

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>64110</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/13/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SURREY PLACE HEALTHCARE AND REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5525 21ST AVE W BRADENTON, FL 34209</b>
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N 000	<p><b>INITIAL COMMENTS</b></p> <p>A re-licensure survey was conducted from _____ to _____ at Surrey Place Healthcare and Rehabilitation, in conjunction with a complaint survey for complaint #2024007344 and #2025002975. Deficiencies were cited at the time of the survey.</p> <p>Compliant #2025002975 had deficiencies cited at N0201.</p> <p>Complaint #2024007344 had no deficiencies.</p>	N 000		
N 054 SS=D	<p>59A-4.107(5), FAC Follow Physician Orders</p> <p>All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift.</p> <p>This Statute or Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to assist one resident with a physician ordered assistive device for hearing for one resident (Resident #9) of eight-residents sampled.</p> <p>Findings included:</p> <p>On _____ at 12:41 p.m., Resident # 9 was observed sitting in her wheelchair, well- groomed, with no signs of distress. Resident # 9 stated her staff get her up without putting in her _____ when they know she needs to wear them.</p> <p>On _____ at 1:30 p.m., Resident #9 was observed sitting up in her wheelchair. Resident # 9 stated she has a hard time hearing because the _____</p>	N 054	<p>On _____ the _____ were provided to resident #16 and placed in her _____. On _____ for resident #16, the Director of Nursing (DON) completed a Medication error Reporting Form.</p> <p>On _____, all other resident records were checked, there were no other residents with a physician ordered assistive device for hearing.</p> <p>On _____, the Director of Nursing/designee provided education to the direct care nurse for resident #16 on adherence and documentation related to physician ordered assistive devices for hearing.</p>	

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE /25
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N 054	<p>Continued From page 1</p> <p>staff do not put her _____ in when they get her up.</p> <p>Review of an Admission Record showed Resident #9 was admitted to the facility on _____.</p> <p>Review of Resident #9's _____ physician orders revealed an order dated _____ for _____ with instructions to put on in the morning and take out at bedtime, be sure to place in charger.</p> <p>On _____ at 11:00 a.m., an interview was conducted with Staff K, Certified Nursing Assistant (CNA, who stated she did not put Resident #9's _____ in when she got her up this morning.</p> <p>On _____ at 12:00 p.m., an interview was conducted with Staff L, Registered Nurse (RN). Staff K, RN stated it is the nurse's responsibility to ensure staff put the resident's _____ in. Staff L, RN also stated she was not sure if Resident # 9 had her _____ because she did not check before she signed off on the resident treatment record. Staff L, RN stated she assumed the aid put Resident #9's _____ in when she got the resident up.</p> <p>On _____ at 12:20 p.m., an interview was conducted with the Director of Nurses (DON). The DON stated her expectations are if a nurse signs off on an order, they would make sure the order is complete before they sign off on the treatment record. The DON also stated the nurse should have checked to see that Resident #9 had her _____ in before signing off on the order.</p> <p>Class III</p>	N 054	<p>On _____, the Director of Nursing/designee provided education to the other nurses on adherence and documentation related to physician ordered assistive devices for hearing. The education was completed by _____.</p> <p>The Director of Nursing/designee will complete 3 audits each week for 12 weeks to ensure physician ordered assistive devices for hearing are placed in the resident's _____ prior to the nurse signing the administration record.</p> <p>The Director of Nursing/designee will review the audits with the monthly Quality Assurance Performance Improvement (QAPI) Committee for three months. The Quality Assurance Performance Improvement committee will evaluate the outcome of the audits and if necessary, amend the improvement plan and continue to monitor until substantial compliance has been determined by the committee.</p>	
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N 063 SS=F	<p>400.23(3)(a)2.(b)1,2,3,5,6;59A-4.108(4) Minimum Nursing Staff</p> <p>59A-4.108(4)</p> <p>In accordance with the requirements outlined in subsection 400.23(3)(a), F.S., the nursing home licensee must have sufficient nursing staff, on a 24-hour basis to provide nursing and related services to residents in order to maintain the highest practicable physical, mental, and well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>400.23(3)(a)2 For purposes of this subsection, direct care staffing hours do not include time spent on nursing administration, activities program administration, staff development, staffing coordination, and the administrative portion of the minimum data set and care plan coordination for Medicaid.</p> <p>400.23(3)(b)1. Each facility must determine its direct care staffing needs based on the facility assessment and the individual needs of a resident based on the resident's care plan. At a minimum, staffing must include, for each facility, the following requirements:</p> <p>a. A minimum weekly average of 3.6 hours of care by direct care staff per resident per day. As used in this sub-subparagraph, a week is defined as Sunday through Saturday.</p> <p>b. A minimum of 2.0 hours of direct care by a certified nursing assistant per resident per day. A facility may not staff below one certified nursing assistant per 20 residents.</p> <p>c. A minimum of 1.0 hour of direct care by a licensed nurse per resident per day. A facility may</p>	N 063		

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N 063	Continued From page 3  not staff below one licensed nurse per 40 residents. 2. Nursing assistants employed under s. 400.211(2) may be included in computing the hours of direct care provided by certified nursing assistants and may be included in computing the staffing ratio for certified nursing assistants if their job responsibilities include only nursing-assistant-related duties. 3. Certified nursing assistants performing the duties of a qualified medication aide under s. 400.211(5) may not be included in computing the hours of direct care provided by, or the staffing ratios for, certified nursing assistants or licensed nurses under sub-subparagraph 1. b. or sub-subparagraph 1. c., respectively. 5. The agency must recognize the use of licensed nurses for compliance with minimum staffing requirements for certified nursing assistants if the nursing home facility otherwise meets the minimum staffing requirements for licensed nurses and the licensed nurses are performing the duties of a certified nursing assistant. Unless otherwise approved by the agency, licensed nurses counted toward the minimum staffing requirements for certified nursing assistants must exclusively perform the duties of a certified nursing assistant for the entire shift and not also be counted toward the minimum staffing requirements for licensed nurses. If the agency approved a facility's request to use a licensed nurse to perform both licensed nursing and certified nursing assistant duties, the facility must allocate the amount of staff time specifically spent on certified nursing assistant duties for the purpose of documenting compliance with minimum staffing requirements for certified and licensed nursing staff. The hours of a licensed	N 063			

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N 063	<p>Continued From page 4</p> <p>nurse with dual job responsibilities may not be counted twice.</p> <p>6. Evidence that a facility complied with the minimum direct care staffing requirements under subparagraph 1, is not admissible as evidence of compliance with the nursing services requirements under 42 C.F.R. s. 483.35 or 42 C.F.R. s. 483.70.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to maintain minimal staffing requirements of 2.0 direct care hours on two ( ) and ( ) of ninety-two days and failed to maintain a weekly average of 3.6 for eight of fourteen weeks during the time period from , to ,</p> <p>Findings included:</p> <p>The facility provided three copies of the " State Minimum Nursing Staff for Long Term Care Facilities" for the period from to during the four-day recertification survey.</p> <p>Review of the first copy revealed no weekly averages had been and the recorded hours were fractions of total hours.</p> <p>On at 3:31 p.m., the Director of Nursing (DON) provided a second copy of for the period of to . The DON stated</p>	N 063	<p>The Certified Nursing Assistant's (CNA) Per Patient Day ( , ) for the specific dates and were reviewed. No actions warranted due to the time has passed.</p> <p>The weekly direct care staffing hours for the specific weeks of /24, - , /24, - , - , - /24 and - for the quarter of through for meeting the weekly direct care average of 3.6 per patient day ( , ) staffing requirement were reviewed. No actions are warranted due to the time has passed.</p> <p>An audit was conducted on the other 6 weeks which are - , - , - , - /24, - , - and - for the Quarter through for meeting the minimum staffing</p>	
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N 063	<p>Continued From page 5</p> <p>the numbers had been changed as she realized the first copy had the Per Patient Day ( ) in the boxes on form. Review of the changes showed the facility recorded Certified Nursing Assistant (CNA) daily hours of 1.9807 on and 1.9528 on</p> <p>Review of the provided second copy of the 2-week staffing form showed the facility did not meet the minimal weekly average requirement during the periods of (3.59), (3.54), (3.58), (3.51), (3.51), (3.57), (3.57), and (3.59), eight of thirteen weeks between to</p> <p>The State Minimum form revealed on the facility had a census of 34 (census on was 63 and on was 65) with daily average of CNA hours of 4.1691, a nursing daily average of 2.5588, and a weekly ( ) average for both disciplines of 4.00. A census and resident room assignments showed on there were 65 residents. The total CNA hours was 141.75 on , divided by 65 residents, would be corrected to 2.18 daily average hours. The total nursing hours were 87.00 with a daily average of 2.5588 for a census of 34, corrected to a daily average of 1.338. The corrected weekly average was 1.364 for nursing and 2.34 for CNA with a weekly average of 3.70 not the 4.0 recorded.</p> <p>During an interview on at 9:04 a.m., the Nursing Home Administrator stated the survey team had been provided with the wrong staffing "again". On at 11:11 a.m., the NHA stated she may have had an incident of low staffing but could not either confirm or deny until</p>	N 063	<p>requirements of 2.0 per patient day ( , ) daily for Certified Nursing Assistants and the weekly average of direct care staffing of 3.60 per patient day ( , ). The results of the audit found that there were no other days during that specific quarter that the daily Certified Nursing Assistant staffing or the weekly average of direct care staffing did not meet the minimum staffing requirement of 2.0 per patient day and 3.6 per patient day respectively.</p> <p>On , the Administrator initiated education for the Director of Nursing, Staffing Coordinator, Business Office Manager, Assistant Business Office Manager/Payroll, Rehab Director and the Activity Director related to meeting the daily minimum staffing for Certified Nursing Assistants of 2.0 per patient day and the definition of direct care staffing and meeting the required minimum weekly average of the 3.6 per patient day for direct care staff. Education was completed by</p> <p>The Director of Nursing/designee will audit the Certified Nursing Assistant staffing and direct care staffing 5 times per week for 12 weeks to ensure that the facility is meeting the Certified Nursing Assistant and direct care staffing requirements.</p> <p>The Director of Nursing/designee will review the audits with the monthly Quality Assurance Performance Improvement (QAPI) Committee for three months. The Quality Assurance Performance Improvement Committee will evaluate the</p>	
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N 063	<p>Continued From page 6</p> <p>she reviewed the Payroll Based Journal (PBJ) data. She reported the facility does not use the state form, " _____ State Minimum Nursing Staff for Long-Term Care Facilities", the facility uses a Key Factor form, which was reviewed daily.</p> <p>Review of the Key Factor forms for the period of _____ to _____, revealed the form did not record a weekly average of daily care staff.</p> <p>An interview was conducted on _____ at 10:01 a.m. with the Staffing Coordinator. The coordinator reported doing the staffing for 3 years and "overall" staffing was pretty good and was only "lousy" with call offs. She stated the facility always had enough aides unless multiple call-offs. The Director of Nursing (DON), Assistant DON (ADON), and herself (Certified Nursing Assistant CNA) would work on the floor if necessary. The coordinator reported the first State _____ form received had listed " _____" and could not go under 2.0 (hours) for CNAs and 1.0 (hours) for nurses. She reported focusing on _____ numbers to make sure the building was within state regulations, and she received the resident census from the Business Office Manager every morning, not the day before. She stated "from my end" the second copy of Staffing _____ were correct. She stated the facility looks at staffing _____ and usually on weekends they get call-offs, so they are really close to the state minimum, and she had to come into work. She stated she thinks the data for _____ was a typo as they were moving a little fast. She reported if short the facility doesn't change numbers, sometimes staff didn't clock out and they do a written time sheet and sometimes if someone left they try to find the justification as to why. She stated the weekend supervisor assists</p>	N 063	<p>outcome of the audits and if necessary, amend the improvement plan and continue to monitor until substantial compliance has been determined by the committee.</p>	

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N 063	<p>Continued From page 7</p> <p>with staffing numbers but doesn't always gets it right and she has to fix it. The weekend supervisor adds the nursing hours and tries to keep them within budget. The staffing coordinator stated she may do CNA and staffing jobs when she comes in to work due to call offs and if the call-offs causes the facility to be under 2.0 for CNA hours she may have to come in. She stated the Assistant Business Office Manager (ABOM) gave the accurate of actual time punches the next day and gave her the actual hours shown on the staffing . She reviewed the time punches from showing she worked as a staffing coordinator from 11:00 p.m. to 7:27 p.m., and stated she must have worked as a CNA and the ABOM put her as nursing. The coordinator stated she does not have an attestation showing she worked only as a CNA and not staffing coordinator on . During a continued interview on at 11:36 p.m., the coordinator stated she has not received any ongoing education on staffing, the previous coordinator had left abruptly and "I kind of learned."</p> <p>An interview was conducted on at 12:50 p.m. with the Staffing Coordinator when she provided a third copy of the " State Minimum Nursing Staff for Long-Term Care Facilities" form. She reported the facility input information from the Key Factor forms onto the Staffing , which she does weekly. She reported the weekly staffing should be under 2.3 for CNAs, the combined weekly average for nurses was 1.0, and CNAs was 2.0, so the weekly average would be 3.0. She stated the facility put the numbers from their PBJ onto the third copy of the staffing .</p>	N 063		
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N 063	<p>Continued From page 8</p> <p>An interview was conducted on _____ at 12:30 p.m. with the ABOM. She reported being new to payroll and the NHA trained her to receive quarterly information. She stated she never used the state form, she reviewed the Key Factor form and reported the form does not include a weekly average of hours. She reported as far as hours, she has been told to look at CNA hours and sometimes "we" have many people due different jobs in different departments. She stated the Staffing Coordinator tells her how many hours to change into aide hours and she can accurately show she has worked hours as a CNA so they can make their hours. She stated the Key Factor form is from the corporate office and the corporation will send emails regarding being short on "points" but does not review that figure as it's for the NHA's _____. She reported the top portion of the Key Factor information came from the BOM regarding payor source and the middle portion comes from timecards. She stated she mainly looked at for CNAs and nursing staff and the NHA looked at the rest.</p> <p>Review of the Facility Assessment revealed "at Surrey Place, we utilize a _____ formula based on our census to determine our staffing needs for direct care of our resident population. The state of Florida has a minimum staffing requirement of 2.0 hour _____ for CNA's and 1.0 hour _____ for licensed nurses with a 3.6 combined weekly average. During a typical week at Surrey Place, we have a staffing range for CNA's from a 2.0-2.3 _____ in a range from 1.0 to a 1.42 _____ for licensed nurses providing direct care period staffing for CNA's and licensed nurses may fluctuate below and/ or above the noted typical week of staff but should not go below the state minimum staffing requirements. In</p>	N 063			

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N 063	Continued From page 9  addition, . . . hours considered as billable time may be included in the . . . for direct care. Not included in this . . . is our nursing management and other support staff in the nursing department unless they are on an indicated assignment; this includes the following positions: - Director of Nursing/ Assistant Director of Nursing - Two MDS nurses/ Nurse liaison - Staffing Coordinator and/ or Medical Records Clerk/ Rehab Technician - Risk Manager  Class III	N 063		
N 201 SS=D	400.022(1)(f), FS Right to Adequate and Appropriate Health Care  (f) 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 observations, interviews, and record review, the facility failed to provide care and services to prevent injuries and for two residents (#123 and #124) of nine sampled residents who utilized . . . , during two of four days observed ( . . . and . . . ).  Findings included:	N 201	On the . . . for resident #123 was positioned and secured properly so the . . . bag nor the tubing touched the floor.  On the . . . for resident #124 was positioned and secured properly so the . . . bag nor the tubing touched the floor.	

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N 201	<p>Continued From page 10</p> <p>1.</p> <p>On _____ at 10:25 a.m., Resident #123's room door was observed open from the main hallway. She was observed in her room seated in her wheelchair and being visited by a family member. Resident #123 was utilizing an _____ . From the hallway, the resident was observed with the _____ bag and tubing hanging directly below the seat of the wheelchair and with the bag and approximately two inches of _____ tubing on the floor. Resident #123 was observed scooting and forth slowly while seated in her wheelchair with the _____ tubing and bag dragging on the floor.</p> <p>Review of Resident #123's medical record revealed she was admitted to the facility on _____ and readmitted from the hospital on _____. Review of the diagnosis sheet revealed diagnoses to include but not limited to retention of _____ and _____ of _____.</p> <p>Review of the current Order Summary Report for the month _____, revealed the following orders for Resident #123:</p> <p>- _____ size 14FR (French) with balloon size 30cc (cubic centimeters) to beside drainage bag for dx. (diagnosis) _____ Retention - every shift related to Retention of the _____, order date _____.</p> <p>A review of the current care plans with a next review date of _____, revealed the following areas:</p> <p>1. _____ function/ _____ or _____ thought process r/t (related to) _____ ) score of 11,</p>	N 201	<p>On _____, all other residents identified with _____ were checked for proper positioning and securing so the _____ bag nor the tubing of the _____ touched the floor. For these other residents, no area of concern identified.</p> <p>On _____ the Director of Nursing (DON)/designee initiated education for nurses, certified nursing assistants and _____ staff related to proper positioning and securing of _____ bags/tubing. Education completed by _____.</p> <p>The Director of Nursing/designee for all residents with _____ will do an audit 2 times a week for 12 weeks to ensure proper positioning and securing the tubing for those residents with _____ so no bag or tubing for _____ are touching the floor.</p> <p>The Director of Nursing/designee will review the audits with the monthly Quality Assurance Performance Improvement (QAPI) Committee for three months. The Quality Assurance Performance Improvement committee will evaluate the outcome of the audits and if necessary, amend the improvement plan and continue to monitor until substantial compliance has been determined by the committee.</p>	

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N 201	<p>Continued From page 11</p> <p>periods of _____, with interventions in place as reviewed.</p> <p>2. _____ of _____. She has a _____ due to _____ retention and is at risk for ( _____, _____), _____ toning as ordered, with interventions to include: Observe for signs and symptoms of discomfort on _____ and frequency, _____ care as ordered, Cover drainage bag for privacy.</p> <p>On _____ at 8:05 a.m., an interview was conducted with Resident #123's nurse, Staff E, Registered Nurse (RN). Staff E, RN confirmed she knew of Resident #123 and had her on her assignment since her admission. Staff E, RN also confirmed Resident #123 utilized an _____ and Resident #123 was discontinued with it yesterday on _____. Staff E, RN said prior to the _____ being discontinued, Resident #123 utilized it at all times to include when in bed and when she is seated in her wheelchair. Staff E, RN stated when Resident #123, or any resident who utilizes an _____, the _____ bag should be placed in a position that is off the floor and the tubing leading from the bag to the resident should be off the floor.</p> <p>Staff E, RN further revealed nursing staff who observe _____ bags positioned on the floor are to reposition the bag. _____, _____ staff can also reposition the bag and any other non-nursing staff can report the observation to nursing staff immediately. Staff E, RN confirmed _____ bag and tubing lying on the floor can present with an accident/tripping hazard, can present a risk for pulling out the tubing, and can present as an _____ risk. Staff E, RN also confirmed Resident #123 does at times slowly self-propel by herself while seated in her wheelchair and she was</p>	N 201		
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NAME OF PROVIDER OR SUPPLIER  
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N 201	<p>Continued From page 12</p> <p>unaware Resident #123 had her bag on the floor and had tubing on the floor from excessive tension.</p> <p>2.</p> <p>On at 12:01 p.m., Resident #124's room was approached and the door was open. From the hallway, Resident #124 was seen in her room while seated next to her bed and in a wheelchair. Resident #124 was utilizing a an . The bag for the was observed hanging below the seat of the wheelchair with a portion of the bag touching the floor. There were liquid contents in the bag during this observed time. The tubing to the , leading from the bag to the resident, was also observed touching the floor with approximately three inches on the floor. The tubing on the floor in excess tension was observed touching the front right wheel of the wheelchair. Resident #124 was observed moving and forth slowly with either her or the front wheelchair tire touching the tubing. The resident was observed with two visitors and one of the visitors repositioned the wheelchair so the resident could be facing towards them. When the visitor was repositioning the resident in the wheelchair, the tires were observed to touch and partially ran over the tubing. The resident's visitor was not aware of the bag and tubing on the floor when repositioning Resident #124.</p> <p>On at 7:20 a.m. Resident #124's room was approached and she was noted in her room, dressed for the day, and seated in her wheelchair. The residents bag was touching the floor and about three inches of the tubing was</p>	N 201		

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N 201	<p>Continued From page 13</p> <p>positioned on the floor.</p> <p>On _____ at 12:00 p.m. Resident #124 was observed seated in her wheelchair next to her bed, resting with her _____ closed. The resident's _____ tubing was in excess tension with approximately two inches of the tubing on the floor. The tubing had yellow liquid contents.</p> <p>Review of Resident #124's medical record revealed she was admitted on _____. Review of the diagnosis sheet revealed diagnoses to include _____, history of _____, and _____ and _____.</p> <p>Review of Resident #124's current Order Summary Report for the month _____ revealed the following orders:</p> <ul style="list-style-type: none"> <li>- _____ size 14 fr. with balloon size 30cc for dx. _____ retention, x (every) shift related to order date _____).</li> <li>- Check placement of _____ strap every shift for anchoring of _____ and tubing.</li> </ul> <p>Review of Resident #124's current care plans with a next review date of _____ revealed the following areas:</p> <ol style="list-style-type: none"> <li>1. Has history of _____, retention. Was being straight _____ intermittently and upon readmission now has a _____ Cath. She is at risk for _____, with interventions in place to include: Check placement of _____ strap every shift for anchoring of _____ and tubing, Cover drainage bag for privacy.</li> </ol> <p>On _____ at 8:05 a.m., an interview was conducted with Resident #124's nurse, Staff E,</p>	N 201		

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N 201	<p>Continued From page 14</p> <p>RN, Staff E, RN confirmed she knew of Resident #124 and had her on her assignment since her admission. Staff E, RN also confirmed Resident #124 utilized an _____, and that Resident #124 utilizes it at all times to include when in bed and when she is seated in her wheelchair, which is most of the day. Staff E, RN confirmed Resident #124 does at times slowly self-propel by herself while seated in her wheelchair and she was unaware there were times Resident #124 had her _____ bag on the floor with the tubing on the floor from in excess tension.</p> <p>On _____ at 8:35 a.m., an interview with Staff F, Certified Nursing Assistants (CNA) and Staff G, CNA. Both confirmed they had Residents #123 and #124 on their routine work assignments. Both confirmed Resident #124 currently utilized an _____ and Resident #123 was utilizing an _____ until _____ where it was discontinued. Staff F, CNA and Staff G, CNA both confirmed they observed both residents with portions of the _____ bag and tubing on the floor, especially when seated in a wheelchair.</p> <p>Staff F, CNA and Staff G, CNA also both confirmed if they see the tubing or bag on the floor, they can either reposition the bag and tubing up off the floor or they can get a nurse to reposition it, depending on the situation and how far the tubing was out and in excess tension.</p> <p>Staff F, CNA and Staff G, CNA revealed they find at times when either of the residents return from _____, they find portions of the tubing on the floor and sometimes a portion of the bag on the floor. Staff F, CNA and Staff G, CNA also revealed _____ staff are able to reposition the tubing and bag up off the floor, but sometimes they don't.</p>	N 201		
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N 201	<p>Continued From page 15</p> <p>Staff F, CNA sated she has reported to her nurse of instances where she found residents returned from _____ and with portions of the tubing and bag on the bare floor. Staff F, CNA and Staff G, CNA revealed Resident #124 has _____ and will sometimes try to stand up when she is seated in her wheelchair, and the tubing will become in excess tension.</p> <p>On _____ at 1:20 p.m., an interview with the _____ Director revealed she and her staff, when assisting with residents and who utilize _____, will first ensure the bag and tubing are properly positioned up off the floor and with tubing free from excessive tension. She revealed they monitor the placement of the tubing and _____ bag when conducting a _____ session and if the _____ and tubing need to be repositioned, she and her staff will reposition immediately. The _____ Director also revealed she and her _____ staff will ensure the _____ and tubing are positioned appropriately and safety upon assisting the resident _____ to their room. She was not aware Resident #123 and #124 had _____ bags and tubing that were touching and laying on the floor.</p> <p>On _____ at 10:30 a.m., the Director of Nursing (DON) provided the " _____ -care of" policy and procedure for review. The policy did not have a review date and revealed the following: Purpose: To provide safe and proper care of the resident with an _____, and to minimize the risk of _____ Procedure: 1. Verify physician's order for _____ care. 2. Identify resident, explain procedure, and provide</p>	N 201		
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N 201	Continued From page 16  privacy. ... 7. Secure tubing with a strap to the inner aspect of the female . . . 8. Position the drainage bag below the level of the resident's . . . Secure to the bed or wheelchair in such a manner that neither the bag nor the spigot touches the floor. Coil excess tubing on bed verifying that there are no obstructions or kinks in tubing.  Class III	N 201		
N 506 SS=D	400.0255(8), FS Discharge/ Transfer Notice  (8) The notice required by subsection (7) must be in writing and must contain all information required by state and federal law, rules, or regulations applicable to Medicaid or Medicare cases. The agency shall develop a standard document to be used by all facilities licensed under this part for purposes of notifying residents of a discharge or transfer. Such document must include a means for a resident to request the local long-term care ombudsman council to review the notice and request information about or assistance with initiating a fair hearing with the department's Office of Appeals Hearings. In addition to any other pertinent information included, the form shall specify the reason allowed under federal or state law that the resident is being discharged or transferred, with an explanation to support this action. Further, the form must state the effective date of the discharge or transfer and the location to which the resident is being discharged or transferred. The form must clearly describe the resident's appeal rights and the procedures for filing an appeal, including the right to request the	N 506		

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N 506	<p>Continued From page 17</p> <p>local ombudsman council review the notice of discharge or transfer. A copy of the notice must be placed in the resident's clinical record, and a copy must be transmitted to the resident's legal guardian or representative and to the local ombudsman council within 5 business days after signature by the resident or resident designee.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to provide notice of transfer before a facility initiated transfer to two residents (Resident # 11 and #60) out of three residents sampled for hospitalization.</p> <p>Findings Included:</p> <p>1.</p> <p>Review of Resident #11's Admission Record revealed Resident #11 had an original admission date of _____ and a re-admission date of _____. Resident #11 was admitted to the facility with diagnosis to include _____, _____, _____ in other conditions classified elsewhere, _____, acute _____ failure with _____, _____ phase, and _____.</p> <p>Review of Resident #11's Change in Condition Evaluation, dated _____ revealed under the section 1a. List the other change: "Right Upper extremity shaking on and off; 02:88 on 2L [liters of _____]; sound _____." The Evaluation revealed under Recommendation of Primary Clinician(s): "Transfer to hospital."</p> <p>Review of Resident #11's Nursing Home Transfer</p>	N 506	<p>The facility is unable to have residents #55, #60 and #11 sign the Nursing Home Transfer and Discharge Notice at the time of discharge to the hospital since the date of their discharge has passed. Residents #55, #60 and #11 were re-admitted and/or returned to the facility after their emergency discharge to the hospital.</p> <p>Other residents discharged after will receive the Nursing Home Transfer and discharge Notice based on the facility policies.</p> <p>The facility policy for Notice of Transfer and/or Discharge was reviewed.</p> <p>On _____ the Director of Nursing/designee initiated education for the nurses, Assistant Director of Nursing, Social Service Director and Medical records related to the facility Notice of Transfer and Discharge policy and Making an Emergency Transfer or Discharge policy. The education included the Nursing Home Transfer and Discharge Notice form. This education was completed by _____.</p> <p>The Social Service Director/designee will</p>	
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N 506	<p>Continued From page 18</p> <p>and Discharge Notice revealed notice was given on with an effective date of . The notice showed Resident #11 was transferred to an acute care facility, with a documented reason, "Your needs cannot be met in this facility." The notice revealed the Social Service Director (SSD) signed the notice on and Resident #11 signed the form on .</p> <p>During an interview on at 11:56 a.m., the Nursing Home Administrator stated if a resident leaves the facility to go to a hospital it is typically an emergency, so she's not sure how the resident would sign the Nursing Home Transfer and Discharge Notice, which is why they would wait for the resident to return or would mail the form to the resident for their signature.</p> <p>2.</p> <p>Review of Resident #60's Admission Record revealed the resident was originally admitted on and readmitted on .</p> <p>Review of Resident #60's Transfer Form showed on the resident was transferred to an acute care facility due to placement of a .</p> <p>Review of Resident #60's physician order, dated at 2:43 p.m. showed the facility was to send the resident to ER for re-insertion of a by the team.</p> <p>Review of Resident #60's Nursing Home Transfer and Discharge Notice showed the notice was given on and effective on . The form</p>	N 506	<p>do a weekly audit for 12 weeks on a minimum of 3 discharged residents each week. Otherwise, if the facility doesn't have at least 3 discharges per week, the Social Service Director/designee will complete the weekly audit on the number of discharges the facility has for that week. This weekly audit will be done to ensure that the facility provided discharged residents the Nursing Home Transfer and Discharge Notice form per the facility policy.</p> <p>The Social Service Director or designee will review the audits with the monthly Quality Assurance Performance Improvement Committee for three months. The Quality Assurance and Performance Improvement Committee will evaluate the outcome of the audits and if necessary, amend the improvement plan and continue to monitor until substantial compliance has been determined by the committee.</p>		

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N 506	<p>Continued From page 19</p> <p>showed the resident was transferred or discharged to an acute care facility due to "Your needs cannot be met in this facility", and did not include a "Brief explanation to support this action". The form did not include resident representative information and was signed by the resident on _____ and showed the resident, legal guardian, or representative received the notice on _____.</p> <p>Review of Resident #60's Minimum Data Set, dated _____ revealed the resident's Brief Interview of Mental Status score was 10, indicating moderate _____.</p> <p>An interview was conducted on _____ at 2:12 p.m. with Staff H, Licensed Practical Nurse (LPN). The staff member reported knowing what the Nursing Home Transfer and Discharge Notice was and thought Social Services completed it.</p> <p>An interview was conducted on _____ at 2:27 p.m. with the Social Services Director (SSD). The SSD confirmed doing the Nursing Home Transfer and Discharge Notice, which were "typically" uploaded into the resident records but may still have them in the office. The SSD stated the facility attempted to complete the Nursing Home Transfer and Discharge Notice, but 9 out of 10 times the transfer/discharge was an emergency, resident was unable to sign, and family was not in the facility so "we" have them sign it when they come from the hospital. The SSD was able to locate both Resident #55 and Resident #60's Nursing Home Transfer and Discharge Notices on top of her desk. The SSD stated the forms are completed then when the resident comes "we get them signed". The SSD reported being aware of the allowed time frame and stated it's an</p>	N 506		

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N 506	Continued From page 20  emergency and mostly wait till they come  Review of the policy titled Social Services, Notice of Transfer and/or Discharge, undated, revealed the following: Policy Statement: The facility will permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless: A. The transfer just charges necessary for the residents welfare and the residence needs cannot be met in the facility; B. The transfer discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; C. The safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident; D. The health of the individuals in the facility would otherwise be endangered; E. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) and stay at the facility; or F. The first hostility ceases to operate. Policy Interpretation and Implementation: 1. Before the facility transfers or discharges a resident, the facility will notify the resident and the representative of the transfer or discharge and the reasons for the move in writing in any language and manner they understand. ... 5. Should the health or safety of the individuals in the facility be endangered or the health of the resident's has improved sufficiently to allow a more immediate transfer or discharge or an immediate transfer or discharge is required by the resident's urgent medical needs or the resident has not resided in the facility for 30 days, notice would be given as soon as practicable. ...	N 506			

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N 506	Continued From page 21  7. The resident, and/ or representative will be provided with the following discharge notice requirements: a. The reason for the transfer discharge; b. The effective date of the transfer discharge; c. The location to which the resident is being transferred or discharged; d. The name, address, and telephone number of the state long term care ombudsman; e. The name, address, and telephone number of each individual or agency responsible for the protection and advocacy of mentally ill or individuals (as applies); and f. Any statement that the resident has the right to appeal to the action to the state which includes the name, address, and telephone number of the state health department agency that has designated to handle appeals and transfers and discharge notices.  8. The social service director will be responsible for preparing the form(s) and for ensuring the resident/ representative receives the forms. If it is necessary to mail the form to the representative, a self-addressed stamped envelope will be included to facilitate the return of the signed form(s). The completed forms will be filed in the residence medical record under the Social Services tab.	N 506			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>105629</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>03/13/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>SURREY PLACE HEALTHCARE AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5525 21ST AVE W BRADENTON, FL 34209</b>		
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F 000	INITIAL COMMENTS  A recertification survey was conducted from _____ to _____ at Surrey Place Healthcare and Rehabilitation, in conjunction with a complaint survey for complaint #2024007344 and #2025002975. The facility was not in compliance with 42 CFR, Part 483, Requirements for Long Term Care Facilities  Compliant #2025002975 had deficiencies cited at F690.  Complaint #2024007344 had no deficiencies.	F 000			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)  §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.  §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623			

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

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F 623	<p>Continued From page 2</p> <p>, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with , established under Part C of the , Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental or related , the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to provide notice of transfer before a facility initiated transfer to two residents (Resident # 11 and #60) out of three residents sampled for hospitalization.</p>	F 623	<p>The facility is unable to have residents #55, #60 and #11 sign the Nursing Home Transfer and Discharge Notice at the time of discharge to the hospital since the date of their discharge has passed. Residents</p>		



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F 623	<p>Continued From page 4</p> <p>would sign the Nursing Home Transfer and Discharge Notice, which is why they would wait for the resident to return or would mail the form to the resident for their signature.</p> <p>2.</p> <p>Review of Resident #60's Admission Record revealed the resident was originally admitted on and readmitted on</p> <p>Review of Resident #60's Transfer Form showed on the resident was transferred to an acute care facility due to placement of a</p> <p>Review of Resident #60's physician order, dated at 2:43 p.m. showed the facility was to send the resident to ER for re-insertion of a by the team.</p> <p>Review of Resident #60's Nursing Home Transfer and Discharge Notice showed the notice was given on and effective on . The form showed the resident was transferred or discharged to an acute care facility due to "Your needs cannot be met in this facility", and did not include a "Brief explanation to support this action". The form did not include resident representative information and was signed by the resident on and showed the resident, legal guardian, or representative received the notice on</p> <p>Review of Resident #60's Minimum Data Set, dated revealed the resident's Brief Interview of Mental Status score was 10, indicating moderate</p> <p>An interview was conducted on at 2:12</p>	F 623	<p>The Social Service Director or designee will review the audits with the monthly Quality Assurance Performance Improvement Committee for three months. The Quality Assurance and Performance Improvement Committee will evaluate the outcome of the audits and if necessary, amend the improvement plan and continue to monitor until substantial compliance has been determined by the committee.</p>		

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F 623	<p>Continued From page 5</p> <p>p.m. with Staff H, Licensed Practical Nurse (LPN). The staff member reported knowing what the Nursing Home Transfer and Discharge Notice was and thought Social Services completed it.</p> <p>An interview was conducted on _____ at 2:27 p.m. with the Social Services Director (SSD). The SSD confirmed doing the Nursing Home Transfer and Discharge Notice, which were "typically" uploaded into the resident records but may still have them in the office. The SSD stated the facility attempted to complete the Nursing Home Transfer and Discharge Notice, but 9 out of 10 times the transfer/discharge was an emergency, resident was unable to sign, and family was not in the facility so "we" have them sign it when they come from the hospital. The SSD was able to locate both Resident #55 and Resident #60's Nursing Home Transfer and Discharge Notices on top of her desk. The SSD stated the forms are completed then when the resident comes "we get them signed". The SSD reported being aware of the allowed time frame and stated it's an emergency and mostly wait till they come .</p> <p>Review of the policy titled Social Services, Notice of Transfer and/or Discharge, undated, revealed the following: Policy Statement: The facility will permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless: A. The transfer just charges necessary for the residents welfare and the residence needs cannot be met in the facility; B. The transfer discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided</p>	F 623			

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F 623	Continued From page 6 by the facility; C. The safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident; D. The health of the individuals in the facility would otherwise be endangered; E. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) and stay at the facility; or F. The first hostility ceases to operate. Policy Interpretation and Implementation: 1. Before the facility transfers or discharges a resident, the facility will notify the resident and the representative of the transfer or discharge and the reasons for the move in writing in any language and manner they understand. ... 5. Should the health or safety of the individuals in the facility be endangered or the health of the resident's has improved sufficiently to allow a more immediate transfer or discharge or an immediate transfer or discharge is required by the resident's urgent medical needs or the resident has not resided in the facility for 30 days, notice would be given as soon as practicable. ... 7. The resident, and/ or representative will be provided with the following discharge notice requirements: a. The reason for the transfer discharge; b. The effective date of the transfer discharge; c. The location to which the resident is being transferred or discharged; d. The name, address, and telephone number of the state long term care ombudsman; e. The name, address, and telephone number of each individual or agency responsible for the protection and advocacy of mentally ill or individuals (as applies);	F 623			

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F 623	Continued From page 7 and f. Any statement that the resident has the right to appeal to the action to the state which includes the name, address, and telephone number of the state health department agency that has designated to handle appeals and transfers and discharge notices. 8. The social service director will be responsible for preparing the form(s) and for ensuring the resident/representative receives the forms. If it is necessary to mail the form to the representative, a self-addressed stamped envelope will be included to facilitate the return of the signed form(s). The completed forms will be filed in the residence medical record under the Social Services tab.	F 623			
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)  §483.15(d) Notice of bed-hold policy and return-  §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and ( ) The information specified in paragraph (e)(1) of this section.	F 625			

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F 625	<p>Continued From page 8</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record reviews and interviews, the facility failed to provide a bed-hold notice at the time of transfer to three (#55, #60, and #11) of three residents sampled for hospitalizations.</p> <p>Findings included:</p> <p>1.</p> <p>Review of Resident #55's Admission Record revealed the resident was originally admitted on _____.</p> <p>Review of Resident #55's Nursing Notes showed on _____ at 11:28 a.m., Resident #55 was sent to the Emergency Room (ER) for evaluation following an incident.</p> <p>Review of Resident #55's uploaded clinical documents did not include a bed-hold notice for the resident's transfer to a higher level of care on _____. The progress notes on _____ did not show the resident or representative was notified of the facility bed-hold notice.</p> <p>Review of the facility provided Admission and Financial Agreement signed by Resident #55's family member and the facility's representative on _____ described the facility's bed-hold policy.</p>	F 625	<p>The facility is unable to provide residents #55, #60 and #11 The bed hold notice at time of their transfer to the hospital since the date of their discharge has passed. Residents #55, #60 and #11 were re-admitted and/or returned to the facility after their emergency discharge to the hospital.</p> <p>Other residents discharged after with a need for an unplanned/emergent transfer/discharge will receive a bed hold form as noted in the facility Bed Hold policy.</p> <p>The facility policy for Bed Hold has been reviewed.</p> <p>On _____, the Director of Nursing/designee initiated education for the nurses, Assistant Director of Nursing, Social Service Director and Medical records related to the Bed Hold policy. This education was completed by _____.</p> <p>The Social Service Director/designee will do a weekly audit for 12 weeks on a minimum of 3 unplanned/emergent transferred residents and/or residents on a therapeutic leave each week. Otherwise, if</p>		

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F 625	<p>Continued From page 9</p> <p>2.</p> <p>Review of Resident #60's Admission Record revealed the resident was originally admitted on and readmitted on</p> <p>Review of Resident #60's Transfer Form showed on the resident was transferred to an acute care facility due to placement of a</p> <p>Review of Resident #60's physician order, dated at 2:43 p.m. showed the facility was to send the resident to ER for re-insertion of a by the team.</p> <p>Review of Resident #60's uploaded documents did not reveal a copy of a bed-hold notice given to the resident's representative on and the resident's progress notes on did not reveal documentation showing the resident or representative had been notified or had received a bed-hold notice at the time of the transfer on</p> <p>Review of the facility provided Bed Hold Policy revealed it was part of the Admission and Financial Agreement signed by Resident #60's legal representative on</p> <p>During an interview on at 2:27 p.m., the Social Services Director (SSD) reported making phone calls to the families and asking if they wanted a bed-hold. The SSD reported "not really" documenting family notifications of bed-hold notifications.</p> <p>3.</p> <p>Review of Resident #11's Admission Record</p>	F 625	<p>the facility doesn't have at least 3 unplanned/emergent transferred residents and/or residents on a therapeutic leave for that week, the Social Service Director/designee will complete the weekly audit on the number of transferred/on leave residents that the facility has for that week. This weekly audit will be done to ensure that the facility provided transferred residents written notice on the facility Bed Hold policy for residents who were transferred for hospitalization or those on a therapeutic leave.</p> <p>The Social Services Director/designee will review the audits with the monthly Quality Assurance Performance Improvement Committee for three months. The Quality Assurance Performance Improvement Committee will evaluate the outcome of the audits and if necessary, amend the improvement plan and continue to monitor until substantial compliance has been determined by the committee.</p>		



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F 625	Continued From page 11 hospitalization or leaves the facility on a therapeutic leave.	F 625			
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3)  §483.20(k) Preadmission Screening for individuals with a mental and individuals with intellectual  §483.20(k)(1) A nursing facility must not admit, on or after , any new residents with: (i) Mental as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; (ii) Intellectual , as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual or authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual  §483.20(k)(2) Exceptions. For purposes of this	F 645			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>105629</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>03/13/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>SURREY PLACE HEALTHCARE AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5525 21ST AVE W BRADENTON, FL 34209</b>		
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F 645	<p>Continued From page 12 section-</p> <p>(i) The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.</p> <p>(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-</p> <p>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,</p> <p>(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and</p> <p>(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.</p> <p>§483.20(k)(3) Definition. For purposes of this section-</p> <p>(i) An individual is considered to have a mental if the individual has a serious mental defined in 483.102(b)(1).</p> <p>(ii) An individual is considered to have an intellectual , if the individual has an intellectual , as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure Level I Preadmission Screening and Resident Review (PASRR) screenings were accurate prior to a admission to</p>	F 645	<p>A new Preadmission Screening and Resident Review (PASRR) was completed on 3/14/25 for resident #41 to include anxiety.</p>		

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F 645	<p>Continued From page 13</p> <p>the facility and did not follow up with a Level II PASRR screen for two residents (Resident #41 and #16) of forty-one sampled residents.</p> <p>Findings included:</p> <p>1.</p> <p>On _____ at 1:45 p.m. Resident #41 was observed in her wheelchair while _____ staff were assisting down the hallway and to the _____ gym.</p> <p>At 1:49 p.m. while in the gym, Resident #41 appeared _____, but was participating in all the exercises that were presented to her. Resident #41 kept saying "I just want to go home and just need to go home."</p> <p>On _____ at 8:00 a.m., Resident #41 was assisted to the 300 unit nurses desk and lobby area. She was seated in her wheelchair and was awaiting a transport ride to an _____.</p> <p>Resident #41 was given information that the transport van would be thirty minutes late. She then started to cry and was very _____ to get out to her doctor's _____ and then planned to return home with home health services the following day.</p> <p>Review of Resident #41's medical record revealed she was admitted to the facility on _____ for short term _____. Review of the diagnosis sheet revealed diagnoses to include adjustment with mixed _____ and depressed _____ (added _____), and major _____ (added _____).</p>	F 645	<p>On _____ Resident #16 Preadmission Screening and Resident Review (PASRR) was re-evaluated by the Minimum Data Set (MDS) Coordinator and a Level II Preadmission Screening and Resident Review (PASRR) was requested and submitted to the Florida Preadmission Screening and Resident Review Portal. On _____ the Minimum Data Set (MDS) Coordinator received a response from Florida Preadmission Screening and Resident Review Portal on the outcome of the Level II request for resident #16 and it was denied.</p> <p>On _____, the Minimum Data Set (MDS) Coordinator initiated an audit of the Level I Preadmission Screening and Resident Reviews (PASRRs) for all current residents to ensure the Level I Preadmission Screening and Resident Reviews are correct based on each individual resident. Identified corrections were addressed and the appropriate corrections were made.</p> <p>In addition, as noted in the Statement of Deficiency, the Minimum Data Set (MDS) Coordinator recently participated in a Webinar by Florida Preadmission Screening and Resident Review Portal on _____. This educational Webinar addressed proper completion for Level II Preadmission Screening and Resident Reviews (PASRRs). The education included need for a Level II Preadmission</p>	

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F 645	<p>Continued From page 14</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated _____ revealed under Section C - _____ Patterns a Brief Interview Mental Status ( _____ ) score 15 out of 15, which indicated Resident #41 was _____</p> <p>Review of Resident #41's electronic medical record revealed a Level I PASRR screen dated _____ completed prior to the resident's admission to the facility, and was signed by a Licensed Clinical Social Worker (LCSW) at a hospital. The screen did not identify Mental Illness/Suspected Mental Illness ( _____ /SMI) diagnoses to include major _____ and _____</p> <p>Further review of the electronic medical record revealed a second Level I PASRR screen dated _____ for Resident #41. Review of the screen revealed it was completed by a Registered Nurse at the admitted facility. Review of Section I of the PASRR screen under _____ /SMI diagnoses indicated diagnosis of major _____. The screen did not identify _____, per Resident #41's admission diagnosis.</p> <p>On _____ at 1:50 p.m., an interview with the Minimum Data Set (MDS) Coordinator, who confirmed she, along with several other staff, are responsible for the assurance of Level I PASRR completion in a timely and accurate manner. The MDS Coordinator confirmed Resident #41 was admitted to the facility on _____ and there were two Level I PASRR screens that were scanned into the electronic record to include one on _____, which was incorrect, and one on _____, which was a corrected version. The MDS Coordinator confirmed Resident #41 had</p>	F 645	<p>Screening and Resident Reviews (PASRR) to be submitted for a resident.</p> <p>Education was provided by the Minimum Data Set (MDS) Coordinator to the Admissions team and RN Management staff related to Level I and Level II Preadmission Screening and Resident Reviews. The education was completed by _____</p> <p>The Minimum Data Set Coordinator/designee is auditing a minimum of three Preadmission Screening and Resident Reviews (PASRRs) each week for 12 weeks to ensure that the admission Preadmission Screening and Resident Reviews are accurate and the follow up related to Level II Preadmission Screening and Resident Reviews (PASRRs) are completed.</p> <p>The Minimum Data Set (MDS) Coordinator/designee will review the audits with the monthly Quality Assurance Performance Improvement Committee for three months. The Quality Assurance Performance Improvement Committee will evaluate the outcome of the audits and if necessary, amend the improvement plan and continue to monitor until substantial compliance has been determined by the committee.</p>	

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F 645	<p>Continued From page 15</p> <p>diagnoses of major _____ and _____ upon her admission, and the Level I PASRR screen that came from the hospital did not reflect _____ /SMI diagnoses of either major _____ or _____. She revealed this Level I PASRR was incorrect and the facility had to complete a new one. She verified the new and revised Level I PASRR screen now only reflected major _____ as an _____ /SMI diagnosis, but they failed to include _____. She revealed the corrected Level I was not correct to reflect all appropriate _____ /SMI diagnoses. The Director of Nursing (DON), who was present for this interview, also confirmed the current corrected Level I PASRR screen for Resident #41 was not correct.</p> <p>2.</p> <p>Review of an Admission Record showed Resident #16 was admitted to the facility on _____ with diagnoses to include but not limited to major _____, recurrent, severe with _____ symptoms, and _____ unspecified</p> <p>Review of the State of Resident #16's Level I PASRR screen dated _____ showed Mental Illness diagnoses listed as _____ and _____. Review of Section _____ : PASRR Screen Completion revealed: Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual _____ indicated. Level II PASRR evaluation not required, was marked.</p>	F 645			

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F 645	Continued From page 16 On _____ at 10:00 am, an interview was conducted with the facility's MDS Coordinator, who stated the PASRRs are reviewed on admission and at the Quality-of-Care meetings to see if there was a change with a resident diagnosis. The MDS Coordinator also stated she received training on how to complete the Level II PASRR last Monday and during the training she learned a _____ is required if a resident has a serious mental illness with _____ or if the resident has an intellectual _____, or _____ with behaviors that are interfering with the resident daily life. The MDS Coordinator stated she has a list of residents who's PASRR has to be redone and submitted for a Level II review and Resident # 16 is one of the residents who is on her list that require a Level II PASRR review. The MDS Coordinator stated the facility does not have a PASRR policy.  On _____ at 10:30 am, an interview was conducted with the DON. The DON stated her expectations are for the PASRR to be accurate and most of the time the PASRR is inaccurate coming in from the hospital. If the PASRR's are inaccurate, her expectations are that they correct them so the PASRR's reflect the resident accurately. The DON stated she depends on her MDS Coordinator to accurately complete the PASRR's.	F 645		
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	F 690		

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F 690	<p>Continued From page 17</p> <p>condition is or becomes such that _____ is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with _____, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an _____ is not _____ unless the resident's clinical condition demonstrates that _____ was necessary;</p> <p>(ii) A resident who enters the facility with an _____ or subsequently receives one is assessed for removal of the _____ as soon as possible unless the resident's clinical condition demonstrates that _____ is necessary; and</p> <p>(iii) A resident who is _____ of _____ receives appropriate treatment and services to prevent _____ and to restore _____ to the extent possible.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide _____ care and services to prevent injuries and _____ for two residents (#123 and #124) of nine sampled residents who utilized _____, during two of four days observed ( _____ and _____).</p>	F 690	<p>On _____ the _____ for resident #123 was positioned and secured properly so the _____ bag nor the tubing touched the floor.</p> <p>On _____ the _____ for resident #124 was positioned and secured</p>		

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F 690	<p>Continued From page 18</p> <p>Findings included:</p> <p>1.</p> <p>On _____ at 10:25 a.m., Resident #123's room door was observed open from the main hallway. She was observed in her room seated in her wheelchair and being visited by a family member. Resident #123 was utilizing an _____ . From the hallway, the resident was observed with the _____ bag and tubing hanging directly below the seat of the wheelchair and with the bag and approximately two inches of _____ tubing on the floor. Resident #123 was observed scooting and forth slowly while seated in her wheelchair with the _____ tubing and bag dragging on the floor.</p> <p>Review of Resident #123's medical record revealed she was admitted to the facility on _____ and readmitted from the hospital on _____. Review of the diagnosis sheet revealed diagnoses to include but not limited to retention of _____ and _____ of _____ .</p> <p>Review of the current Order Summary Report for the month _____, revealed the following orders for Resident #123: - _____ size 14FR (French) with balloon size 30cc (cubic centimeters) to beside drainage bag for dx. (diagnosis) _____ Retention - every shift related to Retention of the _____, order date _____ .</p> <p>A review of the current care plans with a next review date of _____, revealed the following</p>	F 690	<p>properly so the _____ bag nor the tubing touched the floor.</p> <p>On _____, all other residents identified with _____ were checked for proper positioning and securing so the _____ bag nor the tubing of the _____ touched the floor. For these other residents, no area of concern identified.</p> <p>On _____ the Director of Nursing (DON)/designee initiated education for nurses, certified nursing assistants and _____ staff related to proper positioning and securing of _____ bags/tubing. Education completed by _____ .</p> <p>The Director of Nursing/designee for all residents with _____ will do an audit 2 times a week for 12 weeks to ensure proper positioning and securing the tubing for those residents with _____ so no bag or tubing for _____ are touching the floor.</p> <p>The Director of Nursing/designee will review the audits with the monthly Quality Assurance Performance Improvement (QAPI) Committee for three months. The Quality Assurance Performance Improvement committee will evaluate the outcome of the audits and if necessary, amend the improvement plan and continue to monitor until substantial compliance has been determined by the committee.</p>		

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F 690	<p>Continued From page 19</p> <p>areas:</p> <p>1. _____ function/ _____ or _____ thought process r/t (related to) _____ ( _____ ) score of 11, _____ periods of _____, with interventions in place as reviewed.</p> <p>2. _____ of _____. She has a _____ due to _____, retention and is at risk for _____ ( _____ ), _____, _____ toning as ordered, with interventions to include: Observe for signs and symptoms of discomfort on _____ and _____ frequency, _____ care as ordered, Cover drainage bag for privacy.</p> <p>On _____ at 8:05 a.m., an interview was conducted with Resident #123's nurse, Staff E, Registered Nurse (RN). Staff E, RN confirmed she knew of Resident #123 and had her on her assignment since her admission. Staff E, RN also confirmed Resident #123 utilized an _____ and Resident #123 was discontinued with it yesterday on _____. Staff E, RN said prior to the _____ being discontinued, Resident #123 utilized it at all times to include when in bed and when she is seated in her wheelchair. Staff E, RN stated when Resident #123, or any resident who utilizes an _____, the _____ bag should be placed in a position that is off the floor and the tubing leading from the bag to the resident should be off the floor.</p> <p>Staff E, RN further revealed nursing staff who observe _____ bags positioned on the floor are to reposition the bag. _____, _____ staff can also reposition the bag and any other non-nursing staff can report the observation to nursing staff immediately. Staff E, RN confirmed _____ bag and tubing lying on the floor can present with an</p>	F 690			

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F 690	<p>Continued From page 20</p> <p>accident/tripping hazard, can present a risk for pulling out the tubing, and can present as an risk. Staff E, RN also confirmed Resident #123 does at times slowly self-propel by herself while seated in her wheelchair and she was unaware Resident #123 had her bag on the floor and had tubing on the floor from excessive tension.</p> <p>2.</p> <p>On at 12:01 p.m., Resident #124's room was approached and the door was open. From the hallway, Resident #124 was seen in her room while seated next to her bed and in a wheelchair. Resident #124 was utilizing a an . The bag for the was observed hanging below the seat of the wheelchair with a portion of the bag touching the floor. There were liquid contents in the bag during this observed time. The tubing to the , leading from the bag to the resident, was also observed touching the floor with approximately three inches on the floor. The tubing on the floor in excess tension was observed touching the front right wheel of the wheelchair. Resident #124 was observed moving and forth slowly with either her or the front wheelchair tire touching the tubing. The resident was observed with two visitors and one of the visitors repositioned the wheelchair so the resident could be facing towards them. When the visitor was repositioning the resident in the wheelchair, the tires were observed to touch and partially ran over the tubing. The resident's visitor was not aware of the bag and tubing on the floor when repositioning Resident #124.</p>	F 690			

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F 690	<p>Continued From page 21</p> <p>On at 7:20 a.m. Resident #124's room was approached and she was noted in her room, dressed for the day, and seated in her wheelchair. The residents bag was touching the floor and about three inches of the tubing was positioned on the floor.</p> <p>On at 12:00 p.m. Resident #124 was observed seated in her wheelchair next to her bed, resting with her closed. The resident's tubing was in excess tension with approximately two inches of the tubing on the floor. The tubing had yellow liquid contents.</p> <p>Review of Resident #124's medical record revealed she was admitted on . Review of the diagnosis sheet revealed diagnoses to include , history of , and and .</p> <p>Review of Resident #124's current Order Summary Report for the month revealed the following orders: - size 14 fr. with balloon size 30cc for dx. , retention, x (every) shift related to order date ). - Check placement of strap every shift for anchoring of and tubing.</p> <p>Review of Resident #124's current care plans with a next review date of revealed the following areas: 1. Has history of , retention. Was being straight intermittently and upon readmission now has an indwelling . She</p>	F 690			

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F 690	<p>Continued From page 22</p> <p>is at risk for _____, with interventions in place to include: Check placement of _____ strap every shift for anchoring of _____ and tubing, Cover drainage bag for privacy.</p> <p>On _____ at 8:05 a.m., an interview was conducted with Resident #124's nurse, Staff E, RN. Staff E, RN confirmed she knew of Resident #124 and had her on her assignment since her admission. Staff E, RN also confirmed Resident #124 utilized an _____, and that Resident #124 utilizes it at all times to include when in bed and when she is seated in her wheelchair, which is most of the day. Staff E, RN confirmed Resident #124 does at times slowly self-propel by herself while seated in her wheelchair and she was unaware there were times Resident #124 had her _____ bag on the floor with the tubing on the floor from in excess tension.</p> <p>On _____ at 8:35 a.m., an interview with Staff F, Certified Nursing Assistants (CNA) and Staff G, CNA. Both confirmed they had Residents #123 and #124 on their routine work assignments. Both confirmed Resident #124 currently utilized an _____ and Resident #123 was utilizing an _____ until _____ where it was discontinued. Staff F, CNA and Staff G, CNA both confirmed they observed both residents with portions of the _____ bag and tubing on the floor, especially when seated in a wheelchair.</p> <p>Staff F, CNA and Staff G, CNA also both confirmed if they see the tubing or bag on the floor, they can either reposition the bag and tubing up off the floor or they can get a nurse to reposition it, depending on the situation and how far the tubing was out</p>	F 690			

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F 690	<p>Continued From page 23</p> <p>and in excess tension.</p> <p>Staff F, CNA and Staff G, CNA revealed they find at times when either of the residents return from , they find portions of the tubing on the floor and sometimes a portion of the bag on the floor. Staff F, CNA and Staff G, CNA also revealed , staff are able to reposition the tubing and bag up off the floor, but sometimes they don't. Staff F, CNA sated she has reported to her nurse of instances where she found residents returned from , and with portions of the tubing and bag on the bare floor. Staff F, CNA and Staff G, CNA revealed Resident #124 has and will sometimes try to stand up when she is seated in her wheelchair, and the tubing will become in excess tension.</p> <p>On at 1:20 p.m., an interview with the , Director revealed she and her staff, when assisting with residents and who utilize , will first ensure the bag and tubing are properly positioned up off the floor and with tubing free from excessive tension. She revealed they monitor the placement of the tubing and bag when conducting a , session and if the and tubing need to be repositioned, she and her staff will reposition immediately. The , Director also revealed she and her , staff will ensure the and tubing are positioned appropriately and safety upon assisting the resident to their room. She was not aware Resident #123 and #124 had bags and tubing that were touching and laying on the floor.</p> <p>On at 10:30 a.m., the Director of Nursing (DON) provided the "</p>	F 690			

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F 690	Continued From page 24  -care of policy and procedure for review. The policy did not have a review date and revealed the following: Purpose: To provide safe and proper care of the resident with an _____, and to minimize the risk of _____ Procedure: 1. Verify physician's order for _____ care. 2. Identify resident, explain procedure, and provide privacy. ... 7. Secure _____ tubing with a _____ strap to the inner aspect of the female _____. 8. Position the drainage bag below the level of the resident's _____. Secure to the bed or wheelchair in such a manner that neither the bag nor the spigot touches the floor. Coil excess tubing on bed verifying that there are no obstructions or kinks in tubing.	F 690			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)  §483.60(i) Food safety requirements. The facility must -  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812			

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F 812	<p>Continued From page 25</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to 1. Ensure staff who worked in the kitchen initiated proper hygiene in between and after touching soiled dishes and before touching clean dishes in the dish machine room, during two of four days observed ( and ), and 2. failed to follow proper food safety and storage procedures for one resident (Resident # 14) of eight residents sampled.</p> <p>Findings included:</p> <p>1.</p> <p>On at 9:29 a.m., the facility's kitchen was entered and toured with Staff A, Dietary Manager. Staff A, Dietary Manager confirmed they operate a "low temperature" dish washing machine and pointed out the machine in the front right corner of the kitchen. The dish machine area appeared with a large mechanical dish washing machine with a metal table and table chute on the right side, which was used for soiled dishes and prerinse prior to dishes going into the dish washing machine. The left side of the machine was observed with a metal table and metal chute where clean crates of dishes went after coming out of the dish washing machine. Staff B, Dietary Aide (DA) and Staff C, DA were operating the dish washing machine. Staff B, DA and Staff C, DA were both on the right side/soiled side of the machine and were placing soiled breakfast trays, dishes, cups, bowls, or eating/dining ware that came from tray</p>	F 812	<p>On the Certified Dietary Manager (CDM) provided education to the identified dietary staff on proper hygiene when working in the dish room with dirty/soiled and clean dishes. This included proper glove use and washing of before putting gloves on or after taking gloves off.</p> <p>On , the Certified Dietary Manager (CDM) initiated education on hygiene and proper glove use with the other dietary staff. In addition, dietary staff were provided information about the dish machine that included the facility has a low temperature, chemical sanitizing dish machine. The education was completed by .</p> <p>The Registered Dietician reviewed and provided input for updates related to the facility policy for Handwashing for Dietary Staff.</p> <p>The Certified Dietary Manager/designee is doing a minimum of 3 observations per week for 12 weeks related to dietary staff hygiene compliance when they are working with dirty/soiled dishes and clean dishes while in the dish room.</p> <p>The Certified Dietary Manager/designee will review the observations with the monthly Quality Assurance Performance</p>		

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F 812	<p>Continued From page 26</p> <p>cart onto the metal table chute to be pushed over to the prerinse area. Staff B, DA was observed at the prerinse station area wearing blue plastic gloves. She was observed handling soiled eating/dining ware with her _____ and was using a rinse hose to rinse off large debris from the various eating/dining ware. Staff C, DA continued to take soiled eating/dining ware from tray carts and pushed them down the metal chute towards Staff B, DA for prerinseing.</p> <p>At 9:31 a.m. Staff B, DA, after prerinseing soiled eating and dining ware, immediately placed the eating/dining ware into plastic crates and pushed the crate of soiled eating/dining ware into the soiled side of the machine and closed the door with her gloved _____. Staff B, DA continued to receive soiled eating/dining ware from the metal table chute and prerinse with the hose. After the dish washing machine ran its wash and rinse cycle, Staff B, DA walked over to the left side/clean side of the machine, opened the door, and pulled out the crate full of clean and sanitized eating/dining ware with her gloved _____. Staff B, DA did not remove her gloves or wash/sanitize her _____ after handling soiled eating/dining ware and before handling clean and sanitized eating/dining ware. At 9:33 a.m. Staff B, DA stated the type of dish washing machine the facility used was "a high temperature dish washing machine", but she was not able to state what temperatures the wash and rinse cycles get to. She then stated, "I think the wash needs to get to 150 degrees [Fahrenheit]" She was unsure what the rinse cycle temperature should reach. Staff B, DA confirmed there was a chemical sanitizer and they test the clean dishes with a test strip to see if there is enough sanitizer getting through the</p>	F 812	<p>Improvement (QAPI) Committee for three months. The Quality Assurance Performance Improvement committee will evaluate the outcome of the audits and if necessary, amend the improvement plan and continue to monitor until substantial compliance has been determined by the committee.</p> <p>On _____, Resident #14 was assessed for any potentially hazardous food at bedside. No adverse effects noted.</p> <p>On _____, all resident rooms were assessed to ensure that there was no potentially hazardous food at bedside. No additional areas of concern identified.</p> <p>On _____, the current policy related to Storage of Foods Brought to Residents by Family/visitors was reviewed and updated. The Director of Nursing (DON)/designee initiated education for Department Heads, nursing, and housekeeping staff related to food storage at bedside/in the resident room. The education was completed by _____.</p> <p>The Director of Nursing/designee will complete 10 observations each week for 12 weeks to ensure that there is no potentially hazardous food being stored at bedside in a resident's room.</p> <p>The Director of Nursing/designee will review</p>		

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F 812	Continued From page 27  machine and onto the eating/dining ware. She was asked if she was sure the machine was a "high temperature" dish washing machine. Staff B, DA could not answer and then got a verbal cue from the Staff A, Dietary Manager that the machine was a "low temperature", chemical sanitizing dish washing machine. Staff B, DA demonstrated the use and operation of the low temperature dish washing machine at 9:35 a.m. Staff C, DA stood in the right side/soiled side of the machine and continued to place soiled eating/dining ware from the tray carts and on to the metal table chute. Staff B, DA immediately put on blue plastic gloves, was not observed to wash her prior to, and started to prerinse soiled plastic trays with the hose. She placed prerinsed trays into a plastic crate and ran the crate of soiled eating/dining ware into the soiled side of the dish washing machine. After the machine ran its wash and rinse cycle, Staff B, DA opened the door to the dish washing machine and pushed the crate of cleaned and sanitized dishes through to the left side/clean side of the machine with her gloved . She walked over to the left side/clean side of the machine and retrieved the crate of cleaned and sanitized eating/dining ware with her gloved and began to take a new chemical sanitizer test strip and placed it on one of the trays in the crate. Staff B, DA never removed her gloves or washed her after handling the soiled eating/dining ware and prior to handling the clean and sanitized eating/dining ware. Staff B, DA could not get a reading from the test strip, so she walked over to the right side/soiled side of the dish washing machine area and pushed through another crate of soiled eating/dining ware into the machine. While the dish washing machine was	F 812	the audits with the monthly Quality Assurance Performance Improvement(QAPI) Committee for three months. The Quality Assurance Performance Improvement committee will evaluate the outcome of the audits and if necessary, amend the improvement plan and continue to monitor until substantial compliance has been determined by the committee.		

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F 812	<p>Continued From page 28</p> <p>running its cycle, Staff B, DA stood near the machine to wait for the cycle to be finished. Once the wash and sanitize cycle was completed, Staff B, DA was observed walking over to the left side/clean side of the machine and retrieved the clean crate of eating/dining ware with her gloved and began to conduct another chemical sanitizer test with a new test strip. Staff B, DA did not remove her soiled gloves or wash her after handling soiled eating/dining ware. Staff B, DA was observed retrieving soiled eating/dining ware from the soiled side of the dish machine, prerinsed the eating/dining ware, placed the soiled eating/dining ware in empty crates, sent the soiled eating/dining ware through the machine to be clean and sanitized, received the clean eating/dining ware from the clean side of the machine, and handled the clean and sanitized eating/dining ware with her unchanged and unwashed four more times before the surveyor left the area. During most of the observation from 9:31 a.m. through to approximately 9:42 a.m., the Staff A, Dietary Manager was in the kitchen's dish washing machine room observing the operation from both Staff B, DA and Staff C, DA. Staff A, Dietary Manager did not intervene to ensure Staff B, DA washed her after handling soiled eating/dining ware and prior to handling clean and sanitized eating/dining ware.</p> <p>On at 1:43 p.m. an observation was conducted in the facility kitchen with Staff D, DA and Staff B, DA, who were observed in the dish washing machine area and were both on the right side/soiled side of the dish machine. Staff B, DA was observed taking soiled dishes, trays, cups,</p>	F 812			

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F 812	<p>Continued From page 29</p> <p>bowls, or eating/dining ware from received tray carts and placed the eating/dining ware on the metal table chute. She was observed pushing the eating/dining ware down the metal chute to the prerinse station where Staff D, DA was. Staff D, DA was observed with her bare hands taking a rinsing hose and was pre-rinsing the soiled eating/dining ware and placed the eating/dining ware in empty plastic crates to be ran through the dish washing machine. At 1:45 p.m., Staff D, DA was observed pushing a full plastic crate of eating/dining ware into the soiled side of the dish machine with her bare hands and closed the dish washing machine door for it to run its clean and sanitizer cycle. Once the machine finished its cycle, Staff D, DA walked over to the left side of the dish washing machine, opened the door, and pulled the clean and sanitized crate of eating/dining ware out and to the clean table area. Staff D, DA did not wash her hands or don gloves after handling soiled eating/dining ware and prior to handling clean and sanitized eating/dining ware.</p> <p>At 1:47 p.m., Staff B, DA continued to place soiled eating/dining ware on the soiled side of the dish machine table chute and Staff D, DA continued to retrieve the soiled eating ware, pre-rinse them, and set them in a plastic crate to be ran through the dish washing machine. Staff D, DA walked over to the left side/clean side of the dish washing machine and retrieved clean and sanitized crates of eating/dining ware with her bare hands. She was not observed to donning gloves or washing her hands after handling soiled eating/dining ware or prior to receiving and handling clean and sanitized crates of eating/dining ware.</p> <p>Staff D, DA continued to handle and feed crates of</p>	F 812			

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F 812	<p>Continued From page 30</p> <p>soiled eating/dining ware through the soiled side of the machine and received and handled crates of clean and sanitized eating/dining ware with her bare unwashed _____ for four more dishwashing cycles. In between and while the dish washing machine was in cycle, Staff D, DA took plates from an already clean and sanitized crate and stacked them in her _____ and arms and brought them to a metal plate holder. She did this process three times and without washing her _____ after touching and handling soiled eating/dining ware and prior to touching the clean and sanitized plates. The plates were stored in a manner as if ready to use for residents at the next meal/dining service.</p> <p>On _____ at 10:45 a.m., and while in the facility's kitchen, the Staff A, Dietary Manager was interviewed with relation to the dish washing process. Staff A, Dietary Manager revealed the dish machine area is composed of two sides, one soiled side on the right and one clean side on the left. Staff A, Dietary Manager revealed typically there are two staff members in the dish washing machine area. One staff member handles the soiled dishes and runs the eating/dining ware through the soiled side of the machine while another staff member works on the clean side of the machine and receives/handles only clean and sanitized eating/dining ware that came through the machine. Staff A, Dietary Manager explained there are times when she is in the dish washing machine area assisting with cleaning dishes and she will usually be on the clean side, not the soiled side. She revealed she would only be handling clean and sanitized eating/dining ware. She also confirmed if she touches or handles</p>	F 812			

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F 812	<p>Continued From page 31</p> <p>soiled eating/dining ware with her bare _____ or gloved _____, she would remove her gloves and wash her _____, or wash her _____ if she is not gloved, prior to handling clean and sanitized eating/dining ware after they come out from the dish washing machine.</p> <p>Staff A revealed that she saw a lack of handwashing when handling soiled eating/dining ware and during the handling of clean and sanitized eating/dining ware during the observation of Staff B, DA and Staff C, DA on _____.</p> <p>On _____ the Dietary Manager provided an undated policy titled "Dishwashing Machine", which revealed: Policy: The facility will maintain dishwashing machine in a clean condition to minimize the risk of food hazards. Dish washing machines will be cleaned three times a day after each meal. Procedure: 1. Turn the dishwashing machine on. 2. Open drain valves. 3. Remove scrap trays. 4. Spray scrap trays over garbage. 5. Spray down the inside of the dishwashing machine. 6. Scrub stains inside dishwashing machine and on outside drains using an abrasive _____, soaked in warm water and detergent and de-staining solution. 7. Wash the outside of the dishwashing machine and hood with a clean cloth soaked in detergent solution. 8. Wipe down with an approved sanitizing solution. 9. Wipe with clean dampened cloth.</p> <p>The Dietary Manager also provided an undated</p>	F 812			

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F 812	<p>Continued From page 32</p> <p>policy titled " Washing", which revealed: Policy: The facility recognizes that food-borne illness has the potential to harm elderly and frail residents. All Dietary employees will practice good washing practices in order to minimize the risk of and food borne illness.</p> <p>Procedure:</p> <ol style="list-style-type: none"> <li>1. -washing Stations             <ol style="list-style-type: none"> <li>a. Make sure washing stations are located in food preparation areas to encourage employees to wash their frequently. ...</li> <li>c. Make sure all -washing stations are equipped with the following:                 <ol style="list-style-type: none"> <li>i. Hot and running water.</li> <li>ii. cleaning liquid, powder or bar soap.</li> <li>iii. Individual, disposable towels, a continuous towel system that supplies the use with a clean towel or a heated - air -drying device.                     <ul style="list-style-type: none"> <li>. A receptacle for disposable towels.</li> </ul> </li> <li>v. A sign that indicates employees must wash before returning to work.</li> </ol> </li> </ol> </li> <li>2. should be washed after the following occurrences:             <ol style="list-style-type: none"> <li>a. Using the Restroom.</li> <li>b. Handling raw food (before and after).</li> <li>c. Touching the hair, , or body.</li> <li>d. Sneezing or coughing.</li> <li>e. Smoking.</li> <li>f. Eating or drinking.</li> <li>g. Handling chemicals.</li> <li>h. Taking out garbage.</li> <li>i. Clearing tables.</li> <li>j. Touching clothing or aprons.</li> <li>k. Touching un-sanitized equipment, work surfaces, or wash cloths. ...</li> </ol> </li> <li>2.</li> </ol>	F 812			

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F 812	<p>Continued From page 33</p> <p>On _____ at 9:24 AM and on _____ at 3:00 PM, Resident # 14 was observed lying down on her bed dressed in her night gown. She was observed with rotten fruit left on her bedside table for two days. An interview was conducted following the observation with Resident # 14, who stated she was going to eat the fruit later.</p> <p>Review of an Admission Record showed Resident # 14 was admitted to the facility on _____ with diagnoses to include but not limited to _____ in other _____ classified elsewhere, mild, with other behavioral disturbance and _____, unspecified</p> <p>Review of a Quarterly Minium Data Set (MDS) assessment dated _____ revealed a _____ ( _____ ) score of 13, which indicated the resident was _____.</p> <p>During an interview on _____ at 10:00 AM with the Director of Nursing (DON), the DON stated Resident #14 is difficult and she doesn't let the staff take away her food. The DON also stated the resident's husband brings her food from time to time. The DON stated Resident # 14 has had a recent decline and she's assuming the resident did not want the staff to remove the fruit from her room. The DON stated if the resident refused to discard the rotten fruit, they should have reported the behaviors to the nurse or to her. The DON stated her expectations are residents' bedside tables should be cleaned off and old food should be discarded.</p> <p>Review of the facility policy titled Storage of Foods</p>	F 812			

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F 812	Continued From page 34  Brought to Residents by Family/Visitors showed: Policy Statement: Staff must be aware of and approve, food(s) brought to a resident by family/visitors to ensure safe and sanitary storage, handling and consumption of foods. Interpretation and Implementation 7. The Nursing staff is responsible for discarding perishable foods within 3 days or before the use by/expiration date, whichever comes first. 8. The nursing and/or food service staff must discard any food prepared for the residents that shows obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates)	F 812			
F 842 SS=D	Photographic Evidence Obtained Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5)  §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.  §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and ( ) Systematically organized	F 842			

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F 842	<p>Continued From page 35</p> <p>§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>( ) For public health activities, reporting of neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(h)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(h)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p>	F 842			

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F 842	<p>Continued From page 36</p> <p>( ) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, _____, and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review, and interviews, the facility failed to accurately document in the clinical record for one resident (Resident #60) of forty-one sampled residents related to a physical assessment completed during a time the resident was not in the facility.</p> <p>Findings included:</p> <p>An observation on _____ at 8:31 a.m. revealed Resident #60 was sitting up in bed with a meal in front of her. The resident did not appear to be in visible distress.</p> <p>Review of a Skilled Nursing Facility/Nursing Facility (SNF/NF) to Hospital Transfer form showed the resident was transferred to an acute care facility on _____ for a _____ placement by the _____ team.</p> <p>Review of a physician order written on _____ at 2:43 p.m. instructed staff to send Resident #60 to the Emergency Room (ER) for re-insertion of _____ by _____ team.</p> <p>Review of Resident #60's payor source information showed the facility "stop billing" on _____ and the resident became "active" on _____.</p>	F 842	<p>The Director of Nursing (DON) interviewed the nurse who entered the incorrect documentation into the medical record for Resident #60 on _____, and then followed the facility policy for incorrect documentation and struck out the incorrect documentation for Resident #60 on _____.</p> <p>On _____, the Director of Nursing/designee initiated an audit on other residents discharged from _____ to _____ and there were no other residents that had documentation after discharge.</p> <p>On _____, the Director of Nursing provided education to the facility per diem nurse that incorrectly documented on discharged resident #60.</p> <p>On _____, the Director of Nursing/designee initiated education for the other nurses related to accurate and complete resident documentation on current residents only. The education was completed by _____.</p> <p>The Director of Nursing/designee will complete an audit a minimum of one time</p>		

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F 842	<p>Continued From page 37</p> <p>Review of Resident #60's Daily Medicare A/Managed Care Nursing Note dated at 7:07 p.m. revealed a temperature reading from .8 , from , and and readings from . The note showed the resident was alert &amp; oriented to person, there were no changes in the resident's and behavior patterns, the resident was of , and the was clear with a normal odor. The resident was of of with an . The resident's sounds were Within Normal Limits (WNL) and effort was normal. The resident had a regular rate and , pulses were . The residents' pupils were equal, round and reactive to light and accommodation (PERRLA), the hearing was adequate, and speech was clear and appropriate. The resident's , measurement was shown as a smiling revealing the scale of "No Hurt". The resident was noted to have no new changes to skin integrity and no . The note did not reveal if the resident was on any isolation/precautions. The note showed the resident was receiving physical and .</p> <p>An interview was conducted on at 9:38 a.m. with Staff H, Licensed Practical Nurse (LPN). The staff member reported if a resident was discharged, the facility discharged them from the electronic system. Staff H, LPN reviewed the assessment completed on Resident #60 on and stated the nurse may have made a mistake and did not think any nurse would document on a discharged resident. The staff member stated at times and if needed they may go in and make a late entry on the resident but</p>	F 842	<p>per week for 12 weeks. This weekly audit will be to review discharged residents for the week to ensure that there is no incorrect documentation entered after a resident has discharged.</p> <p>The Director of Nursing/designee will review the audits with the monthly Quality Assurance Performance Improvement (QAPI) Committee for three months. The Quality Assurance Performance Improvement committee will evaluate the outcome of the audits and if necessary, amend the improvement plan and continue to monitor until substantial compliance has been determined by the committee.</p>		

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F 842	<p>Continued From page 38</p> <p>would not document an assessment on them.</p> <p>An interview was conducted on _____ at 9:47 a.m. with Staff I, LPN/Assistant Director of Nursing (ADON). Staff I, LPN ADON reported staff document on Daily Medicare with daily notes, for 3 days. She would expect a narrative note for new admissions and any long-term care residents on _____ should be documented on every shift. She reported a resident who had been discharged would "not typically" be documented on, except for a hospital follow up note, but would not document an assessment or a daily Medicare note on a discharged resident. The ADON reviewed Resident #60's chart and confirmed the resident left the facility on _____ and thought the resident had been gone _____ days, thinking the resident came on the _____. Staff I, LPN ADON stated the expectation was to assess and lay _____ on a resident when documenting and the note on _____ was not correct documentation.</p> <p>Review of the undated policy titled Documentation, Clinical, revealed: Policy: The facility clinical staff will document the provision of care and services according to nursing standards and regulatory requirements. When completed, documentation will accurately reflect the clinical care and other services provided to the resident and ensure that the appropriate information is available to all industry interdisciplinary team members. Documentation in the medical record of each resident should provide:</p> <ol style="list-style-type: none"> <li>1. A complete account of the residents care treatment and response to the care.</li> <li>2. Information for the physician when prescribing medications and managing care and treatments.</li> </ol>	F 842			

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F 842	Continued From page 39 3. A description of care and services that can be used for measuring the quality of care provided to a resident. 4. An ongoing record of the physical and mental status of the resident. 5. Information for the development of a plan of care for each resident. 6. Elements to support quality medical care. 7. A legal record that protects the resident, physician, nurse, and the facility. 8. Documentation as recorded to support reimbursement. Documentation Guidelines: 1. All entries in the medical record should be accurate, legible, dated, and timed. ...	F 842			