

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105975	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Community Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3611 Transmitter Road Panama City, FL 32404	
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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 45951 Based on observation, staff interview, resident interview, and records review, the facility failed to ensure the interdisciplinary team assessed and determined residents were capable of self-administration of medications prior to allowing 2 of 4 residents sampled for medication administration to self-administer medications. (Residents #32 and #61) The findings include: During the observation of medication administration on 06/04/2024 at 9:13 AM with Registered Nurse (RN) I, it was observed that oral medications, including a schedule II medication, Hydrocodone-Acetaminophen Tablet 5-325 milligrams (mg) (a medication used for pain), were placed in a medicine cup and left at the bedside for Resident #61 to self-administer. Following this observation, an interview was completed with RN I. She said that Resident #61 was not assessed for self-administration. An observation on 6/4/2024 at about 9:20 AM found Resident #32 with 8 pills loose on the breakfast tray in front of him/her. (photographic evidence obtained) During a follow up interview on 6/4/24 at about 9:30 AM with RN I, she stated she was told there are a number of residents in the facility she can trust to take their medications. RN I said no residents were assessed for self-administration of medications. A review of medical records revealed the medications administered to Resident #32 included: Tradjenta 5 mg (a medication to treat diabetes) Thiamine HCl 100 mg (a mineral supplement) Tenormin 50 mg (used to treat high blood pressure) Tamsulosin HCl Capsule 0.4 mg (used to treat enlarged prostate) Spironolactone 100 mg (used to treat high blood pressure) Oxycodone Hydrochloride 10 mg (Resident #32 said this medication was not administered with other medications during the observation/interview on 06/04/2024) (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 105975	Facility ID: 105975 If continuation sheet Page 1 of 9

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prednisone 20 mg (used to treat arthritis) Multiple Vitamins-Minerals Furosemide 40 mg (a high blood pressure medication) Folic Acid Tablet 1 mg (a mineral supplement) Aspirin Oral Tablet (used to treat cardiovascular risks) Medications left at bedside for Resident #61 to self-administer: Simethicone Oral 1 tablet (used to treat gas) Sennosides-Docusate Sodium Tablet 8.6-50 mg (a laxative) Losartan Potassium Oral Tablet 50 mg (a high blood pressure medication) Lasix Tablet 20 mg (a diuretic) Lamictal Oral Tablet 100 mg (used to treat bipolar disorder) Hydralazine HCl Tablet 25 mg (a high blood pressure medication) GlycoLax Powder mg (a laxative) Duloxetine HCl Capsule Delayed Release Particles 60 mg (an antidepressant) Cetirizine HCl Tablet 10 mg (an antihistamine) Carvedilol Tablet 25 mg (a high blood pressure medication) Alprazolam Oral Tablet 0.25 mg (an anti-anxiety medication) Acetaminophen 325 mg A review of facility Policy for Medication Pass Guideline included the following: Procedure section #9 Administration of medication: Remain with resident until administration of medications complete.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42756 Based on observation, resident interview, staff interview, record review and policy review, the facility failed to ensure that wound assessments, dressing changes and wound care were provided in accordance with physician orders and facility policy for 2 of 3 residents sampled for wound care observations (Resident #7 & #24). The findings include: Resident #24: On 6/3/24 at approximately 11:46 AM, an interview and observation was conducted with Resident #24. The surveyor entered the room as the resident repeatedly said, help me, help me. The resident indicated she wanted to get up. The resident showed the surveyor her left leg. She indicated that her leg was bothering her. Resident #24 had a small, round, uncovered open area lateral to her left knee. Her left lower leg had a dressing. The dressing was dated 5/30 (4 days ago). The dressing had visible dried brown drainage present. (photographic evidence obtained) On 6/4/24 a review of Resident #24's record was conducted. A review of the progress notes and hospital discharge summary from 5/29/24 for Resident #24 revealed that the resident had been in the hospital for treatment of an infected post-surgical wound after surgical repair of a fracture of the left lower leg. She was treated for a systemic infection related to the infected wound. Resident #24 was discharged with an intravenous (IV) access and orders to receive IV antibiotics to treat the infection along with orders for daily dressing changes to the area. The record indicated that the resident was readmitted to the facility from the hospital on 5/29/24. A review of the current physician orders was conducted for Resident #24. There was an order to loosely fill cavity to left knee with 1/4 inch iodoform gauze and cover with dry dressing daily and as needed (PRN) if soiled or dislodged for wound management with a start date of 6/1/24. There was also a physician order for a Calcium Alginate Dressing to left lateral leg every day shift for skin management, evaluate for pain prior, during, and after treatment and medicate as needed. Monitor site for signs and symptoms of infection and notify MD (medical doctor) if issues are detected. Cleanse with wound care cleanser, Dakin's to wound bed, calcium Alginate Ag and dry dressing daily and prn if soiled with a start date of 6/1/24. A review of the June 2024 Treatment Administration Record (TAR) for Resident #24 was conducted. Regarding the physicians order to loosely fill cavity to left knee with 1/4 inch iodoform gauze and over with dry dressing daily, the TAR was not initialed on 6/2/24 indicating this treatment had not been completed. Regarding the physician order for the Calcium Alginate Ag Dressing to left lateral leg every day shift, for skin management eval for pain prior during and after treatment and medicate as needed (PRN), monitor site for signs and symptoms of infection and notify MD, Cleanse with Wound care cleanser, Dakin's to wound bed, calcium Alginate Ag and dry dressing daily and prn if soiled was not initiated on 6/1/24 or 6/2/24 indicating that the dressing had not been changed on those dates. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at approximately 9:45 AM, Resident #24 was observed to have no dressing over her left knee. The dressing on the left lateral leg was clean dry and dated 6/4/24. On 6/5/24 at approximately 10:40 AM, an interview was conducted with Nurse A, a Licensed Practical Nurse (LPN). Wound care was observed for Resident #24. When the observation was conducted, there was no dressing on Resident #24's left knee. Nurse A loosely filled the cavity to left knee with 1/4 inch iodoform gauze and covered the area with a dry dressing. Nurse A LPN was shown the image taken on 6/3/24 with the dressing dated 5/30/24 and no cover over wound on left knee. Nurse A explained that she has been caring for Resident #24 on day shift this week since 6/3/24. She indicated that Resident #24 often removes the dressing over the left knee herself. She also explained that Resident #24 had been discharged from the hospital recently and that she did not realize that daily dressing changes were ordered for the wound on the left lower leg until 6/4/24 when she changed the dressing as ordered. On 6/6/24 at approximately 9:40 AM, an interview was conducted with the Director of Nursing (DON). She was shown the image taken on 6/3/24 of Resident #24's leg with the missing dressing and an old dressing dated 5/30/24 in place. The DON agreed that the dressing on the lower leg should have been changed as ordered. The DON was asked to provide a copy of the facility policy regarding dressing changes and administration of medications and treatments. A review of the facility policy titled Dressing Change was conducted. The purpose of the policy states to change dressings according to physician orders. Step 1 of the procedure listed to verify physician order for most current treatment order. A review of the facility policy titled Medication Pass Guidelines was conducted. The policy indicated that medications should be administered in accordance with frequency prescribed by the physician and that patient refusal should be documented in the record. Resident #7 On 6/4/24, a review of the current physician orders was conducted for Resident #7. She had an order to have a wound to the right sacrum cleansed with wound cleanser pat dry and then mepilex dressing applied every day shift every three days for wound management. The start date for the order was on 4/22/24. A review of the June 2024 Treatment Administration Record (TAR) for Resident #7 was conducted. The physicians order Cleanse wound to right sacrum with wound cleanser pat dry and apply a mepilex dressing every day shift every three days for wound management. Start date 4/22/24. was initialed on the TAR on 6/3/24 indicating this treatment had been completed. A review was also conducted of the May 2024 TAR. The treatment was signed off as being done every 3 days except 5/19/24. A review of the progress notes and evaluations revealed no documentation that the wound had healed. The last weekly skin evaluation was dated 4/30/24. The current care plan indicated that the resident had a wound to the sacrum in the at risk for alteration in nutrition/hydration focus area. The potential for impaired skin integrity area indicated that the resident had a history of shearing of her bottom. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at approximately 8:15 AM, an interview was conducted with Resident #7. She was asked if she had any wounds or open areas on her skin. Resident #7 said she had no open areas. Resident #7 explained that she had a wound previously but she does not have any open areas on her skin presently. On 06/04/24 at 1:41 PM, Nurse A, a Licensed Practical Nurse (LPN), was asked if she could observe the wound on Resident #7's sacrum. Nurse A, LPN asked Resident #7 to turn over in the bed. She had no wound, no abnormality of her skin anywhere on her lower back or sacrum, and no dressing present. Nurse A explained she never put a dressing on Resident #7 because there was no wound. She offered to put a dressing over the resident's sacrum. Nurse A was asked if she had considered contacting the physician to have the order discontinued. Nurse A did not respond. Nurse A was asked how often skin assessments are completed for the residents and pointed out that Resident #7 did not have a documented skin assessment since 4/30/24. She explained that skin assessments are normally completed weekly and confirmed that 4/30/24 was the last skin assessment for Resident #7 in the chart. On 6/6/24 at approximately 9:40 AM an interview was conducted with the Director of Nursing (DON). She was notified that the Resident #7 observations conducted with Nurse A revealed that Resident #7 longer had a wound on her sacrum. However, wound care was being documented as being done on both May and June TARs. She indicated that the resident likely returned from the hospital in April with the order and it has not been discontinued. The DON indicated that this would be addressed. The DON was asked to provide a copy of the facility policy regarding dressing changes and administration of medications and treatments.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45951 Based on observation, interview, and record review, the facility failed to follow physician orders for tube feeding formula for 1 of 1 resident reviewed for tube feeding. (Resident #26) The findings include: During a tour of the facility conducted on 06/03/24 at 11:45 AM, Resident #26 was observed lying in her bed with tube feeding hanging but not infusing. The bottle of tube feeding formula that was observed was Jevity 1.5 (photographic evidence obtained). A second observation was conducted on 06/03/24 at 2:30 PM of Resident #26's tube feeding infusing-the bottle infusing was Jevity 1.5 formula. Initial review of Resident #26's record revealed the tube feeding order written by the physician on 09/24/23 was for Jevity 1.2 formula. This indicates Resident #26 was receiving the wrong tube feeding formula. Resident #26 was last readmitted to the facility on [DATE]. Review of Resident #26's medical history revealed she has a history of Cancer, Difficulty Swallowing, and Gastrostomy Tube Dependency. An interview was conducted with Staff A, a Licensed Practical Nurse, on 06/05/24 at 1:53 PM. Staff A confirmed she was assigned to Resident #26 on 06/03/24. She stated Resident #26's tube feeding bottle was changed by the night shift staff and that she was responsible for stopping it at 10:00 AM and restarting it at 12:00 PM each day, per the physician order. Staff A stated she had not noticed the wrong tube feeding formula was infusing during her shift on 06/03/24. An interview was conducted with the Registered Dietitian on 06/05/24 at 11:40 AM. She stated she was aware that Resident #26 was ordered to receive Jevity 1.2 formula. She said at times, if there were to be a lack of Jevity 1.2, it would be fine for the facility staff to substitute and give a resident Jevity 1.5 instead. She stated she did not know if this was why the staff had chosen to give the incorrect formula on 06/03/24. An interview was conducted with Staff D, the Central Supply Coordinator, on 06/05/24 at 1:15 PM. Staff D stated that the facility did not have a lack of Jevity 1.2 over the weekend or on 06/03/24. She confirmed there was Jevity 1.2 available for the staff to administer to Resident #26. An interview was conducted with the facility's Director of Nursing on 06/05/24 2:18 PM. She stated that she was unaware that Resident #26 had received the wrong tube feeding formula on 06/03/24.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 35609 Based on observations, record reviews, interviews, and policy review, the facility failed to obtain physician orders to administer oxygen for 1 of 4 residents sampled for respiratory care. (Resident #15) The findings include: On 6/3/24 at 12:04 PM, 6/4/24 at 12:48 PM and 3:16 PM, and 6/5/24 at 8:45 AM, Resident #15 was observed in bed receiving humidified oxygen via nasal cannula at 1.5 liters (L) from an oxygen concentrator. On 6/5/24 at 11:17 AM, Resident #15 was observed sitting up in a wheelchair in the hall near their room receiving oxygen via nasal cannula at 2 L from portable oxygen tank. On 6/3/24, a record review was conducted for Resident #15. The record review included a review of the current and discontinued/completed physician orders. There were no orders for oxygen therapy. On 6/5/24 at 8:46 AM, an interview was conducted with Resident #15, who stated they have been using oxygen for 2 to 3 weeks prior to admission to the facility and has been on oxygen continuously since admission to the facility. On 6/5/24 at 10:23 AM, an interview was conducted with Staff H, a Registered Nurse caring for Resident #15. She reviewed the resident's electronic medication administration record and verbally agreed there was no order for oxygen and stated the night shift nurse told her the resident was on oxygen when she gave her report this morning and wrote it on the report sheet that the resident was on 2 L oxygen via nasal cannula. On 6/5/24 at 10:30 AM, an interview was conducted with the Assistant Director of Nursing (ADON), who reviewed the resident's orders and verbally agreed there were no orders for the oxygen and stated she will find out why she was placed on oxygen. On 6/5/24 at 2:16 PM, an interview was conducted with the ADON, who acknowledged that there was no order for the oxygen but it has now been fixed and they have the order for oxygen. On 6/5/24 A review of the policy Daily Review of Physician's Orders, 2015 was conducted. The policy read as follows: Procedure 1. The nurse will review the Physician order section of the medical record daily. 4. The nurse should identify any transcription issue or omission and: Notify supervisor Document on the 24 hour report (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Take action to correct		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45951 Based on observation, interview, and record review, the facility failed to maintain proper infection control protocol for 1 of 1 resident reviewed for transmission based precautions. (Resident #44) The findings included: During a tour of the facility conducted on 06/03/24 at 11:45 AM, Resident #44's room door had an isolation sign for Enhanced Barrier Precautions. An initial review of Resident #44's record revealed a physician's order written on 06/02/24 for Contact Isolation. Further review of Resident #44's record revealed this Contact Isolation order was written due to Resident #44 having an Extended Spectrum Beta-Lactamase (ESBL) infection in her urine requiring the use of Macrobid (an oral antibiotic) from 05/26/24 to 06/09/24. Resident #44 was last readmitted to the facility on [DATE]. A review of Resident #44's medical history revealed she had a history of Chronic Kidney Disease, Urinary Tract Infections, and Dementia. Continued observations were conducted on 06/04/24 and 06/05/24 revealed the Enhanced Barrier Precautions sign on Resident #44's door was not the correct Contact Isolation sign. An interview was conducted with Staff A, Licensed Practical Nurse on 06/05/24 at 1:53 PM. Staff A confirmed she was the nurse assigned to Resident #44 for the week. When asked if Resident #44 was in isolation, she said she was in isolation because she had something going on with her urine but was unable to provide more information without consulting the electronic health record. Staff A reviewed Resident #44's chart and verbalized that Resident #44 was supposed to be on Contact Isolation. When showed the room door, Staff A stated she did not know why there was not a Contact Isolation sign on the door. An interview was conducted with Staff B, Certified Nursing Assistant (CNA) on 06/05/24 at 2:00 PM. Staff B confirmed she was the CNA assigned to Resident #44 for the week. When asked if Resident #44 was in isolation for any reason, she stated Resident #44 was not on isolation. An interview was conducted with the facility's Director of Nursing on 06/05/24 at 2:18 PM. She stated that she was unaware that Resident #44 had an order for Contact Isolation.		