Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95030	A. BUILDING: _____ B. WING _____	05/22/2025

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ROYAL PALM BEACH HEALTH AND REHABILITATION	600 BUSINESS PARK WAY ROYAL PALM BEACH, FL 33411

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N 000	INITIAL COMMENTS An unannounced relicensure survey was conducted on to at Royal Palm Beach Health and Rehabilitation Center. The facility had deficiencies at the time of the survey.	N 000		
N 071	59A-4.109(1), FAC Components of Care Plan (1) Each resident admitted to the nursing home facility must have a plan of care. The plan of care must consist of: (a) Physician's orders, diagnosis, medical history, physical exam and rehabilitative or restorative potential. (b) A preliminary nursing evaluation with physician's orders for immediate care, completed upon admission. (c) A complete, comprehensive, accurate and reproducible assessment of each resident's functional capacity which is standardized in the facility, and is completed within 14 days of the resident's admission to the facility and every twelve months, thereafter. The assessment must be: 1. Reviewed no less than once every 3 months; 2. Reviewed promptly after a significant change, which is a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem, in the resident's physical or mental condition; and, 3. Revised as appropriate to assure the continued accuracy of the assessment. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to revise and update care plan interventions timely for 1 of 4 sampled residents reviewed for , Resident #92; failed to revise and update care plans with changes for	N 071	The statements made on this plan of correction are not an admission to and do not constitute an agreement with alleged deficiencies herein. To remain compliant with all federal and state regulations, the	

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N 071	Continued From page 1 diagnoses and medications for 1 of 5 sampled residents reviewed for unnecessary medications, Resident #76; and failed to develop and implement a care plan for a resident with for 1 of 5 sampled residents reviewed for unnecessary medications, Resident #76. The findings included: Review of the facility's policy, titled, Comprehensive Care Plans, with a reviewed / revised date of , included in part the following: "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing and mental and , , needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. the objectives will be utilized to monitor the residents' progress. Alternative interventions will be documented as needed. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their role and responsibilities for carrying out the interventions initially and when changes are made." 1. Record review revealed Resident #92 was admitted to the facility on with diagnoses that included in part the following: Total Detachment Right , , Left , Category 5 Normal Vision Right , , Other Lack of Coordination, Unspecified Abnormalities of Gait and Mobility, Abnormal Posture, Difficulty in Walking, Need for Assistance with Personal Care,	N 071	facility has taken actions set forth in the plan of correction. The plan of correction constitutes the facility's allegation of compliance such as the deficiencies cited have been corrected by the date certain. On , the DON updated the care plan and added the appropriate intervention for resident # 92. On , the regional reimbursement Coordinator revised and updated the care plans for the changes of diagnosis and medications for resident #76. On , the regional reimbursement Coordinator initiated the care plan for resident #76. On , the Regional Nurse Consultant conducted a quality review of residents who have had a in the past 30 days to ensure that interventions are added to the care plan timely. Follow up based on findings. On , the Regional Reimbursement Coordinator conducted a quality review of residents with new active diagnosis or medication changes in the past two weeks to ensure that care plans were appropriately developed or updated. Follow up based on findings. On , the Regional Nurse Consultant conducted a quality review of current residents with the diagnosis of to ensure that appropriate care plans have been developed. No additional findings noted. By , the licensed nurses including the MDS nurses were educated by the Staff Development Coordinator on the components of N071 with an	

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N 071	Continued From page 2 (Generalized), Segmental and of Lower Extremity, Segmental and of Region, Segmental and of Region, and Scars After Surgery for Detachment . The Minimum Data Set dated documented in Section C a Brief Interview of Mental Status score of 14 indicating an intact response. Review of the facility incident log documented the following: On , an unwitnessed for Resident #92. On , a witnessed for Resident #92. Review of the physician's orders revealed an order dated for, 'Legally every shift'. Review of the Nursing Note for Resident #92 documented the resident "slid from his wheelchair (w/c) while he was trying to stand up. , was trying to change his w/c, because the right side couldn't be locked. Resident stated, I just slide from the chair, because I forgot to lock my w/c when I was trying to stand up to change the w/c. Resident assessed and assisted to chair by staffs. scrape noted in the right interior and left exterior." Review of the care plan for Resident #92 dated with a focus on the resident is at risk for and related injury due to vision . right and left , documented: The goals was to minimize risk for and related injuries through next review date. The interventions included the following: Assist with toileting and transfers as needed. Complete	N 071	emphasis on accurate revisions and updating of care plans. As a systematic change, newly hired licensed nurses, including MDS nurses, will be educated on the components of N071 with an emphasis on accurate revisions and updating of care plans. DON/designee will conduct quality monitoring audits of 10 random residents weekly x 4 weeks then 10 random residents monthly x 2 months to ensure proper revision and updating of the care plans. The findings of these quality monitoring to be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met.	

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Risk Screen as indicated. Cue for safety awareness. Ensure call light is within reach and encourage use for assistance. Keep frequently used items within reach. Orient resident to environment/surroundings. Provide resident teaching to included: Safety measures to reduce risk, use call light to requesting assistance before attempting to transfer or ambulate. / /ST (, , / , , / , ,) Screening for safety. , , screen as indicated. In summary the care plan was not updated after Resident #92 sustained a on .

An interview was conducted on at 12:28 PM with Resident #92 who stated he had the other day when moving from one wheelchair to another wheelchair and scraped both of his arms. He stated he is and had requested a wheelchair that was taller. When they provided him with the wheelchair he later realized the right side of the wheelchair would not lock and this was on the weekend so he went down to the , department to switch out the wheelchair and with all the commotion he had forgotten to lock the left side of the wheelchair before moving from the wheelchair with the broken lock to the new wheelchair and when he stood up the wheelchair moved backward and he and scraped both of his arms.

An interview was conducted on at 12:45 PM with Staff C Licensed Practical Nurse (LPN) who stated she has been working at the facility for about 2 years. When asked about , she stated that for witnessed the nurse will notify the family, the physician and management, as well as assess and monitor the resident. When asked about the care plan being updated if have , she does update any care plan it may be

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N 071	Continued From page 4 updated by management or Minimum Data Set. During an interview conducted on at 1:20 PM with the Director of Nursing who stated she has worked at the facility for about 2 years. When asked about , the DON said the care plan should be updated by the care plan team (MDS team) each time the resident has a . During an interview conducted on at 4:37 PM with the Minimum Data Set (MDS) Assistant who stated she has worked at the facility for 3 months with the Regional MDS Reimbursement Consultant who stated she has worked with the company for 2 years. They stated the full time MDS Coordinator went per diem (as needed) in , . When asked if a resident has a do they update the care plan, they said yes they update the interventions not date on the care plan. The care plan intervention is up dated on day of the or the next day. They stated the nursing staff can also put interventions in the care plan as well. 2. Review of the facility's policy, Unnecessary Drugs - Without Adequate Indication for Use, with a reference date of and a revision date of , documented: "It is the facility's policy that each resident's drug regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical and , , well-being free from unnecessary drugs. Policy Explanation and Compliance Guidelines: 1. The indications for initiating, withdrawing, or withholding medications(s), as well as the use of non-pharmacological approaches, will be determined by assessing the resident's underlying condition, current signs, symptoms,	N 071		

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N 071	Continued From page 5 expressions, preferences, and goals for treatment including identification of underlying causes (when possible). 7. Information gathered during the initial and ongoing evaluations will be incorporated into the resident's comprehensive care plan that reflects person-centered medication related goals and parameters for monitoring the resident's condition, including the likely medication effects and potential for adverse consequences." a. Record review revealed Resident #76 was admitted to the facility on and most recently readmitted after transfer to the hospital per family request r/t / . Review of the resident's most recent complete assessment, a Quarterly MDS, with a reference date of , revealed Resident #76 had a score of 12, indicating the resident was moderately . Resident #76's diagnoses at the time of the assessment included: Non- . It was determined that Resident #76 was not interviewable as evidenced by the resident provided nonsensible answers to simple questions. Review of Resident #76's physicians orders included: , Oral Tablet 50 MG (,) - Give 1 tablet by at bedtime for , , dated . Resident #76 did not have any current orders for , medications Further review of Resident #76's records revealed the following discontinued orders:	N 071		

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N 071	Continued From page 6 Oral Tablet 50 MG (,) - Give 1 tablet by at bedtime for , - that was d/c same day Oral Tablet 10 MG (,) - Give 1 tablet by every 12 hours for , - with an end date of Oral Tablet 10 MG (,) - Give 1 tablet by every 12 hours as needed for , - with an end date of Injection Solution 2 MG/ML (,) - Inject 0.5 mg , every 12 hours as needed for , / agitation - with an end date of Injection Solution 2 MG/ML (,) - Inject 0.5 mg , every 12 hours as needed for , / agitation for 30 Days- with an end date of . Resident #76's care plan for , , medications documented, "Resident is at risk for complications related to the use of , , , drugs related to a diagnosis of , ", Date Initiated: Revision on: . The goal of the care plan was documented as, "Resident will have the smallest most effective dose without side effects throughout the next review", Date Initiated: Revision on: Target Date: Interventions to the care plan included: o Monitor for continued need of medication as related to behavior and Date Initiated: RN LPN [Registered Nurse Licensed Practical Nurse] Resident #76's care plan for , medications documented, "Resident is at risk for adverse reactions to , medications used for , "Date Initiated:	N 071		

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N 071	Continued From page 7 , Revision on: The goal of the care plan was documented as, "Resident will have a minimized risk of adverse reactions through next review date." Date Initiated: Revision on: Target Date: Interventions to this care plan included: o Administer medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Date Initiated: LPN RN o Intervene as needed for safety. The resident is taking meds which are associated with an increased risk of , amnesia, loss of balance, and , that looks like and increases risk of , broken , and . Date Initiated: Certified Nursing Assistant LPN RN o Monitor/document/report PRN any adverse reactions to , : Drowsiness, lack of energy, clumsiness, slow , Slurred speech, and disorientation, , , lightheadedness, , thinking and judgment, memory loss, forgetfulness, , upset, blurred or double vision. UNEXPECTED SIDE EFFECTS: , hostility, rage, aggressive or impulsive behavior, Date Initiated: Resident #76's care plan for behaviors documented, "Resident has behavior problem(s) ...new order for , secondary to having increasing visual , paranoia and agitation, behavior disturbance, sun downing behaviors, - , medication discontinued" Date Initiated: Revision on:	N 071		

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N 071	Continued From page 8 The goal of the care plan was documented as, "Will have a minimized risk of self harm or harm to others through next review." Date Initiated: Revision on: Target Date: Interventions to the care plan included: o Administer medication as ordered (Refer to POS/MAR for current order). Date Initiated: o Services and/or Services as needed and ordered. Date Initiated: Review of Resident #76's electronic and paper-based health record revealed the resident did not have a diagnoses of . During an interview, on at 10:12 AM, with Staff E, LPN, when asked about the order for being for , Staff E stated, "The is for ." When informed that there was no documented diagnosis of or , Staff E did not provide a response. On at 10:20 AM, the Director of Nursing (DON) joined the interview with Staff E and confirmed that there was no diagnoses that included or . During an interview, on at 10:30 AM, with the Social Services Director (SSD), when asked about the care plans being updated based on the medications, diagnoses, and the medications being discontinued, the SSD replied, "those care plans are put in by nursing, MDS puts in the care plans and are following up when something is coming off. If we are missing that, we need to come up with	N 071		

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N 071	Continued From page 9 interventions." The SSD acknowledged that there were no diagnoses that included , , , , or . During an interview, on at 10:42 AM, with the Assistant MDS Coordinator and the Regional MDS Coordinator, when the concerns related to Resident #76's care plan were brought to their attention, while reviewing the resident's record, the MDS Coordinator stated, "there is a psych note , it mentions the GDR (Gradual Dose Reduction) of , and making as needed. As far as their codes go, they have unspecified with agitation, adjustment . it doesn't say anything in their note about , ." On at 11:24 AM, the Regional MDS Coordinator reported that she was reaching out to , , provider in regards to the , and the associated diagnoses. b. Record review revealed Resident #76 was admitted to the facility on and most recently readmitted after a transfer to the hospital per family request due to and . According to the resident's most recent complete assessment, a Quarterly Minimum Data Set (MDS), with a reference date of , Resident #76 had a ( ) score of 12, indicating the resident was 'moderately' , , . Resident #76's diagnoses at the time of the assessment included: Non- , and . Review of Resident #76's electronic and paper-based health records revealed that there	N 071		

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N 071	Continued From page 10 was no care plan to address and provide care to the resident with . During an interview, on at 11:26 AM, with the Regional MDS Coordinator and the Assistant MDS Coordinator, both acknowledged that there was no care plan to address the resident's . Class III	N 071		
N 201 SS=D	400.022(1)(i), FS Right to Adequate and Appropriate Health Care (I) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on record review, observation, and interview, the facility failed to obtain culture results in a timely manner for 1 of 28 sampled residents, (Resident #12); failed to administer medications in a timely manner for 1 of 28 sampled residents (Resident #92); failed to obtain a consult in a timely manner and failed to obtain a culture in a timely manner for 1 of 2 sampled residents for use, Resident #1; and failed to obtain a physician's order for CPAP (Continuous Positive Airway Pressure), and failed to develop and implement a care plan for CPAP for 1 of 1 sampled resident, Resident #304.	N 201	On , Resident #12 was assessed by the provider. is healing without complications and no s/s of current . On , resident #92 was evaluated by the provider with no acute findings noted. On , the medical records/ , , staff made the consult for resident #1. On , resident # 1 was reevaluated by the provider with no acute findings. On , additional CPAP orders were obtained for Resident # 304. On , the care plan for a CPAP was	

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N 201	Continued From page 11 The findings included: 1. Record review revealed Resident #12 was admitted to the facility on with diagnoses included to the right . A comprehensive assessment dated revealed Resident #12 was and required partial / for activities of daily living (ADLs). The assessment further documented the resident had 2 / . Resident #12 was care planned for a right / and a left heel . Review of Resident #12's physician orders revealed an order dated for a culture of the resident's left heel . Review of Resident #12's progress notes revealed a note dated at 11:34 AM that documented: culture for the left heel was ordered by the Care NP (Nurse Practitioner) and is currently labeled as pending collection by the lab. Review of the progress note dated at 5:22 PM documented: culture collected and put in fridge for lab tech to pick up tonight. Review of Resident #12's culture results revealed it was collected on , received on , and reported on . The culture was positive for Extended Spectrum B-Lactamase (ESBL), a multiple drug resistant organism, that requires isolation. Resident #12 was ordered , an .	N 201	revised by the Regional Nurse Consultant. On , the Regional Nurse Consultant conducted a quality review of current residents with cultures ordered in the past 30 days to ensure that the culture was obtained within the appropriate time frame. No additional findings were noted. On , the Regional Nurse Consultant conducted a quality review of medication administrations for the past 24 hours. Follow up based on findings. On , the Regional Nurse Consultant conducted a quality review of current residents with to ensure physician orders for , consults and cultures in the past 30 days have been followed timely. No additional findings were noted. On , DON conducted a quality review of current residents who require the use of a CPAP to ensure proper physician orders and care plans were in place. No additional findings were noted. By , licensed nurses were educated by the Staff Development Coordinator on the components of N201 with an emphasis on obtaining cultures timely and administering medications timely. As a systematic change, newly hired licensed nurses will be educated on the components of N201 with an emphasis on obtaining cultures timely and administering medications timely during orientation. By , licensed nurses were educated by the Staff Development Coordinator on N201 with an emphasis on obtaining	

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N 201	Continued From page 12 on . An interview was conducted with the Assistant Director of Nursing (ADON) on at 12:00 PM. The ADON did not know why there was a delay of 22 days from the time of the collection of the culture to when the culture was received in lab. The ADON stated Resident #12 was started on , ( ) at the time the culture was ordered. The ADON further stated the resident's was resistant to , . There was a delay in effective treatment. 2. Record review revealed Resident #1 was admitted to the facility on . A comprehensive assessment dated documented the resident had mild , and required partial / with activities of daily living (ADLs). The assessment documented that the resident had an . The record revealed Resident #1 was care planned for at risk for related to dependence related to diagnosis of . . An intervention included care every shift and obtain labs as ordered. Review of Resident #1's physician orders revealed an order dated for a urologist consult for a evaluation. An order dated documented to fax results to the urologist. An order dated documented to follow up with the urologist. Review of Resident #1's progress notes revealed a note dated at 3:06 PM that documented: "Resident is scheduled to go see on at 10:45 AM. The	N 201	, consults and cultures timely. As part of a systematic change, newly hired licensed nurses will be educated on N201 with an emphasis on obtaining , consults and cultures timely. By , licensed nurses were educated by the staff development coordinator on the components of N201 with an emphasis on obtaining appropriate physician orders for use of a CPAP as well as implementing a care plan for the CPAP. As part of a systematic change, newly hired licensed nurses will be educated on the components of N201 with an emphasis on obtaining appropriate physician orders for use of a CPAP as well as implementing a care plan for the CPAP during orientation. DON/Designee will conduct quality monitoring of order listing reports 5 times weekly x 4 weeks, then 5 monthly x 2 months to ensure that cultures ordered are obtained timely. DON/Designee will conduct quality monitoring of 5 random residents weekly x 4 weeks, then 10 random residents monthly x 2 months to ensure that medications are administered within the appropriate time frame. The findings of these quality monitoring to be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met. DON/Designee will conduct quality monitoring of order listing reports 5 times weekly x 4 weeks, then 10 order listing reports monthly x 2 months to ensure that cultures and , consults are obtained timely. The	

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	95030	A. BUILDING: _____ B. WING _____	05/22/2025

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N 201	Continued From page 13 , , is only pending if the office gets a referral. They stated they would send it over to pcp (primary care physician) and then wait. I will also call and follow up before , , to see if the referral was completed. If not the , , must be rescheduled until we can obtain a referral. I will continue to follow up." Further record review revealed no follow up for a urologist referral for Resident #1. An interview was conducted with Medical Records staff (MR) on at 12:00 PM. The MR stated she is responsible for making , , and referrals. MR further stated Resident #1 was transferred to the hospital on . MR acknowledged there was no follow up with a urologist consult. 3. Record review revealed Resident #1 was admitted to the facility on . A comprehensive assessment dated documented the resident had mild , and required partial / with activities of daily living (ADLs). The assessment documented that the resident had an . Record review revealed an order dated for a (C&S) for Resident #1. Review of the resident's culture revealed the specimen was collected on and reported on . Resident #1 was started on for a ( ) on . An interview was conducted with the Assistant Director of Nursing (ADON) on . The ADON could not explain the delay in obtaining Resident #1's sample.	N 201	findings of these quality monitoring to be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met. DON/Designee will conduct quality monitoring of 3 residents who require CPAPs weekly x 4 weeks and 5 residents who require CPAPs monthly x 2 months to ensure that proper physician orders and care plans are in place. The findings of these quality monitoring to be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met.	

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N 201	Continued From page 14 4. Review of the facility's policy, titled, Medication Administration, with a reviewed / revised date of included in part the following: "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or . Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician." Record review for Resident #92 revealed the resident was admitted to the facility on with diagnoses that included in part the following: Total Detachment Right , , Left , Category 5 Normal Vision Right , , Other Lack of Coordination, Unspecified Abnormalities of Gait and Mobility, Abnormal Posture, Difficulty in Walking, Need for Assistance with Personal Care, (Generalized), Segmental and , of Lower Extremity, Segmental and , of Region, Segmental and , of Region, and Scars After Surgery for Detachment . The Minimum Data Set dated documented in Section C a Brief Interview of Mental Status ( ) score of 14 indicating an intact response. Review of the Physician's Orders for Resident #92 revealed the following orders: An order dated for Oral Tablet 5 MG Give 1 tablet by in the morning. An order dated for , , Oral Tablet 5 MG (, ,) Give 1 tablet by two times a day.	N 201		

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N 201	Continued From page 15 An order dated for , Oral Tablet 20 MG Give 1 tablet by in the morning. An order dated for Oral Tablet 5 MG Give 1 tablet by at bedtime. An order dated for ER 5 MG Tablet extended release 24 hour, Give 1 tablet by one time a day for Overactive An order dated for Oral Tablet 10 MG Give 1 tablet by at bedtime. An order dated for A-D Oral Tablet 2 MG Give 1 tablet by every 6 hours as needed. An order dated for 4 in 1 Oral Packet ( ) Give 1 packet by in the evening. An order dated for Powder (Polyethylene 3350) Give 17 gram by one time a day for Irregularity. An order dated for Solution 0.5 % Instill 1 drop in both two times a day for detachment An order dated for Incruse 62.5 MCG/ACT Aerosol Powder, breath activated 1 dose inhale orally one time a day for per patient request. Review of the Medication Administration (Admin) Audit Report for Resident #92 from to documented in part the following: On scheduled for 5:00 PM was given at 6:30 PM. On and were scheduled for 9:00 PM and were given at 11:09 PM. On Solution, Incruse and were scheduled for 9:00 AM and given between 10:04 AM and 10:14 AM. On	N 201		

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N 201	Continued From page 16 Solution, Incruse , were scheduled for 9:00 AM and given between 10:32 AM and 10:36 AM. On , were scheduled for 9:00 PM and given at 11:37 PM. On , Solution, Incruse , , and , were scheduled for 9:00 AM and given at 10:10 AM. On Solution was scheduled for 6:00 PM and was given at 8:33 PM. On Incruse , Solution, , , and was scheduled for 9:00 AM given between 11:18 AM and 11:28 AM. On Incruse , Solution, , , and were scheduled for 9:00 AM were given between 10:30 AM and 1:01 PM. On , , , and were scheduled for 9:00 PM and given at 11:08 PM. On , and were scheduled for 9:00 AM and given between 10:11 AM and 10:12 AM. On , , and were scheduled for 9:00 PM and given at 11:23 PM. On Solution, , , and were scheduled for 9:00 AM were given at 12:03 PM. On , and were scheduled for 9:00 PM and given at PM. In summary, the above medications were given outside of the 1 hour before or after the scheduled times and considered late. Some	N 201		

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N 201	Continued From page 17 medications were administered as late as 3 hours and 3 minutes late. An interview was conducted on at 11:44 AM with Resident #92 who stated he sometimes gets his 9:00 AM morning medications late, sometimes hours late. An interview was conducted on at 9:20 AM with Staff B, Registered Nurse (RN), who stated she has worked at the facility for 1 year. When asked when medications are considered late, she said we have 1 hour before and 1 hour after the scheduled to give the medication, if it is more than an hour early or more than an hour late, it is considered late. An interview was conducted on at 12:45 PM with Staff C, Licensed Practical Nurse (LPN), who stated she has been working at the facility for about 2 years. She also serves as a Weekend Supervisor every other weekend and has been doing so for about 1 year. When asked when medications are considered late, she said an hour before and an hour after scheduled time is considered on time. An interview was conducted on at 1:20 PM with the Director of Nursing (DON) who stated she has worked at the facility for about 2 years. When asked when medications are considered late, she said the nurses can administer a medication up to 1 hour before or 1 hour after the scheduled to time or it would be considered to be late. 5. Record review revealed Resident #304 was admitted on with diagnoses that included ( ), Dependency,	N 201		

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N 201	Continued From page 18 , and and . Review of Minimum Data Set (MDS) assessment for Resident #304 dated documented in Section C revealed a Brief Interview of Mental Status ( ) score of 15 indicating intact cognition. Review of Section O revealed a blank space for CPAP (Continuous Positive Airway Pressure). Review of the care plan did not indicate goals, plans and interventions for the CPAP. Observations conducted on at 9:00 AM, at 11:00 AM, and at 2:00 PM, revealed a CPAP machine and tubing on the bedside table next to the left side of Resident #304 bed. An interview was conducted with Resident #304 who when asked how often he uses the CPAP machine, responded, "Everyday". Review of the physician orders for Resident #304 revealed a CPAP order was received on during the last day of the survey after surveyor intervention. Class III	N 201		

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F 000	INITIAL COMMENTS An unannounced recertification survey was completed on to at Royal Palm Beach Health and Rehabilitation Center. The facility was not in compliance with CFR 42, Part 483, Requirements for Long Term Care Facilities.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/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 657	Continued From page 1 Based on interviews and record review, the facility failed to revise and update care plan interventions timely for 1 of 4 sampled residents reviewed for , Resident #92; failed to revise and update care plans with changes for diagnoses and medications for 1 of 5 sampled residents reviewed for unnecessary medications, Resident #76; and failed to develop and implement a care plan for a resident with for 1 of 5 sampled residents reviewed for unnecessary medications, Resident #76. The findings included: Review of the facility's policy, titled, Comprehensive Care Plans, with a reviewed / revised date of , included in part the following: "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing and mental and , , needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. the objectives will be utilized to monitor the residents' progress. Alternative interventions will be documented as needed. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their role and responsibilities for carrying out the interventions initially and when changes are made." 1. Record review revealed Resident #92 was admitted to the facility on with diagnoses	F 657	The statements made on this plan of correction are not an admission to and do not constitute an agreement with alleged deficiencies herein. To remain compliant with all federal and state regulations, the facility has taken actions set forth in the plan of correction. The plan of correction constitutes the facility's allegation of compliance such as the deficiencies cited have been corrected by the date certain. On , the DON updated the care plan and added the appropriate intervention for resident # 92. On , the regional reimbursement Coordinator revised and updated the care plans for the changes of diagnosis and medications for resident #76. On , the regional reimbursement Coordinator initiated the care plan for resident #76. On , the Regional Nurse Consultant conducted a quality review of residents who have had a in the past 30 days to ensure that interventions are added to the care plan timely. Follow up based on findings. On , the Regional Reimbursement Coordinator conducted a quality review of residents with new active diagnosis or medication changes in the past two weeks to ensure that care plans were appropriately developed or updated. Follow up based on findings. On , the Regional Nurse Consultant conducted a quality review of current residents with the diagnosis of to ensure that appropriate care plans have been	

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F 657	Continued From page 2 that included in part the following: Total Detachment Right , , Left , Category 5 Normal Vision Right , , Other Lack of Coordination, Unspecified Abnormalities of Gait and Mobility, Abnormal Posture, Difficulty in Walking, Need for Assistance with Personal Care, (Generalized), Segmental and of Lower Extremity, Segmental and of Region, Segmental and of Region, and Scars After Surgery for Detachment . The Minimum Data Set dated documented in Section C a Brief Interview of Mental Status score of 14 indicating an intact response. Review of the facility incident log documented the following: On , an unwitnessed for Resident #92. On , a witnessed for Resident #92. Review of the physician's orders revealed an order dated for, 'Legally every shift'. Review of the Nursing Note for Resident #92 documented the resident "slid from his wheelchair (w/c) while he was trying to stand up. , was trying to change his w/c, because the right side couldn't be locked. Resident stated, I just slide from the chair, because I forgot to lock my w/c when I was trying to stand up to change the w/c. Resident assessed and assisted to chair by staffs. scrape noted in the right interior and left exterior." Review of the care plan for Resident #92 dated	F 657	developed. No additional findings noted. By , the licensed nurses including the MDS nurses were educated by the Staff Development Coordinator on the components of F657 with an emphasis on accurate revisions and updating of care plans. As a systematic change, newly hired licensed nurses, including MDS nurses, will be educated on the components of F657 with an emphasis on accurate revisions and updating of care plans. DON/designee will conduct quality monitoring audits of 10 random residents weekly x 4 weeks then 10 random residents monthly x 2 months to ensure proper revision and updating of the care plans. The findings of these quality monitoring to be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met.	

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with a focus on the resident is at risk for and related injury due to vision , right and left , , documented: The goals was to minimize risk for and related injuries through next review date. The interventions included the following: Assist with toileting and transfers as needed. Complete Risk Screen as indicated. Cue for safety awareness. Ensure call light is within reach and encourage use for assistance. Keep frequently used items within reach. Orient resident to environment/surroundings. Provide resident teaching to included: Safety measures to reduce risk, use call light to requesting assistance before attempting to transfer or ambulate. / /ST (, , / , , ,) Screening for safety. , , screen as indicated. In summary the care plan was not updated after Resident #92 sustained a on .

An interview was conducted on at 12:28 PM with Resident #92 who stated he had the other day when moving from one wheelchair to another wheelchair and scraped both of his arms. He stated he is and had requested a wheelchair that was taller. When they provided him with the wheelchair he later realized the right side of the wheelchair would not lock and this was on the weekend so he went down to the , , department to switch out the wheelchair and with all the commotion he had forgotten to lock the left side of the wheelchair before moving from the wheelchair with the broken lock to the new wheelchair and when he stood up the wheelchair moved backward and he and scraped both of his arms.

An interview was conducted on at 12:45

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PM with Staff C Licensed Practical Nurse (LPN) who stated she has been working at the facility for about 2 years. When asked about , she stated that for witnessed the nurse will notify the family, the physician and management, as well as assess and monitor the resident. When asked about the care plan being updated if have , she does update any care plan it may be updated by management or Minimum Data Set.

During an interview conducted on at 1:20 PM with the Director of Nursing who stated she has worked at the facility for about 2 years. When asked about , the DON said the care plan should be updated by the care plan team (MDS team) each time the resident has a .

During an interview conducted on at 4:37 PM with the Minimum Data Set (MDS) Assistant who stated she has worked at the facility for 3 months with the Regional MDS Reimbursement Consultant who stated she has worked with the company for 2 years. They stated the full time MDS Coordinator went per diem (as needed) in , . When asked if a resident has a do they update the care plan, they said yes they update the interventions not date on the care plan. The care plan intervention is up dated on day of the or the next day. They stated the nursing staff can also put interventions in the care plan as well.

2. Review of the facility's policy, Unnecessary Drugs - Without Adequate Indication for Use, with a reference date of and a revision date of , documented:
"It is the facility's policy that each resident's drug regimen is managed and monitored to promote or

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F 657	Continued From page 5	F 657		

maintain the resident's highest practicable mental, physical and , well-being free from unnecessary drugs.
Policy Explanation and Compliance Guidelines:
1. The indications for initiating, withdrawing, or withholding medications(s), as well as the use of non-pharmacological approaches, will be determined by assessing the resident's underlying condition, current signs, symptoms, expressions, preferences, and goals for treatment including identification of underlying causes (when possible).
7. Information gathered during the initial and ongoing evaluations will be incorporated into the resident's comprehensive care plan that reflects person-centered medication related goals and parameters for monitoring the resident's condition, including the likely medication effects and potential for adverse consequences."

a. Record review revealed Resident #76 was admitted to the facility on and most recently readmitted after transfer to the hospital per family request related to and .

Review of the resident's most recent complete assessment, a Quarterly MDS, with a reference date of , revealed Resident #76 had a score of 12, indicating the resident was moderately . Resident #76's diagnoses at the time of the assessment included: Non- .

It was determined that Resident #76 was not interviewable as evidenced by the resident provided nonsensible answers to simple questions.

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Review of Resident #76's physicians orders included:
Oral Tablet 50 MG ( ) - Give 1 tablet by at bedtime for , dated .
Resident #76 did not have any current orders for medications

Further review of Resident #76's records revealed the following discontinued orders:
Oral Tablet 50 MG ( ) - Give 1 tablet by at bedtime for - that was d/c same day
Oral Tablet 10 MG ( ) - Give 1 tablet by every 12 hours for - with an end date of
Oral Tablet 10 MG ( ) - Give 1 tablet by every 12 hours as needed for - with an end date of

Injection Solution 2 MG/ML ( ) - Inject 0.5 mg every 12 hours as needed for / agitation - with an end date of
Injection Solution 2 MG/ML ( ) - Inject 0.5 mg every 12 hours as needed for / agitation for 30 Days- with an end date of .

Resident #76's care plan for , medications documented, "Resident is at risk for complications related to the use of , drugs related to a diagnosis of , ", Date Initiated: Revision on: .
The goal of the care plan was documented as, "Resident will have the smallest most effective dose without side effects throughout the next

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review", Date Initiated: Revision on: Target Date:
Interventions to the care plan included:
o Monitor for continued need of medication as related to behavior and Date Initiated: RN LPN [Registered Nurse Licensed Practical Nurse]

Resident #76's care plan for medications documented, "Resident is at risk for adverse reactions to medications used for "Date Initiated: , Revision on:

The goal of the care plan was documented as, "Resident will have a minimized risk of adverse reactions through next review date." Date Initiated: Revision on:
Target Date:
Interventions to this care plan included:
o Administer medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Date Initiated: LPN RN
o Intervene as needed for safety. The resident is taking meds which are associated with an increased risk of , amnesia, loss of balance, and , that looks like and increases risk of , broken , and . Date Initiated: Certified Nursing Assistant LPN RN
o Monitor/document/report PRN any adverse reactions to , : Drowsiness, lack of energy, clumsiness, slow , Slurred speech, and disorientation, , , lightheadedness, , thinking and judgment, memory loss, forgetfulness, , upset, blurred or double vision.

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F 657	Continued From page 8 UNEXPECTED SIDE EFFECTS: , hostility, rage, aggressive or impulsive behavior, Date Initiated: Resident #76's care plan for behaviors documented, "Resident has behavior problem(s) ...new order for , secondary to having increasing visual , paranoia and agitation, behavior disturbance, sun downing behaviors, - , medication discontinued" Date Initiated: Revision on: The goal of the care plan was documented as, "Will have a minimized risk of self harm or harm to others through next review." Date Initiated: Revision on: Target Date: Interventions to the care plan included: o Administer medication as ordered (Refer to POS/MAR for current order). Date Initiated: o , Services and/or , Services as needed and ordered. Date Initiated: Review of Resident #76's electronic and paper-based health record revealed the resident did not have a diagnoses of , . During an interview, on at 10:12 AM, with Staff E, LPN, when asked about the order for , being for , , Staff E stated, "The , is for , ." When informed that there was no documented diagnosis of , or , Staff E did not provide a response.	F 657		

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On at 10:20 AM, the Director of Nursing (DON) joined the interview with Staff E and confirmed that there was no diagnoses that included , , or , .

During an interview, on at 10:30 AM, with the Social Services Director (SSD), when asked about the care plans being updated based on the medications, diagnoses, and the , medications being discontinued, the SSD replied, "those care plans are put in by nursing, MDS puts in the care plans and are following up when something is coming off. If we are missing that, we need to come up with interventions." The SSD acknowledged that there were no diagnoses that included included , , , or , .

During an interview, on at 10:42 AM, with the Assistant MDS Coordinator and the Regional MDS Coordinator, when the concerns related to Resident #76's care plan were brought to their attention, while reviewing the resident's record, the MDS Coordinator stated, "there is a psych note , it mentions the GDR (Gradual Dose Reduction) of , and making as needed. As far as their codes go, they have unspecified with agitation, adjustment . it doesn't say anything in their note about , ."

On at 11:24 AM, the Regional MDS Coordinator reported that she was reaching out to , , provider in regards to the , and the associated diagnoses.

b. Record review revealed Resident #76 was admitted to the facility on and most recently readmitted after a transfer to

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F 657	Continued From page 10 the hospital per family request due to and According to the resident's most recent complete assessment, a Quarterly Minimum Data Set (MDS), with a reference date of , Resident #76 had a ( ) score of 12, indicating the resident was 'moderately' . Resident #76's diagnoses at the time of the assessment included: Non- , and . Review of Resident #76's electronic and paper-based health records revealed that there was no care plan to address and provide care to the resident with . During an interview, on at 11:26 AM, with the Regional MDS Coordinator and the Assistant MDS Coordinator, both acknowledged that there was no care plan to address the resident's .	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	F 684	On , Resident #12 was	

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F 684	Continued From page 11 failed to obtain culture results in a timely manner for 1 of 28 sampled residents, Resident #12; and failed to administer medications in a timely manner for 1 of 28 sampled residents, Resident #92. The findings included: 1. Record review revealed Resident #12 was admitted to the facility on with diagnoses included to the right . A comprehensive assessment dated revealed Resident #12 was , and required partial / for activities of daily living (ADLs). The assessment further documented the resident had 2 / . Resident #12 was care planned for a right / and a left heel . Review of Resident #12's physician orders revealed an order dated for a culture of the resident's left heel . Review of Resident #12's progress notes revealed a note dated at 11:34 AM that documented: culture for the left heel was ordered by the Care NP (Nurse Practitioner) and is currently labeled as pending collection by the lab. Review of the progress note dated at 5:22 PM documented: culture collected and put in fridge for lab tech to pick up tonight. Review of Resident #12's culture results revealed it was collected on , received	F 684	assessed by the provider. is healing without complications and no s/s of current . On , resident #92 was evaluated by the provider with no acute findings noted. On , the Regional Nurse Consultant conducted a quality review of current residents with cultures ordered in the past 30 days to ensure that the culture was obtained within the appropriate time frame. No additional findings were noted. On , the Regional Nurse Consultant conducted a quality review of medication administrations for the past 24 hours. Follow up based on findings. By , licensed nurses were educated by the Staff Development Coordinator on the components of F 684 with an emphasis on obtaining cultures timely and administering medications timely. As a systematic change, newly hired licensed nurses will be educated on the components of F 684 with an emphasis on obtaining cultures timely and administering medications timely during orientation. DON/Designee will conduct quality monitoring of order listing reports 5 times weekly x 4 weeks, then 5 monthly x 2 months to ensure that cultures ordered are obtained timely. DON/Designee will conduct quality monitoring of 5 random residents weekly x 4 weeks, then 10 random residents monthly x 2 months to ensure that	

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F 684	Continued From page 12 on , and reported on . The culture was positive for Extended Spectrum B-Lactamase (ESBL), a multiple drug resistant organism, that requires isolation. Resident #12 was ordered , , an , on . . An interview was conducted with the Assistant Director of Nursing (ADON) on at 12:00 PM. The ADON did not know why there was a delay of 22 days from the time of the collection of the culture to when the culture was received in lab. The ADON stated Resident #12 was started on , ( ) at the time the culture was ordered. The ADON further stated the resident's was resistant to , . There was a delay in effective treatment. 2. Review of the facility's policy, titled, Medication Administration, with a reviewed / revised date of included in part the following: "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or . Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician." Record review for Resident #92 revealed the resident was admitted to the facility on with diagnoses that included in part the following: Total Detachment Right , , Left , Category 5 Normal Vision Right , , Other Lack of Coordination, Unspecified Abnormalities of Gait and Mobility, Abnormal Posture, Difficulty in Walking, Need for	F 684	medications are administered within the appropriate time frame. The findings of these quality monitoring to be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met.	

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F 684	Continued From page 13 Assistance with Personal Care, (Generalized), Segmental and of Lower Extremity, Segmental and of Region, Segmental and of Region, and Scars After Surgery for Detachment . The Minimum Data Set dated documented in Section C a Brief Interview of Mental Status ( ) score of 14 indicating an intact response. Review of the Physician's Orders for Resident #92 revealed the following orders: An order dated for Oral Tablet 5 MG Give 1 tablet by in the morning. An order dated for Oral Tablet 5 MG ( ) Give 1 tablet by two times a day. An order dated for Oral Tablet 20 MG Give 1 tablet by in the morning. An order dated for Oral Tablet 5 MG Give 1 tablet by at bedtime. An order dated for ER 5 MG Tablet extended release 24 hour, Give 1 tablet by one time a day for Overactive An order dated for Oral Tablet 10 MG Give 1 tablet by at bedtime. An order dated for A-D Oral Tablet 2 MG Give 1 tablet by every 6 hours as needed. An order dated for 4 in 1 Oral Packet ( ) Give 1 packet by in the evening. An order dated for Powder (Polyethylene 3350) Give 17 gram by one time a day for Irregularity. An order dated for .	F 684		

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Solution 0.5 % Instill 1 drop in both , two times a day for detachment
An order dated for Incruse , 62.5 MCG/ACT Aerosol Powder, breath activated 1 dose inhale orally one time a day for per patient request.

Review of the Medication Administration (Admin) Audit Report for Resident #92 from to documented in part the following:
On , scheduled for 5:00 PM was given at 6:30 PM.
On , , , and were scheduled for 9:00 PM and were given at 11:09 PM.
On , , , , , , , , , Solution, Incruse , , , and , were scheduled for 9:00 AM and given between 10:04 AM and 10:14 AM.
On , , , , , , , , , , , , , , Solution, Incruse , were scheduled for 9:00 AM and given between 10:32 AM and 10:36 AM.
On , , , were scheduled for 9:00 PM and given at 11:37 PM.
On , , , , , , , , , , , Solution, Incruse , , and , were scheduled for 9:00 AM and given at 10:10 AM.
On , , , Solution was scheduled for 6:00 PM and was given at 8:33 PM.
On , , , , , , Incruse , , , , Solution, , , and , was scheduled for 9:00 AM given between 11:18 AM and 11:28 AM.
On , , , , , , , Incruse , , , , Solution, , , and , were scheduled for

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F 684	Continued From page 15 9:00 AM were given between 10:30 AM and 1:01 PM. On , , , , and were scheduled for 9:00 PM and given at 11:08 PM. On , and , were scheduled for 9:00 AM and given between 10:11 AM and 10:12 AM. On , , , and were scheduled for 9:00 PM and given at 11:23 PM. On , , , Solution, , , , , , , and , were scheduled for 9:00 AM were given at 12:03 PM. On , , and were scheduled for 9:00 PM and given at PM. In summary, the above medications were given outside of the 1 hour before or after the scheduled times and considered late. Some medications were administered as late as 3 hours and 3 minutes late. An interview was conducted on at 11:44 AM with Resident #92 who stated he sometimes gets his 9:00 AM morning medications late, sometimes hours late. An interview was conducted on at 9:20 AM with Staff B, Registered Nurse (RN), who stated she has worked at the facility for 1 year. When asked when medications are considered late, she said we have 1 hour before and 1 hour after the scheduled to give the medication, if it is more than an hour early or more than an hour late, it is considered late. An interview was conducted on at 12:45	F 684		

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F 684	Continued From page 16 PM with Staff C, Licensed Practical Nurse (LPN), who stated she has been working at the facility for about 2 years. She also serves as a Weekend Supervisor every other weekend and has been doing so for about 1 year. When asked when medications are considered late, she said an hour before and an hour after scheduled time is considered on time. An interview was conducted on at 1:20 PM with the Director of Nursing (DON) who stated she has worked at the facility for about 2 years. When asked when medications are considered late, she said the nurses can administer a medication up to 1 hour before or 1 hour after the scheduled to time or it would be considered to be late.	F 684		
F 690 SS=D	CFR(s): 483.25(e)(1)-(3) §483.25(e) §483.25(e)(1) The facility must ensure that resident who is of and on admission receives services and assistance to maintain unless his or her clinical condition is or becomes such that is not possible to maintain. §483.25(e)(2)For a resident with , based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an is not unless the resident's clinical condition demonstrates that was necessary; (ii) A resident who enters the facility with an or subsequently receives one	F 690		

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F 690	Continued From page 17 is assessed for removal of the as soon as possible unless the resident's clinical condition demonstrates that is necessary; and (iii) A resident who is of receives appropriate treatment and services to prevent and to restore to the extent possible. §483.25(e)(3) For a resident with fecal , based on the resident's comprehensive assessment, the facility must ensure that a resident who is of receives appropriate treatment and services to restore as much normal function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to obtain a consult in a timely manner and failed to obtain a culture in a timely manner for 1 of 2 sampled residents for use, Resident #1. The findings included: 1. Record review revealed Resident #1 was admitted to the facility on . A comprehensive assessment dated documented the resident had mild , and required partial / with activities of daily living (ADLs). The assessment documented that the resident had an . The record revealed Resident #1 was care planned for at risk for related to dependence related to diagnosis of . An intervention included	F 690	On , the medical records/ staff made the consult for resident #1. On , resident # 1 was reevaluated by the provider with no acute findings. On , the Regional Nurse Consultant conducted a quality review of current residents with to ensure physician orders for consults and cultures in the past 30 days have been followed timely. No additional findings were noted. By , licensed nurses were educated by the Staff Development Coordinator on F 690 with an emphasis on obtaining consults and cultures timely. As part of a systematic change, newly hired licensed nurses will be educated on F 690 with an emphasis	

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F 690	Continued From page 18 care every shift and obtain labs as ordered. Review of Resident #1's physician orders revealed an order dated for a urologist consult for a evaluation. An order dated documented to fax results to the urologist. An order dated documented to follow up with the urologist. Review of Resident #1's progress notes revealed a note dated at 3:06 PM that documented: "Resident is scheduled to go see on at 10:45 AM. The is only pending if the office gets a referral. They stated they would send it over to pcp (primary care physician) and then wait. I will also call and follow up before to see if the referral was completed. If not the must be rescheduled until we can obtain a referral. I will continue to follow up." Further record review revealed no follow up for a urologist referral for Resident #1. An interview was conducted with Medical Records staff (MR) on at 12:00 PM. The MR stated she is responsible for making and referrals. MR further stated Resident #1 was transferred to the hospital on . MR acknowledged there was no follow up with a urologist consult. 2. Record review revealed Resident #1 was admitted to the facility on . A comprehensive assessment dated documented the resident had mild and required partial / with activities of daily living (ADLs).	F 690	on obtaining consults and cultures timely. DON/Designee will conduct quality monitoring of order listing reports 5 times weekly x 4 weeks, then 10 order listing reports monthly x 2 months to ensure that cultures and consults are obtained timely. The findings of these quality monitoring to be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met.	

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F 690	Continued From page 19 The assessment documented that the resident had an Record review revealed an order dated for a (C&S) for Resident #1. Review of the resident's culture revealed the specimen was collected on and reported on . Resident #1 was started on for a ( ) on . An interview was conducted with the Assistant Director of Nursing (ADON) on . The ADON could not explain the delay in obtaining Resident #1's sample.	F 690		
F 695 SS=D	Care and Suctioning CFR(s): 483.25(i) § 483.25(i) care, including care and suctioning. The facility must ensure that a resident who needs care, including care and suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to obtain a physician's order for CPAP (Continuous Positive Airway Pressure), and failed to develop and implement a care plan for CPAP for 1 of 1 sampled resident, Resident #304. The findings included:	F 695	On , additional CPAP orders were obtained for Resident # 304. On , the care plan for a CPAP was revised by the Regional Nurse Consultant. On , DON conducted a quality review of current residents who require the use of a CPAP to ensure proper physician orders and care plans were in	

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F 695	Continued From page 20 Record review revealed Resident #304 was admitted on with diagnoses that included ( ), , Dependency, , and and . Review of Minimum Data Set (MDS) assessment for Resident #304 dated documented in Section C revealed a Brief Interview of Mental Status ( ) score of 15 indicating intact cognition. Review of Section O revealed a blank space for CPAP (Continuous Positive Airway Pressure). Review of the care plan did not indicate goals, plans and interventions for the CPAP. Observations conducted on at 9:00 AM, at 11:00 AM, and at 2:00 PM, revealed a CPAP machine and tubing on the bedside table next to the left side of Resident #304 bed. An interview was conducted with Resident #304 who when asked how often he uses the CPAP machine, responded, "Everyday". Review of the physician orders for Resident #304 revealed a CPAP order was received on during the last day of the survey after surveyor intervention.	F 695	place. No additional findings were noted. By , licensed nurses were educated by the staff development coordinator on the components of F695 with an emphasis on obtaining appropriate physician orders for use of a CPAP as well as implementing a care plan for the CPAP. As part of a systematic change, newly hired licensed nurses will be educated on the components of F695 with an emphasis on obtaining appropriate physician orders for use of a CPAP as well as implementing a care plan for the CPAP during orientation. DON/Designee will conduct quality monitoring of 3 residents who require CPAPs weekly x 4 weeks and 5 residents who require CPAPs monthly x 2 months to ensure that proper physician orders and care plans are in place. The findings of these quality monitoring to be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met.	
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure	F 700		

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F 700	Continued From page 21 correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and . §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure residents did not use full side rails who were not properly assessed for the use of side rails and consent for side rails had been declined for 1 of 52 sampled residents with side rails, Resident #45. The findings included: Review of the facility's policy, titled, Bed Rails Informed Consent for Use, with no date, included in part the following: "It is the policy of this facility to use bedrails only after an individualized resident assessment, evaluation and care planning by an interdisciplinary team determine it beneficial and appropriate for use to treat the resident's medical symptoms, assist the resident in attaining or maintaining the highest possible physical and well-being and after	F 700	On , the siderails for resident #45 were removed by the maintenance director. On , the Regional Nurse Consultant conducted a quality review of current residents with siderails to ensure that proper assessments and consents were in place. No additional findings were noted. By , current licensed nurses were educated by the Staff Development Coordinator on the components of F 700 with an emphasis on proper assessment and obtaining consent for bedrails. As part of a systematic change, newly hired licensed nurses will be educated on the components of F 700 with an emphasis	

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F 700	Continued From page 22 attempts at using alternatives have proven inadequate or inappropriate." Record review revealed Resident #45 was originally admitted to the facility on with the most recent readmission to the facility on , with diagnoses that included in part the following: Type 2 with Unspecified Injury of Subsequent Encounter, Other Lack of Coordination, Unspecified Abnormalities of Gait and Mobility, Difficulty in Walking, (Generalized), , Repeated , Essential (Primary) , and . Review of the Minimum Data Set (MDS) assessment dated documented in Section C a Brief Interview of Mental Status score of 12 indicating moderate . The MDS documented in Section P for Bed Rail, 'not used'. Review of the physician's orders for Resident #45 revealed an order dated for no side rails. Review of the physician's orders for Resident #45 revealed an order dated to 'admit to hospice on ( ) related to diagnosis of (Hypertensive)'. Review of the Side Rail Evaluation for Resident #45 dated documented in Section D, based on questions answered above, are side rails indicated, answered No. Review of Bed Rails Informed Consent for Use for Resident #45 dated signed by the resident's daughter documented she does not	F 700	on proper assessment and obtaining consent for bedrails. DON/Designee will conduct quality monitoring of 5 residents with siderails weekly x 4 weeks, then 10 residents with siderails monthly x 2 months to ensure that proper assessment and consents are in place. The findings of these quality monitoring to be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met.	

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consent to use of bed rail(s) as recommended and understand related liabilities.

Review of the care plans for Resident #45 dated revealed a focus on the resident 'is at risk for and related injury r/t [related to] , mobility'. The goal was to minimize risk for and related injuries through next review date. The interventions included in part the following: "Ensure call light is within reach and encourage use for assist with standing/transferring and ambulation. Every 15 minutes checks. Remind resident and reinforce safety awareness: Lock brakes on bed, chair, etc. before transferring. When rising from a lying position, sit on side of bed for a few minutes before transferring/ standing. Educate/remind resident to request assistance using call light prior to ambulation. Appropriate footwear. Report to physician and responsible party. In summary side rails were not addressed."

On at 11:38 AM, an observation was made of Resident # 45 lying in bed with full side rails, the right side was up, and the left side was down.

On at 9:00 AM, an observation was made of Resident #45 lying in bed with full side rails up on both sides of the bed.

On at 9:12 AM, an interview was conducted with Staff D, Certified Nursing Assistant (CNA), who stated she has worked at the facility for 2 years and a couple of months. When asked about the side rails for Resident #45, she said he has the side rails on his bed because he is on hospice and the bed came from hospice. When asked are the side rails up all of

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the time, the CNA said yes when he is in bed except for when he is eating like now, then one side is lowered to put the table in front of him so he can eat.

A side-by-side observation was conducted on [redacted] at 3:25 PM with Staff C, Registered Nurse (RN), who acknowledged Resident #45 had full side rails up on both sides of the bed. Staff C said she was unsure if the resident was on hospice and that may be why he has the full side rails. Staff C was not assigned to the resident.

An interview was conducted on at 3:35 PM with the Director of Nursing (DON) and the Administrator, who were asked if they use side rails, and said they only use half and quarter side rails. The DON said for a resident to have side rails, they evaluate for safety, obtain consent for side rails, obtain a physician's order and would have a care plan in place.

A side-by-side observation was conducted on at 3:40 PM with the DON and the Administrator who both acknowledged Resident #45 had 2 full side rails on the bed with one side rail up at the time of the observation.

An interview was conducted on at 4:00 PM with the DON who said the hospice nurse had ordered the fully electric bed for the resident, but they were unable to tell when the bed was delivered or if they had assessed the resident for safety with side rails in a bed. The DON stated Resident #45 was removed from the bed with the full side rails and placed in another bed immediately after she had observed the resident in the bed with the full side rails.

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F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug , ,); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure behavior monitoring for 3 of 5 sampled residents reviewed for unnecessary medications, Residents #34, 76, 14. The findings included: Review of the facility's policy, titled, Behavior Monitoring, with a reference date of and a revision date of , documented, in part: "Policy: Residents who exhibit behavioral concerns may	F 757	On , resident #34 was discharged from the facility. On , resident #76 was evaluated by the psych provider. No recent behaviors noted and no new orders received. On , resident #14 was evaluated by the psych provider. No recent behaviors noted and no new orders received. On , the Director of Nursing conducted a quality review of current residents who require behavior monitoring. No additional findings were	

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F 757	Continued From page 26 require behavior monitoring. Facility will monitor behaviors per their plan of care. Policy Explanation and Compliance Guidelines: 4. Behaviors shall be documented clearly and concisely in the medical record. 5. Behaviors shall be identified, and approaches should be included in the comprehensive plan of care. 6. The plan of care shall be reviewed at least quarterly and revised as needed." 1. Record review documented Resident #76 was admitted to the facility on . According to the resident's most recent complete assessment, a Quarterly Minimum Data Set (MDS) assessment, with a reference date or , Resident #76 had a ( ) score of 12, indicating the resident was moderately . Resident #76's diagnoses at the time of the assessment included: Non- , and . Resident #76's care plan for , medications documented: Residen is at risk for complications related to the use of , drugs related to a diagnosis of , . Date Initiated: Revision on: The goal of the care plan was documented as: Resident will have the smallest most effective dose without side effects throughout the next review Date Initiated: Revision on: Target Date: Interventions to the care plan included: o Monitor for continued need of medication as related to behavior and Date Initiated: o Monitor for changes in mental status and	F 757	noted. By , the Staff Development Coordinator educated licensed nurses on the components of F757 with an emphasis on appropriate completion of the behavior monitoring. As part of a systematic change, licensed nurses will be educated on the components of F757 with an emphasis on appropriate completion of the behavior monitoring during orientation. DON/Designee will conduct an audit of residents who require behavior monitoring weekly x 4 weeks and then 10 residents who require behavior monitoring monthly x 2 months to ensure that the behavior monitoring orders are appropriately completed by the licensed nurses. The findings of these quality monitoring to be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met.	

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F 757	Continued From page 27 functional level and report to MD as indicated Date Initiated: o Monitor for side effects and consult physician and or pharmacist as needed Date Initiated: Review of Resident #76's physicians' orders included: Oral Tablet 50 MG ( ) - Give 1 tablet by at bedtime for , - Medication - Observe for , and/or paranoia. Document:'Y' if resident is having behaviors and 'N' if the resident does not have behaviors. If 'Y' document in the PNs (Progress Notes) - Review of Resident #76's Medication Administration Record in the electronic health records revealed that staff marked an 'X' in the section of the record for the Day medications for 11 of the 21 days of the record and for 18 of the 21 days of the record for the night medications. An interview was conducted on at 10:06 AM with Staff N, Licensed Practical Nurse (LPN), who when asked about documentation of monitoring for the resident's behaviors, replied, "there is a monitor in the computer that we use and we document in progress notes if there are any behaviors. When I am here, it is either yes or no." When asked about documenting behaviors for the PM shift, the LPN replied, "It might be a system thing." An interview ws conducted on at 10:12 AM, with Staff E, LPN, who when asked about documentation of behaviors, replied, "if a resident	F 757		

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is acting out, we give medication and monitor again to see if the medication is affective or not and we document in the behavior monitoring. When asked about the documentation in the MAR, Staff L replied, "I don't know why it appears like that. When there is a behavior, we documented it in the MAR and in the progress note." The LPN acknowledged that the behavior monitoring documentation was not done per the order.

An interview was conducted on at 1:30 PM, with Staff O, Registered Nurse (RN), who when asked about documentation of behaviors, the RN replied, "I put it in the MAR. If there are no behaviors, there is nothing to document. If something happens, you go into the progress notes and document the behavior and what happened." The RN acknowledged that the behavior monitoring was not done per the order.

2. Record review for Resident #14 revealed the resident was admitted to the facility on with a recent readmission on with diagnoses that included in part the following: Major , , Unspecified ' Communication , and General . The Minimum Data Set (MDS) assessment dated documented in Section C a Brief Interview of Mental Status ( ) score of 5 indicating severe .

Review of the Physician's Orders for Resident #14 revealed in part the following: An order dated for Side Effect Observation included: "1-Dystonia, torticollis (stiffness of); 2- symptoms: dry / blurred vision, , /

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F 757	Continued From page 29 retention; 3- ; 4- /drowsiness; 5-Increased / ; 6- abnormalities (, irregular, H.R., NMS); 7- /agitation; 8-Blurred Vision; 9-Sweating / rashes; 10- ; 11- retention / hesitancy; 12- ; 13-Hangover effect; 14- ; 15- ; 16-New Onset every shift for medication side effect monitoring." An order dated for , Medication documented - "Observe for sadness, tearfulness, and/or self-isolation. Document 'Y' if resident has behaviors and 'N' if the resident does not have behaviors. If 'Y' document in the patient notes every shift." An order dated for , Medication documented - "Observe for , and/or paranoia. Document: 'Y' if resident is having behaviors and 'N' if the resident does not have behaviors. If 'Y' document in the patient notes every shift." An order dated for Behavior Monitoring documented - "Observe for (specify resident's behavior). Document: 'Y' if the resident is exhibiting behaviors. 'N' if resident is not exhibiting behaviors. If 'Y' document in the patient notes every shift." An order dated documented for Capsule Delayed Release Particles 30 MG give 1 capsule by two times a day for , An order dated documented for , Oral Tablet 100 MG give 100 mg by at bedtime for with , Review of the Behavior Monitoring Record for Resident #14 from to documented behaviors yes on ,	F 757		

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F 757	Continued From page 30 , and . Review of the behavior and progress notes for Resident #14 from to revealed no documentation of behaviors, interventions or outcomes. Review of the Care Plan for Resident #14 dated with a focus on the resident who has a diagnosis of , and takes medication for management, documented: "The goal was for the resident to have a reduced risk of adverse reactions related to , through the review date. The interventions included in part the following: Monitor / document / report PRN [as needed] adverse reactions to , : change in behavior / / cognition; / ; social isolation, thoughts, withdrawal; decline in ADL [acitivies of daily living] ability, , no ; , , fecal impaction, ; gait changes, rigid , balance problems, movement problems, tremors, cramps, ; / ; fatigue, ; appetite loss, loss, n/v [/], dry , dry , . Observe for changes in /behavior. Record/report changes to physician." Review of the Care Plan for Resident #14 dated with a focus on the resident is at risk for complications related to the use of , , drugs , and , , for management of symptoms of with , , , documented: "The goal was for the resident to have the smallest most effective dose without side effects throughout the next review. The interventions included in part the following: Monitor for continued need of medication as	F 757		

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F 757	Continued From page 31 related to behavior and . Monitor for side effects and consult physician and or pharmacist as needed." Review of the Care Plan for Resident #14 dated with a focus on the resident has a potential for adverse effects related to use of , , medication use , , , , documented: "The goal was for the resident to have a reduced risk of adverse reactions related to medication use through next review date. The interventions included in part the following: Observe side effects and effectiveness. Observe for changes in cognition, /behavior and functional level and report to physician as indicated." 3. Record review for Resident # 34 revealed the resident was admitted on with diagnoses that included Atherosclerotic , , , , and Generalized . Review of MDS assessment for Resident #34 dated , documented in Section C a score of 8 indicating moderate , mental cognition. Review of the physician orders for Resident #34 dated revealed an order for Oral Tablet 50 milligram (MG), give 1 tablet by at bedtime for , . An additional review of physician orders dated revealed , oral tablet 45 MG, give 1 tablet by at bedtime for , . Review of the Medication Administration Record	F 757		

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F 757	Continued From page 32 (MAR) revealed no identification of specific behavior and changes documentation. Some boxes revealed x indicating no behavior, while some boxes revealed a" Y", indicating yes for behavior noted, but no identification of specific behavior. An interview was conducted with Staff A, Social Services Assistant, who has been working here for 2.5 months on at 3:27 PM, who stated when a resident was diagnosed with , and , and receiving medications for these diagnoses, staff monitor their specific behavior. An interview was conducted with the Director Of Nurisng (DON) on at 3:05 PM, who when asked if behaviors are documented in MAR, she responded, "yes". When asked what types of behavior are documented in MAR she stated, whatever the resident is manifesting. An observations was conducted on at 10:00 AM and at 12:00 PM, and the resident was asleep in bed. An observation on at 10:00 AM and at 1:00 PM, and the resident was in the activity room, awake and opening , , but not responding to questions.	F 757		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks.	F 810		

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F 810	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide adaptive equipment for each drink offered to residents who need them when consuming drinks for 1 of 9 residents with orders for adaptive equipment, Resident #19. The findings included: Review of the facility's policy titled, Adaptive Feeding Equipment, with an implemented date of , included in part the following: "Adaptive devices (special devices [special eating equipment and utensils] shall be provided for residents who need or requested them. These may include but are not limited to devices such as silverware with enlarged handles, plate guards, and-or equipment. The dietary department shall be notified of residents needing adaptive equipment; the equipment is stored and maintained in the dietary department. Appropriate utensils shall be placed on the resident's food tray at each meal and returned to the dietary department on the food tray for sanitization." Record review for Resident #19 revealed the resident was originally admitted to the facility on with a readmission on with diagnoses that included in part the following: Non-ST Elevation (NSTEMI) , , Unspecified Protein-Calorie , , , , , , Phase, Need for Assistance with Personal Care, , and . Review of the Minimum Data Set (MDS) assessment dated documented in Section C a Brief Interview of Mental Status	F 810	On , the meal tracker tray cards for resident #19 were updated to include two handled cups for each beverage provided. On , the CDM conducted a quality review of current residents who require adaptive equipment to ensure that the Meal Tracker Tray Card contains the appropriate adaptive equipment with no additional findings noted. On , the Regional Director of Environmental and Food Services educated the Certified Dietary Manager on the components of F810 with an emphasis providing appropriate quantity of adaptive equipment on the meal tray. On , the Certified Dietary Manager educated the dietary staff on the components of F810 with an emphasis providing appropriate quantity of adaptive equipment on the meal tray. As part of a systematic change, newly hired dietary employees will be educated on the components of F810 with an emphasis on providing appropriate quantity of adaptive equipment on the meal tray during orientation. The administrator/designee will conduct 5 observations weekly x 4 weeks, then 10 observations monthly x 2 months to ensure that appropriate adaptive equipment is on the meal tray. The findings of these quality monitoring to be reported to the Quality	

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F 810	Continued From page 34 ( ) score of 4 indicating severe Review of the Physician's Orders for Resident #19 revealed an order dated for "patient to use scoop dish and 2 handle cup with lid to enable maximum intake and minimize spillage of food". Review of the care plan for Resident #19 dated documented a "focus on the resident is at risk for decreased ability to perform ADLS (activities of daily living) in bathing, grooming, personal hygiene, , eating, bed mobility, transfer, locomotion and toileting related to recent hospitalization. The goal was to maintain highest capable level of ADL ability throughout the next review period as evidenced by his/her ability to perform ADLS. The interventions included in part the following: Assist with oral care daily and as needed. Provide adaptive equipment - 2 handled cup with lid, scoop plate with meals." On at 10:30 AM, an observation was made of Resident #19 lying in bed with a Styrofoam cup of water on the overbed table, and no two-handled cup with spouted lid was present. On at 9:40 AM, an observation was conducted of Resident #19 lying in bed with a Styrofoam cup of ice water on her overbed table along with two-handled cup with lid partially filled with clear pale yellow liquid (later identified as apple juice). On the breakfast tray was a carton of milk, a glass of orange juice, no coffee or tea and 1 two-handled cup with spouted lid. An interview was conducted on at 9:43 AM with Staff N, Certified Nursing Assistant	F 810	Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met.	

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F 810	Continued From page 35 (CNA), who stated she has worked at the facility since . When asked about the beverages and two-handled cup for Resident #19, Staff N stated the two-handled cup has apple juice in it that she put in this morning and she would empty the apple juice, rinse the cup and fill it with the orange juice. She stated the two-handled cup on the breakfast tray she would fill with the milk. When asked about a two-handled cup for the resident's water, she said once she is finished with breakfast, she would take the 2 two-handled cups to the kitchen and obtain a clean two-handled cup to bring to the resident's room to fill with the water. An interview was conducted on at 3:08 PM with the Dietary Manager ( ) who stated she has worked at the facility for 1 year. When asked about adaptive equipment, specifically the two handled cups, she said they usually provide them on the meal tray if the resident eats in their room; if the resident eats in the dining room, it would be on the beverage cart located in the dining room. When asked how many two handled cups are provided on a meal tray, she said they should have one for each beverage. When asked about the two handled cups for residnets' water, the stated nursing is responsible to obtain the cups and return them to the kitchen to be cleaned.	F 810		
F 880 SS=E	Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Control The facility must establish and maintain an prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		

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F 880	Continued From page 36 development and transmission of communicable and . §483.80(a) prevention and control program. The facility must establish an prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling and communicable for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable or before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable or should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of ; ( )When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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F 880	Continued From page 37 (v) The circumstances under which the facility must prohibit employees with a communicable or skin from direct contact with residents or their food, if direct contact will transmit the ; and (vi)The hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of . §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to don personal protective equipment (PPE) (gown) for 2 of 2 sampled residents as evidenced during a care for Resident #1, and during , care for Resident #53; failed to provide appropriate means to dispose of used PPE for Resident #97, for 1 of 45 sampled residents on Enhanced Barrier Precautions (EBP); and failed to a according to facility's policy during a check for Resident # 94. The findings included: Review of the policy, titled, Enhanced Barrier Precautions, [EBP] issued on , revealed the following: "PPE for EBP is only necessary	F 880	On , the Staff Development Coordinator provided 1:1 education to Staff G on proper Enhanced Barrier Precautions. On , the Staff Development Coordinator provided 1:1 education for Staff I on Enhanced Barrier Precaution. On , the Staff Development Coordinator provided 1:1 education to Staff L on the proper procedure to and proper hygiene. On , Staff J was given 1:1 education on proper PPE uses for a resident on EBP and proper hygiene. On , Staff Q was given 1:1 education on proper PPE uses for a resident on EBP and proper hygiene. On , a receptacle with	

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F 880	Continued From page 38 when performing high-contact care activities (#2, a); position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room (#2, d)." Review of the policy, titled, , revised on , revealed the following: "the facility will ensure will be cleaned and after each use and according to the manufacturer's instructions for multi-resident use; the will be with a wipe pre-saturated with an EPA registered healthcare that is against , , and , ." 1. Record review revealed Resident #53 was admitted on with diagnoses that included 's without Dyskinesia, Segmental and of region, and Type 2 . Review of most recent Minimum Data Set (MDS) assessment under Section C for the Brief Interview of Mental Status ( ) revealed a score of 15 indicating intact function. Review of the physician orders dated revealed an oder for EBP related to . An observation was conducted on at 3:20 PM with Staff G, Certified Nursing Assistant (CNA), who worked at the facility for 26 years. When doing , care, and changing Resident #53's briefs, Staff G was not wearing PPE. When Staff G, CNA was asked regarding EBP, she responded, "Wash , wear gown and gloves, when resident has ".	F 880	a lid was placed in room of resident #95. On , Staff Development Coordinator conducted a quality review of residents on Enhanced Barrier Precautions to ensure staff are utilizing appropriate PPE and hygiene. On the , Staff Development Coordinator conducted a quality review of residents on transmission-based precautions to ensure that proper waste receptacles were present for staff to discard used PPE. No additional findings were noted. On , the preventionist conducted a quality review of in the center to ensure that they were properly . By , the Staff Development Coordinator educated the current staff on the components of F880 with an emphasis on Proper Donning and Doffing of PPE, Proper adherence to Enhanced Barrier Precautions, and Proper Hygiene. On , the DON educated the ADON/IP on the components of F880 with emphasis on placement of the proper waste receptacles for PPE disposal. By , licensed nurses were educated on the components of F880 with an emphasis on proper technique of by the Staff Development Coordinator. As a part of a systematic change, newly hired staff will be educated on the components of F880 with an emphasis on Proper Donning and Doffing of PPE, Proper adherence to Enhanced Barrier Precautions, and	

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F 880	Continued From page 39 Further interview was conducted with Staff G on at 3:47 PM, who was asked why she did not don a PPE gown while she was doing , care and underwear change to Resident # 53. Staff G stated she was asked to come into the room to answer a call light. She admitted she did not put on PPE gown, and she did not see the EBP sign. She left the room but did not change her mask which she had touched it with her gloved right during , care of this resident. In an interview with Staff I, CNA for 20 years, on at 3:42 PM, she stated both residents in the room have EBP. When asked to explain what the EBP sign means, she responded, "Staff must wear gown, and gloves when providing care to residents in rooms with EBP signposts. When asked what type of care would require PPE gown and gloves, she responded, "When doing , care, you must wear gown and gloves, especially when changing the resident's briefs". She added, " When answering call lights, no gown and gloves are necessary". 2. Record review revealed Resident #94 was admitted on with diagnoses that included , ( ), Type 2 ( ) with , , , , and , , , . Review of the physician orders dated revealed an order for EBP related to . During a medication pass observation on at 3:45 PM, Staff L, Registered Nurse (RN), went inside the room of Resident #94 for a , check. Staff L did not perform hygiene before entering the room. He donned on	F 880	Proper Hygiene. As part of a systematic change, newly hired Preventionists will be educated on F880 with emphasis on placement of the proper waste receptacles for PPE disposal. As part of a systematic change, newly hired licensed nurses will be educated on the components of F880 with an emphasis on proper technique of , . DON/designee will conduct 5 random observations of gown donning and doffing x 4 weeks, then 10 random observations of gown donning and doffing monthly x 2 months to ensure that gowns are being properly worn during high contact care activities. DON/Designee will conduct 10 random hygiene observations weekly x 4 weeks and then 20 random hygiene observations monthly x 2 months to ensure that proper hygiene is performed. DON/designee will conduct 5 observations of , cleaning weekly x 4 weeks then 10 observations of , cleaning monthly x 2 months to ensure proper of equipment. The findings of these quality monitoring to be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met.	

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F 880	Continued From page 40 PPE gown and gloves and performed the check. He left the room and wiped the he had used for Resident #94 with 2 pieces of tissue paper soaked with sanitizer solution. When asked regarding the facility's policy for a used , he responded, "We use the tissue paper and sanitizer, and we let it dry for 2 minutes". An interview ws conducted with Staff E, Licensed Practical Nurse (LPN), on at 3:55 PM, who was observing Staff L. Staff L stated, "There is a required for proper . The facility staff does not use tissue paper soaked with sanitizer solutions for ". An interview was conducted with the Assistant Director of Nursing (ADON) who is the Control staff on at 4:21 PM, who stated, "The facility staff must use the recommended for after use". 3. Record review revealed Resident #1 was admitted to the facility on . A comprehensive assessment dated documented the resident had mild and requires partial / with activities of daily living (ADLs). The assessment documented the resident had an . Resident #1 was care planned for at risk for related to dependence related to diagnosis of . Interventions included enhanced barrier precautions (EBP) and care every shift. An observation of care was conducted	F 880		

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F 880	Continued From page 41 on at 12:20 PM with Staff J and Staff Q, Certified Nurse Assistants. Staff J and Staff Q were waiting in Resident #1's room to perform care. The surveyor entered the resident's room for observation, and Staff J and Staff Q commenced to perform care. Staff J and Staff Q did not have on personal protective equipment (PPE) except gloves. Staff Q was observed cleaning the area. Staff Q then discarded her gloves and donned another pair of gloves without performing hygiene. At the conclusion of care, Staff J and Staff Q acknowledged the above. 4. The Center for Control (CDC) recommendations for the removal of Personal Protective Equipment (PPE) after providing care to a resident on isolation precautions is to remove the PPE prior to exiting the resident's room and discarding in an appropriate waste container. This guidance can be found at: https://www.cdc.gov/ -control/hcp/basics/transmission-based-precautions. The facility's policy, titled, Standards and Guidelines: Personal Protective Equipment, with a reference date of , documented: "Purpose: it is to that extent that we will make every effort to minimize exposures to SARS-CoV-2, the that causes COVID-19 and to treat and provide the best quali8ty care for 'Persons Under Investigation' (PUI) or those 'presumed positive' for COVID-19. The purpose of this clinical policy is to provide care guidance for staff on the current standards for professional practice for COVID-19 (novel coronavirus) and is	F 880		

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F 880	Continued From page 42 subject to changes as the COVID-19 pandemic persists and guidance is provided by the local, state and federal regulatory agencies." Record review revealed Resident #95 was admitted to the facility on . According to the resident's most recent complete assessment, Minimum Data Set (MDS) assessment, with a reference date of , revealed Resident #95 had a ( ) score of 15, indicating the resident was . The MDS documented Resident #93 required partial / for bed mobility and was dependent upon staff for transfers. Resident #95's diagnoses at the time of the assessment included: Shigellosis, , and , Reactive , Sleep , Lack of coordination, , and Abnormal posture. Review of the progress note, date at 10:10, documented, "Note Text: Resident positive for Covid-19; isolation in place and MD [Medical Doctor] / Family notified." Resident #95's care plan for COVID positive, documented, "Resident has active -positive covid 19 Date Initiated: Revision on: ." The goal of the care plan was documented as, " will be resolved without complications by treatment ordered completion date. Date Initiated: Target Date: . Interventions to the care plan included: o Contact Isolation Date Initiated: .	F 880		

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F 880	Continued From page 43 o Droplet Precautions Date Initiated: o Encourage good clean hygiene techniques to avoid cross contamination, especially washing before meals and after movements Date Initiated: o Enhanced Barrier Precautions Date Initiated: o Observe facility policies for control Date Initiated: ." During an interview on at 10:01 AM with Resident #95, it was noted that the only waste receptacles in the resident's room were a small uncovered waste container at the of the resident's bed with a red liner, and the same type of uncovered container at the of the resident's bed, with no additional receptacles for staff to discard used Personal Protective Equipment (PPE). Resident #95 stated that staff donned PPE prior to entering the room and confirmed the diagnosis of COVID-19 the previous week. An interview was conducted on at 2:43 PM with the Preventionist (IP), who when asked about staff removing their PPE, the IP stated that staff should remove PPE prior to exiting the room and that the used PPE should be placed into a red container or a black container with a red bag. At the conclusion of the interview, the IP accompanied the surveyor to the resident's room. Once in the room, it was noted that there was only one small uncovered receptacle at the resident's of the bed and no additional receptacles for staff to discard used PPE after care. The IP acknowledged that there was no appropriate receptacle to discard used PPE into. An interview ws conducted on at 2:57	F 880		

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F 880	Continued From page 44 PM with Staff P, LPN, who when asked about removing PPE when completing care to a resident on droplet precautions, the LPN replied, "You are supposed to remove it at the door, put it in a bag and carry it out. Normally the bins are in the room, I put one in a bin while I was in there earlier today." The LPN acknowledged that there was no appropriate receptacle to discard used PPE.	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observations, the facility failed to ensure each toilet was adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 1 of 68 resident bathrooms room, . The findings included: Review of the facility's policy titled, Call Lights: Accessibility and Timely Response, with a revised date of , included in part the following: "The call system must be accessible to the	F 919	On , the call light in the bathroom of # was unwrapped from the grab bar and assessed to be functional by the maintenance director. On , the Maintenance Director conducted a quality review of the call lights in resident rooms and bathrooms to ensure that they were functioning properly. By , current staff were educated by the Staff Development Coordinator on F919 with an emphasis on ensuring call lights were unwrapped from the grab bar	

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	105494	A. BUILDING _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PALM BEACH HEALTH AND REHABILITATION CENTER	600 BUSINESS PARK WAY ROYAL PALM BEACH, FL 33411

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F 919	Continued From page 45 resident at each toilet and bath or shower facility. The staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director. Ensure the call system alerts staff members directly or goes to a centralized staff work area." On at 9:55 AM, an observation was made of the call device in 's bathroom which had the call cord wrapped around grab bar. On at 9:30 AM, a second observation was made of call device in 's bathroom with the cord wrapped around the grab bar. An interview was conducted on at 3:00 PM with the Director of Maintenance who stated he has worked at the facility for 2.5 to 3 months. When asked about call lights if they are checked for functioning properly, he said he checks all of them including bathrooms to ensure they are functioning properly every month. He also stated they have a Guardian Angel program and staff are assigned to each room and they check the resident rooms daily including the bathrooms. A side-by-side observation was conducted on a 3:10 PM withe the Director of Maintenance (DOM) who acknowledged the call light was wrapped around the grab bar in 's bathroom room. The DOM said it does not function in this fashion, unwrapped the call light from around the grab bar and checked the call light to ensure it was functioning properly. The DOM said the Guardian Angel should have seen the call light and fixed it or notified him to fix it. An interview was conducted on at 3:45 PM with Staff A, Social Service Assistant (SSA),	F 919	and appropriately functioning. As part of a systematic change, the Nursing Home Administrator updated the Angel Rounds form on to include proper call light functioning. NHA/designee will conduct quality monitoring of 10 call lights weekly x 4 weeks and then 20 call lights monthly x 2 months to ensure that call lights are properly functioning. The findings of these quality monitoring to be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met.	

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F 919	Continued From page 46 who stated she has worked at the facility for about 2 months. When asked if she is the Guardian Angel assigned to , she said yes. When asked what she checks, she said one of the things she checks is the call lights, she makes sure they are near each resident in the room, and she checks the call light in the bathroom as well. When asked what she checks for the call light in the bathroom, she said she just checks to make sure it is not missing, and it is not frayed or ripped. When asked if she checks to ensure it is not wrapped around the grab bar or to check if it is working properly, she said she does not check for those things.	F 919		