STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106144	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apopka Health and Rehabilitation Center	2001 Alston Bay Blvd Apopka, FL 32703

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview and record review, the facility failed to ensure an effective discharge planning process to prevent a delay in provision of necessary care and services after discharge from the facility for 1 of 4 residents reviewed for discharge planning, out of a total sample of 48 residents, (#166). Findings: Review of the medical record revealed resident #166 was admitted to the facility on [DATE] with diagnoses including left hip fracture, abnormal gait and mobility, weakness, stroke with left side weakness and paralysis, and brain cancer. The face sheet indicated the resident was discharged home with family on 1/23/24, with no Home Health Care (HHC) services. The Minimum Data Set (MDS) Discharge - return not anticipated assessment, with assessment reference date of 1/23/24, revealed resident #166 required supervision or touching assistance for bathing and lower body dressing, and set up assistance for placing or removing footwear and completing personal hygiene tasks. Review of the medical record revealed resident #166 had a care plan for wish to be discharged to his prior living arrangement, initiated on 1/03/24. The interventions included establish a pre-discharge plan with the resident and family, evaluate progress, and revise the plan as needed. The document indicated Social Services staff and nurses would make arrangements with required community resources such as HHC and physician services to support the resident's independence post discharge, and prepare and give the resident, family member, caregiver contact numbers for all community referrals as indicated. A care plan for activities of daily living (ADL) self-care performance deficit initiated on 1/03/24, revealed resident #166 needed assistance with ADLs due to weakness and fatigue. A care plan for actual skin impairment, initiated on 1/17/24 revealed resident #166 developed a left buttock abscess in the facility. The interventions included administer and apply ointments as ordered by the physician and report any changes in skin status. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed resident #166 had a physician order dated 1/22/24 for discharge home with all medications and HHC for skilled nursing, physical therapy, and occupational therapy services. Another order dated 1/22/24 indicated the resident was to be discharged home with wound care orders to, cleanse the left buttock wound with [normal saline], pat dry, apply skin prep to the peri-wound, apply Mupirocin 2% [antibiotic] ointment to the wound bed, cover with a superabsorbent pad, cover with gauze, cover with a waterproof island border dressing. The physician order revealed wound care and dressing changes were to be done once daily and as needed. Review of an Interdisciplinary Discharge Home form dated 1/19/24 revealed resident #166 had a planned discharge scheduled for 1/23/24. The document included contact information for the HHC agency that was to provide the physician-ordered services in the resident's home. The facility's Rehabilitation Director noted the resident required a commode and a wheelchair. However, the facility's Social Services Director (SSD) at that time added a final discharge note that indicated resident #166 did not require arrangements for durable medical equipment as he had all necessary items. The Discharge Form revealed resident #166 left the facility with his son on 1/23/24 at approximately 10:00 AM. On 4/01/24 at 12:53 PM and 4/05/24 at 8:49 AM, in a telephone interview, resident #166's son explained he had concerns regarding his father's transition from the facility to home. He recalled he was told the HHC agency would order all necessary medical equipment, but that did not happen. The son stated his father was not independently ambulatory, and he required a significant amount of assistance to get into and around the house as he was not provided with a walker. The resident's son said, When I contacted the Home Health Care company, I was informed that my father was not in their network. I received a follow up call from the same company telling me the facility was having a hard time finding a home healthcare company that was in [insurance] network. The son explained he called the facility and spoke with the Business Office Manager (BOM) about his concerns. He explained the facility never arranged the HHC services for his father and he had to purchase a walker and do the dressing changes until he found a HHC agency, with the assistance of personnel at the initially referred HHC agency, that took his father's insurance. The resident's son said, I was taken aback that I had to arrange home health myself. On 4/02/24 at 4:15 PM, the BOM confirmed resident #166's son called the facility on the day his father was discharged home. She said, He was beyond ballistic that his father could not get [medical equipment] and [the Home Health Care agency] did not take his insurance. The BOM stated she immediately notified the previous SSD by telephone and he stated it was a misunderstanding with the insurance company as services should be covered. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/02/24 at 4:27 PM, the Administrator stated she became aware of issues surrounding resident #166's discharge when his son posted a negative online review in February 2024, approximately one month after the resident left the facility. She stated the previous SSD arranged home health services with [name of HHC agency] and the resident was discharged on [DATE]. The Administrator provided email communication dated 1/22/24, the day before discharge, from the HHC agency to the facility with notification that they checked the resident's insurance and discovered they were not in his network. The Administrator stated the previous SSD communicated with the staff at the HHC agency who informed him they would forward the referral to another HHC agency. Review of an email from the second HHC agency revealed resident #166's start of care date for skilled nursing and therapy services was 1/26/24, three days after discharge from the facility. The Administrator confirmed she did not know the staff at the first HHC agency, but she relied on their promise regarding making arrangements with the second HHC agency. She acknowledged the facility's Social Services department, not an outside provider, was ultimately responsible for planning and ensuring a safe discharge. On 4/02/24 at 5:44 PM, the facility's Senior SSD validated if discharge referrals fell through while resident #166 was still in the facility, it was possible to extend the resident's stay if another referral could not be made in a timely manner. She acknowledged there was no documentation by the previous SSD of any issues related to the discharge or confirmation of another HHC referral. The Senior SSD validated it was not acceptable that the resident was discharged home without the care and services ordered by the physician. She explained Social Services staff were expected to oversee discharge arrangements and provide necessary follow-up. On 4/03/24 at 4:15 PM, the Rehabilitation Director confirmed resident #166 required a walker for mobility and prior to discharge, Social Services staff were to order medical equipment and arrange for delivery to ensure the resident's safety at home. On 4/05/24 at 8:29 AM, the Wound Nurse recalled when she last assessed resident #166's buttock wound it had drainage. She said, Treatments should be done as ordered. If ordered daily it should be done to allow for assessment and healing. The Wound Nurse explained the topical antibiotic was necessary for healing, and if the dressing was not changed, there was increased risk of infection and maceration of the skin caused by moisture from the drainage. The facility's policy and procedure for Discharge Planning Process, revised 3/21/21, read, The facility will develop and implement an effective discharge planning process that focuses on the resident's discharge goals.and effectively transition them to post-discharge care. The document indicated the discharge planning process began with identification of each resident's goals and needs and continued with development, implementation, and evaluation of interventions throughout the resident's stay to ensure a successful discharge. The policy revealed the facility would identify post-discharge needs to include nursing and therapy services, and medical equipment.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on interview and record review the facility failed to ensure medical records were accurate pertaining to splint application for 1 of 1 resident reviewed for Range of Motion (ROM)/Mobility, (#66), and failed to ensure medical records were accurate, and systematically organized for 1 resident (#136), of a total sample of 48 residents. Findings: 1. Resident #66, a [AGE] year-old male was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included hemiplegia and hemiparesis following cerebral infarction (stroke) affecting his right dominant side, aphasia (inability to speak), major depressive disorder, conversion disorder with seizures or convulsions, and weakness. The resident's physician's order dated 10/23/23 directed staff to apply a splint to his right wrist following morning care, and to doff the splint prior to bedtime. Instructions were, Monitor skin integrity when applying and removing, discontinue wear if skin becomes red or pt (patient) is in pain. Review of the resident's Treatment Administration Record (TAR) for the period 3/01/24 through 4/03/24 revealed that nurses signed off on the task. However, there was ambiguity pertaining to what was being signed off, the donning of the splint, or the monitoring of the resident's skin integrity. Observations on 4/01/24 at 11:50 AM, 4/02/24 at 10:00 AM, and on 4/02/24 at 3:42 PM, showed resident #66 sitting up in bed watching television. The resident had right hand weakness and did not have a splint on. The splint was noted on the resident's chest of drawers. Resident #66 said the splint was not placed by Therapy, and when asked who placed the splint on, the resident's response was no one. On 4/03/24 at 11:28 AM, and at 11:35 AM, Licensed Practical Nurse (LPN) J stated the resident's right hand splint was placed by the Certified Nursing Assistant (CNA) or Therapy, and nurses signed off on the TAR to indicate that the splint was applied. Observation of the resident conducted with the LPN, showed no splint to the resident's right hand, and the splint was again noted on the resident's bedside table. This was acknowledged by the LPN, who also acknowledged the physician order to don the right hand splint following morning care, and to doff prior to bedtime. LPN J stated the administration details on the resident's TAR revealed documentation and signatures by nurses which indicated the splint was applied, and there were no problems. LPN J's signature was noted on the resident's TAR fourteen (14) times for the period reviewed. On 4/03/24 at 11:39 AM, CNA L stated he worked on the 7 AM to 3 PM shift and provided care for resident #66. He stated the resident required total assistance with activities of daily living, and he was aware of the resident's splint. CNA L said he had not signed off on the task for donning the resident's splint and confirmed PT had not been applying the splint. He said the resident's splint had not been applied for a couple of days, since the resident was no longer on therapy caseload, and he could not apply the splint since he was not trained to don/doff the splint. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/04/24 at 9:47 AM, the Assistant DON (ADON) reviewed physician orders for resident #66, and stated the order pertaining to the splint was inclusive of donning the splint and monitoring skin integrity. The ADON stated she was not sure if nurses were checking off regarding donning the splint or for monitoring of the resident's skin integrity. She stated they should be checking for skin integrity prior to applying the resident's splint. On 4/04/24 at 10:00 AM, LPN K stated she signed off on the resident's TAR to indicate she monitored the resident's skin for redness, irritation, and pain. LPN K verbalized that on 4/01/24, she did not apply the resident's splint, but signed off on the TAR for monitoring the resident's skin integrity. LPN K's signature was noted on the resident's TAR three (3) times for the period reviewed. 2. Resident #136 was admitted to the facility on [DATE] and readmitted on [DATE] after an acute care hospitalization . Her diagnoses included metabolic encephalopathy, hemiplegia/hemiparesis following cerebral infarction (stroke) affecting the left non dominant side, acute and chronic respiratory failure, dysphagia following cerebral infarction, tracheostomy status, gastrostomy status, diabetes type II, major depressive disorder, and hypertension. Review of the resident's Electronic Medical Record (EMR) revealed the Provider progress notes dated 5/20/23, 6/11/23, 6/14/23, 6/23/23, 7/07/23, 8/12/23, 9/03/23, 9/22/23, 9/24/23, 10/08/23, 11/12/23,12/11/23, 12/24/23,1/05/24, 1/09/24, 1/25/24, 1/27/24, 1/31/24, 2/05/24, and 2/21/24 for another resident were uploaded to resident #136's EMR. A total of twenty (20) progress notes in resident #136's medical record did not belong to resident #136. On 4/04/24 at 2:47 PM, the Regional Director of Clinical Services reviewed the resident's EMR, and acknowledged scanned documents were for another resident. She stated the facility's Health Information Coordinator was currently on leave, and findings would be reported to the Executive Director, who would contact the facility's legal department for correction of the affected residents' EMR. On 4/04/24 at 3:06 PM, resident #136's EMR was reviewed with the Executive Director. She acknowledged the Provider progress notes uploaded to the resident's EMR for the dates listed belonged to another resident. The Executive Director stated it, Looked like an oversight, and verbalized she had contacted the facility's Corporate office and informed them of the discrepancy. When asked who reviewed EMR to ensure accuracy, the Executive Director stated she did not know who reviewed the residents' EMRs to ensure documents uploaded belonged to the correct resident. The Standards and Guidelines: Disposition of Medical Records after Scanning/Imaging issued 2/19/2016, and revised 3/27/21 read, Documents should be scanned and uploaded individually .Ensure that the document was uploaded to the correct patient's EHR (Electronic Health Record).