

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER BLUE HERON HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 5085 EAGLESTON BLVD , WESLEY CHAPEL, Florida, 33544	
(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
N0000	INITIAL COMMENTS An re-licensure survey in conjunction with a complaint survey for complaint #2025008860 was conducted at Blue Heron Health and Rehabilitation on 7/28/2025 through 7/31/2025. Deficiencies were identified at the time of survey.	N0000		08/31/2025
N0072 SS = D	Comprehensive Care Plans CFR(s): 59A-4.109(2), FAC; 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 psychosocial 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews, observations, and record review the facility failed to implement a plan of care for a resident at risk for dehydration for one resident (#58) of one resident reviewed. Findings included: On 07/29/25 at 09:40 AM an observation revealed Resident #58 lying in bed, eyes closed and did not respond to verbal or tactile stimuli. There was no hydration or fluids observed at bedside. During an observation on 07/29/25 at 03:00 PM, Resident #58 was observed lying in bed. There was no hydration cup or fluids at bedside. On 7/29/2025 at 3:45 PM an interview was conducted with	N0072	1) Resident #58's plan of care updated to reflect at risk for dehydration on 8/5/2025 with appropriate interventions. 2) An audit of current residents' quarterly hydration risk evaluation was conducted on 08/20/2025 by Director of Nursing, Nurse Management team, or designee to verify residents to be at risk for dehydration. Care plan reviews with intervention updated to include providing necessary assistance, encouragement and offering of fluids throughout shift, as clinically indicated. 3) An in-service education was conducted on 08/19/2025 by the Administrator, Director of Nursing, or designee with all licensed/registered nurses addressing the significance of hydration risk evaluation completed on admission, quarterly, and/or significant change, and the implementation of a plan of care for a resident at risk for dehydration. 4) The nursing management team, Registered Dietitian, and/or Dietary Manager will review each resident with risk factors for dehydration to ensure appropriate interventions are implemented and an updated plan of care is complete. The Director of Nursing (DON), or designee, will complete five (5) random weekly chart audits for six (6) consecutive weeks to review quarterly hydration risk evaluations and verify that appropriate interventions have been put in place to reduce the risk of dehydration. Audits will assure that care plans remain updated to reflect these interventions.	08/31/2025

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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N0072 SS = D	<p>Continued from page 1</p> <p>Resident #58's family member who stated Resident #58 needed extra care and could not get a drink of water on their own. The family member stated staff should check on the resident more frequently than they do and offer fluids.</p> <p>During an observation on 07/30/2025 at 9:07 AM, at 12:00 PM and at 4:10 PM, Resident #58 was observed in room. A water cup was observed on the bedside table dated 7/30/25, 11 a.m.-7 p.m. shift, at 04:14 AM. The cup was observed full of ice water.</p> <p>On 07/31/25 at 08:35 AM Resident #58 was observed sitting up in a reclining wheelchair, eyes opened, awake alert and non-verbal. A water cup was observed on the bedside table dated 7/31/25 on 11-7 a.m. shift. This surveyor marked the water cup indicating the water level on cup to monitor how much water resident was drinking. (Photographic Evidence Obtained).</p> <p>On 07/31/2025 at 11:28 AM an observation was made of Resident #58 sitting up in wheelchair awake, alert and attending activities in activity room. There was no hydration or fluids observed being offered at this time. Upon entering Resident #58's room, an observation was made of the water cup sitting on bedside table with water observed at same level from an earlier observation where this surveyor marked the hydration cup.</p> <p>Review of resident #58's medical record revealed diagnoses of Quadriplegia, Pneumonitis, Moderate -protein calorie malnutrition, Dementia, Chronic Kidney Disease stage 3B and an ileus. The plan of care revealed Resident #58 required assistance with ADLs (Activities of Daily Living) related to activity intolerance, dementia, impaired cognition, quadriplegia; with a goal that the resident will maintain current level of ADL function. The interventions included, "I require staff to feed me my meals." Another focus in Resident 58's care plan showed the resident has chronic urinary tract infections (UTIs) with interventions to observe for changes in urine characteristics, ...frequent urination and change in urgency to void.</p> <p>Review of a quarterly risk assessment for Resident #58 completed on 7/10/25 revealed the resident was at high risk for hydration/dehydration.</p> <p>Resident 58's MDS (minimum data assessment) dated of 7/10/25, section GG revealed - resident has impairment to bilateral upper and lower extremities and is totally dependent for eating and drinking.</p>	N0072	<p>Continued from page 1</p> <p>The results of the audit will be forwarded to the Quality Assurance Committee for review monthly for at least three months with a goal of 100% compliance. Upon completion and 100% compliance for at least three months is achieved, frequency of further review and ongoing need for review will be determined by the QAPI committee.</p>	

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N0072 SS = D	<p>Continued from page 2</p> <p>An interview was conducted with staff member A, Registered Nurse/Unit Manager (RN/UM) on 7/31/25 at 1:38 PM. Staff A revealed Resident #58 is not able to ask for anything, requires total assistance and cannot hold a cup to get own drink of fluid. Staff A stated for a resident with reoccur ring UTIs, the expectation was to monitor for changes in their bowel movements, administer medications as ordered, if constipated or hasn't had a bowel movement, monitor urine output and changes in color, and providing foley catheter care daily and as needed. Staff A stated the staff know to offer fluids to alleviate constipation and/or urinary tract infections. Staff A, RN/UM stated they do quarterly assessments and any resident with a score of 10 or higher is considered at risk for hydration issues. Staff A stated they immediately get a physician order to encourage and offer fluids every two hours.</p> <p>Review of Resident #58's medical record revealed there was no care plan focus initiated for Resident #58 being at risk for dehydration, and there were no physician orders to encourage fluids every two hours.</p> <p>The facility did not provide a dehydration policy.</p>	N0072		

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F0000	INITIAL COMMENTS An unannounced recertification survey in conjunction with a complaint survey for complaint #2025008660 was conducted at Blue Heron Health and Rehabilitation on 7/28/2025 through 7/31/2025. The facility was not in compliance with 42 CFR 483, Requirements for Long Term Care.	F0000		08/31/2025
F0644 SS = E	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview the facility failed to complete the Pre-admission Screening and Resident Review (PASARR) Level II for residents with qualifying mental health diagnosis for three residents (#17, #16, #8) of five residents reviewed for PASARRS. Review of Resident #17's medical record revealed the resident was admitted to facility on 12/11/2022 with diagnoses to include Alzheimer's Disease, Unspecified; Dementia in other diseases classified elsewhere, Mild, without behavioral disturbance, psychotic disturbance,	F0644	1) Resident #8 PASARR was updated on 08/20/2025. Resident #16 PASARR was updated on 08/20/2025. Resident #17 PASARR was updated on 08/20/2025. 2) An audit of all current residents was completed on 08/20/2025 by the Director of Nursing, or designee, to verify the PASARR Level II for residents with qualifying health diagnosis. 3) Admissions team in-serviced by the Executive Director on 08/20/2025 to verify the PASARR Level II for residents with qualifying health diagnosis. Interdisciplinary team in-serviced by the Executive Director and Director of Nursing, on 08/20/2025 to verify the PASARR Level II for residents with qualifying health diagnosis. 4) The Director of Nursing, or designee, will conduct a random audit of five (5) residents per week to verify the PASARR Level II for residents with qualifying health diagnosis for four (4) consecutive weeks, then once a week for four (4) weeks, then once a month for two months, or until substantial compliance is achieved. After substantial compliance, it will be reviewed at a minimum quarterly by Director of Social Services. The results of the audit will be forwarded to the Quality Assurance Committee for review monthly for at least three months with a goal of 100% compliance. Upon completion and 100% compliance for at least three months is achieved, frequency of further review and ongoing need for review will be determined by the QAPI committee.	08/31/2025

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 reverse for further 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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F0644 SS = E	<p>Continued from page 1</p> <p>mood disturbance, and anxiety; unspecified psychosis not due to a substance or known physiological condition; schizoaffective disorder, unspecified, Encephalopathy.</p> <p>Review of Resident #17's PASSAR level I screen dated 12/12/2022 revealed the qualifying diagnoses were not checked and recommendations for a level II PASARR were not acted upon.</p> <p>Review of Resident #16's medical record revealed the resident was admitted to the facility on 1/7/2025. Review of the resident's diagnoses active as of 7/31/25 revealed the resident had diagnoses to include Schizoaffective Disorder, Bipolar Type and Other Bipolar type.</p> <p>Review of Resident #16's PASSAR level I screen dated 01/24/2025 revealed the qualifying diagnoses were not checked and recommendations for a level II PASARR were not acted upon.</p> <p>Review of Resident #16's medication orders revealed the resident was receiving Ziprasidone HCl 20 MG BID (twice daily).</p> <p>An interview with the DON was conducted on 7/31/2025 at 3:14 PM. The DON stated it is her responsibility to ensure the PASARRs completed by the hospital are accurate, and if the PASARR is not accurate, it is the facility's responsibility to complete the assessment again and submit a new PASARR. Upon review of Resident #17's PASSAR, The DON stated Resident #17's PASARR did not have all of the diagnoses and needs another PASARR with correct diagnoses submitted. Upon review of Resident #16's PASARR dated 1/24/2025, The DON stated the PASARR should have diagnosis of Schizoaffective Disorder, bipolar type, and Other Bipolar Disorder, and the resident #16 needs another assessment completed with the correct diagnoses.</p> <p>Resident #8 was admitted to the facility with diagnoses of Parkinson's disease, CHF (congestive Heart Failure), metabolic encephalopathy, generalized anxiety, bipolar disease, pseudobulbar affect, insomnia, and schizoaffective disorder.</p> <p>Review of a Medication Discharge Report dated 12/22/24 revealed Resident #8 was taking Seroquel 100 mg (milligrams) twice a day, Olanzapine 7.5 mg at bedtime, Lorazepam 0.5 mg at bedtime, Nuedexta 20-10 mg twice a day and Depakote 125 mg / 4 capsules at bedtime.</p>	F0644		

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F0644 SS = E	Continued from page 2 Review of Resident #8's level I PASARR completed on 12/22/24 revealed the resident did not have mental illness or suspected mental illness. The diagnoses boxes were unchecked. An interview with the DON conducted on 7/31/25 at 03:30 PM revealed when a resident is admitted or readmitted to the facility, they review the PASRR for correctness and if needed submit a new PASRR or complete a level II PASRR if indicated. The DON stated Resident #8's PASARR should have been corrected and updated and reported not being at the facility during that time. The facility did not provide a PASARR policy.	F0644		
F0656 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 psychosocial 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 psychosocial well-being as required under §483.24, §483.25 or §483.40; and (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. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired	F0656	1) Resident #56's plan of care updated to reflect at risk for dehydration on 8/5/2025 with appropriate interventions. 2) An audit of current residents' quarterly hydration risk evaluation was conducted on 08/20/2025 by Director of Nursing, Nurse Management team, or designee to verify residents to be at risk for dehydration. Care plan reviews with intervention updated to include providing necessary assistance, encouragement and offering of fluids throughout shift, as clinically indicated. 3) An in-service education was conducted on 08/19/2025 by the Administrator, Director of Nursing, or designee with all licensed/registered nurses addressing the significance of hydration risk evaluation completed on admission, quarterly, and/or significant change, and the implementation of a plan of care for a resident at risk for dehydration. 4) The nursing management team, Registered Dietitian, and/or Dietary Manager will review each resident with risk factors for dehydration to ensure appropriate interventions are implemented and an updated plan of care is complete. The Director of Nursing (DON), or designee, will complete five (5) random weekly chart audits for six (6) consecutive weeks to review quarterly hydration risk evaluations and verify that appropriate interventions have been put in place to reduce the risk of dehydration. Audits will assure that care plans remain updated to reflect these interventions.	08/31/2025

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F0656 SS = D	<p>Continued from page 3 outcomes.</p> <p>(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.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(ii) Be culturally-competent and trauma-informed.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interviews, observations, and record review the facility failed to implement a plan of care for a resident at risk for dehydration for one resident (#58) of one resident reviewed.</p> <p>Findings included:</p> <p>On 07/29/25 at 09:40 AM an observation revealed Resident #58 lying in bed, eyes closed and did not respond to verbal or tactile stimuli. There was no hydration or fluids observed at bedside.</p> <p>During an observation on 07/29/25 at 03:00 PM, Resident #58 was observed lying in bed. There was no hydration cup or fluids at bedside.</p> <p>On 7/29/2025 at 3:45 PM an interview was conducted with Resident #58's family member who stated Resident #58 needed extra care and could not get a drink of water on their own. The family member stated staff should check on the resident more frequently than they do and offer fluids.</p> <p>During an observation on 07/30/2025 at 9:07 AM, at 12:00 PM and at 4:10 PM, Resident #58 was observed in room. A water cup was observed on the bedside table dated 7/30/25, 11 a.m. -7 p.m. shift, at 04:14 AM. The cup was observed full of ice water.</p> <p>On 07/31/25 at 08:35 AM Resident #58 was observed sitting up in a reclining wheelchair, eyes opened, awake alert and non-verbal. A water cup was observed on the bedside table dated 7/31/25 on 11-7 a.m. shift.</p>	F0656	<p>Continued from page 3</p> <p>The results of the audit will be forwarded to the Quality Assurance Committee for review monthly for at least three months with a goal of 100% compliance. Upon completion and 100% compliance for at least three months is achieved, frequency of further review and ongoing need for review will be determined by the QAPI committee.</p>	

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F0656 SS = D	<p>Continued from page 4</p> <p>This surveyor marked the water cup indicating the water level on cup to monitor how much water resident was drinking. (Photographic Evidence Obtained).</p> <p>On 07/31/2025 at 11:28 AM an observation was made of Resident #58 sitting up in wheelchair awake, alert and attending activities in activity room. There was no hydration or fluids observed being offered at this time. Upon entering Resident #58's room, an observation was made of the water cup sitting on bedside table with water observed at same level from an earlier observation where this surveyor marked the hydration cup.</p> <p>Review of resident #58's medical record revealed diagnoses of Quadriplegia, Pneumonitis, Moderate -protein calorie malnutrition, Dementia, Chronic Kidney Disease stage 3B and an ileus. The plan of care revealed Resident #58 required assistance with ADLs (Activities of Daily Living) related to activity intolerance, dementia, impaired cognition, quadriplegia; with a goal that the resident will maintain current level of ADL function. The interventions included, "I require staff to feed me my meals." Another focus in Resident 58's care plan showed the resident has chronic urinary tract infections (UTIs) with interventions to observe for changes in urine characteristics, ...frequent urination and change in urgency to void.</p> <p>Review of a quarterly risk assessment for Resident #58 completed on 7/10/25 revealed the resident was at high risk for hydration/dehydration.</p> <p>Resident 58's MDS (minimum data assessment) dated of 7/10/25, section GG revealed - resident has impairment to bilateral upper and lower extremities and is totally dependent for eating and drinking.</p> <p>An interview was conducted with staff member A, Registered Nurse/Unit Manager (RN/UM) on 7/31/25 at 1:38 PM. Staff A revealed Resident #58 is not able to ask for anything, requires total assistance and cannot hold a cup to get own drink of fluid. Staff A stated for a resident with reoccur ring UTIs, the expectation was to monitor for changes in their bowel movements, administer medications as ordered, if constipated or hasn't had a bowel movement, monitor urine output and changes in color, and providing foley catheter care daily and as needed. Staff A stated the staff know to offer fluids to alleviate constipation and/or urinary tract infections. Staff A, RN/UM stated they do quarterly assessments and any resident with a score of 10 or higher is considered at risk for hydration</p>	F0656		

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F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observations, and record review the facility failed to ensure proper hydration was provided for one resident (#58) of one resident sampled. Findings included: On 07/29/25 at 09:40 AM an observation revealed Resident #58 lying in bed, eyes closed and did not respond to verbal or tactile stimuli. There was no hydration or fluids observed at bedside.	F0692	1) Resident #58 was assessed on 08/05/2025 by Licensed Nurse, with no adverse effects noted. The Director of Nursing Services and Registered Dietitian reassessed the hydration status and fluid needs for resident #58 on 08/21/2025. All fluids provided on the resident tray at mealtime and at the resident's bedside were re-evaluated and preferences were readdressed. Appropriate revisions were made to the care plan(s) to reflect current hydration interventions. The revised care plans were reviewed with staff involved in the care of the resident. 2) An audit of current residents' hydration risk evaluations was conducted on 08/20/2025 by Director of Clinical Services, and Nurse Management team to verify a resident to be at risk for dehydration. Care plan reviews with intervention updated to include providing necessary assistance, encouragement and offering of fluids throughout shift, as clinically indicated. 3) An in-service education was conducted on 08/19/2025 by the Administrator, Director of Nursing, or designee with all direct care staff addressing the significance of accurate reporting of fluids consumed during meals, the need to encourage fluid intake, and the provision of sufficient intake between meals to maintain adequate hydration. The in-service also addressed the importance of reporting conditions that alter a resident's fluid needs. 4) The nursing management team, Registered Dietitian, and/or Dietary Manager will review each resident with risk factors for dehydration to ensure appropriate interventions are implemented and an updated plan of care is complete. The Director of Nursing (DON), or designee, will complete five (5) random resident observations or resident and staff interviews on varying shifts and varying days weekly for fluid consumption for six (6) consecutive weeks and review all fluid intake records	08/31/2025

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NAME OF PROVIDER OR SUPPLIER BLUE HERON HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 5085 EAGLESTON BLVD , WESLEY CHAPEL, Florida, 33544	
(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
F0692 SS = D	<p>Continued from page 6 During an observation on 07/29/25 at 03:00 PM, Resident #58 was observed lying in bed. There was no hydration cup or fluids at bedside.</p> <p>On 7/29/2025 at 3:45 PM an interview was conducted with Resident #58's family member who stated Resident #58 needed extra care and could not get a drink of water on their own. The family member stated staff should check on the resident more frequently than they do and offer fluids.</p> <p>During an observation on 07/30/2025 at 9:07 AM, at 12:00 PM and at 4:10 PM, Resident #58 was observed in room. A water cup was observed on the bedside table dated 7/30/25, 11 a.m.-7 p.m. shift, at 04:14 AM. The cup was observed full of ice water.</p> <p>On 07/31/25 at 08:35 AM Resident #58 was observed sitting up in a reclining wheelchair, eyes opened, awake alert and non-verbal. A water cup was observed on the bedside table dated 7/31/25 on 11-7 a.m. shift. This surveyor marked the water cup indicating the water level on cup to monitor how much water resident was drinking. (Photographic Evidence Obtained).</p> <p>On 07/31/2025 at 11:28 AM an observation was made of Resident #58 sitting up in wheelchair awake, alert and attending activities in activity room. There was no hydration or fluids observed being offered at this time. Upon entering Resident #58's room, an observation was made of the water cup sitting on bedside table with water observed at same level from an earlier observation where this surveyor marked the hydration cup.</p> <p>Review of resident #58's medical record revealed diagnoses of Quadriplegia, Pneumonitis, Moderate -protein calorie malnutrition, Dementia, Chronic Kidney Disease stage 3B and an ileus. The plan of care revealed Resident #58 required assistance with ADLs (Activities of Daily Living) related to activity intolerance, dementia, impaired cognition, quadriplegia; with a goal that the resident will maintain current level of ADL function. The interventions included, "I require staff to feed me my meals." Another focus in Resident 58's care plan showed the resident has chronic urinary tract infections (UTIs) with interventions to observe for changes in urine characteristics, ...frequent urination and change in urgency to void.</p> <p>Review of a quarterly risk assessment for Resident #58 completed on 7/10/25 revealed the resident was at high risk for hydration/dehydration.</p>	F0692	<p>Continued from page 6 to ensure that appropriate interventions have been put in place to reduce the risk of dehydration. Audits will assure that care plans remain updated to reflect these interventions.</p> <p>The results of the audit will be forwarded to the Quality Assurance Committee for review monthly for at least three months with a goal of 100% compliance. Upon completion and 100% compliance for at least three months is achieved, frequency of further review and ongoing need for review will be determined by the QAPI committee.</p>	

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NAME OF PROVIDER OR SUPPLIER BLUE HERON HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 5085 EAGLESTON BLVD , WESLEY CHAPEL, Florida, 33544	
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F0692 SS = D	<p>Continued from page 7</p> <p>Resident 58's MDS (minimum data assessment) dated of 7/10/25, section GG revealed - resident has impairment to bilateral upper and lower extremities and is totally dependent for eating and drinking.</p> <p>An interview was conducted with staff member A, Registered Nurse/Unit Manager (RN/UM) on 7/31/25 at 1:38 PM. Staff A revealed Resident #58 is not able to ask for anything, requires total assistance and cannot hold a cup to get own drink of fluid. Staff A stated for a resident with reoccur ring UTIs, the expectation was to monitor for changes in their bowel movements, administer medications as ordered, if constipated or hasn't had a bowel movement, monitor urine output and changes in color, and providing foley catheter care daily and as needed. Staff A stated the staff know to offer fluids to alleviate constipation and/or urinary tract infections. Staff A, RN/UM stated they do quarterly assessments and any resident with a score of 10 or higher is considered at risk for hydration issues. Staff A stated they immediately get a physician order to encourage and offer fluids every two hours.</p> <p>Review of Resident #58's medical record revealed there was no care plan focus initiated for Resident #58 being at risk for dehydration, and there were no physician orders to encourage fluids every two hours.</p> <p>The facility did not provide a dehydration policy.</p>	F0692		