

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Blue Heron Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 5085 Eagleston Blvd Wesley Chapel, FL 33544	
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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 complete the Pre-admission Screening and Resident Review (PASARR) Level II for residents with qualifying mental health diagnosis for three residents (#17, #16, #8) of five residents reviewed for PASARRS. Review of Resident #17's medical record revealed the resident was admitted to facility on 12/11/2022 with diagnoses to include Alzheimer's Disease, Unspecified; Dementia in other diseases classified elsewhere, Mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; unspecified psychosis not due to a substance or known physiological condition; schizoaffective disorder, unspecified, Encephalopathy. Review of Resident #17's PASSAR level I screen dated 12/12/2022 revealed the qualifying diagnoses were not checked and recommendations for a level II PASARR were not acted upon. Review of Resident #16's medical record revealed the resident was admitted to the facility on [DATE]. Review of the resident's diagnoses active as of 7/31/25 revealed the resident had diagnoses to include Schizoaffective Disorder, Bipolar Type and Other Bipolar type. Review of Resident #16's PASARR level I screen dated 01/24/2025 revealed the qualifying diagnoses were not checked and recommendations for a level II PASARR were not acted upon. Review of Resident #16's medication orders revealed the resident was receiving Ziprasidone HCl 20 MG BID (twice daily). An interview with the DON was conducted on 7/31/2025 at 3:14 PM. The DON stated it is her responsibility to ensure the PASARRs completed by the hospital are accurate, and if the PASARR is not accurate, it is the facility's responsibility to complete the assessment again and submit a new PASARR. Upon review of Resident #17's PASSAR, The DON stated Resident #17's PASARR did not have all of the diagnoses and needs another PASARR with correct diagnoses submitted. Upon review of Resident #16's PASARR dated 1/24/2025, The DON stated the PASARR should have diagnosis of Schizoaffective Disorder, bipolar type, and Other Bipolar Disorder, and the resident #16 needs another assessment completed with the correct diagnoses. Resident #8 was admitted to the facility with diagnoses of Parkinson's disease, CHF (congestive Heart Failure), metabolic encephalopathy, generalized anxiety, bipolar disease, pseudobulbar affect, insomnia, and schizoaffective disorder. Review of a Medication Discharge Report dated 12/22/24 revealed Resident #8 was taking Seroquel 100 mg (milligrams) twice a day, Olanzapine 7.5 mg at bedtime, Lorazepam 0.5 mg at bedtime, (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
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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nuedexta 20-10 mg twice a day and Depakote 125 mg / 4 capsules at bedtime. Review of Resident #8's level I PASARR completed on 12/22/24 revealed the resident did not have mental illness or suspected mental illness. The diagnoses boxes were unchecked. An interview with the DON conducted on 7/31/25 at 03:30 PM revealed when a resident is admitted or readmitted to the facility, they review the PASRR for correctness and if needed submit a new PASRR or complete a level II PASRR if indicated. The DON stated Resident #8's PASARR should have been corrected and updated and reported not being at the facility during that time. The facility did not provide a PASARR policy.		

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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. Based on interviews, observations, and record review the facility failed to implement a plan of care for a resident at risk for dehydration for one resident (#58) of one resident reviewed. Findings included: On 07/29/25 at 09:40 AM an observation revealed Resident #58 lying in bed, eyes closed and did not respond to verbal or tactile stimuli. There was no hydration or fluids observed at bedside. During an observation on 07/29/25 at 03:00 PM, Resident #58 was observed lying in bed. There was no hydration cup or fluids at bedside. On 7/29/2025 at 3:45 PM an interview was conducted with Resident #58's family member who stated Resident #58 needed extra care and could not get a drink of water on their own. The family member stated staff should check on the resident more frequently than they do and offer fluids. During an observation on 07/30/2025 at 9:07 AM, at 12:00 PM and at 4:10 PM, Resident #58 was observed in room. A water cup was observed on the bedside table dated 7/30/25, 11 a.m. -7 p.m. shift, at 04:14 AM. The cup was observed full of ice water. On 07/31/25 at 08:35 AM Resident #58 was observed sitting up in a reclining wheelchair, eyes opened, awake alert and non-verbal. A water cup was observed on the bedside table dated 7/31/25 on 11-7 a.m. shift. This surveyor marked the water cup indicating the water level on cup to monitor how much water resident was drinking. (Photographic Evidence Obtained). On 07/31/2025 at 11:28 AM an observation was made of Resident #58 sitting up in wheelchair awake, alert and attending activities in activity room. There was no hydration or fluids observed being offered at this time. Upon entering Resident #58's room, an observation was made of the water cup sitting on bedside table with water observed at same level from an earlier observation where this surveyor marked the hydration cup. Review of resident #58's medical record revealed diagnoses of Quadriplegia, Pneumonitis, Moderate -protein calorie malnutrition, Dementia, Chronic Kidney Disease stage 3B and an Ileus. The plan of care revealed Resident #58 required assistance with ADLs (Activities of Daily Living) related to activity intolerance, dementia, impaired cognition, quadriplegia; with a goal that the resident will maintain current level of ADL function. The interventions included, I require staff to feed me my meals. Another focus in Resident 58's care plan showed the resident has chronic urinary tract infections (UTIs) with interventions to observe for changes in urine characteristics, frequent urination and change in urgency to void. Review of a quarterly risk assessment for Resident #58 completed on 7/10/25 revealed the resident was at high risk for hydration/dehydration. Resident 58's MDS (minimum data assessment) dated of 7/10/25, section GG revealed - resident has impairment to bilateral upper and lower extremities and is totally dependent for eating and drinking. An interview was conducted with staff member A, Registered Nurse/Unit Manager (RN/UM) on 7/31/25 at 1:38 PM. Staff A revealed Resident #58 is not able to ask for anything, requires total assistance and cannot hold a cup to get own drink of fluid. Staff A stated for a resident with reoccur ring UTIs, the expectation was to monitor for changes in their bowel movements, administer medications as ordered, if constipated or hasn't had a bowel movement, monitor urine output and changes in color, and providing foley catheter care daily and as needed. Staff A stated the staff know to offer fluids to alleviate constipation and/or urinary tract infections. Staff A, RN/UM stated they do quarterly assessments and any resident with a score of 10 or higher is considered at risk for hydration issues. Staff A stated they immediately get a physician order to encourage and offer fluids every two hours. Review of Resident #58's medical record revealed there was no care plan focus initiated for Resident #58 being at risk for dehydration, and there were no physician orders to encourage fluids every two hours. The facility did not provide a dehydration policy.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interviews, observations, and record review the facility failed to ensure proper hydration was provided for one resident (#58) of one resident sampled. Findings included: On 07/29/25 at 09:40 AM an observation revealed Resident #58 lying in bed, eyes closed and did not respond to verbal or tactile stimuli. There was no hydration or fluids observed at bedside. During an observation on 07/29/25 at 03:00 PM, Resident #58 was observed lying in bed. There was no hydration cup or fluids at bedside. On 7/29/2025 at 3:45 PM an interview was conducted with Resident #58's family member who stated Resident #58 needed extra care and could not get a drink of water on their own. The family member stated staff should check on the resident more frequently than they do and offer fluids. During an observation on 07/30/2025 at 9:07 AM, at 12:00 PM and at 4:10 PM, Resident #58 was observed in room. A water cup was observed on the bedside table dated 7/30/25, 11 a.m. -7 p.m. shift, at 04:14 AM. The cup was observed full of ice water. On 07/31/25 at 08:35 AM Resident #58 was observed sitting up in a reclining wheelchair, eyes opened, awake alert and non-verbal. A water cup was observed on the bedside table dated 7/31/25 on 11-7 a.m. shift. This surveyor marked the water cup indicating the water level on cup to monitor how much water resident was drinking. (Photographic Evidence Obtained). On 07/31/2025 at 11:28 AM an observation was made of Resident #58 sitting up in wheelchair awake, alert and attending activities in activity room. There was no hydration or fluids observed being offered at this time. Upon entering Resident #58's room, an observation was made of the water cup sitting on bedside table with water observed at same level from an earlier observation where this surveyor marked the hydration cup. Review of resident #58's medical record revealed diagnoses of Quadriplegia, Pneumonitis, Moderate -protein calorie malnutrition, Dementia, Chronic Kidney Disease stage 3B and an Ileus. The plan of care revealed Resident #58 required assistance with ADLs (Activities of Daily Living) related to activity intolerance, dementia, impaired cognition, quadriplegia; with a goal that the resident will maintain current level of ADL function. The interventions included, I require staff to feed me my meals. Another focus in Resident 58's care plan showed the resident has chronic urinary tract infections (UTIs) with interventions to observe for changes in urine characteristics, .frequent urination and change in urgency to void. Review of a quarterly risk assessment for Resident #58 completed on 7/10/25 revealed the resident was at high risk for hydration/dehydration. Resident 58's MDS (minimum data assessment) dated of 7/10/25, section GG revealed - resident has impairment to bilateral upper and lower extremities and is totally dependent for eating and drinking. An interview was conducted with staff member A, Registered Nurse/Unit Manager (RN/UM) on 7/31/25 at 1:38 PM. Staff A revealed Resident #58 is not able to ask for anything, requires total assistance and cannot hold a cup to get own drink of fluid. Staff A stated for a resident with reoccur ring UTIs, the expectation was to monitor for changes in their bowel movements, administer medications as ordered, if constipated or hasn't had a bowel movement, monitor urine output and changes in color, and providing foley catheter care daily and as needed. Staff A stated the staff know to offer fluids to alleviate constipation and/or urinary tract infections. Staff A, RN/UM stated they do quarterly assessments and any resident with a score of 10 or higher is considered at risk for hydration issues. Staff A stated they immediately get a physician order to encourage and offer fluids every two hours. Review of Resident #58's medical record revealed there was no care plan focus initiated for Resident #58 being at risk for dehydration, and there were no physician orders to encourage fluids every two hours. The facility did not provide a dehydration policy.		