STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105429	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FIRST COAST HEALTH & REHABILITATION CENTER	**7723 JASPER AVENUE JACKSONVILLE, FL 32211**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** Based on observation, record review, and staff interviews, the facility failed to maintain an accurate comprehensive assessment for 1 of 37 residents reviewed for comprehensive assessment. (Resident #72) The findings include: An observation on 3/8/20 at 9:47 AM of hospice Resident #72 was laying on his right side with contracted legs in the fetal position wearing a hospital gown. Resident # 72 was awake and alert. Verbal communication with resident was unintelligible. An interview with Resident's #72's family on 3/8/20 at 1:57 PM, revealed the resident is unable to participate in his care due to his condition and he is unable to remember family member's names. A record review was conducted on [DATE] at 9:51 AM on Resident #72. On 2/12/20 a Significant Change was documented in the Minimum Data Set (MDS) assessment. In the assessment, it was documented the resident had bed mobility, transfer activity, and toileting that occurred once or twice by the resident. On 1/31/20 an Annual MDS assessment was made on the resident. In this assessment, it was documented the resident needed extensive assistance by staff to assist with bed mobility, transfer activity, and toileting. An interview was conducted with Employee A, MDS Coordinator, on 3/11/20 at 9:41 AM. A review of the MDS assessment for Significant Change on 2/12/20 and the Annual MDS assessment on 1/31/20 was conducted with Employee A. Employee A stated the update was made by Employee B. Employee A confirmed the MDS assessment for Significant Change on 2/12/20 was not an accurate assessment of Resident #72. Employee A stated the resident has not been able to change his bed position or transfer himself for a long time. Employee A stated the Annual MDS assessment made on 1/31/20 was a more accurate assessment of Resident #72. A second interview with Employee A was conducted on 3/11/20 at 1:42 PM. Employee A stated she spoke with Employee B. Employee A stated Employee B created the Significant Change on 2/12/20 because one had not been done when the resident was placed on hospice in July of 2019. Employee A confirmed again the Significant Change MDS assessment on 2/12/20 was not an accurate assessment of Resident #72.

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

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.