STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105349	A. BUILDING _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE HEALTH AND REHABILITATION CENTER	130 W ARMSTRONG AVENUE DELAND, FL 32720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification survey, in conjuction with a complaint survey for complaint # 2025001700, was conducted from February 24, 2025 through February 27, 2025 at Alliance Health and Rehabilitation Center. The complaint could not be substantiated. The facility was not in compliance with Code of Federal Regulations (CFR) 42, Part 483.73, Requirements for Long-Term Care Facilities due to deficiencies identified during the Recertification survey.	F 000		
F 623	. Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		3/27/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/20/2025

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.

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F 623	Continued From page 1 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and	F 623		

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F 623	Continued From page 2	F 623		

telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
Based on record review and an interview with

Preparation and/or execution of this Plan

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F 623	Continued From page 3 staff, the facility failed to notify the office of the State Long-Term Care Ombudsman of a discharge for one (Residents #104) of three residents whose records were reviewed for transfers/discharges, from a total survey sample of 31 residents. The findings include: A review of the medical record revealed that Resident #104 was admitted to the facility on 12/02/24 and then discharged on 12/05/24. His diagnoses included, but were not limited to, acute on chronic systolic heart failure, cellulitis of the right limb, bacteremia, chronic kidney disease (CKD), and Plural effusion. A review of the Discharge Summary note, dated 12/05/24, revealed that Resident #104 was discharged home at 12:30 PM that day under hospice care. The resident's spouse signed the discharge papers and reviewed the discharge medications. A review of the resident's Minimum Data Set (MDS) assessments revealed a Discharge/Return Not Anticipated MDS assessment with an assessment reference date (ARD) of 12/05/24, indicating a planned discharge. The discharge location was noted as "home". Further review of the record revealed that Resident #104 received an AHCA (Agency for Health Care Administration) Nursing Home	F 623	of Correction does not constitute admission or agreement by the provider of the truth of the items alleged or conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared solely because it is required by the provision of Federal and State Laws code section 1280 and 42 CFR 483. 1. On 2/27/25, Office of the Ombudsman notified of resident # 104's discharge by the Social Service Director. 2. On 3/21/25, the Social Services Director/Designee completed a review of residents discharged in the last 30 days to verify ombudsman notified as required. Follow up based on findings. The review revealed the February log was incomplete and the March logs were still in progress. The February log was updated and an accurate listing was sent to the Office of the Ombudsman. 3. On 3/21/25, the Administrator/Designee completed education with Social Services employees regarding ombudsman notification of resident discharge/transfer. 4. Social Services Director/Designee to complete weekly monitoring of resident discharge/transfers to ensure ombudsman notification completed as required for a period of 3 months or until substantial compliance achieved, then quarterly and as needed. Findings to be reviewed at the monthly QAPI Committee Meeting. Modifications implemented as indicated.	

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Transfer and Discharge Notice on 12/04/24 with an effective discharge date of 12/05/24. The reason for the discharge was noted as "home with hospice services". The areas of the form indicating the date the notice was given to the resident or representative, the date the Ombudsman was notified of the discharge, and the date the clinical record was noted, were all left blank. (Copy obtained)

An interview was conducted with the Social Services Director (SSD) on 02/27/25 at 1:20 PM. She confirmed that the facility was supposed to notify the local Ombudsman's office of resident discharges. She was asked to provide verification of Ombudsman notification for Resident #104. She was unable to provide verification. She stated when she notified the Ombudsman's office via fax, she did not keep the confirmation page.

On 02/27/25 at 2:10 PM, a telephone interview was conducted with the Ombudsman who confirmed that she had not been notified of Resident #104's discharge.

A review of the facility's policy titled Social Services and Case Management: Post-Discharge Plan of Care (undated), revealed the following:
Purpose: Pre-Discharge Planning will be coordinated by the Case Management Social Service Department for the development of "post-discharge plan of care".
7. Contact those service agencies determined to be needed to support resident's needs, resources, and services upon discharge. These may include such services as: home health,

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F 623	Continued From page 5 durable medical equipment, therapy services, meals on wheels, transportation, etc.	F 623		
F 656	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		3/27/25

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F 656	Continued From page 6 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, medical record review, and facility policy and procedure review, the facility failed to ensure the implementation of the comprehensive person-centered care plan for one (Resident #7) of four residents reviewed for falls, out of six residents identified for falls with major injuries, from a total survey sample of 31 residents. Failure to implement the necessary fall interventions on a resident's care plan places them at risk for additional falls and associated injury/pain. The findings include: Resident #7 was observed and interviewed on 02/27/2025 at 9:40 AM. She was lying in bed covered with a blanket up to her chin. No fall mats were observed on the floor on either side of the bed. (Photographic evidence obtained) Resident #7 stated she had been educated on and was encouraged to use her call light prior to	F 656	1. On 2/25/25, resident #7's comprehensive care plan was updated by the Director of Nursing to reflect implemented fall prevention interventions. 2. From 3/20/25 to 3/25/25, the Director of Nursing/Designee completed a review of current facility residents who have experienced a fall to verify the comprehensive care plan reflects the fall prevention interventions implemented. Follow up based on findings. No additional residents were found with interventions not in place as directed by the care plan. 3. On 3/7/25, the Director of Nursing/designee provided education for the interdisciplinary team related to the comprehensive care plan reflecting implemented fall prevention interventions. 4. Director of Nursing/Designee to conduct monitoring of resident comprehensive care plans to verify	

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F 656	Continued From page 7 trying to get up and walk or transfer. Resident #7 was observed a second time on 02/27/2025 at 9:55 AM. She was lying in bed with her eyes closed. No fall mats were on the floor. A review of the resident's face sheet revealed she was admitted to the facility on 11/19/2021 and then readmitted on 01/20/2024. Her diagnoses included osteoporosis, atrial fibrillation, cognitive communication deficit, heart failure, unspecified dementia without behavioral disturbance, hypothyroidism, hyperlipidemia, major depressive disorder, chronic pain, chronic obstructive pulmonary disease (COPD), anemia, nondisplaced fracture of proximal phalanx of left great toe, moderate protein calorie malnutrition, and presence of automatic cardiac defibrillator. (Copy obtained) A review of the quarterly Minium Data Set (MDS) assessment, dated 01/29/2025, revealed that Resident #7 was assessed with a Brief Interview for Mental Status (BIMS) score of 10 out of 15 possible points, indicating moderate cognitive impairment. No signs or symptoms of mood disorder or impairment in upper or lower extremities were documented. A wheelchair was used for mobility. The resident required set-up or supervision only for activities of daily living (ADLs), and had two or more falls since the last assessment. (Copy obtained) A review of the Care Plan, dated 02/11/2025, revealed the following focus areas:	F 656	implemented fall prevention interventions are reflected utilizing the quality-of-care meeting process. Monitoring to be completed weekly x 3 months until substantial compliance or until substantial compliance achieved, then quarterly and as needed. Findings to be reviewed at the monthly QAPI Committee Meeting. Modifications implemented as indicated.	

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The resident is at risk for falls related to impaired balance/gait, use of psychotropic medications, urinary incontinence. Initiated 03/15/2022. Revised 01/14/2025. Goal: Potential for falls/fall-related injuries will be minimized through next review date. Interventions included fall mats while in bed. Initiated 01/12/2025.
The resident has alteration in behavior as evidenced by refusing care at times, has impulsive behaviors, poor safety awareness, will spontaneously get up without calling for assistance and refuses to wear non-skid socks. Falls were documented on 08/27/2024, 9/06/2024, 10/12/2024, 10/28/2024, 12/26/2024, 12/28/2024, and 01/12/2025 x 2. (Copy obtained)

During an interview with Certified Nursing Assistant (CNA) A on 02/27/2025 at 10:53 AM, she looked around Resident #7's room and confirmed that there were no fall mats in the room. She did not get the resident up this morning; therapy got her up and helped her dress. She stated the resident "usually has" fall mats. The resident went to breakfast, came back, got into bed, and then got up just a few minutes ago and left her room. She did not assist the resident to get up this last time either. She stated Resident #7 liked to get up and go back to bed throughout the day. She would prefer to be in bed all day but they encouraged her to get up.

During an interview with Physical Therapist B on 02/27/2025 at 11:03 AM, he stated he thought there was a fall mat on the floor on the side of the bed nearest the window, but not one under her wheelchair. He stated he helped the resident get

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dressed and go to the restroom. He then stated he recalled that there were no fall mats down at all but there should have been. He confirmed that the resident could propel her wheelchair independently. He did not take her to breakfast; she wheeled herself down to the main dining room. He stated the CNAs were responsible for ensuring that the floor mats were in place.

During an interview with Resident #7 on 02/27/2025 at 12:49 PM, she was observed in bed under the covers. Fall mats were observed on either side of the bed that looked clean and new. The resident stated the fall mats on the floor were put down this afternoon, and it was the first time they had ever put mats down in her room. She was asked again if they had ever placed fall mats next to her bed on the floor. She chuckled and said, "No, not ever". She stated she needed them so she would not get hurt if she fell out of bed. She had never fallen out of bed, but she had fallen on the floor in her room.

During an interview with CNA A on 02/27/2025 at 12:53 PM, she stated she put the mats down in the resident's room. She found them in the resident's closet next to her clothes. CNA A stated she had not put the mats in the closet and confirmed that the mats did not belong in the closet with the resident's clean clothing.

During an interview with the Director of Nursing (DON) on 02/27/2025 at 1:04 PM, she stated she was unaware that the fall mats were not down on the floor this morning when the resident was in bed. She stated, "Well, we will do better." She

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F 656	Continued From page 10 confirmed that the CNAs were responsible for placing the fall mats down for the resident's safety. A review of the facility's policy and procedure titled Nursing Admission At Risk - Post Fall and Quarterly Evaluation (Copyright 2010, otherwise undated) revealed: Purpose: To evaluate and monitor risk for falls and status for implementation of interventions. To prevent or reduce risk of fall and any associated injury. 5. The licensed nurse will evaluate resident for appropriate fall interventions per responses obtained in effort to minimize residents fall and/or injury. 6. The licensed nurse will inform the resident's physician of fall risk and obtain approval for application of safety devices, if applicable, will complete order for the same and transcribe to the Treatment Administration Record (TAR) for continuity of care. 7. The licensed nurse will ensure the application of safety equipment/interventions and notify staff of resident's risk for fall and related injury. (Copy obtained) .	F 656		