STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105612	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silvercrest Health and Rehabilitation Center	910 Brookmeade Drive Crestview, FL 32539

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 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** 50082 Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 2 of 25 sampled residents to meet the residents nursing needs that are identified in the comprehensive assessment. (Resident #31 & #2) The findings include: Resident #31 On 04/21/25 at approximately 11:05 AM, Resident #31 was seen sitting in his wheelchair wearing a cardiac Life Vest (The LifeVest is a wearable cardiovascular defibrillator designed to protect individuals at risk of sudden cardiac death). A record review for Resident #31 revealed no orders for the cardiac Life Vest, and no mention of the cardiac Life Vest in the cardiac care plan. (photographic evidence obtained) On 04/23/25 at approximately 03:25 PM, an interview the Director of Nursing (DON) was conducted. The DON was asked what documentation is expected from nursing for a resident with a cardiac Life Vest. The DON stated there should be a cardiac care plan that would include the cardiac Life Vest. However, when shown that the cardiac care plan for Resident #31 did not contain language regarding the cardiac Life Vest, the DON stated, It should have been in the care plan. Resident #2 On 4/22/2025, a record review was conducted for Resident #2. The record indicated that Resident #2 was hospitalized on [DATE]-[DATE] with acute chronic respiratory infection. The physicians' orders included an order for Cefdinir Oral Capsule 300 MG (an antibiotic), give 300 mg by mouth two times a day for infection, ordered 3/28/25 and stopped 4/23/25. The care plan for Resident #2 did not include infection or antibiotic use. A review of Resident #2's diagnosis list included, ACUTE RESPIRATORY FAILURE WITH HYPOXIA and PNEUMONIA DUE TO METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS. The quarterly minimum data set (MDS) were positive for Infections (Pneumonia) and antibiotic use. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/23/25 at approximately 02:16 PM, an interview with Staff E, a registered nurse (RN)/MDS coordinator, was conducted about Resident #2's infection and if there should be a care plan for infection/antibiotic use. The RN/MDS coordinator stated Resident #2 has been in and out of the hospital lately for respiratory infections. She stated, Yes, she should have a care plan for infection, I must have missed this.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 28603 Based on family interview, record review, and staff interview, the facility failed to provide appropriate physician ordered services to increase range of motion or prevent further decrease in range of motion for 1 of 3 residents sampled for limited range of motion. (Resident #19) The findings include: A telephone interview was conducted with Resident #19's sister on 4/21/25 at 2:12 PM. She stated the resident had limited range of motion in his knees and was not receiving any services for the issue. A review of Resident #19's electronic medical record revealed a current physician order dated 1/28/25 stating to provide a functional maintenance program to provide stretching exercises to the bilateral knees while in bed to maintain knee extension. The current plan of care for Alteration in activities of daily living and Reduced range of motion with a diagnosis of bilateral knee contractures (revised 1/30/25) indicated that a functional maintenance program for knee stretches was started on 1/27/25 with a nursing intervention of range of motion to bilateral knees.A review of the task menu for April 2025 revealed no documented entries of the functional maintenance program and stretching exercises being performed as ordered. A review of the facility's Functional Maintenance Programs form for Resident #19, dated 1/10/25, revealed staff should stretch the resident's knees while in bed to maintain knee extension and prevent further contractures and verbally cue resident to improve standing posture when upright. An interview was conducted with Employee A (Registered Nurse) on 4/23/25 at 1:31 PM. Employee A stated she was in charge of the functional maintenance program. She stated that care is documented in the task menu. She reviewed the task documentation for Resident #19 and confirmed the care had not been documented as completed in the last 30 days. She then stated if it is not documented, the care had not been done.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43857 Based on record review, interviews and facility policy review, the facility failed to provide medications at a timely manner for 1 of 3 residents receiving antibiotic medications via intravenous route. (Resident # 156) The findings include: On 4/21/25, Resident #156 had a pump used for intravenous therapy inside his room. On 4/21/25, Resident #156's medical records were reviewed. He was admitted to the facility on [DATE] following a stay at a hospital. Hospital records dated 4/4/25 indicated a physician discharge order to receive Ceftriaxone (a medication given to treat bacterial infections) 2 Grams (GM) daily for 14 days. Admission medication orders dated 4/4/25 stated to start Ceftriaxone 2 GM. Medication Administration Records (MAR) revealed Ceftriaxone's first dose was administered on 4/8/25. A progress note dated 4/5/25 explained that the medication was not at the facility. On 4/7/25, a progress note stated the pharmacy sent intravenous medications but was waiting for the pump to be delivered. On 4/23/25, a late note was entered into the electronic medical record indicating the reasons that antibiotic medication was delayed, due to the pharmacy needing clarification and pharmacy not delivering a pump for administration. On 4/23/25 at 9:42 AM, an interview was conducted with the Director of Nursing (DON). She reviewed Resident #156's medical records. She verified the resident did not receive the ordered antibiotics until 4/8/25, three days after the physician's orders. The DON stated she did an audit and asked Staff B, a Licensed Practical Nurse (LPN), about this. Staff B had told her that the person that had placed the first order had written to give 1 GM instead of 2 GM, and the pharmacy had requested clarification, delaying the delivery and subsequent administration. On 4/23/25 at 10:25 AM, an interview was conducted via telephone with the Pharmacy. They verified that the order for Ceftriaxone was received on 4/4/25, but the order read to use 1 GM and clarification was requested. They stated the clarification was received on 4/6/25. On 4/23/25 at 4:00 PM, an interview was conducted with the Medical Director. He stated it was unfortunate that the antibiotics were delayed for 3 days. The facility policy named Medication Delivery Expectations (dated October 2019) stated that the purpose was to ensure all residents will receive their medications as ordered and to ensure if medications was not received, center immediately intervene and medication is received within 4 hours.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50082 Based on observations and interviews, the facility failed to ensure all drugs and biologicals were stored in locked compartments for 1 of 4 medication carts. The findings include: On 4/21/25 at approximately 11:47 AM, an observation was made of an unlocked and unattended medication cart. Four staff members walked by the unlocked medication cart between 11:47 AM and 11:49 AM, at which time the licensed practical nurse (LPN), Staff C, came out of a resident's room and acknowledged that he left the medication cart unlocked. On 04/24/25 at approximately 09:56 AM, the Assistant Director of Nursing (ADON) stated that the expectation is to lock the medication cart and computer screen when the nurse leaves the medication cart.