

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105706	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/10/2024
NAME OF PROVIDER OR SUPPLIER  West Orange Center for Nursing and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE  1556 Maguire Rd Ocoee, FL 34761	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36489</p> <p>Based on observation, interview, and record review, the facility failed to promote the right to a clean, comfortable, and homelike environment for 4 of 6 residents reviewed for environmental concerns out of a total sample of 9 residents, (#5, #6, #7, and #9), on 2 of 2 units, (A &amp; B Wings).</p> <p>Findings:</p> <p>1. Review of the medical record revealed resident #6 was admitted to the facility on [DATE]. Her diagnoses included type 2 diabetes, and a skin infection with surgical amputation of her right great toe.</p> <p>Review of a progress note dated 5/07/24 at 9:49 PM revealed resident #6 arrived on the A Wing and was assisted to her room.</p> <p>On 5/08/24 at 11:10 AM, resident #6's granddaughter expressed dissatisfaction with the condition of her grandmother's room and bathroom when she arrived from the hospital the previous night. She stated it was obvious the room had not been properly cleaned and prepared for a new resident. The granddaughter provided photographs that showed stained sheets on the bed, a significant amount of dried, brown urine stains underneath the toilet seat, and a used plastic container with brown paper towel inside was on the lid of the toilet. The plastic container was of the type used to collect and measure body fluids such as urine. The granddaughter explained after she complained, it took about two hours for someone to remove the container. She stated when no staff returned to replace the sheets as requested, she asked for clean sheets and changed them herself.</p> <p>On 5/08/24 at 12:22 PM, the facility's Admissions Concierge stated she was made aware of resident #6's planned admission yesterday, 5/07/24 at 8:25 AM. She stated she provided the marketing liaison at the hospital with the room number for the new resident and then updated the nurse of the pending admission. The Admissions Concierge confirmed the room was to be cleaned after removal of the previous resident's items, in preparation for the new resident. She stated she also told the Certified Nursing Assistant on the 3:00 PM to 11:00 PM shift about resident #6's expected arrival. The Admissions Concierge recalled she saw a housekeeper in the room during the day on 5/07/24. She stated she checked the room at about 4:00 PM, but did not go into the bathroom.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/09/24 at 11:37 AM, the Floor Technician stated on Wednesday 5/08/24, he was informed of the granddaughter's complaints and the need to clean resident #6's room. He validated the condition of the toilet was as described by the granddaughter and shown in the photograph. The Floor Technician stated Housekeeper D told him she cleaned the room on Tuesday, 5/07/24. He said, I told her she should pay more attention to cleaning. He explained all rooms were to be cleaned once daily, but prior to a new admission, rooms required a special deep clean procedure.</p> <p>Review of a Deep Clean Check Off List (undated) revealed the procedure included thorough cleaning of the bed frame, mattress, call bell, air conditioning unit, furniture, floors, blinds, and the toilet.</p> <p>On 5/09/24 at 11:57 AM, Housekeeper D stated she cleaned resident #6's room in the morning on 5/07/24, after the breakfast meal carts left the unit. She explained after lunch, she was instructed to do a deep clean for that room as there would be a new resident. Housekeeper D acknowledged a deep clean involved cleaning all areas and surfaces of the room and bathroom. She did not respond when asked to explain why the condition of the resident's room did not reflect requirements of the deep cleaning procedure.</p> <p>On 5/09/24 at 12:17 PM, the Rehab Director confirmed she spoke with resident #6's granddaughter on Wednesday 5/08/24. She verified the granddaughter expressed concerns about the lack of cleanliness of the room on admission and pointed out issues including dirty window blinds. The Rehab Director acknowledged she viewed the granddaughter's photographs of the dirty bathroom and said, I apologized and told her it was not acceptable.</p> <p>2. Review of the medical record revealed resident #5 was admitted to the facility on [DATE]. Her diagnoses included right hip fracture, history of falling, abnormal gait and mobility, and need for assistance with personal care.</p> <p>Review of the Minimum Data Set (MDS) with assessment reference date of 4/29/24 revealed resident #5 had a Brief Interview for Mental Status score of 15 which indicated she was cognitively intact.</p> <p>On 5/08/24 at 10:26 AM, resident #5 confirmed there was a roach problem on the unit and in her room on the 500 hall. She stated she was in the A Wing common room with a visitor a few days ago, when a big roach ran across the room. The resident stated the incident occurred during the day, but she also saw big roaches in the hallway at night, headed towards her room. She explained she even used her trash can to squash a small roach on the floor. She pointed to the trash can beside her bed and said, It's under there. Resident #5 stated she asked her daughter to bring a can of roach spray for her yesterday and she stored it inside her bedside commode. She said, I wouldn't be able to sleep if I saw one near me.</p> <p>On 5/09/24 at 10:06 AM, Registered Nurse A lifted the lid of resident #6's bedside commode and removed a full can of ant, roach, and spider spray. Photographic evidence was obtained.</p> <p>Review of the A Wing Pest Sighting/Evidence Log showed documentation on 3/29/24 of roach issues on the 400, 500, and 600 hallways. On 5/03/24, the MDS Coordinator noted roaches in the MDS office and in rooms 608, 609, 610, and 611. The log indicated on 5/09/24, roaches issues were identified in room [ROOM NUMBER].</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Review of the medical record revealed resident #7 was admitted to the facility on [DATE]. Her diagnoses included type 2 diabetes, heart disease, and need for assistance with personal care.</p> <p>On 5/10/24 at 2:10 PM, resident #7 was interviewed in her room on the B Wing. She said, We have a bad roach problem, day and night. The roaches are the biggest issue. I kill the little bitty ones, but the big ones are hard to catch. The resident explained she used to be able to catch the big roaches, but she was no longer fast enough. Resident #7 confirmed she told numerous staff members, many times. During the interview, a large dark brown roach scurried from behind the oxygen concentrator near the resident's wheelchair and traveled approximately six feet to stop under the roommate's bed. The roach remained under the bed for less than one minute, then quickly crossed the room, and headed towards the area behind resident #7's bedside table. The roommate, resident #9, interjected and stated she was not surprised the roach ran around the room as it was a huge problem and everyone was aware. Resident #9 complained she had a roach in her bed as recently as last night.</p> <p>Review of the facility's policy and procedure for Resident Rights, revised on 9/09/22, revealed residents had rights to a dignified existence and .a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p>		

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<p>F 0626</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36489</p> <p>Based on interview and record review, the facility failed to re-admit residents who were transferred to a higher level of care for treatment of acute conditions, for 2 of 3 residents reviewed for hospitalization , out of a total sample of 9 residents, (#2 and #3).</p> <p>The facility's failure to permit residents who required its care and services to return from the hospital resulted in extended stays in acute care settings after medical issues were resolved, and necessitated adjustment to unfamiliar personnel and routines in new skilled nursing facilities (SNFs), actual harm, for residents #2 and #3.</p> <p>Findings:</p> <p>1. Review of the medical record revealed resident #3 was admitted to the facility on [DATE]. His diagnoses included weakness, need for assistance with personal care, cognitive communication deficit, history of alcohol abuse, and noncompliance with medical treatments. The resident's medical record was updated on 10/16/23 with diagnoses of major depressive disorder, adjustment disorder with anxiety, and primary insomnia. On 12/18/23, resident #3 was diagnosed with bipolar II disorder and on 1/03/24 he was diagnosed with anxiety disorder. The resident's Admission Record or face sheet showed he had a court-appointed legal guardian who was his emergency contact and care conference representative.</p> <p>Review of the Minimum Data Set (MDS) Discharge-Return Anticipated assessment with assessment reference date (ARD) of 1/26/24 revealed resident #3 was discharged to a short-term general hospital. The document revealed during the 7-day look back period, resident #3 had physical behavioral symptoms directed towards others on one to three days, verbal behavioral symptoms directed towards others on four to six days, and other behavioral symptoms that were not directed towards others on one to three days. The document showed resident #3 rejected evaluation or care such as medications and assistance with activities of daily living on one to three days. He was totally dependent on staff for toileting hygiene, bathing, dressing, and personal hygiene. The resident required substantial to maximal assistance for bed mobility, was totally dependent on staff for transfers, and did not walk. The document indicated resident #3 had an indwelling urinary catheter. The MDS assessment revealed the resident received antipsychotic, antidepressant, hypnotic, anticoagulant, antibiotic, and opioid medication.</p> <p>Review of the medical record revealed resident #3 had a care plan initiated on 9/14/23 for falls related to weakness, bedbound status, and has not walked in 3 years.</p> <p>A care plan was initiated on 9/18/23 for behavior problems related to history of noncompliance with medications, treatment, and wound care, and verbal aggression including use of profanity, screaming, threatening, and cursing. The interventions instructed staff to administer medications as ordered and monitor or document medication effectiveness, anticipate and meet his needs, encourage him to comply with care, divert his attention, discuss his behavior, explain all procedures before starting, and intervene as necessary to protect the rights and safety of others.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Progress Notes for January 2024 revealed resident #3 completed a course of antibiotic medication for a urinary tract infection (UTI) on 1/16/24. A note dated 1/16/24 indicated the interdisciplinary team (IDT) met to discuss resident #3's status and plan of care. There were no recommendations made for changes to the plan of care and no documentation of behavioral concerns. A note dated 1/16/24 revealed the resident's guardian was updated on the progress of his wounds, and there was no evidence of discussion of additional concerns. An IDT note dated 1/23/24 revealed the resident's plan of care was reviewed again with no changes required.</p> <p>Review of the Medication Administration Records for December 2023 and January 2024 revealed resident #3 received Seroquel 200 mg at bedtime as ordered, except for 1/23/24 and 1/24/24 when nursing documentation showed he refused the drug.</p> <p>Nursing notes from 1/12/24 to 1/22/24 indicated resident #3 was calm and did not exhibit behavioral symptoms. Documentation on 1/23/24 and 1/24/24 indicated nurses observed behaviors. A note dated 1/24/24 revealed he refused medication and hygiene care despite several attempts, and also cursed at staff. Progress notes dated 1/25/24 showed the resident continued to exhibit escalating behavioral symptoms, cursing/yelling at staff members and is using racial slurs. Staff were eventually able to calm him and he accepted medications and personal hygiene care. The facility notified the Advanced Practice Nurse Practitioner who ordered a urinalysis, a test of the urine to check for disorders including a UTI.</p> <p>Review of a Situation, Background, Appearance, Review and Notify (SBAR) form dated 1/26/24 revealed resident #3 had a change in condition related to altered mental status with symptoms of verbal aggression. The SBAR form read, Resident is screaming, cursing, lose his voice from yelling. Order to send out to [name of hospital] for evaluation and treatment. The document indicated the resident was in the facility for long term care.</p> <p>Review of resident #3's hospital record revealed an Emergency Department (ED) Provider Note dated 1/26/24 at 2:13 PM. The physician wrote that resident #3 presented to the hospital for questionable altered mental status. According to [Emergency Medical Services] they were called for an altered mental status however they state the patient always acts like this. I attempted to call the facility twice both which times they hung up and I was unable to speak with any representatives. The physician's assessment showed the resident's vital signs were stable and he was in no acute distress. His admission diagnosis was cystitis, an inflammation of the bladder which is usually caused by a UTI, and he was started on intravenous antibiotic therapy. The document read, Based on the patient's presentation, it is expected that they will cross 2 midnights of care in the hospital.</p> <p>Review of the hospital record revealed a note dated 1/29/24, written by the hospital's Social Worker, regarding an attempt to arrange resident #3's return to the facility. The SW documented she spoke with the facility's admission staff who informed her the resident had only been there with short-term benefits, and the facility was unable to accept [the resident] back due to being aggressive/violent towards other residents. The SW contacted the resident's guardian who informed her he was in the facility with long-term care benefits. Due to the facility's refusal to re-admit resident #3 and the absence of a home discharge location, the resident's guardian authorized the hospital SW to pursue alternate SNF placement.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of hospital Case Management (CM) notes revealed resident #3 was medically cleared for discharge from the hospital on 1/29/24. However, over the next 10 weeks, the resident remained in the acute care hospital while the SW made continuous attempts to identify a SNF that would accept resident #3 for long-term care. A CM note dated 4/01/24 indicated the SW eventually found a SNF in another county, over 100 miles away from the facility where he resided pre-hospitalization. The note revealed there was a barrier to the discharge as the assigned court-appointed guardian was unable to follow the resident in that county, and arrangements would have to be made for a new guardian. A CM note dated 4/02/24 read, Unable to move forward with [discharge] until a new court appointed guardian. A CM note dated 4/09/24 revealed the hospital SW discussed resident #3's behaviors with his assigned nurse who stated he was cooperative and showed no signs of aggression. A CM note dated 4/12/24 revealed a local facility accepted resident #3 for long-term care on condition that the hospital arranged for a private sitter for three days to offer support during the resident's adjustment to the new facility. Review of the hospital Discharge Summary dated 4/13/24 revealed resident #3 was discharged to the local SNF with physician orders that included Seroquel 300 mg at bedtime. Review of the hospital record revealed when resident #3 arrived at the local SNF, staff refused to admit him due to verbal behavioral symptoms. There was no evidence the requested sitter was present to assist with a smooth transition to the new location. The transport company returned the resident to the hospital and he was readmitted for aggressive behavior. Resident #3 was restrained briefly in the ED to permit diagnostic testing, and soon calmed down. A Psychiatry Consult note dated 4/15/24 read, .the patient is calm, cooperative, not agitated, not threatening. The psychiatrist made a diagnosis of adjustment disorder with mixed disturbance emotion and indicated no medication changes were necessary. The resident was discharged to the SNF in another county on 4/19/24, once arrangements were finalized for the transfer of guardianship.</p> <p>On 5/08/24 at 2:35 PM, in a telephone interview, resident #3's court-appointed guardian stated the resident had a history of cardiac arrest with oxygen deprivation and alcoholism. She explained those factors contributed to his cognitive impairment and behavioral issues, and although he could be easily agitated and verbally aggressive, he never physically hurt anyone. The guardian stated on the day resident #3 was sent to the hospital, he had a UTI which probably worsened his behavioral symptoms. She explained the facility refused to take the resident back and the hospital eventually found another SNF. When asked if she knew why the facility could not re-admit resident #3, she said, That was my question. Why would another skilled nursing facility be able to provide different or better care? I really hoped they would have taken him back. The hospital and I tried to get them to take him back. I was very upset and I hoped they would take him back. The guardian confirmed she called the facility and someone told her they would not accept him. She explained she attended a care plan meeting in December 2023 or January 2024, and nobody at the facility mentioned anything out of the ordinary or that they wanted to get rid of him. She said, I am frustrated that he was being discharged for baseline behaviors that needed to be addressed. I don't think they exhausted all the available options. The guardian felt it was unfair for resident #3 to remain in the hospital for over two months, especially since his infection was resolved and his behavior was no different. She recalled while resident #3 was in the hospital, the attending physician updated her regularly, and never reported any worsening behaviors that prevented him from returning to the facility. The guardian explained the resident was currently at baseline in a regular long-term care bed in a SNF in another county. She stated the resident's court-appointed attorney said the resident liked her, but he would now have to build a relationship with a new guardian.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/08/24 at 10:42 AM and 5/09/24 at 11:34 AM, in telephone interviews with a hospital Case Manager, he explained resident #3 was admitted to the hospital on 1/26/24 and was medically cleared to return to the facility on [DATE]. He stated on 1/29/24, the hospital SW contacted the resident's guardian and facility admissions staff to arrange his return to the facility. The Case Manager stated the facility was unwilling to re-admit resident #3 and it took approximately 10 weeks, until 4/19/24, to locate a facility that would accept him for long-term care. He stated during the resident's extended stay in the hospital, he was seen by psychiatry and had minimal changes made to his medications. The Case Manager acknowledged the hospital record revealed a physician's note dated 2/27/24 that indicated resident #3 swung at a staff member and the physician planned to order restraints if the behavior continued. He stated there were no physician orders for restraints to indicate the behavior reoccurred.</p> <p>On 5/08/24 at 12:06 PM, the facility's Social Services Director (SSD) recalled resident #3 had behavioral issues. She explained nursing staff often used to ask her to intervene and talk him down. The SSD stated the resident was sometimes verbally abusive to staff, but never physically abusive. The SSD stated after she calmed the resident down, he was usually apologetic as he did not mean to offend anyone. She verified resident #3 was bedbound, unable to transfer himself to a wheelchair, and refused to get out of bed.</p> <p>On 5/08/24 at 2:55 PM, the Director of Nursing denied knowledge of the facility's refusal to re-admit resident #3 from the hospital. She confirmed the facility was able to meet the resident's needs prior to the hospital transfer.</p> <p>On 5/08/24 at 3:24 PM, the SSD acknowledged a hospital case manager called her to ask if the facility would re-admit resident #3. She stated she confirmed the facility would re-admit the resident. The SSD said, We do not turn down patients who already live here. We don't dump. This is their home. The SSD stated the resident's guardian called next and informed her the facility was not an appropriate setting for the resident. She said, I don't know what transpired between the guardian and the hospital. The SSD did not respond when informed her statement was inconsistent with the details provided by the hospital CM and the resident's guardian.</p> <p>On 5/08/24 at 3:32 PM, in a telephone interview, the facility's Outside Marketer/Care Liaison explained her role was to work with hospital case management staff to arrange admissions and re-admissions to the facility. She stated her last note dated 3/08/24 indicated the hospital planned to send resident #3 to a brain injury clinic. The Care Liaison stated she discussed the resident's return to the facility with facility nursing staff and they were concerned about his aggressive behaviors towards other residents. She explained he was a danger to other residents as he could walk. She said, Even his guardian did not want him to return. Unfortunately, I don't think I have it documented. They were all phone conversations. The Care Liaison stated the facility could not care for residents with severe brain injuries nor those who received excessive doses of medication, so the hospital canceled the referral. She stated she checked on the resident during his hospital stay and often observed that he was sedated or chemically restrained, and on some days he was even physically restrained. The Care Liaison acknowledged the hospital was not a discharge location. She was unaware resident #3 was not a threat to residents as he had been bedbound for years prior to admission to the facility. She did not respond when informed that her statements were not corroborated by the resident's medical record and interviews with hospital case management staff and the resident's guardian.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/08/24 at 4:34 PM, Certified Nursing Assistant (CNA) C stated she was regularly assigned to care for resident #3. She stated he often yelled, cursed, was very disrespectful, and used racial slurs. She confirmed he was never physical with her during care, and his behavior never really changed.</p> <p>On 5/09/24 at 12:09 PM, CNA F described resident #3 as very loud. She stated he shouted and yelled, never got out of bed, and could not walk. CNA F recalled the resident sometimes swung at staff during care. She acknowledged there were other residents in the facility who were combative or hit out at staff and CNAs were trained to re-approach later, use two people for care, and be careful. She stated there was another resident on the same unit who used to scream and shout a lot.</p> <p>On 5/10/24 at 12:22 PM, the Rehab Director recalled when resident #3 refused to participate in therapy or directed profane language at staff, she would go to his room to talk to him and re-direct him. She stated he had been bedbound for about two years in another SNF before admission to this facility. The Rehab Director stated she never felt physically threatened by the resident. She verified he might swing at staff occasionally but he was not the only resident who did so. The Rehab Director said, We have difficult residents and we redirect, re-approach, reorient to give care.</p> <p>Review of the Facility assessment dated [DATE] revealed the facility could meet the care needs of residents who had nervous system conditions including traumatic brain injury and psychiatric and mood disorders such as psychosis, impaired cognition, mental disorders, depression, bipolar disorder, and anxiety. The document indicated staff would provide behavior and mental health care to include management of medical conditions and identification and implementation of interventions to support residents with psychiatric conditions.</p> <p>2. Review of the medical record revealed resident #2 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. His diagnoses included end-stage kidney disease with hemodialysis, left leg above knee amputation, type 2 diabetes with long-term insulin use, and need for assistance with personal care.</p> <p>Review of the MDS Medicare 5-day assessment with ARD of 2/16/24 revealed resident #2 had no behavioral symptoms and did not reject evaluation or care that was necessary to achieve his goals for health and well-being. The MDS assessment indicated the resident had functional impairment in range of motion with an impairment of one leg, and he used a prosthetic device and a wheelchair for mobility. The resident required partial to moderate assistance for toileting hygiene, bathing, and dressing. He was always incontinent of bladder and bowel and needed a mechanically altered, therapeutic diet. The MDS assessment revealed resident #2 had medically complex conditions and he received Occupational and Physical Therapy services for two days, from 2/14/24 to 2/15/24, prior to hospitalization on [DATE].</p> <p>Review of a Notice of Denial of Medical Coverage letter dated 2/14/24 revealed resident #2's insurance company authorized SNF services until midnight on 2/23/24.</p> <p>Review of a nursing progress note dated 2/16/24 revealed that at approximately 3:50 AM, a CNA called the nurse to resident #2's room. The nurse indicated the resident moved his mouth but did not open his eyes. She checked his blood glucose level and obtained a critically low reading. The resident did not respond to two rounds of emergency medications administered by the nurse, and he was transferred to the hospital via ambulance.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the hospital record revealed a History &amp; Physical dated 2/16/24 that indicated resident #2's chief complaint and admission diagnosis was acute metabolic encephalopathy (brain disorder) due to hypoglycemia or low blood sugar. The document read, Based on the patient's presentation, it is expected that they will cross 2 midnights of care in the hospital. Review of a Discharge Summary dated 2/19/24 revealed the physician described resident #2 as stable and expected him to return to the facility within 24 hours. A CM note dated 2/19/24 revealed the resident had active discharge orders. The CM notified the facility's Care Liaison who told her the patient has seven skilled days and the facility was unable to accept a 3-day waiver. A CM note on 2/21/24 indicated the facility's Care Liaison informed the hospital patient request has been sent for [physician] review, please look for an alternative. CM sent referrals to additional facility, waiting for response. A CM note dated 2/25/24 indicated the resident's length of stay was now nine days although his discharge plan on admission was to return to the facility. When the hospital CM reached out to the facility's Care Liaison regarding the delay, she informed the CM the resident was a complex case. A revised Discharge Summary dated 2/29/24 read, Case management working on placement. The hospital record showed resident #2 was eventually discharged to another SNF on the evening of 2/29/24.</p> <p>On 5/08/24 at 10:42 AM, in a telephone interview, a hospital Case Manager stated resident #2 was admitted to the hospital through the ED on 2/16/24 and medically cleared on 2/19/24, but the facility did not want to re-admit him due to an insurance issue. He explained the facility's Care Liaison told hospital case management staff the facility was unable to accept resident #2 as he had only seven Medicare covered days left and after that he would have to pay privately for his stay in the facility or apply for Medicaid as a payer source. The Case Manager stated resident #2's acute care needs were met and he should have left the hospital. However, he remained in the hospital for approximately two weeks, until the hospital found placement for him at another SNF. He said, We did not want him sitting in the hospital. It's not good for any patient's psychosocial well-being. The Case Manager explained any hospitalization was stressful for patients and families, even more so if there were changes with a discharge location. He stated the hospital provided hemodialysis and limited therapy services, but not the degree of therapy available in the SNF setting. The Case Manager stated there was a conference call between three hospital Case Management staff and the facility's [NAME] President (VP) of Census Development and the Care Liaison in an attempt to resolve the issue. The Case Manager stated hospital staff informed the facility representatives the Centers for Medicare &amp; Medicaid Services (CMS) regulations indicated the SNF was obligated to re-admit resident #2 after his acute care needs were met in the hospital. He recalled the Care Liaison and the VP of Census Development informed the hospital that resident #2 could not return unless his family provided the necessary financial information to complete a Medicaid application. The Care Manager stated the hospital advised the facility representatives the financial aspect could be addressed in the facility and it should not delay discharge from hospital. He recalled the VP of Census Development stated he addressed the issue with senior leadership at the corporate level and the decision was made to deny resident #2's return to the facility. The Case Manager recalled the hospital representatives reiterated the decision was a regulatory violation, but the VP of Census Development stated they felt differently about the interpretation of that regulation.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/08/24 at 4:41 PM, the facility's Business Office Manager (BOM) recalled at the time resident #2 was last transferred to the hospital, he had seven paid Medicare days left. She explained prior to admission, the facility's Central Intake would request authorization from insurance companies. The BOM stated resident #2 required a new authorization each time he was readmitted. She stated when he did not return to the facility, she assumed he was discharged home. The BOM stated she would contact Central Intake to check whether resident #2's insurance company declined to authorize re-admission. As of 5/10/24 at 4:00 PM, despite numerous requests, the BOM did not provide the requested information.</p> <p>On 5/09/24 at 10:59 AM, the Administrator stated she was not aware of a decision to refuse readmission for resident #2. She confirmed she was aware there were issues related to the family's compliance with requests for information needed to change his payer source. The Administrator acknowledged if the resident remained in the facility after he exhausted his Medicare paid days but refused to provide the necessary documents, the facility had the option to proceed with a 30-day discharge notice for non-payment.</p> <p>On 5/10/24 at 3:08 PM, in a telephone interview, the VP of Census Development confirmed he participated in a conversation with hospital case management. He recalled the hospital wanted the facility to re-admit resident #2 prior to the family and resident completing the Medicaid application process. The VP of Census Development said, His insurance would not authorize him and the family would not cooperate. [Name of the facility] did not refuse to take him back. If there was a denial we would have been notified.</p> <p>On 5/10/24 at 3:24 PM, after review of the medical record, the SSD validated the insurance company authorized resident #2's stay in the facility until midnight on 2/23/24. She stated she was under the impression the resident or family called 911 for the hospital transfer as they had done that in the past to avoid discharge home from the facility when the insurance decided to cut his therapy. The SSD denied knowledge that the resident was sent out for critically low blood sugar, possibly resulting from a medication error, and was not allowed to return. She stated she was told the insurance company Case Manager wanted the resident to reserve the Medicare days he had left in case he needed them after he went home.</p> <p>In a telephone interview on 5/14/24 at 9:46 AM, in response to an email sent on 5/10/24 at 10:36 AM, resident #2's insurance company Case Manager reviewed his chart and discovered a SNF authorization was opened on 2/21/24. She explained an authorization stayed open for at least five days. The Case Manager provided details from a Communication Note dated 2/22/24 at 9:36 AM regarding a conversation between the insurance company and a representative of the facility's offsite corporate representative. The note read, Received call from [name of facility's corporate representative], that the facility isn't accepting [the resident] back, so she requested auth[orization] be voided.</p> <p>On 5/14/24 at 2:06 PM, in a telephone interview, the facility's Administrator explained [name of corporate representative] did not work onsite at the facility. She said, It is someone in corporate. I'm not sure of the person's title.</p> <p>(continued on next page)</p>		

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F 0626  Level of Harm - Actual harm  Residents Affected - Few	Review of the facility's policy and procedure for Transfer and Discharge, revised in November 2023, read, It is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer of discharge from the facility, except in limited circumstances. The document defined a transfer as the movement of a resident from one certified facility to another with the expectation of return to the original site. A facility-initiated transfer or discharge was one that the resident was opposed to or did not initiate .and/or is not in alignment with the resident's stated goals for care and preferences. The policy indicated residents had the right to remain in the facility unless a transfer was necessary for the resident's welfare and his/her needs could not be met in the facility, the resident's behaviors endangered the safety and health of individuals in the facility, or if the resident refused to pay for his/her stay after appropriate notice was given. The document revealed a notice must be provided at least 30 days before a facility-initiated transfer or discharge. The policy specified that discharge would not be initiated based solely on payer source or change in payer source. The document indicated residents who were transferred to the hospital for their safety and welfare .will be permitted to return to the facility upon discharge from the acute care setting. The policy revealed residents had the right to return to the facility from the hospital pending appeal of a facility-initiated discharge and the facility would document the danger the failure to discharge the resident would pose.		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36489</p> <p>Based on interview and record review, the facility failed to ensure effective communication, collaboration, and oversight of changes to the plan of care by members of the interdisciplinary team (IDT) for 1 of 3 residents reviewed for hospitalization , out of a total sample of 9 residents, (#2).</p> <p>The facility's failure to thoroughly review medication orders resulted in administration of an excessive dose of insulin that rendered a resident unresponsive due to a critically low blood glucose level, and required transfer to a higher level of care for treatment, actual harm, for resident #2.</p> <p>Findings:</p> <p>Review of the medical record revealed resident #2 was admitted to the facility on [DATE] and last readmitted on [DATE]. His diagnoses included type 2 diabetes with long-term insulin use, end-stage kidney disease with hemodialysis, left leg above knee amputation, and the need for assistance with personal care.</p> <p>Review of the Minimum Data Set (MDS) Medicare 5-day assessment with assessment reference date of 2/16/24 revealed resident #2 had clear speech, clear comprehension, and was able to express his ideas and wants. He had a Brief Interview for Mental Status score of 15 which indicated he was cognitively intact. The MDS assessment showed the resident had no behavioral symptoms and did not reject evaluation or care that was necessary to achieve his goals for health and well-being. The document indicated resident #2 had medically complex conditions.</p> <p>Resident #2 had a care plan for diabetes with use of insulin, initiated on 12/14/23. The goal was the resident would have no complications related to diabetes. The interventions instructed nurses to check his blood glucose levels as ordered, administer medication as ordered, monitor for effectiveness and side effects, and monitor for signs and symptoms of low blood glucose.</p> <p>Review of resident #2's medical record revealed an Admission Summary that showed he was readmitted from the hospital on 2/13/24 at approximately 8:00 PM.</p> <p>An Order Audit Report dated 2/13/24 at 10:08 PM revealed resident #2's attending physician ordered Detemir insulin 20 units once daily for diabetes. The order was confirmed a few minutes later at 10:12 PM by the evening shift Nursing Supervisor.</p> <p>Review of an Order Audit Report dated 2/14/24 at 12:50 PM revealed an Advanced Practice Registered Nurse (APRN) ordered Levemir 22 units at bedtime for type 2 diabetes. The order was confirmed on 2/15/24 at 10:55 AM by a Unit Manager (UM) who no longer worked at the facility.</p> <p>Detemir is the generic name for Levemir, a man-made long-acting insulin that starts to work several hours after injection and keeps working evenly over 24 hours. If prescribed once daily, Levemir is usually administered in the evening or at bedtime. The most common adverse reaction of insulin is hypoglycemia and long-standing diabetics may be less aware of symptoms (retrieved on 5/24/24 from www.drugs.com/levemir.html).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident #2's Medication Administration Record (MAR) for February 2024 revealed he received a one-time dose of Detemir 22 units on 2/14/24 at 9:00 AM. The document indicated a nurse also signed for an additional dose of Detemir 20 units on 2/14/24 at 9:00 AM. The MAR was updated to reflect a new order for Levemir 22 units at bedtime on 2/14/24 at 9:00 PM, but the document was not initialed by a nurse to verify the dose was given. On 2/15/24 a 9:00 AM, resident #2 received 20 units of Detemir and the MAR showed he received an additional 22 units of Levemir 12 hours later at 9:00 PM, a total of 42 units in 24 hours.</p> <p>Review of a nursing progress note dated 2/16/24 revealed that at approximately 3:50 AM, a Certified Nursing Assistant called the nurse to resident #2's room. The note read, Upon arrival writer observed resident moving his mouth but not opening his eyes. Writer immediately check his blood sugar which read 25. The document indicated the nurse gave two doses of Glucagon in an attempt to increase his blood glucose level, but the resident remained unresponsive. The nurse contacted the resident's physician who instructed her to send resident #2 to the hospital via 911 for further evaluation.</p> <p>According to the American Diabetes Association (ADA), hypoglycemia or low blood glucose occur when the blood glucose level falls below 70 milligrams per deciliter (mg/dL). As blood glucose continues to drop, the brain is deprived of glucose and it stops functioning as it should. The ADA indicates a critical, life-threatening blood glucose value is one that is less than 54 mg/dL. Initially, hypoglycemia causes symptoms such as blurred vision, difficulty concentrating, confusion, slurred speech, numbness, and drowsiness. If untreated, low blood sugar levels can starve the brain of glucose, causing seizures, coma, and death (retrieved on 5/24/24 from <a href="http://www.diabetes.org/living-with-diabetes/treatment-care/hypoglycemia">www.diabetes.org/living-with-diabetes/treatment-care/hypoglycemia</a>).</p> <p>Review of the Weights and Vitals Summary revealed resident #2's blood glucose level was checked on 2/16/24 at 5:30 AM and 5:35 AM, with resulting readings of 25 mg/dL.</p> <p>A blood sugar level below 54 mg/dL requires immediate action and severe hypoglycemia can be treated with an injection or nasal spray of Glucagon, a hormone that raises blood glucose levels (retrieved on 5/24/24 from <a href="http://www.medlineplus.gov">www.medlineplus.gov</a>).</p> <p>Review of the Emergency Medical Services (EMS) Run Sheet revealed a call was received from the facility on 2/16/24 at 5:15 AM, almost 90 minutes after the nurse indicated she was made aware of the resident's change in condition. The document indicated upon arrival at the facility, EMS personnel discovered resident #2 unresponsive. According to the Run Sheet, the nurse informed them she gave three doses of Glucagon and their primary impression of the resident was diabetic hypoglycemia. Resident #2 was transported to the hospital by ambulance with lights and sirens and arrived at the Emergency Department (ED) on 2/16/24 at 5:46 AM.</p> <p>Review of the hospital record revealed a History &amp; Physical dated 2/16/24 that indicated resident #2 presented to the ED with altered mental status and per EMS report, he had a blood glucose level of 38 mg/dL. The document revealed his chief complaint and admission diagnosis was acute metabolic encephalopathy (brain disorder) due to hypoglycemia or low blood sugar. The ED physician documented that resident #2 was difficult to assess as he was somnolent and did not stay alert or awake long enough to respond to questions. A physician progress note dated 2/23/24 revealed resident #2's long-acting insulin was discontinued on admission to the hospital. Review of the hospital Discharge Summary dated 2/29/24 revealed physician orders for Humalog fast-acting insulin three times daily according to a sliding scale, and Humulin N intermediate-acting insulin 5 units twice daily.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/09/24 at 3:02 PM, the Director of Nursing (DON) recalled resident #2 was a very brittle diabetic as his blood glucose levels varied widely. She validated she was not aware the resident's insulin order was changed two days before he was found unresponsive until informed by State Survey Agency staff. She stated she did not recall any investigation regarding the resident's transfer to the hospital for unresponsiveness with a low blood sugar as this would have been viewed as a change in condition, not an incident.</p> <p>Review of the Weights and Vitals Summary for the period 10/31/23 to 2/15/24 revealed during a 4-month period that covered several admissions, resident #2's blood glucose level was checked approximately three to four times daily. The 9-page document showed his readings were below 70 mg/dL on only two other occasions, 52 mg/dL on 12/20/23 and 68 mg/dL on 2/08/24, and otherwise remained between 70 mg/dL and 453 mg/dL. Resident #2's blood glucose level never dropped to 25 mg/dL as it did on the morning of 2/16/24 after he received a combined dose of Levemir 42 units in the previous 24 hours.</p> <p>On 5/10/24 at 9:23 AM, the DON explained the facility held a clinical team meeting, Monday through Friday at 9:00 AM, that was attended by herself, UMs, the Assistant DON, the Social Services Director, the Administrator, and the Certified Dietary Manager. She stated during these meetings, the IDT reviewed the charts of newly admitted residents, the previous day's events, nursing notes regarding high priority items or events, and any other concerns placed on the 24-hour report. The DON stated high priority items included all new orders, and laboratory and radiology results. She validated the daily IDT meeting was the opportune setting for identification of any discrepancies related to new physician orders.</p> <p>On 5/10/24 at 12:26 PM, in a telephone interview, the APRN stated she did not recall the exact circumstances surrounding her order for Levemir 22 units for resident #2. She explained either a nurse or the UM probably called or informed her during facility rounds that the resident's blood glucose levels were trending upward. The APRN confirmed she would have ordered an increase of two units, from Levemir 20 units once daily to 22 units once daily after review of the medical record. She stated her order would never be to add Levemir 22 units to an existing daily dose of Levemir 20 units. The APRN verified no nurse or member of nurse management contacted her regarding clarification of insulin orders. She stated the facility never informed her resident #2 was found unresponsive with a critically low blood glucose level. The APRN reiterated she would never have doubled resident #2's daily dose of insulin in that way, especially since he was a dialysis patient. She said, On those patients, we make changes slowly.</p> <p>On 5/10/24 at 10:26 AM, in a telephone interview, resident #2's attending physician was informed the resident received Levemir insulin 20 units in the morning on 2/15/24 according to his orders, then received an additional 22 units of Levemir insulin 12 hours later per the order of another practitioner. The attending physician stated he was not aware an additional dose of insulin was ordered to provide the resident with more than double the dosage he intended. He acknowledged the incident and outcome were concerning.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>5/10/24 at 1:07 PM and 2:17 PM, the DON stated her investigation showed at the time the APRN reviewed resident #2's medical record and wrote the order for Levemir 22 units at bedtime, the attending physician's order for 20 units showed as discontinued. She explained since there was no active order for long-acting insulin, the APRN wrote the order for Levemir 22 units, an increased dosage of only two units based on resident #2's blood glucose readings. The DON explained the APRN's order was transcribed to the MAR for administration at bedtime and scheduled for 9:00 PM. When asked why the attending physician's order for Levemir 20 units daily at 9:00 AM was not visible to the APRN and then re-appeared on the MAR as a continuing order, she said, There were two orders bouncing back and forth due to the pharmacy process. She explained the facility had an automatic therapeutic interchange agreement with the physicians and as a result, the pharmacy could make adjustments to medication orders to reflect its formulary drugs. The DON stated the original order for Levemir 20 units that was entered under the attending physician's name was for a vial of Levemir. She explained the pharmacy discontinued that order and replaced it with an order for a Levemir pre-filled FlexPen. She acknowledged the APRN might have reviewed the orders at the time the pharmacy was in process of making that change. The DON stated the pharmacy's order was system-generated but still needed to be confirmed by a nurse. She validated the APRN's new order was confirmed by resident #2's UM but the order for Levemir 20 units was not discontinued at that time. The DON stated the IDT review process in the daily clinical meeting involved reviewing new physician orders, but the team did not actually pull up residents' charts during the process. She acknowledged the IDT would therefore not be able to identify if there was an associated order that needed to be discontinued or if there were any contraindications. The DON validated IDT members were ultimately responsible for the identification of concerns and discrepancies regarding medication orders. She confirmed resident #2's new order for Levemir 22 units at bedtime would not have triggered concerns as a isolated order, but if chart had been reviewed, the IDT would have noticed that the original order for Levemir 20 units in the morning remained active. The DON stated the facility never identified the IDT review process as a concern with the potential to cause medication errors.</p> <p>Review of the Facility assessment dated [DATE] revealed the facility could care for residents with common conditions including endocrine and metabolic diseases such as diabetes. The document indicated nursing leadership participated in daily clinical meetings to review clinical issues on each unit. The Facility Assessment revealed general care and services would include management of medical conditions by on-site physicians, nursing assessments, and early identification of changes in condition.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36489</p> <p>Based on observation, interview, and record review, the facility failed to ensure timely and effective pain management, according to professional standards of practice, for 1 of 1 resident reviewed for pain management out of a total sample of 9 residents, (#6).</p> <p>Findings:</p> <p>Review of the medical record revealed resident #6 was admitted to the facility on [DATE]. Her diagnoses included type 2 diabetes, a skin infection with surgical amputation of her right great toe, peripheral vascular disease, and heart disease.</p> <p>Resident #6 had a care plan for risk for pain related to her right foot wound initiated on 5/08/24. The goal was the resident would not have interruptions in normal activities due to pain. The care plan interventions included administer pain management as ordered, and monitor and record pain characteristics such as quality, severity, anatomical location, onset, and duration. The document instructed nursing staff to monitor, record, and report the resident's complaints of pain or requests for pain treatment.</p> <p>A care plan for pain medication related to resident #6's right foot wound and acquired absence of her right great toe was initiated on 5/08/24. The goal was the resident would be free of discomfort. The approaches instructed nurses to administer pain medications as ordered.</p> <p>Review of the medical record revealed resident #6 had a physician order dated 5/07/24 for Tramadol 25 milligrams (mg) every eight hours as needed for severe pain, levels 7 to 10. The order was revised on 5/08/24 to administer Tramadol 50 mg every six hours as needed for moderate to severe pain.</p> <p>On 5/08/24 at 10:01 AM, 11:10 AM, and 1:39 PM, resident #6's granddaughter stated her grandmother was admitted to the facility at about 9:30 PM the previous night. She expressed frustration that her grandmother had not received the proper medication. The granddaughter recalled when she arrived at the facility last night, her grandmother was crying and complained of severe pain in her right foot. Resident #6's granddaughter stated she asked a nurse to administer pain medication. She said, She was to get 25 mg of Tramadol and the nurse did give a pill at about 10-ish. The granddaughter explained she left the facility and returned a few hours later, at about 4:00 AM. She stated she found her grandmother crying again, as she sat upright on the side of the bed with her legs hanging down. Resident #6 told her granddaughter the pain was much worse when her legs were elevated so she decided to remain seated instead of lying down. The granddaughter indicated when she asked the nurse for another dose of pain medication for her grandmother, the nurse informed her the pharmacy delivery had not yet arrived and .she didn't have anything to give her now.</p> <p>On 5/08/24 at 1:27 PM, Licensed Practical Nurse (LPN) B confirmed she was resident #6's assigned nurse yesterday, during the evening shift. LPN B explained she did not have access to the facility's medication dispensing machine, but when the resident's granddaughter requested pain medication, another nurse retrieved it from the machine.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105706	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/10/2024
NAME OF PROVIDER OR SUPPLIER  West Orange Center for Nursing and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE  1556 Maguire Rd Ocoee, FL 34761	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/08/24 at 1:39 PM, resident #6 sat in a wheelchair in her room. Her eyes were closed, her brow was furrowed, and she explained she asked for pain medication about 15 minutes ago. The resident described her pain as severe, sharp, and intermittent, and she made a grabbing motion towards her right foot. Resident #6 explained the onset of pain was usually sudden and although it might go away for a while, it returned with the same severity if she did not receive pain medication. The resident verified when the nurse gave her a pain pill last night, her pain level was level 10, on a 0 to 10 scale. She validated at 4:00 AM this morning when her granddaughter returned to the facility, she again had level 10 pain. Resident #6 stated the nurse never brought any pain medication this morning and she eventually fell asleep sitting up. She confirmed she received pain medication only once in the 16 hours since admission.</p> <p>On 5/08/24 at 1:49 PM, the Director of Nursing (DON) stated an Advanced Practice Nurse Practitioner (APRN) assessed resident #6 early this morning. She acknowledged after assessing and speaking with the resident, the APRN increased the dosage and frequency of her pain medication.</p> <p>On 5/08/24 at 3:54 PM, in a telephone interview, Registered Nurse (RN) E stated she was assigned to resident #6 for the overnight shift which ended at 7:00 AM this morning. In a statement that conflicted with findings of interviews conducted with resident #6 and her granddaughter, RN E denied knowledge of the resident's complaints of pain during the night shift. She stated she was never asked to administer pain medication for the resident.</p> <p>On 5/09/24 at 9:58 AM, resident #6's son complained that despite an increase in the dosage of his mother's pain medication, they still had problems managing her pain. He said, They come in and ask if she's in pain, and if she's not in pain at that moment, they don't come back for a while. By then she is really hurting. He stated her pain was not constant, and he described it as all over the place. Resident #6's son stated neither he nor his mother was aware the pain medication was not scheduled at regular intervals, but had to be requested.</p> <p>Review of resident #6's Medication Administration Record (MAR) for May 2024 revealed no nursing documentation regarding administration of Tramadol 25 mg on 5/07/24 during the evening shift. The document showed resident #6 received her first dose of pain medication, Tramadol 50 mg, on 5/08/24 at 1:41 PM. The MAR indicated the resident's pain levels were 0 to 4 between 5/07/24 and 5/08/24, and not level 10 as reported by the resident and described by her granddaughter.</p> <p>A Nurses Note dated 5/07/24 at 10:38 PM read, Resident complain of pain at surgical site pain medication tramadol 25 mg was given will continue to monitor. The note did not include a description of the pain or its severity. The document was created by LPN B the following day, on 5/08/24 at 11:41 AM, after State Survey Agency staff identified pain management concerns for resident #6.</p> <p>On 5/09/24 at 1:08 PM, the DON discussed the absence of documentation regarding Tramadol 25 mg that was allegedly given to resident #6 on Tuesday, 5/07/24. The DON confirmed she investigated the situation and said, We have a little concern. She explained the pharmacy provided a report that showed removal of Tramadol 50 mg from the medication dispensing machine on 5/08/24, but there was no transaction recorded for the drug on 5/07/24.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/09/24 at 1:24 PM, the evening shift Nursing Supervisor validated resident #6's granddaughter came to the nurses' station soon after the resident's admission on 5/07/24. She recalled the granddaughter informed the nurses of the resident's pain. The Nursing Supervisor stated after LPN B assessed resident #6, she returned to the nurses' station and explained the resident's medications were not yet available. The Nursing Supervisor stated she called the pharmacy to obtain an authorization and access code to retrieve Tramadol 50 mg from the medication dispensing machine. She stated LPN B administered half a tablet and they wasted the other half.</p> <p>On 5/09/24 at 4:31 PM, the DON stated she followed up with the pharmacy and there was no documentation to show an authorization code was provided for the Nursing Supervisor to access the medication dispensing machine on 5/07/24. The DON acknowledged although resident #6 and her granddaughter confirmed the nurse administered a pill, there was no evidence the pill was Tramadol.</p> <p>On 5/10/24 at 9:16 AM, the DON stated pharmacy staff made an onsite visit within the last 24 hours and conducted a medication reconciliation that showed no discrepancies. She validated the Tramadol count in the machine matched the pharmacy's record.</p> <p>The facility's policy and procedure for Pharmacy Services, revised in June 2023, revealed the facility would provide pharmaceutical services to ensure accurate acquiring, dispensing, and administration of all routine and emergency drugs to meet the needs of each resident.</p> <p>Review of the medication dispensing machine Transactions record for the period 5/02/24 to 5/08/24 revealed no drugs were removed from the machine on 5/07/24.</p> <p>A Tramadol Transaction report for resident #6 was provided to the DON from the pharmacy in an email dated 5/09/24 at 11:36 AM. The document showed Tramadol 50 mg was pulled from the machine on 5/08/24 at 1:38 PM. The email read, The cabinet was not accessed for medication May 6-7.</p> <p>Review of the facility's policy and procedure for Pain Management, revised in August 2023, revealed the facility would provide pain management for residents that was consistent with professional standards of practice, person-centered care plans, and residents' goals. The document indicated the facility would prevent or manage a resident's pain by observation of non-verbal indicators such as restlessness, grimacing, and negative vocalizations. The policy revealed nurses would conduct pain assessments that included key characteristics and descriptors. The document showed pharmacological interventions would include consideration of around the clock administration of pain medication rather than as needed.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36489</p> <p>Based on interview and record review, the facility failed to ensure the medical record accurately reflected the status of and services provided for 1 of 3 residents reviewed for hospitalization , out of a total sample of 9 residents, (#2).</p> <p>Findings:</p> <p>Review of the medical record revealed resident #2 was admitted to the facility on [DATE] and last readmitted on [DATE]. His diagnoses included type 2 diabetes with long-term insulin use.</p> <p>Resident #2 had a care plan for diabetes with use of insulin, initiated on 12/14/23. The goal was the resident would have no complications related to diabetes. The interventions instructed nurses to check his blood glucose levels and administer diabetes medication as ordered by the physician.</p> <p>A nursing progress note dated 2/16/24 revealed at approximately 3:50 AM, resident #2 was discovered unresponsive in bed with a critically low blood glucose level. The resident's physician gave an order to send the resident to the hospital via 911 for further evaluation.</p> <p>Review of a Hospital Transfer Form dated 2/16/24 at 5:40 AM revealed resident #2 was transferred to the hospital.</p> <p>Review of the medical record indicated resident #2 was not readmitted from the hospital.</p> <p>Review of the Weights and Vitals Summary revealed a nurse documented resident #2's blood glucose level on 2/18/24 at 6:09 PM as 165 milligrams per deciliter (mg/dL) and on 2/18/24 at 6:45 PM as 145 mg/dL.</p> <p>Review of the Medication Administration Record (MAR) for February 2024 revealed documentation of medications given to resident #2 two days after he was discharge from the facility as follows:</p> <p>2/18/24 at 8:00 AM Sevelamer Carbonate 1600 mg</p> <p>2/18/24 at 9:00 AM Amlodipine 5 mg</p> <p>2/18/24 at 9:00 AM Finasteride 5 mg</p> <p>2/18/24 at 9:00 AM Saccharomyces boulardii 250 mg</p> <p>2/18/24 at 9:00 AM Dorzolamide HCl-Timolol Maleate Ophthalmic Solution 2-0.5%</p> <p>2/18/24 at 9:00 AM Pregabalin 25 mg capsule</p> <p>2/18/24 at 9:00 AM Cyclopentalate HCl Ophthalmic Solution 1%</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2/18/24 at 9:00 AM Dicyclomine HCl 20 mg</p> <p>2/18/24 at 10:00 AM Prednisone 50 mg</p> <p>2/18/24 at 12:00 PM Sevelamer Carbonate 800 mg</p> <p>2/18/24 at 1:00 PM Cyclopentalate HCl Ophthalmic Solution 1%</p> <p>2/18/24 at 1:00 PM Dicyclomine HCl 20 mg</p> <p>The MAR revealed the assigned nurse checked and recorded resident #2's blood glucose levels on 2/18/24 at 7:30 AM and 11:30 AM.</p> <p>On 5/10/24 at 1:07 PM, the Director of Nursing (DON) was informed of nursing documentation on resident #2's MAR that indicated on 2/18/24 during the 7:00 AM to 3:00 PM shift, the assigned nurse administered all scheduled medications and checked his blood glucose levels, although the resident had been in the hospital since 2/16/24. She reviewed the medical record and validated the documentation was inaccurate. The DON stated her expectation was nurses would document the actual care provided and medications administered.</p> <p>Review of the facility's policy and procedure for Documentation in the Medical Record, revised in November 2023, read, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident through complete, accurate, and timely documentation. The policy indicated licensed staff would document services provided in the resident's medical record, at the time of service. The document read, False information shall not be documented.</p>