STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105729	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chipola Health and Rehabilitation Center	4294 3rd Avenue Marianna, FL 32446

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide an environment that is clean and in good condition in 3 of 50 occupied rooms. (Rooms 106B, 107A, 108A/B) The findings include: A tour of the 100 hall was conducted with the Environmental Services Director (EVS Director) on 5/29/25 at 12:20 PM. The following issues were observed: Resident room [ROOM NUMBER]B's privacy curtain had a reddish-brown smear with a quarter sized clump of what appeared to be reddish black crusted matter. Resident room [ROOM NUMBER]'s privacy curtains had multiple brownish red droplet stains. Resident 108A's privacy curtains had numerous grey stains with flecks of brown substance and a grey stain along the bottom portion of the curtain. Resident 108B's privacy curtain had numerous grey and reddish orange stains with dried flecks of a brown substance. (Photographic evidence obtained) An interview was conducted with the EVS director who stated that he will usually change out the curtains when soiled but was having issues getting the curtain width needed for resident privacy.

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, records reviews, and review of the faciity's policy and porcedure, the facility failed to conduct an accurate assessment by not assigning the proper code to the Minimum Data Set (MDS) that corresponds to the appropriate aspect of the resident care in 2 out of 6 residents. (Resident #24 and #7) The findings include: Resident #24 On 05/28/2025 at approximately 09:10 AM, a record review was performed for Resident #24 that was admitted with a past medical history including cerebrovascular disease, Diabetes-type 2 with neuropathy, Peripheral Vascular Disease, Hypertension, Alzheimer's disease, and Gastrointestinal hemorrhage. The 4/25/25 MDS section for skin documented that the resident did not have a diabetic foot ulcer. However, the 02/06/25 MDS documented that the resident did have a diabetic foot ulcer. A review of the physician's progress note dated 05/14/25 and signed by the wound care doctor documented that the resident still had a diabetic wound of the right lateral heel. On 05/28/25 at approximately 4:52PM, an interview was conducted with Nurse E, a Registered Nurse (RN) and MDS Coordinator. She reviewed the MDS dated [DATE] and confirmed miscoding the diabetic foot ulcer as it does not reflect the resident's current condition. She acknowledged the quarterly assessment completed on 02/06/25 is the proper coding according to the resident's assessment. Resident #7 On 05/28/25 at approximately 5:00 PM, a record review was performed for Resident #7, who was admitted with a diagnosis of nontraumatic intracerebral hemorrhage. Resident #7 has a medical history of Diabetes Mellitus type 2, protein calorie malnutrition, seizures, hypertension, aphasia and requires total care, and dependence for all Activities of Daily Living. The annual MDS skin assessment dated [DATE] acknowledges that a pressure ulcer/injury was present at stage 3. However, the section about pressure ulcer/injury care was documented as a No. A record review verified that the resident is receiving pressure ulcer care as of 02/19/25. On 05/28/25 at approximately 5:30 PM, an interview was conducted with Nurse E. She reviewed the annual MDS skin assessment that noted the pressure ulcer/injury being present but the pressure ulcer/injury care documented as No. She acknowledged miscoding this section and stated that the answer should have been yes since the resident is receiving pressure ulcer care. A policy titled MDS (effective 11/30/2014 and last revised 09/25/2017) was reviewed. It states, Each person completing a section or portion of a section of the MDS signs the Attestation Statement indicating its accuracy.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observations, interviews, records and policy review, the facility failed to maintain acceptable parameters of nutritional status and electrolyte balance for 1 out of 2 enteral feeding residents by not following physician orders for enteral fluid hydration. (Resident #45) The findings include: On 05/28/25 at approximately 1:15 PM an observation was made with Nurse B with Resident #45 for her scheduled enteral feeding. After checking the placement of the percutaneous endoscopic gastrostomy tube (PEG tube) (a tube to provide nutrition directly into the stomach), Nurse B proceeded with 120cc of water via a syringe to the PEG tube, then administrated 1 carton of Jevity 1.5 per order and completed with another 120cc of water. An interview was conducted after the enteral feeding with Nurse B on 05/28/25 at approximately 1:45 PM. She explained that Resident #45 has an order for water flush of 240cc every 6 hours, so she combines the hydration order with the feeding schedule. Nurse B was asked to clarify the resident's enteral feeding and hydration orders. She stated that Resident #45 receives 240cc of water every 6 hours for hydration and acknowledged that she has been combining this hydration order with the enteral feeding order. The nurse demonstrated awareness of the order to flush with 60cc of water before and after each feeding order 5 times a day. However, she admitted to not following the hydration order as written and recognized that by not administering the full prescribed volume, the resident was missing 120cc of water per feeding. She verbalizes understanding that the resident is Nothing by Mouth (NPO), and therefore entirely dependent on enteral intake to meet hydration needs. Nurse B also acknowledged that hydration requirements are calculated by the Registered Dietitian (RD) and following these orders are important for maintaining the resident's hydration and overall health status. A medical record for Resident #45 was reviewed on 05/28/25 at approximately 2:30PM. On 04/29/25 orders were written as follows: Jevity1.5, 1 carton via peg tube, 5 times a day; Flush enteral tube with 240cc of water every 6 hours; Every shift flush the enteral tube with 60 cc of water before and after medications/feeding.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based upon observations and record reviews, the facility failed to ensure adequate documentation of narcotic sheets on 2 out of 3 medication carts. The findings include: On 5/28/25 at 08:00 AM, while observing medication administration and reviewing medications, an observation was made of the narcotic signage sheet for each shift to confirm accurate count of controlled drugs. It was observed that the narcotic control sheet was not signed on 4/22/25, 4/24/25, 5/2/25, 5/13/25, and 5/15/25 on the medication cart for the 100 unit. On the 300 unit, the narcotic count sheet was lacking signatures for 4/8/25, 4/12/25, 12/27/24. 12/28/24, and 1/3/25. On 5/28/25 at 08:20 AM, an interview with Nurse B was conducted. She stated, Yes there should always be a signature of the nurse coming onto shift and going off shift stating that the narcotic count is correct on each shift. She further stated that the purpose of the count is to ensure that no drug diversion has occurred and that each resident has the correct number of medications. The facility policy for controlled substances states, In addition to the medication sheet and the schedule II narcotic sheet; the number of controlled substances on hand must be counted and verified at the end of each shift. The narcotic sign in sheet must be completed at the end of each shift every day. The outgoing nurse or her designee will count all controlled substances being stored. Both staff members signs that the count and verification have been completed.

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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** Based on observations, interviews, and policy review, the facility failed to facilitate consideration of precautions and safe administration of medication for 2 out of 6 residents as evidenced by 2 expired insulin pens present in the medication cart. The findings include: On [DATE] at approximately 08:55AM, an observation was made during medication administration and overview of the medication cart. An expired insulin pen for Basaglar 100unit/ML KWIKPEN was opened on [DATE] with a discard date of [DATE] (after 28 days) for Resident #7 and an expired insulin Novolin R 100unit/ML Flexpen opened on [DATE] with a discard date of [DATE] (after 28 days) for Resident #24 was found on the top drawer of the medication cart. (Photographic evidence obtained) On [DATE] at approximately 09:00AM, an interview was conducted with Nurse A. She confirmed the expiration dates on the Insulin Basaglar and Novolin R and explained that she has not checked her cart for a while. She proceeded by removing the expired insulins from her cart. On [DATE] at approximately 11:30AM, a record review of the Medication Administration Record (MAR) for Resident #24 was conducted. On [DATE], Novolin R 1 unit was administered at 6:30 AM, Novolin R 7 units was given at 11:30 AM, Novolin R 5 units was given at 4:30 PM, and Novolin R 5 units wasgiven at 9:00 PM per the sliding scale order. Additionally, Basaglar 100unit/ML, 6 units subcutaneously was given to Resident #7 at 9:00 PM. (Photographic evidence obtained) A policy titled Disposal/Destruction of Expired or Discontinued Medication last revised on [DATE] was reviewed. Section 4 of the policy states: Facility should place all discontinued or outdated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interviews and medical record reviews, the facility failed to maintain a complete and accurately documented clinical record as evidenced by inaccurate and missing documentation on the Medication Administration Record (MAR) for 1 out of 6 residents. (Resident #24) The findings include: Resident #24's medical record was reviewed on 05/28/25. An order for Aminocaproic Acid oral 0.25GM/ML, give 30ml twice per day for bleeding, was received with a start date on 05/23/25. The Medication Administration Record (MAR) shows that on May 24th, 25th, 26th, 27th and 28th, 2025 at 09:00AM, Nurse F and Nurse A indicated that the medication Aminocaproic Acid was not available. Similarly, the MAR stated this medication was not available at 5:00PM on May 23rd, 24th and 25th, 2025. However, on May 26th and May 27th at 5:00 PM, Nurse H and Nurse G documented the medication as given, despite the morning staff having recorded it as unavailable. Additionally, the MAR for Resident #24 for medication Linzess oral capsule 145 MCG, give one capsule by mouth in the morning with an administration scheduled at 06:30AM, is missing the signature by staff for 05/11/2025. The MAR for Novolin R injection Solution 100unit/ML subcutaneous injection per sliding scale requires a blood glucose check for Resident #24. The documentation is missing a blood sugar result, documentation if the insulin was given, and staff signature on 05/11/25 at 06:30 AM. An interview was conducted on 05/28/25 at approximately 2:14PM with Nurse A, a Licensed Practical Nurse. She confirmed that the medication Aminocaproic Acid was currently not available and that the facility was awaiting delivery from the pharmacy. She verified that the medication was not located in the medication room, not available in the automated medication dispenser system, and not stored anywhere within the facility. She also explained that a code 9 on the MAR indicates that the medication is not available. She confirmed being the nurse on duty for 05/26/25, 05/27/25 and 05/28/25 and that the medication has not been delivered by the pharmacy. An interview was conducted with the Director of Nursing (DON) on 05/28/25 at approximately 2:36 PM. She explained the process for pharmacy delivery. When an order is received, the pharmacy receives it electronically. The contracted pharmacy is scheduled to deliver twice a day, once in the morning and once in the afternoon. She proceeded to explain that if the medication is not available, she usually gets an email that explains the delay in obtaining the medication. She was not made aware that the medication Aminocaproic Acid for Resident #24 had not been delivered. When asked why the MAR for Resident #24 for medication Aminocaproic Acid Ask was signed by Nurse G and Nurse H on 05/26/25 and 05/27/25 while the medication was unavailable, she was unable to explain how the medication could have been given, as it had not yet been delivered to the facility by the pharmacy. An interview was conducted on 05/28/25 at approximately 4:49 PM with Nurse G about the medication being signed off when it was not available on 05/26/25. She explained that it was a mistake and should have been documented as not available. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A second interview was conducted with the DON on 05/29/25 at approximately 09:44 AM. She clarified that it is her expectation for the ordered medication to be delivered by pharmacy within 24 hours. She further indicated that it is her expectation for the staff to notify her if a medication is delay in delivery. She also explained that it is the expectation of the facility to have accurate documentation on the medication administration as the medications are given and any missing signatures are not acceptable. She indicated that staff receive education on PCC upon hire.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews and record review, the facility failed to follow accepted infection prevention and control standards including hand hygiene, proper use of Personal Protective Equipment (PPE) and storage of oxygen tubing, to prevent the spread of infections by staff involved in direct resident care in 4 out 7 residents observed. (Resident #11, #7, #45, and #24) The findings include: Resident #11 An observation was made on 05/27/25 at approximately 10:54AM with Resident #11. There was an oxygen concentrator on the left side of her bed with oxygen tubing connected to it and the prong end of the tubing on the floor. At approximately 12:01PM, the oxygen tubing was still on the floor. At approximately 12:39PM, the oxygen tubing was stored in a plastic bag dated 05/26/25 located above the head of the bed. (Photographic evidence obtained) An interview was conducted with Nurse A at approximately 11:03 AM. She observed the resident and the oxygen tubing on the floor and explained that the resident removes her oxygen often. A second interview was conducted with Nurse A at approximately 12:43PM. She explained that she turned off the oxygen concentrator and secured the oxygen tubing in the storage bag provided. She denied changing the oxygen tubing at that time. When made aware that the oxygen tubing was observed on the floor, she responded that she believed it was placed on the side rail. Upon realizing that the tubing had made contact with the floor, she disregarded and replaced the oxygen tubing. Nurse A confirmed understanding the risk of contamination and potential infection transmission and the importance of proper handling of respiratory equipment. Resident #7 An observation was conducted on 05/27/25 at approximately 1:07PM with Resident #7, who was on Enhanced Barrier Precautions (EBP). During an observation with Staff C and Staff D, both Certified Nursing Assistants (CNA), entered the resident's room to provide incontinence care. Both staff members donned gloves upon entering; however, hand hygiene was not performed prior to resident contact. At approximately 1:19 PM, Staff D exited the room to retrieve additional supplies and re-entered the resident's room and resumed care without performing hand hygiene before contact with the resident. Hand washing was observed by Staff C and Staff D after completion of resident's care. Additionally, both staff member did not don the required Personal Protective Equipment (PPE) as required by the EBP despite the sign posted at the resident's door indicating the need for PPE and care plan for EBP. An interview was conducted on 05/27/25 at approximately 1:26 PM with Staff C and Staff D following the observation of care provided to Resident #7. Both staff members acknowledged that they did not perform hand hygiene prior to providing resident care. They stated that they are aware it is the facility policy and standard of care to wash hands before resident contact care. They verbalized understanding of the risk of Health Care Associated Infections (HAI) and the importance of hand hygiene in infection prevention among the vulnerable residents. Resident #45 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/28/25 at approximately 1:15 PM, an observation was made with Resident #45 for her scheduled enteral feeding. Nurse B was observed attempting to don personal protective equipment (PPE) prior to entering the resident's room. She secured the gown over her head; however, after multiple attempts to tie the gown at the waist, her arms remained exposed, indicating improper donning of PPE by failure to fully cover the required body areas for Enhanced Barrier Precautions (EBP). An interview was conducted on 05/28/25 at approximately 1:45PM with Staff B following the observation of care provided to Resident #45. She acknowledged her confusion regarding the correct procedure for donning PPE. She realized that she did not properly secure the gown sleeves, resulting in incomplete coverage of the arms. She recognized that failure to don the gown correctly compromised the effectiveness of the barrier protection and the importance of standard infection control practices. Resident #24 On 05/29/25 at approximately 09:51 AM, an observation was made with Resident #24 for his dressing change to the right heel. The procedure was performed with Nurse A with the assistance of CNA C, who supported the resident's foot. Nurse A initially performed proper hand hygiene using hand sanitizer and gowning with appropriate PPE. After removing the soiled dressing, she performed hand hygiene and applied a new pair of gloves. However, at that time, she exited the room wearing her gloves to retrieve a missing calcium alginate dressing. She touched the doorknob and upon returning, resumed the dressing change without changing her gloves or performing hand hygiene. At the completion of the wound care, both staff members performed hand hygiene. On 05/29/25 at approximately 10:04AM following the dressing change, an interview was conducted with Staff A. She admitted not following proper hand hygiene but believed it was acceptable because she only touched the corner of the dressing. She did not recognize this as a breach in infection control protocol.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations, interviews and medical record review, the facility failed to provide reasonable accommodation for resident needs by ensuring that the call bell was accessible for 5 out 12 residents observed in the 300 hallways. (Residents #7, #301, #8, #3, #23) The findings include: The following issues were noted with call lights: • An observation was made on 05/27/25 at approximately 12:58 PM for Resident #7. He was resting in bed, but his call bell was on the floor. • An observation was made on 05/27/25 at approximately 11:10 AM, 1:37 PM and 2:53 PM for Resident #301. The call bell for Resident #301 was attached to the lower right-side rail, making the call bell unreachable by the resident. • An observation was made on 05/27/25 at approximately 10:55 AM for Resident #8. She was resting in bed and her call bell was observed on the floor behind the headboard out of reach. • Upon observation of Resident #3 on 5/27/25 at 11:00 AM, the call light was observed laying on the floor under the bed where Resident #3 could not reach. • On 5/27/25 at 11:30 AM, Resident #23's call light was observed hanging between the side rail and mattress out of reach of the resident. Resident #23 is blind and when asked she could not locate her call light to call for assistance. Interviews were conducted on 05/27/25 with Staff C and D, both Certified Nursing Assistants (CNA). They confirmed these call bells were out of reach for the residents and should have been placed within easy reach of the residents.