STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106002	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedrock Rehabilitation and Nursing Center at Wedge	1010 Carpenters Way Lakeland, FL 33809

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observation, interview, and record review, the facility failed to honor and maintain resident dignity related to staff not knocking or announcing prior to entering occupied rooms for three (#94, #9, and #22) of thirty-eight sampled residents. Findings included: 1. On 12/16/2024 at 9:55 a.m., Resident #94 was observed in her room and seated in her wheelchair next to her bed. Resident #94 was noted dressed for the day and well groomed. She was observed to reside in the secured/dementia unit, and was residing in a room by herself. She had no initial concerns other than staff just coming in her room without knocking. She revealed this happened during the day and night and she got especially startled when she was in bed and sleeping and staff came in her room without her knowing. Resident #94 revealed there were times when staff yelled out to her while at the side of her bed and she knew they did not knock before coming in the room. She revealed she had spoken to a nurse about it but things had not changed. On 12/16/2024 at 1:10 p.m., while touring the 600 Secured unit, Staff C, Certified Nursing Assistant (CNA) was observed to walk into Resident #94's room without first knocking and/or announcing herself. Resident #94 was in the room during the time of the observation. On 12/17/2024 at 7:20 a.m., while on the 600 Secured unit, Staff C was observed walking into Resident #94's room without first knocking and/or announcing herself. Resident #94 was in her room and seated in her wheelchair during the time of the observation. On 12/18/2024 at 11:12 a.m., an interview was conducted with Resident #94. She was in her room and seated in her wheelchair. During the interview, Staff C walked into the room without first knocking and/or announcing herself. Staff C reached the middle of the room and then said she did not knock and should have before coming in the room. On 12/19/2024 at 8:15 a.m., an interview with Staff F, Unit Manager for 500/600/700 halls, confirmed all staff should knock and announce prior to going in resident rooms. She said usually would monitor staff and walk up and down the hallways to ensure this was happening. She had to provide verbal education to staff on the unit at times, and also revealed facility wide education had been provided to all staff in the past. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Bedrock Rehabilitation and Nursing Center at Wedge		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Carpenters Way Lakeland, FL 33809	

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #94's medical record revealed she was admitted to the facility on [DATE]. Review of the diagnosis sheet revealed diagnoses to include but not limited to: cognitive communication deficit, Alzheimer's, and need for assistance with ADLs. A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 8 of 15, which indicated moderate cognitive impairment. 50434 2. During an observation on 12/16/2024 at 9:50 a.m., a Certified Nurse Assistant (CNA) entered the room of Resident #9 and turned the light on. The staff member did not knock, announce themselves or let Resident #9 know they were coming in and turning the light on. During an observation 12/16/2024 at 11:09 a.m., a housekeeping staff member was observed entering room [ROOM NUMBER] without knocking or announcing himself. During an observation on 12/17/24 at 2:19 p.m., two housekeeping staff members entered room [ROOM NUMBER] without knocking or announcing themselves. They were working on replacing the privacy curtain. They did not speak to the residents to tell them what they were doing. 3. During an observation on 12/18/2024 at 10:03 a.m., a CNA was observed entering Resident #22's room, they flipped the light switch on, walked to Resident #22's bed and knocked on the foot board of the bed, stating It's time to get ready for Dialysis. During an interview on 12/18/2024 at 10:45 a.m., Staff H, CNA, stated before she entered a resident's room, she would knock or announce herself before entering the rooms of the residents. She stated that in the mornings, they go in and out of different resident rooms and it was a habit to just walk into their rooms and turn their lights on without knocking or announcing themselves. During an interview on 12/18/2024 at 10:45 a.m., Staff I, CNA, stated before she entered a room she would knock on the door and announce herself. She stated, you should let the resident know you are going to turn on their lights, because some residents like having their lights off. During an interview on 12/18/2024 at 2:35 p.m., Staff F, Licensed Practical Nurse (LPN), Unit Manager stated her expectation of staff was that they knocked on doors before entering the resident's room and asked the resident if it was okay to turn their light on. During an interview on 12/18/2024 at 2:51 p.m., with Director of Nursing (DON), he stated he would expect staff to knock before entering rooms and to announce them self. A review of the Dignity policy and procedure dated 4/1/2022, was conducted and revealed the following: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. The policy interpretation and implementation section revealed; (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Residents shall be treated with dignity and respect at all times. 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self worth. 7. Residents' private space and property shall be respected at all times. a. Staff will announce themselves and request permission before entering residents' rooms.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50434 Based on observation, interview, and record review, the facility did not ensure a resident centered care plan was developed for two (#73 and #109) out of 24 residents sampled. Findings Included: 1. During an observation on 12/16/2024 at 9:32 a.m., Resident #73 was observed in his room dressed for the day with one shoe on and the other shoe off. Resident #72 was observed sitting next to his bed in a wheelchair with a blanket over his head. Attempted to interview Resident #73 and he did not respond to any questions. During an observation on 12/18/2024 at 11:30 a.m., Resident #73 was observed sitting in a wheelchair dressed for the day, in the 800 hall. Review of Resident #73 admission record revealed an admitted [DATE]. Resident #73 was admitted to the facility with diagnoses not limited to Parkinson's disease without dyskinesia, without mention of fluctuations, Mood disorder due to known psychological condition with depressive features, Major depressive disorder, recurrent, unspecified, and Post Traumatic Stress Disorder (PTSD), unspecified. Review of Resident #73's Minimum Data Set (MDS) dated [DATE] revealed in section C - Cognition, a Brief Interview for Mental Status (BIMS) score of 7 out of 15 which indicated severe cognitive impairment. Review of Section I, Active diagnosis, revealed Parkinson's disease, Malnutrition, Anxiety Disorder, Depression, Post Traumatic Stress Disorder. A review of Resident #73's care plan revealed no focus, goal, or interventions related to PTSD. During an interview on 12/18/2024 at 10:45 a.m., Staff I, Certified Nurse Assistant (CNA) stated Resident #73 had behaviors of refusing care, she stated she had worked with him for a while, so she knew how to que him to help him complete ADL care. She was not sure if Resident #73 had a diagnosis of PTSD but could see where he would because he sometimes starts asking if they are in a battlefield. She stated he was in the army for a long time. She stated that when the resident started to exhibit behaviors, she would redirect him. She stated he liked hot chocolate, so she used that as an incentive. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/2024 at 10:38 a.m., Staff J, MDS Coordinator Director, Staff K, Registered Nurse (RN), and Staff L, Licensed Practical Nurse (LPN), stated they looked at the history and physical and the physician orders, and used that to build their care plans. They usually started the individual care plan from the day the resident came in and was completed by day 6. They went to clinical meetings daily, with the Director of Nursing (DON), Unit Managers, Social Services, and Therapy. Staff J, MDS Coordinator Director discussed any changes and translated it to the team. Staff L, LPN reviewed the orders daily for any order changes. Staff L, LPN printed antibiotics that were active. The social worker would let them know the advance directives in the morning meetings and the same thing for changes to advanced directives. Social services was the one who put in the actual careplan for the advanced directive. The care plan for PTSD was included in the behavioral care plan. They stated there was not a separate care plan for PTSD. 48441 2. A review of Resident #109's Admission Record showed an admitted [DATE]. A review of Resident #109's current physician orders showed an order dated 10/30/2024 for Do Not Resuscitate A review of Resident #109's care plan showed a focus area of Advance Directive must be current and reflect the resident/family/Responsible Party's decision. [resident] current decision is: Full Code. Interventions included: -Notify staff caring for resident regarding advance directive. -Provide and renew information regarding advanced directives with resident family responsible party including DNR -Provide emotional support during decision making process -Review advanced directives decision with resident family responsible party to ensure there is still an agreement. [photographic evidence obtained] A review of the facility's policy titled, Baseline Care Plan, Comprehensive Care Plan and Ongoing Care Plan Updates, effective April 1, 2022, showed the following policy statement: Bedrock care will follow a uniform process for initiating the baseline care plan upon admission, the comprehensive care plan upon CAA completion, and ensuring care plans are updated to reflect the resident status. Baseline Care Plan: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care. The base line care plan will: Be developed within 48 hours of a residence admission (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	include the minimum health care information necessary to properly care for a resident including, but not limited to: o Initial goals based on admission orders o Physician orders, o Dietary orders o Therapy services o Social services and o PASARR recommendations, if applicable Comprehensive Care Plan: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under Any services that would otherwise be required under but are not provided due to the resident's exercise of rights under including the right to refuse treatment. Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. A comprehensive care plan must be: Develop within seven days after completion of the comprehensive assessment. o Upon completion of the resident's Comprehensive Admission MSDS /CAA's, the IDT (Interdisciplinary Team) will validate the Care Areas triggered have been addressed in the comprehensive care plans in [electronic medical records]. o After completion of the comprehensive care plans in the electronic medical record, staff nurses and interdisciplinary team members are responsible for updating the residents care plans electronically to accurately reflect changes in the residents needs and preferences. Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The services provided or arranged by the facility, as outlined by the comprehensive care plan, will: o Meet professional standards of quality. o Be provided by qualified persons in accordance with each resident's plan of care. o Be culturally competent and trauma informed.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observation, interview, and record review, the facility failed to provide care and services for three (#90, #58, and #80) of thirty-eight sampled residents related to 1. Staff did not identify and treat a skin tear on Resident #90's right arm; 2. Lack of insulin monitoring for Resident #58; and 3. Lack of monitoring for blood thinners for Resident #80. Findings included: 1. On 12/16/2024 at 10:45 a.m. and 2:30 a.m., Resident #90 was observed seated in a chair in the activities/lounge area with other residents seated next to her. Staff were in the same room either interacting with Resident #90 or interacting with other residents in this room. Resident #90 was pleasant and was able to answer simple yes and no questions. Further observations revealed Resident #90 had several wounds on her right arm. She was observed rubbing her right arm with her left hand. Her right arm had four very small scabbed over lesions as well as one open wound/skin tear that was approximately one inch by one inch in size. The wound/skin was open to air with no evidence of bandages on her arm. The resident had cognitive deficits and could not express what happened. There were two Certified Nursing Assistants, Staff C and Staff D, in the room and they were both asked if they knew what happened to Resident #90's arm. Staff C was shown the open wound/skin tear on Resident #90's right arm and she confirmed the wound/skin tear was open to air. She revealed Resident #90 picked at her arms as a behavior. Neither Staff C or Staff D could say how Resident #90 obtained the open area on her right arm. On 12/17/2024 at 7:20 a.m. Resident #90 was observed in the secured unit seated in a chair in the activities lounge. She was observed dressed for the day and was wearing a short sleeved shirt. Resident #90's right arm was again observed with an open wound/skin tear which was approximately one inch by one inch in size. Her arm was observed without a bandage. Staff E, Licensed Practical Nurse (LPN) was in the immediate area, at her medication cart and preparing medications for other residents in the room. Staff E said she was familiar with all the residents in the unit and she had two aides who were working with her today. Staff E said she knew Resident #90 and that she predominantly spoke Spanish. Staff E said the resident had impaired cognition preventing her from speaking about her medical care. Staff E could not remember if Resident #90 had any recent falls without first looking at her medical record. She confirmed the wound/skin tear on Resident #90's right arm was one inch by one inch in size, with slight drainage and was open to air. Staff E revealed she was not sure what happened or how long ago the wound/skin tear happened. She was able to say the resident picked at the wound and that was why there was no bandage on it. Staff E then looked in the record and revealed the skin tear happened as a result from room mate altercation on around 12/5/2024. Review of Resident #90's medical record revealed she was admitted to the facility on [DATE]. Review of the current diagnosis sheet revealed diagnoses to include but not limited to: Muscle weakness, Need for assistance with personal care, Dementia, and Alzheimer's. Review of the current Physician's Order Sheet dated for the month of 12/2024, revealed the following but not limited to: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Clean right leg with NSS, apply xeroform and covered with adhesive gauze until heal. Keep clean and dry - Every night shift and x 8 hrs as need for management. (12/17/2024) 2. Monitor laceration to head until heal x shift for 1 month. (11/19/2024) 3. Weekly skin sweeps x night shift x Monday (10/21/2024) Review of the nurse progress notes dated from admitted [DATE] through to current 12/18/2024 did not reveal any type of wound/skin tear on Resident #90's right arm. Further, there was no documentation identifying any incidents that created a large wound/skin tear on her right arm. Review of the Nurse Weekly skin observation sheets dated, revealed: 1. 11/24/2024 - Blank with nothing documented. No documentation to support skin tear on R arm. 2. 11/26/2024 - Blank with nothing documented. No documentation to support skin tear on R arm. 3. 12/3/2024 - Checked Yes for skin issues Note for location revealed; Healing scab to front of head scalp. There was no documentation to support skin tear on R arm. 4. 12/10/2024 - Blank with nothing documented. No documentation to support skin tear on R arm. 5. 12/17/2024 - Checked yes for skin issues. Documentation in notes revealed healing scab to right forearm and forehead. Note: This note identified old scabbed areas, but did not indicate the current open skin tear on the right arm. On 12/18/2024 at 11:55 a.m., Staff F, LPN, 500/600/700 revealed the resident had been identified in the record and progress notes of an incident between Resident #90 and another resident on 12/5/2024 and that Resident #90 received a laceration on her head. Staff F revealed there was no evidence of a skin tear on the right arm during that incident. Staff F revealed she could not find any documentation that supported identifying that skin tear until the review of yesterday's evening (12/17/2024) nursing assessment. Staff F did not know Resident #90 had a skin tear on her right arm on 12/16/2024 or 12/17/2024 and not until it was brought to her attention on the morning of 12/18/2024. She revealed it is an expectation that staff were observing the resident and doing skin checks on a daily basis. She could not say why this skin tear was not identified and reported/investigated on 12/16/2024 at the very least. Staff F further confirmed there was no documented evidence of the Physician and family being notified of this R arm skin tear. 48441 2. A review of Resident #58's Admission Record showed an initial admitted [DATE] with a recent readmitted [DATE]. According to the Admission Record, Resident #58 had diagnoses not limited to Type II Diabetes and heart failure. A review of Resident #58's current physician orders showed the following orders related to his diabetes: -Empagliflozin oral tablet 25 milligrams (mg) give one tablet by mouth one time a day (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Insulin Glargine subcutaneous solution pen-injector 100 units/milliliter (u/ml), inject 25 units subcutaneously at bedtime for DM (Diabetes Mellitus) On 12/19/2024 at 11:46 a.m., an interview was conducted with Staff M, Licensed Practical Nurse/Unit Manager (LPN/UM). Staff M stated when administration of any injectable insulin, a resident would have a finger stick to check their blood sugar. Staff M stated this was a routine practice and when the order was in the medical record there was the opportunity to check the blood sugar prior to injection of insulin. Staff M stated Resident #58 had Lantus, brand name for Glargine, ordered at nighttime and agreed the resident should have his blood sugar checked prior to administration. Upon review of Resident #58's physician orders, Staff M stated there were no physician orders to check the blood sugar prior to administration nor orders to monitor the resident for any potential side effects and/or adverse effects for a diabetic patient. A review of Resident #58's care plan dated 12/15/2024, showed a focus are of Diabetes Mellitus with interventions to include but not limited to: -Blood sugar as ordered by doctor. - Check all of body for breaks and skin and treat promptly as ordered by doctor. -Diabetes medication as ordered by doctor. Monitor and document for side effects and effectiveness -Monitor/document/ report PRN (as needed) any signs and symptoms of hyperglycemia. -Monitor/document/report PRN any signs and symptoms of hypoglycemia. On 12/19/2024 at 3:30 p.m., an interview was conducted with the primary physician for Resident #58. The primary physician for Resident #58 stated he was very familiar with the resident. The primary physician stated Resident #58 had recently returned from the hospital. The primary physician stated normally we would check the resident's accu-check for the first three days to determine further determination of the resident's insulin regimen and/or blood sugar check frequencies. The primary physician stated hypoglycemia was more of a concern for residents on insulin injectable. The primary physician agreed Resident #58 should have had his blood sugar checked for the first three days minimum upon his return to the facility. Upon request for a policy and/ or procedure for monitoring a resident on injectable insulin, the facility denied such policy existed in their facility. 50434 3. During an interview on 12/16/2024 at 12:15 p.m., Resident #80 was observed in bed dressed in a hospital gown. Resident #80 was observed with a dark red liquid flowing from her nose into her mouth. Resident #80 had a towel over her shoulder that had bright red spots on it. Resident #80 stated she had been having nosebleeds frequently. She stated any time she moved her head or sneezed her nose started to bleed. She stated staff was aware of it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/2024 at 4:00 p.m., Resident #80 stated she had not had a nose bleed today. Resident #80 was observed to not have her oxygen cannulas on and the oxygen compression machine was off. She stated she was very happy that she had not had a nosebleed today. Review of Resident #80's admission record revealed an admitted [DATE]. Resident #80 was admitted to the facility with diagnoses not limited to nonrheumatic aortic valve stenosis, acute embolism and thrombosis of unspecified deep veins of right lower extremity, and atherosclerotic heart disease of native coronary artery without angina pectoris. Review of Resident #80's Quarterly Minimum Data Set (MDS) dated [DATE] Section C. Cognitive, revealed a Brief Interview for Mental Status (BIMS) of 14 out 15 which indicated intact cognition. Review of Section GG, Functional Status revealed no impairment to upper/lower extremity. Resident #80 was dependent for toileting. Set up or clean up assistance eating, shower/bathe. Review of Section N, Medications revealed Antidepressant, Anticoagulant, Opioid, Antiplatelet. Review of Section O, Special Therapy, Oxygen therapy, Continuous. Review of Resident #80's Medical Record revealed: Orders: Start Date: 11/22/2023 Clopidogrel Bisulfate Oral Tablet &5 mg (Clopidogel Bisulfate) give one tablet by mouth one time a day related to atherosclerotic heart disease of native coronary artery without angina pectoris Start Date: 10/18/2024 Eliquis Oral Tablet 5 MG (Apixaban) give one tablet by mouth two times a day for Deep Vein Thrombosis (DVT) Start Date: 11/24/2023 Anticoagulants- check for bleeding and bruising Q shift every shift for monitoring Review of Resident #80's Orders revealed no orders for the monitoring of Nosebleeds. Review of Resident #80's Medication Administration Record (MAR) for December revealed: Clopidogrel Bisulfate Oral Tablet 5 MGF nosebleeds (Clopidogel Bisulfate) was given December 1st through December 19th. Eliquis Oral Tablet 5 MG (Apixaban) was given December 1st through December 18th. Anticoagulants- check for bleeding and bruising Q shift every shift for monitoring was completed for December 1st through December 18th with no indications of bleeding. Review of Resident #80's Care Plan dated 03/08/2024 revealed: Focus: [Resident #80] is on anticoagulant therapy Goal: [Resident #80] will be free from discomfort or adverse reactions related to anticoagulant use through the review date (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions: [Resident #80] is on anticoagulant therapy-Administer Anticoagulant medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Labs as ordered. Report abnormal lab results to MD. Monitor/document/report PRN adverse reactions of anticoagulant therapy. Review of Resident #80's care plan revealed no focus, goal or interventions related to Nosebleeds. Review of Resident #80's progress notes revealed: 09/16/2024-Hospice Note: Hold Plavix x 7 days Hold Eliquis x 7 days for epistaxis 08/19/2024 HX of Progress Note CC: Epistaxis focusing on nurse's report of nose bleeding. Per Nurse she was bleeding from both Nares. Currently on Eliquis. She is seen resting in bed, states bleeding stopped. No bleeding noted at time of assessment. Hold Eliquis for 72 hours. During an interview on 12/18/2024 at 10:45 a.m., Staff H, Certified Nurse Assistant (CNA), stated Resident #80 was a total care resident and could make her needs known. She stated Resident #80 had nosebleeds and depending on the severity of the nosebleeds they did different things. She stated, On Monday it was hard to tell if it was blood or pasta sauce on her face. She stated the resident was known to pick her nose and cause it to bleed. The staff had to keep tissues out of her room, so she was not putting them in her nose. She stated the resident's oxygen had humidity with it but the resident liked to take it off because she did not like the liquid in her nose. She stated if the nosebleed was bad she would let the nurse know. She stated she had witnessed Resident #80 sneeze and her nose began to bleed a lot. During an interview on 12/18/2024 at 11:30 a.m., Staff A, Licensed Practical Nurse (LPN), stated Resident #80 had nosebleeds and hospice was aware. She stated when Resident #80's nosebleeds they provided her with gauze. She stated if the nose bleed continued for 30 minutes she would call hospice who would tell her to stop the blood thinners. She stated sometimes if the resident was having a nose bleed and her blood thinner was due, she would just go ahead and hold it and then call Hospice for orders. She stated she used to document notes about Resident #80's nose bleeding in her charts but recently she had not been documenting notes. During an interview on 12/18/2024 at 2:35 p.m., Staff F, LPN, Unit Manager stated she was new and still getting to know who the residents were. She was not aware of Resident #80 having nosebleeds. She stated as a nurse, she would document the nosebleeds in the resident's chart. She stated she was unsure if the nurses were documenting anything about her nosebleeds. During a phone interview on 12/18/2024 at 4:47 p.m., the Medical Physician stated he was not aware of the frequency of nosebleeds. He stated he would expect staff to document the nosebleeds and communicate with him. He stated even with Resident #80 being on Hospice he would expect for them to communicate with him as well. He stated it would potentially be inappropriate for Resident #80 to continue blood thinners, while having the nosebleeds. He stated now knowing he would need to do a reconciliation of her medication, a gradual dose reduction (GDR) and do an exam of her of nose to find out what might be causing nosebleeds. Review of the facilities policy dated April 1, 2022, titled Charting and Documentation revealed: Policy Statement (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedrock Rehabilitation and Nursing Center at Wedge	1010 Carpenters Way Lakeland, FL 33809

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All services provided to the resident, or any changes in the residence medical or mental condition, shall be documented in the residence medical record. Policy Interpretation and Implementation 1. Observations, medications administered, services performed, etcetera, will be documented in the resident's clinical records. A. The facility utilizes the methodology of charting by exception. 2. Injuries may only be recorded in the residence clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy. Certified nursing assistants may only make entries in the residents' medical chart as permitted by facility policy. 3. Incidents, accidents, or changes in the residence condition must be recorded. 4. Information documented, in the resident's clinical record is confidential and may only be released in accordance with state law and facility policy. 5. To ensure consistency and charting and documentation of the resident's clinical record, only approved abbreviations and symbols may be used when recording entries in the residents clinical records. 6. Documentation of procedures and treatment shall include care specific details and shall include at a minimum A. the date and time the procedure/treatment was provided B. The name and title of the individual who provided the care C. The assessment data and/or any unusual findings obtained during the procedure/treatment D. How the resident tolerated the procedure/treatment E. Whether the resident refused the procedure/treatment F. Notification of family, physician or other staff, if indicated G. The signature and title of the individual documenting Review of the facilities policy dated April 1 2022, titled Change In Condition revealed: Policy The facility will notify the resident, his or her attending physician, and are representative of changes in the residence medical mental condition and or status (e.g, changes in level of care). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Change in the resident status or condition can be addressed by a staff member. The staff member noticing a change in the residence condition shall report to the nursing supervisor/charge nurse and initiate further evaluation. The nurse or the nursing supervisor/charge nurse should: Policy Interpretation and Implementation 1. Notify the residents attending physician or on call physician when there has been: D. I need to alter the residence medical treatment H. Instructions to notify the physician or physician extender of changes in the residence condition. 8. The nurse/nurse supervisor/charge nurse will record in the residence medical record information relative to changes in the residence medical mental condition or status. All attempts to notify the attending physician and the party responsible will be documented. The facility was asked to provide a policy on monitoring a resident on anticoagulants and a policy was not provided.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50434 Based on observation, interview, and record review, the facility failed to ensure communication between the facility and the Dialysis Center for one (#22) out of 24 residents sampled. Findings Included: During an interview on 12/16/2024 at 9:50 a.m., Resident #22, stated he had concerns about not receiving medications on time. He stated that he had had a cough for a few weeks and what they were giving him was not working. During an interview on 12/18/2024 at 10:00 a.m., Resident #22, stated he reminded staff to check his vitals when he got back from dialysis. He stated they did not check his AV (Arteriovenous) fistula when he returned from dialysis. During an observation on 12/18/2024 at 10:00 a.m., a red binder was observed on Resident #22's bedside table. Inside the binder was a Communication Sheet, dated 12/16/2024, with Resident #22's name, room number, and vitals pre-dialysis and post dialysis on it. There was no other writing on the sheet. Review of Resident #22's admission record revealed an admitted [DATE] and a re-admitted [DATE]. Resident #22 was admitted to the facility with diagnoses not limited to of muscle wasting and atrophy, unspecified abnormalities of gait and mobility, need for assistance with personal care, type 2 diabetes, legal blindness, dependence on renal dialysis, end stage renal disease, and major depressive disorder. Review of Resident #22's Minimum Data Set (MDS) dated [DATE] revealed Section C. Cognitive, a Brief Interview Mental Status (BIMS) of 15 out of 15 which indicated intact cognition. Review of Section GG, Functional Status revealed no impairment to upper/lower extremity, set up and clean up assistance with eating, oral hygiene, personal hygiene. Supervision Touching for toileting hygiene, upper/lower body dressing. Partial moderate assistance for shower/bathe. Review of Section O. Special Treatments revealed dialysis. Review of Resident #22's medical record revealed: Progress Notes: No progress notes were found for communication with dialysis. Miscellaneous Document Tab: Review of the Misc tab revealed progress notes from dialysis for the dates of 12/16/2024, 12/10/2024, and 11/272024. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/2024 at 10:45 a.m., Staff H, Certified Nurse Assistant (CNA) stated Resident #22 was a blind resident but could do a lot for himself. She stated she helped him get to the bathroom. She stated during mealtimes she made sure he knew where the plate was and where everything on his plate was located. She stated he was on dialysis and went on Monday, Wednesdays and Fridays. She stated she made sure he was up and dressed for his 12:00 p.m., chair time. During an interview on 12/18/2024 at 11:30 a.m., Staff A, Licensed Practical Nurse (LPN) stated Resident #22 was a blind resident who was on dialysis. She stated Resident #22 had a binder that he took with him to dialysis and dialysis would add notes to the book for communication. During an interview on 12/18/2024 at 2:35 p.m., Staff F, Licensed Practical Nurse (LPN), Unit Manager, stated residents on dialysis had a communication book they used. She stated residents took it with them to dialysis and dialysis sent it back with the resident. She stated the dialysis center had not been putting any notes in the books, so they called and requested the report. She thought the communication sheets from the book got scanned into the Electronic Medical Record (EMR). During an interview on 12/18/2024 at 2:51 p.m., the Director of Nursing, (DON) stated they had paper tools that allow them to communicate with dialysis. He stated dialysis was not writing on the form so they requested their reports weekly, on Mondays. He stated when they called, they checked to see if there were any changes in orders, or concerns with weights. He stated they hold the reports in a book located at the nurse's station for the dietician to review on Tuesdays. Once the dietician reviewed the reports it was scanned into the miscellaneous folder of the resident's EMR. During an interview on 12/18/2024 at 5:00 p.m., the DON brought a 128-page fax of dialysis reports for Resident #22. The fax cover page was dated 12/18/2024. The DON stated he requested for them today because he wanted to make sure he had them all. He stated all the notes were not in Resident #22's EMR because they do not have a full-time medical records clerk. Photographic evidence obtained. During an interview on 12/18/2024 at 5:30 p.m., the DON brought in Resident #22's dialysis communication book and revealed there was no new communication from dialysis in the book and stated he would have to call them to get the report. During an interview on 12/19/2024 at 10:19 a.m., the Dietician stated for dialysis residents she called the dialysis dietician directly and got the post dry weights and the target dry weights. She documented her notes in the resident's EMR. She updated her notes every quarter or as necessary. She stated Resident #22 just triggered to have his weights reviewed this week. She stated she just got a hold of dialysis center today. She stated she trusts the weights that were in his chart because he had been stable. She stated that she did not review dialysis reports weekly. Review of the facilities policy dated April 1st, 2022, titled dialysis communication, revealed, Purpose To provide ongoing communication and collaboration between the nursing home and dialysis provider regarding dialysis care and services, assessment of the resident's condition and ongoing monitoring for complications as needed. Policy (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility will utilize the dialysis communication forum each time a resident attends dialysis as a tool to relay pertinent information regarding the residence condition and coordinate care and services with the dialysis provider. Procedure 1. The licensed nurse will complete & the portions of that it dialysis communication forum that includes A. the facility's name and contact information B. Code status C. Allergies D. Diet E. The name and contact information for the dialysis center where the resident will be receiving treatment. F. Who transported the resident to dialysis G. Resident vital signs H. Medications administered I. PermaCath or shunt condition prior to dialysis J. Any change in condition, physician orders or lab work completed since the residents' last dialysis treatment K. What time does the resident left for dialysis L. The resident's full name date of birth attending physician medical record and room numbers 2. The licensed nurse will document any changes in condition and the MRI. 3. The original dialysis communication form will be sent with the resident to dialysis. 4. The bottom portion of the form will be completed and signed by the dialysis center personnel. Information included in this section A. Residents vital signs including pre and post dialysis weight. B. Dialysis start and end times C. Any new recommendations from the dialysis center (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. PermaCath/shunt site condition E. Any change in condition including any event that may have occurred while at dialysis F. Lab values G. Medications received at dialysis 5. The completed form will then be sent back to the nursing home with the resident or transportation company. 6. The receiving nurse will review the dialysis communication form for any pertinent information or recommendations to be addressed. 7. The licensed nurse will document any changes in condition and the ER. 8. A copy of the dialysis communication form will be maintained as part of the residence medical record.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 20536 Based on observation and interview, the facility failed to ensure residents and visitors were provided with an updated/current Daily Staffing Census posting during one of four days observed. Findings included: On 12/16/2024 at 9:00 a.m., the building was entered and met with Staff B, the front desk receptionist. While in the lobby and at the front desk, the Daily Census Staffing Form was observed placed in a clear plastic envelope and placed where residents and visitors could view it. Review of the Daily Census Staffing Form revealed it was dated 12/15/2024, which was the previous day from this observation. It was determined the front lobby desk did not have the up- to- date Daily Census Staffing form for review. Interview with Staff B revealed she was not sure who was responsible for updating the form, but she knew the form was usually updated every day to reflect accurate nursing numbers for each shift. Staff B confirmed the form was not reflective of the current date. On 12/19/2024 at 7:37 a.m., an interview with Staff G, Staffing Coordinator revealed she was the staff member who typically updated the Daily Census Staffing form Monday through Fridays and would update and change the form in the morning when she came in; which was typically at 7:00 a.m. or a little after 7:00 a.m. Staff G said when she was not working on most weekends, a weekend nurse supervisor would update the form and place the updated form on the reception desk in the front lobby. Staff G confirmed the lobby front desk was the only place where this form/document was kept for visitor/residents review. Staff G confirmed she was not able to get to the Daily Census Staffing form on Monday 12/16/2024 in a timely manner. She also confirmed the form was not accurate to reflect that date, and it was reflective of day 12/15/2024. A review of the Posting Direct Care Daily Staffing Numbers policy and procedure dated 4/6/2022, revealed: Facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. The policy interpretation and implementation section revealed; (Directly responsible for resident care means that individuals are responsible for residents' total care or some aspect of the residents' care including, but not limited to, assisting with activities of daily living (ADL), performing gastrointestinal feeds, giving medications, supervising care given by CNAs, and performing nursing assessments to admit residents or notify physician's of change of condition.) 1. The information record on the form shall include: a. The name of the facility. b. The date for which the information is posted. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. The resident census at the beginning of the shift for which the information is posted. d. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift; 1) Registered Nurses 2) Licensed Practical nurses or licensed vocational nurses (as defined under State law). 3) Certified Nurse Aides. e. Clear and readable format. f. In a prominent place readily accessible to residents and visitors. 2. Public access to posted nurse staffing data. The facility will, upon oral or written request, make nurse staffing data available. 3. The previous shift's forms shall be maintained with the current shift form for a total of 24 hours of staffing information in a single location. Once a form is removed, it shall be forwarded to the Director of Nursing Services' office and filed. 4. Inquiries concerning our direct care staffing information should be referred to the Director of Nursing Services or the Administrator.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observation, interview, and record review, the facility failed to ensure all resident room bathrooms were provided and maintained with a fully operational call light system in one of six hall//units, to include the 600 hall/unit. Findings included: On 12/16/2024 at 9:30 a.m., 2:00 p.m., 12/17/2024 at 8:00 a.m., 1:00 p.m., 12/18/2024 at 2:00 p.m., and 12/19/2024 at 7:28 a.m. the following resident rooms were observed in the 600 secured/dementia unit: 1. room [ROOM NUMBER] bathroom metal hand rail had a white fabric call cord wrapped and tied to the wall hand rail. It was tied and wrapped in a manner that prevented it to appropriately actuate the call system if pulled below the hand rail. 2. room [ROOM NUMBER] bathroom wall mounted call system was missing a cord to pull and actuate the alarm. 3. room [ROOM NUMBER] bathroom hand rail had a white fabric call cord wrapped and tied to the wall hand rail. It was tied and wrapped in a manner that prevented it to appropriately actuate the call system if pulled below the hand rail. 4. room [ROOM NUMBER] bathroom wall mounted call system was missing a cord to pull and actuate the alarm. 5. room [ROOM NUMBER] bathroom hand rail had a white fabric call cord wrapped and tied to the wall hand rail. It was tied and wrapped in a manner that prevented it to appropriately actuate the call system if pulled below the hand rail. 6. room [ROOM NUMBER] bathroom hand rail had a white fabric call cord wrapped and tied to the wall hand rail. It was tied and wrapped in a manner that prevented it to appropriately actuate the call system if pulled below the hand rail. On 12/19/2024 at 7:30 a.m., interviews with Staff C and Staff D, Certified Nursing Assistants (CNAs), both confirmed the above listed resident room bathrooms with either missing call light cords, or call light cords that were wrapped around the bathroom wall hand bars. Staff C and Staff D also confirmed if a resident were on the floor in the bathroom, they would either not be able to reach the cord because it was missing, or would not be able to pull on the cord to make it actuate due to being wrapped or tied around the hand bar. Staff C and staff D revealed they usually observed rooms and bathrooms for safety and equipment maintenance but there were times when the residents in this dementia/secured unit would pull off the cords or mess with the cords. Staff C and Staff D confirmed they should have caught those missing cords and cords tied around the hand rails before. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/19/2024 at 7:47 a.m., an interview with Staff F, 500/600/700 Unit Manager, confirmed call light cords should be within reach when the resident was in bed as well as within reach and accessible in the resident bathrooms. Staff F confirmed there were several resident bathrooms that were either missing call light cords or cords wrapped around on hand rails, making it difficult to actuate the call system should a resident need to use it. Staff F confirmed the 600 unit was a dementia/secured unit and most of the residents do not use the call light due to their cognitive deficits. However, all call lights needed to be maintained to use in both resident rooms and resident bathrooms, as well as a community shower room. The Director of Nursing (DON) provided the Call Bells policy and procedure dated 4/1/2022, for review. The Policy stated; It is the policy of the facility that all residents are to have access to call bells at all times, even if it is generally believed that the resident is unable to use it. Staff are expected to be as vigilant as possible in keeping the call bell within reach of the resident. It is acknowledged that some residents have the capability to remove or move away from the call bell. The facility provides a variety of types of call bells to assist each resident in having the best means of communicating with staff. The call system must be accessible to residents: - While in their bed - Other sleeping accommodations within the resident's room and for situations where the resident chair is on the opposite side of the call light, a manual bell will be offered/ The System must be accessible to residents who sustain a fall The guidelines section of the policy revealed; 1. Explain and demonstrate the use of the call light to the new resident. 2. Be sure the call light is plugged in and within reach at all times. 3. Report any defective call lights to Maintenance. 4. Residents should be provided with an alternate device to alert staff of need. 5. Answer the resident's call light courteously and as soon as possible. Photographic evidence was obtained.