Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35960940	A. BUILDING: _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KISSIMMEE NURSING & REHABILITATION CENTER	2511 JOHN YOUNG PARKWAY NORTH KISSIMMEE, FL 34741

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	INITIAL COMMENTS Relicensure and complaints surveys #2025001274 and #2025001894 were conducted from to . The complaints were not substantiated, but Kissimmee Nursing & Rehabilitation Center had deficiencies found at the time of the visit.	N 000		
N 071 SS=D	59A-4.109(1), FAC Components of Care Plan (1) Each resident admitted to the nursing home facility must have a plan of care. The plan of care must consist of: (a) Physician's orders, diagnosis, medical history, physical exam and rehabilitative or restorative potential. (b) A preliminary nursing evaluation with physician's orders for immediate care, completed upon admission. (c) A complete, comprehensive, accurate and reproducible assessment of each resident's functional capacity which is standardized in the facility, and is completed within 14 days of the resident's admission to the facility and every twelve months, thereafter. The assessment must be: 1. Reviewed no less than once every 3 months; 2. Reviewed promptly after a significant change, which is a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem, in the resident's physical or mental condition; and, 3. Revised as appropriate to assure the continued accuracy of the assessment. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to revise and implement appropriate interventions including the provision	N 071	Preparation and/or execution of this plan does not constitute admission or agreement by the provide of the truth of	

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N 071	Continued From page 1 of adequate supervision to prevent for 2 of 4 residents reviewed for , of a total sample of 59 residents, (#3 and #51). Findings: 1. Review of resident #3's medical record revealed she was originally admitted to the facility on and readmitted from a short-term, acute hospital on . Her diagnoses included of , type 2 , , hearing loss, and . Review of the quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of revealed resident #3's ( ) score of 3 out of 15, which indicated severe . The MDS assessment showed resident #3's hearing was highly , and her vision was , . She required supervision for eating, and substantial assistance from staff for toileting, lower body , upper body , putting on/taking off footwear, and personal hygiene. She was dependent on staff for showers. The MDS assessment revealed resident #3 required supervision or touching assistance for rolling left and right, sit to lying, lying to sitting, and to wheel up to 150 in the wheelchair. She required substantial assistance for sit to stand, chair/bed-to-chair transfer and from a bed to chair (or wheelchair), toilet transfer and tub/shower transfer. Walking was "not attempted due to medical condition or safety concerns." She was frequently of . Since the previous MDS assessment, she had one with no injury. Review of resident #3's comprehensive care plan	N 071	the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. (a) Immediate action(s) taken for the resident(s) found to have been affected include: New risk evaluations were completed for Resident #51 to reflect accurate information, and their care plans and Kardex's were updated to reflect accurate risk assessments, with appropriate and individualized prevention interventions implemented. Resident #3 is no longer residing at the facility. (b) Identification of other residents having the potential to be affected was accomplished by: All Residents who have had a have the potential to be affected. The MDS Coordinator and Unit Managers conducted a facility-wide audit of risk assessments and care plans for residents with a score of 12 or less to identify any discrepancies. (c) Actions taken/systems put into place to reduce the risk of future occurrence include: Starting on all Direct Care staff (RNs, LPNs, and C.N.A.S) staff will receive mandatory training regarding review and use of Care Plan/Kardex prior to providing care to Residents. This education will also be completed upon hire and at least annually. All Direct Care staff	

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N 071	Continued From page 2 revised on revealed a focus of risk for . Interventions included to , and meet the resident's needs and encourage her to use the call light for assistance as needed. A care plan for cognition revised on directed staff to "Cue, reorient and supervise as needed." A care plan for a behavior problem related to in inappropriate places specifically the trash can was initiated . The interventions directed staff to offer and escort the resident to the toilet frequently and to remove the trash container from her room/area. A communication problem due to a language barrier care plan revised revealed resident #3 spoke Spanish and had hearing loss. Review of resident #3's medical record revealed the following Change in Condition Evaluations: * with injury, bump on forehead * in the left , and * with no injury Review of the Investigation Worksheet for the on revealed resident #3's daughter was with the resident at the time of the . The form showed the occurred in the bathroom and the resident required supervision. The Recommendations/Interventions included assisting the resident to the bathroom after meals, ensure the call light was within reach, educate the family to ask for help toileting, and checks. Review of the Investigation Worksheet for the on revealed resident #3's was leaning forward to pick something up from the floor. The form indicated resident #3 required supervision. The form included the number of in the last 30 days was 2 and in the past 31-180 days she had two . A bump on the	N 071	will be in-service by . Any Direct Care staff not in-serviced by this date will be in-serviced prior to their next scheduled shift. We have no Agency staff currently. All newly hired Direct Care staff will be in-service by the ADON during their orientation. Starting on all Licensed nurses (RNs and LPNs) and MDS staff on the proper completion of risk assessments, individualized care planning, and the importance of ensuring interventions are documented in the Kardex. All Licensed nurses (RNs and LPNs) and MDS staff will be in-service by . Any Licensed nurses (RNs and LPNs) and MDS staff not in-serviced by this date will be in-serviced prior to their next scheduled shift. We have no Agency staff currently. All newly hired Licensed nurses (RNs and LPNs) and MDS staff will be in-service by the ADON during their orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing or Designee will review a sample of five residents risk evaluations, care plans and Kardex s weekly for four weeks, then monthly for three months to ensure continued compliance. Any discrepancies identified will be corrected immediately, and trends will be addressed through additional staff training or process adjustments. Findings will be reported in the monthly QA/QAPI meeting for further review and action as needed for a	

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N 071	Continued From page 3 forehead was noted. The nurse statement included she called the physician and resident #3 was sent to the hospital for evaluation. Review of the following Risk Evaluation form revealed resident #3 scored below 10 on . The Risk Evaluation form read, "Total score of 10 or ABOVE represents HIGH RISK. Initiate a Risk Care Plan for High Risk Components/Factors (i.e. , Unsteady Gait,) regardless of resident not scoring a 10 or above." The form showed resident #2 was ambulatory and . The questions, "Walking, turning around and facing opposite direction and moving on and off toilet" was answered as "Not steady, but able to stabilize without staff assistance." Her vision was incorrectly marked as adequate . Review of a Progress Note dated revealed resident #3 was discussed during the Patient at Risk (PAR) meeting. The note read, "Resident continues to be monitored and educated on using call lights to ask for assistance . . ." Another Progress Note entered on included "New intervention: Reinforce to resident to call for assistance to include things on the floor." A Progress Noted dated read, "Despite advising the resident to stay herself in bed for safety and call for assistance the resident does not follow instruction and many times in the frequent rounds the resident has been found standing, walking and making her bed." A Progress Note dated included resident #3 "consistently does not utilize call light as instructed." A Progress Note dated read, " . . . The resident did not use the call bell to call for assistance." On at 4:04 PM, resident #3 was observed	N 071	minimum of 3 months. (e) Date of compliance .	

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N 071	Continued From page 4 lying in bed on her right side, with , closed. A dark purple and light green was noted on her left forehead, measuring approximately 8 x 6 centimeters. There was a trash can next to her bed, and the call light was on the bed rail. On at 10:20 AM, resident #3 was observed sitting on her wheelchair washing her in the bathroom sink. When asked in Spanish what happened to her , she smiled but did not answer. She was wearing slippers. On at 10:21 AM, Certified Nursing Assistant (CNA) J entered resident #3's room. CNA J stated resident #3 a few days ago. CNA J stated resident #3 was hard of hearing, wore , but said they did not work. She shared resident #3 needed supervision. On at 10:52 AM, during a telephone interview, resident #3's daughter explained her mother suffered from . She mentioned it had become "very dangerous" lately because she liked going to the bathroom by herself. She shared her mother had recently in the bathroom and again a few days later. Resident #3's daughter said her mother "cannot see well, is legally , can see shadows, is hard of hearing on both , and not even with , [can she] understand. She does not speak English. She is declining." She stated her mom was sent to the hospital after the last two . She indicated she was visiting her mom when she in the bathroom, but she did not hurt herself. She recalled a couple of days later, she was called because her mother was sent to the hospital with a "big hematoma" on her , . She stated her mom told her she poked her , and she noticed her mom's , was and black and blue. She explained she was told the	N 071		

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N 071	Continued From page 5 second time her mother she bent over to get something from the floor, forward and hit herself on the table. She shared the showed an hematoma outside the . She stated she usually did not visit during the day, but her sister and herself visited mostly during dinner to ensure her mother was taken to eat. She shared her mother used to participate in activities, enjoyed coloring books but she had declined "a lot." She indicated when she attended Care Plan meetings, she "always mentioned concerns about the availability of someone to care for her." She mentioned her mom often refused showers and could go up 2 weeks without a bath, but she received it from CNA H because "she is very patient with her, and she talks her into it." Resident #3's daughter stated her main concern was her . She said she felt the CNAs did not check on her mother often. She stated her mom would get up unassisted and would not use the call light. She indicated the CNAs should do rounds and checked on her often because her mother "still think she can do things" by herself. On at 3:08 PM, CNA H stated there was a strong odor of in the room because resident #3 on the trash can and on the floor. She explained resident #3 vision and hearing were , . She shared resident #3 liked to "fix everything by herself, fixes the bed." CNA H stated resident #3's , looked like someone hit her but she tended to get too close to things to see them and that was "probably what happened to her." She stated they tried to place floor mats next to resident #3's bed but resident #3 removed them while she pointed to a floor mat located behind the of the bed. She explained she checked on resident #3 every time she finished caring for each of her residents because resident #3 liked to fix her drawers and	N 071		

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N 071	Continued From page 6 wanted to do things by herself. On at 1:12 PM, the General & Restorative Unit Manager (UM) stated were discussed every morning during clinical meetings by the Interdisciplinary Team (IDT). She explained the IDT reviewed the incident report, looked for any type of injuries, and discussed any new interventions required after reviewing the care plan. She indicated any new interventions were added by the MDS Coordinator attending the meeting. She mentioned resident #3's mentioned on was because of her on . She stated resident #3 again on while attempting to reach out for something and was sent out to the hospital. She indicated resident #3 required frequent checks. When asked what frequent checks meant, she explained it was "to put , on the resident but no specific time frames" were required. She indicated a new intervention to offer toileting after meals would show up in the Kardex (care plan used by CNAs). On at 11:56 AM, Registered Nurse (RN) A stated she was not working when resident #3 but explained the resident was monitored frequently, every 15 minutes by the CNA and nurses. She indicated resident #3 required one-staff assistance to transfer but the resident transferred herself at times and she did not use the call light. She mentioned resident #3 was disoriented, and could not follow instructions. She shared resident #3's hearing and vision was , and although she did not walk, she tried to get up from her wheelchair. RN A stated resident #3 required supervision "all day long" and a safe environment to avoid . Review of resident #3's comprehensive care plan	N 071		

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N 071	Continued From page 7 did not include resident #3 required frequent, 15 minutes checks. On at 1:25 PM, MDS Coordinator L shared the interventions from the risk management report after the included assistance with activities and monitor for changes. She stated the care plan was updated on to include , , , to screen and resident and family education. She mentioned the intervention after the on was to offer resident #3 a reacher and educate her on use. She said she was surprised with the intervention because resident #3 had and her was very low. MDS Coordinator L validated interventions for frequent supervision or to offer toileting after meals were not included in the care plan. On at 1:50 PM, the Director of Nursing (DON) explained during clinical meeting they reviewed the Investigation Worksheet and witness statements, came up with a root cause for the and interventions to prevent future . She indicated any interventions they decided would be updated to the care plan if not already there. She read the intervention included on the IDT note dated , "Reinforce to resident to call for assistance to include things on the floor" and validated it was not appropriate for this resident due to her cognition. She mentioned resident #3 needed frequent checks at least every 15 minutes. She mentioned resident #3 needed to be in a highly visible area to be closely observed by CNAs and nurses to prevent . 2. Review of resident #51's medical record revealed she was originally admitted to the facility on and readmitted from a short-term,	N 071		

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N 071	Continued From page 8 acute hospital on . Her diagnoses included , , and . Review of the quarterly MDS assessment with ARD of revealed resident #51's score of 3 out of 15, which indicated severe . The MDS assessment showed no rejection of care necessary to obtain goals for her health and well-being. Resident #51 required set-up for eating and substantial assistance from staff for oral hygiene and upper body . The MDS assessment showed she was dependent on staff for toileting, showers, lower body , putting on/taking off footwear, and personal hygiene. The MDS assessment revealed resident #3 required substantial assistance from staff for sit to lying and lying to sitting. She was dependent on staff to roll left and right in bed, sit to stand, chair/bed-to-chair transfer, toilet transfer and tub/shower transfer. Walking was "not attempted due to medical condition or safety concerns." She required supervision or touching assistance to wheel 50 to 150 in the wheelchair. She was always of and . Since the previous MDS assessment, she had two with no injury. Review of resident #51's comprehensive care plan revised on revealed a focus of risk for related to attempt to get up unassisted, , gait/balance problems, and unaware of safety needs. Interventions included , and meeting the resident's needs and dycem (non-slip ,) to wheelchair. A care plan for , cognition revised on directed staff to "Cue, reorient and supervise as needed."	N 071		

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N 071	Continued From page 9 Review of resident #51's medical record revealed the following Change in Condition Evaluations: * - resident found on the floor in the TV room lying on her left side and on the left side of the forehead. Resident sent to the hospital for evaluation and treatment. * - with no injury Review of the following Risk Evaluation form revealed score below 10. * - score of 4. The question if resident had any since admission or prior assessment was answered No. * - score 9. The question if resident had any since admission or prior assessment was incorrectly answered No. Ambulatory and were selected. Review of the Investigation Worksheet for the on revealed resident #51's unwitnessed occurred on the hallway/TV room at 8:35 PM. The question, "Did resident require supervision?" was answered "No." The resident was using a wheelchair. Number of in the last 30 days was 1 and number of in the past 31-180 days was 2. Resident #51 did not sustain an injury. A Intervention Strategies sheet was attached and listed 51 possible interventions to reduce the risk of , but none were selected. Review of the Investigation Worksheet dated revealed resident #51's was again in the TV room area when the unwitnessed occurred. was selected as a behavior at the time of this . The question, "Did resident require supervision?" was answered TV. The resident was using a wheelchair. Number of in the last 30 days and number of in the past 31-180 days was left bank. Resident #51 did not sustain an injury. A Post- Analysis/Review	N 071		

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N 071	Continued From page 10 form revealed risk factors of poor safety awareness, history of aggression, and worsening in the evening. The analysis included supervision and read, "Encouraged to be in common area per plan of care for closer supervision due to poor safety awareness." The possible contributing factors mentioned evening behavioral changes. The interventions to prevent reoccurrence included increased supervision during late afternoon/evening hours, behavioral interventions such as music , , , sensory activities and environmental modifications in the afternoon/evening. On at 3:17 PM, CNA H recalled 2 or 3 Saturdays ago at approximately 8:00 PM resident #51 was in the TV area with other residents. CNA H stated she went to discard soiled linens in the soiled utility room and when she returned resident #51 had from her wheelchair. She shared some time ago the facility used chair alarms, but staff were told they could not use chair alarms any longer. She indicated she found those helpful because staff ran when they heard the alarms. CNA H stated resident #51 used to hit the walls and the physician prescribed a cream to place on her which was helpful, but she did not think resident #51 was getting it any longer. She shared resident #51's behaviors changed a lot in the evenings, as she was a "sundowner" and did not remember anything. She indicated the resident was transferred with a but she thought resident #51 stood up and on her right side. On at 1:36 PM, the General & Restorative Unit Manager (UM) stated resident #51's care plan included the use of a dycem when she was in the wheelchair. A few minutes later, at 1:53 PM, while resident #51 was sitting in	N 071		

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N 071	Continued From page 11 her wheelchair, the UM checked under the , and the sides of her seat cushion and stated she could not see the dycem. On at 1:57 PM, Occupational ( ) M stated dycem was used under the wheelchair cushion to prevent sliding. On at 1:59 PM, CNA H recalled resident #51 had a dycem when she was in another room. She said she was "not sure who threw it away" because she had not seen the dycem recently. She mentioned the last time she saw the dycem was a month or so ago. She indicated she had not mentioned to anyone about not seeing the dycem because resident #51 was currently working with , , so they would review the wheelchair and provided a new one if needed. CNA H indicated the dycem was not in resident #51's wheelchair and repeated she did not see it today or any day this past week. When asked to show the safety/ interventions in resident #1's Kardex (plan of care), CNA H accessed it electronically. She pointed out the safety information, interventions or dycem did not appear on the Kardex. She stated she only used the computer to document the care she provided the residents. On at 4:35 PM, the Director of Rehabilitation confirmed resident #51 was currently on case load since . She indicated she participated in the clinical meetings. She stated if an intervention for the use of dycem was identified, she placed it in the wheelchair. She explained once the dycem was provided to the resident, it would be nursing's responsibility to continue placing it in the wheelchair. She shared if nursing needed another dycem for a resident, nursing needed to let her know.	N 071		

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N 071	Continued From page 12 Review of the Evaluation & Plan of Treatment for Certification Period of - revealed treatment approaches included wheelchair management training. The goals included ability to reposition herself while seated in the wheelchair and increase , sitting balance to facility upright posture. The current referral indicated resident #51 was referred to due to from the wheelchair. History of was answered, "No." Her prior level of function revealed resident was dependent with ADL management except feeding and was dependent with mobility and transfers using a . Her safety awareness was identified as "intact." The clinical impression read, "Patient exhibits new onset of decreased , alignment and decrease in strength." The notes did not reference the use of a dycem. Review of Treatment Encounter Note(s) from to included training repositioning in wheelchair to patient and caregiver, training to nursing on positioning and in wheelchair and locking , rests into place. The note dated included instruction to "patient in proper body mechanics, safety precautions and self care/skin checks specifically, in order to increase functional mobility skills and increase safety and decrease need for assistance with partial carryover demonstrated during training, due to safety awareness and patient's comprehension skills." On at 12:03 PM, RN A stated prevention interventions for resident #51 included close/frequent supervision, every 15 minutes. She indicated resident #51 participated in activities or stayed in the TV room where the staff kept "an , " on her. She stated nurses, CNAs	N 071		

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N 071	Continued From page 13 and , , would be responsible to ensure the dycem was on resident #51's wheelchair before the resident was transferred to it. She indicated she did not recall if the dycem was in her wheelchair today. She mentioned resident #51 was working with . On at 12:23 PM, CNA N stated today was the first day by herself on her first assignment. She explained she had a 2-day orientation then shadowed on the floor for 3 days. She shared she received report about her assigned residents this morning. She indicated she did not recall reviewing the Kardex during her training. She stated she did not recall seeing a dycem in resident #51's wheelchair when she was transferred this morning. CNA N asked, "Is the resident supposed to have it?" On at 12:56 PM, MDS Coordinator L validated interventions included in the investigation packet were not all included in the care plan. She reviewed the care plan and stated she saw offering the resident afternoon naps and to keep in in a common area for supervision. She stated she was surprised the increased supervision intervention was not there. She indicated "everyone" knew resident #51 and "everyone" kept "an , " on her. On at 3:43 PM, the DON explained once a investigation was completed, the MDS Coordinator attending the meeting added new interventions to the care plan. Later on at 2:10 PM, the DON stated the UM was responsible for communicating with the CNAs before they started their assignments. She indicated her expectation was the nursing staff communicated any new interventions to each other and the care plan was updated with the	N 071		

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N 071	Continued From page 14 appropriate interventions. Review of the policy titled Accidents and Supervision reviewed on read, "The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents." The guidelines mentioned potential hazards and risks would be documented and communicated across all disciplines. The implementation of interventions included communicating the interventions to all relevant staff, documenting interventions, and ensuring the interventions were put into action. The policy revealed the facility would provide adequate supervision to prevent accidents. The form read, "Adequacy of supervision: Defined by type and frequency. Based on the individual resident's assessed needs and identified hazards in the resident environment." Review of the policy titled Comprehensive Care Plans revised on read, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and needs that are identified in the resident's comprehensive assessment." The guidelines revealed the care planning process included an assessment of the resident's strengths and needs, incorporating the resident's personal and cultural preferences in developing goals of care. The form read, "Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made."	N 071		

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N 071	Continued From page 15 Class III	N 071		
N 072 SS=D	59A-4.109(2), FAC; Comprehensive Care Plans 59A-4.109 FAC (2) The nursing home licensee develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and , , needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and social well-being. The care plan must be completed within 7 days after completion of the resident assessment. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure an individualized comprehensive care plan was implemented for 1 of 1 resident reviewed for safety precautions, (#92); and for 1 of 2 residents reviewed for communication, (#56), of a total sample of 59 residents. Findings: 1. A review of the medical record revealed resident #92 was admitted to the facility on with diagnoses that included , , (fluid on the), , , , ( ), , speech disturbances, and .	N 072	Preparation and/or execution of this plan does not constitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. (a) Immediate action(s) taken for the resident(s) found to have been affected include: For Resident #92, the pads were placed per the Resident's care plan. Resident #92 was reassessed to ensure all precautions were properly implemented. CNA Q was re-educated on the	

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N 072	Continued From page 16 The Minimum Data Set (MDS) Annual assessment with an assessment reference date (ARD) of revealed resident #92 had a ( ) that could not be conducted as the resident was rarely or never understood. A review of the resident's medical record revealed current comprehensive care plans with a focus on related to , , , . Interventions included medication as ordered and padding to side rails. On at 3:10 PM, resident #92 was lying in bed but the rails of the bed were not padded for safety in case of . On at 10:02 AM, assigned Certified Nursing Assistant (CNA) Q verified the resident's unpadded rails. CNA Q stated she did not know why the pads were in the corner of the room and not on the bed. She did not know who put them there. On at 10:04 AM, the and Restorative Unit Manager stated the bed rails were only padded at night because that was when the resident got agitated. On at 4:31 PM, the Director of Nursing stated she expected the staff to review resident's care plans and implement the listed interventions. 2. Resident #56 was initially admitted to the facility on and readmitted from an acute care hospital on . Her diagnoses included , , , (, , that affects the lower half of the body), , , (skin), major , , and , .	N 072	importance of following care plan interventions, especially for residents with . For Resident #56, the care plan was updated to reflect the resident's Primary language of Spanish with intervention of utilizing an interpreter as indicated. (b) Identification of other residents having the potential to be affected was accomplished by: All Residents with a diagnosis of and Residents who do not speak English proficiently have the potential to be affected. A facility-wide audit of all residents with was conducted to ensure appropriate interventions were care planned and in place MDS Coordinator conducted an audit of all residents with limited English proficiency to ensure their communication needs were appropriately care planned. (c) Actions taken/systems put into place to reduce the risk of future occurrence include: Nurse leadership team, including Director of Nursing, Assistant Director of Nursing, Unit Managers, and MDS Nurses received in-service training on by Regional Nurse on the requirement for comprehensive Resident Centered care plans with focus on Residents with and/or limited English proficiency. Starting on all Direct Care staff (RNs, LPNs, and C.N.A.S) will receive mandatory training importance of following individualized care plan	

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N 072	Continued From page 17 Review of the MDS quarterly assessment with Assessment Reference Date of revealed resident #56 had a score of 15 out of 15 which indicated intact cognition. The MDS assessment noted her primary language was Spanish, and she wanted an interpreter to communicate with a physician or health care staff. The section revealed resident #56 experienced social isolation often. The MDS assessment showed resident #56 had lower extremities , and was dependent on staff for toileting, shower, personal hygiene and putting on/off footwear. She was always of and . Review of resident #56's care plan did not include a focus on communication, resident's primary language or her desire for an interpreter to communicate with a doctor or health care staff, as indicated by the MDS assessment. On at 12:06 PM, interview with resident #56 was conducted in Spanish. She explained she recently had a problem with a nurse who gave her a medication that was discontinued and another medication she refused to take. She shared she took one pill out and tried to explain to the nurse in "her little English" that medication was discontinued 2 weeks prior. She added she showed the nurse another pill she only wanted to take every other night. She explained during the conversation one pill on the floor and the nurse picked it up from the floor and placed it in her cup. Resident #56 stated she asked the nurse why she did that and that she was not supposed to place a pill that on the floor in her cup. The resident indicated when she requested to speak with a supervisor, the nurse got agitated and raised her voice at her. The resident stated a supervisor did not visit her that	N 072	interventions, ensuring safety interventions are in place for precautions per plan of care, and on communicating with Residents with limited English proficiency per plan of care to include use of Propio 1 Interpreter Line. All Direct Care staff will be in-service by . Any Direct Care staff not in-serviced by this date will be in-serviced prior to their next scheduled shift. We have no Agency staff currently. All newly hired Direct Care staff will be in-service by the ADON during their orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing or designee will conduct weekly audits of 5 Residents with or Limited English Proficiency for four weeks, then 10 monthly for at least three months, to ensure care plans are accurately implemented and followed. Any discrepancies found will result in immediate correction and staff re-education. Audit results will be reviewed in the facility's monthly Quality Assurance and Performance Improvement (QAPI) meetings. (e) The compliance date is .	

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N 072	Continued From page 18 night, she cried and could not sleep. She mentioned she preferred to be cared for by Spanish speaking staff and had communicated her choice previously to the staff. On at 12:30 PM, Licensed Practical Nurse (LPN) I stated she was "very familiar" with resident #56. She shared she had never had any problems with this resident as she communicated with her in Spanish. She indicated she had instructed resident #56 to let staff or management know whenever she experienced any issues. LPN I shared resident #56 usually waited for her to share her concerns because she felt comfortable with her. On at 1:17 PM, MDS Coordinator L indicated when a resident's primary language was not English, she added a communication care plan. She shared she knew resident #56 for as long she had lived in the facility. She shared resident #56 could say a few words in English and could understand English better than she could speak it. She explained when she talked with resident #56, the resident would let her know to get someone to translate when they could not understand each other. MDS Coordinator L looked through resident #56's care plan, including resolved focus areas and interventions and validated there was not one for communication. She indicated one should have been created. She stated they reviewed the care plan every quarter and resident #56 attended the meetings which were held in her room. She shared there was always someone in the meeting who spoke Spanish. MDS Coordinator L reviewed the quarterly MDS assessment dated and acknowledged resident #56 expressed her desire to have an interpreter when communicating with physicians or health care staff.	N 072		

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N 072	Continued From page 19 Review of the policy titled Comprehensive Care Plans revised on revealed, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and , ˛ ˛ needs that are identified in the resident's comprehensive assessment." The guidelines revealed the care planning process included an assessment of the resident's strengths and needs, incorporating the resident's personal and cultural preferences in developing goals of care. Class III	N 072		
N 101 SS=D	400.141(1)(j), FS; 59A-4.118(2), FAC Resident Medical Records 400.141(1)(j) FS Keep full records of resident admissions and discharges; medical and general health status, including medical records, personal and social history, and identity and address of next of kin or other persons who may have responsibility for the affairs of the resident; and individual resident care plans, including, but not limited to, prescribed services, service frequency and duration, and service goals. The records must be open to agency inspection. The licensee shall maintain clinical records on each resident in accordance with accepted professional standards and practices, which must be complete, accurately documented, readily accessible, and systematically organized.	N 101		

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N 101	Continued From page 20 59A-4.118(2) FAC Each medical record must contain sufficient information to clearly identify the resident, his or her diagnosis and treatment, and results. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to accurately document the administration of medications in the Medication Administration Record (MAR) for 1 of 3 residents reviewed for , , of a total sample of 59 residents, (#18). Findings: Review of resident #18's medical record revealed he was readmitted to the facility on with diagnoses including type 2 , , , and of . Review of resident #18's Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date (ARD) of revealed a ( ) score of , which indicated he was . The MDS assessment noted no rejection of evaluation or care necessary to obtain his goals for health and well-being. Review of resident #18's medical record revealed a care plan for acute/ , related to process and general discomfort revised on . The interventions directed nurses to administer per orders and to "Monitor/document for side effects of , medication." Review of resident #18's physician orders revealed an order for , 325 milligrams (mg)	N 101	Preparation and/or execution of this plan does not constitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. (a) Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 18 assessed for , . No , . Notified physician and advised to discontinue order. (b) Identification of other residents having the potential to be affected was accomplished by: All Residents receiving , medication have the potential to be affected. An audit was conducted for all current Residents receiving , meds to ensure the , assessment was completed and the , medication administration was documented. (c) Actions taken/systems put into place to reduce the risk of future occurrence include: Starting on all Nursing staff (RNs, LPNs) will receive mandatory Education for all nurses on accurately documenting of prn medications on the	

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N 101	Continued From page 21 dated . The order instructed the nurses to give 2 tablets every 6 hours as needed for , . On at 12:07 PM, resident #18 complained of , on his left . He stated his , level was 10 out of 10 while holding his left with his right . He mentioned he told the nurse but had not received anything for the , . On at 12:09 PM, Certified Nursing Assistant (CNA) J entered the room because the call light was on and told resident #18 she informed the nurse. When asked how long ago she informed the nurse, CNA J answered about 5 minutes ago. On at 12:11 PM, Registered Nurse (RN) D entered the room with a medication cup in her . RN D informed resident #18 she brought him two , for his , . CNA J entered the room at 12:15 PM and assisted RN D to sit resident #18 up and he took the two pills. Resident D did not assess his , level or location of the , . Review of the MAR for , revealed , was documented as administered once on and on . There was no documentation in the MAR of the , given by RN D on . Review of resident #18's progress notes revealed no note entered on by RN D regarding his , or the , given. On at 11:11 AM, RN D stated she did not work the day before ( ) and could not now recall why she did not document the , as given on . . .	N 101	MAR. All Nursing staff will be in-service by . Any Nursing staff not in-serviced by this date will be in-serviced prior to their next scheduled shift. We have no Agency staff currently. All newly hired Nursing staff will be in-service by the ADON during their orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not reoccur: DON, Unit managers or designee will observe 2 nurses medication administration of 2 residents 3 times a week for 2 weeks then 2 nurse's medication administration for 2 residents once a week for (3) months to ensure compliance. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. (e) The date of compliance is .	

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N 101	Continued From page 22 On at 12:00 PM, the General & Restorative Unit Manager (UM) shared her responsibilities included ensuring documentation was completed by the nurses. The UM stated she did not see documented as given on . She indicated accurate documentation was important, it was the expectation and "Nursing 101." On at 2:53 PM, the Director of Nursing stated she expected nurses to document medications administered and their effectiveness accurately. Review of the facility's policy entitled Charting and Documentation revised in read, "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care." The form listed the information to be documented in the medical record, including medications administered. "Documentation in the medical record will be objective . . , complete and accurate." Review of the facility's policy titled Medication Administration revised on revealed licensed nurses were to sign the MAR after administration of the medication. The form indicated for "medications requiring vital signs, record vital signs onto the MAR." Class III	N 101		

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N 181	Continued From page 23	N 181		
N 181 SS=D	400.022(1)(a), FS Right to Civil, Religious Liberties & Choice (1) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following: (a) The right to civil and religious liberties, including knowledge of available choices and the right to independent personal decision, which will not be infringed upon, and the right to encouragement and assistance from the staff of the facility in the fullest possible exercise of these rights. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to promote dignity in dining for 1 of 4 residents reviewed for dignity, of a total sample of 59 residents, (#51). Findings: Review of resident #51's medical record revealed she was initially admitted to the facility on with diagnoses including 's , , and . Review of resident #51's Minimum Data Set quarterly assessment with Assessment Reference Date of revealed a score of 3 out of 15, which indicated severe , . On at 3:23 PM, Certified Nursing Assistant (CNA) H explained the interventions in	N 181	Preparation and/or execution of this plan does not constitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. (a) Immediate action(s) taken for the resident(s) found to have been affected include: CNA H was counseled regarding the inappropriate , and provided immediate re-education on maintaining resident dignity and respectful communication. (b) Identification of other residents having	

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N 181	Continued From page 24 place to assist resident #51. During the conversation, CNA H described resident #51 by saying, "she is a feeder." CNA H affirmed that was the term used to refer to the residents who required assistance eating. CNA H asked, "Should we not call them like that?" Later, on at 1:59 PM, CNA H repeated, "She is a feeder" while pointing to the eating section of the Kardex (plan of care) describing the care for resident #51. On at 8:05 AM, the Director of Nursing stated CNAs should not refer to resident as "feeders." She acknowledged using those terms as, "A dignity issue." Review of the CNA Competency form signed by CNA H on revealed she passed the required competencies for her job. The form listed Dignity and Individuality and read, "[CNA] maintains and enhances a patient's self-worth." Review of the facility's policy titled Promoting/Maintaining Resident Dignity revised on revealed an intent to protect and promote resident rights and to treat each resident with respect and dignity. Class III	N 181	the potential to be affected was accomplished by: All Residents who require assistance during meals have the potential to be affected. Residents with a score 12 and over were interviewed by the Social Services Staff and Administrator to determine if they have experienced or witnessed any undignified language or treatment. (c) Actions taken/systems put into place to reduce the risk of future occurrence include: Starting on all staff will receive mandatory training on resident rights, dignity, and person-centered communication, with a focus on respectful language. All staff will be in-service by . Any staff not in serviced by this date will be in serviced prior to their next scheduled shift. We have no Agency staff currently. All newly hired staff will be in-service by the ADON during their orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing (DON) or designee will conduct 5 meal service audits weekly for 1 month, then 10 monthly for at least two additional months, to ensure staff are promoting dignity. Findings from audits will be reviewed in the facility's Quality Assurance and Performance Improvement meetings, and corrective actions will be taken as needed. Compliance monitoring will continue	

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	35960940	A. BUILDING: _____ B. WING _____	C 02/28/2025

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N 181	Continued From page 25	N 181	until sustained improvement is demonstrated, as determined by QAPI oversight. (e) Date of compliance .	
N 201 SS=D	400.022(1)(i), FS Right to Adequate and Appropriate Health Care (I) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to have ongoing communication and collaboration with the facility regarding care and services for 1 of 1 sampled residents who receive , (#12); and failed to provide an ongoing program of activities to meet the needs and interests of 1 of 5 residents reviewed for activities, (#58), of a total sample of 59 residents. Findings: 1. Review of resident #12's medical record revealed an admission date of . His Quarterly Minimum Data Set dated indicated a Brief Interview of Mental Status score of , which indicated moderate . His diagnoses included: , dependence on , and	N 201	Preparation and/or execution of this plan does not constitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. (a) Immediate action(s) taken for the resident(s) found to have been affected include: The Unit Manager contacted the provider to obtain Resident #12's updated treatment records, including recent lab results, treatment schedules, and any noted concerns. Resident #12's care plan was reviewed and updated to reflect current care needs, including	

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N 201	Continued From page 26 unspecified with unspecified severity, without behavioral disturbance. Review of resident #12's medical record revealed physician's orders dated for to occur on Monday, Wednesday, and Friday at Center #1. Review of resident #12's medical record revealed no documentation of communication having occurred between staff from Center #1 and the facility nursing staff from to . On at 2:30 PM, the South Subacute Unit (SSU) Unit Manager (UM) said that she expected the facility's Communication Record to be completed by the facility's nursing staff and for the form to be sent with the resident when he attended a treatment at Center #1. She said nursing staff should then review the form from the center upon his return, and include it into his medical record. The UM verified there were no Communication Records nor any other communication documentation with Center #1 in the resident's paper medical record maintained on the Unit. A few minutes later on at 2:40 PM, the SSU UM continued that if the Communication Record was not returned from Center #1 then she expected resident #12's assigned nurse to call Center #1 upon resident #12's return or by the next day to receive an update on resident #12's condition. The UM described information needed by the facility included vital signs, level, lab values, or medications provided during the session, and nurses should then obtain the previous Communication Record on	N 201	communication protocols between the facility and the provider. (b) Identification of other residents having the potential to be affected was accomplished by: All residents receiving have the potential to be affected. A facility-wide audit was conducted to identify all residents receiving and assess the adequacy of communication and documentation related to their care. (c) Actions taken/systems put into place to reduce the risk of future occurrence include: Starting on all Licensed staff (RNs and LPNs,), including unit managers, received education on care coordination, proper documentation, and the importance of interdisciplinary collaboration. All Licensed staff (RNs and LPNs,), including unit managers will be in-service by . Any Licensed staff (RNs and LPNs,), including unit managers not in-serviced by this date will be in-serviced prior to their next scheduled shift. We have no Agency staff currently. All newly hired Licensed staff (RNs and LPNs,), including unit managers will be in-service by the ADON during their orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing or designee will conduct weekly audits of all resident's records for one month, ensuring	

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N 201	Continued From page 27 the next , treatment. On at 8:07 AM, telephonically spoke with Clinical Manager #1 of , Center #1 and he stated that the facility used to send a binder for communication to be documented in but he hasn't seen that "in awhile". He said resident #12 has been receiving , services with them since , . He recalls speaking with facility staff, but not after every , session. On at 8:27 AM, telephonically spoke with Clinical Nurse #1 of , Center #1 who said he has spoken with a facility staff person when for example they call to say resident #12 arrived late for his session. He confirmed facility nurses did not call him after every session for an update on resident #12's post treatment condition. He recalled that in the past six months resident #12 had been late to one scheduled session. He stated that the facility used to send a binder that communications would be documented in and returned with resident #12 to the facility but it had been six months or more since he had seen that binder nor any other kind of communication document. He described that sometimes it was difficult to get in touch with resident #12's nurse at the facility. He explained that the front desk would transfer his call but there would be no response after the transfer or he would have to leave a message with the front desk. On at 1:25 PM, the Assistant Director of Nursing (ADON) said that communication with resident #12's , facility was important to coordinate care for him-such as to know if there were any changes in his condition during the session or any post session follow-up. She said if the , Communication Record was not returned from , Center #1 she would	N 201	accurate documentation and proper communication with , providers, followed by monthly audits of 3 , resident's records for an additional three months. Audit results will be reviewed in the facility's Quality Assurance and Performance Improvement (QAPI) meetings, with corrective actions taken as needed. Compliance monitoring will continue until sustained improvement is demonstrated, as determined by QAPI oversight. (e) The date of compliance is .	

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N 201	Continued From page 28 expect the facility's nurse to call Center #1 after the session and document any updates in his condition in his facility medical record or call and request the Communication Record to be faxed to the facility. The ADON verified there was no documentation from to of the Communication Records in his electronic medical record nor was there documentation that facility nurses called Center #1 post treatment for the information. 2. Resident #58 was admitted to the facility on with diagnoses including 's , , , , and open-angle with findings. The Minimum Data Set (MDS) Annual assessment, with an assessment reference date of , revealed resident #58 had a of , which indicated mild . The MDS revealed that resident #58 was visually and required large print in newspapers and books but not regular print. A review of the resident's comprehensive care plan revealed the resident's activities should be compatible with physical and mental capabilities, such as large print holders, if the resident lacked strength and task segmentation. On at 9:52 AM, Activity Aide R was observed as they entered resident #58's room, handed the resident a red bag, and left the room. The resident opened the bag and removed the items. The bag contained a regular print sudoku puzzle book and a coloring book. Resident #58	N 201		

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N 201	Continued From page 29 expressed frustration as she explained she could not see what was in those books. She stated, "I cannot see in these books; my , are no good, and glasses do not help." There was no other activity for resident #58 at that time. On at 9:45 AM, resident #58 was observed standing holding onto the door of her room; there were no activities going on for her. On at 9:33 AM, resident #58 was observed along with the Activity Director. The resident was sitting on the bed, and no activity was ongoing. The resident stated she gave the books to the lady, pointing to the room mate, lying in bed B. The Activity Director acknowledged that the suduko book and coloring book the resident received for the activity did not meet the resident's needs. Resident #58 should have received large print books compatible with her physical and mental capabilities. Review of the facility's Assessment dated , revealed, "The care required by the resident population using evidenced-based, data-driven methods that consider the types of , conditions, physical and behavioral health needs, , overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessment." Class III	N 201		
N 917 SS=D	400.147(8), FS Report , Neglect, & .	N 917		

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N 917	Continued From page 30 (8) , neglect, or , must be reported to the agency as required by 42 C.F.R. s. 483.13(c) and to the department as required by chapters 39 and 415. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to report allegations of and neglect to the State Agency (SA) and protect the resident during the investigation for 1 of 2 residents reviewed for , of a total sample of 59 residents, (#56). Findings: Review of resident #56's medical records revealed she was originally admitted to the facility on and readmitted from a short-term, acute hospital on . Her diagnoses included , , , (, that affects the lower half of the body), , (skin), major , , and . Review of resident #56's Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date of revealed a score of 15 out of 15 which indicated intact cognition. The MDS assessment noted her primary language was Spanish, and she wanted an interpreter to communicate with a doctor or health care staff. The section revealed resident #56 experienced social isolation often. The MDS assessment noted rejection of evaluation or care necessary to obtain goals for health and well-being from 1 to 3 days. Resident #56 had lower extremities , and was dependent on staff for toileting, showers, personal hygiene, and putting on/off footwear. She was always	N 917	Preparation and/or execution of this plan does not constitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required (a) Immediate action(s) taken for the resident(s) found to have been affected include: Upon identification of the deficiency, the facility immediately self-reported the allegation to the State Agency. The accused nurse was removed from the schedule pending an investigation. Resident #56 was assessed by social services to ensure emotional and physical well-being. Supportive interventions, including psych services and reassurance, were provided. (b) Identification of other residents having the potential to be affected was accomplished by: All Residents have the potential to be affected. A review of grievances for the last 60 days was conducted by the Interdisciplinary Team, which included the Administrator, Social Services, DON, RVP, and Regional Nurse to determine if any other allegations of or neglect	

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N 917	Continued From page 31 of and . On at 12:06 PM, an interview was conducted with resident #56 in Spanish. Resident #56 explained she had been a resident of this facility for over two years. She shared a recent problem with a nurse who, during the night medication pass, brought her a medication that had been discontinued and another medication she wanted to take every other night. She stated the pills were brought in a cup. She explained she took the discontinued pill out of the cup and told the nurse that medication was discontinued two weeks before. She shared that nurse only spoke English and she spoke very little English, so she tried her best to explain she was not taking that pill and pointed to another in the cup explaining she had told nurses before she only wanted to take it every other night. She indicated while she was talking to the nurse one of the pills on the floor and the nurse picked the pill from the floor and placed it in her cup with the other medications. Resident #56 stated she asked the nurse why she placed the pill from the floor in her cup and that she was not supposed to do that. The resident explained she asked the nurse for a supervisor. She indicated the nurse was visibly agitated and raised her voice at her. Resident #56 showed a picture she had of the two pills. One pill was white and elongated and the resident stated that was 80 milligrams (mg). The other medication was a yellow and blue capsule which the resident indicated was used to treat . She explained she told the , , , nurse practitioner she no longer wanted to take it, and it was discontinued. She stated she took the medications in the cup that night except for the 2 pills which she kept. She stated the nurse asked to return the 2 pills she did not take, and she told the nurse she would not	N 917	had been unreported or inadequately investigated. Any identified concerns were immediately self-reported and addressed. (c) Actions taken/systems put into place to reduce the risk of future occurrence include: The Coordinator and Director of Nursing were educated on by the RVP on reporting requirements utilizing FHCAs Decision Tree. Starting on all staff will receive mandatory training on identification, mandatory reporting, and investigation protocols. All staff will be in-service by . Any staff not in-serviced by this date will be in-serviced prior to their next scheduled shift. We have no Agency staff currently. All newly hired staff will be in-service by the ADON during their orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrator or designee will conduct audits of five grievances per week for two months, followed by ten grievances per month for a minimum of three additional months, to ensure appropriate reporting and implementation of protective actions. Results of the audits will be reviewed in the facility's Quality Assurance and Performance Improvement (QAPI) meetings, with corrective actions implemented as needed. (e) The date of compliance is .	

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N 917	Continued From page 32 return the pills to her until she spoke with a supervisor. She indicated the nurse left the room and did not bring or call a supervisor. She mentioned she felt and disappointed because she expected a different attitude from the nursing personnel. She indicated after the nurse left her room, she overheard the nurse yelling at a resident in another room. Resident #56 stated that night she cried and could not asleep. She indicated the worst happened the next morning. She recalled she spoke with MDS Coordinator L early the next morning and asked her to get someone who spoke Spanish and could translate what she wanted to share. She stated MDS Coordinator L brought someone who spoke Spanish, and she explained what happened the previous night. She stated MDS Coordinator L notified the management about the incident. She mentioned shortly after she spoke with MDS Coordinator L, the Director of Nursing (DON) came to her room screaming at her and calling her a liar because, according to her, the discontinued medication was not in the medication cart. She indicated the DON came in with the night nurse and each one insulted her and asked her for the pills she kept. Resident #56 stated she told them she would not return the pills because that was her evidence and without it, she would have no proof of what happened. She mentioned she could not eat all day, and she was nervous and upset. She shared after that encounter, she called the state's Department of Children and Families (DCF), and a DCF investigator visited her the same day. She indicated after she showed the pills to the DCF Investigator, who took pictures of the pills, she handed them to Licensed Practical Nurse (LPN) I. She stated she told the DCF Investigator the DON and the nurse yelled at her and were disrespectful to her. She shared she had called	N 917		

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N 917	Continued From page 33 DCF a few weeks prior to report concerns about other residents who did not get personal care all day and a DCF Investigator visited the facility at that time and spoke to those residents directly. She shared she was "now labeled as problematic." She also shared an incident with a Certified Nursing Assistant (CNA) who did not change her for hours and she was wet and uncomfortable. She indicated on that occasion, a male nurse came to her room around 9:00 PM and after explaining the situation to him, he asked the CNA to change her but the CNA responded she was not assigned to resident #56. She indicted the male nurse had to find another CNA to change her. She stated after the CNA changed her, the Night Supervisor told her she did not have an assigned CNA, she was not a priority at the facility, and the priority was her roommate. She shared she preferred Spanish speaking staff to ensure there was no miscommunication. She also shared Registered Nurse (RN) P, the nurse who gave the wrong medication and yelled at her, was assigned to her again even though she was told by the DCF Investigator that she had told the facility the nurse could not get close to her again. She mentioned she had told a Spanish speaking staff she did not want that nurse assigned to her again. She shared RN P came to her room a few days after the pill incident and asked for her ␣ to check her ␣ . She stated she told RN P to leave her room because she was not supposed to be there again. She stated RN P left the room and made a gesture toward her as she left the room. She said that made her cry. She mentioned she was afraid RN P would give her the wrong medication or do something to her in retaliation. She said, "The staff knows how to retaliate to residents who speak up." She shared she had been told by staff on more than one occasion let me take good care of you so you do	N 917		

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N 917	Continued From page 34 not call DCF or the State. She stated she had made new friends at the facility and would hate to separate from them as she had no family near her otherwise, she would have requested to be transferred to a different facility. Review of the Reportable Log from to on the first day of survey did not reveal or neglect allegations reported by resident #56. Review of DCF reports showed they visited resident #56 at the facility on , and . Review of resident #56's Progress Notes revealed a note entered as a late entry on by RN A dated which read, "On Friday I did not touch the resident to do anything for her because she did refused my service while I was by the resident door. I called a coworker from medical record, the coworker translate for me, then I called the supervisor, the supervisor was the one taking care of her." On at 1:36 PM, the Administrator (NHA) stated the DON and her were the coordinators. The surveyor reported the allegations of verbal/emotional from resident #56 to the NHA. The NHA stated no one had yelled at resident #56. The NHA shared resident #56 was admitted before she came to the facility. She shared since resident #56 applied for Medicaid and lost her Social Security benefits, she was "mad" and often complained about the food and care. She indicated resident #56 would complain to the State if she did not get what she wanted and accused staff. She mentioned she had "done multiple reportable and grievances on her." The NHA said resident #56	N 917		

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N 917	Continued From page 35 "got mad and complained about no one changing her." She stated she interviewed "everyone." The NHA shared resident #56 had a concern with medications and kept two pills and "She constantly says she is calling the state." The NHA confirmed DCF "came out for her" last week. She stated the DCF Investigator mentioned it was about medications and not being changed. The NHA said "That would not be neglect, she didn't use the work neglect." She recanted her statement and added she did not "feel the time frame would be neglect" because the CNA told resident #56 she would come at 8:00 PM to change her and the CNA said she was there 10 or 15 minutes late. She added, "If it was 1 to 2 hours wait for care, she would have reported it." She stated she would start reporting every time DCF came to the facility. She recalled DCF was there twice, but the DCF Investigator did not mention anyone yelling at resident #56. She mentioned she would find out who translated for the DON when she spoke with resident #56. She stated a reportable was done on for another resident and resident #56. Later at 2:04 PM, the NHA asked if resident #56 mentioned the DON was yelling as well as the nurse because she "would have to suspend her and do the reportable." She showed she submitted a reportable on when DCF came to the facility for another resident. She then confirmed there was no report submitted for resident #56's allegation of and neglect this month. On at 9:04 AM, resident #56 indicated no one translated for her when the DON and RN P were yelling to her. She repeated about three days later after the incident, she was again assigned RN P after telling them she did not want that same nurse assigned to her. She stated the Specialized Subacute (SSU) Unit Manager (UM)	N 917		

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	35960940	A. BUILDING: _____ B. WING _____	C 02/28/2025

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N 917	Continued From page 36 took over for RN P that day and gave her medications. On at 1:53 PM, the NHA said she "has been handling for a while." She shared she had a grievance from resident #56 on about a CNA being 15 minutes late and them offering resident #56 a private room because she liked to keep her room at 60 degrees, and they have people wanting to leave out of her room for that reason. She explained on morning she complained about the pill being dropped and the nurse tried to give her the pill. She stated DCF came a couple of hours after that, but it was not about the pill. She recalled the DCF Investigator asked questions about resident #56, requested a sheet and went to interview the resident. She stated she did not submit a reportable to AHCA because she "did not know what DCF came here about." The NHA showed the Notice to Subjects form left by DCF, which showed a report number and the names and phone numbers for the DCF Investigator and supervisor. On at 12:30 PM, LPN I stated she was "very familiar" with resident #56 and "have never had any problems with this resident." She shared she had instructed the resident to let staff or management know if she had any issues, but the resident preferred to wait for her to share her concerns. LPN I said, "She is an easy to take care of resident." She explained she received report from RN P on that resident #56 alleged a medication was dropped on the floor and she gave her a medication that was discontinued. She stated resident #56 complained about RN A that morning and mentioned she did not want RN A to take care of her again. LPN I stated resident #56 showed the	N 917		

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N 917	Continued From page 37 pills she kept and gave them to her after she spoke with the DCF Investigator. LPN I explained she had translated for the DON and RN A in the room with resident #56 and RN A called LPN I a liar, but she was translating, not accusing her. She shared RN A said someone must have given the resident those medications to get her in trouble. She explained while translating in the room for the DON and RN A, resident #56 was crying and wanted to get out of bed. She recalled RN A spoke to resident #56 with "an attitude, accusing the resident she was lying." She stated RN A denied the medication was dropped on the floor and stated she discarded the medication the resident refused. She stated she asked RN A to leave the room because of the "disrespectful tone" used toward resident #56. She indicated the DON told the resident she would investigate her concerns. LPN I stated the DON was already in resident #56's room before she got there to translate and the resident was "already agitated" by the time she arrived. She recalled on she told administration resident #56 requested they not assign RN P to care for her again. On at 1:17 PM, MDS Coordinator L shared she performed daily visits to her assigned residents for "mock survey" which included resident #56's room. She recalled resident #56 called her into her room early one morning because she was upset with the nurse assigned to her. MDS Coordinator L stated resident #56 asked her to let the NHA know but explained it was approximately 6:30 AM and she spoke with the Night Supervisor instead. She shared she could tell resident #56 was upset, not crying, "just frustrated, angry." She stated LPN I translated for her and the Night Supervisor when resident #56 shared what happened during the night. MDS Coordinator L reflected she had "never had	N 917		

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N 917	Continued From page 38 problems with (resident #56) at all in the many years together." On at 9:13 AM, during a telephone interview, the DCF Investigator confirmed she visited resident #56 last week. She explained every time DCF came to a facility they discussed the allegations with the facility representative during their entrance conference. She recalled mentioning to the NHA resident #56's report about the supervisor "screaming" at her. On at 3:19 PM, the DON stated the Night Supervisor called her at around "6:00 something" on to report the incident with resident #56. She recalled she talked to resident #56 that morning and asked the resident what happened. She recounted resident #56's complaint about a pill that was dropped on the floor and showed her the two pills, the one dropped to the floor and one that was discontinued. She stated she told resident #56 to give her a moment to talk to the nurse and left the room to investigate what happened. The DON indicated she spoke with RN A and confirmed the discontinued medication was not in the medication cart. The DON mentioned after speaking with the nurse, she returned to resident #56's room with RN A and LPN I. The DON stated RN A denied resident #56's allegation and was upset when she started asking questions, while resident #56 was crying. She indicated LPN I translated while consoling resident #56. The DON instructed RN A to write a progress note. On at 5:50 PM, the SSU UM confirmed she took over the care of resident #56 one day last week when the resident did not want RN P, her assigned nurse. She stated she had not done the assignment.	N 917		

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N 917	Continued From page 39 On at 2:43 PM, the NHA repeated the DCF investigator did not inform her of the reason of her visit on . She confirmed DCF visited the facility but it was not in reference to resident #56. She stated she did not remember a visit from DCF to resident #56 on . She said at her "former building they did not report the DCF visits." She indicated she was told DCF reported their visits to the SA and was not given a directive by this company. She stated she did not remember anything about her conversation with the DCF investigator on except he mentioned resident #56 had an issue with food and she sent the Dietary Manager to speak with the resident. She stated the DCF Investigators did not share the allegations, only requested paperwork which she provided, and when they came she was not told, "half of the times" what their visits were about. She said she reported and neglect "for almost everyone." When asked why RN P was allowed to continue working on until the end of her shift after they were made aware of the allegation of by resident #56, the NHA responded that when she realized RN P was involved in the incident she was suspended. The NHA shared when they identified they had assigned the same nurse to resident #56 last week, she was switched to the UM. Later at 4:05 PM, the NHA explained the DON was suspended on and brought the next day because she "was able to rule out quickly" she did not yell at resident #56. The facility's policy , Neglect and , , implemented and reviewed/revised on revealed how to prevent, identify, investigate, protect residents and report allegations. The guidelines mentioned	N 917		

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N 917	Continued From page 40 the facility would designate an Prevention Coordinator who was responsible for reporting allegations or suspected , neglect, or . to the state survey agency and other officials in accordance with state law. The facility's policy instructed facility staff on the investigation of different types of alleged violations, and read, "Identifying and interviewing all involved persons, including the alleged victim, alleged , , , witnesses, and others who might have knowledge of the allegations; . . . Providing complete and thorough documentation of the investigation." Class III	N 917		

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F 000	INITIAL COMMENTS Recertification survey was conducted in conjunction with complaint surveys #2025001274 and #2025001894 from to . The complaints were not substantiated, but Kissimmee Nursing & Rehabilitation Center was not in compliance with 42 CFR Part 483 and 488, requirements for Long Term Care Facilities.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		

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 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to promote dignity in dining for 1 of 4 residents reviewed for dignity, of a total sample of 59 residents, (#51). Findings: Review of resident #51's medical record revealed she was initially admitted to the facility on with diagnoses including 's , , and . Review of resident #51's Minimum Data Set quarterly assessment with Assessment Reference Date of revealed a score of 3 out of 15, which indicated severe . On at 3:23 PM, Certified Nursing Assistant (CNA) H explained the interventions in place to assist resident #51. During the conversation, CNA H described resident #51 by saying, "she is a feeder." CNA H affirmed that was the term used to refer to the residents who required assistance eating. CNA H asked,	F 550	Preparation and/or execution of this plan does not constitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. (a) Immediate action(s) taken for the resident(s) found to have been affected include: CNA H was counseled regarding the inappropriate and provided immediate re-education on maintaining resident dignity and respectful communication. (b) Identification of other residents having the potential to be affected was accomplished by: All Residents who require assistance during meals have the potential to be affected.	

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F 550	Continued From page 2 "Should we not call them like that?" Later, on at 1:59 PM, CNA H repeated, "She is a feeder" while pointing to the eating section of the Kardex (plan of care) describing the care for resident #51. On at 8:05 AM, the Director of Nursing stated CNAs should not refer to resident as "feeders." She acknowledged using those terms as, "A dignity issue." Review of the CNA Competency form signed by CNA H on revealed she passed the required competencies for her job. The form listed Dignity and Individuality and read, "C.N.A. maintains and enhances a patient's self-worth." Review of the facility's policy titled Promoting/Maintaining Resident Dignity revised on revealed an intent to protect and promote resident rights and to treat each resident with respect and dignity.	F 550	Residents with a score 12 and over were interviewed by the Social Services Staff and Administrator to determine if they have experienced or witnessed any undignified language or treatment. (c) Actions taken/systems put into place to reduce the risk of future occurrence include: Starting on all staff will receive mandatory training on resident rights, dignity, and person-centered communication, with a focus on respectful language. All staff will be in-service by . Any staff not in serviced by this date will be in serviced prior to their next scheduled shift. We have no Agency staff currently. All newly hired staff will be in-service by the ADON during their orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing (DON) or designee will conduct 5 meal service audits weekly for 1 month, then 10 monthly for at least two additional months, to ensure staff are promoting dignity. Findings from audits will be reviewed in the facility's Quality Assurance and Performance Improvement meetings, and corrective actions will be taken as needed. Compliance monitoring will continue until sustained improvement is demonstrated, as determined by QAPI oversight.	

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F 550	Continued From page 3	F 550		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to notify emergency contact and Power of Attorney of changes in medication for 1 of 1 residents reviewed for notification of emergency contact, of a total sample of 59 residents, (#20). Findings: Resident #20 was admitted to the facility on with diagnoses including , , , ( ), , , and , following	F 552	(e) Date of compliance . Preparation and/or execution of this plan does not constitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. (a) Immediate action(s) taken for the resident(s) found to have been affected include: The responsible party for Resident	

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F 552	Continued From page 4 ( ) affecting left non-dominant side, type 2 , , adjustment with mixed , and depressed , and personal history of , . The Admission Record contained essential information including resident #1's selected emergency contacts with their associated telephone numbers. The document listed the resident's son as emergency contact #1 and the healthcare Power of Attorney. Resident #1's daughter was emergency contact #2. The hospital transfer form dated revealed that resident #20 required a surrogate when making healthcare decisions and his status was alert, but disoriented and could not follow simple instructions. Review of a , , consult from revealed resident #20 was alert and oriented to self only. He believed he was "in the dome and waiting for his bus" at the time of the evaluation. The resident was unable to participate in a meaningful conversation. He had poor judgement and insight as well as , short and long-term memory. A social service progress note on revealed resident #20's son, who was his healthcare surrogate/POA, was contacted to discuss the resident's discharge plan due to the resident having a ( ) score of which suggested severe , , . Review of hospital discharge paperwork from revealed a physician's order for , , DR 125 milligrams (mg) capsules with	F 552	#20 was notified of the , dosage adjustment and current medication regime for , . (b) Identification of other residents having the potential to be affected was accomplished by: All Residents have the potential to be affected. A review of all recent medication changes over the past 14 days was conducted to ensure responsible parties were notified as required. (c) Actions taken/systems put into place to reduce the risk of future occurrence include: Starting on all Licensed staff (RNs and LPNs) will receive mandatory training on the requirement/policy to notify residents and/or responsible parties of medication changes and the facility□s Notification of Changes Policy, ensuring clear expectations for timely documentation. All Licensed staff will be in-service by . Any Licensed staff not in serviced by this date will be in-service prior to their next scheduled shift. We have no Agency staff currently. All newly hired Licensed staff will be in-service by the ADON during their orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing or designee will conduct audits of medication changes Monday thru Friday for 2 weeks, then 10	

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F 552	Continued From page 5 capsules (250mg) in the morning at 9:00 AM, 4 capsules (500mg) at lunch time at 2:00 PM, and 4 capsules (500mg) at bedtime at 9:00 PM for . Review of resident #20's Electronic Medication Administration Record (EMAR) revealed an order for , DR 125mg, 2 tablets by three times a day with a start date of at 9 AM. Resident #1 received the 9:00 AM dose on as was ordered at that time then the order was corrected by the physician to read 250mg in the morning and 500mg at lunch and bedtime as reflected in the hospital discharge paperwork. Review of resident #20's physical chart revealed a handwritten physician order sheet dated reading "change , order to 750mg every 12 hours with a diagnosis of , , ." This order was given over the phone by the Medical Director's PA. The order was received by the Unit Manager of the Specialized Subacute Unit (SSU). Resident #20's EMAR reflects this change. , is a medication used to treat various types of by affecting chemicals in the body that may be involved in causing (retrieved from www.drugs.com/ , on). On at 6:00 PM, resident #20's son and health POA revealed the medication his father was discharged from the hospital on was changed by the facility's physician without the family's notification. He explained the at the hospital had worked out a dosing and timing schedule that the family felt was	F 552	monthly for three months, to ensure responsible party notifications are completed and documented. Any instances of non-compliance will result in immediate re-education and corrective action. Audit results will be reviewed during the facility's monthly Quality Assurance and Performance Improvement meetings. (e) Date of Compliance .	

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F 552	Continued From page 6 appropriate. Resident #20's son said the family visited daily and the change in the medication affected their father's alertness and ability to participate in , , , . On at 4:40 PM, the Unit Manager (UM) of the Specialized Subacute Unit (SSU) revealed the change in resident #20's , was made to try and taper the medication. She acknowledged they did not notify resident #20's son of the change in medication. The UM stated she could not find documentation regarding a notification to family of the , change in the resident's clinical record. Facility policy titled Notification of Changes revised indicated when a resident was incapable of making decisions the representative would make any decisions that had to be made.	F 552		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident was evaluated for safe self-administration of medications for 1 of 2 residents reviewed for choices, of a total sample of 59 residents, (#5). Findings: Review of resident #5's medical record revealed she was initially admitted to the facility on	F 554	Preparation and/or execution of this plan does not constitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. (a) Immediate action(s) taken for the resident(s) found to have been affected	

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F 554	Continued From page 7 and readmitted from a short-term, acute hospital on . Her diagnoses included , , lymphedema, and , . Review of the Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date of revealed resident #5 had a score of 15 out of 15 which indicated intact cognition. The MDS assessment noted rejection of care necessary to obtain goals for her health and well-being occurred 4 to 6 days, but less than daily, during the look- period. On at 11:06 AM, resident #5 was observed in bed with a medication cup containing various pills on her bedside table, along with a breakfast tray. There was no staff present in the room at that time. A few minutes later, Registered Nurse (RN) D entered the room and asked resident #5 to please take her medications because she could not leave them for her to take later. Resident #5 took the pills and returned the empty medication cup to RN D. Review of resident #5's medical record did not reveal a physician order or plan of care for self-administration of medications. On at 11:11 AM, RN D stated she had never left medications at bedside before. She indicated the medications in resident #5's cup included 2 tablets of , and one of each of the following , , , Softener, and , for a total of 6 pills. RN D said resident #5 "always wants to keep the meds." RN D validated she stepped out of the room and left the medication with resident	F 554	include: The nurse ensured that Resident #5 took medications provided. The physician was notified of the incident, and no negative outcomes were identified. The nurse involved was re-educated on proper medication administration practices, including the requirement to observe the resident taking medications and ensure proper documentation. (b) Identification of other residents having the potential to be affected was accomplished by: All Residents have the potential to be affected. (c) Actions taken/systems put into place to reduce the risk of future occurrence include: Starting on all Licensed staff (RNs and LPNs) will receive mandatory training on medication administration policies, emphasizing the prohibition of leaving medications unattended. All Licensed staff will be in-service by . Any Licensed staff not in serviced by this date will be in-service prior to their next scheduled shift. We have no Agency staff currently. All newly hired Licensed staff will be in-service by the ADON during their orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur: The DON or designee will conduct weekly audits of medication administration	

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F 554	Continued From page 8 #5 as she had not yet taken the medication. RN D explained she had not mentioned to the Unit Manager (UM) or Director of Nursing (DON) resident #5's request to keep her medications and take them later herself. She descibed how she stepped out of the room to ensure her medication cart was locked. RN D said, "Everybody knows about her. She wants to keep all her meds; she wants to take time and that is why we give her meds last." On at 12:46 PM, the General & Restorative Unit UM stated it was acceptable to leave medications at bedside, "as long as the resident is coherent and there is no ." She shared she "has personally done the same the thing" but not at this facility. The UM stated RN D went to the room and collected the cup. The UM said, "You cannot force the patient to take the pills right that second." When asked about the facility's policy for medications left at bedside, she responded she did not know if there was "a process to it here." On at 2:53 PM, the DON stated she spoke with RN D who validated she turned her and left resident #5 with the cup of pills. The DON validated RN D was not supposed to leave medications in resident #5's room without being present when she took them. The DON stated a nurse could not leave any medications at bedside and must witness when the resident took the medication. Review of the facility's policy titled Resident Self-Administration of Medication revised on revealed an intent "to support each resident's right to self-administer medication." The policy read, "A resident may only	F	with 2 nurses for at least 2 Residents 3 times a week for 2 weeks, then at least 8 Residents monthly for three months to ensure adherence to the policy. Any non-compliance identified will result in immediate re-education and corrective action. Audit findings will be reviewed during the facility's monthly Quality Assurance and Performance Improvement (QAPI) meetings. (e) Date of compliance	

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F 554	Continued From page 9 self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely." The policy guidelines included each resident was offered the opportunity to self-administer medications during routine assessment by the interdisciplinary team and the resident's preference would be documented on the appropriate form and placed in the medical record.	F 554		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of , neglect, , , or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving , neglect, , or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609		

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F 609	Continued From page 10 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to report allegations of and neglect to the State Agency (SA) and protect the resident during the investigation for 1 of 2 residents reviewed for , of a total sample of 59 residents, (#56). Findings: Review of resident #56's medical records revealed she was originally admitted to the facility on and readmitted from a short-term, acute hospital on . Her diagnoses included , , , (, , that affects the lower half of the body), , , (skin), major , , and , , . Review of resident #56's Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date of revealed a score of 15 out of 15 which indicated intact cognition. The MDS assessment noted her primary language was Spanish, and she wanted an interpreter to communicate with a doctor or health care staff. The section revealed resident #56 experienced social isolation often. The MDS assessment noted rejection of evaluation or care necessary to obtain goals for health and well-being from 1 to 3 days. Resident #56 had lower extremities , and was dependent on staff for toileting, showers, personal hygiene, and putting on/off footwear. She was always	F 609	Preparation and/or execution of this plan does not constitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required (a) Immediate action(s) taken for the resident(s) found to have been affected include: Upon identification of the deficiency, the facility immediately self-reported the allegation to the State Agency. The accused nurse was removed from the schedule pending an investigation. Resident #56 was assessed by social services to ensure emotional and physical well-being. Supportive interventions, including psych services and reassurance, were provided. (b) Identification of other residents having the potential to be affected was accomplished by: All Residents have the potential to be affected. A review of grievances for the last 60 days was conducted by the Interdisciplinary Team, which included the Administrator, Social Services, DON, RVP, and Regional Nurse to determine if	

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F 609	Continued From page 11 of . and . On at 12:06 PM, an interview was conducted with resident #56 in Spanish. Resident #56 explained she had been a resident of this facility for over two years. She shared a recent problem with a nurse who, during the night medication pass, brought her a medication that had been discontinued and another medication she wanted to take every other night. She stated the pills were brought in a cup. She explained she took the discontinued pill out of the cup and told the nurse that medication was discontinued two weeks before. She shared that nurse only spoke English and she spoke very little English, so she tried her best to explain she was not taking that pill and pointed to another in the cup explaining she had told nurses before she only wanted to take it every other night. She indicated while she was talking to the nurse one of the pills on the floor and the nurse picked the pill from the floor and placed it in her cup with the other medications. Resident #56 stated she asked the nurse why she placed the pill from the floor in her cup and that she was not supposed to do that. The resident explained she asked the nurse for a supervisor. She indicated the nurse was visibly agitated and raised her voice at her. Resident #56 showed a picture she had of the two pills. One pill was white and elongated and the resident stated that was 80 milligrams (mg). The other medication was a yellow and blue capsule which the resident indicated was used to treat . She explained she told the , , , nurse practitioner she no longer wanted to take it, and it was discontinued. She stated she took the medications in the cup that night except for the 2 pills which she kept. She stated the nurse asked to return the 2 pills she	F 609	any other allegations of or neglect had been unreported or inadequately investigated. Any identified concerns were immediately self-reported and addressed. (c) Actions taken/systems put into place to reduce the risk of future occurrence include: The Coordinator and Director of Nursing were educated on by the RVP on reporting requirements utilizing FHCAs Decision Tree. Starting on all staff will receive mandatory training on identification, mandatory reporting, and investigation protocols. All staff will be in-service by . Any staff not in-serviced by this date will be in-serviced prior to their next scheduled shift. We have no Agency staff currently. All newly hired staff will be in-service by the ADON during their orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrator or designee will conduct audits of five grievances per week for two months, followed by ten grievances per month for a minimum of three additional months, to ensure appropriate reporting and implementation of protective actions. Results of the audits will be reviewed in the facility's Quality Assurance and Performance Improvement (QAPI) meetings, with corrective actions implemented as needed.	

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F 609	Continued From page 12 did not take, and she told the nurse she would not return the pills to her until she spoke with a supervisor. She indicated the nurse left the room and did not bring or call a supervisor. She mentioned she felt and disappointed because she expected a different attitude from the nursing personnel. She indicated after the nurse left her room, she overheard the nurse yelling at a resident in another room. Resident #56 stated that night she cried and could not asleep. She indicated the worst happened the next morning. She recalled she spoke with MDS Coordinator L early the next morning and asked her to get someone who spoke Spanish and could translate what she wanted to share. She stated MDS Coordinator L brought someone who spoke Spanish, and she explained what happened the previous night. She stated MDS Coordinator L notified the management about the incident. She mentioned shortly after she spoke with MDS Coordinator L, the Director of Nursing (DON) came to her room screaming at her and calling her a liar because, according to her, the discontinued medication was not in the medication cart. She indicated the DON came in with the night nurse and each one insulted her and asked her for the pills she kept. Resident #56 stated she told them she would not return the pills because that was her evidence and without it, she would have no proof of what happened. She mentioned she could not eat all day, and she was nervous and upset. She shared after that encounter, she called the state's Department of Children and Families (DCF), and a DCF investigator visited her the same day. She indicated after she showed the pills to the DCF Investigator, who took pictures of the pills, she handed them to Licensed Practical Nurse (LPN) I. She stated she told the DCF Investigator the	F 609	(e) The date of compliance is .	

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DON and the nurse yelled at her and were disrespectful to her. She shared she had called DCF a few weeks prior to report concerns about other residents who did not get personal care all day and a DCF Investigator visited the facility at that time and spoke to those residents directly. She shared she was "now labeled as problematic." She also shared an incident with a Certified Nursing Assistant (CNA) who did not change her for hours and she was wet and uncomfortable. She indicated on that occasion, a male nurse came to her room around 9:00 PM and after explaining the situation to him, he asked the CNA to change her but the CNA responded she was not assigned to resident #56. She indicted the male nurse had to find another CNA to change her. She stated after the CNA changed her, the Night Supervisor told her she did not have an assigned CNA, she was not a priority at the facility, and the priority was her roommate. She shared she preferred Spanish speaking staff to ensure there was no miscommunication. She also shared Registered Nurse (RN) P, the nurse who gave the wrong medication and yelled at her, was assigned to her again even though she was told by the DCF Investigator that she had told the facility the nurse could not get close to her again. She mentioned she had told a Spanish speaking staff she did not want that nurse assigned to her again. She shared RN P came to her room a few days after the pill incident and asked for her ␣ to check her ␣ . She stated she told RN P to leave her room because she was not supposed to be there again. She stated RN P left the room and made a gesture toward her as she left the room. She said that made her cry. She mentioned she was afraid RN P would give her the wrong medication or do something to her in retaliation. She said, "The staff knows how to

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retaliate to residents who speak up." She shared she had been told by staff on more than one occasion let me take good care of you so you do not call DCF or the State. She stated she had made new friends at the facility and would hate to separate from them as she had no family near her otherwise, she would have requested to be transferred to a different facility.

Review of the Reportable Log from to , on the first day of survey did not reveal or neglect allegations reported by resident #56.

Review of DCF reports showed they visited resident #56 at the facility on , and .

Review of resident #56's Progress Notes revealed a note entered as a late entry on by RN A dated which read, "On Friday , , I did not touch the resident to do anything for her because she did refused my service while I was by the resident door. I called a coworker from medical record, the coworker translate for me, then I called the supervisor, the supervisor was the one taking care of her."

On at 1:36 PM, the Administrator (NHA) stated the DON and her were the coordinators. The surveyor reported the allegations of verbal/emotional from resident #56 to the NHA. The NHA stated no one had yelled at resident #56. The NHA shared resident #56 was admitted before she came to the facility. She shared since resident #56 applied for Medicaid and lost her Social Security , benefits, she was "mad" and often complained about the food and care. She indicated resident

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#56 would complain to the State if she did not get what she wanted and accused staff. She mentioned she had "done multiple reportable and grievances on her." The NHA said resident #56 "got mad and complained about no one changing her." She stated she interviewed "everyone." The NHA shared resident #56 had a concern with medications and kept two pills and "She constantly says she is calling the state." The NHA confirmed DCF "came out for her" last week. She stated the DCF Investigator mentioned it was about medications and not being changed. The NHA said "That would not be neglect, she didn't use the work neglect." She recanted her statement and added she did not "feel the time frame would be neglect" because the CNA told resident #56 she would come at 8:00 PM to change her and the CNA said she was there 10 or 15 minutes late. She added, "If it was 1 to 2 hours wait for care, she would have reported it." She stated she would start reporting every time DCF came to the facility. She recalled DCF was there twice, but the DCF Investigator did not mention anyone yelling at resident #56. She mentioned she would find out who translated for the DON when she spoke with resident #56. She stated a reportable was done on for another resident and resident #56. Later at 2:04 PM, the NHA asked if resident #56 mentioned the DON was yelling as well as the nurse because she "would have to suspend her and do the reportable." She showed she submitted a reportable on when DCF came to the facility for another resident. She then confirmed there was no report submitted for resident #56's allegation of and neglect this month.

On at 9:04 AM, resident #56 indicated no one translated for her when the DON and RN P

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were yelling to her. She repeated about three days later after the incident, she was again assigned RN P after telling them she did not want that same nurse assigned to her. She stated the Specialized Subacute (SSU) Unit Manager (UM) took over for RN P that day and gave her medications.

On . . at 1:53 PM, the NHA said she "has been handling for a while." She shared she had a grievance from resident #56 on . . about a CNA being 15 minutes late and them offering resident #56 a private room because she liked to keep her room at 60 degrees, and they have people wanting to leave out of her room for that reason. She explained on morning she complained about the pill being dropped and the nurse tried to give her the pill. She stated DCF came a couple of hours after that, but it was not about the pill. She recalled the DCF Investigator asked questions about resident #56, requested a sheet and went to interview the resident. She stated she did not submit a reportable to AHCA because she "did not know what DCF came here about." The NHA showed the Notice to Subjects form left by DCF, which showed a report number and the names and phone numbers for the DCF Investigator and supervisor.

On at 12:30 PM, LPN I stated she was "very familiar" with resident #56 and "have never had any problems with this resident." She shared she had instructed the resident to let staff or management know if she had any issues, but the resident preferred to wait for her to share her concerns. LPN I said, "She is an easy to take care of resident." She explained she received report from RN P on that resident #56

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alleged a medication was dropped on the floor and she gave her a medication that was discontinued. She stated resident #56 complained about RN A that morning and mentioned she did not want RN A to take care of her again. LPN I stated resident #56 showed the pills she kept and gave them to her after she spoke with the DCF Investigator. LPN I explained she had translated for the DON and RN A in the room with resident #56 and RN A called LPN I a liar, but she was translating, not accusing her. She shared RN A said someone must have given the resident those medications to get her in trouble. She explained while translating in the room for the DON and RN A, resident #56 was crying and wanted to get out of bed. She recalled RN A spoke to resident #56 with "an attitude, accusing the resident she was lying." She stated RN A denied the medication was dropped on the floor and stated she discarded the medication the resident refused. She stated she asked RN A to leave the room because of the "disrespectful tone" used toward resident #56. She indicated the DON told the resident she would investigate her concerns. LPN I stated the DON was already in resident #56's room before she got there to translate and the resident was "already agitated" by the time she arrived. She recalled on she told administration resident #56 requested they not assign RN P to care for her again.

On at 1:17 PM, MDS Coordinator L shared she performed daily visits to her assigned residents for "mock survey" which included resident #56's room. She recalled resident #56 called her into her room early one morning because she was upset with the nurse assigned to her. MDS Coordinator L stated resident #56 asked her to let the NHA know but explained it

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F 609	Continued From page 18	F 609		

was approximately 6:30 AM and she spoke with the Night Supervisor instead. She shared she could tell resident #56 was upset, not crying, "just frustrated, angry." She stated LPN I translated for her and the Night Supervisor when resident #56 shared what happened during the night. MDS Coordinator L reflected she had "never had problems with (resident #56) at all in the many years together."

On at 9:13 AM, during a telephone interview, the DCF Investigator confirmed she visited resident #56 last week. She explained every time DCF came to a facility they discussed the allegations with the facility representative during their entrance conference. She recalled mentioning to the NHA resident #56's report about the supervisor "screaming" at her.

On at 3:19 PM, the DON stated the Night Supervisor called her at around "6:00 something" on to report the incident with resident #56. She recalled she talked to resident #56 that morning and asked the resident what happened. She recounted resident #56's complaint about a pill that was dropped on the floor and showed her the two pills, the one dropped to the floor and one that was discontinued. She stated she told resident #56 to give her a moment to talk to the nurse and left the room to investigate what happened. The DON indicated she spoke with RN A and confirmed the discontinued medication was not in the medication cart. The DON mentioned after speaking with the nurse, she returned to resident #56's room with RN A and LPN I. The DON stated RN A denied resident #56's allegation and was upset when she started asking questions, while resident #56 was crying. She indicated LPN I translated while consoling

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F 609	Continued From page 19	F 609		

resident #56. The DON instructed RN A to write a progress note.

On at 5:50 PM, the SSU UM confirmed she took over the care of resident #56 one day last week when the resident did not want RN P, her assigned nurse. She stated she had not done the assignment.

On at 2:43 PM, the NHA repeated the DCF investigator did not inform her of the reason of her visit on . She confirmed DCF visited the facility but it was not in reference to resident #56. She stated she did not remember a visit from DCF to resident #56 on . She said at her "former building they did not report the DCF visits." She indicated she was told DCF reported their visits to the SA and was not given a directive by this company. She stated she did not remember anything about her conversation with the DCF investigator on except he mentioned resident #56 had an issue with food and she sent the Dietary Manager to speak with the resident. She stated the DCF Investigators did not share the allegations, only requested paperwork which she provided, and when they came she was not told, "half of the times" what their visits were about. She said she reported and neglect "for almost everyone." When asked why RN P was allowed to continue working on until the end of her shift after they were made aware of the allegation of by resident #56, the NHA responded that when she realized RN P was involved in the incident she was suspended. The NHA shared when they identified they had assigned the same nurse to resident #56 last week, she was switched to the UM. Later at 4:05 PM, the NHA explained the DON was suspended on

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F 609	Continued From page 20 and brought the next day because she "was able to rule out quickly" she did not yell at resident #56. The facility's policy , Neglect and , implemented and reviewed/revised on revealed how to prevent, identify, investigate, protect residents and report allegations. The guidelines mentioned the facility would designate an Prevention Coordinator who was responsible for reporting allegations or suspected , neglect, or , to the state survey agency and other officials in accordance with state law. The facility's policy instructed facility staff on the investigation of different types of alleged violations, and read, "Identifying and interviewing all involved persons, including the alleged victim, alleged , , , witnesses, and others who might have knowledge of the allegations; . . . Providing complete and thorough documentation of the investigation."	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected " with major injury" status for 1 of 4 residents reviewed for , of a total sample of 59 residents, (#109). Findings:	F 641	Preparation and/or execution of this plan does not constitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required.	

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F 641	Continued From page 21 Resident #109's medical record revealed he was initially admitted to the facility on and readmitted from an acute care hospital on . His diagnoses included , (bone), difficulty walking, and . On at 11:40 AM, resident #109 stated he coming out of the bathroom about 3 weeks ago, and broke his right ; he said he was transported to the hospital but did not have surgery. Review of resident #109's MDS Discharge Assessment with an Assessment Reference Date (ARD) of and a 5-day assessment with an ARD of revealed that his " status" was incorrectly assessed. On at 5:15 PM, MDS Transitional Nurse K explained he was responsible for completing this MDS. He acknowledged both MDS's did not indicate under the category of with "major injury" resident #109's . He verified the information submitted in the MDS was not accurate. He said he reviewed hospital documentation before completing the MDS assessment and care plan. Review of the Centers for Medicare & Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual Section J: Health Conditions, , , Prognosis, Problem Conditions, and . The manual revealed coding instructions for section J1900: Number of Since Admission/Entry or Reentry or Prior Assessment. The instructions directed the user to code the number of , major injury-bone , , ,	F 641	(a) Immediate action(s) taken for the resident(s) found to have been affected include: The MDS for Resident #109 has been reviewed and corrected to accurately reflect the with major injury. The Care Plan for Resident #109 has been reviewed and updated to include interventions related to prevention and management. (b) Identification of other residents having the potential to be affected was accomplished by: All Residents who have had a have the potential to be affected. A facility-wide audit of all current residents who experienced in the past 90 days has been conducted to ensure the MDS accurately reflects their history and any major injuries. (c) Actions taken/systems put into place to reduce the risk of future occurrence include: On all staff responsible for MDS completion, including the MDS Coordinator and MDS Assistant, have been re-educated by Regional Nurse on the proper coding of with major injuries to include training on accurate MDS documentation, specifically regarding Section J1900 (with Injury). Also, education was provided to ensure that all hospital diagnoses, including , are promptly reviewed and incorporated into MDS assessments and care plans.	

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F 641	Continued From page 22 closed injuries with altered , and/or hematoma ( ). The directions continued, "Review any follow-up medical information received pertaining to the , even if this information is received after the ARD (e.g., emergency room , , ( ), Computed (CT) scan results), and ensure that this information is used to code the assessment." The facility's policy and procedure, MDS 3.0, was reviewed on . The document read, "1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate, and standardized assessment of each resident's functional capacity, using the RAI specified by the State."	F 641	(d) How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing (DON) or designee will conduct weekly audits of 3 completed MDS for accuracy in section J1900, with a focus on with major injuries, for 2 months, then monthly for at least three additional months. Audit results will be reviewed in the facility's Quality Assurance and Performance Improvement meetings, and corrective actions will be implemented as needed. Compliance monitoring will continue until sustained improvement is demonstrated, as determined by QAPI oversight. (e) Date of compliance .	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and , needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and well-being as required under §483.24, §483.25 or §483.40; and	F 656		

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F 656	Continued From page 23 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. ( )In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and -informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure an individualized comprehensive care plan was implemented for 1 of 1 resident reviewed for safety precautions, (#92); and for 1 of 2 residents reviewed for communication, (#56), of a total sample of 59 residents.	F 656	Preparation and/or execution of this plan does not constitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required.	

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F 656	Continued From page 24 Findings: 1. A review of the medical record revealed resident #92 was admitted to the facility on with diagnoses that included (fluid on the), , , ( ), , speech disturbances, and . The Minimum Data Set (MDS) Annual assessment with an assessment reference date (ARD) of revealed resident #92 had a ( ) that could not be conducted as the resident was rarely or never understood. A review of the resident's medical record revealed current comprehensive care plans with a focus on related to , , , . Interventions included medication as ordered and padding to side rails. On at 3:10 PM, resident #92 was lying in bed but the rails of the bed were not padded for safety in case of . On at 10:02 AM, assigned Certified Nursing Assistant (CNA) Q verified the resident's unpadded rails. CNA Q stated she did not know why the pads were in the corner of the room and not on the bed. She did not know who put them there. On at 10:04 AM, the and Restorative Unit Manager stated the bed rails were only padded at night because that was when the resident got agitated. On at 4:31 PM, the Director of Nursing stated she expected the staff to review resident's	F 656	(a) Immediate action(s) taken for the resident(s) found to have been affected include: For Resident #92, the pads were placed as per the Resident's care plan. Resident #92 was reassessed to ensure all precautions were properly implemented. CNA Q was re-educated on the importance of following care plan interventions, especially for residents with . For Resident #56, the care plan was updated to reflect the resident□s Primary language of Spanish with intervention of utilizing an interpreter as indicated. (b) Identification of other residents having the potential to be affected was accomplished by: All Residents with a diagnosis of and Residents who do not speak English proficiently have the potential to be affected. A facility-wide audit of all residents with was conducted to ensure appropriate interventions were care planned and in place. MDS Coordinator conducted an audit of all residents with limited English proficiency to ensure their communication needs were appropriately care planned. (c) Actions taken/systems put into place to reduce the risk of future occurrence include: Nurse leadership team, including Director of Nursing, Assistant Director of	

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F 656	Continued From page 25 care plans and implement the listed interventions. 2. Resident #56 was initially admitted to the facility on and readmitted from an acute care hospital on . Her diagnoses included , , , {, , that affects the lower half of the body), , , {skin }, major , , and , . Review of the MDS quarterly assessment with Assessment Reference Date of revealed resident #56 had a score of 15 out of 15 which indicated intact cognition. The MDS assessment noted her primary language was Spanish, and she wanted an interpreter to communicate with a physician or health care staff. The section revealed resident #56 experienced social isolation often. The MDS assessment showed resident #56 had lower extremities , and was dependent on staff for toileting, shower, personal hygiene and putting on/off footwear. She was always of and . Review of resident #56's care plan did not include a focus on communication, resident's primary language or her desire for an interpreter to communicate with a doctor or health care staff, as indicated by the MDS assessment. On at 12:06 PM, interview with resident #56 was conducted in Spanish. She explained she recently had a problem with a nurse who gave her a medication that was discontinued and another medication she refused to take. She shared she took one pill out and tried to explain to	F 656	Nursing, Unit Managers, and MDS Nurses received in-service training on by Regional Nurse on the requirement for comprehensive Resident Centered care plans with focus on Residents with and/or limited English proficiency. Starting on all Direct Care staff {RNs, LPNs, and C.N.A.S) will receive mandatory training importance of following individualized care plan interventions, ensuring safety interventions are in place for precautions per plan of care, and on communicating with Residents with limited English proficiency per plan of care to include use of Propio 1 Interpreter Line. All Direct Care staff will be in-service by . Any Direct Care staff not in-serviced by this date will be in-serviced prior to their next scheduled shift. We have no Agency staff currently. All newly hired Direct Care staff will be in-service by the ADON during their orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing or designee will conduct weekly audits of 5 Residents with or Limited English Proficiency for four weeks, then 10 monthly for at least three months, to ensure care plans are accurately implemented and followed. Any discrepancies found will result in immediate correction and staff re-education. Audit results will be reviewed in the	

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the nurse in "her little English" that medication was discontinued 2 weeks prior. She added she showed the nurse another pill she only wanted to take every other night. She explained during the conversation one pill on the floor and the nurse picked it up from the floor and placed it in her cup. Resident #56 stated she asked the nurse why she did that and that she was not supposed to place a pill that on the floor in her cup. The resident indicated when she requested to speak with a supervisor, the nurse got agitated and raised her voice at her. The resident stated a supervisor did not visit her that night, she cried and could not sleep. She mentioned she preferred to be cared for by Spanish speaking staff and had communicated her choice previously to the staff.

On at 12:30 PM, Licensed Practical Nurse (LPN) I stated she was "very familiar" with resident #56. She shared she had never had any problems with this resident as she communicated with her in Spanish. She indicated she had instructed resident #56 to let staff or management know whenever she experienced any issues. LPN I shared resident #56 usually waited for her to share her concerns because she felt comfortable with her.

On at 1:17 PM, MDS Coordinator L indicated when a resident's primary language was not English, she added a communication care plan. She shared she knew resident #56 for as long she had lived in the facility. She shared resident #56 could say a few words in English and could understand English better than she could speak it. She explained when she talked with resident #56, the resident would let her know to get someone to translate when they could not

facility's monthly Quality Assurance and Performance Improvement (QAPI) meetings.

(e) The compliance date is .

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F 656	Continued From page 27 understand each other. MDS Coordinator L looked through resident #56's care plan, including resolved focus areas and interventions and validated there was not one for communication. She indicated one should have been created. She stated they reviewed the care plan every quarter and resident #56 attended the meetings which were held in her room. She shared there was always someone in the meeting who spoke Spanish. MDS Coordinator L reviewed the quarterly MDS assessment dated and acknowledged resident #56 expressed her desire to have an interpreter when communicating with physicians or health care staff. Review of the policy titled Comprehensive Care Plans revised on revealed, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and needs that are identified in the resident's comprehensive assessment." The guidelines revealed the care planning process included an assessment of the resident's strengths and needs, incorporating the resident's personal and cultural preferences in developing goals of care.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		

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F 657	Continued From page 28 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to revise and implement appropriate interventions including the provision of adequate supervision to prevent for 2 of 4 residents reviewed for , of a total sample of 59 residents, (#3 and #51). Findings: 1. Review of resident #3's medical record revealed she was originally admitted to the facility on and readmitted from a short-term, acute hospital on . Her diagnoses included of , type 2 , hearing loss, and .	F 657	Preparation and/or execution of this plan does not constitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. (a) Immediate action(s) taken for the resident(s) found to have been affected include: New risk evaluations were completed for Resident #51 to reflect accurate information, and their care plans and Kardex's were updated to reflect accurate risk assessments, with	

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F 657	Continued From page 29 Review of the quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of revealed resident #3's ( ) score of 3 out of 15, which indicated severe . The MDS assessment showed resident #3's hearing was highly , and her vision was . She required supervision for eating, and substantial assistance from staff for toileting, lower body , upper body , putting on/taking off footwear, and personal hygiene. She was dependent on staff for showers. The MDS assessment revealed resident #3 required supervision or touching assistance for rolling left and right, sit to lying, lying to sitting, and to wheel up to 150 in the wheelchair. She required substantial assistance for sit to stand, chair/bed-to-chair transfer and from a bed to chair (or wheelchair), toilet transfer and tub/shower transfer. Walking was "not attempted due to medical condition or safety concerns." She was frequently of . Since the previous MDS assessment, she had one with no injury. Review of resident #3's comprehensive care plan revised on revealed a focus of risk for . Interventions included to , and meet the resident's needs and encourage her to use the call light for assistance as needed. A care plan for cognition revised on directed staff to "Cue, reorient and supervise as needed." A care plan for a behavior problem related to in inappropriate places specifically the trash can was initiated . The interventions directed staff to offer and escort the resident to the toilet frequently and to remove the trash container from her room/area. A	F 657	appropriate and individualized prevention interventions implemented. Resident #3 is no longer residing at the facility. (b) Identification of other residents having the potential to be affected was accomplished by: All Residents who have had a have the potential to be affected. The MDS Coordinator and Unit Managers conducted a facility-wide audit of risk assessments and care plans for residents with a score of 12 or less to identify any discrepancies. (c) Actions taken/systems put into place to reduce the risk of future occurrence include: Starting on all Direct Care staff (RNs, LPNs, and C.N.A.S) staff will receive mandatory training regarding review and use of Care Plan/Kardex prior to providing care to Residents. This education will also be completed upon hire and at least annually. All Direct Care staff will be in-service by . Any Direct Care staff not in-serviced by this date will be in-serviced prior to their next scheduled shift. We have no Agency staff currently. All newly hired Direct Care staff will be in-service by the ADON during their orientation. Starting on all Licensed nurses (RNs and LPNs) and MDS staff on the proper completion of risk assessments, individualized care planning, and the importance of ensuring	

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F 657	Continued From page 30 communication problem due to a language barrier care plan revised revealed resident #3 spoke Spanish and had hearing loss. Review of resident #3's medical record revealed the following Change in Condition Evaluations: * with injury, bump on forehead * in the left , and * with no injury Review of the Investigation Worksheet for the on revealed resident #3's daughter was with the resident at the time of the . The form showed the occurred in the bathroom and the resident required supervision. The Recommendations/Interventions included assisting the resident to the bathroom after meals, ensure the call light was within reach, educate the family to ask for help toileting, and checks. Review of the Investigation Worksheet for the on revealed resident #3's was leaning forward to pick something up from the floor. The form indicated resident #3 required supervision. The form included the number of in the last 30 days was 2 and in the past 31-180 days she had two . A bump on the forehead was noted. The nurse statement included she called the physician and resident #3 was sent to the hospital for evaluation. Review of the following Risk Evaluation form revealed resident #3 scored below 10 on . The Risk Evaluation form read, "Total score of 10 or ABOVE represents HIGH RISK. Initiate a Risk Care Plan for High Risk Components/Factors (i.e. , Unsteady Gait,) regardless of resident not	F 657	interventions are documented in the Kardex. All Licensed nurses (RNs and LPNs) and MDS staff will be in-service by . Any Licensed nurses (RNs and LPNs) and MDS staff not in-serviced by this date will be in-serviced prior to their next scheduled shift. We have no Agency staff currently. All newly hired Licensed nurses (RNs and LPNs) and MDS staff will be in-service by the ADON during their orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing or Designee will review a sample of five residents' risk evaluations, care plans and Kardex's weekly for four weeks, then monthly for three months to ensure continued compliance. Any discrepancies identified will be corrected immediately, and trends will be addressed through additional staff training or process adjustments. Findings will be reported in the monthly QA/QAPI meeting for further review and action as needed for a minimum of 3 months. (e) Date of compliance .	

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scoring a 10 or above." The form showed resident #2 was ambulatory and . The questions, "Walking, turning around and facing opposite direction and moving on and off toilet" was answered as "Not steady, but able to stabilize without staff assistance." Her vision was incorrectly marked as adequate .

Review of a Progress Note dated revealed resident #3 was discussed during the Patient at Risk (PAR) meeting. The note read, "Resident continues to be monitored and educated on using call lights to ask for assistance . . ." Another Progress Note entered on included "New intervention: Reinforce to resident to call for assistance to include things on the floor." A Progress Noted dated read, "Despite advising the resident to stay herself in bed for safety and call for assistance the resident does not follow instruction and many times in the frequent rounds the resident has been found standing, walking and making her bed." A Progress Note dated included resident #3 "consistently does not utilize call light as instructed." A Progress Note dated read, " . . . The resident did not use the call bell to call for assistance."

On at 4:04 PM, resident #3 was observed lying in bed on her right side, with , closed. A dark purple and light green was noted on her left forehead, measuring approximately 8 x 6 centimeters. There was a trash can next to her bed, and the call light was on the bed rail.

On at 10:20 AM, resident #3 was observed sitting on her wheelchair washing her in the bathroom sink. When asked in Spanish what happened to her , she smiled

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but did not answer. She was wearing slippers.

On at 10:21 AM, Certified Nursing Assistant (CNA) J entered resident #3's room. CNA J stated resident #3 a few days ago. CNA J stated resident #3 was hard of hearing, wore ˘ but said they did not work. She shared resident #3 needed supervision.

On at 10:52 AM, during a telephone interview, resident #3's daughter explained her mother suffered from . She mentioned it had become "very dangerous" lately because she liked going to the bathroom by herself. She shared her mother had recently in the bathroom and again a few days later. Resident #3's daughter said her mother "cannot see well, is legally , can see shadows, is hard of hearing on both , and not even with ˘ [can she] understand. She does not speak English. She is declining." She stated her mom was sent to the hospital after the last two . She indicated she was visiting her mom when she in the bathroom, but she did not hurt herself. She recalled a couple of days later, she was called because her mother was sent to the hospital with a "big hematoma" on her ˛ . She stated her mom told her she poked her ˛ and she noticed her mom's ˛ was and black and blue. She explained she was told the second time her mother she bent over to get something from the floor, forward and hit herself on the table. She shared the showed an hematoma outside the . She stated she usually did not visit during the day, but her sister and herself visited mostly during dinner to ensure her mother was taken to eat. She shared her mother used to participate in activities, enjoyed coloring books but she had declined "a

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lot." She indicated when she attended Care Plan meetings, she "always mentioned concerns about the availability of someone to care for her." She mentioned her mom often refused showers and could go up 2 weeks without a bath, but she received it from CNA H because "she is very patient with her, and she talks her into it." Resident #3's daughter stated her main concern was her . She said she felt the CNAs did not check on her mother often. She stated her mom would get up unassisted and would not use the call light. She indicated the CNAs should do rounds and checked on her often because her mother "still think she can do things" by herself.

On at 3:08 PM, CNA H stated there was a strong odor of in the room because resident #3 on the trash can and on the floor. She explained resident #3 vision and hearing were , . She shared resident #3 liked to "fix everything by herself, fixes the bed." CNA H stated resident #3's , looked like someone hit her but she tended to get too close to things to see them and that was "probably what happened to her." She stated they tried to place floor mats next to resident #3's bed but resident #3 removed them while she pointed to a floor mat located behind the of the bed. She explained she checked on resident #3 every time she finished caring for each of her residents because resident #3 liked to fix her drawers and wanted to do things by herself.

On at 1:12 PM, the General & Restorative Unit Manager (UM) stated were discussed every morning during clinical meetings by the Interdisciplinary Team (IDT). She explained the IDT reviewed the incident report, looked for any type of injuries, and discussed any new

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interventions required after reviewing the care plan. She indicated any new interventions were added by the MDS Coordinator attending the meeting. She mentioned resident #3's mentioned on was because of her on . She stated resident #3 again on while attempting to reach out for something and was sent out to the hospital. She indicated resident #3 required frequent checks. When asked what frequent checks meant, she explained it was "to put , on the resident but no specific time frames" were required. She indicated a new intervention to offer toileting after meals would show up in the Kardex (care plan used by CNAs).

On at 11:56 AM, Registered Nurse (RN) A stated she was not working when resident #3 but explained the resident was monitored frequently, every 15 minutes by the CNA and nurses. She indicated resident #3 required one-staff assistance to transfer but the resident transferred herself at times and she did not use the call light. She mentioned resident #3 was disoriented, and could not follow instructions. She shared resident #3's hearing and vision was , and although she did not walk, she tried to get up from her wheelchair. RN A stated resident #3 required supervision "all day long" and a safe environment to avoid .

Review of resident #3's comprehensive care plan did not include resident #3 required frequent, 15 minutes checks.

On at 1:25 PM, MDS Coordinator L shared the interventions from the risk management report after the included assistance with activities and monitor for

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changes. She stated the care plan was updated on to include , , to screen and resident and family education. She mentioned the intervention after the on was to offer resident #3 a reacher and educate her on use. She said she was surprised with the intervention because resident #3 had and her was very low. MDS Coordinator L validated interventions for frequent supervision or to offer toileting after meals were not included in the care plan.

On at 1:50 PM, the Director of Nursing (DON) explained during clinical meeting they reviewed the Investigation Worksheet and witness statements, came up with a root cause for the and interventions to prevent future . She indicated any interventions they decided would be updated to the care plan if not already there. She read the intervention included on the IDT note dated , "Reinforce to resident to call for assistance to include things on the floor" and validated it was not appropriate for this resident due to her cognition. She mentioned resident #3 needed frequent checks at least every 15 minutes. She mentioned resident #3 needed to be in a highly visible area to be closely observed by CNAs and nurses to prevent .

2. Review of resident #51's medical record revealed she was originally admitted to the facility on and readmitted from a short-term, acute hospital on . Her diagnoses included , , , and .

Review of the quarterly MDS assessment with ARD of revealed resident #51's

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score of 3 out of 15, which indicated severe . The MDS assessment showed no rejection of care necessary to obtain goals for her health and well-being. Resident #51 required set-up for eating and substantial assistance from staff for oral hygiene and upper body . The MDS assessment showed she was dependent on staff for toileting, showers, lower body , putting on/taking off footwear, and personal hygiene. The MDS assessment revealed resident #3 required substantial assistance from staff for sit to lying and lying to sitting. She was dependent on staff to roll left and right in bed, sit to stand, chair/bed-to-chair transfer, toilet transfer and tub/shower transfer. Walking was "not attempted due to medical condition or safety concerns." She required supervision or touching assistance to wheel 50 to 150 in the wheelchair. She was always of and . Since the previous MDS assessment, she had two with no injury.

Review of resident #51's comprehensive care plan revised on revealed a focus of risk for related to attempt to get up unassisted, , gait/balance problems, and unaware of safety needs. Interventions included and meeting the resident's needs and dycem (non-slip) to wheelchair. A care plan for , cognition revised on directed staff to "Cue, reorient and supervise as needed."

Review of resident #51's medical record revealed the following Change in Condition Evaluations:
* - resident found on the floor in the TV room lying on her left side and on the left side of the forehead. Resident sent to the hospital

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F 657	Continued From page 37 for evaluation and treatment. * - with no injury Review of the following Risk Evaluation form revealed score below 10. * - score of 4. The question if resident had any since admission or prior assessment was answered No. * - score 9. The question if resident had any since admission or prior assessment was incorrectly answered No. Ambulatory and were selected. Review of the Investigation Worksheet for the on revealed resident #51's unwitnessed occurred on the hallway/TV room at 8:35 PM. The question, "Did resident require supervision?" was answered "No." The resident was using a wheelchair. Number of in the last 30 days was 1 and number of in the past 31-180 days was 2. Resident #51 did not sustain an injury. A Intervention Strategies sheet was attached and listed 51 possible interventions to reduce the risk of , but none were selected. Review of the Investigation Worksheet dated revealed resident #51's was again in the TV room area when the unwitnessed occurred. was selected as a behavior at the time of this . The question, "Did resident require supervision?" was answered TV. The resident was using a wheelchair. Number of in the last 30 days and number of in the past 31-180 days was left bank. Resident #51 did not sustain an injury. A Post- Analysis/Review form revealed risk factors of poor safety awareness, history of aggression, and worsening in the evening. The analysis included supervision and read, "Encouraged to be in	F 657		

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common area per plan of care for closer supervision due to poor safety awareness." The possible contributing factors mentioned evening behavioral changes. The interventions to prevent reoccurrence included increased supervision during late afternoon/evening hours, behavioral interventions such as music , , , sensory activities and environmental modifications in the afternoon/evening.

On at 3:17 PM, CNA H recalled 2 or 3 Saturdays ago at approximately 8:00 PM resident #51 was in the TV area with other residents. CNA H stated she went to discard soiled linens in the soiled utility room and when she returned resident #51 had from her wheelchair. She shared some time ago the facility used chair alarms, but staff were told they could not use chair alarms any longer. She indicated she found those helpful because staff ran when they heard the alarms. CNA H stated resident #51 used to hit the walls and the physician prescribed a cream to place on her which was helpful, but she did not think resident #51 was getting it any longer. She shared resident #51's behaviors changed a lot in the evenings, as she was a "sundowner" and did not remember anything. She indicated the resident was transferred with a but she thought resident #51 stood up and on her right side.

On at 1:36 PM, the General & Restorative Unit Manager (UM) stated resident #51's care plan included the use of a dycem when she was in the wheelchair. A few minutes later, at 1:53 PM, while resident #51 was sitting in her wheelchair, the UM checked under the , and the sides of her seat cushion and stated she could not see the dycem.

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On at 1:57 PM, Occupational , ( ) M stated dycem was used under the wheelchair cushion to prevent sliding.

On at 1:59 PM, CNA H recalled resident #51 had a dycem when she was in another room. She said she was "not sure who threw it away" because she had not seen the dycem recently. She mentioned the last time she saw the dycem was a month or so ago. She indicated she had not mentioned to anyone about not seeing the dycem because resident #51 was currently working with , , so they would review the wheelchair and provided a new one if needed. CNA H indicated the dycem was not in resident #51's wheelchair and repeated she did not see it today or any day this past week. When asked to show the safety/ interventions in resident #1's Kardex (plan of care), CNA H accessed it electronically. She pointed out the safety information, interventions or dycem did not appear on the Kardex. She stated she only used the computer to document the care she provided the residents.

On at 4:35 PM, the Director of Rehabilitation confirmed resident #51 was currently on case load since . She indicated she participated in the clinical meetings. She stated if an intervention for the use of dycem was identified, she placed it in the wheelchair. She explained once the dycem was provided to the resident, it would be nursing's responsibility to continue placing it in the wheelchair. She shared if nursing needed another dycem for a resident, nursing needed to let her know.

Review of the Evaluation & Plan of Treatment

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for Certification Period of -
revealed treatment approaches included wheelchair management training. The goals included ability to reposition herself while seated in the wheelchair and increase , sitting balance to facility upright posture. The current referral indicated resident #51 was referred to due to from the wheelchair. History of was answered, "No." Her prior level of function revealed resident was dependent with ADL management except feeding and was dependent with mobility and transfers using a . Her safety awareness was identified as "intact." The clinical impression read, "Patient exhibits new onset of decreased , alignment and decrease in strength." The notes did not reference the use of a dycem.

Review of Treatment Encounter Note(s) from to included training repositioning in wheelchair to patient and caregiver, training to nursing on positioning and in wheelchair and locking , rests into place. The note dated included instruction to "patient in proper body mechanics, safety precautions and self care/skin checks specifically, in order to increase functional mobility skills and increase safety and decrease need for assistance with partial carryover demonstrated during training, due to safety awareness and patient's comprehension skills."

On at 12:03 PM, RN A stated prevention interventions for resident #51 included close/frequent supervision, every 15 minutes. She indicated resident #51 participated in activities or stayed in the TV room where the staff kept "an , " on her. She stated nurses, CNAs and , would be responsible to ensure the

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dycem was on resident #51's wheelchair before the resident was transferred to it. She indicated she did not recall if the dycem was in her wheelchair today. She mentioned resident #51 was working with .

On at 12:23 PM, CNA N stated today was the first day by herself on her first assignment. She explained she had a 2-day orientation then shadowed on the floor for 3 days. She shared she received report about her assigned residents this morning. She indicated she did not recall reviewing the Kardex during her training. She stated she did not recall seeing a dycem in resident #51's wheelchair when she was transferred this morning. CNA N asked, "Is the resident supposed to have it?"

On at 12:56 PM, MDS Coordinator L validated interventions included in the investigation packet were not all included in the care plan. She reviewed the care plan and stated she saw offering the resident afternoon naps and to keep in in a common area for supervision. She stated she was surprised the increased supervision intervention was not there. She indicated "everyone" knew resident #51 and "everyone" kept "an , " on her.

On at 3:43 PM, the DON explained once a investigation was completed, the MDS Coordinator attending the meeting added new interventions to the care plan. Later on at 2:10 PM, the DON stated the UM was responsible for communicating with the CNAs before they started their assignments. She indicated her expectation was the nursing staff communicated any new interventions to each other and the care plan was updated with the

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F 657	Continued From page 42	F 657		

appropriate interventions.

Review of the policy titled Accidents and Supervision reviewed on read, "The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents." The guidelines mentioned potential hazards and risks would be documented and communicated across all disciplines. The implementation of interventions included communicating the interventions to all relevant staff, documenting interventions, and ensuring the interventions were put into action. The policy revealed the facility would provide adequate supervision to prevent accidents. The form read, "Adequacy of supervision: Defined by type and frequency. Based on the individual resident's assessed needs and identified hazards in the resident environment."

Review of the policy titled Comprehensive Care Plans revised on read, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and needs that are identified in the resident's comprehensive assessment." The guidelines revealed the care planning process included an assessment of the resident's strengths and needs, incorporating the resident's personal and cultural preferences in developing goals of care. The form read, "Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are

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F 657	Continued From page 43 made."	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and , well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide an ongoing program of activities to meet the needs and interests of 1 of 5 residents reviewed for activities, of a total sample of 59 residents, (#58). Findings: Resident #58 was admitted to the facility on with diagnoses including 's , , , and open-angle with findings. The Minimum Data Set (MDS) Annual assessment, with an assessment reference date of , revealed resident #58 had a of , which indicated mild . The MDS revealed that resident #58 was visually , and required large print in newspapers and books but not regular print.	F 679	Preparation and/or execution of this plan does not constitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. (a) Immediate action(s) taken for the resident(s) found to have been affected include: Resident #58 was assessed for activity preferences. Preferences were added to the care plan. (b) Identification of other residents having the potential to be affected was accomplished by: All Residents with visual , have the potential to be affected.	

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F 679	Continued From page 44 A review of the resident's comprehensive care plan revealed the resident's activities should be compatible with physical and mental capabilities, such as large print holders, if the resident lacked strength and task segmentation. On at 9:52 AM, Activity Aide R was observed as they entered resident #58's room, handed the resident a red bag, and left the room. The resident opened the bag and removed the items. The bag contained a regular print sudoku puzzle book and a coloring book. Resident #58 expressed frustration as she explained she could not see what was in those books. She stated, "I cannot see in these books; my , are no good, and glasses do not help." There was no other activity for resident #58 at that time. On at 9:45 AM, resident #58 was observed standing holding onto the door of her room; there were no activities going on for her. On at 9:33 AM, resident #58 was observed along with the Activity Director. The resident was sitting on the bed, and no activity was ongoing. The resident stated she gave the books to the lady, pointing to the room mate, lying in bed B. The Activity Director acknowledged that the suduko book and coloring book the resident received for the activity did not meet the resident's needs. Resident #58 should have received large print books compatible with her physical and mental capabilities. Review of the facility's Assessment dated , revealed, "The care required by the resident population using evidenced-based, data-driven methods that consider the types of	F 679	100% audit of all MDS assessments to identify residents with visually , . (c)Actions taken/systems put into place to reduce the risk of future occurrence include: The Administrator provided education to Activity Director and Activity Staff starting on regarding resident activity preferences and ensuring activities are compatible with the Resident□s physical and mental capabilities. Activity Director and Activity Staff will be in-service by . The Activity Director and Activity Staff not in serviced by this date will be in serviced prior to their next scheduled shift. We have no Agency staff currently. All newly hired Activity Director and Activity Staff will be in-service by the ADON during their orientation. The Activity Director will complete Activity Preference assessment on all visually , residents (d)How the corrective action(s) will be monitored to ensure the practice will not reoccur: The Administrator or designee will interview at least 5 residents weekly for 4 weeks for activity preferences offered as desired, then interview 10 residents monthly for the 3 months. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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F 679	Continued From page 45 , conditions, physical and behavioral health needs, , overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessment."	F 679	(e) The compliance date is .	
F 698 SS=D	CFR(s): 483.25(l) §483.25(l) . The facility must ensure that residents who require receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to have ongoing communication and collaboration with the facility regarding care and services for 1 of 1 sampled residents who receive , of a total sample of 59 residents, (#12). Findings: Review of resident #12's medical record revealed an admission date of . His Quarterly Minimum Data Set dated indicated a Brief Interview of Mental Status score of , which indicated moderate , . His diagnoses included: , dependence on , and unspecified with unspecified severity, without behavioral disturbance. Review of resident #12's medical record revealed physician's orders dated for to occur on Monday, Wednesday, and Friday at	F 698	Preparation and/or execution of this plan does not constitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. (a) Immediate action(s) taken for the resident(s) found to have been affected include: The Unit Manager contacted the provider to obtain Resident #12's updated treatment records, including recent lab results, treatment schedules, and any noted concerns. Resident #12's care plan was reviewed and updated to reflect current care needs, including communication protocols between the facility and the provider.	

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F 698	Continued From page 46 Center #1. Review of resident #12's medical record revealed no documentation of communication having occurred between staff from Center #1 and the facility nursing staff from to . On at 2:30 PM, the South Subacute Unit (SSU) Unit Manager (UM) said that she expected the facility's Communication Record to be completed by the facility's nursing staff and for the form to be sent with the resident when he attended a treatment at Center #1. She said nursing staff should then review the form from the center upon his return, and include it into his medical record. The UM verified there were no Communication Records nor any other communication documentation with Center #1 in the resident's paper medical record maintained on the Unit. A few minutes later on at 2:40 PM, the SSU UM continued that if the Communication Record was not returned from Center #1 then she expected resident #12's assigned nurse to call Center #1 upon resident #12's return or by the next day to receive an update on resident #12's condition. The UM described information needed by the facility included vital signs, level, lab values, or medications provided during the session, and nurses should then obtain the previous Communication Record on the next treatment. On at 8:07 AM, telephonically spoke with Clinical Manager #1 of Center #1 and he stated that the facility used to send a binder for	F 698	(b) Identification of other residents having the potential to be affected was accomplished by: All residents receiving have the potential to be affected. A facility-wide audit was conducted to identify all residents receiving and assess the adequacy of communication and documentation related to their care. (c) Actions taken/systems put into place to reduce the risk of future occurrence include: Starting on all Licensed staff (RNs and LPNs,), including unit managers, received education on care coordination, proper documentation, and the importance of interdisciplinary collaboration. All Licensed staff (RNs and LPNs,), including unit managers will be in-service by . Any Licensed staff (RNs and LPNs,), including unit managers not in-serviced by this date will be in-serviced prior to their next scheduled shift. We have no Agency staff currently. All newly hired Licensed staff (RNs and LPNs,), including unit managers will be in-service by the ADON during their orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing or designee will conduct weekly audits of all residents records for one month, ensuring accurate documentation and proper communication with	

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F 698	Continued From page 47 communication to be documented in but he hasn't seen that "in awhile". He said resident #12 has been receiving , services with them since , . He recalls speaking with facility staff, but not after every , session. On at 8:27 AM, telephonically spoke with Clinical Nurse #1 of , Center #1 who said he has spoken with a facility staff person when for example they call to say resident #12 arrived late for his session. He confirmed facility nurses did not call him after every session for an update on resident #12's post treatment condition. He recalled that in the past six months resident #12 had been late to one scheduled session. He stated that the facility used to send a binder that communications would be documented in and returned with resident #12 to the facility but it had been six months or more since he had seen that binder nor any other kind of communication document. He described that sometimes it was difficult to get in touch with resident #12's nurse at the facility. He explained that the front desk would transfer his call but there would be no response after the transfer or he would have to leave a message with the front desk. On at 1:25 PM, the Assistant Director of Nursing (ADON) said that communication with resident #12's , facility was important to coordinate care for him-such as to know if there were any changes in his condition during the session or any post session follow-up. She said if the , Communication Record was not returned from , Center #1 she would expect the facility's nurse to call , Center #1 after the session and document any updates in his condition in his facility medical record or call and request the , Communication Record	F 698	providers, followed by monthly audits of 3 , residents' records for an additional three months. Audit results will be reviewed in the facility's Quality Assurance and Performance Improvement (QAPI) meetings, with corrective actions taken as needed. Compliance monitoring will continue until sustained improvement is demonstrated, as determined by QAPI oversight. (e) The date of compliance is .	

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F 698	Continued From page 48 to be faxed to the facility. The ADON verified there was no documentation from to of the , Communication Records in his electronic medical record nor was there documentation that facility nurses called , Center #1 post , treatment for the information.	F 698		
F 842 SS=D	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 §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- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842		

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F 842	Continued From page 49	F 842		

operations, as permitted by and in compliance with 45 CFR 164.506;
( ) 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.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
( ) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, , and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to accurately document

Preparation and/or execution of this plan does not constitute admission or

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F 842	Continued From page 50 the administration of medications in the Medication Administration Record (MAR) for 1 of 3 residents reviewed for , of a total sample of 59 residents, (#18). Findings: Review of resident #18's medical record revealed he was readmitted to the facility on with diagnoses including type 2 , , and of . Review of resident #18's Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date (ARD) of revealed a ( ) score of , which indicated he was . The MDS assessment noted no rejection of evaluation or care necessary to obtain his goals for health and well-being. Review of resident #18's medical record revealed a care plan for acute/ , related to process and general discomfort revised on . The interventions directed nurses to administer per orders and to "Monitor/document for side effects of medication." Review of resident #18's physician orders revealed an order for 325 milligrams (mg) dated . The order instructed the nurses to give 2 tablets every 6 hours as needed for . On at 12:07 PM, resident #18 complained of on his left . He stated his level was 10 out of 10 while holding his left with his right . He mentioned he told the nurse	F 842	agreement by the provide of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. (a) Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 18 assessed for . No . Notified physician and advised to discontinue order. (b) Identification of other residents having the potential to be affected was accomplished by: All Residents receiving medication have the potential to be affected. An audit was conducted for all current Residents receiving meds to ensure the assessment was completed and the medication administration was documented. (c) Actions taken/systems put into place to reduce the risk of future occurrence include: Starting on all Nursing staff (RNs, LPNs) will receive mandatory Education for all nurses on accurately documenting of prn medications on the MAR. All Nursing staff will be in-service by . Any Nursing staff not in-serviced by this date will be in-serviced prior to their next scheduled shift. We have no Agency staff currently. All newly hired Nursing staff will be in-service by the ADON during their orientation.	

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F 842	Continued From page 51 but had not received anything for the , . On at 12:09 PM, Certified Nursing Assistant (CNA) J entered the room because the call light was on and told resident #18 she informed the nurse. When asked how long ago she informed the nurse, CNA J answered about 5 minutes ago. On at 12:11 PM, Registered Nurse (RN) D entered the room with a medication cup in her . RN D informed resident #18 she brought him two , for his , . CNA J entered the room at 12:15 PM and assisted RN D to sit resident #18 up and he took the two pills. Resident D did not assess his , level or location of the , . Review of the MAR for , revealed , was documented as administered once on and on . There was no documentation in the MAR of the , given by RN D on . Review of resident #18's progress notes revealed no note entered on by RN D regarding his , or the , given. On at 11:11 AM, RN D stated she did not work the day before ( ) and could not now recall why she did not document the , as given on . On at 12:00 PM, the General & Restorative Unit Manager (UM) shared her responsibilities included ensuring documentation was completed by the nurses. The UM stated she did not see , documented as given on . She indicated accurate documentation	F 842	(d) How the corrective action(s) will be monitored to ensure the practice will not reoccur: DON, Unit managers or designee will observe 2 nurses medication administration of 2 residents 3 times a week for 2 weeks then 2 nurse's medication administration for 2 residents once a week for (3) months to ensure compliance. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. (e) The date of compliance is .	

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F 842	Continued From page 52 was important, it was the expectation and "Nursing 101." On at 2:53 PM, the Director of Nursing stated she expected nurses to document medications administered and their effectiveness accurately. Review of the facility's policy entitled Charting and Documentation revised in read, "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care." The form listed the information to be documented in the medical record, including medications administered. "Documentation in the medical record will be objective . . , complete and accurate." Review of the facility's policy titled Medication Administration revised on revealed licensed nurses were to sign the MAR after administration of the medication. The form indicated for "medications requiring vital signs, record vital signs onto the MAR."	F 842		
F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.	F 849		

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F 849	Continued From page 53 (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to	F 849		

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alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's .
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of , and symptoms associated with the illness and related conditions; and all other hospice services that are necessary for the care of the resident's illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, ,

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F 849	Continued From page 55	F 849		

and , , including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the

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F 849	Continued From page 56 medical care provided by other physicians. ( ) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and , , well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to maintain effective communication between nursing staff and hospice to promote adequate treatment, monitoring, and continuity of care for 2 of 2 residents reviewed for hospice care and services, out of a total sample of 59	F 849	Preparation and/or execution of this plan does not constitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed	

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F 849	Continued From page 57 residents, (#3 and #469). Findings: 1. Review of resident #3's medical record revealed she was originally admitted to the facility on and readmitted from a short-term, acute hospital on . Her diagnoses included of , type 2 , hearing loss, and . Review of the quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of revealed resident #3's ( ) score of 3 out of 15, which indicated severe , . The MDS assessment showed resident #3's was receiving hospice care. Review of resident #3's comprehensive care plan revealed a focus of hospice care related to prognosis initiated on . The interventions included coordinating care plan with hospice and notifying hospice of any change in condition or medication changes. Review of resident #3's medical record revealed the following Change in Condition Evaluation forms: * with injury, bump on forehead * in left , and * with no injury The forms included documentation the physician and resident's representative were notified but did not include notifying hospice. Review of resident #3's Progress Notes revealed the following:	F 849	solely because it is required. (a) Immediate action(s) taken for the resident(s) found to have been affected include: The Hospice provider was made aware on of the on regarding resident #3 during an in-person visit. The hospice provider was made aware on of the on for resident #469 via phone call with case manager. In person communication re: between hospice provider and facility occurred on . Residents #3 and #469 are no longer residing at the facility. (b) Identification of other residents having the potential to be affected was accomplished by: All Residents receiving Hospice services have the potential to be affected. A facility-wide audit was conducted to identify all residents receiving hospice services and assess the adequacy of communication of with hospice providers occurred timely. (c) Actions taken/systems put into place to reduce the risk of future occurrence include: Starting on all Nursing staff (RNs and LPNs), including unit managers, received education on hospice care communication, proper documentation, and the importance of interdisciplinary collaboration. Nursing staff (RNs and LPNs), including unit managers, will be in-service by . Any Nursing staff	

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F 849	Continued From page 58 * - "The CNA (Certified Nursing Assistant) observed the resident on the toilet floor. The resident was attempting to transfer to the toilet without assistance and to the floor . . . denied any , or discomfort . . . Physician notified. Family notified. monitoring began at 5:15 [PM] and will continue to be monitored for any changes." * - Resident #3 was sent by ambulance to the hospital for a CT (Computed ,) Scan of the as ordered by the facility's physician. * - Resident #3 returned from the hospital around 6:30 pm. "Left noted. Per hospital paperwork, "labs and imaging show no signs of bleeds, no signs of or ." Resident's daughter was in the room when resident came from hospital." * - 911 was called, resident and "large bump" noted. Nurse called the facility's physician who ordered the resident be transferred to the hospital for evaluation, the supervisor on duty, and resident #3's daughter were notified. On at 1:12 PM, the General & Restorative Unit Manager (UM) stated were discussed every morning during clinical meetings by the Interdisciplinary Team (IDT). She explained the IDT reviewed the incident report, looked for any type of injuries, and discussed any new interventions required after reviewing the care plan. She indicated she expected the nurses to call hospice about any issues or changes in conditions on hospice residents. She would expect the nurses to document notification to hospice, the physician and the family in Change in Condition Evaluation form or in a progress note. She indicated she did not verify if the nurses communicated the changes in condition to	F 849	(RNs and LPNs), including unit managers not in-serviced by this date will be in-serviced prior to their next scheduled shift. We have no Agency staff currently. All newly hired Nursing staff (RNs and LPNs), including unit managers, will be in-service by the ADON during their orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing or designee will conduct weekly audits of all hospice residents' records for 4 weeks, ensuring accurate documentation and proper communication with hospice providers, followed by monthly audits of 3 hospice residents' records for an additional three months. Audit results will be reviewed in the facility's Quality Assurance and Performance Improvement (QAPI) meetings, with corrective actions taken as needed. Compliance monitoring will continue until sustained improvement is demonstrated, as determined by QAPI oversight. (e) The date of comliance is .	

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hospice.

On at 3:48 PM, the Director of Nursing stated nurses were expected to document any communication with the hospice nurse. She indicated "anything" that happened to a resident receiving hospice services was called to hospice and documented in the medical record.

On at 8:38 AM, during a telephone interview, Hospice Registered Nurse (RN) O explained she visited resident #3 at least every other week. She indicated when a resident , the facility would be expected to take any necessary immediate action, like sending a resident to the hospital, if required. She stated hospice was not always informed at that moment, but the expectation was the facility informed hospice as soon as possible after the change in condition was identified. She indicated she learned through the hospice CNA on about resident #3's and that she was taken to the hospital. She shared the facility did not always notify them of resident #3's changes. Later on at 9:18 AM, RN O shared she looked through their triage notes and found no calls from the facility informing them about resident #3's , or transfer to the hospital. RN O stated she learned the details of the during her visit to the facility on . She indicated they did not receive a call reporting the on either.

Review of the facility's policy titled Coordination of Hospice Services dated read, "when a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable

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physical, mental, and , , well-being." The Guidelines read, "The facility will immediately contact and communicate with the hospice staff, attending physician/practitioner and the family resident representative regarding any significant changes in the resident's status, clinical complications or emergent situations."

Review of the Nursing Facility Services Agreement between [name of hospice provider] and the facility dated read, "The Nursing Facility shall notify Hospice when the Hospice Patient experiences a change of condition and shall notify the Hospice Patient's attending physician and family of significant change in condition."

2. Review of the electronic medical record revealed resident #469 was admitted to the facility on and discharged on . Some of her medical diagnoses included , , unspecified , type 2 , and .

According to the most recent Annual MDS assessment dated , resident #469 had , cognition with a score of 4 out of 15, which indicated severely , cognition. The assessment indicated resident #469 utilized a wheelchair for mobility, had a life expectancy of less than six months, and was admitted to the care of Hospice provider #2's care on .

On at 5:21 PM, in a telephone interview, resident #469's granddaughter explained she was informed about her grandmother's and , on by the hospice nurse and wanted her grandmother to be transferred to the

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hospital. She revealed that her grandmother was declining and she , on . Resident #469's granddaughter said that the facility never informed her nor any other family members that her grandmother had .

On at 9:55 AM, in a telephone interview, Hospice provider #2's Nurse Case Manager Registered Nurse (RN) F said she was assigned to resident #469 since , . She explained that on she received a call from the Hospice Social Worker who informed her that resident # 469 was screaming in , and had learned that the resident had a few days before. RN F said she headed out to see the resident after the phone call and on arrival, resident #469 was on her bed, yelling, with her flexed upward. RN F recalled resident 469's right , and was and she was more . She discovered the resident had on and the results from an completed just a few hours before she got there indicated a right , . RN F also received orders for an increased dosage of , , medicated the resident, and informed the resident's granddaughter immediately who then requested for the resident to be sent to the Emergency Room. RN F explained she had seen the resident the day before on but was not informed of the . She explained resident #469 was within normal limits during her assessment on . She recalled that on a Hospice after-hours nurse also saw the resident for increased , , yelling and screaming out but was not made aware of the .

On at 11:10 AM, via telephone call Advent Health Hospice Social Worker said that

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on she was visiting another resident and as she passed by resident #469's room, she saw the resident's right hanging off the bed and she was yelling out. She then went to the Director of Nursing (DON) to assist her with positioning resident #469 in the bed so that her was not hanging off to the side of the bed. The DON told her that the resident had last week and that the hospice nurse RN F, was informed. The Hospice Social Worker said she immediately called RN F and the Hospice Supervisor, and both confirmed they had not been informed the resident on .

A review of the medical record showed documentation on at 3:24 PM, by RN A which described, "A noise is heard in the hallway of #200. When arriving, the resident is seen on the floor in front of the room. The skin is checked, no is seen. She states that she is not in at the moment. She is transferred to a wheelchair and a 2-liter is placed. [The physician] is notified, and he gives medical orders and calls family members."

On at 10:42 AM, via telephone, RN A confirmed her documentation as she recounted the events which took place on the day the resident . She said that she did not call Hospice and that the Unit Manager (UM) for the General and Restorative (G and R) unit was the one who called Hospice.

On at 2:49 PM, the UM for the General & Restorative Unit recalled the day resident #469 and gave an outline of the event. She acknowledged she did not call hospice provider #2 to inform them about the incident and stated that RN A was the one who called the physician,

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F 849	Continued From page 63 the family and hospice. The UM said that the communication between the nurse and the hospice should have been documented, however, she could not show any documentation of this notification in the resident's electronic medical record. A review of hospice provider #2's and the Skilled Nursing Facility Integrated Plan of Care dated and under the section, Assessment/Nursing Care, it detailed the facility nurse was to provide services required by plan of care and notify hospice regarding changes in patient status, comfort level and /or new orders. On at 3:48 PM, the Director of Nursing (DON) stated the facility nurse should communicate with the hospice nurses. Her expectation was for nurses to call hospice at any time for any change in condition, , , etc. then to document the communication. The DON said going forward, she also wanted to be notified if a resident , in addition to the family, the physician, and hospice. A review of the Facility's Policy on Coordination of Hospice Services implemented on revealed in section 10, "The facility will immediately contact and communicate with the hospice staff, attending physician/practitioner and the family resident representative regarding any significant changes in the resident's status, clinical complications or emergent situations.	F 849		
F 880 SS=D	Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Control The facility must establish and maintain an	F 880		

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F 880	Continued From page 64 prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable and . §483.80(a) prevention and control program. The facility must establish an prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling and communicable for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable or before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable or should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of ; ( )When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the agent or organism involved, and	F 880		

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F 880	Continued From page 65 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable or skin from direct contact with residents or their food, if direct contact will transmit the ; and (vi)The hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of . §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review during the medication administration task, facility staff failed to the , monitor between residents for 1 out of 5 residents reviewed for medication administration, of a total sample of 59 residents, (#1). Findings: On at 10:09 AM, during the Medication Administration task, it was observed that Registered Nurse (RN) D used a portable , monitoring device to take the , of resident #98. She then proceeded to	F 880	Preparation and/or execution of this plan does not constitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. (a) Immediate action(s) taken for the resident(s) found to have been affected include: The , monitor was Residents #98 and #1 received a skin	

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F 880	Continued From page 66 the next resident #1 for medication administration. She did not the , monitor after using it for resident # 98, nor before using it on resident #1. RN D explained that she was stressed and had forgotten to clean the device between residents as she was supposed to. On at 9:46 AM, the Preventionist (IP) said that the purple top wipes were used to equipment for one minute and they always tried to follow the manufacturer's drying and contact times. She described that facility staff recently had an in-service concerning sanitizing the vital sign machines. The IP explained she would often conduct audit checks with staff, but was unable to explain why RN D did not the , monitoring device between use on the two residents. She said her expectation would be that staff cleaned equipment every time between residents which was important to prevent received from cross contamination. The IP provided evidence of a recent inservice dated to to clean/sanitize equipment between use of each resident with , wipes (purple top) but RN D had not signed that inservice. On at 2:53 PM, the Director of Nursing (DON) explained the expectation was that staff would clean the , monitoring device, or any equipment used between residents to avoid cross contamination. A review of the facility's policy on Cleaning and of Resident Care Items and Equipment Revised , revealed, "Resident Care Equipment, including reusable	F 880	check and there was no evidence of . Inservice for RN D on proper of , monitor by IP nurse. 2. (b)Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. All , monitors were . (c). Actions taken/systems put into place to reduce the risk of future occurrence include: Starting on all licensed and certified nursing staff (RNs, LPNs, and C.N.A.s) were educated in Prevention and Control Policy, proper of the , monitor, and their roles in preventing the spread of communicable and . licensed and certified nursing staff (RNs, LPNs, and C.N.A.s) will be in-service by . Any licensed and certified nursing staff (RNs, LPNs, and C.N.A.s) not in-serviced by this date will be in-serviced prior to their next scheduled shift. We have no Agency staff currently. All newly hired licensed and certified nursing staff (RNs, LPNs, and C.N.A.s), will be in-service by the ADON during their orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not	

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F 880	Continued From page 67 items and durable medical equipment will be cleaned and according to current CDC (Centers for Control) recommendations for and the OSHA (Occupational Safety and Health Administration) Bloodborne Standard.	F 880	recur: The IP nurse or designee will observe 2 staff 3 times a week for proper of , monitor for 2 weeks then 2 staff twice weekly for 2 weeks then 2 staff monthly for up to 3 months. Any deficient practice found during the audits will be corrected immediately by the IP nurse or designee and/or corrective action done as appropriate. This plan of correction will be monitored at the QAPI meeting until such time consistent substantial compliance has been met. The IP Nurse will report the audit findings in the QAPI meeting. (e) The date of compliance is .	
F 881 SS=D	Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) prevention and control program. The facility must establish an prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An stewardship program that includes use protocols and a system to monitor use. This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to develop a comprehensive system to monitor use in the facility from through the time of the survey.	F 881	Preparation and/or execution of this plan does not constitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan	

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F 881	Continued From page 68 Findings: Review of the Control Report dated to included the Surveillance Monthly Report dated to which revealed in the Summary by Category that there was 1 , Tract/ , that occurred with a resident, #23. Review of the Order Listing Report dated to which included medication classes revealed residents #99, #53, #87, and #20 were also receiving in , for , tract/ , . Review of resident #99's medical record revealed an order dated for a , . The , lab report indicated a collection and report date of . There was no , testing that followed the , . A physician's order with a start date of stated to give , 500 milligrams (mg) 1 tablet by one time a day for a , ( ) for 5 days. Review of resident #53's medical record revealed an order dated for , (an) 500 mg, one tablet to be taken by twice daily for a for seven days. The facility's medication administration record indicated this medication was administered starting and the Order Listing Report for to indicated the course of was completed. Review of resident #87's medical record revealed an order dated for (also known -an) 500 mg by	F 881	of correction is prepared and/or executed solely because it is required. (a) Immediate action(s) taken for the resident(s) found to have been affected include: The Preventionist conducted an audit of all residents currently receiving to ensure appropriate indications, duration, and monitoring. The facility notified prescribing providers to ensure compliance with stewardship guidelines and discontinued or adjusted any orders that did not meet clinical necessity. (b) Identification of other residents having the potential to be affected was accomplished by: All Residents receiving have the potential to be affected. (c) Actions taken/systems put into place to reduce the risk of future occurrence include: Starting on all Nursing staff (RNs and LPNs) will receive education by the Preventionist on stewardship, including appropriate specimen collection, early signs of , and the risks of overuse. All Nursing staff (RNs and LPNs) will be in-service by . Any Nursing staff (RNs and LPNs) not in-serviced by this date will be in-serviced prior to their next scheduled shift. We have no Agency staff currently. All newly hired Nursing staff (RNs and LPNs) will be in-service by the ADON during their orientation.	

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F 881	Continued From page 69 two times a day for , , for seven days. The facility's medication administration record indicated that this medication was administered starting and the Order Listing Report for to indicated it was completed. Review of resident #20's medical record revealed on hospital discharge orders for (an) 500 mg one dose in morning and one dose before bedtime for all 10 doses. This discharge summary dated indicated it was prescribed related to a . The facility's medication administration record revealed the (also known as -an) 500 mg one dose in the morning and one at bedtime for 10 doses were given to . On at 12:13 PM, the Assistant Director of Nursing (ADON)/ Preventionist (IP) said she did not do a look between months to analyze if residents have repeated . She also said she had not assessed residents' use regarding if there were physician trends in prescribing. On at 1:15 PM, the ADON/IP stated she usually reviewed , labs ordered by physicians to analyze if culture and sensitivities had been included in the order because such an additional test would reveal if the ordered was appropriate treatment for the organism identified. She confirmed she overlooked resident #99's , which did not include a , analysis. She verified that resident #99 was prescribed and received an course after the , dated results were	F 881	The Preventionist was educated by the Regional Nurse on regarding Stewardship and Control Policy (c) How the corrective action(s) will be monitored to ensure the practice will not recur; The Preventionist will conduct audits of all new orders for compliance with stewardship protocols 5 days per week for 2 weeks then at least 5 weekly for two months, and monthly thereafter. Findings will be reported during the monthly QAPI meetings, and corrective actions will be implemented as needed. Compliance with the Stewardship Program will be reviewed during the facility's annual control risk assessment.	

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F 881	Continued From page 70 reported. On at 2:55 PM, the ADON/IP stated that when a resident started receiving an the resident should appear on that month's Control Report which she said she submitted monthly during the facility's Quality Assurance meeting which included participation of the facility's Medical Director. She reviewed the Control Report dated to and compared it to the Order Listing Report with classes for to . The IP verified that residents #99, #53, #87, and #20 were not a part of the Control Report dated to and they should have been. Review of the facility's surveillance policy with a date reviewed/revised of indicated all residents and their would be tracked. Review of the facility's stewardship commitment statement dated and signed by the Administrator, Director of Nursing (DON), Medical Director, IP, and consultant pharmacist stated that they would collaborate with prescribers, nurses, and the consultant pharmacist to create a system that monitored and shared reports regarding use in the facility.	F 881		