STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106036	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Healthcare and Rehabilitation Center and Reh	124 W Norvell Bryant Hwy Hernando, FL 34442

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for 2 of 9 residents reviewed for nutrition (Residents #35 and #54).Findings include: 1) Review of Resident #35's Weights and Vitals Summary showed the resident weight was 157 lbs (pounds) on 11/3/2024, and 141.1 lbs on 5/1/2025, which is a 10.13% weight loss. Review of Resident #35's physician order dated 2/3/2025 read, Frozen Nutritional Treat two times a day for at risk for malnutrition/PCM [Protein Calorie Malnutrition]/weight loss. Review of Resident #35's quarterly MDS assessment dated [DATE] showed no weight loss documented under Section K0300- Weight Loss. During an interview on 6/18/2025 at 10:23 AM, the Registered Dietician stated. [Resident #35's name] has been on my radar past two months. She triggered for 10% weight loss over the past 6 months. During an interview on 6/18/2025 at 2:10 PM, the MDS Coordinator stated, [Resident #35's name] MDS Section K was coded incorrectly. I would have to check with the dietician and correct it. [Resident #35's name] has had weight lost in the last 6 months. During an interview on 6/18/2025 at 2:30 PM, the Director of Nursing stated, The facility follows RAI [Resident Assessment Instrument] manual [for MDS assessment]. 2) Review of Resident #54's physician order dated 5/2/2023 read, House Shake Regular three times a day for nutritional supplement offer 120 ml [milliliter] and document amount consumed. Review of Resident #54's physician order dated 7/5/2023 read, Regular diet mechanical soft texture, thin consistency, fortified foods with all meals related to unspecified dementia with behavioral disturbance. Review of Resident #54's quarterly MDS assessment dated [DATE] showed no therapeutic diet documented under Section K- Swallowing/Nutritional Status. Review of Resident #54's Dietary Profile dated 5/5/2025 read, Current Nutritional Supplement(s): B1. House Shake. List other Dietary Interventions . B2. Fortified Foods. During an interview on 6/18/2025 at 2:09 PM, the MDS Coordinator stated, [Resident #54's name] is on supplements and a fortified diet. Therapeutic diet should have been marked yes. It will need to be corrected.

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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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to coordinate assessments for the residents with newly evident or possible serious mental disorder for 1 of 3 residents reviewed for mood and behavior (Resident #80). Findings include: Review of Resident #80's Preadmission Screening and Resident Review (PASRR) dated 11/23/2022 showed no diagnosis or suspicion of serious mental illness or intellectual disability. Review of Resident #80's admission record showed the resident was admitted on [DATE] with the diagnoses including cognitive communication deficit (onset date of 1/14/2023), dementia with psychotic disturbance (onset date of 10/20/2023), delusional disorders (onset date of 1/17/2025), other specified persistent mood disorders (onset date of 1/17/2025), recurrent major depressive disorder (onset date of 10/11/2024), and generalized anxiety disorder (onset date of 11/17/2023). Review of Resident #80's physician order dated 2/21/2025 read, Olanzapine Oral Tablet 10 mg [milligrams] (Olanzapine), Give 10 mg by mouth at bedtime related to Delusional Disorders. During an interview on 6/19/2025 at 4:02 PM, the Director of Nursing stated, The PASRR is incorrect, and a new one should be completed. During an interview on 6/19/2025 at 1:46 PM, the Regional Nurse Consultant stated that a new PASRR should be completed. Review of the facility policy and procedures titled Role of Admissions and Social Services in PASRR with the last review date of 12/19/2024 read, Policy: The facility will ensure each resident in a nursing facility is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs by coordinating with the appropriate, State-designated authority. The facility will ensure that individuals with a mental disorder or intellectual disabilities continue to receive the care and services they need in the most appropriate setting, when a significant change in their status occurs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to revise the comprehensive care plan after a significant change for 1 of 6 residents reviewed (Resident #96). Findings include: During an interview on 6/17/2025 at 4:00 PM, Resident #96 stated, I have not had dialysis for over 2 weeks. My access dressing has not been changed. It fell off and a nurse put this gauze over it. They are checking to see if my kidney function is better. During an interview on 6/17/2025 at 4:10 PM, Staff E, Licensed Practical Nurse (LPN), stated, [Resident #96's name] last day of dialysis was 5/29/2025. Kidney function is being evaluated. No dressing changes are performed by LPNs. Only RNs [Registered Nurses] can perform dressing changes for CVC [Central Venous Catheters]. When dialysis was started, there was an order that dialysis catheter dressing to be changed at dialysis center. There is no current order for dressing changes. Review of Resident #96's care plan read, [Resident #96's name] has potential for complications related to hemodialysis for treatment of ESRD [End Stage Renal Disease]. Right-sided tunneled dialysis catheter placed 4/14/2025. Receives dialysis on: Tues [Tuesdays], Thurs [Thursdays], & Satur [Saturdays] @ [at] 9 AM. Receives dialysis at [name and phone number of the dialysis center]. Further review of the care plan did not show that dialysis treatments had been placed on hold after the last treatment date of May 29, 2025. During an interview on 6/18/2025 at 2:08 PM, the Minimum Data Set (MDS) Coordinator, stated, [Resident #96's name] should have had her care plan revised to reflect dialysis being placed on hold. I will be updating the care plan. During an interview on 6/18/2025 at 4:47 PM, the Director of Nursing (DON) stated, Care plan should be revised to update that [Resident #96's name] dialysis is on hold and a call needs to be placed to the physician regarding hemodialysis central venous catheter access care and dressing change since dialysis is not seeing the resident to change the dressing. Review of the facility policy and procedures titled Comprehensive Assessments and Care Plans with the last review date of 12/19/2024 read, It will be the standard of this facility to make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS [Centers for Medicare and Medicaid Services] . Guidelines . 10. The plan of care reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

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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. Based on observation, interview, and record review, the facility failed to ensure residents received health care services consistent with professional standards of practice for 1 of 1 resident with central venous catheter (Resident #96) and 1 of 3 residents reviewed for wound care (Resident #54). Findings include: 1) During an observation on 6/17/2025 at 4:00 PM, Resident #96 was sitting in her wheelchair watching TV. There was a clean gauze over dialysis central venous catheter access site. The dressing was not dated. During an interview on 6/17/2025 at 4:00 PM, Resident #96 stated, I have not had dialysis for over 2 weeks. My access dressing has not been changed. It fell off and a nurse put this gauze over it. They are checking to see if my kidney function is better. During an interview on 6/17/2025 at 4:10 PM, Staff E, Licensed Practical Nurse (LPN), stated, [Resident #96's name] last day of dialysis was 5/29/2025. Kidney function is being evaluated. No dressing changes are performed by LPNs. Only RNs [Registered Nurses] can perform dressing changes for CVC [Central Venous Catheters]. When dialysis was started, there was an order that dialysis catheter dressing to be changed at dialysis center. There is no current order for dressing changes. During an interview on 6/19/2025 at 12:30 PM, the Assistant Director of Nursing (ADON) stated, I have placed a call to the nephrologist, but have not received a return call. During an interview on 6/19/2025 at 3:30 PM, the Director of Nursing (DON) stated, A call was placed to the dialysis center requesting to have the nephrologist call our facility and the dialysis facility stated the nephrologist will fax to our facility an order regarding CVC [Central Venous Catheters] dressing/site care in the morning. Review of Resident #96's physician order dated 4/17/2025 read, Dialysis catheter dressing to be changed at Dialysis Center. Review of Resident #96's physician orders showed an order dated 5/2/2025 for dialysis on Tuesdays, Thursdays, and Saturdays with the chair time being from 9:00 AM to 1:00 PM. Review of Resident #96's progress noted authored by the DON on 5/30/2025 at 5:17 PM read, Spoke with [dialysis center’s staff name] from [dialysis center’s name]. She stated [Nephrologist’s name] gave an order to hold dialysis for 2 weeks. Transport and patient aware. During an interview on 6/19/2025 at 4:25 PM, the DON stated, We do not have a policy for care of hemodialysis central venous catheters. 2) Review of Resident #54’s progress noted dated 5/8/2025 read, Noted resident pressure injury on the coccyx area. Assessed resident status and checked for any other injury. Provided wound care and secured with a CDD (Clean Dry Dressing). Notified MD [Medical Doctor] and family. Will continue to monitor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #54’s Nursing PRN (as needed) skin check dated 5/8/2025 showed skin breakdown on the coccyx area. Review of Resident #54’s physician orders did not show an order for wound care. Review of Resident #54’s Treatment Administration Record for May 2025 and June 2025 did not show any wound care to the coccyx area. During an interview on 6/19/2025 at 10:00 AM, Staff N, Certified Nursing Assistant (CNA), stated, “[Resident #54’s name] has an open area in her back side. The nurses apply zinc cream to the area.” During an observation on 6/19/2025 at 10:03 AM with Staff D, Licensed Practical Nurse (LPN), and Staff N, CNA, Resident #54’s coccyx area had a small elongated open area approximately 2 centimeters with loss of the epidermal layer. During an interview on 6/19/2025 at 3:08 PM, Staff O, Registered Nurse (RN), stated, When we find any open area, we must inform the provider and the Director of Nursing. Basically, put a dressing and have the wound care nurse look at it. The unit manager would let the wound care nurse about the wound and orders would be put in the system. I don't know why there are no orders in the system. Last time I checked, it was improving. I checked about two weeks ago. No concerns had been reported to me. The nurse is the one responsible for the would care. The wound care nurse comes once a week. During an interview on 6/19/2025 at 3:12 PM, Staff P, CNA, stated, [Resident #54's name] has an open area on her back. I noticed a few weeks ago. The nurses occasionally put cream on it. During an interview on 6/19/2025 at 3:23 PM, the DON stated, I don't remember if someone called me to tell me [Resident #54's name] had a new open area. The staff are supposed to call me and call the provider. They are supposed to get an order, and the unit manager makes sure to put it in the system and wound care would see the patient. [Resident #54's name] wound must have gotten overlooked. Review of the facility policy and procedures titled Wound Care with the last review date of 12/19/2024 read, Policy: It will be the policy of this facility to provide assessment and identification of residents at risk of developing pressure injuries, other wounds and the treatment of skin impairment. Procedure… 6. Wound care procedures and treatments should be preformed according to physician orders… 10. Document in the clinical record when treatment are performed. 11. Document the progression of the wound being treated. Such observations should include items size, staging (if applicable), odors, exudate, tunneling, etiology, etc.

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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. Based on observation, interview, and record review, the facility failed to ensure residents received appropriate respiratory care consistent with professional standards of practice for 2 of 6 residents reviewed for respiratory care (Residents #29 and #96).Findings include: 1) During an observation on 6/17/2025 at 10:05 AM, Resident #29 was receiving oxygen via a portable oxygen tank attached to her wheelchair at 2 liters per minute. An oxygen concentrator was to the right of the bed and did not have a bottle of water attached to provide humidity. During an interview on 6/17/2025 at 10:18 AM, Resident #29 stated, I feel I am not getting enough oxygen. Activated call light. I think my oxygen should be on 3 liters per minute. Review of Resident #29's physician order dated 5/2/2025 read, Oxygen at 2-4 liters/minute via nasal cannula with humidity to maintain O2 [oxygen] saturation above 90% PRN [as needed] every 1 hours as needed related to chronic obstructive pulmonary disease. During an observation on 6/17/2025 at 2:00 PM, Resident #29 was self-ambulating in hallway while in a wheelchair with nasal cannula in place receiving oxygen at 3 liters per minute without humidity. During an observation on 6/18/2025 at 8:50 AM, Resident #29 was in her wheelchair at bedside, receiving oxygen from the concentrator at 3 liters per minute. There was no water bottle attached to the concentrator. During an interview on 6/18/2025 at 8:50 AM, Resident #29 stated she was not getting air from O2 tank. O2 gauge was set at 3 liters per minute and the level in O2 tank was close to red level (empty). Resident #29 activated the call light and Staff B, Licensed Practical Nurse (LPN), responded to the call light and Resident #29 informed the nurse she needed another tank. Staff B attached the resident to oxygen concentrator while another staff member went to get another oxygen tank. During an interview on 6/18/2025 at 11:45 AM, the Director of Nursing (DON) stated, When the resident is moved to a wheelchair and needs continuous oxygen, staff should check the tank to see how much is left in the tank. The order for humidity should be followed as ordered. During an observation on 6/19/2025 at 8:35 AM, Resident #29 was sitting in her wheelchair, receiving oxygen at 3 liters per minute without humidity. 2) During an observation on 6/17/2025 at 4:00 PM, Resident #96 was sitting in her wheelchair watching television. CPAP mask was hanging from the bed rail. The bag was not dated and was on top of the bedside table. During an interview on 6/17/2025 at 4:00 PM, Resident #96 stated, Staff did not put the mask back in the bag and should not have it hanging from my bed. Review of Resident #96's physician order dated 6/9/2025 read, Continuous Positive Airway Pressure (CPAP) every shift. During an interview on 6/17/2025 at 4:10 PM, Staff E, LPN, stated, CPAP mask should be placed in the bag and not hung on the side of the bed. Review of the facility policy and procedures titled Respiratory Care with the last review date of 12/19/2024 read, Policy: It is the policy of this facility to provide respiratory care and safe oxygen administration to meet the needs of the residents. Procedure: 1. Verify that there is a physician's order for respiratory procedures or oxygen use. Review the physician's orders for oxygen administration, nebulizer treatments, inhalers, trach care, chest tube/PleurX care, BiPAP [Bilevel Positive Airway Pressure], CPAP or medication administration. 6. BiPAP and CPAP respiratory equipment should be used per physician orders and maintain infection control techniques. 8. Oxygen therapy may be humidified or non-humidified, depending on the needs of the resident, the plan of care or physician orders. A portable oxygen cylinder (e-tank) may be utilized when appropriate to allow for resident portability or may be provided by a concentrator or piped in oxygen.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure that it was free of medication error of five percent or greater. The error rate was 5.88%.Findings include: During an observation on 6/18/2025 at 5:05 AM, Staff L, Licensed Practical Nurse (LPN), donned personal protective equipment and entered Resident #82's room. Staff L cleaned the needleless connector and flushed with normal saline, followed by a 5-milliliter heparin flush. Staff L cleaned the needleless connector and the tubing connector, connected the intravenous tubing and started the infusion. During an interview on 6/18/2025 at 6:04 AM, Staff L, LPN, stated, Normally I do a heparin flush before and after medication administration. Review of Resident #82's physician order dated 5/20/2025 read, Heparin Lock Flush Solution 10 unit/ml [milliliter] use 10 ml intravenously every shift for flush. During an interview on 6/18/2025 at 12:28 PM, the Director of Nursing (DON) stated, I would like nursing staff to follow physician orders, and the protocol would be based on the orders. I would follow the SASH [Saline, Administer medication, Saline, Heparin] protocol. During an interview on 6/19/2025 at 1:57 PM, Medical Doctor #1 stated, There are no side effects, but the nurse should follow SASH protocol. Review of the facility's Competency Chelcist: IV [Intravenous] Flush Procedure read, Objective: Ensure proper technique and adherence to infection control protocols when flushing an intravenous (IV) line to maintain patency and prevent complications. Competency Criteria. 2. IV Flush Procedure. Aspirates gently to check for blood return (if required by facility protocol . If using heparin flush (per protocol), follows appropriate dosage and administration guidelines. 2) During an observation on 6/18/2025 at 7:45 AM, Staff M, LPN, prepared and crushed all medications individually for Resident #73. Staff M poured and crushed one 20-milligram tablet of Omeprazole Delayed Release into a medication cup. Staff M entered Resident #73's room. Staff M set work area and checked the placement for Resident #73's gastric tube. Staff M was getting ready to administer the medication. The surveyor requested Staff M to stop and exit Resident #73's room for an interview. During an interview on 6/18/2025 at 7:45 AM, Staff M, LPN, stated, Delayed release medication should not be given via g-tube [gastrostomy tube]. I will have to contact the provider and get the order updated. Review of Resident #73's physician order dated 1/12/2025 read, Omeprazole Oral Capsule Delayed Release 20 MG (Omeprazole), Give 1 capsule via G-Tube one time a day for GERD [Gastroesophageal Reflux Disease]. During an interview on 6/18/2025 at 9:50 AM, the DON stated, Nurses should call provider before administering any medication they have questions about and clarify the order before giving the medication. Delayed release should not be given via gastric tube. Review of the facility policy and procedures titled Medication Administration Via Enteral Feeding Tube with the last review date of 12/19/2024 read, Policy: Medications shall be prepared and administered according to the following established guidelines. Common Medications Not to Crush: Some medications and dosage form should not be crushed. If there are any questions regarding the crushing of medications, call the pharmacy.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to accommodate resident food preferences for vegetarian residents for 1 of 9 residents reviewed for nutrition (Resident #11). Findings include: During an observation on 6/16/2025 at 12:16 PM, Resident #11 was eating in her room independently. The resident's meal ticket highlighted the words vegetarian meals add ranch dressing. Meal tray contained scalloped potatoes, cabbage, which contained small pieces of scattered bacon, corn bread, and a dessert (Photographic evidence obtained). During an interview on 6/16/2025 at 12:16 PM, Resident #11 stated, The cabbage has bacon, and I will not eat it because I do not eat bacon, since I am a vegetarian. The food options for a vegetarian are very poor. Review of Resident #11's physician order dated 8/23/2022 read, NAS (No Added Salt) diet, Regular texture, thin consistency, for diet VEG [vegetarian]. Review of Resident #11's Dietary Profile dated 3/7/2025 read, Current Diet Order: NAS, Regular, Vegetarian. Food Allergies/Intolerances: No known food allergies. Narrative Note: Resident continues on a NAS, Vegetarian diet with regular textures and thin liquids. Her PO [by mouth] intake is good, and her weight is stable. During an interview on 6/19/2025 at 10:55 AM, Staff J, Certified Nursing Assistant (CNA), stated, [Resident #11's name] did verbalize she had gotten bacon on her cabbage, but did not want her plate removed because she would eat the scallop potatoes. During an interview on 6/19/2025 at 10:58 AM, the Certified Dietary Manager (CDM) stated, When the line starts, the dietary aide will go ahead and call out the food items. The cook is the one placing the items in the plate and then another dietary aide will check the plate before going on the cart. I spoke to the cook and he does not recall. I had two types of cabbage, one that did not have bacon and one that had bacon, and different utensils were used. [Resident #11's name] is vegetarian, and we provide her with choices she often refuses. During an interview on 6/19/2025 at 11:05 AM, Staff K, Cook, stated, [Resident #11's name] is a vegetarian. No one came back regarding cabbage with bacon. This has never happened, and I am unable to recall the type of cabbage she got. During an interview on 6/19/2025 at 2:50 PM, the Director of Nursing stated, Nurses should check meal tray and make sure preferences are honored. The CDM does the resident preferences, and they are done frequently. Nursing will also fill out a diet slip for communication with the kitchen. Review of the facility policy and procedures titled Meal Distribution with the last review date of 12/19/2024 read, Policy: It is the policy of this facility that meals are transported to the dinning locations in a manner that insures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner. Procedure. 4. The nursing staff shall be responsible for verifying meal accuracy and timely delivery of meals to residents/patients. Review of the facility policy and procedures titled Provide Diet to Meets Needs of Each Resident with the last review date of 12/19/2024 read, Policy: The purpose of the food and nutrition services (FNS)/dietary department is to provide high quality, nutritious, palatable and attractive meals in a safe, sanitary manner. Food will be prepared in a form to accommodate resident allergies, intolerances, and personal, religious and cultural preferences, based on reasonable effort.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to ensure medical records were complete and accurate for 1 of 6 residents reviewed for medication management (Resident #108).Findings include: Review of Resident #108's physician order dated 5/9/2025 read, Humalog Kwikpen Subcutaneous Solution Pen-injector 100 unit/ml [milliliter] (Insulin Lispro), Inject as per sliding scale: if 0-150= 0 units if BS [Blood Sugar] less than 60 initiate hypoglycemic protocol and notify MD [Medical Doctor], 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units if BS greater than 400 give 12 units and notify MD, subcutaneously before meals and at bedtime related to type 2 diabetes mellitus with hyperglycemia. Review of Resident #108's Medication Administration Record (MAR) for administration of Humalog Kwikpen for June 2025 showed no entries documented for blood sugar and insulin coverage on 5/18/2025 at 6:30 AM. Review of Resident #108's MAR for administration of Humalog Kwikpen for June 2025 showed no entries documented for blood sugar and insulin coverage on 6/4/2025 at 6:30 AM. During an interview on 6/18/2025 at 12:24 PM, the Director of Nursing stated, Staff are expected to document accurately and make sure medication administration record is filled out as required. During an interview on 6/19/2025 at 8:32 AM, Staff H, Licensed Practical Nurse (LPN), stated, I don't know why there is a blank on the documentation. I remember doing his [Resident #108] accu-check. If I don't recall incorrectly, it was 174 and he needed coverage. I remember there was a situation with another resident. It might have been missed documentation, but I did do his blood sugar check and insulin administration. During an interview on 6/19/2025 at 12:59 PM, Staff I, LPN, stated, I cannot answer why it is blank. I can speculate and say something was happening. I am very familiar with him and I always make sure to check his blood sugar and provide coverage I leave him for last with three other residents because we have a routine since he goes to sleep late at night so I do him closer to 5:30. I cannot tell you why is blank, but I always document on my residents and do his accu-check as ordered. Review of the facility policy and procedures titled Medication Administration with the last review date of 12/19/2024 read, Policy: It will be the policy of this facility to administer medications in a timely manner and as prescribed by the physician, unless otherwise clinically indicated or necessitated by other circumstances such as lack of availability of medication or refusals of medications by the resident. Procedure. 9. The individual administering the medication must initial the resident's MAR on the appropriate line and date for specific day when administering the next resident's medication. If the facility is utilizing Electronic Health Records (EHR) and eMAR, an electronic signature is appropriate. 14. When medications are administered, the individual administering the medication must record in the resident's medical record/MAR. Review of the facility policy and procedures titled Charting and Documentation with the last review date of 12/19/2024 read, Policy: It is the policy of this facility that services provided to the resident, or any changes in the resident's medical condition, shall be documented the resident's clinical record as is needed. Procedure: 1. Observations, medications administered, services performed, etc., should be documented in the resident's clinical records.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106036	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Healthcare and Rehabilitation Center and Reh	124 W Norvell Bryant Hwy Hernando, FL 34442

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure staff used appropriate personal protective equipment (PPE) while providing care to the residents who were on transmission-based precautions for 1 of 2 residents reviewed for contact precautions (Resident #82) and failed to ensure staff performed hand hygiene during meal distribution. Findings include: 1) During an observation on 6/17/2025 at 8:33 AM, Staff A, Certified Nurse Assistant (CNA), entered Resident # 82's room without donning personal protective equipment (PPE). Staff A exited the resident room with a breakfast tray and placed the tray in the food cart. There was a PPE supply and Transmission Based Precautions -Contact Isolation signage posted on Resident #82's room door. During an interview on 6/17/2025 at 8:34 AM, Staff A, CNA, stated, I should have worn gown and gloves. Review of the facility policy and procedure titled “Transmission Based Precautions” with the last review date of 12/19/2024 read, Contact Precautions: Contract precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, spread by direct or indirect contact with the resident or the resident's environment… Guidelines for Contact Precautions… Gloves… 2. Wear gloves whenever touching the resident’s intact skin or surfaces and articles near the resident (e.g. medical equipment, bed rails). [NAME] gloves upon entry into the room or cubicle… Gowns 1. [NAME] gown upon entry into the room or cubicle. Remove gown and observe hand hygiene before leaving the resident care environment. 2) During an observation on 6/18/2025 at 8:36 AM, Staff D, Licensed Practical Nurse (LPN), performed hand hygiene and removed a tray from the meal cart in the dining room. Staff D walked over to Resident #64, who was sitting in the common dining room in the memory care unit, and set up her breakfast. Staff D asked Resident #64 if she would like jelly on her breakfast. Without wearing gloves, Staff D applied the jelly, touching the edges of the bread with her bare hands. Staff D returned to the breakfast cart and performed hand hygiene, removed another tray and walked over to Resident #54 and set up breakfast meal. Staff D asked Resident #54 if she would like jelly on her bread and proceeded to spread the jelly on Resident #54's bread, touching the edges of the bread and readjusting the bread on the plate with her hands without wearing gloves. Staff D returned to the breakfast cart and applied hand sanitizer. Staff D delivered another tray to Resident #76. Staff D asked Resident #76 if she would like jelly on her bread and applied the jelly, touching the bread while applying it without wearing gloves. During an interview on 6/18/2025 at 9:54 AM, the Director of Nursing stated, Staff should use gloves when touching food items for residents. During an interview on 6/18/2025 at approximately 10:30 AM, Staff D, LPN, stated, I am fairly new to the unit and the aides usually assist the residents. I should have worn gloves, but I had sanitized my hands and did not wear them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106036	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Healthcare and Rehabilitation Center and Reh	124 W Norvell Bryant Hwy Hernando, FL 34442

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedures titled Meal Distribution with the last review date of 12/19/2025 read, Policy: It is the policy of this facility that meals are transported to the dinning locations in a manner that insures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner. Procedure… 5. Proper food handling techniques to prevent contamination and temperature maintenance will be used during meal delivery and at point of service dining.