STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105539	A. BUILDING _____ B. WING _____	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHCARE AND REHAB OF SANFORD	950 MELLONVILLE AVE SANFORD, FL 32771

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Off hours weekend recertification survey was conducted from to . Healthcare and Rehab of Sanford was not in compliance with 42 CFR Part 483 and 488, requirements for Long Term Care Facilities.	F 000		
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 observation, interview, and record review, the facility failed to provide , for 1 of 3 residents reviewed for range of motion (ROM), of a total sample of 36 residents, (#75). Finding: Resident #75 was admitted to the facility on with diagnoses of , , and , following an affecting his left non-dominant side, atrophy and type 2 . Resident #75 was able to express simple needs and answer questions appropriately. On at 12:30 PM, resident #75 was observed in bed, his left arm and were . The resident stated he had a	F 684	1. The physician for resident #75 was notified on and new orders were given for a , , evaluation for a split program for management. , evaluation was completed on . New orders were given by , , , for a management program on . 2. On , an audit was completed by Director of Nursing/designee to ensure residents with a current management program have an appropriate , and physician order. , , evaluations and clarification orders were received as necessary. 3. From to , education was provided to the licensed nurses and	

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 684	Continued From page 1 and was supposed to wear a , everyday. He stated no one helped him with the , , and added, "I can't put them on myself." Review of the of the Occupational , discharge summary dated , noted resident #75 met the goal of wearing a left upper extremity extension , and a resting , . The discharge instructions noted resident #75 would remain in the facility as a long term care resident with an updated , ˬ program in place. Review of the resident's current Activities of Daily Living (ADL) Care Plan noted, "Apply left extension for Management or Maintenance up to 6 hours or as tolerated. Not to be worn at the same time with the left resting , ..." On at 1:02 PM, and at 12:59 PM, the resdient was observed in bed eating lunch. The resident did not have the extension or the resting , on. On at 3:45 PM, resident #75 was observed lying in bed, his left arm was bent at the and his left was at his . The resident used his right to grasp his left , trying to move/extend the left arm. He stated he was not able to straighten out his left arm. He said a Certified Nursing Assistant (CNA) used to put the , on him, but she no longer worked at the facility. He pointed to the of drawers at the end of his bed. He stated the , were in the second drawer from the top. The resident gave permission to open the drawer and both the extension and resting , were in the drawer. The resident explained	F 684	CNAs by the Director of Nursing/designee on following physician orders for , ˬ programs and ensuring there is appropriate documentation in the resident's electronic health record, including documentation of resident refusals. 4. An audit will be completed by Director of Nursing/designee weekly for four weeks and then monthly for two months to ensure residents with a current management program have on appropriate , according to physician orders. The results of the audits will be reported to the Quality Assessment, Assurance, and Compliance Committee monthly for three months or the until the committee has determined substantial compliance has been met.	

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F 684	Continued From page 2	F 684		

he had not worn the , for the past 4 months. The 200 Wing Unit Manager (UM) entered the resident's room and was informed resident #75 had not been seen wearing , for the past 3 days. The resident told her he wanted to wear the , .

On at 4:02 PM, the UM explained the nurses and the CNAs were responsible for placing the , on the residents. She stated there was a task section in the Electronic Health Record that indicated where staff would find the orders for the , . The UM stated the nurses documented the , were placed on the resident on , and at 9:09 AM, 9:20 AM and 9:04 AM respectively. The UM did not provide any other evidence that verified the resident had been wearing the , .

On at 4:30 PM, the Rehab Director and the Occupation , indicated the , department determined what type of , the resident would need and how long it should be worn. They stated if the , were not worn as ordered, the could worsen.

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
	75906	A. BUILDING: _____ B. WING _____	04/30/2025

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HEALTHCARE AND REHAB OF SANFORD	950 MELLONVILLE AVE SANFORD, FL 32771

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N 000	INITIAL COMMENTS Off hours weekend re-licensure survey was conducted from to . Healthcare and Rehab of Sanford had a deficiency at the time of the visit.	N 000		
N 201 SS=D	400.022(1)(l), FS Right to Adequate and Appropriate Health Care (l) 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 observation, interview, and record review, the facility failed to provide , for 1 of 3 residents reviewed for range of motion (ROM), of a total sample of 36 residents, (#75). Finding: Resident #75 was admitted to the facility on with diagnoses of , and , following an affecting his left non-dominant side, atrophy and type 2 . Resdient #75 was able to express simple needs and answer questions appropriately. On at 12:30 PM, resident #75 was observed in bed, his left arm and were . The resident stated he had a and was supposed to wear a , everyday. He stated no one helped him with the , and	N 201	1. The physician for resident #75 was notified on and new orders were given for a , , evaluation for a split program for management. evaluation was completed on . New orders were given by , , , for a management program on . 2. On , an audit was completed by Director of Nursing/designee to ensure residents with a current management program have an appropriate , and physician order. , , evaluations and clarification orders were received as necessary. 3. From to , education was provided to the licensed nurses and CNAs by the Director of Nursing/designee on following physician orders for ,	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/25

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N 201	Continued From page 1 added, "I can't put them on myself." Review of the of the Occupational , discharge summary dated , noted resident #75 met the goal of wearing a left upper extremity extension , and a resting , . The discharge instructions noted resident #75 would remain in the facility as a long term care resident with an updated , program in place. Review of the resident's current Activities of Daily Living (ADL) Care Plan noted, "Apply left extension for Management or Maintenance up to 6 hours or as tolerated. Not to be worn at the same time with the left resting , ..." On at 1:02 PM, and at 12:59 PM, the resdient was observed in bed eating lunch. The resident did not have the extension or the resting , on. On at 3:45 PM, resident #75 was observed lying in bed, his left arm was bent at the and his left was at his . The resident used his right to grasp his left , trying to move/extend the left arm. He stated he was not able to straighten out his left arm. He said a Certified Nursing Assistant (CNA) used to put the , on him, but she no longer worked at the facility. He pointed to the of drawers at the end of his bed. He stated the , were in the second drawer from the top. The resident gave permission to open the drawer and both the extension and resting , were in the drawer. The resident explained he had not worn the , for the past 4 months. The 200 Wing Unit Manager (UM) entered the resident's room and was informed resident #75	N 201	programs and ensuring there is appropriate documentation in the resident's electronic health record, including documentation of resident refusals. 4. An audit will be completed by Director of Nursing/designee weekly for four weeks and then monthly for two months to ensure residents with a current management program have on appropriate , according to physician orders. The results of the audits will be reported to the Quality Assessment, Assurance, and Compliance Committee monthly for three months or the until the committee has determined substantial compliance has been met.	

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N 201	Continued From page 2 had not been seen wearing , for the past 3 days. The resident told her he wanted to wear the , . On at 4:02 PM, the UM explained the nurses and the CNAs were responsible for placing the , on the residents. She stated there was a task section in the Electronic Health Record that indicated where staff would find the orders for the , . The UM stated the nurses documented the , were placed on the resident on , and at 9:09 AM, 9:20 AM and 9:04 AM respectively. The UM did not provide any other evidence that verified the resident had been wearing the , . On at 4:30 PM, the Rehab Director and the Occupation , indicated the , department determined what type of , the resident would need and how long it should be worn. They stated if the , were not worn as ordered, the could worsen. Class III	N 201		