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
	35961040	A. BUILDING: _____ B. WING _____	C 02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY HEALTH AND REHABILITATION CENTER	724 NW 19TH ST MIAMI, FL 33136

(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 A unannounced compliant survey 2025001429 was conducted at University Healthcare and Rehabilitation Center on , . Two allegations were substantiated with deficiency. The facility had deficiencies at the time of the survey. The following is a description of the non-compliance:	N 000		
N 110 SS=D	400.141(1)(h) FS; 59A-4.122(1) FAC Physical Environment - Safe, Clean, Homelike 400.141(1)(h) FS Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner. 59A-4.122(1) FAC The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible This Statute or Rule is not met as evidenced by: Based on interviews and record reviews, the facility's staff failed to operate equipment in a safe manner to ensure one resident (Resident #1) out of four sampled residents received adequate supervision to prevent accidents as evidenced by during transfer, Resident #1 sustained injuries that were not reported immediately by staff and were discovered by a family member. The findings included:	N 110	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the terms or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by provisions of the Federal and State laws. IMMEDIATE CORRECTIVE ACTION: Staff A was counseled by Director of	

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N 110	Continued From page 1 On at 8:15 AM Resident#1 was observed in bed with open repeating the word "NO" when greeted, a small discoloration was noted under the right , a scratch was noted on the right and a small scratch on the left . Record review of a demographic sheet for Resident#1 revealed an initial admission date of and readmission date of with diagnosis that included: and Unspecified . Record review of an Annual Minimum Data Set reference dated revealed Resident#1 is moderately , , required substantial/maximal assistance for chair/bed-to-chair transfer and had no since admission/entry or reentry or the prior assessment. Further review of a care plan initiated on and revised on revealed Resident#1 is at risk for related to , , mobility and had a that occurred on , had goals to have no episodes of and suffer no injuries from . The interventions included: Encourage resident to ask for assistance when attempting to transfer. Review of a physician's order sheet revealed orders dated for precaution every shift and order dated for bed in lowest position every day and night shift. Review of progress notes revealed no documentation related to the incident that occurred during the resident's transfer. Record review of a Risk Assessment dated revealed Resident#1 was at a low risk for	N 110	Nursing and competency was completed regarding safe patient transfers on . Resident #1 did not have any negative outcomes related to the alleged deficient practice. Nursing staff was in-serviced by the Director of , with competency completed on safe resident transfers on and . IDENTIFICATION OF OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED: Any resident requiring assistance with transfers have the potential to be affected by the alleged deficient practice. A facility wide audit was conducted on to identify any residents needing assistance with transfer to ensure that staff are aware and that facility policy is being followed. SYSTEMATIC CHANGES: The Assistant Director of Nursing conducted ongoing in-services with nursing staff regarding safe transfers and proper notification of resident's representative and physician. Nursing staff was in-serviced by the Director of , with competency completed on safe resident transfers on and . MONITORING: The Director of Nursing/Designee will conduct weekly random observation and competency checks with nursing staff x	

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N 110	Continued From page 2 Review of a skin check dated revealed Resident #1's skin was intact with no redness or noted. On at 11:35 AM, the Director of Nursing (DON) stated, "After witnessing or discovering that a resident had a or injury of unknown origin, the protocol is for the staff to report to the doctor and family, we do an incident report and staff should document. Staff monitor residents to prevent depending on their risk for example by taking residents to activities. [Resident#1] hit her on the arm rest of the wheelchair during transfer because the Certified Nursing Assistant was not looking or holding the resident for a moment. [Resident #1] was listed on the Incident Log for after The CNA reported to us on that the resident hit her on the wheelchair during transfer. When an incident report is completed, it triggers for other assessments. The Skin check is dated because the incident happened on that date, but I completed the Skin check for the Resident on " Record review of a policy titled, "Safety and Supervision of Residents" (Revised , Reviewed ,) Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation. Systems Approach to Safety: 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined	N 110	four weeks, then monthly random observation and competency checks x 3 months to ensure nursing staff are transferring residents safely according to facility policy and procedures. The Director of Nursing/Designee will report findings to the Quality Assurance committee monthly for 3 months to ensure substantial compliance is achieved and maintained.	

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N 110	Continued From page 3 by the individual resident's assessed needs and identified hazards in the environment. Interview with the Director of Nursing/ Coordinator/Risk Manager on at 11:25 AM. He stated, "She did not have a . She hit her with the wheelchair. The CNA was trying to transfer her from the bed to the wheelchair. She pulled the wheelchair closer to the bed and she let the resident go while she was sitting on the edge of the bed. The did not come right away. At the moment, she didn't have a . The incident was on , the were noticed on . When the incident happened, she didn't have any , the were noted on . The family came and saw the patient and asked the nurse and she hadn't noticed the . The CNA did not notify the facility about the incident on and she was supposed to. She was reprimanded for not telling anyone about the incident. She did not have a . She hit her on the handrest of the wheelchair. We did an incident report. The doctor was notified, an order was given for of the and . There were no ." Interview with Staff A, CNA on at 12:52 PM via Spanish translator. She revealed on , she bathed the resident, dressed her and she was going to transfer her to the wheelchair. She had her on the edge of the bed, she held her with one and held the	N 110		

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N 110	Continued From page 4	N 110		

wheelchair with the other. The resident lost control of her body and leaned forward, and she bumped her on the wheelchair handrest. The correct way to transfer a resident from the bed to the wheelchair is that you grab the resident, have them stand and then turn them. She confirmed that the wheelchair was not positioned before transferring the resident. She checked her and she didn't see anything and didn't think she had to report it. She was supposed to report the incident to the nurse but did not."

Interview with Staff B, Registered Nurse (RN) on at 1:19 PM. She stated, "I work from 7:00 AM to 7:00 PM and during the day skilled nursing was done. The resident had no complaints of , . After dinner, the daughter visited and asked me about something on her . Throughout the day I never saw anything on her . When I looked on the left side of her under the hair, I saw the . I did not see any on her . I made an assessment to . . . Her vital signs were stable and no complaint of , . I called the DON/ Coordinator and reported the on . I called the doctor, and he gave an order for an . The , was negative. I endorsed it to the night shift for checks. The CNA is supposed to tell the nurse when something happens and if they hit their ."

Record review of the Accidents and Incidents-Investigating and Reporting Policy and Procedure (revision date , reviewed); Policy Statement-All accidents or incidents involving residents, employees, visitors, vendors, occurring on our premises shall be investigated and reported to the administrator; Policy Interpretation -2h) The date/time the

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N 110	Continued From page 5 injured person's family was notified and by whom. Class III	N 110		
N 199 SS=D	400.022(1)(j), FS Right to be Informed of Medical Condition (j) The right to be adequately informed of his or her medical condition and proposed treatment, unless the resident is determined to be unable to provide informed consent under Florida law, or the right to be fully informed in advance of any nonemergency changes in care or treatment that may affect the resident's well-being; and, except with respect to a resident adjudged , , the right to participate in the planning of all medical treatment, including the right to refuse medication and treatment, unless otherwise indicated by the resident's physician; and to know the consequences of such actions. This Statute or Rule is not met as evidenced by: Based on records reviewed and interviews the facility failed to immediately inform the resident's representative and physician about an accident that resulted in an injury which required medical attention for one resident (Resident #1) out of four sampled residents, as evidenced by during assisted transfer Resident#1 hit her on the wheelchair and the incident went unreported after was identified and reported the family member to staff. There were 143 residents residing in the facility at the time of the survey. The findings included: On at 8:15 AM Resident#1 was observed	N 199	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the terms or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by provisions of the Federal and State laws. IMMEDIATE CORRECTIVE ACTION: Staff A was counseled by Director of Nursing and competency was completed regarding safe patient transfers and reporting of incidents on .	

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N 199	Continued From page 6 in bed with , open repeating the word "NO" when greeted, a small discoloration was noted under the right , a scratch was noted on the right and a small scratch on the left . Record review of a demographic sheet for Resident#1 revealed an initial admission date of and readmission date of with diagnosis that included: and Unspecified . Record review of an Annual Minimum Data Set reference dated revealed Resident#1 is moderately , , required substantial/maximal assistance for chair/bed-to-chair transfer and had no since admission/entry or reentry or the prior assessment. Further review of a care plan initiated on and revised on revealed Resident#1 is at risk for related to , , mobility and had a that occurred on , had goals to have no episodes of and suffer no injuries from . The interventions included: Encourage resident to ask for assistance when attempting to transfer. Review of a physician's order sheet revealed orders dated for precaution every shift and order dated for bed in lowest position every day and night shift. Review of progress notes revealed no documentation related to the incident that occurred during the resident's transfer. Record review of a Risk Assessment dated revealed Resident#1 was at a low risk for .	N 199	Resident #1 did not have any negative outcomes related to the alleged deficient practice. Staff B received 1:1 education from the Director of Nursing regarding proper notification of changes in condition to physician and resident's representative according to facility policy on . Nursing staff was in-serviced by the Director of Nursing regarding proper notification of changes in condition to physician and resident's representative according to facility policy on . IDENTIFICATION OF OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED: Any resident in the facility have the potential to be affected by the alleged deficient practice. A facility wide audit was conducted on to identify any residents with change in condition without proper notification of physician and resident's representative. No issues were identified. SYSTEMATIC CHANGES: The Assistant Director of Nursing conducted ongoing in-services with nursing staff regarding safe transfers and proper notification of resident's representative and physician. The Director of Nursing/Designee will review all new incidents/changes in	

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N 199	Continued From page 7 Review of a skin check dated revealed Resident #1's skin was intact with no redness or noted. On at 11:35 AM, the Director of Nursing (DON) stated, "After witnessing or discovering that a resident had a or injury of unknown origin, the protocol is for the staff to report to the doctor and family, we do an incident report and staff should document. Staff monitor residents to prevent depending on their risk for example by taking residents to activities. [Resident#1] hit her on the arm rest of the wheelchair during transfer because the Certified Nursing Assistant was not looking or holding the resident for a morment. [Resident #1] was listed on the Incident Log for after The CNA reported to us on that the resident hit her on the wheelchair during transfer. When an incident report is completed, it triggers for other assessments. The Skin check is dated because the incident happened on that date, but I completed the Skin check for the Resident on ." Interview with the Director of Nursing/ Coordinator/Risk Manager on at 11:25 AM. He stated, "She did not have a . She hit her with the wheelchair. The CNA was trying to transfer her from the bed to the wheelchair. She pulled the wheelchair closer to the bed and she let the resident go while she was sitting on the edge of the bed. The did not come right away. At the moment, she didn't have a . The incident was on , the were noticed on . When the incident happened, she didn't have any , the were noted on . The family came	N 199	condition during the morning meeting to ensure proper notification of resident's representative and physician according to facility policy. MONITORING: The Director of Nursing/Designee will conduct daily rounds and chart review x 5 days, then weekly x 4 weeks, then random biweekly review, to ensure that physician and resident's representative are promptly notified of significant changes in condition. The Director of Nursing/Designee will report findings to the Quality Assurance committee monthly for 3 months to ensure substantial compliance is achieved and maintained.	

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N 199	Continued From page 8 and saw the patient and asked the nurse and she hadn't noticed the . The CNA did not notify the facility about the incident on and she was supposed to. She was reprimanded for not telling anyone about the incident. She did not have a . She hit her on the handrest of the wheelchair. We did an incident report. The doctor was notified, an order was given for of the and . There were no ." Interview with Staff A, CNA on at 12:52 PM via Spanish translator. She revealed on , she bathed the resident, dressed her and she was going to transfer her to the wheelchair. She had her on the edge of the bed, she held her with one and held the wheelchair with the other. The resident lost control of her body and leaned forward, and she bumped her on the wheelchair handrest. The correct way to transfer a resident from the bed to the wheelchair is that you grab the resident, have them stand and then turn them. She confirmed that the wheelchair was not positioned before transferring the resident. She checked her and she didn't see anything and didn't think she had to report it. She was supposed to report the incident to the nurse but did not." Interview with Staff B, Registered Nurse (RN) on at 1:19 PM. She stated, "I work from 7:00 AM to 7:00 PM and during the day skilled nursing was done. The resident had no complaints of , . After dinner, the daughter visited and asked me about something on her . Throughout the day I never saw anything on her . When I looked on the left side of her under the hair, I saw the . I did not see any on her , I made an assessment to . Her	N 199		

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N 199	Continued From page 9 vital signs were stable and no complaint of , . I called the DON/ Coordinator and reported the on . I called the doctor, and he gave an order for an , . The , was negative. I endorsed it to the night shift for checks. The CNA is supposed to tell the nurse when something happens and if they hit their ." Record review of the Accidents and Incidents-Investigating and Reporting Policy and Procedure (revision date , reviewed ,); Policy Statement-All accidents or incidents involving residents, employees, visitors, vendors, occurring on our premises shall be investigated and reported to the administrator; Policy Interpretation and Interpretation -2h) The date/time the injured person's family was notified and by whom. Class III	N 199		

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F 000	INITIAL COMMENTS An unannounced complaint survey 2025001429 was conducted on , , at University Health and Rehabilitation Center. Two allegations were substantiated with deficiencies. The facility was not in compliance with CFR 42, Part 483, Requirements for Long-Term Care Facilities. The following is a description of the non-compliance:	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-( )(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or , , status (that is, a deterioration in health, mental, or , , status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		

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 580	Continued From page 1 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. ( ) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on records reviewed and interviews the facility failed to immediately inform the resident's representative and physician about an accident that resulted in an injury which required medical attention for one resident (Resident #1) out of four sampled residents, as evidenced by during assisted transfer Resident#1 hit her on the wheelchair and the incident went unreported after was identified and reported the family member to staff. There were 143 residents residing in the facility at the time of the survey. The findings included:	F 580	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the terms or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by provisions of the Federal and State laws. IMMEDIATE CORRECTIVE ACTION: Staff A was counseled by Director of Nursing and competency was completed regarding safe patient transfers and	

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F 580	Continued From page 2 On at 8:15 AM Resident#1 was observed in bed with open repeating the word "NO" when greeted, a small discoloration was noted under the right , a scratch was noted on the right and a small scratch on the left . Record review of a demographic sheet for Resident#1 revealed an initial admission date of and readmission date of with diagnosis that included: and Unspecified . Record review of an Annual Minimum Data Set reference dated revealed Resident#1 is moderately , , required substantial/maximal assistance for chair/bed-to-chair transfer and had no since admission/entry or reentry or the prior assessment. Further review of a care plan initiated on and revised on revealed Resident#1 is at risk for related to , mobility and had a that occurred on , had goals to have no episodes of and suffer no injuries from . The interventions included: Encourage resident to ask for assistance when attempting to transfer. Review of a physician's order sheet revealed orders dated for precaution every shift and order dated for bed in lowest position every day and night shift. Review of progress notes revealed no documentation related to the incident that occurred during the resident's transfer. Record review of a Risk Assessment dated	F 580	reporting of incidents on . Resident #1 did not have any negative outcomes related to the alleged deficient practice. Staff B received 1:1 education from the Director of Nursing regarding proper notification of changes in condition to physician and resident's representative according to facility policy on . Nursing staff was in-serviced by the Director of Nursing regarding proper notification of changes in condition to physician and resident's representative according to facility policy on . IDENTIFICATION OF OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED: Any resident in the facility have the potential to be affected by the alleged deficient practice. A facility wide audit was conducted on to identify any residents with change in condition without proper notification of physician and resident's representative. No issues were identified. SYSTEMATIC CHANGES: The Assistant Director of Nursing conducted ongoing in-services with nursing staff regarding safe transfers and proper notification of resident's representative and physician. The Director of Nursing/Designee will review all new incidents/changes in	

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	106100	A. BUILDING _____ B. WING _____	C 02/17/2025

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F 580	Continued From page 3 revealed Resident#1 was at a low risk for . Review of a skin check dated revealed Resident #1's skin was intact with no redness or ,, noted. On at 11:35 AM, the Director of Nursing (DON) stated, "After witnessing or discovering that a resident had a or injury of unknown origin, the protocol is for the staff to report to the doctor and family, we do an incident report and staff should document. Staff monitor residents to prevent depending on their risk for example by taking residents to activities. [Resident#1] hit her on the arm rest of the wheelchair during transfer because the Certified Nursing Assistant was not looking or holding the resident for a moment. [Resident #1] was listed on the Incident Log for after The CNA reported to us on that the resident hit her on the wheelchair during transfer. When an incident report is completed, it triggers for other assessments. The Skin check is dated because the incident happened on that date, but I completed the Skin check for the Resident on ." Interview with the Director of Nursing/ Coordinator/Risk Manager on at 11:25 AM. He stated, "She did not have a . She hit her with the wheelchair. The CNA was trying to transfer her from the bed to the wheelchair. She pulled the wheelchair closer to the bed and she let the resident go while she was sitting on the edge of the bed. The did not come right away. At the moment, she didn't have a	F 580	condition during the morning meeting to ensure proper notification of resident's representative and physician according to facility policy. MONITORING: The Director of Nursing/Designee will conduct daily rounds and chart review x 5 days, then weekly x 4 weeks, then random biweekly review, to ensure that physician and resident's representative are promptly notified of significant changes in condition. The Director of Nursing/Designee will report findings to the Quality Assurance committee monthly for 3 months to ensure substantial compliance is achieved and maintained.	

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F 580	Continued From page 4	F 580		

. The incident was on , the were noticed on . When the incident happened, she didn't have any , the were noted on . The family came and saw the patient and asked the nurse and she hadn't noticed the . The CNA did not notify the facility about the incident on and she was supposed to. She was reprimanded for not telling anyone about the incident. She did not have a . She hit her on the handrest of the wheelchair. We did an incident report. The doctor was notified, an order was given for , of the and , . There were no

Interview with Staff A, CNA on at 12:52 PM via Spanish translator. She revealed on , she bathed the resident, dressed her and she was going to transfer her to the wheelchair. She had her on the edge of the bed, she held her with one and held the wheelchair with the other. The resident lost control of her body and leaned forward, and she bumped her on the wheelchair handrest. The correct way to transfer a resident from the bed to the wheelchair is that you grab the resident, have them stand and then turn them. She confirmed that the wheelchair was not positioned before transferring the resident. She checked her and she didn't see anything and didn't think she had to report it. She was supposed to report the incident to the nurse but did not.

Interview with Staff B, Registered Nurse (RN) on at 1:19 PM. She stated, "I work from 7:00 AM to 7:00 PM and during the day skilled nursing was done. The resident had no complaints of . . After dinner, the daughter visited and asked

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F 580	Continued From page 5 me about something on her . Throughout the day I never saw anything on her . When I looked on the left side of her under the hair, I saw the . I did not see any on her . I made an assessment to . Her vital signs were stable and no complaint of . I called the DON/ Coordinator and reported the on . I called the doctor, and he gave an order for an . The was negative. I endorsed it to the night shift for checks. The CNA is supposed to tell the nurse when something happens and if they hit their ." Record review of the Accidents and Incidents-Investigating and Reporting Policy and Procedure (revision date , reviewed); Policy Statement-All accidents or incidents involving residents, employees, visitors, vendors, occurring on our premises shall be investigated and reported to the administrator; Policy Interpretation and Interpretation -2h) The date/time the injured person's family was notified and by whom.	F 580		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the	F 689	Preparation and execution of this plan of	

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F 689	Continued From page 6	F 689		

facility failed to ensure one resident (Resident #1) out of four sampled residents received adequate supervision to prevent accidents as evidenced by during transfer, Resident #1 sustained injuries that were not reported immediately by staff and were discovered by a family member.

The findings included:

On at 8:15 AM Resident#1 was observed in bed with , open repeating the word "NO" when greeted, a small discoloration was noted under the right , , a scratch was noted on the right and a small scratch on the left .

Record review of a demographic sheet for Resident#1 revealed an initial admission date of and readmission date of with diagnosis that included: and Unspecified .

Record review of an Annual Minimum Data Set reference dated revealed Resident#1 is moderately , , , required substantial/maximal assistance for chair/bed-to-chair transfer and had no since admission/entry or reentry or the prior assessment.

Further review of a care plan initiated on and revised on revealed Resident#1 is at risk for related to , , mobility and had a that occurred on , had goals to have no episodes of and suffer no injuries from . The interventions included: Encourage resident to ask for assistance when attempting to transfer.

Review of a physician's order sheet revealed

correction does not constitute admission or agreement by the provider of the terms or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by provisions of the Federal and State laws.

IMMEDIATE CORRECTIVE ACTION:
Staff A was counseled by Director of Nursing and competency was completed regarding safe patient transfers on . Resident #1 did not have any negative outcomes related to the alleged deficient practice.

Nursing staff was in-serviced by the Director of , , with competency completed on safe resident transfers on and .

IDENTIFICATION OF OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED:

Any resident requiring assistance with transfers have the potential to be affected by the alleged deficient practice.

A facility wide audit was conducted on to identify any residents needing assistance with transfer to ensure that staff are aware and that facility policy is being followed.

SYSTEMATIC CHANGES:

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F 689	Continued From page 7 orders dated for precaution every shift and order dated for bed in lowest position every day and night shift. Review of progress notes revealed no documentation related to the incident that occurred during the resident's transfer. Record review of a Risk Assessment dated revealed Resident#1 was at a low risk for . Review of a skin check dated revealed Resident #1's skin was intact with no redness or noted. On at 11:35 AM, the Director of Nursing (DON) stated, "After witnessing or discovering that a resident had a or injury of unknown origin, the protocol is for the staff to report to the doctor and family, we do an incident report and staff should document. Staff monitor residents to prevent depending on their risk for example by taking residents to activities. [Resident#1] hit her on the arm rest of the wheelchair during transfer because the Certified Nursing Assistant was not looking or holding the resident for a moment. [Resident #1] was listed on the Incident Log for after The CNA reported to us on that the resident hit her on the wheelchair during transfer. When an incident report is completed, it triggers for other assessments. The Skin check is dated because the incident happened on that date, but I completed the Skin check for the Resident on ." F 689 The Assistant Director of Nursing conducted ongoing in-services with nursing staff regarding safe transfers and proper notification of resident's representative and physician. Nursing staff was in-serviced by the Director of , , with competency completed on safe resident transfers on and . MONITORING: The Director of Nursing/Designee will conduct weekly random observation and competency checks with nursing staff x four weeks. then monthly random observation and competency checks x 3 months to ensure nursing staff are transferring residents safely according to facility policy and procedures. The Director of Nursing/Designee will report findings to the Quality Assurance committee monthly for 3 months to ensure substantial compliance is achieved and maintained.			

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F 689	Continued From page 8	F 689		

Interview with the Director of Nursing/ Coordinator/Risk Manager on at 11:25 AM. He stated, "She did not have a . She hit her with the wheelchair. The CNA was trying to transfer her from the bed to the wheelchair. She pulled the wheelchair closer to the bed and she let the resident go while she was sitting on the edge of the bed. The did not come right away. At the moment, she didn't have a . The incident was on , the were noticed on . When the incident happened, she didn't have any , the were noted on . The family came and saw the patient and asked the nurse and she hadn't noticed the . The CNA did not notify the facility about the incident on and she was supposed to. She was reprimanded for not telling anyone about the incident. She did not have a . She hit her on the handrest of the wheelchair. We did an incident report. The doctor was notified, an order was given for of the and . There were no ."

Interview with Staff A, CNA on at 12:52 PM via Spanish translator. She revealed on , she bathed the resident, dressed her and she was going to transfer her to the wheelchair. She had her on the edge of the bed, she held her with one and held the wheelchair with the other. The resident lost control of her body and leaned forward, and she bumped her on the wheelchair handrest. The correct way to transfer a resident from the bed to the wheelchair is that you grab the resident, have them stand and then turn them. She confirmed that the wheelchair was not positioned before transferring the resident. She

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F 689	Continued From page 9	F 689		

checked her and she didn't see anything and didn't think she had to report it. She was supposed to report the incident to the nurse but did not."

Interview with Staff B, Registered Nurse (RN) on at 1:19 PM. She stated, "I work from 7:00 AM to 7:00 PM and during the day skilled nursing was done. The resident had no complaints of . After dinner, the daughter visited and asked me about something on her . Throughout the day I never saw anything on her . When I looked on the left side of her under the hair, I saw the . I did not see any on her . I made an assessment to . Her vital signs were stable and no complaint of . I called the DON/ Coordinator and reported the on . I called the doctor, and he gave an order for an . The was negative. I endorsed it to the night shift for checks. The CNA is supposed to tell the nurse when something happens and if they hit their ."

Record review of the Accidents and Incidents-Investigating and Reporting Policy and Procedure (revision date , reviewed); Policy Statement-All accidents or incidents involving residents, employees, visitors, vendors, occurring on our premises shall be investigated and reported to the administrator; Policy Interpretation -2h) The date/time the injured person's family was notified and by whom.

Agency for Health Care Administration

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N 000	INITIAL COMMENTS A unannounced compliant survey 2025001429 was conducted at University Healthcare and Rehabilitation Center on , . Two allegations were substantiated with deficiency. The facility had deficiencies at the time of the survey. The following is a description of the non-compliance:	N 000		
N 110 SS=D	400.141(1)(h) FS; 59A-4.122(1) FAC Physical Environment - Safe, Clean, Homelike 400.141(1)(h) FS Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner. 59A-4.122(1) FAC The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible This Statute or Rule is not met as evidenced by: Based on interviews and record reviews, the facility's staff failed to operate equipment in a safe manner to ensure one resident (Resident #1) out of four sampled residents received adequate supervision to prevent accidents as evidenced by during transfer, Resident #1 sustained injuries that were not reported immediately by staff and were discovered by a family member. The findings included:	N 110		

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N 110	Continued From page 1 On at 8:15 AM Resident#1 was observed in bed with , open repeating the word "NO" when greeted, a small discoloration was noted under the right , a scratch was noted on the right and a small scratch on the left . Record review of a demographic sheet for Resident#1 revealed an initial admission date of and readmission date of with diagnosis that included: and Unspecified . Record review of an Annual Minimum Data Set reference dated revealed Resident#1 is moderately , , required substantial/maximal assistance for chair/bed-to-chair transfer and had no since admission/entry or reentry or the prior assessment. Further review of a care plan initiated on and revised on revealed Resident#1 is at risk for related to , , mobility and had a that occurred on , had goals to have no episodes of and suffer no injuries from . The interventions included: Encourage resident to ask for assistance when attempting to transfer. Review of a physician's order sheet revealed orders dated for precaution every shift and order dated for bed in lowest position every day and night shift. Review of progress notes revealed no documentation related to the incident that occurred during the resident's transfer. Record review of a Risk Assessment dated revealed Resident#1 was at a low risk for	N 110		

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N 110	Continued From page 2 Review of a skin check dated revealed Resident #1's skin was intact with no redness or noted. On at 11:35 AM, the Director of Nursing (DON) stated, "After witnessing or discovering that a resident had a or injury of unknown origin, the protocol is for the staff to report to the doctor and family, we do an incident report and staff should document. Staff monitor residents to prevent depending on their risk for example by taking residents to activities. [Resident#1] hit her on the arm rest of the wheelchair during transfer because the Certified Nursing Assistant was not looking or holding the resident for a moment. [Resident #1] was listed on the Incident Log for after The CNA reported to us on that the resident hit her on the wheelchair during transfer. When an incident report is completed, it triggers for other assessments. The Skin check is dated because the incident happened on that date, but I completed the Skin check for the Resident on ." Record review of a policy titled, "Safety and Supervision of Residents" (Revised , Reviewed) Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation. Systems Approach to Safety: 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined	N 110		

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N 110	Continued From page 3 by the individual resident's assessed needs and identified hazards in the environment. Interview with the Director of Nursing/ Coordinator/Risk Manager on at 11:25 AM. He stated, "She did not have a . She hit her with the wheelchair. The CNA was trying to transfer her from the bed to the wheelchair. She pulled the wheelchair closer to the bed and she let the resident go while she was sitting on the edge of the bed. The did not come right away. At the moment, she didn't have a . The incident was on , the were noticed on . When the incident happened, she didn't have any , the were noted on . The family came and saw the patient and asked the nurse and she hadn't noticed the . The CNA did not notify the facility about the incident on and she was supposed to. She was reprimanded for not telling anyone about the incident. She did not have a . She hit her on the handrest of the wheelchair. We did an incident report. The doctor was notified, an order was given for of the and . There were no ." Interview with Staff A, CNA on at 12:52 PM via Spanish translator. She revealed on , she bathed the resident, dressed her and she was going to transfer her to the wheelchair. She had her on the edge of the bed, she held her with one and held the	N 110		

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N 110	Continued From page 4	N 110		

wheelchair with the other. The resident lost control of her body and leaned forward, and she bumped her on the wheelchair handrest. The correct way to transfer a resident from the bed to the wheelchair is that you grab the resident, have them stand and then turn them. She confirmed that the wheelchair was not positioned before transferring the resident. She checked her and she didn't see anything and didn't think she had to report it. She was supposed to report the incident to the nurse but did not."

Interview with Staff B, Registered Nurse (RN) on at 1:19 PM. She stated, "I work from 7:00 AM to 7:00 PM and during the day skilled nursing was done. The resident had no complaints of , . After dinner, the daughter visited and asked me about something on her . Throughout the day I never saw anything on her . When I looked on the left side of her under the hair, I saw the . I did not see any on her . I made an assessment to . . . Her vital signs were stable and no complaint of , . I called the DON/ Coordinator and reported the on . I called the doctor, and he gave an order for an . The , was negative. I endorsed it to the night shift for checks. The CNA is supposed to tell the nurse when something happens and if they hit their ."

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N 110	Continued From page 5 injured person's family was notified and by whom. Class III	N 110		
N 199 SS=D	400.022(1)(j), FS Right to be Informed of Medical Condition (j) The right to be adequately informed of his or her medical condition and proposed treatment, unless the resident is determined to be unable to provide informed consent under Florida law, or the right to be fully informed in advance of any nonemergency changes in care or treatment that may affect the resident's well-being; and, except with respect to a resident adjudged , , the right to participate in the planning of all medical treatment, including the right to refuse medication and treatment, unless otherwise indicated by the resident's physician; and to know the consequences of such actions. This Statute or Rule is not met as evidenced by: Based on records reviewed and interviews the facility failed to immediately inform the resident's representative and physician about an accident that resulted in an injury which required medical attention for one resident (Resident #1) out of four sampled residents, as evidenced by during assisted transfer Resident#1 hit her on the wheelchair and the incident went unreported after was identified and reported the family member to staff. There were 143 residents residing in the facility at the time of the survey. The findings included: On at 8:15 AM Resident#1 was observed	N 199		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35961040	A. BUILDING: _____ B. WING _____	C 02/17/2025

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N 199	Continued From page 6 in bed with , open repeating the word "NO" when greeted, a small discoloration was noted under the right , a scratch was noted on the right and a small scratch on the left . Record review of a demographic sheet for Resident#1 revealed an initial admission date of and readmission date of with diagnosis that included: and Unspecified . Record review of an Annual Minimum Data Set reference dated revealed Resident#1 is moderately , , required substantial/maximal assistance for chair/bed-to-chair transfer and had no since admission/entry or reentry or the prior assessment. Further review of a care plan initiated on and revised on revealed Resident#1 is at risk for related to , , mobility and had a that occurred on , had goals to have no episodes of and suffer no injuries from . The interventions included: Encourage resident to ask for assistance when attempting to transfer. Review of a physician's order sheet revealed orders dated for precaution every shift and order dated for bed in lowest position every day and night shift. Review of progress notes revealed no documentation related to the incident that occurred during the resident's transfer. Record review of a Risk Assessment dated revealed Resident#1 was at a low risk for .	N 199		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 199	Continued From page 7 Review of a skin check dated revealed Resident #1's skin was intact with no redness or noted. On at 11:35 AM, the Director of Nursing (DON) stated, "After witnessing or discovering that a resident had a or injury of unknown origin, the protocol is for the staff to report to the doctor and family, we do an incident report and staff should document. Staff monitor residents to prevent depending on their risk for example by taking residents to activities. [Resident#1] hit her on the arm rest of the wheelchair during transfer because the Certified Nursing Assistant was not looking or holding the resident for a morment. [Resident #1] was listed on the Incident Log for after The CNA reported to us on that the resident hit her on the wheelchair during transfer. When an incident report is completed, it triggers for other assessments. The Skin check is dated because the incident happened on that date, but I completed the Skin check for the Resident on ." Interview with the Director of Nursing/ Coordinator/Risk Manager on at 11:25 AM. He stated, "She did not have a . She hit her with the wheelchair. The CNA was trying to transfer her from the bed to the wheelchair. She pulled the wheelchair closer to the bed and she let the resident go while she was sitting on the edge of the bed. The did not come right away. At the moment, she didn't have a . The incident was on , the were noticed on . When the incident happened, she didn't have any , the were noted on . The family came	N 199		

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N 199	Continued From page 8 and saw the patient and asked the nurse and she hadn't noticed the . The CNA did not notify the facility about the incident on and she was supposed to. She was reprimanded for not telling anyone about the incident. She did not have a . She hit her on the handrest of the wheelchair. We did an incident report. The doctor was notified, an order was given for of the and . There were no ." Interview with Staff A, CNA on at 12:52 PM via Spanish translator. She revealed on , she bathed the resident, dressed her and she was going to transfer her to the wheelchair. She had her on the edge of the bed, she held her with one and held the wheelchair with the other. The resident lost control of her body and leaned forward, and she bumped her on the wheelchair handrest. The correct way to transfer a resident from the bed to the wheelchair is that you grab the resident, have them stand and then turn them. She confirmed that the wheelchair was not positioned before transferring the resident. She checked her and she didn't see anything and didn't think she had to report it. She was supposed to report the incident to the nurse but did not." Interview with Staff B, Registered Nurse (RN) on at 1:19 PM. She stated, "I work from 7:00 AM to 7:00 PM and during the day skilled nursing was done. The resident had no complaints of , . After dinner, the daughter visited and asked me about something on her . Throughout the day I never saw anything on her . When I looked on the left side of her under the hair, I saw the . I did not see any on her , I made an assessment to . Her	N 199		

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N 199	Continued From page 9 vital signs were stable and no complaint of , . I called the DON/ Coordinator and reported the on . I called the doctor, and he gave an order for an , . The , was negative. I endorsed it to the night shift for checks. The CNA is supposed to tell the nurse when something happens and if they hit their ." Record review of the Accidents and Incidents-Investigating and Reporting Policy and Procedure (revision date , reviewed ,); Policy Statement-All accidents or incidents involving residents, employees, visitors, vendors, occurring on our premises shall be investigated and reported to the administrator; Policy Interpretation and Interpretation -2h) The date/time the injured person's family was notified and by whom. Class III	N 199		

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F 000	INITIAL COMMENTS An unannounced complaint survey 2025001429 was conducted on , , at University Health and Rehabilitation Center. Two allegations were substantiated with deficiencies. The facility was not in compliance with CFR 42, Part 483, Requirements for Long-Term Care Facilities. The following is a description of the non-compliance:	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-( )(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or , , status (that is, a deterioration in health, mental, or , , status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		

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 580	Continued From page 1	F 580		

physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
( ) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on records reviewed and interviews the facility failed to immediately inform the resident's representative and physician about an accident that resulted in an injury which required medical attention for one resident (Resident #1) out of four sampled residents, as evidenced by during assisted transfer Resident#1 hit her on the wheelchair and the incident went unreported after was identified and reported the family member to staff. There were 143 residents residing in the facility at the time of the survey.

The findings included:

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F 580	Continued From page 2	F 580		

On at 8:15 AM Resident#1 was observed in bed with , open repeating the word "NO" when greeted, a small discoloration was noted under the right , a scratch was noted on the right and a small scratch on the left .

Record review of a demographic sheet for Resident#1 revealed an initial admission date of and readmission date of with diagnosis that included: and Unspecified .

Record review of an Annual Minimum Data Set reference dated revealed Resident#1 is moderately , , required substantial/maximal assistance for chair/bed-to-chair transfer and had no since admission/entry or reentry or the prior assessment.

Further review of a care plan initiated on and revised on revealed Resident#1 is at risk for related to , , mobility and had a that occurred on , had goals to have no episodes of and suffer no injuries from . The interventions included: Encourage resident to ask for assistance when attempting to transfer.

Review of a physician's order sheet revealed orders dated for precaution every shift and order dated for bed in lowest position every day and night shift.

Review of progress notes revealed no documentation related to the incident that occurred during the resident's transfer.

Record review of a Risk Assessment dated

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F 580	Continued From page 3 revealed Resident#1 was at a low risk for . Review of a skin check dated revealed Resident #1's skin was intact with no redness or ,, noted. On at 11:35 AM, the Director of Nursing (DON) stated, "After witnessing or discovering that a resident had a or injury of unknown origin, the protocol is for the staff to report to the doctor and family, we do an incident report and staff should document. Staff monitor residents to prevent depending on their risk for example by taking residents to activities. [Resident#1] hit her on the arm rest of the wheelchair during transfer because the Certified Nursing Assistant was not looking or holding the resident for a moment. [Resident #1] was listed on the Incident Log for after The CNA reported to us on that the resident hit her on the wheelchair during transfer. When an incident report is completed, it triggers for other assessments. The Skin check is dated because the incident happened on that date, but I completed the Skin check for the Resident on ." Interview with the Director of Nursing/ Coordinator/Risk Manager on at 11:25 AM. He stated, "She did not have a . She hit her with the wheelchair. The CNA was trying to transfer her from the bed to the wheelchair. She pulled the wheelchair closer to the bed and she let the resident go while she was sitting on the edge of the bed. The did not come right away. At the moment, she didn't have a	F 580		

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F 580	Continued From page 4	F 580		

. The incident was on , the were noticed on . When the incident happened, she didn't have any , the were noted on . The family came and saw the patient and asked the nurse and she hadn't noticed the . The CNA did not notify the facility about the incident on and she was supposed to. She was reprimanded for not telling anyone about the incident. She did not have a . She hit her on the handrest of the wheelchair. We did an incident report. The doctor was notified, an order was given for , of the and , . There were no

Interview with Staff A, CNA on at 12:52 PM via Spanish translator. She revealed on , she bathed the resident, dressed her and she was going to transfer her to the wheelchair. She had her on the edge of the bed, she held her with one and held the wheelchair with the other. The resident lost control of her body and leaned forward, and she bumped her on the wheelchair handrest. The correct way to transfer a resident from the bed to the wheelchair is that you grab the resident, have them stand and then turn them. She confirmed that the wheelchair was not positioned before transferring the resident. She checked her and she didn't see anything and didn't think she had to report it. She was supposed to report the incident to the nurse but did not.

Interview with Staff B, Registered Nurse (RN) on at 1:19 PM. She stated, "I work from 7:00 AM to 7:00 PM and during the day skilled nursing was done. The resident had no complaints of . . After dinner, the daughter visited and asked

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F 580	Continued From page 5 me about something on her . Throughout the day I never saw anything on her . When I looked on the left side of her under the hair, I saw the . I did not see any on her . I made an assessment to . Her vital signs were stable and no complaint of . I called the DON/ Coordinator and reported the on . I called the doctor, and he gave an order for an . The was negative. I endorsed it to the night shift for checks. The CNA is supposed to tell the nurse when something happens and if they hit their ." Record review of the Accidents and Incidents-Investigating and Reporting Policy and Procedure (revision date , reviewed); Policy Statement-All accidents or incidents involving residents, employees, visitors, vendors, occurring on our premises shall be investigated and reported to the administrator; Policy Interpretation and Interpretation -2h) The date/time the injured person's family was notified and by whom.	F 580		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the	F 689		

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F 689	Continued From page 6	F 689		

facility failed to ensure one resident (Resident #1) out of four sampled residents received adequate supervision to prevent accidents as evidenced by during transfer, Resident #1 sustained injuries that were not reported immediately by staff and were discovered by a family member.

The findings included:

On at 8:15 AM Resident#1 was observed in bed with , open repeating the word "NO" when greeted, a small discoloration was noted under the right , a scratch was noted on the right and a small scratch on the left .

Record review of a demographic sheet for Resident#1 revealed an initial admission date of and readmission date of with diagnosis that included: and Unspecified .

Record review of an Annual Minimum Data Set reference dated revealed Resident#1 is moderately , , required substantial/maximal assistance for chair/bed-to-chair transfer and had no since admission/entry or reentry or the prior assessment.

Further review of a care plan initiated on and revised on revealed Resident#1 is at risk for related to , , mobility and had a that occurred on , had goals to have no episodes of and suffer no injuries from . The interventions included: Encourage resident to ask for assistance when attempting to transfer.

Review of a physician's order sheet revealed

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F 689	Continued From page 7 orders dated for precaution every shift and order dated for bed in lowest position every day and night shift. Review of progress notes revealed no documentation related to the incident that occurred during the resident's transfer. Record review of a Risk Assessment dated revealed Resident#1 was at a low risk for . Review of a skin check dated revealed Resident #1's skin was intact with no redness or noted. On at 11:35 AM, the Director of Nursing (DON) stated, "After witnessing or discovering that a resident had a or injury of unknown origin, the protocol is for the staff to report to the doctor and family, we do an incident report and staff should document. Staff monitor residents to prevent depending on their risk for example by taking residents to activities. [Resident#1] hit her on the arm rest of the wheelchair during transfer because the Certified Nursing Assistant was not looking or holding the resident for a moment. [Resident #1] was listed on the Incident Log for after The CNA reported to us on that the resident hit her on the wheelchair during transfer. When an incident report is completed, it triggers for other assessments. The Skin check is dated because the incident happened on that date, but I completed the Skin check for the Resident on ." F 689		

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F 689	Continued From page 8	F 689		

Interview with the Director of Nursing/ Coordinator/Risk Manager on at 11:25 AM. He stated, "She did not have a . She hit her with the wheelchair. The CNA was trying to transfer her from the bed to the wheelchair. She pulled the wheelchair closer to the bed and she let the resident go while she was sitting on the edge of the bed. The did not come right away. At the moment, she didn't have a . The incident was on , the were noticed on . When the incident happened, she didn't have any , the were noted on . The family came and saw the patient and asked the nurse and she hadn't noticed the . The CNA did not notify the facility about the incident on and she was supposed to. She was reprimanded for not telling anyone about the incident. She did not have a . She hit her on the handrest of the wheelchair. We did an incident report. The doctor was notified, an order was given for of the and . There were no ."

Interview with Staff A, CNA on at 12:52 PM via Spanish translator. She revealed on , she bathed the resident, dressed her and she was going to transfer her to the wheelchair. She had her on the edge of the bed, she held her with one and held the wheelchair with the other. The resident lost control of her body and leaned forward, and she bumped her on the wheelchair handrest. The correct way to transfer a resident from the bed to the wheelchair is that you grab the resident, have them stand and then turn them. She confirmed that the wheelchair was not positioned before transferring the resident. She

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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checked her and she didn't see anything and didn't think she had to report it. She was supposed to report the incident to the nurse but did not."

Interview with Staff B, Registered Nurse (RN) on at 1:19 PM. She stated, "I work from 7:00 AM to 7:00 PM and during the day skilled nursing was done. The resident had no complaints of . After dinner, the daughter visited and asked me about something on her . Throughout the day I never saw anything on her . When I looked on the left side of her under the hair, I saw the . I did not see any on her . I made an assessment to . Her vital signs were stable and no complaint of . I called the DON/ Coordinator and reported the on . I called the doctor, and he gave an order for an . The was negative. I endorsed it to the night shift for checks. The CNA is supposed to tell the nurse when something happens and if they hit their ."

Record review of the Accidents and Incidents-Investigating and Reporting Policy and Procedure (revision date , reviewed); Policy Statement-All accidents or incidents involving residents, employees, visitors, vendors, occurring on our premises shall be investigated and reported to the administrator; Policy Interpretation -2h) The date/time the injured person's family was notified and by whom.