

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105747	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Rosewood Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3107 North H Street Pensacola, FL 32501	

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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>43857</p> <p>Based on observations, resident record review, interviews, and facility policy review, the facility failed to evaluate a resident for self-administration of medications for 1 of 1 resident sampled. (Resident #103)</p> <p>The findings include:</p> <p>On 8/19/24 at 12:49 PM, Resident #103 was observed with an inhaler at bedside. She stated she had an inhaler at bedside so she could use it when she needed it. Resident #103 stated it was just albuterol and she had it for a long time. The inhaler's label read Albuterol Sulfate. This inhaler was again observed on the bedside table on 8/20/24 at 5:07 PM. (Photographic evidence was obtained)</p> <p>A review of Resident #103's medical record was conducted. A physician's orders stated, Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate), 2 puff inhale orally every 6 hours as needed for shortness of breath and was dated 4/19/24. The Medication Administration Record (MAR) for July and August 2024 revealed Albuterol Sulfate was scheduled as needed but was not documented. The resident's care plan did not include goals or intervention related to self-administration of medications.</p> <p>On 08/20/24 at 6:09 PM, an interview was conducted with Director of Nursing (DON). The DON reviewed Resident #103's records and stated the resident had never expressed she wanted to self administer the inhaler. The DON stated the facility did not have any residents that self-administered medications.</p> <p>A review of facility policy Self-administration of medication was conducted. The policy stated, A resident may not be permitted to administer or retain any medication on his/her room unless so ordered, in writing, by the attending physician and approved by the Interdisciplinary Care Plan Team. Should the resident's attending physician permit the resident to administer his/her medications (S) the following conditions will apply: the physician's orders must be given prior to self-administration; storage of medications in the resident's room must be such that it will prevent access by other residents.</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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>50783</p> <p>Based upon record review, observations, and interviews the facility failed to submit a level II screening for 1 out of 3 residents reviewed with a significant change in mental health and newly evident diagnosis of a serious mental disorder. (Resident #107)</p> <p>The findings include:</p> <p>On 8/20/24, a record review of Resident #107's level I PASARR was completed. The PASARR was dated 10/28/22 and had no indication of mental health or suspected mental health or intellectual disability indicated. However, review of the resident's medical record indicated added diagnoses of Disorganized Schizophrenia on 04/18/2023, major depressive disorder on 1/16/23, and Vascular Dementia severe, with other behavioral disturbances on 04/20/23. (Photographic evidence obtained)</p> <p>Upon interview and review of the medical health history with the Director of Nursing (DON) on 8/20/24 at approximately 05:04 PM, the DON stated myself and the Assistant Director of Nursing review and complete the PASARRs on all new residents and submit new ones as needed or as indicated. When asked about a level II PASARR for Resident #107, she stated she would have to review the health history and review medical records from the hospital and the records from the facility where Resident #107 resided prior to the current admission.</p> <p>During a follow up interview with the DON on 08/21/24 at approximately 10:00 am, the DON stated, There was no documentation of any mental health issues prior to her being admitted to our facility that I could find. We did not apply for a level II screening when the new diagnosis was added in April 2023. However, we did submit a Level II screen today.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>50082</p> <p>Based on staff interviews and electronic medical record (EMR) review, the facility failed to develop a comprehensive person-centered care plan for antibiotic use for 1 of 2 residents sampled for care planning. (Resident #111)</p> <p>The findings include:</p> <p>A review of the physician's orders reveals an order placed on 12/16/2023 for Minocycline HCl Oral Capsule 100 MG - Give 1 capsule by mouth one time a day for infection (a broad-spectrum antibiotic used to treat infections).</p> <p>A review of the comprehensive care plan initiated on 09/12/2022 and last updated on 08/09/2024 does not include antibiotic use. (photographic evidence obtained)</p> <p>A review of the annual minimum data set (MDS) (a standardized assessment tool that measures health status in nursing home residents), dated 05/24/2024, indicated no infections but did indicate yes for Antibiotic use.</p> <p>On 08/21/2024 at approximately 11:21 AM during an interview with Staff G, Registered Nurse (RN) and MDS coordinator, she reviewed the EMR and confirms there is no care plan in place for Resident #111 for antibiotic use. She indicated that there should be a care plan for antibiotic use.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39374</p> <p>Based on observations, interviews, and record review, the facility failed to ensure activities of daily living (ADL) for bathing and grooming were provided to 1 of 6 residents sampled for ADL care. (Resident #42)</p> <p>The findings include:</p> <p>During an observation and interview on 08/19/2024 at 11:50AM, Resident #42 said his scalp is really dry because he doesn't get his hair washed and would like to receive a shower in the shower room. Resident #42 said he has only had one shower where he was taken to the shower room since he's been admitted to the facility, and he needs someone to take him because he can't use his legs. He added, most of the time they only provide a bed bath, and his hair doesn't get washed. Resident #42 has amputation of left hand and forearm, nails on right hand are noted to be dirty and long, extending past the tip of the finger with the middle finger noted to be very thick and discolored, long, and curved in toward the tip of the finger. The resident was noted to have an odor of urine.</p> <p>A review of Resident #42's medical record showed he was admitted to the facility on [DATE] and had diagnoses of anoxic brain damage, adult failure to thrive, major depressive disorder, anesthesia and parasthesia of skin (lack of sensation), diabetes mellitus, type 2, osteoarthritis, and acquired absence of left upper limb. The record showed Resident #42 weighed 130 pounds and had a brief interview for mental status (BIMS) score of 12 (a score of 8-12 indicates moderately impaired cognition). On 08/20/2024, a review of bathing documentation revealed Resident #42 was scheduled to receive a shower on Mondays, Wednesdays, and Fridays, but there was no documentation of any bed bath or shower occurring between 08/12/2024 and 08/20/2024. The most recent documented shower for the resident was dated 07/31/2024 and the most recent bed bath documented was dated 08/11/2024. There was no documentation of refusal of care, no care plan related to behaviors of refusing care, and no documentation of attempts to bathe resident or offer showers on days when there was no shower documented.</p> <p>During an observation on 08/20/2024 at 2:10pm, Resident #42 was in his wheelchair in the hallway, wearing a red ballcap with his hair sticking out on the sides beneath the cap and appeared unwashed, there was a faint odor of urine detected.</p> <p>On 08/21/2024 at 9:23 am, in an interview, Certified Nursing Assistant (CNA) A, who was standing in Resident #42's room, said she has only had this assignment for two days and hasn't bathed Resident #42, but believes he is on the 3:00 pm - 11:00 pm shower schedule. She said Resident #42 mentioned to her that he would like a shower, and she usually provides care like wiping the resident down in between when they ask and she motioned to her underarm area. Resident #42 was observed at 10:05am on 08/21/2024 returning from the smoking area wearing a blue ball cap and still had an odor of urine. Later in the day, at 12:29PM, Resident #42 was observed sitting in his wheelchair in his room and said he was waiting for lunch. The observation revealed Resident #42 had a substance that appeared to be dried, flaked off skin in his ear and a flaky particle that also appeared to be dried skin in the hair sticking out under his ball cap. There was an odor of urine and cigarette smoke.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation of Resident #42 at 4:04 PM on 08/21/2024, he was in his bed with his shirt off, and appeared not to have had a shower. In an interview immediately following this observation, CNA D described and demonstrated the method for documenting a shower or bed bath using the electronic documentation system. During the interview, she said she had showered Resident #42 before and takes him to the shower room.</p> <p>On 08/22/2024 at 8:34AM, Resident #42 was observed in bed, alert and oriented, with shirt off, hair appeared freshly washed and combed, no odors noted. The resident was noted to have dirt and/or debris under his fingernails on his right hand, which remained long and untrimmed, with the middle fingernail was still thick and discolored, extending past the tip of finger and curling back toward the tip of his middle finger. Resident #42 was asked if he was offered nail care during his bath, and he replied no and added he would like them trimmed, especially the middle finger which is very long. Resident #42 said he had a shower last night and it is only the second time he has received a shower since being in the facility.</p> <p>On 08/22/2024 at 8:39AM, Registered Nurse (RN) B explained in an interview the expectation for ADL care is that CNA reports to the nurse when done and the nurse assigned to the hall would note if anything needed to be followed up on such as not completing the care. RN B observed Resident #42's nails and agreed the nails needed to be cleaned and trimmed. She also agreed that the middle fingernail which was very thick and discolored should be assessed by a nurse prior to trimming. In a follow up interview with RN B, she said she confirmed that a registered nurse can trim that nail, and she will have the nurse assigned trim the nail today.</p> <p>On 08/22/2024 at 9:04 AM, during an interview, CNA E showed where the ADL care supplies are kept, and the implements used for nail care. CNA E said that he offers nail care during the bath and that should be completed.</p> <p>On 08/22/24 at 11:22 AM, the staff development coordinator, RN C, was asked during an interview to describe what she teaches as far as bathing and nail care. RN C said that the expectation is residents are provided a shower in the shower room unless specifically refusing or stating a preference for a bed bath and the expectation taught for bathing includes ensuring nails are clean.</p> <p>On 08/22/24 11:40 AM, during an interview, the Director of Nursing (DON) said Resident #42 is care planned for fabricating stories and will say that he did not get showers but then he refuses. The DON was told that Resident #42 was consistent about his desire for a shower throughout the week since Monday, 08/19/2024, and specifically that his hair doesn't get washed, which was consistent with observations of the resident having flakes of skin in his hair, appearing un-showered, and having an odor of urine about him. The DON said he only gets showers on Monday, Wednesday and Fridays and he often refuses. She said that she was the one who went in today to trim his middle fingernail, which was very thick. She agreed the nail was long and had not been trimmed. The DON was shown that no documentation in the record was found which demonstrated a nurse had been notified and the resident refused the care to his nail or other refusals of care or bathing. She left and said she would look for documentation in the record of these behaviors to provide. At 12:07 PM, the DON came back and provided one page of documentation with a late entry written by RN B that Resident #42 was offered a shower earlier in the shift, stated that he would prefer it after dinner and his smoke break. Resident refused x 2 when asked at the requested time. Will reattempt tomorrow. The note was entered on 08/21/2024 at 15:39PM as a late entry for 08/20/2024. No other documentation of refusals of care or behavior of fabricating stories were provided for Resident #42.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/22/2024 at 12:27 PM, in a follow up interview with Resident #42 about whether he refused care of a shower, he said he thinks he did ask to have the shower after he smokes, but he wouldn't refuse a shower unless it was time to go smoke.</p> <p>Review of policies provided for bathing and nail care included under the heading Key Procedural Points for Shower/Tub Bath - Dependent Resident: 2. Insofar as practical, encourage the resident to participate in the bath care. 6. Trim the resident's toenails or fingernails unless otherwise instructed by the staff/Charge Nurse. Key Procedural Points of the section titled Fingernails/Toenails, Care of included: 1. Nails can be cleaned during bath care.</p>		