STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105839	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace of Kissimmee, The	221 Park Place Blvd Kissimmee, FL 34741

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51234 Based on observation, interview, and record review the facility failed to ensure accommodation for residents who needed their call bell within their reach to alert staff to care needs for 2 of 4 sample residents, (#1 and #2). Findings: 1. Resident #1 was admitted on [DATE], pertinent diagnoses included: cerebral infarction (stroke) and hemiplegia and hemiparesis (paralysis and weakness on one side of the body) following cerebral infarction affecting right dominant side. Review of resident #1's Minimum Data Set (MDS) assessment dated [DATE] showed she was impaired on one side of her upper and lower extremities. The assessment revealed she was dependent on staff for bed mobility and to move from a position from lying to sitting. Walking 10 feet was not attempted because the resident did not perform this activity prior to the current illness/injury. The self-care section indicated resident #1 was totally dependent on staff for oral, toileting, and personal hygiene, showers/baths, and upper and lower body dressing. Resident #1's Activities of Daily Living (ADL) care plan regarding Functional Status/Rehabilitation Potential noted the resident required staff assistance with ADLs and an approach dated 12/03/20 stated keep call light within easy reach. On 7/16/24 at 9:43 AM, resident #1 was observed lying in bed, right arm flexed at her elbow with her hand toward her face and her fingers were flexed to her palm. The call bell was on the floor near the wall at the head of her bed on her right side, out of her reach. On 7/16/24 at 12:10 PM, resident #1 was again observed lying in bed, with her right arm flexed at her elbow and her hand toward her face with her fingers flexed to her palm. The call bell remained on the floor near the wall at the head of her bed on her right side. On 7/16/24 at 12:45PM, Certified Nursing Assistant (CNA) A stated call bells should be placed in reach of a resident before the CNA left the resident's room so they could be used. CNA A verified she provided care for resident #1 earlier in the day. (continued on next page)

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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NAME OF PROVIDER OR SUPPLIER: Terrace of Kissimmee, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 221 Park Place Blvd Kissimmee, FL 34741	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/24 at 12:46PM, resident #1 was observed in the company of the South wing Unit Manager (UM) lying in her bed. The UM verified resident #1's call bell was on the floor at the wall by the head of the bed on her right side. 2. Resident #2 was admitted [DATE] with diagnoses that included history of falling, other lack of coordination, abnormal posture, cerebral infarction due to occlusion or stenosis of small-artery-chronic Lacunar infarction (stroke), and type 2 diabetes mellitus with diabetic neuropathy, and unspecified (nerve pain/numbness). Review of resident #2's MDS assessment dated [DATE] in the self-care section it was noted the resident needed substantial/maximal assistance from staff for oral, toileting, and personal hygiene, showers/baths, and upper and lower body dressing. Review of resident #2's Care Plan for risk for falls had an approach, dated 10/22/19, to keep her call light within reach, encourage its use, and for staff to answer call light promptly. On 7/16/24 at 9:40 AM, resident #2 was observed lying in bed leaned to her left side, the call bell on the floor, by the wall at the head of her bed toward her right side. Soft fall mats were on both sides of the bed. A Breakfast tray was present on the table at her left side. On 7/16/24 at 12:37 PM, resident #2 was again observed lying in bed, with a blanket over her body. The breakfast tray at her bedside had been removed. The call bell was still laying on the floor, near the wall, on her right-hand side. On 7/16/24 at 12:40 PM, during an observation with the South wing UM, she verified resident #2's call bell was on the floor at the head of the bed out of reach of the resident. She verified Resident #2 had been provided care in their room by staff prior to this observation. On 7/16/24 at 1:37 PM, during an interview with the UM and Assistant Director of Nursing (ADON) the ADON stated resident #1 and resident #2 should both have their call bells within reach because they needed staff to help them with care. They confirmed staff should check that all residents had their call bells accessible for them to use before they left resident rooms.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51234 Based on observation, interview, and record review the facility failed to ensure a dependent resident received the necessary services to maintain activities of daily living (ADL) regarding nail and oral care for 1 of 4 sampled residents, (#1). Resident #1 was admitted on [DATE], with diagnoses to include cerebral infarction (stroke) and hemiplegia and hemiparesis (paralysis and weakness on one side of the body) following cerebral infarction affecting right dominant side. Review of resident #1's Minimum Data Set (MDS) Quarterly assessment dated [DATE] noted in the functional abilities self-care section the resident was dependent, meaning the resident was unable to provide any effort, to complete her oral and personal hygiene. The MDS showed her Brief Interview for Mental Status Summary Score was 7/15 which indicated severe cognitive impairment. Section E of the assessment indicated resident #1 did not exhibit physical or verbal behavioral symptoms towards others nor did she display other behavioral symptoms not towards others during the look back period. Resident #1 had care plans with problem start dates of 5/12/23 for having behavioral symptoms, e.g. screaming and yelling out during routine ADL care as well as resisting routine ADL care by pushing back during repositioning, bathing, and incontinence care. She refused to get out of bed was also noted. Interventions included avoid power struggles, reiterate the purpose and advantages of treatment and if the resident resisted care stop and try the task later. No care planning for oral care nor nail care refusal was noted. On 7/16/24 at 12:10 PM, resident #1 was observed lying in her bed, her eyes open and alert to self with Certified Nursing Assistant (CNA) A at her bedside. CNA A confirmed resident #1's fingernails all extended beyond their fingertips with varying degrees of dark, soiled material underneath the nails. CNA A with resident #1's permission removed resident #1's socks and observed her toenails. CNA A verified resident #1's toenails extended beyond the toenail tips and were to varying degrees curved and thickened. When resident #1 was asked if she would like CNA A to trim and clean her fingernails today she smiled and nodded her head affirmatively. CNA A stated she had informed resident #1's nurse recently that her nails needed trimming. She explained resident #1 had sometimes refused cleaning and trimming nail care, but admitted the resident preferred her to some other staff. Resident #1 opened her mouth on request to show her dentition which was noted to have a thick yellow-white build-up of debris. CNA A said resident #1 had sometimes refused oral cleaning. CNA A was unsure when the resident had last received oral care. Review of the undated Certified Nursing Assistant's Job Description, Duties and Responsibilities section under Personal Nursing Care Functions the document noted the CNA should assist residents with daily dental and mouth care as well as nailcare including clipping, trimming and cleaning the fingernails. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/24 at 12:25 PM, the South Wing Unit Manager (UM) observed resident #1 in her bed and verified her fingernails all extended beyond the fingertips and had varying degrees of dark, soiled material underneath the nails. Then the UM with resident #1's permission to remove her socks, observed her toenails. Verified with UM that all toenails extended beyond the toenail tips and were to varying degrees curved and thickened. UM said she would be able to cut the resident's fingernails and toenails except for her great toes due to the nails' long length and thickness. On 7/16/24 at 12:46 PM, the UM observed the interior of resident #1's mouth, and she verified the buildup of yellowed material on resident #1's dentition and the yellow/white debris in her mouth. On 7/16/24 at 1:37 PM, during an interview with the UM and the Assistant Director of Nursing (ADON) they verified they could find no documentation of when resident #1's nail care or nail trimming had been done. When asked for documented refusals the ADON provided two occasions, 7/02/24 and on 7/11/24, that nail care was refused by resident #1. The UM and ADON verified there was no documentation of the resident's refusals about nail care had been communicated to the resident's family nor her physician. The ADON said it was an expectation that all residents received oral care in order to maintain oral hygiene even if a physician orders nothing by mouth. The UM said oral care for residents was usually provided in the morning, again in the evening, and when the resident requested care. For residents with dentures the dentures would be removed and cleaned in the evening, even if the resident did not take in nutrition via their mouth. Neither the UM nor ADON could find documentation in resident #1's record of when she last had oral care. The UM stated there was one refusal of oral care on 9/23 but the ADON presented documentation of only two refusals of oral care by resident #1 dated: 7/02/24 and 7/06/24. The ADON said she was working on educating the facility nurses on the importance of documenting refusals of care. The ADON verified resident #1's family nor physician were notified about oral care refusals. The Activities of Daily Living policy most recently reviewed 12/2023 noted residents who were unable to carry out ADLs themselves would receive services necessary to maintain good grooming and personal and oral hygiene. The policy implementation included if residents with cognitive impairment resisted care, staff would attempt to identify the underlying cause and not just assume the resident was refusing or declining care.