STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105690	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pines Rehabilitation Center	1111 S Highland Ave Clearwater, FL 33756

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observations, interviews and record review, the facility failed to ensure the resident's living environment promoted, maintained and enhanced dignity and respect for three (#56, #265, #264) of four residents sampled. Findings included: 1. Resident #56 was admitted to the facility on [DATE] with diagnoses to include dementia, and developmental disorders of scholastic skills. Review of an annual MDS (Minimum Data Set) dated 05/31/24, section C showed Resident #56 had a Brief Interview for Mental Status (BIMS) score of 00 which indicated severe impairment. On 08/26/24 10:54 a.m. and 12:32 p.m., Resident #56 was observed in his room laying on his bed. His roommate was performing sexual acts on himself exposed to Resident #56. The privacy curtain was partially drawn. Review of a care plan dated 06/09/21 showed a cognition focus. Resident has impaired cognitive function/dementia or impaired thought processes related to developmental disability. Interventions included to promote dignity, talk with resident and ensure privacy . Report to nurse any changes in cognitive function, specifically changes in: decision making ability, memory, recall, awareness of surroundings and others, difficulty expressing self and difficulty understanding others. A communication focus in the care plan showed the resident has a problem with communication. He is usually understood, usually expresses ideas or wants, he is able to verbalize his needs or wants, make decisions in regards to routine daily care and decline what he doesn't want. Review of the care plan did not show interventions related to Resident #56's exposure to his roommate's sexual activities. On 08/27/24 at 3:51 p.m., an interview was conducted with Staff G, CNA (Certified Nursing Assistant). She said, Resident #56's roommate [acts out sexually] all the time. We redirect him. As soon as you tell him to stop, he starts all over again. She stated Resident #56 did not say anything about the behavior. She said, I know, it's kind of unfair. We try and make sure the curtain is pulled. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/28/24 at 9:28 a.m., an observation was made of Resident #56's roommate displaying sexual behaviors as he laid on his bed. The privacy curtain was wide open exposing him to the public. Resident #56 could be seen from the hallway trying to pull the privacy curtain so he could not see what his roommate was doing. The resident was observed lifting his left hand to cover his eyes and pointing with his right hand to his roommate on the bed. The resident repeatedly said, I don't like it. I don't like this. He continued to attempt to pull the privacy curtain which was stuck. Staff I, Personal Care Attendant (PCA) was observed down the hallway. Staff I came to the door and walked into the room and observed this resident's roommate performing sexual acts on himself. She said, Oh no! and immediately walked out. She did not immediately assist Resident #56 who was trying to pull the curtain. She stated this resident's roommate did this all the time. After waiting for approximately 5 minutes, Staff I returned to the room and without asking Resident #56 escorted him out of the room. On 08/28/24 at 9:40 a.m., an interview was conducted with Staff H, CNA. She stated when they observe Resident #56's roommate engaged in the sexual behavior, they tell him to cover up. She stated he did this 24/7. She said, Resident #56's roommate only comes out of the room during meals and then he is back at it. It's an ongoing thing. It has been like this for at least seven months . She stated they try to cover him and redirect Resident #56 out of the room when possible. She stated this resident did not like it. On 08/28/24 at 9:46 a.m., an interview was conducted with Staff C, Licensed Practical Nurse (LPN). She observed Resident #56's roommate in his bed acting out sexually. She stated Resident #56 spent most of his time outside the room. She said, I spoke to this resident regarding his roommate's behavior. He has mental retardation he does not always give a clear answer. The nurse was observed walking into the room in wheeling Resident#56 to the dining room without asking him. On 08/28/24 at 10:05 a.m., an interview was conducted with Staff E, LPN/ Unit Manager. He stated he had never spoken to Resident #56 about his roommate's behavior. He said, I don't know why I have never thought about this resident and his thoughts about this issue. All residents deserve to be treated with dignity. He stated he didn't know if they could move him or not. On 08/28/24 at 10:12 a.m., an interview was conducted with the Social Services Director (SSD). The SSD stated behavioral care plans were completed by the facility's Minimum Data Set (MDS) nurse. She stated the staff should ensure dignity and privacy was provided for both residents. She said, The CNAs should close the curtain or door if they observe the behavior. She said regarding Resident #56, I would not like that. I don't know what to do it is over my head. I have never received a concern. It is not appropriate for him. We can definitely assess the roommate situation it is a dignity issue. On 08/28/24 at 10:31 a.m., an interview was conducted with Staff F, LPN/MDS and the Regional Clinical Reimbursement Consultant. Staff F stated Resident #56 had never said anything about the roommate's behavior. She said, I mean they are cognitively impaired. When asked if other residents should be subjected to the sexual behavior against their will, both the MDS and RNC stated they could not answer that question. Staff F stated she could not speculate how Resident #56 felt. She stated it was the first time she heard about the concern. She said, should have his dignity. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/28/24 at 11:01 a.m., an interview was conducted with the Nursing Home Administrator (NHA). She stated the expectation was for staff to close the curtain and remove Resident #56 from the room. She stated both Resident #56 and his roommate had a right to privacy and dignity. On 08/29/24 at 10:59 a.m., an interview was conducted with Resident #56's Psychiatric Physician Assistant (PA). He stated he had not spoken with this resident regarding exposure to his roommate's sexual behaviors. He said, I have not been notified he was verbalizing concerns. I just know it would not be his favorite thing to watch the behavior. He stated if the resident was verbalizing concerns, he needed to be evaluated and see if the facility would do something about it or maybe they could move him. He stated they should protect other residents from this behavior. 2. On 8/26/2024 at 10:58 a.m., Resident #264's urinary catheter bag was visible from the hallway, hanging on the frame of the bed closest to the door. No cover was seen. On 8/26/2024 at 11:20 a.m., Resident #266's urinary catheter bag was visible from the hallway, hanging on the frame of the bed closest to the door. No cover was seen. On 8/26/2024 at 4:15 p.m., Resident #264's urinary catheter bag was visible from the hallway, hanging on the frame of the bed closest to the door. No cover was seen. On 8/26/2024 at 4:20 p.m., Resident #266's urinary catheter bag was visible from the hallway, hanging on the frame of the bed closest to the door. No cover was seen. On 8/27/2024 at 9:31 a.m., Resident #264's urinary catheter bag was visible from the hallway, hanging on the frame of the bed closest to the door. No cover was seen. On 8/27/2024 at 9:40 a.m., Resident #266's urinary catheter bag was visible from the hallway, hanging on the frame of the bed closest to the door. No cover was seen. During an interview on 8/27/2024 at 4:55 p.m., Staff BB, Licensed Practical Nurse (LPN) stated, there was usually a cover on the urinary catheter bags. I'm not sure why there isn't one on these two catheters. During an interview on 8/28/2024 at 10:04 a.m.,, Staff R, Registered Nurse (RN) stated, the urinary catheter bags should have been covered, did not understand why they were not. Review of a facility policy titled, Resident Rights, effective February 2021, showed the facility strives to assure that each resident has a dignified existence . The facility will protect and promote the rights of each resident. The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. Each resident/or representative will be presented with a copy of the Federal and/or State-specific [NAME] of Resident Rights. Review of the Resident [NAME] of Rights showed: Our facility will protect and promote each of the following rights: Exercise of Rights: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. You have the right to exercise your rights as a resident of the facility and as a citizen, or resident of the United states 2. You have the right to be free of interference, coercion, discrimination or reprisal from the facility in exercising your rights. 6. The facility must provide equal access to quality of care regardless of diagnosis, severity, condition or payor source. 19. You have the right to personal privacy and confidentiality of your personal and clinical records. Personal privacy includes privacy in accommodations . 37. Dignity/self-determination and participation: You have the right to receive care from the facility in a manner and in an environment that promotes, maintains or enhances your dignity and respect in full recognition of your individuality. 48223

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observations interviews, and record review, the facility failed to ensure call lights were within reach in eight resident rooms (207A/B, 206B, 210A/B, 214B, 305, 307, 312 and 314) in two (200 and 300) of four halls. Findings included: During multiple facility tours of halls 200 and 300, call lights were observed on the floors as follows: On 08/26/24 at 10:52 a.m., a call light was observed on the floor in room [ROOM NUMBER]. On 08/26/24 at 10:57 a.m., a call light was observed on the floor in room [ROOM NUMBER]. On 08/26/24 at 11:06 a.m., a call light was observed on the floor in room [ROOM NUMBER]. On 08/28/24 at 12:08 p.m., and on 08/29/24 at 9:36 a.m., a call light was observed on the floor in room [ROOM NUMBER]. On 08/28/24 at 9:32 a.m., an interview was conducted with Staff H, Certified Nursing Assistant (CNA). She stated she made sure the call lights are within reach during her rounds. She said, If I see them on the floor or under the bed, I pick them up. On 08/29/24 at 10:03 a.m., an interview was conducted with Staff C, Licensed Practical Nurse (LPN). She stated the residents should have access to their call lights. She said, Yes, even if they have cognition challenges, they should have it. We have a few residents who are alert and use their call lights. She stated they educated the CNAs to ensure they place them within reach. During multiple facility tours of the 200 hall, call lights were observed on the floors as follows: On 08/26/24 at 10:58 a.m., a call light was observed on the floor in room [ROOM NUMBER] B. On 08/26/24 at 11:04 a.m., a call light was observed on the floor in room [ROOM NUMBER] A and B. On 08/26/24 at 11:10 a.m., a call light was observed on the floor in room [ROOM NUMBER] A and B. On 08/26/24 at 11:20 a.m., a call light was observed on the floor in room [ROOM NUMBER] B. On 08/27/24 at 9:41 a.m., a call light was observed on the floor in room [ROOM NUMBER] A and B. On 08/27/24 at 9:43 a.m., a call light was observed on the floor in room [ROOM NUMBER] B. On 08/27/24 at 9:45 a.m., an interview was conducted with Staff CC, CNA. Staff CC, CNA stated call lights should be within reach for the residents. Staff CC, CNA said, I didn't notice them on the floor, I will put them within reach now. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/27/24 at 4:55 p.m., Staff BB, LPN stated the residents should have access to their call light, in case they need assistance. I didn't notice they were not within the residents reach. During an interview on 8/28/24 at 9:30 a.m., the Director of Nursing (DON) stated the facility did not have a policy and procedure for call light placement, although the call light should be within the reach of the resident. 48223

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observations, interviews, and record review, the facility failed to ensure a resident had privacy in his room for one (#9) of two residents sampled. Findings included: Resident #9 was readmitted to the facility on [DATE] with a primary diagnosis of dementia. Other diagnoses included Schizophrenia, major depressive disorder and age-related cognitive decline. Review of a quarterly MDS (Minimum Data Set) dated 07/16/24, section C showed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 00 that indicated severe cognitive impairment. During facility tours of the secured unit on 08/26/24 at 10:54 a.m., and 12:32 p.m., Resident #9 was observed in his room, laying on his bed performing sexual acts on himself. The resident's privacy curtain was not enclosed. The resident was in Bed A, which was closer to the door, leaving him exposed to other residents, visitors, and employees. This resident was also fully exposed to his roommate. On 08/27/24 at 3:42 p.m., Resident #9 was observed wandering in halls. He was observed heading to his room and pulling his pants down. The resident's body was visible from the hallway. Review of a care plan initiated on 04/06/20 showed a behavioral focus, Resident #9 has, a behavior problem related to publicly disrobes, publicly masturbates and gropes, wandering, and insinuates he would like sexual favors from staff. Interventions included to administer medications as ordered, monitor/document for side effects and effectiveness, approach in a calm manner, caregivers to provide opportunity for positive interaction, attention. Stop and talk with him when passing by and to document behaviors and resident's response to interventions. An activities focus in the care plan initiated on 07/17/24 showed Resident #9 required staff's assistance with involvement of activities related to severe cognitive impairment, non-verbal, behavioral symptoms that may affect participation-has inappropriate sexual behavior of touching himself. The interventions section showed when behavior is exhibited, remove him from situation and take to alternate location as needed. The care plan did not address dignity and privacy concerns for Resident #9 and his roommate. On 08/27/24 at 3:51 p.m., an interview was conducted with Staff G, CNA (Certified Nursing Assistant). She said, Resident #9 [acts out sexually] all the time. We redirect him. As soon as you tell him to stop, he starts all over again. She stated the roommate did not say anything about the behavior. She said, I know, it's kind of unfair. We try and make sure the curtain is pulled. On 08/28/24 at 9:28 a.m., an observation was made of resident #9 displaying sexual behaviors as he laid on his bed. The privacy curtain was wide open, exposing him to the public. His roommate could be seen from the hallway trying to pull the privacy curtain so he could not see what his roommate was doing. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/28/24 9:38 a.m., a fell ow resident in the secured unit was observed standing outside Resident #9's window with the blinds open. He was observed shaking his head to the left and right in a disagreeing movement. Resident #9 was in his bed uncovered performing sexual acts on himself. On 08/28/24 at 9:40 a.m., an interview was conducted with Staff H, CNA. She stated when they observe Resident #9 engaging in the sexual behavior, they tell him to cover up. She stated he did this 24/7. She said, He only comes out of the room during meals and then he is back at it. It's an ongoing thing. It has been like this for at least seven months . She stated they tried to cover him and redirect the roommate out of the room when possible. She stated the roommate did not like it. On 08/28/24 at 9:46 a.m., an interview was conducted with Staff C, Licensed Practical Nurse (LPN). She observed Resident #9 in his bed acting out sexually as another Resident was watching through the blind that was open. She said, I agree this is not good. The blind should not be open. We should provide him privacy. She stated the resident should not be observed by others. He should have privacy in his room. On 08/28/24 at 10:05 a.m., an interview was conducted with Staff E, LPN/ Unit Manager. He stated Resident #9 acts out sexually all the time. When they see him doing that, they pull the curtain to provide him privacy. He stated sometimes he walks by, and the curtain is not pulled. Sometimes it's open. On 08/28/24 at 10:12 a.m., an interview was conducted with the Social Services Director (SSD). The SSD stated behavioral care plans are completed by the facility's MDS nurse. She stated Resident #9 was care planned related to [performing sexual acts on himself]. She stated the resident saw psychiatry. She said, He has the right to do that, but he should not be seen from the hallway. She stated the staff should ensure dignity and privacy was provided for those residents. She stated the residents in the secured unit were confused and needed constant redirection. She said, The CNAs should close the curtain or door if they observe the behavior. On 08/28/24 at 10:31 a.m., an interview was conducted with Staff F, LPN/MDS nurse. She stated the Resident #9 was cognitively impaired and he acted out sexually. She stated this resident should have privacy when engaged in the sexual acts. On 08/28/24 at 11:01 a.m., an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated the expectation was for staff to close the curtain and remove the roommate from the room. She stated if the CNAs observed Resident #9 performing the behavior, they should immediately intervene and give him privacy. She stated both Resident #9 and his roommate had a right to privacy and dignity. On 08/29/24 at 11:50 a.m., an interview was conducted with Resident #9's guardian. She stated the resident was known for sexually inappropriate behaviors. She said, He should be provided privacy. It is his right. The other residents should be protected. I know he has not acted out on other people, but he propositions staff and other residents. She stated she expected the residents to be treated with dignity. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/29/24 at 10:59 a.m., an interview was conducted with Resident #9's Psychiatric Physician Assistant (PA). He stated he was aware of this resident's sexual behaviors, and he was receiving medications. He stated if this resident had displayed increased sexual activity, he should be evaluated. He stated the resident should be monitored to see if the medications were working or not. He stated staff should be ensuring he had privacy. He said, If he starts acting out sexually the curtain should be pulled for his privacy. Review of a facility policy titled, Resident Rights, effective February 2021, showed the facility strives to assure that each resident has a dignified existence . The facility will protect and promote the rights of each resident. The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. Each resident/or representative will be presented with a copy of the Federal and/or State-specific [NAME] of Resident Rights. Review of the Resident [NAME] of Rights showed: Our facility will protect and promote each of the following rights: Exercise of Rights: 1. You have the right to exercise your rights as a resident of the facility and as a citizen, or resident of the United states 2. You have the right to be free of interference, coercion, discrimination or reprisal from the facility in exercising your rights. 6. The facility must provide equal access to quality of care regardless of diagnosis, severity, condition or payor source. 19. You have the right to personal privacy and confidentiality of your personal and clinical records. Personal privacy includes privacy in accommodations . 37. Dignity/self-determination and participation: You have the right to receive care from the facility in a manner and in an environment that promotes, maintains or enhances your dignity and respect in full recognition of your individuality.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observations, interviews, and facility policy review, the facility failed to ensure resident rooms were maintained in a clean and sanitary manner in three (300, 200, 100) of three halls observed, during 4 of 4 days of survey. Findings included: On 08/26/24 at 10:25 a.m., upon entering the secured unit in hall 300, a strong urine odor was noted. On 08/26/24 at 10:26 a.m., an immediate interview was conducted with Staff AA, Certified Nursing Assistant (CNA). She confirmed the smell. She stated this was not the first time. She stated she did not know why the unit had a foul odor. On 08/26/24 at 11:02 a.m., an interview was conducted with Staff L, Regional Housekeeping Manager. He said, Yes, it smells in here. It could be because of soiled depends or a foul wound. He stated some of the residents urinated on the floors which could be the source of the foul smell. On 08/26/24 at 10:49 a.m., room [ROOM NUMBER] was observed with stains and scratches on the walls, stained floors, and dirt and grime along the base boards. On 08/26/24 at 10:57 a.m., room [ROOM NUMBER] was observed with stained privacy curtains, stains and scratches on the walls, grime on the baseboards, and broken dresser and nightstand drawers. On 08/26/24 at 11:06 a.m., room [ROOM NUMBER] was observed with stained walls and raised plastering on the door surface. On 08/26/24 at 11:15 a.m., room [ROOM NUMBER] was observed with wet ,stained floors, bed linens on the floor, stained walls, grime on the baseboards, and a trash can without a bag and a soiled brief in the can. On 08/26/24 at 11:18 a.m., an interview was conducted with Staff AA. She stated resident's linens should not be on the floor. She said, We will pick them up. They should not be on floor. On 08/26/24 at 11:28 a.m., room [ROOM NUMBER] was observed with dirt on the floor corners and chipped missing tiles on the bathroom floor corner by the door. The room's door frame was observed with rusty debris on the bottom corners, stains behind the door and floors, stained walls, and base boards with dirt and grime. A pair of black pants and a book were observed on the floor under bed B. This observation was made during two of four days of survey. The main door was observed without a door knob during 3 of 4 days of survey. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/26/24 at 11:23 a.m., an interview was conducted with Staff K, Housekeeping Manager from a sister facility. She stated she was at this facility helping the housekeeper just that day only. She stated she had never been at this facility before but had been asked to come and help out. She observed the unkempt rooms and confirmed the foul odor. She said, No, residents should not live in an unclean environment. It is not acceptable. On 08/26/24 at 11:24 a.m., an observation was made of Staff M, Housekeeping Manager from a sister facility setting up a cleaning cart outside a resident's room. He stated he did not work at this facility but had been asked to come and help. Staff M said, It is not clean and sanitary in here. Yes, it smells. This unit definitely needs cleaning. That is why I came to help. He stated he did not normally come to assist with housekeeping. He stated he was at this location only this day because of the survey. On 08/26/24 at 11:28 a.m., an interview was conducted with Staff L, Regional Housekeeping Manager. He said, We are lacking in accountability. We will clean the unit today. It is not to our standards right now. The residents should be in a sanitary environment. It should be clean. On 08/26/24 at 11:33 a.m., an interview was conducted with Staff J, Housekeeping Manager. He stated the unit smelled like urine. He said, It is not clean in here. Some residents urinate on the floor. The plan is to clean the rooms three times daily. He stated the CNAs should help in the mornings because it smelled like that all the time. On 8/26/24 at 11:36 a.m., Staff N, Housekeeping Aide was observed cleaning a resident's room. She stated she worked at this facility. She stated this was not her regular assignment. She stated the aide who normally cleaned this unit had been out sick. She stated she did not know if anyone had been assigned to clean the secured unit the previous weekend. On 08/27/24 at 2:49 p.m., an observation was made of linens on the floor in room [ROOM NUMBER]. On 8/27/24 at 3:42 p.m., an observation was made of broken nightstands for bed A and B and a broken dresser drawer in room [ROOM NUMBER]. On 8/28/24 at 9:23 a.m., room [ROOM NUMBER] was observed with a bedside table with stains and dried up syrup on the table surface. Observations were made of stains on walls, blinds, floors, and dirt on the baseboards. On 8/28/24 at 9:24 a.m., an interview was conducted with Staff N, Housekeeping Aide. She stated she was assigned to clean both her assignment and the other aide's assignment in halls 200 and 300. She said, The staff who works here is still out sick. I am doing my best working both assignments. On 08/28/24 at 9:30 a.m., room [ROOM NUMBER] was observed with stains on the floor. On 08/28/24 at 9:31 a.m., room [ROOM NUMBER], was observed with stained walls and the handwashing sink without a trim, exposing wood and a white bubbled rough surface. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/28/24 at 9:32 a.m., room [ROOM NUMBER] was observed without a door handle. This observation was made three of three days of survey. An immediate interview was conducted with Staff H, CNA. She stated this door had not had a door handle for approximately 3 weeks. She stated it was hard for both staff and residents to push the door open. In a follow -up interview on 08/28/24 at 12:52 p.m., Staff L, Regional Housekeeping Manager stated he had just noticed the door knob missing in room [ROOM NUMBER]. He stated he would get it fixed. He stated the facility's manager should be conducting more rounds. On 08/28/24 9:40 a.m., an interview was conducted with Staff H, CNA. She stated the secured unit had a moldy musty smell. She confirmed it had been an ongoing problem. On 08/28/24 from 9:56 a.m. to 10:08 a.m., a tour of the secured unit's residents smoking area was conducted with the facility's Floor Technician. A portion of the fence was observed fallen, leaving a wide-open space leading outside the facility. The path leading to the resident's smoking area was observed with multiple bees, wasps, and cobwebs on the walls along the pavement. The floor technician stated he would notify maintenance of the observed concerns. On 08/28/24 at 10:05 a.m., an interview was conducted with Staff J, Housekeeping Manager. He stated the aide who cleaned the secured unit was out sick and he had not found a replacement. On 08/29/24 at 2:23 p.m., an interview was conducted with the Director of Maintenance (DOM). He stated he was not sure why there was a musty smell in the secured unit. He stated he had a problem with ventilation in that unit, but he did not know if that was the issue. He said, I know the rooms need painting. They are old. Some rooms need furniture. Especially in the secured unit. He stated he conducted rounds and made a list. He stated he handled emergency concerns first. He stated he did not know room [ROOM NUMBER] did not have a door knob. He stated he was not aware. He said, The residents should have a door knob. I do not know who removed it or how long it had been. He stated he did not know about the bees, wasps problem until the previous day. He stated he was working on the identified concerns. On 08/29/24 at 02:27 p.m., an interview was conducted with the Nursing Home Administrator (NHA). She stated they had one maintenance man on staff (The DOM). She said, Our process is to identify areas of concern and address one issue at a time. Immediate concerns are handled first, and then we go down the list. The NHA confirmed the floors needed to be redone. She stated it was hard to find similar tiles. She said, We scrub and do the best we can. I know some of them need to be replaced. On 8/26/24 at 10:51 a.m., during a tour of room [ROOM NUMBER], the sealant in the front of the bathroom sink appeared rough, missing on the outer edges, and had pale green and rust colored buildup. Rust colored drainage was noted on the sink. There were holes in the shower tile with tan and grey colored buildup between the tiles. The sealant on the base of the shower wall was rough with rust colored buildup. The floor between the bedroom and the bathroom had buildup of dirt and grime. (Photographic Evidence Obtained). On 8/26/24 at 10:54 a.m., during a tour of room [ROOM NUMBER] there was unpainted patch areas in three areas of the wall around the air conditioner unit. There were dry brown colored areas on the floor with buildup of dirt and grime in the crevices. (Photographic Evidence Obtained). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/26/24 at 11:11 a.m., during a tour of 200 hall the paint on the hallway wall outside of room [ROOM NUMBER] was peeling. There were depressions in the wall and buildup of dirt and grime in the door jam and base trim crevices. (Photographic Evidence Obtained). On 8/26/24 at 11:44 a.m., during a tour of room [ROOM NUMBER]-2 the wall behind the top of the bed had deep gouges, portions of the paint and the outer dry wall was peeled and white chalk like material was exposed. In the bathroom, the drain was 1/3 covered with debris, and there was a large amount of brown with black speckled biofilm on the gout. The calking between the wall and the toilet stool appeared rough and there was a separation between the toilet and the wall on the side and top. The caulking around the sink was rough with spots of separation from the sink. The faucet's handle, base and spout contain dry, hard, chalky, rust, grey, and tan deposits. (Photographic Evidence Obtained). On 8/26/24 at 12:15 p.m., during a tour of 300 hall, the wall behind the bed headboard in room [ROOM NUMBER]-2 was in disrepair. Deep gouges, portions of the paint and the outer dry wall was peeled and white chalk like material was exposed. There were white particles laying on the floor below. (Photographic Evidence Obtained). An interview was conducted with the Maintenance Director and Nursing Home Administrator (NHA) on 8/29/24 at 2:04 p.m. The Maintenance Director said the facility's management team completes rounds each morning. When maintenance related issues were identified staff members were expected to log the issue in the facility's building management platform. He checked the web-based system daily and address the most immediate first. The Maintenance Director said the facility's current priority was addressing leaks in the facility. He said the building was old and had many ongoing maintenance issues. The facility had one staff member assigned to maintenance duties. An interview was conducted with the Housekeeping Manager and the Housekeeping District Manager on 8/29/24 at 2:36 p.m. The Housekeeping Manager said all resident rooms were cleaned daily. The daily cleaning included emptying the trash, high dusting, clean surfaces of the room, sweep floors, and mop. There were three house keepers assigned to work on weekdays and two on the weekends. The Housekeeping District Manager said the gout between the tiles could be cleaned, and he planned to retrain staff. A review of the facility's policy and procedure titled physical environment, effective August 2024. The policy statement is a safe, clean, comfortable, and homelike environment is provided for each resident, allowing the use of personal belongings to the greatest extent possible. Sufficient space and equipment in dining, health services, recreation, and program areas are provided to enable staff to provide residents with needed services. All essential mechanical, electrical, and resident care equipment is maintained in safe operating condition through the facilities preventative maintenance program. The procedure showed 1) Encourage residents to bring their individual possessions within the limits of the safety of the resident and others. 2) Maintain sufficient space and equipment in dining, health services, recreation, and program areas. Remove unnecessary clutter. 3) Assure flame proof cubicle curtains are available and in place at all times to assure resident privacy. 4) Assure an applicable working system is in place and within reach for residents to summon assistance, including, but not limited to typical call light with cord, manual call bell, specialty call bell as needed (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy, titled housekeeping procedures, revised 9/5/ 2017. The section titled bathroom cleaning showed material needed includes a cart, dust mop, damp mop, dustpan, dust brush, high duster, bucket and ringer, quat disinfectant, three spray bottles, 3 pals, rags, sponges, scraper, johnny mop, wet floor sign, paper towels, toilet tissue, plastic trash bags. Use a seven-step method. Dry steps 3) Pick up trash, use dust mop. Wet steps: 4) sanitize sinks, light, mirror, sink, fixtures and pipes. 5) sanitize commode, tank, bowl and base. Use brush for inside of bowl. 6) Spot clean-walls, partitions, light switches. 7) Damp mop. Start in far corner get behind commode, move trash can, mop out the door. The section titled daily patient room cleaning B) Do a quick straighten up. C) Follow five step room cleaning method: 1) empty trash. 2) Horizontal Dusting. 3) Spot clean. 4) Dust mopped floor; pick up with dustpan. 5) damp mop floor . the section titled Complete Room Cleaning showed A) set up calendar outlining what rooms are to be cleaned on certain days. B) Coordinate with charge nurse at the start of shift to have the room ready. F) Follow 5-Step room cleaning method: 1) Empty Trash, 2) Horizontal dusting, 3) Spot Nurse, 4) Dust mop floor, 5) Damp mop floor. 49227

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on record review and staff interviews, the facility failed to ensure the Preadmission Screening and Resident Reviews (PASRRs) for residents with a mental disorder and individuals with intellectual disability with qualifying mental health diagnosis, were updated for five (#9, #22, #7, #39 and #23) of six residents sampled. Findings included: Resident #9 was originally admitted to the facility on [DATE] with a primary diagnosis of dementia onset date 10/01/22. Other diagnoses included Schizophrenia, Major depressive disorder with an onset date of 10/10/19. Review of a level I PASRR for Resident #9 dated 10/09/19 revealed page 2 of the PASRR was missing and the qualifying diagnoses were not checked. The level I PASRR showed the primary diagnosis of Dementia was not checked. This diagnosis was initiated after the PASRR was completed. Review of a PASRR level II determination summary report dated 09/13/19 showed this determination was submitted prior to the diagnosis of Dementia becoming primary. The report further showed the diagnosis of Schizophrenia was not considered. On 08/28/24 at 4:43 p.m., an interview was conducted with Staff F, Licensed Practical Nurse, (LPN)/MDS (Minimum Data Set). She stated if the resident acquired a new diagnosis, the PASRR should be updated. She stated a level II PASRR should be updated with diagnosis like Schizophrenia and Dementia. A review of Resident #7's admission record showed an admitted [DATE] with diagnoses to include Major Depressive Disorder, Unspecified Dementia, and Unspecified Psychosis. A review of level I PASRR for Resident #7 dated 5/24/23 showed the qualifying diagnoses were not checked and the need for a level II PASRR was not identified or acted upon. During an interview on 8/28/24 at 3:11 p.m. with the Director of Nursing (DON). The DON said if PASRR revisions were needed, the Social Services Director (SSD) would contact the PASRR people. The DON said she was responsible for completing the PASRRs and she did not have access to the PASRR's web-based submission program. The DON said after admission the Interdisciplinary Team (IDT) reviewed each PASRR for accuracy. During an interview on 8/28/24 at 3:39 p.m. with the SSD and the Nursing Home Administrator (NHA), the SSD said she was unable to access the PASRR web-based submission program and referred revisions to the DON. During an interview on 8/28/24 at 4:40 p.m., the NHA said the facility staff who could complete the level 1 screening, did not have access to the PASRR web-based program. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident of Resident #22's admission record showed an admitted [DATE] with diagnoses to include Anxiety, Major Depressive Disorder, and Unspecified Dementia with mood disturbance. A review of level I PASRR for Resident #22 dated 6/6/22, showed the qualifying diagnose of Dementia was not checked and the need for a level II PASRR was not identified or acted upon. A review of Resident #39's admission record showed an admitted [DATE] with diagnoses to include Anxiety, Vascular Dementia with other behavioral disturbance, and Major Depressive Disorder. A review of level I PASRR for Resident #39 dated 7/10/19, showed the qualifying diagnoses of Dementia was not checked and the need for a level II PASRR was not identified or acted upon. A review of Resident #23's admission record showed an admitted [DATE] with diagnoses to include Major Depressive Disorder, Parkinsonism, Epilepsy, Traumatic Brain Injury, and cognitive social or emotional deficit following other nontraumatic intracranial hemorrhage. A review of Resident #23's medical record did not reveal a level I PASRR. The facility was not able to locate a PASRR for the resident. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policy and procedure titled PASRR Requirements Level I & Level II, dated effective February 2021 showed: Topic: Pre-Admission Screening & Resident Review (PASRR) pre admission screening will be conducted prior to admission as the PASRR process is federally mandated pre admission screening program (see 42 CFR S483.100) required to be performed on all individuals prior to admission to a nursing home. The screening is reviewed by admissions for suspicion of serious mental illness and intellectual disability to ensure appropriate placement in the least restrictive environment and to identify the need to provide applicants with needed specialized services. PASRR screening applies to all new admissions into a Medicaid certified nursing facility and includes private pay, Medicare, and Medicaid admissions regardless of payer source. * The screening is typically done by discharge planners and hospital staff as a step in the discharge process. It is separate from a medical needs assessment, which most often occurs after a person applies for Medicaid and is required step to qualify for Medicaid long term care assistance. Procedure: 1. During the admission process, business development will communicate with the facility regarding prospective admissions. A level 1 PASRR will be provided prior to admission to the skilled nursing facility. Facility administration will confirm that a level 1 review has been completed prior to transfer to the SNF setting. 2. Determine if a serious mental and/or intellectual disability or related condition exists while reviewing the PASRR form completed by the acute care facility. (Trigger for level 2 completion) 3. If serious mental illness or ID is indicated, determine if the resident/patient will be admitted from a hospital for an acute care stay and the attending physician has certified that the individual is likely to require less than 30 days of nursing facility services. Assure that the certification is signed and dated. 4. If the physician indicates the stay will likely be less than 30 days SNF services, the patient/resident can be admitted to an SNF. If anticipated stay becomes longer than the 30 days a level 2 must be completed prior to day 40. Florida facilities (form 004 part A effective November 2014) assure that sections one through 5 are completed prior to admission. If section IV (provisional admission) this applicable, the form is only valid if the MD has signed and dated the form. If the admission is a provisional admission, the social service director must start a tickler file and assure the level 2 is completed within the state specified time frame. * Delirium - within seven days of admission * caregiver respite within 14 days of admission * emergency placement within seven days of admission * 30 day hospital exemption within 30 to 40 days of admission if the pre admission screening requires a level 2 evaluation submit all required documents to the required agency timely, so that a level 2 can be completed within the required time frames. 49227 48223

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49227 Based on observation, interview, and record review, the facility failed to ensure accommodations were in place for two (#25 and #61) of two sampled residents with limited English proficiency. Findings Included: On 8/26/24 at 4:09 p.m. during observation and interview, Resident #61 used their personal cell phone to translate from English to Vietnamese to communicate with staff. Review of the admission record showed Resident #61 was admitted on [DATE] with diagnoses including paraplegia, depression, anxiety, and heart failure. Review of Resident #61's quarterly Minimum Data Set (MDS), dated [DATE], Section A, Identification Information showed the resident's preferred language is Vietnamese. Section C- Cognitive Pattern revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Review of Resident #61's care plans showed a focus plan in place for communication related to a problem with communication: Primary Language other than English: Vietnamese. The care plan interventions included, [Resident #61] uses his cell phone with a translation app for communication. Review of the admission record showed Resident #25 was admitted on [DATE], with diagnoses including Alzheimer's Disease, dementia, and visual disturbance. Review of Resident #25's quarterly MDS, dated [DATE], Section C- BIMS Score of 5, which indicated severe cognitive impairment. Review of Resident #25's care plans showed a focus plan in place for communication related to Alzheimer's, Spanish speaking, . blind. Resident #25's care plan's interventions Utilize Spanish staff to assist in communication. During an interview on 8/29/24 at 8:27 a.m., Staff P, Certified Nursing Assistant (CNA) said she writes on a paper and show it to them (residents) to assist with communicating. She taught herself Spanish to be able to communicate with Resident #25. During an interview on 8/29/24 at 8:42 a.m., Staff E, Licensed Practical Nurse (LPN), Unit Manager (UM) said Resident #61 used his personal phone to communicate with staff. He said the facility's therapy department had a communication board for residents who's preferred language was not English. Staff E, LPN, UM, said staff anticipates resident's needs and there are Spanish speaking staff who communicates with Resident #25. He said he did not know if Spanish speaking staff were always available in the facility. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/28/24 at 4:15 p.m., the Director of Nursing (DON) said the facility's staff have access to a language [translation] line. During an interview on 8/28/24 at 6:00 p.m., the Nursing Home Administrator (NHA) said Resident #61 used their own phone to communicate with staff. Currently staff did not have access to interpreting services for the residents. Review of a facility policy titled, Policy and Procedures for Communications with Persons with Limited English proficiency (LEP) Office for Civil Rights, effective August 2024. The policy showed [name of facility]will take reasonable steps to ensure that persons with limited English proficiency have meaningful access and an equal opportunity to participate in our services, activities, programs, and other benefits. The policy of the [name of facility] is to ensure meaningful communication with LEP residents and their authorized representatives regarding their medical care and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to, waivers of rights, consent to treatment forms, financial and insurance benefit forms, etc. Interpreters, translators, and other aids needed to comply with this policy shall be provided without cause to the person being served, and residents and their representatives will be informed of the availability of such free assistance. Language assistance will be provided through the use of qualified translators technology and telephonic interpretation services. Staff will be provided with notice of policy and procedure, and staff that may have direct contact with LEP individuals will be trained in effective communication techniques, including the use of qualified interpreters. The [name of facility] will review and update the facility assessment annually to identify the language access needs of our resident population, as well as update and monitor the implementation of this policy and these procedures, as necessary. Procedure 1) process to identify individuals who need sign language interpreters or assistive services: the [name of facility] will promptly identify the language and communication needs of the LEP person. Language identification cards (or I speak cards and posters are available online In addition, when records are kept of past interactions with residents or resident representatives, the language used to communicate with the LEP person will be included as part of the record.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observation, interview, and record review, the facility failed to address a change in condition for one (#46) of two residents reviewed. Findings included: Resident #46 was admitted to the facility on [DATE] with diagnoses to include unspecified Dementia, Major depressive disorder and Anxiety among other diagnoses. Review of a care plan for Resident #46 showed a psychotropic medication focus, the resident uses psychotropic medications related to antidepressant to manage depression, anticonvulsant to manage behavior management, anti-anxiety to manage anxious behaviors, an anti-psychotic to manage bipolar. Interventions included psychotropic side effects monitoring such as: confusion, disturbed gait, drooling, and drowsiness. Administer medications as ordered, observe/document for side effects and effectiveness. Report to physician negative outcomes associated with use of drug. A quarterly Minimum Data Set (MDS) dated [DATE] showed Resident #46 had a Brief Interview for Mental Status (BIMS) score of 99 which indicated severe cognitive impairment. On 08/26/24 at 9:32 a.m., Resident #46 was observed in his bed. His eyes were closed. The resident did not respond to greeting. Staff A, CNA was in the room providing 1:1 supervision. She stated the resident previously had multiple falls. She said, He is much sleepier today. On 08/26/24 at 1:04 p.m., an observation was made of Resident #46 being assisted with meal. He did not eat. Staff A, CNA stated he ate some during breakfast. She said, He will not open his eyes now. The nurse is going to check his vitals. On 08/26/24 at 1:08 p.m. the resident was observed unresponsive, not easily aroused. Staff D, Registered Nurse (RN) stated the CNA had notified her the resident was lethargic and difficult to arouse. She stated she obtained his vitals. His blood pressure was 107/65 She stated she had notified the physician and had received orders to transfer the resident to the Emergency Department (ED). Review of a document titled Name of Hospital, ED Nursing Documentation dated 08/26/24, showed reason for visit, Patient from [name of facility] for AMS (Altered Mental Status), he has a history of dementia, however he is acting more altered than normal. Review of a document titled Name of Hospital, ED Physician Notes dated 08/26/24, showed under HPI (History of Present illness) showed, the patient is a [AGE] year-old male presents for AMS per SNF (skilled nursing facility) staff at [name of facility]. Staff reports patient was at his baseline this morning however seemed altered today around lunchtime when he became completely unresponsive. CBG (Capillary Blood Glucose) at that time was reportedly around 90. Report dementia at baseline. Is somewhat ambulatory with staff, however, mainly sits in bed and requires frequent assistance. Staff states he's usually verbal, however cannot form words clearly at his baseline. Staff denies any recent falls trauma to the head, vomiting and fevers. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/24 at 9:36 a.m., Resident #46 was observed outside his room, sitting in his wheelchair with Staff B, CNA providing 1:1 supervision. The resident was observed nodding to sleep and unable to keep his head up. Staff B stated he was doing much better today. On 08/27/24 at 10:26 a.m., an interview was conducted with Staff C, Licensed Practical Nurse (LPN). She stated Resident #46 went to the hospital the previous day and returned around 6:40 p.m. without new orders. She stated the resident continued with some sleepiness. On 08/27/24 at 4:19 p.m., Resident #46 was observed in bed, sleeping. Staff B, CNA was observed sitting at his bedside. She stated the resident appeared to be drowsy. She stated he was not conversing. On 08/28/24 at 9:45 a.m. and 12:50 p.m., Resident #46 was observed in his room, in bed with Staff B CNA providing 1:1 supervision at his bedside. Staff B stated the resident was on 1:1 supervision for aggressive behaviors. She stated he had not been aggressive lately but had behaviors in the past. She confirmed he had been sleeping a lot, not getting out of bed. On 08/28/24 at 1:59 p.m., an interview was conducted with Staff C, LPN she stated the resident was back at a new baseline. She said, He is in bed now mostly. That is a recent change. He is typically out and about. Very aggressive. He has slowed down. Review of August 2024 physician orders for Resident #46 showed newly added orders: Quetiapine Fumarate Oral Tablet 200 MG (Milligrams), Give 200 mg by mouth two times a day for bipolar, 8/23/24. Ativan Oral Tablet 0.5 MG (Lorazepam) *Controlled Drug* Give 1 tablet by mouth three times a day for Anxiety, 8/22/24 Trazodone HCl Oral Tablet 100 MG (Trazodone HCl), Give 1 tablet by mouth at bedtime for depression, 7/31/24. Melatonin Oral Tablet 3 MG (Melatonin), 7/4/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/28/24 at 5:10 p.m., an interview was conducted with Staff E, LPN/ Unit Manager. He stated the resident was moved to the secured unit due to exit seeking behaviors. He stated his baseline was wandering, multiple falls, impulsive, always rocking, chewing all kinds of stuff, aggressive behaviors such as throwing coffee at others, hitting, kicking, He stated he had suffered falls due to trying to get up or pick up things off the floor. The unit manager stated the significant change started about a couple weeks prior. He said, He is in bed more. Yesterday he was up in his chair, his 1:1 assisted him with his dinner. He used to feed himself but was now requiring staff to feed him. Staff E stated he had observed the resident mellow, low key, almost sedated all the time. He said, The doctor changed his Seroquel to 200 mg twice a day, previously it was 50 mg twice daily His Ativan is now 0.5 mg three times a day, and he is also taking Trazodone 100 mg at bedtime. He weighs 145 lbs. Staff E stated he did not know if the resident was sedated. He said, He is definitely sleeping more. I don't know if he is sedated. The PA (Physician Assistant) comes monthly. I have not notified him of this change. The UM stated he had worked with the resident the day before. He said, Yes, he was sleepy a lot. I do think that is a heavy Seroquel dose. I thought it was more like 100 mg. I will call the doctor. Staff E, LPN stated the resident went to the ED on Monday for sedation, he was not easy to arouse and had returned without orders. Staff E stated if they did not find anything wrong with the resident at the ED on Monday, then he should have been seen by a doctor yesterday or today to figure out what was causing him to be sedated. He stated he would find out if he saw the ARNP (Advanced Registered Nurse Practitioner. Review of record revealed no documentation of the doctor's visit. On 08/28/24 at 5:27 p.m., an interview was conducted with the Director of Nursing. The DON stated the resident should be reviewed for appropriate medications dosage and response. The DON said, it sounds like he is lethargic. I think that is a significant dose increase. I will let the doctor know. During this interview, the DON reviewed the August 2024 Medical Administration Record (MAR) for this resident and stated the nurses were documenting a check mark under side effects monitoring. She stated the check mark denoted administered. The DON stated the monitoring should show if the behavior or side effect was present or not, and document a response with a Yes or No. She stated a Yes response should be followed by a note describing the behavior or side effect which was observed. On 08/29/24 at 9:55 a.m., an interview was conducted with Staff C, LPN. She stated the resident was more alert today and was needing redirection unlike the past few days. She stated related to the increased dose of Seroquel, there was an order to hold the Ativan if the resident was sedated. She stated she did not know if any of doses were held. She stated the order had been changed to PRN (as needed). She stated the nurses monitored behaviors related to medications. The behaviors should be documented in the progress notes. She sated they were in constant communication with the Nurse Practitioner. She said, I understand nothing is documented. Review of the Electronic Medical Record (EMR) showed there were no Ativan doses held. Review of the EMR showed there were no notes related to concerns of sedation and drowsiness. Review of the EMR showed the PA was not notified of the side effects or behaviors in relation to the increased medication doses. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/29/24 at 11:10 a.m., an interview was conducted with Resident #46's PA. He stated staff should be monitoring the resident for sedation. He said, I put in an order for them to hold the Ativan if sedated. I expect them to let me know how he is doing. The PA stated the previous Friday he had increased the resident's medications. He stated he needed an aggressive response to the aggressive behaviors. He stated he was notified the previous day he was a little more sedated. He said, The nurses should let me know when there is a change. I am trying to reduce the agitation, but we also don't want to send him to the other extreme. He should be closely monitored for sleep, meal intake and other behaviors to confirm the efficacy of the medications and make changes as needed. I will try to back off the meds. The PA stated the medication response such as sedation should be monitored. He stated he did not typically put in orders to monitor behaviors. He said, It is a facility-by-facility basis on how they handle the monitoring of medications' side effects and behaviors. I expect a call if there is a change in mood or behavior. If I don't hear anything, I assume the resident okay, They should communicate with the physician and keep me informed of any changes. On 08/29/24 at 01:46 p.m., The Regional Nurse Consultant (RNC) stated a change in condition (CIC) should be documented if the resident has had any kind of change that requires a response. She stated the facility had no CIC policy. She said, We follow the EINTERACT CIC evaluation form.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20311 Based on observations, interview and record review the facility failed to ensure that services were provided to address resident vision needs for one (#105) of 48 residents sampled. Findings included: Review of Resident #105's face sheet revealed he was admitted to the facility on [DATE]. Review of the resident's MDS dated [DATE] revealed a BIMS score of 15 which indicated intact cognition. During an interview with Resident #105 on 08/26/24 at 12:08 p.m., the resident said he had been waiting since June for transportation to go the eye doctor. He said he had not seen an eye specialist since admission to the facility. A review of the progress note showed on 6/21/24 3:16 p.m., General-the resident brought to the writer's attention that he has a detached retina to his left eye, requested lubricating eye drops to help with the discomfort in the right eye. Per MD needs medical attention ASAP (As Soon As Possible). Ophthalmology consult is in place. Care plan remains ongoing for the resident at this time. Review of the resident's care plan initiated on 7/11/24 revealed the following: The resident has impaired visual function r/t detached retina, The interventions includes Vision consult as needed. Review of the progress notes revealed the following: -6/22/24 08:46 [8:46 a.m.] General-Order for ophthalmology/eye appt asap for L retinal detachment per MD. -6/22/24 13:08 [1:08 p.m.] General- A/O x 3 OOB ambulating around in room denies any type discomfort no s/s distress noted refused pneuovac (sic) despite education voiced understanding continues to c/o unable to see out of lt [left] eye -6/28/24 00:33 [12:33 a.m.] Schedule an Ophthalmology Consultation for detached retina ASAP every shift for 30 Days REFERRED TO S.S. TO SCHED: -6/29/24 00:38 [12:38 a.m.] emar [electronic medication administration record] note-Schedule an Ophthalmology Consultation for detached retina ASAP. every shift for 30 Days social services to schedule consultation -6/30/24 15:39 [3:39 p.m.] emar note: Schedule an Ophthalmology Consultation for detached retina ASAP. every shift for 30 Days weekend (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-7/1/24 18:27 [6:27 p.m.] Social Service Note: SSD spoke with resident regarding Ophthalmology consult needed. Unit manager aware and has been assisting resident with appointment. Resident stated that he was in no pain and did not want to go to the hospital. Resident is alert and oriented X 4 with a BIMS score of 15. He is able to make his needs and wants to be known. Resident was calm and eating dinner. SSD will update resident when appointment is set. The ophthalmologist is scheduled to see resident at the facility on July 3rd if needed. SSD will continue to assist. -7/2/24 12:49 [p.m.] General-Writer was informed by social services that resident was to be transferred out of facility to Hospital ER for further evaluation of Detached Retinal. Resident aware of transfer. Call placed out to ARNP and made aware of arrangements. ambulance non-emergency called, awaiting arrival. -7/2/24 14:32 2:32 [p.m.] General- ambulance non-emergency transport to ER for possible admission for surgery due to Retinal detachment. Awaiting arrival. -7/3/24 00:45 [12:45 a.m.] emar note-Schedule an Ophthalmology Consultation for detached retina ASAP. every shift for 30 Days ATTEMPTED TO SEND TO E.R. FOR TX. , E.R. SENT RESIDENT BACK TO FACILITY WITHOUT TREATING. -7/3/24 13:51 [1:51 p.m.] General-Scheduled exam with The Eye vendor on 7/16/24 at 10 am for f/u Left retinal detachment and possible cataract removal -7/4/24 02:01 [a.m.] emar note-Schedule an Ophthalmology Consultation for detached retina ASAP. every shift for 30 Days S.S. working on Appt. -7/14/24 07:22 [a.m.] emar note-Schedule exam with The Eye vendor ASAP for f/u Left retinal detachment and possible cataract removal every day shift for eye appt asap for OS retinal detachment Weekend -7/14/24 15:10 [3:10 p.m.] emar note- Schedule an Ophthalmology Consultation for detached retina ASAP. every shift for 30 Days Weekend -7/16/24 11:23 [a.m.] Social Service note-SSD called The Eye vendor and scheduled a new appointment for Monday July 22th at 2:10 PM. SSD called and arranged transportation for appointment with physician. Resident is scheduled to be picked up for appointment at 11:05 PM Reservation number 80265. If transportation has not arrived by 11:05 staff needs to call transportation vendor. -7/16/24 14:51 [2:51 p.m.] General-Transportation did not arrive for eye appointment. Appointment was missed. -7/21/24 08:55 [a.m.] Emar note-Schedule an Ophthalmology Consultation for detached retina ASAP. every shift for 30 Days weekend -7/21/24 17:28 [5:28 p.m.] emar note-Schedule an Ophthalmology Consultation for detached retina ASAP. every shift for 30 Days weekend (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-7/23/24 11:44 [a.m.] Social Service note-SSD called The Eye vendor and scheduled a new appointment for Monday July 29th at 12:55 PM. SSD called vendor Ambulance and arranged transportation for resident to go to appointment. Transportation vendor will arrive at our facility on Monday 7/29/24 at 11:15 AM. Resident needs to be reminded the night before appointment 7/28/24 and the morning of the appointment. RETURN TRIP NEEDS TO BE ARRANGED. -8/13/24 12:47 [p.m.] Social Service Note-SSD called The Eye vendor and scheduled a new appointment for Friday August 30th at 12:00 PM. Round trip transportation needs to be arranged. -8/14/24 05:51 [a.m.] general scheduled appt The Eye vendor Friday August 30th at 12:00 PM Review of the physician order revealed the following: -6/20/24 14:41 [2:41 p.m.] phone order-Ophthalmic, Auditory, Psychological, Psychiatric, Dental, Physiatry, and Podiatry services as needed -6/21/24 23:52 [11:52 p.m.] verbal order-Schedule an Ophthalmology Consultation for detached retina ASAP. -6/22/24 08:39 [a.m.] written order-Schedule exam with The Eye vendor ASAP for f/u Left retinal detachment and possible cataract removal -7/3/24 13:49 [1:39 p.m.] phone order-Scheduled exam with The Eye vendor on 7/16/24 at 10 am for f/u Left retinal detachment and possible cataract removal -7/24/24 09:15 [a.m.] phone order-scheduled a new appointment for Monday July 29th at 12:55 PM with eye vendor. Transport Ambulance at pickup time 1115 am -8/14/24 05:38 [a.m.] phone order-scheduled appt The Eye vendor Friday August 30th at 12:00 PM During an interview on 08/29/24 at 9:13 a.m. with the SSD, she said now if transportation did not come for the resident's 8/30/24 appointment, the facility would pay for a ride share vendor.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49227 Based on observation, interview, and record review, the facility failed to monitor for medication related side effects and behaviors for two (#10 and #73) of five residents reviewed for unnecessary medications. Findings Included: 1. Review of Resident #10's admission record showed he was admitted on [DATE] with diagnoses including epilepsy, mood disturbance, dementia, cognitive communication deficit, schizoaffective disorder, seizures, and anxiety. Review of Resident #10's orders showed, Levetiracetam tablet 500 milligrams (mg) every 12 hours for seizures, Escitalopram Oxalate tablet 20 mg daily for depression, and Olanzapine tablet 20 mg at bedtime for schizoaffective disorder. Review of care plans showed Resident #10 has a behavior problem related to yelling out in the hallway, refuses to go to bed, places self on the floor, .combative with staff. The care plan interventions include document behaviors and resident response to interventions. Review of Resident #10's medication administration and treatment administration records, dated 8/1/24 to 8/31/24 does not show documentation of Resident #10's behaviors. During an interview on 8/28/24 at 8:23 a.m., Staff C, Licensed Practical Nurse (LPN) said resident's behaviors were documented by exception in the progress notes. 2. Resident #73 was admitted to the facility on [DATE] with diagnoses to include unspecified dementia unspecified severity, with other behavioral disturbance and anxiety disorder among other diagnoses. Review of August 2024 Physician Orders for Resident #73 showed Donepezil HCl Oral Tablet 10 MG (Milligram), Give 1 tablet by mouth at bedtime for dementia. Trazodone HCl Oral Tablet 50 MG, Give 1 tablet by mouth at bedtime for sedative. Review of the MAR (Medication Administration Record) dated August 2024 showed, Resident #73 was admitted with Risperdal 0.5 MG, Give 1 tablet by mouth at bedtime for antipsychotic discontinued on 08/02/24. Review of the MAR showed there were no orders for behavior monitoring. Review of psychotropic progress notes dated 07/26/24, 08/02/24, 08/09/24 and 08/23/24 showed under care plan recommendations to continue to monitor for mood sedation, sedation, medication side effects and behaviors. Staff was educated on communication, redirection and non-pharmacological techniques to redirect patient as needed. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the August 2024 MAR showed there was no behavior monitoring documented. The MAR showed side effects monitoring without indication of the presence of side effects or response thereof. On 08/28/24 at 5:27 p.m., an interview was conducted with the Director of Nursing. The DON stated the resident should be reviewed for appropriate medications dosage and response. The DON said, it sounds like he is lethargic. I think that is a significant dose increase. I will let the doctor know. During this interview, the DON reviewed the August 2024 Medical Administration Record (MAR) for this resident and stated the nurses were documenting a check mark under side effects monitoring. She stated the check mark denoted administered. The DON stated the monitoring should show if the behavior or side effect was present or not, and document a response with a Yes or No. She stated a Yes response should be followed by a note describing the behavior or side effect which was observed. Review of a facility policy titled, Behavior Monitoring Record, dated October 2021, showed: To quantitatively document the frequency of identified behavioral symptoms. To document the type of interventions used to reduce or eliminate the behavior and the effectiveness of the intervention. To document side effects of psychoactive medications in the EMR. The behavior monitoring record will be initiated on residents taking psychoactive medications that require behavior monitoring. It will also be used to track behavior symptoms that interfere with the ability to function or receive care. Procedure: 1. Enter the following information into electronic medical record. 2. Describe the specific behavior to be monitored. 3. Called the interventions determined to address the specific behavior. 4. Enter the frequency of the behavior on each shift. 5. Enter the letter code (or #code) of the intervention(s) chosen to address the behavior. 6. Enter the outcome code of the intervention(s). 43453

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 49227 Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than 5.00%. 32 medication administration opportunities were observed, and six errors were identified for two residents (#110 and #107) of six residents observed. These errors constituted a 18.75% medication error rate. Findings Included: On 8/28/24 at 10:08 a.m., a medication administration observation was conducted with Staff U, Registered Nurse (RN) for Resident #110. Staff U, RN administered insulin subcutaneously and Cyanocobalamin (Vitamin B 12) intramuscularly. Resident #110's electronic medication administration record (eMAR) was highlighted in red. Staff U, RN, confirmed the medications were late. Review of Resident #110's August 2024 MAR showed insulin administration was due at 0800 with meal and Cyanocobalamin was scheduled to be given at 9:00 a.m. On 8/28/24 at 10:13 a.m., a medication administration observation was conducted with Staff U, RN for Resident #107. Staff U, RN prepared and administered Amlodipine 10 milligrams (mg) for high blood pressure, Naloxegol Oxalate 625mg for irritable bowel syndrome (IBS), Mirabegron ER 50 mg for bladder, Fluticasone-Salmeterol inhalation 250/50 for chronic obstructive pulmonary disease (COPD), Guaifenesin 10 milliliters (ml) for sore throat, and Percocet 10/325 mg for pain. Resident #107's (eMAR) was highlighted in red. Staff U, RN, confirmed Amlodipine, Naloxegol Oxalate, Mirabegron ER and Fluticasone/Salmeterol were due at 9:00 a.m. and were administered late. Review of Resident #107's August 2024 MAR showed Amlodipine, Naloxegol Oxalate, Mirabegron ER and fluticasone/salmeterol were due at 9:00 a.m. During an interview on 8/28/24 at 10:39 a.m., Staff U, RN said, I always have medications to administer after 10:00 a.m. During an interview on 8/28/24 at 1:40 p.m., the Director of Nursing (DON) said medications should be administered one hour before and one hour after the time the medication was scheduled to be administered. During an interview on 8/29/24 at 8:19 a.m., the DON said she was told by the facility's corporate nurse. Late medication administration orders were obtained from Resident #110's and #107's physician on 8/28/24. Review of Resident #107's progress note, dated 8/28/24 at 3:07 p.m. showed, Md was notified of meds being late. MD stated it was okay to give late. Review Resident #107's orders on 8/29/24 did not show an order to administer Amlodipine, Naloxegol Oxalate, Mirabegron ER and Fluticasone/Salmeterol late. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #110's progress note, dated 8/28/24 at 3:05 p.m. showed, Md was notified of meds being late. MD stated it was okay to give late. Review of Resident #107's orders on 8/29/24 did not show an order to administer insulin and Cyanocobalamin (Vitamin B 12) late. Review of the facility's policy titled, Medication Administration, General Guidelines, dated 05/16. Policy: Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Procedures: Medication Administration: 1) medications are administered in accordance with written orders of the prescriber 3) Medication administration time in parameters include the following: b) Medications to be given with meals are to be scheduled for administration at the resident's meal times. 13) medications are administered within 60 minutes of scheduled time, except before or after mail orders, which are administered based on mealtimes. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the nursing care center. Documentation: 2) if a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time . The space provided on the front of the MAR for that dosage administration is initialed and circled. And explanatory node is entered on the reverse side of the record provided for PRN documentation 4) The resident's MAR/TAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration end time. Initials on each MAR/TAR are verified with a full signature in the space provided or on the nursing care centers master employee signature log .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20311 Based on observation, record review, and interview, the facility failed to appropriately store and secure medications related to medication at the bedside on one (100 hall) of four resident hallways for Resident #20 and in two (200 hall and Birch hall) of four medication rooms. Findings included: 1. Review of Resident #20's profile revealed that this resident was readmitted to the facility on [DATE] and had diagnoses that included mood disorder and neutropenia. Review of the Minimum Data Set (MDS) dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderate cognitive impairment. During an observation on [DATE] at 10:54 a.m., Resident #20 was noted sitting on his bed and his nightstand drawer was open. Closer observations revealed that there were two bottles of eye drops in the drawer of the resident's nightstand. During an interview with the resident at this time he said, That's mine. (Photographic Evidence obtained). On [DATE] at 11:35 a.m., an observation of Resident #20's nightstand drawer revealed the two bottles of eye drops were still in the drawer. During an interview with the resident at this time, he reported that he received the eye drops from a local hospital. During an interview on [DATE] at 11:37 a.m. with Staff D, Registered Nurse, (RN), she reported that if a resident was not assessed to be able to administer their medication independently they should not have medications accessible to them. During the interview Staff D observed the two bottles of eye drops in the resident's nightstand drawer. Staff D reported that she was not aware of the resident having medication in his nightstand and the medications should not be there and should be appropriately stored. On [DATE] at 12:03 p.m., an interview was conducted with the Traveling Director of Nursing (DON), RN. The Traveling DON said medications should be stored in the medication cart or the medication room. She said the medications should not be in the resident's nightstand drawer. 2. On [DATE] at 9:16 a.m., during an observation of the Birch Unit medication room and an interview with Staff T, Registered Nurse (RN), Unit Manger (UM), Staff E, Licensed Practical Nurse (LPN), UM, and Staff X, LPN, a grey plastic shopping bag with medication bottles was observed stored in the above the counter cabinet. Staff T, RN, UM and Staff R, LPN UM both said they did not know what medications were in the bag and why it was stored in the medication room. A second observation was a container with a medication box with a broken seal that contained a bottle of Brimonidine Tartrate and two unopen boxes containing Latanoprost and Brimonidine Tartrate each box with patient specific labels. Stored in the same container were six boxes of unopened over the counter (OTC) eye medications. Staff X, LPN said the boxes with resident specific medications should have been disposed of and immediately removed from the container. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:41 a.m. an observation and interview of the 200-hall medication room was conducted with Staff T, RN, UM and Staff E, LPN UM. In the above the counter cabinet was a see-through plastic bag containing four medication bottles with the label of two separate residents alongside four small white pills not in a medication bottle. Staff E, LPN, UM said medication bottles belonged to an expired resident and a discharged resident. Staff E, LPN UM said when a resident expired their medications were disposed of in the pharmaceutical waste container. When residents were discharged home the resident was notified to pick up the medications. If the resident did not pick up the medication, the medication was disposed of in the pharmaceutical waste container. Staff T, RN, UM and Staff E, LPN UM both said they did not know why the white pills were in the bag. Staff E, LPN UM immediately removed the medications from the cabinet. Two corrugated cardboard boxes of disposable isolation gowns were on top of the counter in the Birch Hall Medication Room. An interview was conducted with the Director of Nursing (DON) on [DATE] at 12:03 p.m. The DON said medications belonging to expired and discharged resident should not be stored in the medication room. Once a resident expired their medications should be destroyed or sent to the pharmacy. The medication for discharged residents should be sent to pharmacy. The DON said isolation gown boxes should not be stored in the medication room. A review of the facilities policy titled, Medication Storage, Storage of Medications, Section 4.1, dated , d+[DATE]. Policy Statement: medication and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective Drug Administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medication. Procedures: 1) The provider pharmacy dispenses medications and containers that meet state and federal labeling requirements, including requirements of good manufacturing practices established by the United States pharmacopeia (USP). Medications are to remain in these containers and stored in a controlled environment. This may include such containers as medication carts, medication rooms, medication cabinets, or other suitable containers. 3) In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aids) are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access. 4) Internally administered medications are stored separately from medication used externally such as lotions, creams, ointments, and suppositories. 6) Eye medications are stored separately from ear medications and inhalers, ETC. 14) Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal . 15) Medication storage should be kept clean, well lit, organized and free of clutter. 16) Medication storage conditions are monitored on a regular basis as a random quality assurance (QA) check as problems are identified, recommendations are made for corrective action to be taken. 49227

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20311 Based on observations, interview, and record review, the facility failed to ensure residents received adequate dental care and services for two (#78, #84) of 48 sampled residents. Findings included: 1. Review of Resident #78's face sheet revealed the resident was admitted to the facility on [DATE] with diagnoses that included Major Depressive Disorder and Kyphosis. Review of the resident's Minimum Data Set (MDS) dated [DATE], showed a Brief Interview for Mental Status (BIMS) of 15 which indicated intact cognition. During observations of Resident #78 on 08/26/24 at 11:14 a.m., the resident was noted to have broken and missing teeth. Closer observations of the resident's mouth revealed the teeth that were present in his mouth were brown in color. During an interview with the resident at this time, he reported he did get some teeth removed, but was supposed to get dentures and nothing had been done about getting the dentures. Review of the resident care plan related to dental revealed, The resident has a potential or actual oral/dental problem r/t resident has natural teeth with broken teeth tooth extractions on going working towards getting dentures. with an initiated date of 01/16/2022, and a most recent revision date of 04/10/2024. Continued review of the care plan revealed interventions that included Dental Consult as needed with an initiated date of 01/16/2022. Review of the Annual Minimum Data Set (MDS) dated [DATE] revealed the following: -Obvious or likely cavity or broken natural teeth -yes -Mouth or facial pain, discomfort or difficulty with chewing-Yes Review of the residents physician Orders dated 11/10/21 revealed that he had a current order for Ophthalmic, Auditory, Psychological, Psychiatric, Dental, Physiatry, and Podiatry services as needed. Review of the dental consults revealed the following -2/19/24-Patient presents for consult. Patient is having more extractions done offsite. Once extractions are completed, partials will be fabricated. -3/12/24-Patient presents for consult. Patient is interested in extraction of tooth #26. SDS office will follow up for approval. -4/15/24- Complete extraction for tooth #26. Office has medical clearance. Patient presents for extraction. Patient anesthetized with 2 [NAME] of Lidocaine. Broken tooth #25 and 26 extracted. Gauze placed. POQ given. Next Visit: post Op. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/21/24-Follow up on extractions sites #25, 26. Patient presents for post op. Patient healing with out pain. No follow up needed. Continued review of the resident's entire record revealed that there was no documentation related to dentures or partials. An interview on 08/28/24 at 9:24 a.m. with the Social Service Director (SSD) revealed she knew the resident had been seen by the dental vendor. She reported that she was aware the resident wanted dentures, but the in-house dental vendor would not take his insurance. She reported that to her knowledge the resident had not been fitted for dentures. During an interview on 08/28/24 at 1:04 p.m. with the SSD, she reported she spoke to the resident and called the oral surgeon who reported the resident was a no-show 3 times and they would no longer see him. She reported the following 3 instances: -1st appointment-The dental vendor called the resident's phone to confirm his appointment but did not get him and the vendor canceled the appointment. The SSD reported she was not sure of the date of this occurrence. -2nd appointment-Transportation for the appointment never arrived. The SSD reported she was unsure as to why they did not do the pick up. -3rd appointment-The Oral surgeon never received the medical clearance. The SSD reported the resident reported to her that the completed clearance form was given to a nurse, but the nurse never forwarded the form to the oral surgeon. Continued interview with the SSD at this time revealed she did not feel it was appropriate that the resident did not receive his dental care. 2. Review of Resident #84' face sheet revealed he was admitted to the facility on [DATE] with diagnoses that included Major depressive disorder, and generalized anxiety. Review of the the resident's MDS dated [DATE] revealed a BIMS score of 15 which indicated intact cognition. An interview with Resident #84 on 08/27/24 at 9:50 a.m. revealed he had some missing and broken teeth and he had never had his teeth cleaned. Observations of the resident's mouth revealed some broken and discolored teeth. Review of the resident's care plan revealed there was not a care plan in place to address the resident's dental needs. Review of the MDS dated [DATE] revealed the resident had Obvious or likely cavity or broken natural teeth Review of the physician orders dated 8/11/22 revealed a current order for Ophthalmic, Auditory, Psychological, Psychiatric, Dental, Physiatry, and Podiatry services as needed. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the dental cleaning schedule from 4/18/24-8/23/24 revealed no entries for Resident #84. During an interview on 08/28/24 at 8:57 a.m. with the SSD, she reviewed items on her computer and reported the resident was an individual who would refuse services and then complain that he did not receive the services. She reported he was seen by the in-house vendor hygienist for cleaning and by the dentist. She reported he saw the hygienist every 6 months and had treatment as needed. She reported she was unsure why there was no documentation that would indicate the resident had been seen by the hygienist.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51097 Based on record review and interview, the facility failed to collaborate and coordinate care with hospice related to code status for one (#69) of two residents reviewed for hospice services. Findings included: Review of Resident #69's Admission Record revealed the resident was admitted to the facility on [DATE] and had diagnoses that included Cerebral Infarction, Emphysema, Unspecified Dementia and Major Depressive Disorder. Review of the resident's current physician orders revealed .hospice care for terminal diagnosis of cerebrovascular disease .[burgundy] team . with an order date of 06/17/24. Continued review of the resident's orders revealed Full Resuscitation with an order date of 08/20/24. A review of the hospice plan of care located in the hard chart revealed an Advanced Directive of Full Code Start Effective Date: 06/12/24. A review of the order listing report provided by the Director of Nursing (DON) revealed the resident order of DNR [Do Not Resuscitate] with an order date of 06/13/24 and was discontinued on 08/20/24 On 8/28/24 at 5:10 p.m., an interview was conducted with Staff E, Licensed Practical Nurse/Unit Manager (LPN/UM) and the Social Services Director (SSD). Staff E, LPN/UM stated they did not have any hospice documentation at the facility except for the initial visit which was located in the hard chart. He stated hospice was supposed to send it to them each time they came to visit the resident. The SSD stated she had been in contact with someone from hospice via email regarding code status but did not know where the hospice notes were located. Staff E, LPN/UM, SSD, and DON were unable to locate a current hospice care plan, or hospice communication sheets for Resident #69. On 08/29/24 hospice notes were provided by the Nursing Home Administrator (NHA). A review of the hospice plans of care revealed an Advanced Directive of Full Code was in place for the following hospice visit dates: 06/19/24, 07/03/24, 07/17/24, 07/31/24, 08/14/24, and 08/28/24. A review of policy titled Advance Medical Directives with an effective date of February 2021 and no revision date, revealed any current advanced directives should be place in the medical record and to update the care plan.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51097 Based on observations and interviews, the facility failed to maintain an effective infection prevention and control program by failing to ensure staff members donned appropriate personal protective equipment (PPE) before entering the rooms of residents with transmission based precaution signage on the door for four (#2, #86, #104, #38) of four residents and two (#102 and #217) of four rooms sampled in the secure unit. Findings included: 1. On 08/26/24 at 10:15 a.m., a tour of the secure unit was conducted which revealed three residents (#86, #104, #38) had contact isolation signage posted on the door to their rooms. The signs showed everyone must: Put on gloves and gown before room entry, discard gloves and gown before room exit. An interview was conducted with Staff Z, Certified Nursing Assistant (CNA) on 08/26/24 at 10:35 a.m. She stated there was no one on isolation in the unit. An interview was conducted with Staff AA, CNA on 08/26/24 at 10:37 a.m. She stated there was no one on isolation in the unit and was unsure why Resident #86 was on contact isolation. An interview was conducted with Staff D, Registered Nurse (RN) on 08/26/24 at 10:40 a.m. She stated Residents #86, and #38 were on isolation for Covid precautions. She was unsure why the contact isolation signage was posted on the door. An observation was conducted on 08/26/24 at 11:21 a.m. outside Resident #86's room. A contact isolation sign was present on the door with instructions to put on gloves and gown before room entry, discard gloves and gown before room exit. A caddy containing isolation gowns, gloves, and one N95 mask was observed inside the room to the left of the doorway. Staff M, Housekeeping Manager from a sister facility, entered Resident #86's room wearing a Kn95 mask. Resident #86 was observed in bed dressed in day clothes with no mask on. The Housekeeping Manger emptied the trash inside the room and exited the room to put the trash on his cart located outside of the room. He entered and exited the room multiple times without donning or doffing PPE. On 08/26/24 at 11:23 a.m., Staff J, Housekeeping Manager was observed entering Resident #86's room without donning or doffing PPE and began cleaning the bed by the window. Resident # 86 was observed in bed dressed in day clothes with no mask on. On 08/26/24 at 11:25 a.m., an interview was conducted with Staff J. He stated for him to know which resident was on transmission-based precautions he would look at the sign on the resident's door. Upon looking at the contact isolation sign located on the door of Resident #86's room, he stated I am not sure what I need to put on. On 08/26/24 at 1:15 p.m., a review of Resident #86's physician's orders revealed an order for Isolation precaution for COVID . with an order date of 08/19/24 and completed date of 08/24/24. On 08/26/24 at 10:45 a.m., Staff D, RN was observed assisting Resident #104 without using PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/26/24 at 10:46 a.m., Staff Z, CNA was observed assisting resident #104 without using PPE. On 08/26/24 at 2:00 p.m., a review of Resident #104's physician's orders revealed an order for Isolation precaution for COVID . with an order date of 08/19/24 and completed date of 08/25/24 On 08/26/24 at 12:53 p.m., Resident #38 was observed in the dining room eating lunch at a table with two other residents with no PPE On 08/26/24 at 2:00 p.m., a review of Resident #38's physician's orders revealed an order for Isolation precaution for COVID . with an order date of 08/19/24 and completed date of 08/24/24. On 08/26/24 at 1:40 p.m., a Transmission Based Precaution List was provided by the Nursing Home Administrator which revealed Residents #104, and #38 were Covid positive. On 08/27/24 at 9:43 a.m., no isolation signs were present on any rooms in the secure unit. On 08/27/24 at 9:45 a.m., Staff C, Licensed Practical Nurse (LPN) stated there was no isolation on the secure unit. On 08/27/24 at 3:35 p.m., an isolation sign Special Contact/Droplet isolation was present on Residents #104's, and #38's door to their rooms in the secure unit. The sign indicated the use of gown, gloves, N95 respirator and eye protection before entering and exiting the room. On 08/27/24 at 3:40 p.m., an interview was conducted with Staff E, Licensed Practical Nurse/Unit Manager (LPN/UM). He stated he thinks Resident #104 is off isolation for Covid and the only resident on isolation is Resident #104. 20311 Observations of the 100 hall on 08/27/24 at 9:51 a.m., revealed room [ROOM NUMBER] had a isolation sign posted on the door indicating droplet precautions. Staff X was noted to enter room [ROOM NUMBER] with a mask, gown and gloves. Continued observations revealed Staff X exited room [ROOM NUMBER] discarding her gloves and gown, but kept her mask on and proceeded to walk to other resident rooms. Observations on 08/27/24 at 10:03 a.m. of room [ROOM NUMBER], revealed a droplet isolation sign and caddy were mounted on the room door. The caddy was noted to only have gloves and gowns in it. It was noted there were no masks or eye protection in the caddy. Continued observation at this time revealed Staff Y walked into room [ROOM NUMBER] and did not don gloves, mask, gown, or eye protection. Photographic evidence obtained. An interview on 08/27/24 at 10:13 a.m. with Staff X, Certified Nursing Assistant, CNA, revealed the resident in room [ROOM NUMBER] was on droplet precautions due to being COVID positive. She said to enter this room she must don a gown, gloves, and wash her hands. She said she did not need the use of eye protection and she kept the same mask on when exiting the room. She said she was trained to keep the mask on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Staff Y, CNA on 08/27/24 at 10:17 a.m., revealed she was aware of entering an isolation room and knew she should have put on a gown and gloves because there was a caddy on the door. She reported she was not sure if there was a sign on the door so she was not sure what type of isolation was in place for room [ROOM NUMBER]. Observations on 08/27/24 at 10:24 a.m., revealed Staff D, Registered Nurse (RN) entered room [ROOM NUMBER] and donned a mask, gown, and gloves. Continued observations revealed when Staff D exited the isolation room she kept the same surgical mask on her face. Interview with Staff D at this time revealed room [ROOM NUMBER] was on droplet precautions due to a COVID positive resident. She reported she should have donned a gown, eye protection, done hand hygiene, and wore gloves and a mask. She confirmed that she did not wear eye protection and used the same mask after exiting the room. She reported that she should have had goggles on and she should have changed the mask. 48223 On 8/26/24 at 12:33 p.m., Staff DD, CNA was observed wearing a KN95 mask, removed a tray from the meal cart and entered room [ROOM NUMBER], which had a droplet isolation sign on the door. Staff DD, CNA did not don any PPE. Staff DD, CNA was observed touching the over the bed table and setting up the resident's meal tray. Staff DD, CNA exited the room at 12:35 p.m., no hand hygiene was performed nor was any doffing of PPE. An interview was conducted with Staff DD, CNA on 08/26/24 at 12:36 a.m. Staff DD, CNA confirmed entering room [ROOM NUMBER] and acknowledged the droplet isolation sign on the door. Staff DD stated, I don't need to wear a gown or any other PPE to drop off the meal tray and I have my mask on. Staff DD, CNA continued to state not having to change the mask upon exiting the room. An interview was conducted with Staff V, LPN on 08/26/24 at 12:40 p.m. Staff V, LPN stated the resident in room [ROOM NUMBER] was on droplet isolation. Staff should be following the signage, which stated to wear a gown, gloves, N95 mask, and eye protection to enter the room, even if just dropping off the tray. During an interview on 8/27/24 at 4:06 p.m., the DON said staff were expected to wear a mask, shield, gown, and gloves when entering the room with a resident on COVID/ droplet precautions. The appropriate mask could be found in the caddy outside of the resident's room. Staff were expected to replace masks with a new one prior to caring for the resident. Staff were expected to remove PPE including the mask upon existing the resident's room. The approved mask for Covid is a N95, not a KN95. On 8/26/24 at 10:35 a.m. an Enhanced Barrier sign was present on Residents #2's door. Review of Resident #2's progress notes, dated 8/25/24 showed urine culture results received and Resident #2 has Extended-spectrum beta-lactamase (ESBL). Review of Resident #2's physician orders did not reveal any active order for contact precautions. During an interview on 8/29/24 at 10:57 a.m. the Infection Control Preventionist (ICP) stated if a resident has ESBL in the urine the protocol is to place the resident on Contact Precautions. The ICP confirmed that Resident #2 should be on contact precautions, no enhanced barrier. Prior to this week no one oversaw the PPE supply nor the signage. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedures titled Infection Prevention and Control Program dated Effective October 2021 revealed: Policy: The infection prevention and control program is comprehensive program that addresses detection, prevention and control of infections and communicable diseases among residents, visitors, volunteers, and those individuals providing services under contractual agreements and personnel. The infection prevention and control program, in addition, will facilitate activities to improve antibiotic use to reduce adverse events, prevent emergence of antibiotic resistance, and promote better outcomes for residents. Goals: The goals of the infection prevention and control program are to: a. Provision of a safe sanitary, and comfortable environment b. Decrease the risk of infection and communicable disease development and transmission to residents, volunteers, visitors, individuals providing services under a contractual agreement and personnel. Review of the facility's policy and procedure titled Barrier Precautions revealed: Policy: . Contact Precautions are used when the employee expects to be in direct or indirect contact with a patient and/or his or her environment including a person's room or objects in contact with the person, that has an infection with an organism transmitted fecal-orally, such as colostrum difficile, or wound and skin infections, or multidrug resistant bacteria such as methicillin resistant staphylococcus aureus (MRSA). PPE required before entering a contact precaution designated room is always gloves and a gown. Mask and eye protection are additionally required if contact with bodily secretions is possible. Enhanced Barrier precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug resistant organisms that employ targeted gown and glove use during high contact resident activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP is indicated for residents with any of the following: . Droplet precautions are necessary when an employee is within three to six feet of a resident infected with a pathogen, such as influenza. Infections are transmissible through air droplets by coughing, sneezing, talking, and close contact with an infected patients breathing period patient should be placed in an individualized room, if possible.

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 48223 Based on interview and record review, the facility failed to maintain an ongoing antibiotic stewardship program for two out of three months reviewed. Findings included: Review of the facility's infection prevention documentation did not reveal any documentation related to an ongoing surveillance of resident infections and antibiotic orders for the months of July and August of 2024. During an interview on 8/26/2024 at 3:30 p.m., the Nursing Home Administrator (NHA) stated the Infection Control Preventionist (IPC) was the Staff R, Registered Nurse (RN) Unit Manager (UM). During an interview on 8/27/2024 at 10:30 a.m., Staff R, RN stated she was not responsible for Infection Control. Staff R, RN stated she was hired as the UM. During an interview on 8/27/2024 at 1:40 p.m., the NHA confirmed there was confusion as to who was the ICP but Staff R, RN UM was the designated IPC. During an interview on 8/29/2024 at 10:57 a.m., the Director of Nursing (DON) and the IPC who was also the Unit Manager stated they were both new to the building and not currently working on any surveillance or audits in relations to Infection Control Practices. Neither were able to discuss any information for past practice or provide any information from prior months. During the interview, the ICP and DON were unable to produce their monthly antibiotic stewardship program reports for the month of July and August to date for this year. The ICP stated the goal was to run weekly reports with the attempt to concurrently review the use of current residents' antibiotic orders and based on the McGreer's criteria to meet the criteria for an infection and the appropriate antibiotic was ordered with an end date. Neither the DON or the ICP knew who the contact was for the Department of Health in case of an outbreak. They said they would have to get with the NHA. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105690	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pines Rehabilitation Center	1111 S Highland Ave Clearwater, FL 33756

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facilities policy and procedure titled: Infection Prevention and Control Program effective October 2021 showed: Procedure: The Major Activities of the Program are: a. Surveillance of infections and communicable disease There is on-going monitoring for infections and communicable diseases among residents, visitors, volunteers, and those individuals providing services under a contractual arrangement and personnel and subsequent documentation of infections that occur b. Antibiotic Stewardship Ongoing tracking of antibiotic prescribing, antibiotic use, and developing antibiotic resistance patterns with documentation and education. Tracking of antibiotic will include: antifungals, antivirals, and all formulations of the antibiotics used. c. Implementation of infection control and prevention measures Prevention of spread of infections is accomplished by use of Standard Precaution, organism specific precautions, and other barriers, appropriate treatment and follow-up, and employee work restrictions for illness. d. Prevention of Infection and Communicable Diseases Staff, volunteers, visitor, those individuals providing services under contractual bases and resident education is done to focus on risk of infection and practices to decrease risk. Policies, procedures and aseptic practices are followed by personnel in performing procedures and in disinfection of equipment, if indicated. Immunizations are offered as appropriate to residents and personnel to decrease the incidence of vaccine preventable infections diseases. * Exposure Control