STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105637	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marianna Health and Rehabilitation Center	4295 Fifth Avenue Marianna, FL 32446

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50783 Based on observations, interviews and record reviews the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, for 1 of 37 residents reviewed. (Resident #105) The findings include: Resident #105 On 1/27/25, during the initial tour, Resident #105 was found to be unavailable for interview. When asked about Resident #105's whereabouts, staff stated that she was currently in the hospital. Upon record review, it was discovered that Resident #105 was transferred to the hospital on 1/24/25 due to abnormal lab readings. Resident #105 was admitted to the hospital for further care and treatment and was diagnosed with respiratory failure secondary to worsening of urinary tract infection. Upon further review of the medical record, Resident #105 was also admitted to the hospital on 4/14/24 - 4/17/24, 5/11/24 - 5/20/24, 5/30/24 - 6/6/24, 7/6/24 - 7/12/24, and 1/8/25 - 1/13/25 with abnormal vital signs of tachycardia and abnormal respirations, and altered mental status. Admitting diagnoses for each hospitalization revealed worsening urinary tract infections and sepsis. On 1/29/25 at 1:40 pm, an interview was conducted with Staff Member C, a Certified Nursing Assistant (CNA). CNA C stated she had worked at the facility for a year now. She stated she works with Resident #105 with her morning activities of daily living. Staff C reported that the resident has been sick the last several weeks and has not wanted to get up to her wheelchair. Staff C stated she informed the nurse that the resident was not feeling well. An interview with Staff Member B, a Licensed Practical Nurse, was performed on 1/29/25 at approximately 2:00 pm, Nurse B revealed that the facility process for a resident with a change in condition is for the nurse is to assess the resident, and notify the physician and the supervisor. If we receive orders from the physician, the nurse will implement the orders. Staff member B stated that they use the Situation, Background, Assessment, Recommendation (SBAR) form to keep track of assessments and recommendations. Staff Member B stated that if a person is sent out to the hospital, a transfer packet is also done, with the bed hold notice, transfer sheet, EMS sheet for need of transport, and it is documented electronically under assessments. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Staff Member D, the Registered Nurse (RN) unit manager, was completed on 1/29/25 at 2:30 pm. She was asked if the SBAR was an expectation of the nurses to complete when there is a change in a resident's status. Staff member D stated it is the expectation to complete a SBAR when a resident has a change in condition and when they are transferred to the hospital. However, some staff nurses will put in a communication note, or a progress note instead of an SBAR assessment. On 1/29/25 at 3:00 pm, an interview with the Director of Nursing (DON) was performed. She confirmed that a SBAR assessment is to be completed by nursing staff when a change in condition is observed. A transfer packet is also to be completed on all residents when there is a change in condition that requires them to be transferred to the hospital for further treatment. The DON was asked if a SBAR assessment was completed on Resident #105 prior to being transferred out to the hospital. The DON stated that the resident has had several hospitalization s, but she was unsure if an SBAR was completed. The DON confirmed that it was her expectation that the nurses complete an SBAR assessment for each resident when a change occurs. The DON was then asked what measures are used to prevent hospitalization of a resident with a urinary tract infection. The DON stated they encourage the resident to drink fluids, call the physician if the resident does not show improvement of symptoms, provide peri-care for residents who are incontinent and dependent on staff, and implement probiotics and medications as prescribed by physician. The DON was asked if these measures were implemented for Resident #105 with each hospitalization . The DON stated Resident #105 refused to get up out of bed and always fussed about not getting the therapy she needed. The DON stated, Her family was always complaining about something. I have a grievance in the book in regard to her therapy, but she refused to participate when the therapist went to work with her. The DON stated there was a SBAR assessment completed for this last hospitalization on [DATE]. The DON was asked if one was competed on the other hospitalization s in April, May, and July of 2024. The DON stated that she did not see one, but the nurses could have put a progress note in about it. The DON revealed a progress note written on 5/30/24, 7/6/24, and on 1/8/24 indicating a change in Resident #105's status. Upon further record review, Resident #105 was admitted to the facility on [DATE] and was diagnosed with a urinary tract infection on 4/17/24. On 6/6/24, Resident #105 was noted to have a new diagnosis of Extended spectrum beta lactamase (ESBL) resistant urinary tract infection. On 1/30/25 at approximately 10:34 AM, an interview was completed with the Infection Control Preventionist (ICP). She stated she tracks and trends when a resident is admitted to the facility with an infection or if they acquire an infection while here at the facility. She reviews the physician orders every morning in clinical meeting, and reviews the progress notes for the last 24 hours to see if a resident has documented symptoms of a possible infection. She states she reviews the facility map for patterns of any infections and showed a facility map colored coded by types of infections. When asked about the response if a pattern in one unit reveals an increase of urinary tract infections (UTI's), she stated she would bring up the concern to the clinical team and monitor for handwashing and performance of proper peri-care. She stated they will do staff training with the staff nurses and CNAs on that unit when a pattern of infections is present. She was asked about any tracking and trending related to Resident #105 to review her infections and hospitalization s. On 1/30/25 at approximately 12:15 PM, the ICP provided a handwritten form of Resident #105 hospitalization s which reveals the resident was diagnosed with a UTI when admitted to the hospital on 4/14/24, 5/11/24, 5/30/24, 7/6/24, and 1/8/25 and had no prior antibiotic therapy. (photographic evidence obtained) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the care plan for Resident #105 reveals she is at risk for urinary tract infections with history of ESBL. Care plan goal states that the resident will have no complications of UTIs and will minimize risk for complications for worsening UTIs through next review date. Resident #105 was hospitalized six times with in the last year related to worsening of urinary tract infections.

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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. 50783 Based upon observations, interviews, and record reviews the facility failed to provide care and services to prevent further decrease in range of motion for 1 of 1 residents reviewed for range of motion issues. (Resident #99) The findings include: On 1/27/25 at approximately 11:00 AM, an observation of Resident #99 revealed contractures of bilateral hands. Resident #99 had hand splints laying on top of the refrigerator at his bedside. At approximately 3:30 pm, the resident was observed lying in bed again with no splints to bilateral hands. Bilateral hand splints are observed to still be on top of the refrigerator at bedside. Resident #99 was resting with his eyes closed. A record review at 3:45 pm on 1/27/25 revealed a physician's order for splints to bilateral hand/wrist to maintain neutral wrist alignment. Wear 3-5 times a week for 3-6 hours a day. On 1/28/25 at approximately 9:00 am, the resident was lying in bed with the head of the bed elevated at approximately 60-70 degrees. An oxygen nasal cannula was observed on the resident with staff at bedside assisting Resident #99 with breakfast due to contractures of bilateral hands. Resident #99 was awake and alert and denied having pain or discomfort at this time. Once again, the bilateral hand splints werelaying on top of the refrigerator at bedside. At 10:00 am, Resident #99 was laying in bed awake and alert. This surveyor asked about his hand contractures. He revealed that he had a stroke and is unable to use them. Resident #99 stated he is not getting therapy services currently. When asked if he wears his hand splints every day, he stated, No they don't put them on me. The resident demonstrated that he is unable to open his hands and extend his fingers when asked. At 1:00 pm, Resident #99 again stated that no one comes in to apply his hand splints or assist with range of motion exercises. Bilateral hand splints were observed on top of the refrigerator at bedside. At 4:00 pm, the bilateral hand splints were still observed on top of the refrigerator at bedside. On 1/29/25 at approximately 8:30 am, 12:30 pm, 2:00 pm, and at 4:00 pm, observations of Resident #99 revealed bilateral hand splints were not applied to Resident #99's hands and wrist. Bilateral hand splints were observed on top of the refrigerator at bedside during each observation throughout the day. Upon review of the medical record on 1/28/25 at 11:00 am, Resident #99 was found to have a physician order for a restorative program for range of motion and hand splints. Resident #99 has a diagnosis of bilateral hand contractures, knee contractures post CVA (stroke), dated 2/11/2023. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon further record review, Resident #99 was on restorative program services. Documentation shows services were provided in November 2024 on the 4th, 5th, 8th, 11th, 12th, and the 13th for 15 minutes each visit. No documentation was observed for the month of December 2024. January 2025's restorative documentation reveals that the resident received services on the 2nd, 3rd, 6th, 7th, 8th, 9th, 13th, 14th, and the 16th. Resident #99 is care planned (initiated on 6/11/2024) for limited mobility related to contractures of upper and lower extremities with the goal that Resident #99 will remain free of complications related to immobility . On 01/29/25 at 12:40 PM, an interview with the Assistant Director of Nursing (ADON) was performed about the restorative program. She stated that there is a Certified Nusing Assistant (CNA) that does all the splinting and range of motion for residents on restorative care. The ADON stated that they just hired a new person to assist with restorative programs but this person has not started yet. An interview with the Director of Nursing (DON) on 1/29/25 at approximately 1:00 pm revealed that the therapy manager is over the restorative program at this time. The DON stated that, if the Restorative Nursing Aide (RNA) is not in facility, then the nurses and CNAs on the unit are expected to carry out the program. The nurse then documents on the TAR (treatment administration record) and the CNAs document on the plan of care (POC) under task. The DON reviewed Resident #99's range of motion exercises and application of splints to bilateral hands and wrist and acknowledged that no task for restorative was found in the POC. The TAR noted that a nurse signed off indicating that the splints had been applied on 1/28/25 and 1/29/25. She acknowledged that the splints and exercises were not being consistently done.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 50783 Based on observations, record review, and interviews, the facility failed to provide proper care and services for 1 out of 2 residents reviewed for hemodialysis services. (Resident #50) The findings include: On 01/27/25 at approximately 12:30 pm, Resident #50 was observed sitting in a wheelchair in his room. Resident #50 revealed that he just returned from dialysis treatment. He denied having any pain or discomfort. He stated he receives dialysis treatments on Mondays, Wednesdays, and Fridays from early in the morning and until around lunch time. Upon further interview with Resident #50, he voiced concerns in regard to a few weeks ago, after my treatment when I got back, my arm was hurting pretty bad. Resident #50 rubbed his right upper arm with his left hand and pulled his shirt sleeve up and to show his dialysis shunt site. He stated he informed the nurse of the pain. He stated the nurses did nothing in regards to the pain. He stated the nurses did not check his shunt site. When asked if he informed the dialysis center upon return, he responded, No I had to go to the hospital a few days later. On 1/27/25 at approximately 3:00 PM, the record review revealed no dialysis orders at all. Upon further review, the facility has no communication record to or from the dialysis center. The progress notes and nurse documentation revealed a progress note dated 12/23/24 stating that a family member requested Resident #50 be sent to hospital due to complaints of pain to his right arm. The nurse assessed Resident #50 and medicated Resident #50 with pain medication. The nurse documented that the bruit and thrill are present (phrases indicating blood flow occurring over a fistula site). On 12/24/24, Resident #50 continued to voice complaints of pain to the right upper arm and once again Resident #50 is medicated for pain. However, no assessment of the arteriovenous (AV) shunt was documented for two shifts. On 12/25/24, Resident #50 continued to voice complaints of pain to the right upper arm and once again Resident #50 was medicated for pain on the first shift with no assessment documented of the dialysis shunt site. On 12/25/24 at 06:30 pm, Resident #50 was observed in bed crying. When the nurse questioned Resident #50, he stated that he wanted to go to the hospital because his right arm is hurting. He stated the area to his dialysis had a pain radiating down his entire arm. He stated, on a scale of 1-10, that his pain is a 10. The resident was medicated with PRN pain medication and he stated that the medication was not effective. Emergency Medical Services were called at this time. Resident #50 was admitted to the hospital on 12/25/24. After his transfer to the hospital, he underwent a surgical procedure to declot his Arteriovenous fistula. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/28/25 at 4:52 PM,an interview with the Director of Nursing (DON) was performed. The DON stated that dialysis communication sheets should be scanned into the electronic medical recors and, if they are not there, they can be found in the resident's medical paper chart. The DON stated that all residents receiving dialysis treatment have orders for what day the resident attends dialysis, where they go for dialysis treatments, and to monitor site prior to treatment and post treatment. The DON stated that nurses assess the resident before leaving for their treatment and assess again after the resident returns from treatment. However, the DON was not able to locate any physician orders or documentation of assessment prior to dialysis treatment and post dialysis treatment when Resident #50 returned to the facility. The DON located a communication sheet under the miscellaneous section of the paper chart from November 2024 and one from early December 2024. The DON acknowledged that Resident #50 should have orders to monitor what days he goes to dialysis, where he goes to receive dialysis, monitor for symptoms of infection at the dialysis fistula site, and documentation of bruit and thrill at the dialysis fistula site. A record review of Facility policy, End Stage Renal disease states, Care of a resident with End stage renal disease reveals residents with end stage renal disease will be care for according to currently recognized standards of care. Staff caring for residents with end-stage renal disease shall be trained in the care and special needs of these residents. Education and training of staff include specifically: the nature and clinical management of ESRD including infection prevention and nutritional needs. The type of assessment data that is to be gathered about the resident's condition on a daily pr per shift basis. How to recognize and intervene in medical emergencies such as hemorrhages and septic infections. Upon reviewing education records no education training has been completed related to Residents with End Stage Renal Disease and the care they receive.

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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. 48176 Based on observation, record review and interview, the facility failed to provide needed medications as ordered for 2 of 5 residents sampled. (Resident #543 and #69) The findings include: Resident #543 On 1/27/25 at approximately 1:20 PM CST, Resident #543 stated she was in pain and but had not received her pain medication all weekend. She was observed in a fetal position and was having a hard time talking but kept saying, it hurts, it hurts. On 1/27/25 at approximately 4:28 PM CST, Staff J, a Registered Nurse (RN), stated during an interview that the reason that Resident #543 was in so much pain was because the facility had run out of her pain medication. Per the medical record, her order was for HYDROcodone-Acetaminophen Oral Tablet 10-325 MG, Give 1 tablet by mouth as needed every 8 hours for pain. Based on the Medication Administration Record (MAR), Resident #543 did not receive her pain medication on January 24, 25, 26 or 27, 2025, even though the facility logged her pain level each time as a 9 on a 1-10 scale. On 1/27/25 at 5:06 PM, Staff J was asked why the resident was out of medication. Staff J stated, The only reason I can think of is someone forgot to renew the order. When asked if the facility had an emergency medication supply, she stated, We do, we have a Pyxis machine. She stated that Staff H, also an RN, was her nurse all weekend and she had no idea why Staff H did not get a code for the Pyxis since Resident #543 was in pain. On 1/28/25 at 5:05 PM, during an interview with the Director of Nursing (DON), she was asked if it was not acceptable for a medication to run out. She stated that staff had access to after hours doctors for a reason and, if they could not get the order, they know to call her and she will get it done. She also stated, We have emergency meds for a reason. On 01/29/25 at 10:34 AM, the DON in a follow up interview stated that the order states the medication was routine and they should have given the medication every 8 hours whether she was in pain or not. Staff also should have notified someone that they were out of the medication. More importantly, staff should not have run out of the medication. On 1/29/25 at 12:04 PM Staff F, also an RN, and Staff G, a Licensed Practical Nurse (LPN), were interviewed. Staff F stated she was not sure why the medication was not ordered, and that it was the responsibility of Staff H, who worked that weekend. Staff G stated she works with Resident #543 and was not aware that Resident #543 was out of pain medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 2:09 PM, an interview was held with Staff H, who worked with Resident #543 during the weekend and marked the medication as not available on the first day it ran out. She stated she was waiting for Monday to have the prescription signed. When asked why the emergency doctor was not called, she stated, I did not know this facility had access to after-hours doctors. Resident 543's Care Plan, dated 2/23/25, states for pain management the interventions include, administer pain medications as ordered and anticipate the residents need for pain relief and respond immediately to any complaint of pain. 51224 Resident #69: During an observation of Resident #69 on 01/28/25 at approximately 12:10 PM, Resident #69 was in the hallway sitting in her wheelchair. The residents' eyes appeared droopy, red, and irritated. On 01/28/25 at approximately 2:12 PM, Resident #69 was obsereved still in her wheelchair in the day area with no changes to her eyes. On 01/28/25 at approximately 2:28PM, Resident #69 was observed requesting medication for a headache. On 1/29/25 at approximately 8:45 am, Resident #69 was observed in the hallway sitting in her wheelchair again with noticeably red eyes. On 1/29/25 at approximately 4:02 PM, Resident #69 was observed in her room sitting in a wheelchair and again both eyes appeared red and irritated. On 1/28/25 at approximately 12:10 PM, when asked if her eyes hurt or were itchy, Resident #69 nodded yes. On 1/29/25 at approximately 8:45 am, when asked if her eyes hurt or were itchy, Resident #69 again stated yes. On 1/29/25 at approximately 11:45 AM during an interview with Staff I, a licensed practical nurse (LPN), the LPN verified Resident #69 had an as needed (PRN) eye drop medication (Systane Gel 0.4-0.3%) with an order that read, instill 1 drop in both eyes as needed for RED EYES THREE TIMES A DAY. The LPN verified that the medication was in the drawer and presented a brand new unopened box of Systane gel dated in black marker 01/28/25. The LPN was asked if Resident #69 is assessed for eye redness routinely, and the LPN stated she was. Upon review of Resident #69's physician orders, it was noted in the electronic medical record (EMR) that Systane Gel 0.4-0.3 % Instill 1 drop in both eyes, as needed for RED EYES THREE TIMES A DAY was placed on 06/20/2022. According to the EMR, the last dose of Systane gel was administered on 02/19/2024. (Photographic evidence obtained)