but I do not recall exactly where. The nurse stated the resident sat in his wheelchair until his family member came at dinner time around 6:00 p.m. The nurse stated the family member took the resident back to his room and the aide told her the family member put Resident #59 back to bed and said the resident was uncomfortable. The nurse stated it was time for the night medications, so she gave the resident some Lorazepam and Trazodone. She said she left around 11:00 p.m. after her shift and she did not do another assessment on Resident #59. Staff B, RN stated she found out two days later the resident was injured. She said she could not say it was a fall because the incident was unwitnessed. She stated for the residents that are care planned and get down on the floor she would not report the incident. She stated she did provide care for Resident #59 after the incident and he was always in bed, agitated, and receiving Morphine for the pain. She stated she was not aware if Resident #59 had a previous fall or if he was care planned for falls. An interview was conducted on 6/04/2025 at 10:56 a.m. with Staff D, CNA. Staff D stated, On 5/12/25 I went down the hall to check on all my residents and I saw the resident on the floor by the roommates bed. I checked on him and he was ok, so I went and got the nurse, I did not touch him or move him. The nurse came down to see the resident. She took vitals and looked at his head. Then three of us picked him up off the floor. He was combative swinging, punching and kicking us so that is why we had three people. He was placed in his wheelchair. Staff D stated Resident #59 did not speak so he could not say he was in pain, and they would have to see if he had a grimace to know if he was in pain. She said she did not see the resident do that. She stated she wheeled the resident to the dining room and gave him a cookie. She said he sat in the chair and ate his cookie. She said she did not see him again until after dinner and he was in his room with a family member who had helped him back into bed. She said the family member told her the resident had pain and stated, I hope I did not hurt him. She said she informed the nurse what the family member told her. She said on 5/14/2025 a family member told her she heard the resident had a fall and she asked me what happened. She stated she told the family member she had found the resident on the floor on 5/12/2025. She said they took x-rays and found out the resident had a fracture. She stated when she found the resident on the floor she did what she was supposed to do and notified the nurse. She stated she did not tell anyone else. The aide stated she had received education on reporting falls and had signed a paper yesterday. An interview was conducted on 6/04/2025 at 11:16 a.m. with the NHA and the DON. The NHA stated she did not report the incident because she felt finding the resident on the floor was not the cause of the injury. She stated she felt after looking at all the information and doing the investigation the injury occurred when the family member admitted transferring the father to the bed and stated, I hope I did not hurt him. The DON and the NHA stated the nurse did not follow the proper policy and procedure required for a change of status, or unwitnessed fall and report it immediately to the DON. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview was conducted on 6/05/2025 at 9:09 a.m. with the Primary Care Provider (PCP) for Resident #59. The PCP stated he had taken care of Resident #59 for 40 years and knew the entire family well. He stated the resident suffered from bad dementia and was quite combative. The doctor stated the resident had trouble walking and had a history of falls. He stated he received a call from the family about a hip problem and told him the resident had a broken hip. The PCP stated after a discussion with the family it was decided Resident #59 had no quality of life and due to dementia he would not be a candidate for an operation. The PCP stated it was decided to just provide palliative care and pain medications for the fracture. The doctor stated he heard there was a fall, but no one had witnessed the fall so he was not aware of the details. He stated he was not notified on 5/12/25 of a fall and did not find out until 5/14/25 when the family called him. The doctor stated Resident #59 had a high tolerance for pain and when he went to see him he was on medications, and his pain was about a six. He stated the resident could withstand a lot of pain. A review of the facility policy entitled Incident Reporting for Residents or Visitors, revised 8/2023, revealed the following: Policy: All accidents and unusual occurrences involving a resident or visitor will be documented and reported so as to meet all regulatory requirements. Fundamental Information: Adverse Event-An untoward, undesirable, and usually unanticipated event that causes death or serious injury to risk thereof. Procedure 1 When an unusual occurrence is discovered, the employee making the discovery will notify his or her immediate supervisor of the discovery. The supervisor will notify the Administrator and DON immediately. 8 The person discovering the event must complete the Incident/Accident Report prior to completing the shift. A review of the facility policy entitled Procedural Guidelines: Change in Condition, revised 9/2023 revealed the following: Purpose: The center will inform the resident, consult with the resident's physician, and notify the resident's family member or legal representative when there is a change requiring such notification. Fundamental Information: Situations requiring notification include: 1 An accident involving the resident which: -Resulting in injury. (continued on next page)

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Riviera Palms Rehabilitation Center	926 Haben Blvd Palmetto, FL 34221

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Potential to require physician intervention. 2 A significant change in the resident's physical, mental, or psychosocial status that is , a deterioration in health, mental, or psychosocial status in life-threatening conditions or clinical complications. 6 Upon the identification of a change in condition in a resident, the nurse will complete an evaluation of the resident's status, and document findings on the SBAR Change in Condition in the resident's medical record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure a person centered care plan was implemented related to communication for one resident (#31) out of 24 residents sampled. Findings Included: During an observation on 06/02/2025 at 9:46 a.m., Resident #31 was observed lying in bed dressed in a hospital gown. Resident #31 was only able to respond to yes or no questions. Review of Resident#31 admission record revealed and admission date of 10/29/2021. Resident #31 was admitted to the facility with diagnosis to include Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Essential (Primary) Hypertension, Anemia, Unspecified, Hyperlipidemia, Unspecified, Aphasia, Muscle Weakness (Generalized), Other Abnormalities of Gait and Mobility, Dysphagia, Oral Phase, Personal History of Transient Ischemic Attack (Tia), And Cerebral Infarction Without Residual Deficits. Review of Resident #31's Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section B. Hearing Speech and Vision revealed Speech Clarity, unclear speech, makes self-understood, sometimes understood, and ability to understand others, usually understands. Section C. Cognitive patterns revealed a Brief Interview Mental Status (BIMS) of 00 out of 15 showing severe cognitive impairment. Review of Resident #31's care plan dated 10/29/2021 revealed no care plan for communication. During an interview on 06/02/2025 with Staff S, Certified Nursing Assistant (CNA) stated Resident #31 requires assistance with his meals. She stated he is nonverbal but will shake his head to yes or no questions. During an interview on 06/04/2025 at 2:19 p.m., Speech Therapist stated she does speech Screenings quarterly with Resident #31. She stated he was nonverbal and can answer yes or no questions. The Speech Therapist said, He should be care planned for his communication. During an interview on 06/04/2025 at 2:26 p.m., Staff T, MDS Coordinator, stated Resident #31 communicates by gestures and shakes his head to yes or no questions. It is obvious when you speak with him how he communicates. Staff would know how he communicates by looking at Kardex. The Kardex tells you about the resident. I do not see a communication care plan for him. He has a cognitive function care plan, and it is the same as communication. During an interview on 06/05/2025 at 3:56 p.m., the Director of Nursing (DON), stated Resident #31 was nonverbal and answers yes or no questions. She stated staff uses the Kardex to know how to communicate with the residents. She would expect Resident #31 to have a communication care plan. Review of the facility's policy titled Comprehensive Person-Centered Care Plans dated 08/2023 revealed, Policy: The center will develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to offer resident centered activities for two dependent residents (#77 and #99) of two reviewed for activities. Findings included : During an observation and interview on 6/4/25 at 12:33 P.M., Resident #99 was sitting in a wheelchair close to her over the bed table with a writing pad. When spoken to the resident pointed to her family member to respond. The family member said Resident #99 is not capable of doing activities on her own. The family member stated when the resident resided on the first floor he would take her outside. Review of Resident #99's admission record revealed an initial admission on [DATE] and an admission date on 5/30/25 with diagnoses to include apraxia (neurological disorder that affects movement), dysphonia (voice impairment), dysarthria and anarthria, disorder of the central nervous system, abnormalities of gait and mobility. Review of Resident #99's activities evaluation dated 5/30/25, revealed current interests include crafts/arts, Scottish music listening to country music, educational/intellectual activities, and interest participating in happy hour and food social events. In section EF, considerations revealed resident enjoys group activities that provide music and movement Review of a Resident #99's progress note effective 5/6/25 revealed .enjoys small group activities that provide sensory stimulation and social comfort like music, outdoor activities, Review of Resident #99's care plan revealed the following focus: Person-Centered Care. The goal showed [Resident #99's] preferences will be honored by staff when providing care. (created on 4/30/25 and revised on 6/3/25). Interventions included: Enjoys being around animals such as pets, enjoys listening to music, enjoys participating in their favorite activities Focus: [Resident #99] is self-directed in choosing preferred activities, both group and independent. Goal: [Resident #99] will continue to make own choices regarding daily activities . (created on 5/6/25 and revised on 6/3/25). Interventions included: offer activity material for resident to pursue diversified activities and remain occupied in/out of room such as .CD player and music, coloring books .listening to Scottish music and country, social gatherings with husband and friends, continue assistance with dance performance as dance instructor . Review of Resident #99's documentation survey report dated May 25 revealed participation in ice cream/food social and outdoor activity/outing once in 29 days and reading/newspaper two times in 29 days. From 6/1/25 to 6/5/25 no activities of Resident #99's interest were offered. During an observation and interview on 6/4/25 at 12:57 P.M. Resident #77 was observed lying in bed and a visitor was assisting the resident to eat. Resident #77 said he does not get up out of bed daily. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #77's admission revealed 3/23/25, admission date with diagnoses to include, Parkinson's Disease, dementia, abnormalities of gait and mobility. Review of Resident #77's activities evaluation, dated 4/1/25, revealed preferences to include small group activities, .day room activities .Resident #77's likes include old tunes, magazines, news. pet visits, crosswords The resident requires reminders/cues .needs a wheelchair to get to and from activity areas. Review of Resident #77's progress notes dated, 4/1/25 revealed Resident is alert and cooperative with staff. Not interested at this time in group settings. Will remail active in room with self-directed activities, family visits and therapy Review of Resident #77's care plan revealed the following: Focus: Person-Centered Care. The goal showed: [Resident #77's] preferences will be honored by staff when providing care. (created on 3/28/25 and revised on 4/10/25). Interventions includeed: Enjoys being around animals such as pets, enjoys listening to music, enjoys participating in their favorite activities Focus: [Resident #77's] is self-directed when choosing preferred activities, both group and independent (created 4/1/25 and revised on 4/10/25). Interventions included: offer activity material for resident to pursue diversified activities and remail occupied in and out of room. Review of Resident #77's documentation survey report dated May 25 revealed participation in activities other than talking/conversation showed reading/newspaper/magazines activity occurred on three of 31 days. During an interview on 6/4/25 at 12:37 P.M. Staff I, Certified Nursing Assistant (CNA) said she has not observed the activity staff assist Resident #99 with in-room activities. During an interview on 6/5/25 at 10:35 A.M. Staff K, CNA said activity staff do not come into the residents' room for activities, visitors and we talk with the resident. During an interview on 6/5/25 and 12:36 P.M. the Activities Director (AD) said, each day the Daily Chronicle is given to all residents by activity department staff and the distribution daily one to one visitation are completed. The AD said she completes an assessment for all new admissions, develop plan of care related to activities and the resident's participation in activities are documented daily. During an interview on 6/5/25 at 1:19 P.M. with Staff L, CNA, Activities Assistant (AA) said on 6/4/25 and 6/5/25 Resident #99 was sleeping when she distributed the Daily Chronicle, and she did not communicate with the resident. Staff L, CNA, AA said activities are provided to residents who come down to the activity. During an interview on 6/5/25 at 2:00 P.M. the Director of Nursing (DON) said every resident should participate in activities and participation or no participation should be documented. During an interview on 6/5/25 at 2:23 P.M. the Nursing Home Administrator (NHA) said resident's activities should be person centered .I understand the concern. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's June 2025 activity calendar showed room visits are offered twice weekly. Review of facility's policy titled activity program, revised 8/2023 revealed the following policy: Each center provides an ongoing program of activities designed to meet (in accordance with the comprehensive assessment) the interests and the physical, mental, and psychosocial well-being of each resident. The procedure showed: -Individualized and group activities are provided that: -Reflect the schedules, choices, and rights of the residents, are offered at hours convenient to the residents, including evenings, holidays, and weekends, and reflect the cultural and religious interests of the residents -The activity program consists of individual and small and large group activities that are designed to meet the needs and interests of each resident and includes, at a minimum: -Social activities: Indoor and outdoor activities .creative activities, intellectual and educational activities, . individualized activities, In-room activities . -The activity program is designed to encourage restoration to self-care and maintenance of normal activity, which is geared to the individual resident's needs. When developing the resident's activity and social care plans, the resident will be given an opportunity to choose when, where, and how he or she will participate in activities and social events .activities are scheduled daily .adequate space and equipment are provided to ensure that needed services identified the resident's plan of care are met. -Documentation: Document the resident's participation in activities or refusal to participate in the progress notes as needed. Document refusals in the care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure a safe environment free from hazards for one (Resident #29) out of 24 residents sampled. Findings Included: During an observation on 06/02/2025 at 9:55 a.m., A pink disposable razor was identified on top of the toilet bowl of Resident #29's bathroom. (photographic evidence obtained) During an interview on 06/02/2025 at 2:13 p.m., Resident #29 stated she uses the restroom in her room. She stated she was not sure whose razor was in the bathroom and thought it may belong to her roommate. During a phone interview on 06/04/2025 at 10:40 a.m., Resident #29's family member stated he would not bring in a razor for Resident #29 because it is sharp and would not be safe for her to use on her own. Review of Resident #29's admission record revealed a re-admission date of 05/15/2020 and an initial admission date of 01/08/2020. Resident #29 was admitted to the facility with diagnosis to include Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified, Other Lack of Coordination, Unspecified Abnormalities of Gait and Mobility, Unspecified Lack of Coordination, Cognitive Communication Deficit, and Other Symptoms and Signs Involving Cognitive Functions and Awareness. Review of Resident #29's Quarterly Minimum Data Set (MDS) dated [DATE] Section C. Cognitive Patterns revealed a Brief Interview Mental Status (BIMS) of 05 out of 15 showing Severe cognitive impairment. Review of Resident #29's care plan dated 04/22/2025 revealed: Focus: Resident #29 has impaired cognitive function/impaired thought process related to cognitive deficit, history of Cerebrovascular accident, history of Transient ischemic attack. Goal: Attempts for residents to communicate basic needs on a daily basis will be provided through the review date.Interventions included: Cue, reorient and supervise as needed; engage resident in simple, structured activities that avoid overly demanding tasks, keep routine consistent and try to provide consistent care as much as possible; Medications as ordered; monitor any changes in cognitive function, specifically changes in: decision making, memory recall, general awareness, level of consciousness, mental status and/or difficulty, expressing self/understanding others. During an interview on 06/02/2025 at 2:17 p.m., Staff N, Certified Nursing Assistant (CNA), stated razors are kept by staff and brought out when residents need them. She observed the pink razor on the back of the toilet of room [ROOM NUMBER] and stated she believed it belongs to Resident #29's roommate because of the cognition level of the two residents. She stated this razor does not look like it came from the facility because the razors from the facility are blue. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/03/2025 at 12:29 p.m., Staff O, CNA stated she assists residents with shaving. She stated they have disposable razors that they use.Staff O state once the razor has been used it is tossed. During an interview on 06/03/2025 at 1:36 p.m. Staff P, CNA, stated razors should not be in the rooms of the residents. CNA's get the razors from the supply room on shower days. They are put in a sharps container once they have been used. All residents need assistance with using a razor and cannot use them on their own. During an interview on 06/03/2025 at 1:38 p.m., Staff Q, Licensed Practical Nurse (LPN), stated Razors are only used on shower days. Sometimes family members bring in big bag of supplies and when they go into the residents' rooms, they find items they should not have. When they find the items, they usually take the items from the residents and educate the family. They don't know what the family is bringing in. During an interview on 06/03/2025 at 4:49 p.m., Staff R, LPN, stated she was assigned to Resident #29 and her roommate. She stated Resident #29 requires assistance to go to the bathroom so she would not enter the bathroom by herself. She stated Resident #29 could not use a razor by herself because of her cognition and there should not be a razor in her room. During an interview on 06/03/2025 at 5:20 p.m., the Director of Nursing (DON), stated family, can bring any items of preference if it is not prescription or over-the-counter medications. Family can bring in razors for an alert and oriented resident. The DON stated the family goes to the nurse station with the items so everything can be labeled and inventoried. Alert and oriented residents who could use razors on their own have a lock box to keep these items in. The DON stated, It cannot be Resident 29's roommate because she does not have family to bring in items. The facility was asked to provide a policy related to hazards. The facility did not have a policy.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure licensed nursing staff were knowledgeable and competent to provide care and services for four residents (#59, #74, #29, and #35) out of forty residents sampled related to: 1) failure to recognize and provide treatment for an unwitnessed fall; 2) failure to follow physician orders for laboratory testing; 3) failure to provide a safe hazard free environment; and 4) failure to complete resident identification prior to administration of medications. This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and or death to Resident #59 and resulted in the determination of Immediate Jeopardy on 6/04/2025. The findings of Immediate Jeopardy were determined to be removed on 6/05/2025 and the severity and scope was reduced to a D after verification of removal of immediacy of harm. Findings included: 1. Resident #59 was admitted to the facility on [DATE] with diagnoses to include: dementia, coronary artery disease, atrial fibrillation, hypertension, failure to thrive, major depression disorder, insomnia, and cardiac pacemaker. The resident was placed in Hospice care on 2/7/2025. A review of the Minimum Data Set (MDS), dated [DATE], revealed Resident #59 had a Brief Interview of Mental Status score of 00, indicating severe cognitive impairment. A review of the Order Summary Report, dated May 2025, for Resident #59 revealed the following: -Regular diet, soft and bite sized texture, thin liquids consistency -Alerting bracelet: located on left ankle, check for placement every shift -Do Not Resuscitate, Palliative Care -Hospice Diagnosis: Cerebral Atherosclerosis -May go on leave with supervision -Citalopram Hydrobromide oral tablet 40 milligram (mg) one time a day for depression -Depakote sprinkles 250 mg twice a day for depression -Morphine Sulphate 0.25 milliliter (ml) every 4 hours as needed (PRN) for pain 5-10/SOB (shortness of breath) order started on 2/03/2025 -Trazodone Hydrochloride 25 mg daily at bedtime -STAT (Emergent) x-ray Right hip ordered 5/14/2025 (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Lorazepam 0.5 mg every 8 hours for anxiety/agitation/restlessness/sob started 5/22/2025 -Morphine Sulphate 0.25 ml every six hours for chronic pain and continue PRN Morphine started 5/22/2025 -Release body to FH (funeral home) 5/26/2025 A review of a radiology report, dated 5/14/2025 revealed: X-ray Right Hip Acute intertrochanteric fracture of the right femur with varus angulation and mild displacement. Lesser trochanteric avulsion fragment is mildly displaced. No dislocation. No other fractures are identified. Moderate right and mild left hip arthrosis. Conclusion: Acute fracture of the right hip. A review of the Care Plan for Resident #59 revealed the following: Focus: Risk for falls--initiated 3/1/2025 Interventions included: 1:1 supervision started on 4/3/2025 and completed on 4/7/2025 Family educated not to transfer resident 5/16/2025 Post event skin check 4/3/2025 Focus: Right Hip fracture-initiated 5/15/2025 Interventions included: Monitor signs/symptoms complications related to mobility alteration; joint stiffness/pain, swelling, decline in mobility/self-care, contracture formation, creaking/clicking with joint movement, pain after exercise/weight bearing. A review of the Progress Notes for Resident #59 revealed the following: -4/3/25 post fall review completed reads: 3/31 at 915 a.m. Therapy walking by room and saw resident become unsteady and fall. nonskid socks floor not wet. call light within reach. adequate lighting. -5/12/25 Resident fall--no nursing notes indicating the event occurred at all -5/14/25 Resident family is at bedside and reporting that resident is having pain to right hip. Resident does not verbalize pain but grimaces with movement. MD notified and stat X-ray ordered. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-5/14/25 LATE ENTRY: IDT (Interdisciplinary team) note-for 5/12/2025 at 1640 CNA (Certified Nursing Assistant) found resident on the floor and notify nurse. Nurse assessed resident and full ROM (range of motion) to all extremities. Nurse attempted to get resident off the floor and resident was being combative, kicking and hitting the staff. After giving resident some space making sure there was no items around resident that would harm him. Resident was able to assist with transfer and 2 other staff members helped. He was placed back on his w/c (wheelchair) and brought to the dining room. Snack given and resident ate it without discomfort. No complaints of pain or facial grimacing noted. He had a small skin tear to his elbow. Cleansed with NS (normal saline) and LOTA (left open to air). Hospice was notified with NNO (no new orders) at this time. Resident [family member] came in about an hour after incident . He was notified of incident, and he stayed to assist with dinner resident ate 100% of his dinner and [family member] stated he transferred his dad back to bed and he complained of pain. He stated, I hope I didn't hurt him. Nurse educated son on not transferring resident without staff assistance. Medications administered and resident is resting in bed . -5/15/25 IDT note: CNA reported resident was on the floor on 5/12/25 at 1640 p.m. Nurse assessed resident and full ROM to all extremities. Son came in to assist resident with dinner and transferred resident to bed without waiting for assistance. He was educated by nurse on calling for assistance he stated, He complained of pain I hope I didn't hurt him. Resident was medicated at the time. Following day resident was not complaining of pain and continued his normal activities without difficulties .On 5/14/25 Resident [family member] took resident outside to the courtyard as usual without any concerns. She brought him back to his room and transferred him to bed without assistance. She then grabbed hospice nurse and told her that her dad was complaining of pain. Hospice ordered X-ray of right hip, and result obtained with right trochanteric fracture mild displaced . 5/26/25 Resident with family at bedside. No VS noted, pronounced by 2. MD notified, order to release body received. Spouse notified. Hospice notified. Resident passed at 1045 a.m. -5/17/25 Minimally responsive to verbal/tactile stimulation. Per family report, no longer able to swallow and is not accepting fluids .lethargic. -5/26/25 Resident with family at bedside. No vital signs noted., pronounced by 2 A review of the Narcotic Log for Resident #59 revealed a prn pain medication order for Morphine Sulphate was available since 2/04/2025. No pain medications were administered to the resident until after the unwitnessed fall on 5/12/2025. The first doses of Morphine were administered on 5/14/2025 after an X-ray was taken and confirmed a fracture to the right hip. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/03/2025 at 2:56 p.m. an interview was conducted with the Director of Nursing (DON). The DON stated Resident #59 had a fall on 5/12/25 but it was not reported to her until 5/14/25. She stated the incident was reported by a family member to the hospice nurse and her at the same time. She stated she had no knowledge of the fall prior to 5/14/25 and she could find no notes related to the fall on 5/12/25 in the progress notes. The DON stated an investigation was started but no other reports were filed related to the incident. The DON stated the family member reported to the hospice nurse that an aide told her Resident #59 had a fall on 5/12/25. The DON said during an interview with Staff D, CNA, she told her on 5/12/25 she saw Resident #59 on the floor by the roommates bed, and the door to the room, and he was laying on his right side. Staff D, CNA told the DON she notified Staff B, Registered Nurse (RN), and the nurse came to do an assessment. The DON stated this was an unwitnessed fall. The DON said she spoke with Staff B, RN to take a statement about the incident. The DON stated, Staff B, RN said she assumed this was a behavior problem because the resident would be on the floor occasionally. The DON stated Staff B, RN did not call the doctor, notify the DON, or report the incident as a fall. The DON said Staff D, CNA told her the resident did not complain of pain and was put in a wheelchair after being found on the floor. The DON said the aide told her a family member helped Resident #59 back to bed after dinner, and mentioned the resident had pain so she went to tell the nurse. The DON said the family member was unaware the resident was found on the floor at the time. The DON stated the nurse noted a scratch to the elbow at the time and said the resident had no obvious signs of pain. The DON stated the nurse said Resident #59 was combative when they tried to get him off the floor and it took three of them. The DON said she spoke with other nurses and aides who provided care to Resident #59 on 5/13/25 and they reported no pain was observed. The DON said hospice ordered an X-ray to be done stat on 5/14/25. The DON stated the resident complained of pain when she went in to assess him after finding out about the fall. She stated, He definitely had pain when I moved his leg around. The DON stated the family member said the resident was complaining of pain. She said the X-ray results came back with confirmation of a fracture. She stated, she completed the investigation and determined the nurse did not follow policy and report the incident as an unwitnessed fall immediately. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riviera Palms Rehabilitation Center	926 Haben Blvd Palmetto, FL 34221

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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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/03/2025 at 4:51 p.m. an interview was conducted with Staff B, RN. Staff B stated she was familiar with the resident and had cared for him intermittently because she was a float person. She stated she would provide care once or twice a week for Resident #59. Staff B, RN, stated on 5/12/25 she was coming on shift, and she had just finished counting narcotics. She said Staff D, CNA came to her to let her know Resident #59 was on the floor and she did not know what happened. She stated the resident would get on the floor sometimes and sometimes he would need help to get up. She stated she went to see the resident and noticed a scratch on his arm, and she called for help. She said Resident #59 was combative and it took three of them to get him up and put him in a wheelchair. Staff B, RN stated the resident was kicking them and, His range of motion seemed fine to me because he kicked me in the stomach, so I assumed it was one of his get down on the floor days. She said, I documented the incident somewhere, but I do not recall exactly where. The nurse stated the resident sat in his wheelchair until his family member came at dinner time around 6:00 p.m. The nurse stated the family member took the resident back to his room and the aide told her the family member put Resident #59 back to bed and said the resident was uncomfortable. The nurse stated it was time for the night medications, so she gave the resident some Lorazepam and Trazodone. She said she left around 11:00 p.m. after her shift and she did not do another assessment on Resident #59. Staff B, RN stated she found out two days later the resident was injured. She said she could not say it was a fall because the incident was unwitnessed. She stated for the residents that are care planned and get down on the floor she would not report the incident. She stated she did provide care for Resident #59 after the incident and he was always in bed, agitated, and receiving Morphine for the pain. She stated she was not aware if Resident #59 had a previous fall or if he was care planned for falls. An interview was conducted on 6/04/2025 at 10:56 a.m. with Staff D, CNA. Staff D stated, On 5/12/25 I went down the hall to check on all my residents and I saw the resident on the floor by the roommates bed. I checked on him and he was ok, so I went and got the nurse, I did not touch him or move him. The nurse came down to see the resident. She took vitals and looked at his head. Then three of us picked him up off the floor. He was combative swinging, punching and kicking us so that is why we had three people. He was placed in his wheelchair. Staff D stated Resident #59 did not speak so he could not say he was in pain, and they would have to see if he had a grimace to know if he was in pain. She said she did not see the resident do that. She stated she wheeled the resident to the dining room and gave him a cookie. She said he sat in the chair and ate his cookie. She said she did not see him again until after dinner and he was in his room with a family member who had helped him back into bed. She said the family member told her the resident had pain and stated, I hope I did not hurt him. She said she informed the nurse what the family member told her. She said on 5/14/2025 a family member told her she heard the resident had a fall and she asked me what happened. She stated she told the family member she had found the resident on the floor on 5/12/2025. She said they took x-rays and found out the resident had a fracture. She stated when she found the resident on the floor she did what she was supposed to do and notified the nurse. She stated she did not tell anyone else. The aide stated she had received education on reporting falls and had signed a paper yesterday. An interview was conducted on 6/04/2025 at 11:16 a.m. with the NHA and the DON. The NHA stated she did not report the incident because she felt finding the resident on the floor was not the cause of the injury. She stated she felt after looking at all the information and doing the investigation the injury occurred when the family member admitted transferring the father to the bed and stated, I hope I did not hurt him. The DON and the NHA stated the nurse did not follow the proper policy and procedure required for a change of status, or unwitnessed fall and report it immediately to the DON. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 6/04/2025 at 3:51 p.m. with Staff C, Hospice RN. Staff C, RN stated she had taken care of Resident #59 the entire time he was in hospice care at the facility. She stated he was declining from dementia, and he was still eating some and was able to get out of bed and take walks with his family. She stated due to his dementia he was always combative, and he had a few falls while at the facility. She stated he did not speak, and he could be hard to handle but he had never hurt himself before. She stated he was never able to get up and walk or get into a wheelchair by himself, he always needed assistance. She stated prior to the fall he was having a slow decline due to dementia that was typical for the disease. She stated he had started to lose weight and was weak. She stated she was in to see the resident early in the morning of the 14th. She said they had him up in a wheelchair. She said she was seeing another patient when an aide told her the family member wanted to talk to her. Staff C, RN stated the family member told her there was something not right and informed me the facility had found him on the floor a few days before. She said that was the first time she had heard of a fall. She said she informed the DON, the nurse, and the unit manager and none of them appeared to know he was on the floor at all. She said she got an order for an X-ray, and they determined he had a fracture. She stated the family was very involved in the care of Resident #59 and spent many hours a day with him. She stated the family was able to properly assist the resident from a wheelchair to the bed. The hospice doctor gave orders for him to remain in bed and have pain medication around the clock as well as needed. The RN stated a meeting was held with the family and the decision was to allow the resident to just receive comfort measures and pain management for the fracture. She stated the family members were able to tell when the resident was in pain and they would call and let her know if he was comfortable or if he needed more. She stated Ativan was added for agitation as he got closer to death. She stated prior to the fracture he did not appear to be in a lot of pain and really did not require the Morphine that was ordered for him. She stated she was not aware that the resident would throw himself on the floor and it was not ever relayed to her he did so. A telephone interview was conducted on 6/04/2025 at 4:24 p.m. with the Power of Attorney (POA) for Resident #59. The POA stated she was notified by another family member on 5/14/2025 that the resident had a fracture, and he had been found on the floor a couple of days before. The POA stated a family member who was visiting on the 14th observed the resident during a transfer to the bed and the resident yelling in pain. The family member told her she went to the hospice nurse and asked the nurse to come and see the resident and informed her of the incident from 5/12/25 when he was found on the floor. The POA stated she was not informed of the resident being found on the floor and the nurse never even filed a report or told the doctor. The POA stated the family has been assisting the resident with all of his care and they were capable of assisting him in and out of bed. She stated they knew how to be careful, go slowly, and pivot him into the bed. The POA said on 5/12/25 when the family helped him at dinner and then took him back to his room he had pain when moving and it was reported by the family member to the facility nursing staff. The POA stated prior to the hip fracture they were getting him up in his chair and taking him to meals. She said they would take him outside for a walk and he never had pain. The POA stated they did have some type of normal routine prior to the fall. The POA stated the doctor said surgery was not an option, and he was too weak to be treated so the best thing we could do is keep him comfortable. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview was conducted on 6/05/2025 at 9:09 a.m. with the Primary Care Provider (PCP) for Resident #59. The PCP stated he had taken care of Resident #59 for 40 years and knew the entire family well. He stated the resident suffered from bad dementia and was quite combative. The doctor stated the resident had trouble walking and had a history of falls. He stated he received a call from the family about a hip problem and told him the resident had a broken hip. The PCP stated after a discussion with the family it was decided Resident #59 had no quality of life and due to dementia he would not be a candidate for an operation. The PCP stated it was decided to just provide palliative care and pain medications for the fracture. The doctor stated he heard there was a fall, but no one had witnessed the fall so he was not aware of the details. He stated he was not notified on 5/12/25 of a fall and did not find out until 5/14/25 when the family called him. The doctor stated Resident #59 had a high tolerance for pain and when he went to see him he was on medications, and his pain was about a six. He stated the resident could withstand a lot of pain. 2. On 6/2/25 at 1:26 p.m., an observation of Resident #74 revealed she was seated in a wheelchair by the nurse's station with an activity book in her hand. She was observed looking at the activity book and turned the pages. A review of Resident #74's admission record revealed an admission date of 8/3/23 with diagnoses to include unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, major depressive disorder, recurrent, unspecified, and cognitive communication deficit. A review of Resident #74's physician orders revealed the following: -Sertraline Hydrochloride [HCl] tablet 100 milligrams (mg) give 1 tablet by mouth at bedtime for depression, with a start date of 11/22/24. -Depakote tablet delayed release 125 MG (divalproex sodium) give 1 tablet by mouth two times a day for mood disorder related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; major depressive disorder, recurrent, unspecified, with a start date of 4/7/25. -Depakote [also known as Valproate or Valproic Acid] level every night shift every 6 month(s) starting on the last day of month for 1 day(s), with an order date of 7/24/24, start date of 7/31/24, and no end date. A review of Resident #74's care plan revealed the following: (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-[Resident #74] is at risk for complication of Antidepressant Medication Therapy r/t [related to] Depression Date Initiated: 02/08/2024, with interventions to include, . Consult with pharmacy, provider to consider dosage reduction when clinically appropriate. Date Initiated: 02/08/2024 . Monitor for side effects and adverse reactions of psychoactive medications: anticholinergic effects, irregular heartbeat, drowsiness, unsteady gait, tardive dyskinesia, EPS [Extrapyramidal symptoms] (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal idealizations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Date Initiated: 02/08/2024 . Monitor ongoing s/s [signs and symptoms] of depression unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. [negative] mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance, Psych [psychiatry] evaluation as indicated. -[Resident #74] is at risk for complications r/t Anticonvulsant medication use Date Initiated: 06/12/2024, with interventions to include, . Consult with pharmacy, provider to consider dosage reduction when clinically appropriate. Date Initiated: 06/12/2024 . Educate family/caregivers about risks, benefits and the side effects of medications. Date Initiated: 06/12/2024 . Monitor for side effects and adverse reactions of psychoactive medications: anticholinergic effects, irregular heartbeat, drowsiness, unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal idealizations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Date Initiated: 06/12/2024 . Monitor ongoing s/s of depression unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear, of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance. A review of Resident #74's laboratory (lab) results for Depakote levels revealed they were completed on 8/1/24 with no other lab results for Depakote found in the medical record. A review of Resident #74's Treated Administration Record (TAR), dated January 2025, revealed the following order marked as completed, Depakote level every night shift every 6 month(s) starting on the last day of month for 1 day(s) -Start Date 7/31/2024. A review of Resident #74's progress notes from 9/2024 to 6/2025 revealed no documentation related to Depakote levels being completed or notification to the medical provider (MD) about labs not being completed. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/3/25 at 5:36 p.m., an interview was conducted with the Director of Nursing (DON). She said the order on the TAR alerts the nurse of when a lab needs to be completed. She said Resident #74's lab order was placed for the night shift to complete. The DON stated the check mark in the TAR means, It was completed. She said she would look in the lab book to see if there was Depakote level results for Resident #74. A review of March 2025 pharmacy recommendations was completed with the DON which revealed the following comments, [Resident #74] receives Divalproex Sodium [also known as Depakote] DR [delayed release] does not have trough concentration documented in the medical record since August 21,2024. The DON stated, The resident was off of Depakote per her [family member's] request. The [family member] wanted her off the medication. She said she thinks Resident #74 was not taking Depakote from January 2025 to April 2025. A review of Resident #74's discontinued physician orders for Depakote, from 10/2024 to 4/2025, revealed the following: -Depakote tablet delayed release 125 MG (divalproex sodium) give 2 tablet by mouth two times a day for depression, with a start date of 10/29/24 and end date of 1/14/25. -Depakote tablet delayed release 125 MG (divalproex sodium) give 1 tablet by mouth two times a day for depression, with a start date of 1/15/25 and end date of 3/3/25. -Depakote tablet delayed release 125 MG (divalproex sodium) give 1 tablet by mouth two times a day for depression related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; major depressive disorder, recurrent, unspecified, with a start date of 3/22/25 and end date of 4/7/25. On 6/4/25 at 9:23 a.m., a follow-up interview with the DON was conducted. She said she checked the lab book and did not find Depakote lab results for Resident #74. The DON said the unit manager (UM) was calling the lab to see if it was completed and if there are results. O 6/4/25 at 9:49 a.m., an interview was conducted with Staff G, Licensed Practical Nurse (LPN)/UM. She said the lab orders are reflected on the TAR. Staff G, LPN/UM stated, The 11:00 a.m. - 7:00 p.m. shift takes care of the lab. She said the nurse would see the lab order in the resident's TAR, then they would prepare the lab requisition, and put it in the lab book for the lab staff member when they arrive. Staff G, LPN/UM said she looked at the 24-hour report in the mornings and on Monday's they look at the 72-hour report for lab orders that need to be completed. She stated the Depakote lab order for Resident #74 was a standing order and it was a Glitch in the system. She said Staff H, Regional Nurse Consultant and former DON put in the original order which should have been triggered to complete every 6 months, but the order didn't populate. She stated, It didn't populate the next day that I had a lab to follow-up on. Staff G, LPN/UM confirmed the lab order did populate on the TAR for the nurse that night on 1/31/25. She said the check mark on the TAR for Depakote levels, on 1/31/25, meant the nurse signed off and acknowledged they were going to prepare the requisition for the lab. She said it did not mean the lab was completed. Staff G, LPN/UM said she had not been able to find a lab requisition for Resident #74. She said she spoke to the Medical Director today to let him know it was a missed lab. Staff G, LPN/UM said she received orders from the Medical Director to get the lab completed today and to change the Depakote level labs to be completed annually. She said there should have been documentation about what happened with the lab orders, if the MD was notified, and if the MD still wanted the lab completed and if so, then it needed to be re-ordered. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/4/25 at 4:48 p.m., the DON said the facility does not have a policy related to following physician orders, including lab orders. 3. During an observation on 06/02/2025 at 9:55 a.m., A pink disposable razor was identified on top of the toilet bowl of Resident #29's bathroom. (photographic evidence obtained) Review of Resident #29's Quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview Mental Status (BIMS) score of 05 out of 15, indicating severe cognitive impairment. During an interview on 06/02/2025 at 2:17 p.m., Staff N, Certified Nursing Assistant (CNA), stated razors are kept by staff and brought out when residents need them. She observed the pink razor on the back of the toilet and stated she believed it belonged to Resident #29's roommate because of the cognition level of the two residents. She stated the razor did not look like it came from the facility because the razors from the facility are blue. During an interview on 06/03/2025 at 12:29 p.m., Staff O, CNA stated she assists residents with shaving. She stated they have disposable razors that they use. Once the razor has been used it is tossed. During an interview on 06/03/2025 at 1:36 p.m. Staff P, CNA, stated razors should not be in the rooms of the residents, CNA's get the razors from the supply room on shower days. They are put in a sharps container once they have been used. All residents need assistance with using a razor and cannot use them on their own. During an interview on 06/03/2025 at 1:38 p.m., Staff Q, Licensed Practical Nurse (LPN), stated razors are only used on shower days. Sometimes family members bring in big bag of supplies and when they go into the residents' rooms, they find items they should not have. When they find the items, they usually take the items from the residents and educate the family. She said they do not know what the family is bringing in to the facility. During an interview on 06/03/2025 at 4:49 p.m., Staff R, LPN, stated she was assigned to Resident #29 and her roommate. She stated Resident #29 requires assistance to go to the bathroom so she would not enter the bathroom by herself. She stated Resident #29 cannot use a razor by herself because of her cognition and there should not be a razor in her room. During an interview on 06/03/2025 at 5:20 p.m., the Director of Nursing (DON), stated family can bring any items of preference if it is not prescription or over-the-counter medications. Family can bring in razors for an alert and oriented resident. The family goes to the nurse station with the items so everything can be labeled and inventoried. Alert and oriented residents who could use razors on their own have a lock box to keep these items in. The razor found in Resident #29's bathroom belonged to Resident #29. It was brought in by Resident #29's son and they sent out a text for education. It cannot be Resident 29's roommate because she does not have family to bring in items. 4. Resident #35's admission record revealed an admission date of 2/25/25 with diagnoses to include heat failure, hypertension and Diabetes Type 2. (continued on next page)

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