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

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility failed to promote the right to self-administer medication for 2 of 7 residents reviewed for choices, out of a total sample of 48 residents, (#87 and #161). Findings: 1. Review of the medical record revealed resident #87 was admitted to the facility on [DATE] with diagnoses including accidental poisoning by unspecified drugs, spinal stenosis, abnormality of gait and mobility, and weakness. The Minimum Data Set (MDS) Significant Change in Status assessment with assessment reference date (ARD) of 2/01/24 revealed resident #87 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated he had moderate cognitive impairment. The document revealed the resident had no behavioral symptoms and did not exhibit inattention, disorganized thinking, or altered level of consciousness in the look back period. The MDS assessment showed resident #87 received scheduled and as needed pain medication for occasional, moderate pain. Review of the medical record revealed a care plan for potential and/or actual pain was initiated on 7/25/23. The goals were the resident would not experience an overall decline in function or have an interruption in normal activities due to pain. The interventions included administer pain medication as ordered and monitor for effectiveness, consider premedication for treatments, and report changes in type and location of pain. On 4/02/24 at 10:07 AM, a bottle of Biofreeze was observed on resident #87's tray table. The container was approximately 1/3 full and the resident explained he purchased the medication and used it regularly. He said, I put it on my legs and CNAs [Certified Nursing Assistants] put it on my back. Biofreeze is a topical medication used to treat muscle or joint pain. The manufacturer's instructions read, Use exactly as directed on the label, or as prescribed by your doctor. (Retrieved on 4/08/24 from www.drugs.com/mtm/biofreeze.html). (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/02/24 at 10:11 AM, the 400 unit Unit Manager (UM) explained residents were not permitted to keep any medication at the bedside unless there was a physician order for the drug and the resident was assessed for the ability to self-administer the medication safely. The UM was not aware resident #87 had a container of Biofreeze in his room. He reviewed the resident's electronic medical record (EMR) and stated there was no physician order for Biofreeze and no documentation of an assessment for safe self-administration of medication. On 4/02/24 at 10:14 AM, resident #87's assigned nurse, Licensed Practical Nurse (LPN) M validated the bottle of Biofreeze remained on the resident's tray table. The resident informed LPN M he had been using the medication and wanted to keep it in his room. 2. Review of the medical record revealed resident #161 was admitted to the facility on [DATE] with diagnoses including right hip fracture, neuropathy, and generalized muscle weakness. The MDS Admission assessment with ARD of 3/18/24 revealed resident #161 had adequate hearing and vision. She had a BIMS score of 13 which indicated she was cognitively intact. On 4/02/24 at 9:21 AM, resident #161 had a box with a bottle of eye drops on her tray table. The pharmacy label on the box indicated the bottle contained Polymyxin B-Trimethoprim Ophthalmic Solution to be administered to the left eye, four times daily. The resident also had a small tube of antibiotic ointment on the tray table. The resident pointed across the room at a box of Refresh lubricant eye drops and explained she had been using the non-prescription eye drops but it had not been effective. She stated she called her eye doctor who prescribed new eye drops, and her husband retrieved the medication from the pharmacy. Resident #161 stated she managed her medications at home, and she had been doing her own eye drops, which she kept in her room, since admission to the facility. On 4/02/24 at 10:35 AM, LPN O checked resident #161's room and discovered Polymyxin B-Trimethoprim eye drops with a box of Refresh eye drops. She confirmed all medication used in the facility required a physician order. LPN O explained resident #161 was not supposed to have any medication at the bedside unless she was assessed to verify she was capable of safely administering her own medication. Polymyxin B and Trimethoprim ophthalmic solution is a medication used to treat bacterial eye infections (retrieved on 4/08/24 from www.drugs.com/mtm/polymyxin-b-and-trimethoprim-ophthalmic.html). On 4/02/24 at 10:52 AM, the 300 unit UM validated residents were not allowed to have medication in their rooms unless facility staff completed the appropriate self-administration assessment. She explained if staff determined the resident could safely administer her medication, a nurse would obtain physician orders for the medication and authorization to keep it at bedside. The 300 unit UM acknowledged the facility's policy and procedures were not implemented. Review of the Order Summary Report revealed as of 4/02/24 at approximately 11:00 AM, there was no physician order for resident #161's eye drops and no assessment to show the resident was capable of administering her medications safely. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure for Self-Administration of Meds, revised on 3/27/21, read, . residents who wish to self-administer their medications may do so, if it is determined that they are capable of doing so. The guidelines indicated staff would assess the resident's mental and physical abilities to determine if he/she was capable of self-administering medications. The policy revealed the assessment would include the resident's ability to read and understand labels, comprehension of the purpose and proper dosage and administration times, and the ability to recognize the risks and side effects of medications. The document indicated medications would be stored in a safe and secure place in the resident's room and nurses were responsible for documenting the doses administered by the resident.

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48878 Based on observation, interview, and record review, the facility failed to honor resident's rights to choose their preferred shower days and time for 1 of 9 residents reviewed for choices, of a total sample of 48 residents (#21). Findings: Review of the medical record revealed resident #21 was admitted to the facility on [DATE] and readmitted on [DATE] from the hospital. Her diagnosis included hemiplegia and hemiparesis following cerebral infarction (stroke) affecting left non-dominant side, morbid (severe) obesity, abnormalities of gait and mobility, heart failure, and type 2 diabetes. Resident #21's Quarterly Minimum Data Set (MDS) with an assessment reference date of 3/15/24 revealed the resident scored 15 out of 15 on the Brief Interview for Mental Status which indicated she did not have cognitive impairment. The MDS assessment also indicated resident #21 required maximal assistance with bathing and participated in her assessment and goal setting. The MDS assessment dated [DATE] revealed it was very important to the resident to choose her bathing preferences. It also noted the resident did not exhibit behavior symptoms or rejection of care necessary to achieve the resident's goals for health and well-being. Review of resident #21's medical record revealed a care plan was initiated on 1/18/22. The care plan indicated the resident expressed personal and lifestyle preferences with goals that included resident's preferences would be honored as able and interventions that included showers as her bathing preference on Monday, Wednesday, and Friday during the day shift. The bathing task report for resident #21 noted her scheduled shower days were Tuesday and Fridays on the 3-11 shift. In March and April 2024, the task report revealed she had a bed/towel bath on Tuesday, March 5th, at 10:50 PM. Additionally, she received showers on Friday, March 8th, at 6:06 PM and the following Tuesdays: March 12th, at 10:48 PM, March 19th, at 10:16 PM, and March 26th, at 8:38 PM. However, the task report indicated she refused bathing on the following Fridays: March 15th, at 8:16 PM, March 22nd, at 7:49 PM, and March 29th, at 9:59 PM, as well as on Tuesday April 2nd, at 9:55 PM. On 4/01/24 at 11:52 AM, resident #21 stated the Certified Nursing Assistants (CNA)s consistently offered her baths in the evening and on days she did not prefer. She conveyed she had made known to staff she preferred showers on Monday, Wednesday, and Fridays, however, staff insisted those were not her shower days and did not accommodate her preference. On 4/03/24 at 1:04 PM, CNA H confirmed resident #21 received showers on the 3-11 PM shift. On 4/03/24 at 11:33 AM, resident #21 stated she was again offered a shower the previous evening, Tuesday, April 2nd, but declined because she was feeling tired. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/03/24 at 11:45 AM, the Licensed Practical Nurse Unit Manager (UM) on the 200 unit accessed resident #21's care plan and confirmed the care plan, initiated on 1/18/22, indicated the resident preferred to receive showers on Mondays, Wednesdays, and Fridays during the day shift. Upon checking the resident's CNA task report, she commented the resident was scheduled to receive showers on Tuesday and Friday during the 3-11 shift, rather than the preferred day shift. The UM acknowledged resident #21's current shower schedule did not honor the resident's choices and stressed it was very important the resident received showers on the days and times she selected, as it was her right. On 4/03/24 at 12:40 PM, the Assistant Director of Nursing stated resident #21's care plan indicated a preference for showers on Monday, Wednesday, and Friday during the day. She verified the resident's scheduled shower days were Tuesday and Friday in the evening, which did not honor the resident's choices. She emphasized the importance of ensuring resident #21's right to receive showers on the days she preferred. The facility's Resident Right's policy read, The facility will ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility .The facility will make every effort to assist each resident in exercising his/her rights .observing resident's choices whenever able .The facility will provide for residence and reception of services with reasonable accommodation of resident needs and preferences .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35086 Based on observation, interview and record review, the facility failed to ensure resident's wishes for a Do Not Resuscitate Order (DNRO) were honored for 1 of 3 residents reviewed for hospice, of a total sample of 48 residents (#151) . Findings: Resident #151 was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included cerebral infarction (stroke), acute kidney failure, idiopathic pulmonary fibrosis (lung scarring of unknown origin), acute respiratory failure, repeated falls, weakness, anxiety, depression, and dysphagia (difficulty swallowing). The Admission Minimum Data Set assessment with Assessment Reference date [DATE], revealed the resident's cognitive status was intact with a Brief Interview of Mental Status score of ,d+[DATE]. The assessment indicated she required partial to moderate assistance with her activities of daily living. Review of the resident's physician orders on [DATE] revealed an Advanced Directive order dated [DATE] for full code. This order conflicted with an order dated [DATE] which was signed by the resident and hospice physician for DNRO. The yellow DNRO order was noted in the Hospice notebook found on the counter of the 300-unit nurses' station. The current comprehensive care plan initiated on [DATE], showed resident #151 to be a full code with the goal: If the resident's heart stops, or if they stop breathing, Cardio Pulmonary Resuscitation (CPR) be initiated in honor with their full code wishes. On [DATE] at 1:10 PM, resident #151 was observed in her room, alert and oriented to person, place, and time. She sat in her wheelchair feeding herself lunch and said it was her choice to have Hospice services. Review of the medical record showed a Hospice Medicare Election form signed and dated by the resident on [DATE] and a certification of terminal illness for [DATE] to [DATE] with primary diagnosis of idiopathic pulmonary fibrosis. On [DATE] at 4:01 PM, Licensed Practical Nurse (LPN) A said she was the usual day nurse for resident #151 and was familiar with her care. LPN A stated should she find the resident without a pulse or not breathing she would first look on the dashboard on the computer. LPN A confirmed the dashboard for resident #151 currently had her code status as full code, so she would call the code and start CPR. LPN A added they also have a DNR Code Status Book on the code cart which she checked and did not find a DNRO for the resident #151. LPN A verified she would not look in the Hospice notebook at the nurses' station for a residents' code status. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 4:18 PM, a telephone interview was conducted with Hospice Team manager B who verified that it was Hospice physician D who signed the DNRO order for the resident #151 on [DATE]. Hospice Team Manager B explained the process when Hospice Registered Nurse (RN) I did the admission she would have placed the DNRO form in the Hospice notebook at the nurses' station. Hospice Team manager B reviewed RN I's notes and said the nurse only mentioned having a discussion with the patient regarding the DNR but did not document any communication with the facility staff regarding the change in code status. Hospice Team manager B said she would inform Hospice Admission manager E about the concerns regarding lack of communication with the facility staff for change in code status. On [DATE] at 5 PM, the Director of Nursing acknowledged resident #151's Advanced Directive would not have been honored from [DATE] to [DATE] till brought to their attention by surveyor on [DATE]. On [DATE] at 10:19 AM, a telephone interview was conducted with Hospice Admission manager E and Hospice Clinical Team Lead F. They were informed the facility staff was not aware of the change in code status for resident #151 which was obtained by Hospice RN I while doing the admission on [DATE]. The hospice management staff was also made aware that resident went 6 weeks with potential that the facility or emergency medical staff could have performed CPR on her if her breathing or heart stopped. Admission manager E stated, she would follow up with Hospice Executive Director regarding concern the Hospice staff did not communicate code status with the facility staff regarding change in Advance Directive from Full code to DNR. Review of the facility Standards and Guidelines for Advance Directive revised [DATE] read, It will be the standard of this facility that the resident has the right to request, refuse, an/or discontinue treatment Advance Care Planning is a process of communication between individuals and their healthcare agent

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on interview, and record review, the facility failed to ensure a copy of the notice for transfer/discharge to the hospital was sent to a representative of the Office of the State Long-Term Care Ombudsman for 1 of 3 residents reviewed for hospitalization , of a total sample of 48 residents, (#136). Findings: 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 census revealed resident #136 was hospitalized on [DATE], and readmitted to the facility on [DATE]. The eInteract Change in Condition Evaluation form dated 2/29/24 indicated the resident was sent to the Emergency Department for further evaluation and treatment. Review of the resident's clinical records revealed the Nursing Home Transfer and Discharge Notice for the resident could not be found. On 4/04/24 at 3:26 PM, the Social Services Director (SSD) stated that Social Services was responsible to submit a copy of the Nursing Home Transfer and Discharge Notice to the office of the Ombudsman. She stated the notifications were submitted monthly. Review of the resident's medical record, and a binder located in the SSD's office did not reveal a copy of the Nursing Home Transfer and Discharge Notice, or any evidence to indicate a copy of the notice was submitted to the Ombudsman. This was acknowledged by the SSD, who explained she was hired three weeks ago and was told all documents would be scanned into the facility's electronic medical record. On 4/04/24 at approximately 5:00 PM, and at 5:17 PM, the SSD provided a Nursing Home Transfer and Discharge Notice for the resident dated 2/29/24. However, no documentation/evidence could be identified to indicate the notice was submitted to the Ombudsman's office. The SSD then provided a fax transmission log dated 4/01/24 for discharges for March 2024 that were submitted to the office of the Ombudsman. She stated she could not locate a transmission log to indicate discharges/transfer for February 2024 were submitted to the Ombudsman's office as required. Review of the facility's discharges revealed that fifteen (15) residents were discharged to the hospital for the period 2/01/24 to 2/29/24. The facility could not provide documentation to indicate the Ombudsman office was provided with a list/copy of the discharges for February 2024. Request to the facility for a corresponding policy/procedure regarding notification of discharges was not met.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35086 Based on interview and record review, the facility failed to complete a significant change in status assessment within the required timeframe of 14 days for 1 of 3 resident reviewed for Hospice services, of a total sample of 48 residents, (#151). Findings: Resident #151 was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included cerebral infarction (stroke), acute kidney failure, idiopathic pulmonary fibrosis (lung scarring of unknown origin), acute respiratory failure, repeated falls, weakness, anxiety, depression, and dysphagia (difficulty swallowing). The Admission Minimum Data Set assessment with assessment reference date (ARD) 1/23/24, revealed the resident's cognitive status was intact with a Brief Interview of Mental Status score of 14/15, and she required partial to moderate assistance with her activities of daily living. The assessment did not indicate resident #151 received Hospice services. Although the physician order in the electronic medical record for Hospice services was dated 3/10/24 resident #151 had signed the election for Medicare Election Statement on 2/15/24. The facility payer source showed Hospice Medicaid pending status as of 2/15/24. On 4/03/24 a telephone interview was conducted with the Hospice Case manager C who said her start of care date for Hospice services was on 2/15/24. Review of the medical record for resident #151 revealed certification of terminal illness for period dates: 2/15/24 to 5/15/24 with primary diagnosis of idiopathic pulmonary fibrosis. Review of the facility documentation in the electronic medical record showed the most recent MDS assessment with the ARD 1/23/24. No Significant Change in Status Assessment (SCSA) MDS was located in resident #151's medical record. On 4/03/24 at 4:32 PM, the Registered Nurse MDS Coordinator confirmed the SCSA had not been initiated by the facility and should have been done within 14 days when resident #151 went on Hospice 2/15/24. She stated the reason it was not done in a timely manner was due to a lack of communication between Social Services, MDS and nursing staff. She explained the usual process was at the morning or clinical meeting they would go over who went onto Hospice then they would update care plans, Advanced Directives as well as initiate the SCSA. The MDS Coordinator verified the SCSA was now out of compliance, and they were not aware till brought to their attention by surveyor. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Centers for Medicare and Medicaid Services (CMS) Resident Assessment instrument Version 3.0 Manual, October 2023 Chapter 2 Page 2-25 read, An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving their highest practicable well-being

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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** 35086 Based on observation, interview, and record review the facility failed to develop comprehensive person-centered plan of care for end-of-life care for 1 of 3 residents reviewed for Hospice, of a total sample of 48 residents, (#151). Findings: Resident #151 was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included cerebral infarction (stroke), acute kidney failure, idiopathic pulmonary fibrosis (lung scarring of unknown origin), acute respiratory failure, repeated falls, weakness, anxiety, depression, and dysphagia (difficulty swallowing). The Admission Minimum Data Set (MDS) assessment with Assessment Reference date 1/23/24, revealed the resident's cognitive status was intact with a Brief Interview of Mental Status score of 14/15, and she required partial to moderate assistance with her activities of daily living. Review of the medical record showed a Hospice Medicare Election form signed and dated by the resident on 2/15/24 and a certification of terminal illness for 2/15/24 to 5/15/24 with primary diagnosis of idiopathic pulmonary fibrosis. Further review revealed no care plan for Hospice or end-of-life care for resident #151 in her medical record. On 4/01/24 at 1:10 PM, resident #151 was observed in her room alert and oriented to person, place, and time. She sat in a wheelchair feeding herself lunch and indicated it was her choice to receive Hospice services. On 4/03/24, a telephone interview was conducted with Hospice case manager C who said resident #151's start of care date for Hospice services was 2/15/24. On 4/03/24 at 4:32 PM, the Registered Nurse MDS Coordinator acknowledged a comprehensive person center care plan was never initiated for resident #151 when she went onto Hospice service for end-of-life care on 2/15/24. She stated the reason it was not done was due to a lack of communication between Social Services, MDS and nursing staff. She explained the usual process was at the morning or clinical meeting they would go over who went onto hospice then update the care plans, advanced directives, as well as initiate the significant change in status assessment. Review of the facility policies and procedures for Comprehensive Assessments and Care Plans revised on 4/05/21 read, The facility will develop and implement a comprehensive person-centered care plan for each resident .prepared by the interdisciplinary team to formulate and advance directive and participate in advance care planning .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility failed to provide adequate assistance with activities of daily living (ADLs) related to bathing, skin care, and shaving for 2 of 3 residents reviewed for ADLs, out of a total sample of 48 residents, (#134 and #87). Findings: 1. Review of the medical record revealed resident #134 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, recurrent depressive disorder, and weakness. The Minimum Data Set (MDS) Quarterly assessment with assessment reference date (ARD) of 3/07/24 revealed resident #134 had clear speech and a Brief Interview for Mental Status (BIMS) score of 13 which indicated he was cognitively intact. The document showed during the look back period, resident #134 had no behavioral symptoms and did not reject evaluation or care that was necessary to achieve his goals for health and well-being. The MDS assessment revealed the resident depended on staff for assistance with self-care as his performance was either unsafe or of poor quality. He required partial to moderate assistance for personal hygiene and bathing, and substantial to maximal assistance for lower body dressing and putting on and taking off footwear. Review of the medical record revealed a care plan for personal and lifestyle preferences was initiated on 6/08/23. The interventions included the resident's preference for three bed baths or showers every week during the day shift. A care plan for ADL self-care performance deficit related to limited mobility, initiated on 6/03/23, had a goal the resident would be free of complications related to ADL deficit. The interventions included assistance of one to two staff for ADL care and praise all efforts at self-care. On 4/01/24 at 11:25 AM, resident #134 showed his hands and all fingernails were square-shaped with sharp edges and approximately one third inch long. The resident's hair was long and greasy and his facial hair was unkempt. The resident explained nursing staff did not cut his fingernails or shave him regularly. He stated he felt those tasks took more time than the staff wanted to spend. Resident #134 stated he received occasional bed baths, got showers approximately once monthly, and nursing staff, Pass the water through my hair once a week or so. The resident complained his hair was too long and he needed someone to check his toenails. On 4/01/24 at 11:32 AM, the 400 unit Unit Manager (UM) stated resident #134 was scheduled for baths twice weekly, on Wednesdays and Saturdays. He explained nail care was to be done on these days and additionally as needed. He validated the resident's fingernails were over 1/3 inch long and described them as, way longer than normal. The UM confirmed the resident's fingernails should definitely have been cut by staff, and nurses who completed his weekly skin checks should have noticed the issue. Resident #134 informed the UM he wanted to be shaved daily and the UM acknowledged the resident did not have a well-groomed appearance. The UM removed the resident's socks and a large amount of dried skin flakes fell from each sock, visibly landing on the mattress and forming a small pile. (continued on next page)

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Apopka Health and Rehabilitation Center	2001 Alston Bay Blvd Apopka, FL 32703

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/01/24 at 11:45 AM, the 400 unit UM provided a shower sheet dated Wednesday 3/27/24 which indicated resident #134 refused a shower but the Certified Nursing Assistant (CNA) gave a bed bath instead. The UM stated he was not able to find a shower sheet for Saturday 3/30/24. He confirmed CNAs were expected to wash the resident's entire body during a bed bath, which required removing his socks to wash his feet. The UM validated the appearance of resident #134's feet and the quantity of dried skin in his socks indicated he probably did not receive a full bed bath or shower as scheduled. Review of the 400 unit Shower Schedule revealed resident #134 was to have showers on Wednesdays and Saturdays during the 3:00 PM to 11:00 PM shift and as needed on Sundays. The document read, Please notify the nurses of any shower refusals and skin impairments. Review of nursing progress notes dated 3/01/24 to 4/05/24 revealed no documentation of refusal of ADL care by resident #134. 2. Review of the medical record revealed resident #87 was admitted to the facility on [DATE] with diagnoses including congestive heart failure, type 2 diabetes, spinal stenosis, and abnormality of gait and mobility. The MDS Significant Change in Status assessment with ARD of 2/01/24 revealed resident #87 had a BIMS score of 12 which indicated moderate cognitive impairment. The document showed the resident had no behavioral symptoms and did not reject evaluation or care that was necessary to achieve his goals for health and well-being. The MDS assessment revealed the resident required substantial to maximal assistance for bathing and partial to moderate assist for personal hygiene tasks. A care plan for ADL self-care performance deficit related to limited mobility and weakness, dated 7/25/23, revealed goals to keep the resident clean and comfortable and maintain his current level of ADL function. The interventions instructed staff to assist resident #87 with ADLs. On 4/01/24 at 11:54 AM, resident #87 had a scruffy appearance. His moustache was thick and untrimmed, and he had a significant amount of unkempt, long facial hair on his cheeks and chin. The resident explained he preferred a moustache only and staff either assisted with shaving him or he attempted to shave himself if provided with razors. He said, I've been asking all my CNAs for razors for the past three days. Nobody brings them. The resident stated no staff had offered to shave him for a while. On 4/01/24 at 12:02 PM, the 400 unit UM confirmed resident #87's facial hair was untidy and stated he definitely needed to be shaved. Review of the 400 unit Shower Schedule revealed resident #87 was to have showers on Wednesdays and Saturdays during the 7:00 AM to 3:00 PM shift and as needed on Sundays. The document read, Please notify the nurses of any shower refusals and skin impairments. Review of nursing progress notes dated 3/01/24 to 4/05/24 revealed no documentation of refusal of ADL care by resident #87. Review of the CNA job description (undated) revealed CNAs would perform necessary care and services for residents. Essential job functions and duties included, Assist residents with activities of daily living including bathing, grooming. The document revealed CNAs would ensure residents' comfort while assisting them to achieve their highest functional level. The expectation for implementation of nursing care was CNAs would provide hygiene care, nail care, bathing and grooming according to residents' plans of care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure for ADL Care and Assistance revised on 3/27/21, revealed the facility would provide residents with assistance for bathing and maintenance of personal hygiene.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on observation, interview and record review, the facility failed to ensure a right-hand resting splint was applied per physician order and the resident's plan of care, for 1 of 1 resident reviewed for range of motion/mobility, of a total sample of 48 residents, (#66). Findings: 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, major depressive disorder, conversion disorder with seizures or convulsions, and weakness. Review of the quarterly Minimum Data Set assessment with Assessment Reference date of 1/22/24, revealed resident #66 was rarely/never understood, and was assessed with functional limitation in range of motion (ROM) to one side of his upper and lower extremities. The resident's physician's order dated 10/23/23 directed staff to apply splint to his right wrist following morning care, and 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 Physical Therapy/Occupational Therapy (PT/OT) annual screen conducted on 3/05/24 revealed the, Therapist completed OT screen today (3/05/24) and found pt (patient) has decrease in RUE (right upper extremity) ROM. Recommendation: OT indicated. Review of the Occupational Therapy discharge summary for dates of service 3/05/24 through 3/25/24 revealed upper extremity resting hand splint training was provided for staff. The training sign-in sheet dated 10/16/23, indicated staff were trained how, To don/doff resting hand splint and the wear schedule was Don in AM, doff in PM 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 sat 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 applied by therapy, and when asked who applied the splint, the resident's response was, No one. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/03/24 at 11:28 AM, and at 11:35 AM, Licensed Practical Nurse (LPN) J stated resident # 66 was awake, alert, oriented, had right arm paresis/hemiplegia, wore a splint on his right hand, and was currently on therapy caseload. The LPN stated the resident's right hand splint was applied by the Certified Nursing Assistant (CNA) or therapy, and nurses signed off on the Treatment Administration Record (TAR) to indicate the splint was applied. The surveyor shared with LPN J there were no observations of resident #66 wearing his splint for the days of survey to date, and the splint was seen on the resident's bed side table. 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. 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. On 4/03/24 at 3:34 PM, the Rehabilitation Director stated once splint/orthotics had been trialed on residents, and deemed to be safe, the CNAs were trained to perform the task by therapy. The Rehabilitation Director stated when the resident was discharged from therapy, nursing staff were then responsible to apply the splint/orthotic. She stated resident #66 was discharged from OT on 3/25/24, and nursing was responsible for the splint application. On 4/03/24 at 4:00 PM, the Director of Nursing stated the expectation was for nurses to follow physician orders in the electronic medical record, and sign off on the TAR to indicate the resident's splint was applied, and skin integrity monitored. On 4/04/24 at 9:47 AM, the Assistant DON (ADON) reviewed physician orders for the resident, 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 on the TAR regarding donning the splint or for monitoring 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 if the resident was on therapy caseload, they would apply the splint, otherwise the splint would be placed by nursing staff on the unit. She 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. The facility did not provide a policy pertaining to splint application.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review the facility failed to provide care and services for an intravenous (IV) access site according to professional standards of practice to prevent infection for 1 of 1 resident reviewed for IVs, of a total sample of 48 residents, (#18). Findings: Review of the medical record revealed resident #18 was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included ischemic cardiomyopathy, moderate protein-calorie malnutrition, type 2 diabetes, and dementia. Review of the Minimum Data Set (MDS) Medicare Part A Discharge assessment with assessment reference date of 3/12/24 revealed resident #18 received antibiotic medication during the seven day look back period. Review of the medical record revealed an Infectious Disease Consultant Provider Note dated 3/26/24. The specialist physician assessed resident #18 and noted a non-healing right heel wound with osteomyelitis or a bone infection. The note read, Plan: Will start Ertapenem as the wound had a foul smell and had profuse drainage. Ertapenem is an antibiotic that is used to treat severe infections. It is administered by injection into a muscle or infused through a vein (retrieved on 4/18/24 from www.drugs.com/mtm/ertapenem.html). Review of the Order Summary Report revealed resident #18 had a physician order dated 3/27/24 for Ertapenem 1 gram IV once daily for 14 days, to treat his wound infection. There was an order dated 3/28/24 for insertion of a midline IV and orders dated 3/29/24 to change the transparent dressing every seven days and as needed. The physician orders instructed nurses to measure the external catheter length during dressing changes and observe for leakage, loosening or soiling of the dressing, and for signs and symptoms of infection, infiltration, and extravasation, or leaking from the IV into surrounding tissue. A midline catheter is a small tube that is inserted into a vein in the arm. The catheter is used to administer medications and take blood samples and can remain in place for up to 30 days. After insertion, the catheter is secured with a sterile, transparent dressing which prevents infection and permits easy monitoring of the insertion site for signs of infection. The dressing should be changed as directed or whenever it is loose, wet, or soiled, (retrieved on 4/18/24 from www.drugs.com/cg/midline-catheter.html). Resident #18 had a care plan for IV therapy related to a wound infection initiated on 3/29/24. The goal was the resident would not suffer any complications related to IV therapy. The interventions instructed nurses to change the IV dressing and maintain the IV device per the facility standard, and monitor the catheter insertion site every shift for signs of infiltration and infection. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/01/24 at 12:28 PM, resident #18 had a left upper arm IV access line with a transparent dressing dated 3/30/24 covering the insertion site. Beneath the clear dressing, there was a bloody, folded gauze pad at the insertion site. On 4/01/24 at 12:34 PM, Licensed Practical Nurse (LPN) M confirmed resident #18 had a bloody gauze under his left arm dressing. She recalled she was informed the area bled a lot when the IV was inserted. LPN M confirmed she was assigned to care for resident #18 during the 7:00 AM to 7:00 PM shift but she had not yet assessed the resident's IV access site. When asked if the dressing needed to be changed, LPN M stated she was unsure as it was scheduled once weekly. On 4/03/24 at 1:53 PM and 2:11 PM, LPN N stated she was aware resident #18 had a midline to the left upper arm. She confirmed she had not inspected the dressing since the start of the 7:00 AM shift as she would check the site close to the end of her shift when she administered his IV medication at 6:00 PM. LPN N was asked to check the resident's dressing. She confirmed there were no initials on the dressing to indicate which nurse performed IV site care and said, It's just dated, 3/30/24 on dressing. Joint observation of the transparent dressing revealed the gauze was now totally saturated with blood and yellow-colored fluid. Review of the Medication Administration Record for March 2024 revealed LPN N initialed the document to confirm she changed resident #18's IV dressing on 3/30/24. On 4/03/24 at 2:02 PM and 2:16 PM, the 400 unit Unit Manager (UM) reviewed resident #18's medical record and noted the midline was inserted on 3/28/24 but the resident pulled it out and another midline was inserted on 3/29/24. He explained the gauze must have been placed during a dressing change done over the weekend. The UM reviewed nursing progress notes and acknowledged there was no documentation of issues with bleeding at the site or the need to use gauze, and no instructions to change the dressing more frequently due to bleeding. On 4/03/24 at 2:25 PM, the Regional Director of Clinical operations assessed resident#18's left upper arm IV site and validated the bloody gauze remained under the transparent dressing for four days, since 3/30/24. She was informed when the issue was brought to LPN M's attention on 4/01/24, the nurse stated the dressing was to be changed every seven days. The Regional Director of Clinical operations confirmed the current dressing posed an infection control concern and stated her expectation was nurses would monitor IV sites appropriately and address concerns in a timely manner. On 4/03/24 at 2:32 PM, the facility's Medical Director validated the bloody gauze pad left underneath resident #18's transparent dressing placed him at risk for infection as it was a medium for bacterial growth. On 4/05/24 at 11:22 AM, the Assistant Director of Nursing (ADON) stated she discovered the gauze was placed under the resident's transparent dressing by LPN N as the site was still bleeding the day after the midline was inserted. The ADON explained if it was necessary to use gauze, the dressing should be changed every 48 hours to prevent negative outcomes. Review of the Pharmascript Infusion IV Access Line Maintenance Protocol, effective 2/07/20, revealed midline transparent dressings should be changed 24 hours after insertion and then weekly as needed. The document read, Gauze should only be used if patients are sensitive to clear, transparent dressings and must be changed[every] 2 days. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy and procedure for Site Care of Peripheral Venous Catheter, revised in February 2019, provided general guidance on routine IV insertion site inspection, site care, and application of a sterile dressing to reduce or prevent the complications of catheter related infection. The document indicated a sterile, transparent dressing would be used to cover IV sites and the dressing would be labeled with the date, the nurse's initials, and the insertion date from the previous dressing. The policy revealed nurses would document the dressing change procedure, characteristics of the site.

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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).