

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105805	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Radiant Nursing and Rehab at Palatka		STREET ADDRESS, CITY, STATE, ZIP CODE 501 S Palm Ave Palatka, FL 32177	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44571</p> <p>Based on record review and interview, the facility failed to ensure accuracy of Minimum Data Set (MDS) assessments for 1 (Resident #55) of 4 residents reviewed for discharge assessments.</p> <p>Findings include:</p> <p>Review of Resident #55's admission record documented that Resident #55 was admitted to the facility on [DATE] with diagnoses including: altered mental status, chronic obstructive pulmonary disease (COPD), seizures, cerebral infarction, transient cerebral ischemic attack, anxiety disorder, dysphagia and osteoarthritis.</p> <p>Review of Resident #55's Minimum Data Set (MDS) titled Discharge Return Not Anticipated dated 11/20/2024 showed the resident was discharged to acute hospital on 11/20/2024.</p> <p>Review of Resident #55's social services notes dated 11/14/2024 at 9:31 AM read, Met with resident and resident stated [Resident #55's Niece's name] came up here and talked to her about transferring and the resident stated she wanted to transfer where she [Social Services Director's name] was working. Referral process initiated.</p> <p>Review of Resident #55's social services note dated 11/15/2024 read, Received a call from [Facility name] who stated they approved the referral and will pick up the resident on 11/20/2024 at 10:00 AM.</p> <p>Review of Resident #55's Admission & Discharge Summary dated 11/20/2024 read, Resident [Resident #55's name] transferred to SNF [skilled nursing facility].</p> <p>During an interview on 2/4/2025 at 1:50 PM, the MDS Coordinator confirmed Resident #55 was discharged to another skilled nursing facility and the MDS dated [DATE] was inaccurate.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105805	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Radiant Nursing and Rehab at Palatka		STREET ADDRESS, CITY, STATE, ZIP CODE 501 S Palm Ave Palatka, FL 32177	
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy and procedure titled Resident Assessment Instruments (RAI) with the last review date of 1/25/2024 read, Policy: It is the policy of the facility to adhere to the following procedures related to the proper documentation and utilization of a resident's Minimum Data Set (MDS) to ensure a comprehensive and accurate assessment of residents will be completed in the format and in accordance with time frames stipulated by Department of Health and Human Services Center for Medicare and Medicaid Services. This assessment system will provide a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacities and assist staff to identify health problems for care plan development.</p> <p>Review of the facility form titled Certifying Accuracy of the Resident Assessment read, 2. Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment . 4. The resident assessment coordinator is responsible for ensuring that an MDS assessment has been completed for each resident.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105805	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Radiant Nursing and Rehab at Palatka		STREET ADDRESS, CITY, STATE, ZIP CODE 501 S Palm Ave Palatka, FL 32177	

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>49777</p> <p>Based on observation, interview and record review, the facility failed to ensure the drugs and biologicals used in the facility were stored in accordance with currently accepted professional principle in 1 of 4 hallways.</p> <p>Findings include:</p> <p>During an observation on 2/3/2025 at 10:55 AM, Resident #15 was sleeping in bed and there was one bottle of Artificial Tears Ophthalmic Solution (Artificial Tear Solution) on the resident's beside table.</p> <p>Review of Resident #15's physician order dated 1/17/2024 read, Artificial Tears Ophthalmic Solution (Artificial Tear Solution), Instill 1 drop in both eyes four times a day for dry eyes and irritation.</p> <p>During an interview on 2/3/2025 at 10:58 AM, Staff A, Licensed Practical Nurse (LPN), stated Eye drops should not be at the bedside not secured.</p> <p>During an interview on 2/3/2025 at 11:08 AM, the Director of Nursing (DON) stated, Medications need to be secured and there are times when family members bring in eye drops we are not aware of. The medication has been brought to the patient.</p> <p>Review of the facility policy and procedure titled Medication Labeling and Storage with the last review date of 1/7/2025 read, Policy Statement: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light control.</p>