

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 405018	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Ryder Memorial Hospital Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Ave Font Martelo Humacao, PR 00792	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51637</p> <p>Based on the observations made through the initial pool process and the request for policies and procedures to the administrative staff conducted on 03/24/2025 through 03/26/2025 from 8:00 AM to 3:30 PM, it was determined that the facility failed to provide a respectable service where the residents' dignity was maintained. This deficiency was identified in 1 out of 24 cases reviewed during the initial pool process (Resident #265).</p> <p>1. Resident #265 is an [AGE] year-old female admitted on [DATE] with a diagnosis of decondition. The resident was observed on 03/24/2025 at 10:11 AM leaving the scale with no pants or sheets covering her legs so she was exposed to view.</p> <p>On 03/25/2025 at 9:15 AM a policy was requested from the facility regarding the procedure for female wheelchair use and was not provided.</p> <p>The facility failed to treat each resident with respect and dignity and provide care and services in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.</p>

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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47632</p> <p>Based on observation and eighteen records reviewed (RR) on 03/24/2025 through 03/26/2025 from 9:00 AM to 3:00 PM, it was determined that the facility did not ensure providing in making decisions regarding medical care and treatment with the resident or representative in advance directives 2 out of 18 records reviewed. (R. R #106 and #108).</p> <p>Findings include:</p> <p>1. During the evaluation of the records review on 03/25/2025, the following was found:</p> <p>a. R.R #215 is a [AGE] year-old male admitted [DATE] with Infected Sacral Ulcer. Noted in the record review on 03/26/2025 at 10:13 AM, the advance directive was observed without the signature of the resident or representative.</p> <p>b. R.R #217 is a [AGE] year-old male admitted on [DATE] with Amputation of the First Toe of the Right Foot. Noted in the record review on 03/25/2025 at 2:10 PM, that the resident was on Family Department Service and that the advance directive was not signed by a proxy.</p> <p>It was verified that the resident had signed an X on the advance directive document. A request was made on 03/25/2025 at 8:43 AM to employee administrator #1 for a policy indicating when the resident was unable to sign and was unavailable.</p> <p>Social Work employee #8 was interviewed on 3/25/2025 at 11:44 AM and stated that when a resident is in the Family Services Department, staff is responsible for signing all the resident's paperwork.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15884</p> <p>Based on observations and interviews with residents, facility administrator and physical environment personnel during the survey for the physical environment, it was determined that the facility failed to ensure that resident's sleeping rooms have comfortable and safe temperature levels and room environment is not homelike. This deficient practice was identified in 5 out of 20 residents' rooms.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During the tour of physical environment with a nurse, performed on 03/25/2025 at 10:30 AM all residents' sleeping rooms were visited. Residents located in room [ROOM NUMBER], 106 and 114 referred that room temperature was very cold. Those residents were observed covered with blankets and complained about low temperatures. 2. Resident located in rooms # 105,# 106 and # 114 stated during individual interviews on 03/25/2025 from 10:30 AM through 11:00 AM they would prefer warmer temperatures. It was identified that those rooms did not have a thermostat to be used to regulate the temperature of the room. 3. Physical environment personnel (employee #3) stated during interview on 03/25/2025 at 11:40 AM that resident rooms #105,# 106 and # 114 did not have a thermostat to be used to regulate the temperature of the room. He explains that room air condition temperature is set between 71 degrees and 81 degrees. That every resident room air condition system had a thermostat that continuously monitors the temperature in the room and sends signals to the control board to adjust the cooling output of the air conditioner as needed , however it is impossible to read or identify what the room temperature is. 4.The facility administrator (employee #1) was asked on 03/25/2025 at 1:20 PM if facility had a system or mechanism to monitor resident rooms temperature in order to adjust this temperature based on each resident preference. She stated that the facility did not have a mechanism or procedure to monitor resident rooms temperature in order to adjust this temperature based on each resident preference. <p>17959</p> <ol style="list-style-type: none"> 5. During the tour for physical environment with an LPN Nurse (employee #17) on 03/24/2025 from 8:45 AM till 10:45 AM on patients' rooms 116 A, 116C and 117C the following was observed: <ol style="list-style-type: none"> a. On resident room [ROOM NUMBER] the bathtub curtain has one of the holes on the right side broken and lacks one of the hooks which makes the curtain touch the floor. b. On resident room [ROOM NUMBER]C wall behind the patient's bed, paint detachment was observed. The arm of the TV, wheelchair and the air conditioning grill were observed with mold. <p>47384</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. Based on observations of the physical environment, review of policies procedures on 03/24/2024 from 8:30 AM through 4:00 PM, it was determined that the facility failed to promote the resident right to receive services in a safe, clean, comfortable and homelike environment. This deficient practice could affect 24 out of 24 residents admitted receiving care at the facility.</p> <ol style="list-style-type: none"> 1. Black mold spots were observed on ceiling tile of cubicle #5 on the Physical Treatment area. 2. Lifted paint was observed on back wall of cubicle #3 on the Physical Treatment area. 3. Black mold spots were observed on ceiling tile of open area on the Physical Treatment area. 4. Excessive dust was observed on filter grills of two AC units on the Physical Treatment area. 5. Excessive vegetative material was found on the bottom part of the emergency exit door next to station #4. 6. Exterior wall of treatment station #5 (orange wall) was observed with broken gypsum board on the bottom part of the wall. 7. Several residents were interviewed, and they reported that the rooms were very cold. Room temperatures were taken, and the following was found: <ol style="list-style-type: none"> a. room [ROOM NUMBER]- 71 degrees b. room [ROOM NUMBER] -73 degrees c. room [ROOM NUMBER] - 68 degrees d. room [ROOM NUMBER] - 69 degrees e. room [ROOM NUMBER] - 67 degrees f. room [ROOM NUMBER] - 68 degrees g. room [ROOM NUMBER] - 69 degrees h. room [ROOM NUMBER] - 72 degrees i. room [ROOM NUMBER] - 73 degrees <p>The facility does not have a specific policy for room temperature, but they adjust to the temperature policy for the medication room [NAME] de Temperatura de Cuarto de Medicamento which states parameters between 71- and 81-degrees Fahrenheit.</p> <p>8.Extractor grill on room [ROOM NUMBER] on wall of rooms were observed with rust and excessive dust.</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51637</p> <p>Based on review of twelve medical records, resident interview and interview with the Administrator (employee #1) performed from 03/24/2025 thru 03/26/2025, from 8:00 AM thru 3:30 PM, it was determined that the facility failed to develop and implement baseline care plan within 48 hours of a resident's admission in order to promote the continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services. This deficient practice was identified in 2 out of 12 cases reviewed. (RR #265, #266) and fail to update information based on the comprehensive care plan identified on 5 out of 6 records reviews. (Residents #6, # 7, #10, #13 and #108).</p> <p>Findings include:</p> <p>1. Record Review #265 is an [AGE] year-old female admitted on [DATE] with a diagnosis of decondition.</p> <p>-The resident was admitted for rehabilitation and therapy services. Record review conducted on 03/24/2025 at 2:25 PM, it was identified that the resident's plan of care was identified with another patient's label.</p> <p>-The facility removed the label with the other patient's name and proceeded to place the correct label without signing or evaluating other options.</p> <p>-A policy stating the process to follow when this occurs was requested and the facility did not provide one.</p> <p>2. File review #266 is an [AGE] year-old female admitted on [DATE] with a diagnosis of L+ femur fracture.</p> <p>-The resident was interviewed during the initial pool on 03/24/2025 at 8:55 AM and stated that she suffers from urinary incontinence. She also stated that she is kept in a diaper in the SNF and when she calls the nurse call system, she is diapered after approximately 30 minutes.</p> <p>-During the care plan review conducted on 03/24/2025 at 1:18 PM it was noted that the incontinent care plan was not opened by nursing.</p> <p>The facility failed to implement a care plan that provided follow-up to the residents' current problems.</p> <p>17959</p> <p>3. Resident #6 is an 83-year male admitted on [DATE] at 10:20 PM with diagnosis of Left hip fracture status post-op. admitted for rehabilitation with Physical Therapy and Occupational therapy.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. During the record review performed on 03/24/2025 at 1:18 PM, it was found that the MDS was performed and signed for MD on 1/18/2025, LDN signed on 1/20/2025, PT on 1/22/2025, OT on 1/23/2025, Pharmacy on 1/25/2025 and Social Worker on 1/20/2025. However, LND and Phycology signed on 3/20/2025 sixty-two days later than the admission. The MDS lacks the intervention of the Recreative therapist since admission to 66 days later.</p> <p>b. The consultation report to Speech Pathology performed on 3/20/2025 at 9:30 AM lacks reason to request the Speech Pathology evaluation, no date, time and signature of Attending Physician signature.</p> <p>c. The PMR consultation report lacks who notified the consultant, date, time and to whom.</p> <p>4. Resident #7 is a 73 -year female admitted on [DATE] at 2:57 PM with diagnosis of Right Total Hip Replacement status post-op. admitted for rehabilitation with Physical Therapy daily.</p> <p>a. During the record review performed on 03/24/2025 at 2:03 PM the standardized admission orders miss the signature of the register nurse, title, license number, date and time.</p> <p>b. The physician admission evaluation was maintained in blank.</p> <p>c. The physician's orders performed on 3/24/2025 at 2:03 PM lack the physician signature.</p> <p>d. On 3/24/2025 at 2:03 PM no evidence of the physical therapy evaluation in patient record.</p> <p>e. The discharge planning performed on 3/22/2025 per Interdisciplinary Equipment did not have the physician and the physical therapist participation.</p> <p>5. Resident #10 is a 61-year male admitted on [DATE] with primary diagnosis of Amputation of right finger of left toe, Osteomyelitis and Acute Renal Failure, Metabolic Acidosis, HBP, CVD, HTN Decondition, Peripheral Vascular Disease, Hyperlipidemia. On 01/03/2025 at 6:40 PM the resident was transferred to [NAME] Hospital at Telemetry because the laboratory results were altered.</p> <p>The record was reviewed on 03/25/2025 at 9:54 AM and the following was identified:</p> <p>a. The Interdisciplinary Discharge Planning was performed on 12/17/2024 and there is no evidence of the Physical Therapy participation.</p> <p>b. The infection history, allergy history and vaccination history it's in blank.</p> <p>6. Resident #13 is a 45-year male admitted on [DATE] and discharge on 12/27/2024 with diagnosis of Stroke, Debility, Gota, Dermatitis, Hight Blood Pressure and Raynaud's Syndrome. The record was reviewed on 03/25/2025 at 11:12 AM and the following was identified:</p> <p>a. The physician progress note did not have the hour and date when the physician documented.</p> <p>b. The PMR, Physical Therapy and Occupational Therapy consult lacks information. Physician signature and license number.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. Discharge orders did not have the date when the physician wrote the order.</p> <p>d. The Interdisciplinary Discharge plan lacks disposition of case.</p> <p>e. The protocol for Pulmonary prevention was maintained in blank, only have the physician signature, lacks the nurse's signature, date and time.</p> <p>f. Vaccination history was maintained in blank.</p> <p>g. Photography consent form lacks resident name</p> <p>47632</p> <p>7. R.R #108 is a [AGE] year-old male admitted on [DATE] with Amputation of the First Toe of the Right Foot. Noted in the record review on 03/25/2025 at 2:10 PM, lack of signatures of the resident or representative in the following documents:</p> <p>a. Permission to take photo.</p> <p>b. Consent to Admission.</p> <p>c. Commitment to pay.</p> <p>d. Certification of patient and/or family orientation.</p> <p>e. Interdisciplinary Care Plan.</p> <p>f. Advance directives.</p> <p>g. Baseline Care Planning.</p> <p>h. Guidance received on care plans.</p> <p>i. Use of bedside rails.</p> <p>j. Estimated administration of Influenza, Pneumococcal and Covid -19 vaccines.</p> <p>k. Validation of education offered to patient or family members.</p> <p>l. Guidance on Minimum Data Set (MDS).</p> <p>Social Work Employee #8 was interviewed on 03/25/2025 at 11:44 AM regarding the documents with an X signed by the resident, she stated that the X is valid as a signature, she was asked for a policy that she would have to verify if the administrator had the policy which she did not have created.</p> <p>The social worker also stated that the resident is in a mental state of disorientation period and is in the service of the Family Department at the Yabucoa location, they are responsible for signing those documents that are pending in the medical record.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15884</p> <p>Based on observations on 03/24/25 through 03/26/25 from 8:30 AM till 4:00 PM and interview with Nursing personnel (employee #16), it was identified that facility failed to evidence the participation of Interdisciplinary Team (IDT) professionals in the development, implementation and review of the comprehensive person-centered care plan for a resident who is identified with non-compliance with the drug regimen. This deficient practice affects 3 out of 12 residents included in the sample selection. (Resident, #4, #67, #217).</p> <p>Findings include:</p> <p>1. The following information was identified while reviewing the medical record of resident #67 with the Nursing personnel (employee #16), on 03/26/2025 at 9:00 AM:</p> <p>a. RR #67 is a 45 male resident admitted on [DATE] with a diagnosis of Right Knee Replacement. According with information documented in the medical record this resident had history of Anxiety Disorder and Depression (other than bipolar).</p> <p>b. When the resident was admitted to the facility on [DATE] nursing personnel perform medication reconciliation. During medication reconciliation resident notifies that he refuses to take Zoloft Elavil and Klonopin since he was receiving services at the hospital before being admitted to the SNF.</p> <p>c. Zoloft PO is a prescription medication that can help treat depression and other mental health conditions, Elavil PO, that is a tricyclic antidepressant used to treat depression and mood disorders and Klonopin PO is used to prevent and treat anxiety disorders.</p> <p>d. Comprehensive plan of care for this resident was prepared by the interdisciplinary team on 03/20/2025. Pharmacy and medications areas of this plan include the medications that the resident is refusing and not using. No information was documented as notified to the physician or pharmacist in relation to resident refusal of those prescribed medications used to treat depression and other mental health conditions. So, using this type of medications can create a chemical imbalance and result side effects.</p> <p>47632</p> <p>2. Resident #4 is a [AGE] year-old female admitted [DATE] with osteomyelitis sacral ulcer stage 4, according to the information collected in the medical record.</p> <p>a. On 3/24/2025 at 1:20 PM, it was noted in the medical record that the interdisciplinary care plan was not completed by recreational therapy, nutrition and pharmacy staff. The interdisciplinary care plan in the expected outcomes on the evaluation date there was no continuity or outcomes according to the care plan.</p> <p>On 03/25/2025 at 9:03 AM, medication pass nurse #11, referred that they discuss the interdisciplinary care plan every Tuesday with the nursing staff.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/25/2025 at 10:05 AM, employee #12, MDS coordinator, was interviewed and stated that cases are evaluated individually in the first seven days when they are completing the MDS, but officially the interdisciplinary group has not met since the pandemic.</p> <p>3. Resident #217 is a [AGE] year-old male admitted with amputation of the first toe of the right foot according to the information collected in the medical record.</p> <p>a. Minimum Data Set (MDS) resident Assessment and Car Screening noted incomplete participation in the assessment and setting (identify all active participants in the assessment process) the part of another legally authorized representative and Cognitive Skill for Daily Decision Making (decision making related to daily living tasks) blank.</p> <p>b. During the evaluation of the medical record on 03/26/2025 at 2:40 PM, it was noted that the resident was not oriented to his care plan or given the opportunity to participate in the care .</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15884</p> <p>Based on observations performed on 03/24/25 through 03/26/25 from 8:30 AM till 4:00 PM and interview with Nursing personnel (employee #16), and Administrator (employee #1) it was identified that facility failed to develop and implement comprehensive person-centered care plan for a resident who is identified with social service's needs and failed to guarantee participation of the interdisciplinary group in the comprehensive care plan meetings This deficient practice affects 1 out of 12 residents included in the sample selection. (Resident #3).</p> <p>Findings include:</p> <p>1. The following information was identified while reviewing the medical record of resident #3 with the Nursing personnel (employee #16), on 03/25/2025 at 9:15 AM:</p> <p>a.RR #3 is an 80 male resident admitted on [DATE] with a diagnosis of Right Femur Fracture. Accordingly with information documented on the medical record Social Worker Initial Assessment resident lives alone in an independent elderly apartments complex. Apparently, the resident begins to experience disorientation episodes, felt down and fractured right hip. After surgery the resident was admitted receiving rehabilitation in the SNF and the social worker of the SNF communicate with resident daughter on 01/20/2025.</p> <p>Accordingly with information documented by the social worker in the medical record, resident daughter notifies the social worker that she and her sister were in charge to provide care to their mother who had Alzheimer, they notify that cannot take care of their father or have the economic resources to pay for housing and care for their father.</p> <p>On 01/31/2025 the case was referred to Puerto Rico State Social Family Department in order to request help to locate the resident when was discharged home from the SNF.</p> <p>b. The Social worker follow-up with the social services department of Puerto Rico state social family department on 02/03/2025, 02/04/2025, 02/05/2025,02/06/2025,02/10/2025,02/11/2025 and 02/18/2025.</p> <p>There is no evidence of any other social worker intervention for this case, after 02/18/2025.</p> <p>c. On 03/25/2025 facility administrator document that communicated with social services department of Puerto Rico state social family department in order to request information of status of resident location. The Social services department of Puerto Rico state social family department requests a certification of resident medical conditions.</p> <p>d. The comprehensive care plan of this resident was reviewed by IDT</p> <p>on 03/17/2025. Social services areas were not triggered or included in this comprehensive care plan.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>e. Facility administrator stated on interview on 03/25/2025 at 10:00 AM that facility social worker resigns from her position on 02/19/2025. She informs that this social worker who resign from her position was recruited by contract as part-time position on 03/27/2025 while facility recruit another social worker. She also informs that another part-time social worker was recruited on 03/21/2025 while the facility recruit a full time social worker.</p> <p>f. The surveyor asked the facility administrator (employee #1) on 03/25/2025 at 10:30 AM if there is the possibility that those part-time social worker employees failed to participate and document the development and implementation of case #3 social services comprehensive plan. The administrator (employee #1) stated that there is the possibility that they did not document interventions carried out to follow-up with the State social services department of Puerto Rico Social family department the status of resident location.</p> <p>47632</p> <p>2. The MDS coordinator employee #12 was interviewed on 03/25/2025 at 10:05 AM about the meetings held by the interdisciplinary group. She said that they used to meet once a week, but since the pandemic they no longer meet.</p> <p>The meetings that are held individually with part of the interdisciplinary group are the first seven days when staff come in to fill out the MDS and then they take the opportunity to discuss the relevance of a resident. Virtual meetings were not considered according to employee #12 MDS coordinator.</p> <p>The only interdisciplinary group meetings that were held were the weekly nursing staff meetings every Tuesday according to nursing employee #14.</p> <p>Administrator employee #1 was interviewed on 3/25/2025 at 10:25 AM, she stated that they had not met due to Covid-19, but now she knew she was going to meet with staff to start interdisciplinary group meetings.</p> <p>The facility did not ensure participation of the interdisciplinary group to work together to provide the greatest benefit to the residents.</p> <p>The facility did not develop an alternative method, i.e., face-to-face or virtual meetings, for the interdisciplinary group members to provide input into the development and review of the resident's plan of care.</p>		

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NAME OF PROVIDER OR SUPPLIER Ryder Memorial Hospital Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Ave Font Martelo Humacao, PR 00792	
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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15884</p> <p>Based on observations performed on 03/24/25 through 03/26/25 from 8:30 AM till 4:00 PM and interview with Nursing personnel (employee #16), it was identified that facility failed to evidence that identify irregularities in the medication review were documented, reported and if necessary to the attending physician and pharmacist. This deficient practice affects 3 out of 12 residents included in the sample selection. (Resident #67, #265 and #268).</p> <p>Findings include:</p> <p>1.The following information was identified while reviewing the medical record of resident #67 with the Nursing personnel (employee #16), on 03/26/2025 at 9:00 AM:</p> <p>a.RR #67 is a 45 male resident admitted on [DATE] with a diagnosis of Right Knee Replacement. According to the information documented in the medical record this resident had history of Anxiety Disorder and Depression (other than bipolar).</p> <p>b. When the resident was admitted to the facility on [DATE] nursing personnel perform medication reconciliation. During medication reconciliation resident notified that he refused to take Zoloft Elavil and Klonopin since he was receiving services at the hospital before being admitted to the SNF.</p> <p>c. Zoloft PO is a prescription medication that can help treat depression and other mental health conditions, Elavil PO, that is a tricyclic antidepressant used to treat depression and mood disorders and Klonopin PO is used to prevent and treat anxiety disorders.</p> <p>No evidence was found documented on the medical record or drug regimen review of the oversight by pharmacy or physician when was identified that this resident is refusing previously ordered for depression and other mental health conditions. This resident had history of anxiety disorder and Depression (other than bipolar) accordingly with information documented in the medical record.</p> <p>d. The reason why residents refuse to take those medications was not found documented as part of the documentation of the drug regimen review.</p> <p>e. No evidence was found documented related to information provided to resident #67 in relation of the possible effects that he could experience when stopping antidepressants and other mental health medications or withdrawal symptoms.</p> <p>51637</p> <p>2. Record Review #265 is an [AGE] year-old female admitted on [DATE] with a diagnosis of decondition.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Record review conducted on 03/24/2025 at 2:25 PM, it was noted that medication reconciliation by pharmacy was incomplete. Although she had a signed medication reconciliation within the stipulated time, it lacked documentation indicating the reaction or interaction of each medication and suggestions or consultation with the medical director if necessary.</p> <p>3. Record review #268 is a [AGE] year-old male admitted on [DATE] with a diagnosis of lumbar discitis osteomyelitis.</p> <p>-Record review conducted on 03/24/2025 at 1:44 PM noted that the medication reconciliation by pharmacy was incomplete. Although he had a signed medication reconciliation within the stipulated time frame, it lacked documentation indicating the reaction or interaction of each medication and suggestions or consultation with the medical director if necessary. In addition, the resident was prescribed opioids for pain after the initial medication reconciliation and there was no follow-up medication reconciliation.</p> <p>During the interview with pharmacy licensee employee #7 conducted on 03/25/2025 at 11:09 AM she indicated that medication reconciliations are initial only and are not provided follow-up unless there is a specific order for it. She also indicated that there was no documentation other than the signature on the stipulated document for medication reconciliation.</p> <p>4. The facility failed to provide or promote a mechanism to ensure that the review of each resident's medication regimen is monitored to improve their condition, reduce risks or deterioration of their condition.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51637</p> <p>Based on dining observations, review of policies procedures and facility staff interview performed on 03/24/2025 through 03/26/2025 from 8:00 AM through 3:30 PM, it was determined that the facility failed to ensure that each resident (R), receives and the facility provides food and drink that is palatable, attractive, and at a safe and appetizing temperature. This deficiency affects 1 out of 12 residents admitted receiving services (R #268).</p> <p>Findings include:</p> <p>1. Resident interview #268 is a [AGE] year-old male admitted on [DATE] with a diagnosis of lumbar discitis osteomyelitis.</p> <p>-During the initial pool process on 03/24/2025 at 8:21 AM resident #268 indicated that when food is brought in sometimes there are foods that are not to his liking, when this happens the staff does not offer him some substitute food to ensure he has adequate food intake.</p> <p>-Record reviewed conducted on 03/24/2025 at 1:44 PM noted that the dietician made an estimate of the resident's tastes and needs, and these went to the kitchen for preparation.</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51637</p> <p>Based on dining observations, review of policies procedures and facility staff interview performed on 03/24/2025 through 03/26/2025 from 8:00 AM through 3:30 PM, it was determined that the facility failed to ensure that each resident receives food that accommodates resident allergies, intolerances, and preferences. This deficiency was identified in 1 out of 12 residents of the sample selection (Resident #268).</p> <p>1. Resident interview #268 is a [AGE] year-old male admitted on [DATE] with a diagnosis of lumbar discitis osteomyelitis.</p> <p>-During the initial pool process on 03/24/2025 at 8:21 AM resident #268 indicated that when food is brought in sometimes there are foods that are not to his liking, when this happens the staff does not offer him some substitute food to ensure he has adequate food intake.</p> <p>-Record reviewed conducted on 03/24/2025 at 1:44 PM noted that the dietician made an estimate of the resident's tastes and needs, and these went to the kitchen for preparation.</p> <p>The facility failed to ensure that resident preference was granted, and recommendation of the nutritionist was granted.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47384</p> <p>Based on observations of the Kitchen, review of policies procedures and facility staff interview performed on 03/24/2025 from 8:00 AM through 3:30 PM, it was determined that the facility failed to comply with the required sink compartment sanitations. This deficient practice could affect 24 out of 24 residents admitted receiving care at the facility.</p> <p>Findings include:</p> <p>Review of facility's policy and procedure [NAME], Enjuage y Saneamiento, Cleaning and Disinfection of three compartment Sinks regarding the process of cleaning and sanitization of kitchen equipment was reviewed on 03/24/2025 at 11:30 AM and it says that compartment one (1) must have a temperature of 110 F, on compartment two (2) and on compartment three (3) utensils should be for 30 seconds with a sanitizing solution concentration of 200 ppm. Test strip container was verified and stated that concentration testing should be taken with a temperature of 75 degrees Fahrenheit.</p> <p>1. During the visual inspection and staff interview it was noticed that 3 compartment sinks were not prepared as stated in the facility policies and procedures. It was observed that the staff working the sink did not have knowledge of the temperatures required in the sanitization compartments. It was requested that the concentration of sanitizer be taken on the third compartment, and the concentration measurement was found to be higher than the requirement of 200 ppm. Overuse of the sanitizing agent could be harmful.</p> <p>2. During observation of the dry storage area, loose rice and beans were observed underneath the storage racks. A tuna can was observed left on the floor.</p> <p>3. Lettuce was observed cut and wrapped in plastic wrapping with no date.</p> <p>4. Prepared cereal (farina) was observed on container with no date of preparation.</p> <p>5. Mandarin oranges were observed on container, apple juice wrapping, and plastic was inside container with oranges.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20423</p> <p>Based on observation during medication pass performance on 03/25/2025 from 8:22 AM till 9:30 AM, it was determined that the facility failed to ensure establish and maintain an infection prevention and control program relate to hand washing during the drug pass and failed to ensure establish and maintain an infection prevention and control program related to changing gloves in bed baths in 1 out of 1 resident observed (RR #215)</p> <p>51829</p> <p>Findings include:</p> <p>1. During the drug past performance on 03/25/2024 from 8:22 AM till 9:30 AM, it was observed two register nurses in the process medication administration, and it was found the following.</p> <p>a. On 03/25/2025 at 8:55 AM RN #10 failed to follow appropriate hand washing process during the medication administration and failed to hand wash 1 out to 7 opportunities for hand wash 14.28%.</p> <p>b. On 03/25/2025 at 8:22 AM RN #11 failed to follow appropriate hand washing process during the medication administration and failed to hand wash 9 out to 11 opportunities for hand wash 81.81%.</p> <p>47632</p> <p>2. R.R #215 is a [AGE] year-old male admitted [DATE] with Infected Sacral Ulcer. During the bed bathing procedure by Licensed Practical Nurse (LPN) employee #15, she performed 3 water changes and did not perform 3 glove changes.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>47384</p> <p>Based on observations performed on 03/24/2025 from 8:30 AM through 3:30 PM, it was determined that the facility failed to maintain all patient care equipment in safe operating condition. This deficient practice affects 24 out of 24 residents admitted receiving treatment at the facility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During a visual inspection of the equipment in the physical therapy area, it was observed that of 7 wheelchairs observed, 3 of these had peeling paint and signs of rust, and clinical tape on the arm rests. 2. It was also observed that of 15 walkers available, 5 of them showed signs of rust and wear and tear. 3. Two (2) out of two (2) of pedal floor exerciser were observed with signs of rust.