STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105539	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEALTHCARE AND REHAB OF SANFORD	950 MELLONVILLE AVE SANFORD, FL 32771

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected terminal status for 2 of 6 residents on hospice services (#29 and #57), and injury related to a fall for 1 of 5 residents reviewed for accidents (#93), from a total sample of 40 residents. Findings: 1. Resident #29 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the medical record revealed resident #29 had a physician's orders [REDACTED]. Section J, Health Conditions of the MDS quarterly assessment with assessment reference date (ARD) of 12/14/19, revealed resident #29 did not . have a condition or chronic disease that may result in a life expectancy of less than 6 months. However, section O Special Treatments, Procedures, and Programs indicated resident #29 was on hospice care. 2. Resident #57 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of his medical record revealed a care plan for Terminal [DIAGNOSES REDACTED]. The MDS significant change in status assessment with ARD of 1/16/20, revealed section J indicated no condition or chronic disease that may result in a life expectancy of less than 6 months. Section O showed resident #57 was on hospice care. On 3/10/20 at 12:55 PM, the Clinical Reimbursement Director (CRD) stated she was responsible for the completion of accurate MDS assessments. The CRD stated residents #29 and #57 received hospice care and services for terminal diagnoses, therefore section J of their MDS assessments should indicate a life expectancy of less than 6 months. She explained the assessments required modification. 3. Resident #93 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the medical record revealed a Change in Condition Evaluation dated 2/06/20. The form indicated resident #93 fell , hit her head and sustained a hematoma to the back of her head and complained of a headache. A hematoma is defined as a mass or swelling comprised of clotted blood that forms as a result of a broken blood vessel. (www.merriam-webster.com) Section J Health Conditions of the MDS quarterly assessment with ARD of 2/18/20, revealed resident #93 had 1 fall with no injury. However, the instructions for section J indicated hematomas or any fall-related injury that caused pain should be coded as Injury (except major). On 3/11/20 at 4:41 PM, the CRD was prompted to review resident #93's change in condition forms and discovered nursing documentation of the fall with head injury. The CRD stated section J was incorrect and did not reflect the injury associated with resident #93's fall. She stated the facility did not have a policy and procedure for MDS assessment accuracy. The CRD explained she used the Resident Assessment Instrument (RAI) for guidance. Review of the Centers for Medicare & Medicaid Services' (CMS) Long-Term Care Facility RAI User's Manual (October 2019) revealed instructions for completion of Section J regarding falls. The Steps for Assessment included reviewing information from all available sources, incident reports, fall logs and progress notes.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and/or implement individualized care plans for 1 of 3 resident reviewed for activities (#28), 2 of 5 residents reviewed for accidents (#14 and # 93), and 1 of 3 residents reviewed for nutrition (#16), from a total sample of 40 residents. Findings: 1. Resident #28 was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) quarterly assessment with assessment reference date (ARD) of [DATE] revealed resident #28 had moderate difficulty hearing and used a hearing appliance. Resident #28 usually understood verbal content but missed some parts of the message even if he used his hearing device. Review of resident #28's medical record revealed a care plan for impaired communication initiated on [DATE] that indicated he Uses sound amplifier to assist with hearing. The care plan goals were resident #28 would communicate his needs with minimal frustration and use his hearing device. The interventions included Encourage use of hearing device/devices. A care plan for preference and choice, initiated on [DATE], revealed resident #28 preferred to get out of bed early in the morning, on the overnight shift. The care plan goal was to acknowledge his preferences for changes in time or routine. Interventions included encourage resident #28's involvement in his plan of care. A care plan for activities, initiated on [DATE], revealed resident #28 was Independently capable of pursuing their own activities without facility intervention . The care plan revealed resident #28 preferred . music with staff, group social events and visiting with his brother and sister-in-law. Review of the certified nursing assistant (CNA) care plan or kardex revealed directions to . offer to put resident back to bed after family visit . place personal items within reach . assist resident with (morning) care and assist for transfers on 11PM to 7AM (shift) . The kardex suggested CNAs should use television as a diversional activity if resident #28 was upset. The Communication section of the kardex did not include resident #28's use of a hearing device. On [DATE] at 12:10 PM, resident #28 was in bed with no hearing device noted. He explained he did not like to get out of bed for activities and meals. Instead, he preferred to remain in bed and watch television. Resident #28 was hard of hearing and had difficulty understanding speech in normal tones. He stated he could not really hear the television, and had not been able to watch it for a while because his remote was broken. On [DATE] at 2:14 PM, the Activity Director (AD) stated resident #28's preferred activity was to stay in his room and watch television. He was informed during observations from [DATE] to [DATE] the television was off and resident #28 stated the remote was broken. The AD checked the remote and explained it required new batteries. On [DATE] at 2:56 PM, resident #28 informed the Activities Assistant (AA) he had a hearing device in his bedside table drawer. The AA retrieved the device and noted it did not have batteries or ear phones. Resident #28 nodded when the AA asked him if the device helped him hear better. The AA stated it was not right that resident #28 did not use his hearing device. He said, It would be helpful for him to be able to hear. On [DATE] at 3:01 PM, resident #28's assigned nurse Registered Nurse (RN) A recalled he used a hearing amplifier in the past, but she had not seen him use it for a long time. She stated resident #28's brother and sister-in-law would replace the batteries for him. CNA B stated she was regularly assigned to resident #28 during her 8 months on staff. CNA B stated she had never seen resident #28 with a hearing device and was not informed he had one. On [DATE] at 3:03 PM, CNA C stated he recalled he last saw resident #28 use his hearing device about a year ago. CNA C reviewed the kardex and noted there was no information regarding use of a hearing amplifier device. CNA C stated if the information was not on the kardex, staff would not know they should provide resident #28 with his device. On [DATE] at 3:31 PM, the Maintenance Director stated he recalled resident #28 used a hearing amplifier about a year ago before his brother died . On [DATE] at 9:34 AM, RN A was informed resident #28's care plan indicated he preferred to get up early in the morning, on the night shift. RN A stated resident #28 would not want to get up early in the morning. On [DATE] at 9:40 AM, the Wing 100 Unit Manager (UM) stated she was not aware resident #28 had a hearing device. She explained residents' care plans were reviewed at least quarterly by an interdisciplinary team (IDT). When asked why resident #28's care plans inaccurately reflected a preference to get up early and why staff did not provide him with his amplifier, the Wing 100 UM said, I have no idea. On [DATE] at 11:03 AM, the AD stated although resident #28's brother died about 1 year ago and his sister-in-law no longer visited, the care plan still

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.

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) included this information. He explained resident #28's preferred activity was television, and he liked to watch sports and murder mysteries. He also liked to play the air guitar to rock and roll and country music. The AD stated he was not aware resident #28 had a hearing device although it was documented in the care plan for communication. The AD stated he was a member of the IDT that reviewed residents' care plans at scheduled meetings. He explained he was responsible for developing and implementing activities care plans. During review of resident #28's activities care plan, the AD stated the interventions did not provide individualized and detailed information about this resident. On [DATE] at 4:49 PM, the Clinical Reimbursement Director (CRD) stated she was responsible for the care planning process. She explained care plans were intended to reflect a resident's current status to ensure appropriate care and services were provided. She reviewed resident #28's care plan and stated although each department developed interventions, the IDT members met quarterly to discuss all approaches. The CRD could not explain why the IDT members were not aware resident #28 had a hearing device or why the information was not on the kardex. The CRD was informed resident #28's activities and choices care plans were not individualized and accurate. She stated there were concerns with the facility's care planning process. The CRD said, I have noticed that we need a focused look at the care plans. 2. Resident #14 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of a Change in Condition form dated [DATE] at 9:58 AM, revealed resident #14 had a witnessed fall in her room and hit her head on the bedside table. Resident #14's care plan for risk for falls, initiated on [DATE], had goals to minimize the risk of falls and to prevent fall-related injuries. Interventions initiated on [DATE] included Floor mats to sides of bed while in bed. The kardex showed bedside floor mats as a safety intervention. On [DATE] at 4:24 PM, resident #14 lay in bed. She had a large purple and yellow bruise under her right eye. Resident #14 stated she fell in her room, but could not recall when or what she was doing at the time. She stood up from her bed and walked slowly towards the bathroom and returned to her bed a few minutes later. Observation of the room revealed no floor mats. Oxygen tubing coiled was noted on the floor at bedside. On [DATE] at 1:11 PM, resident #14 was in bed. She stated she was at the [MEDICAL TREATMENT] center that morning, and appeared tired as she dozed off during conversation. There were no floor mats noted in resident #14's room. On [DATE] at 9:40 AM, resident #14 was in bed with her eyes closed. There were no floor mats at bedside or anywhere in the room. On [DATE] at 12:39 PM, Licensed Practical Nurse (LPN) D recalled resident #14 had a fall with bad facial bruising and swelling about 4 weeks before, when she was a resident on the other unit, the 100 unit. LPN D stated resident #14 was on fall precautions, but could verbalize only non-skin socks and safety reminders as current interventions. On [DATE] at 4:28 PM, CNA J stated she was assigned to resident #14 but was not aware she should have floor mats. During review of the kardex with CNA J, she discovered the instruction to ensure bedside floor mats were in place when resident #14 was in bed. Observation of resident #14's room with CNA J revealed no floor mats. On [DATE] at 5:18 PM, the Director of Nursing (DON) explained the IDT met on [DATE], the morning after resident #14's fall, and selected floor mats as a new fall prevention intervention. The DON was informed resident #14 did not have floor mats available in her room. He stated assigned nursing staff were responsible for ensuring care plan interventions were in place. On [DATE] at 9:44 AM, the 100 UM stated resident #14 fell when she was a resident on that unit about 1 month ago. The 100 UM said, To my knowledge the floor mats were transferred to the other unit with resident. 3. Resident #93 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS quarterly assessment with ARD of [DATE] revealed resident #93 required supervision for walking, and had 1 fall since the prior assessment. Review of the medical record revealed a care plan for [MEDICAL CONDITION], initiated on [DATE], with goal that resident #93 would be free from injury from [MEDICAL CONDITION] activity. The interventions included post-[MEDICAL CONDITION] activities such as taking vital signs and performing Neurochecks. Neurochecks or neurological checks are usually done after a fall to identify signs and/or severity of a head injury. The evaluation includes checking level or consciousness, vital signs, pupil size and reactivity to light, and hand grip strength. Standard clinical nursing practice suggests this evaluation should be done immediately after the fall, then at regular intervals, gradually decreasing in frequency over a specified time. (www.hcpro.com) Review of a Change in Condition form dated [DATE] at 4:05 PM revealed resident #93 fell and hit the back of her head. The physician was notified and recommended Neurochecks. The facility's policy and procedure for Neurological Evaluation (February 2020) revealed a neurological assessment would be completed after a fall with a known head injury. The purpose was To collect data that visually determines whether the Resident is stable, improving, or deteriorating. the document indicated the suggested evaluation frequency of every 15 minutes for 1 hour, every hour for 4 hours, every 4 hours for 8 hours, and every 8 hours for 72 hours. Review of a Neurological Assessment Flowsheet for resident #93 revealed Neurochecks were initiated at the time of her fall on [DATE] at 4:05 PM. The document indicated she was evaluated according to the policy and procedure until 8:50 PM that evening. However, documentation of evaluations done on [DATE] at 12:50 AM, 4:50 AM and 8:50 AM was incomplete, and there was no evidence Neurochecks continued until [DATE] as required. On [DATE] at 6:16 PM, the DON stated medical records staff was not able to locate any additional documentation of Neurochecks related to resident #93's fall on [DATE]. The DON stated Neurochecks were not conducted by nursing staff according to care plan intervention, physician's orders [REDACTED]. 4. Resident #16 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of resident #16's medical record revealed a care plan for nutrition was initiated on [DATE]. The interventions included Registered Dietitian (RD) consult and follow-up, supplements as ordered, and document meal consumption. Resident #16 had a physician's orders [REDACTED]. The order directed nurses to record the percentage of the supplement resident #16 consumed. On [DATE] at 10:01 AM, the RD explained she reviewed resident #16's intake during her twice weekly visits to the facility. She said, She is taking in 50 to 100% of Resource 120 ml supplement 4 times daily. On [DATE] at 12:44 PM, assigned nurse LPN D stated resident #16 usually consumed 100% of the Resource supplement drink. Review of the Medication Administration Record [REDACTED]. However, the MAR indicated [REDACTED]. On [DATE] at 1:39 PM, the RD was asked how she determined whether resident #16's intake was adequate without documentation on the MAR. She explained she obtained information on the percentage of supplement consumed through discussion with the nurses during her twice weekly visits. The RD reviewed the order and confirmed nurses should be recording the percentage consumed 4 times daily. She recalled she had not seen any documentation of percentages since the previous year. The RD provided a copy of resident #16's MAR from February 2019 and showed the last time nurses documented the percentage of Resource 2.0 supplement consumed was on [DATE]. On [DATE] at 2:48 PM, LPN E and RN F stated they were regularly assigned to resident #16 and administered her Resource 2.0 supplement as ordered. LPN E and RN E were asked to read the directions on the MAR. Both nurses stated their initials on the MAR indicated [REDACTED]. Review of the policy and procedure for Care Plan - Interdisciplinary Plan of Care from Interim to Meeting effective [DATE], revealed the comprehensive care plan was a communication tool for the IDT to ensure the highest practicable well-being for each resident. The policy indicated the care plan should address ways to preserve and enhance strengths, needs and preferences. In addition, care plans should apply current standards of practice, and assess and plan to meet residents' medical and nursing needs.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to provide finger nail care to dependent residents, to promote and ensure the highest practicable well being for 3 of 3 sampled residents, (#73, #76, #354). Findings: 1. On Sunday, 3/8/20, at 2:03 PM, resident #354 was observed with long, dirty finger nails. The resident stated that he had taken a shower but could not remember the date of his last shower. The resident expressed that we wanted his finger nails cut/trimmed. He added that his nails were the longest ever. Further observations of his nails revealed that they were approximately 5 millimeters (mm) in length with black debris under the nails. On [DATE] at 9:43 AM, the resident was lying in bed. He was awake but confused and his finger nails remained the same. They had not been cut/trimmed. On 3/10/20 at 11:45 AM, the resident was resting in bed, and complained that he did not have any clothes. Certified Nursing Assistant (CNA) B was in the room providing care to the resident's roommate. CNA B stated that she would go to the laundry and get the resident's clothes. Resident #354's finger nails were still long with black debris and had not been cut/trimmed. Review of the 2/29/20 Admission Minimum Data Set (MDS) assessment, noted that the resident scored a 5 out 15 on the Brief Interview for Mental Status (BIMs) which indicated cognition was severely impaired. The MDS also noted that the resident required extensive assistance from staff for bed mobility, transfers, walking, locomotion and personal hygiene. The resident's Activities of Daily Living (ADL) care plan dated 2/24/19 noted that staff were to check the resident's finger nail length and trim and clean them on bath day and as necessary. On 3/10/20 at 4:15 PM, resident #354 was lying in bed on

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) his left side. His finger nails were long and needed to be cleaned. The resident stated that he wanted his nails to be cut/trimmed and asked, how much would that cost. Review of the resident's shower schedule revealed that resident #354 was scheduled for showers on Wednesdays and Saturdays on the 3-11 shift. On 3/11/20 at 11:09 AM, the Speech Therapist (SLP) was with the resident in his room. The resident displayed his hands and stated he needed to get his finger nails cut/trimmed. At that time the resident was informed that he would be interviewed again, after his speech therapy. The resident responded, don't forget about the finger nails. On 3/11/20 at 11:27 AM, the resident's direct care staff, CNA O, stated that resident #354 was able to make his needs known. When informed about the resident's finger nails, CNA O stated that she had not noticed that his finger nails needed to be trimmed. CNA O stated that finger nails were trimmed and cleaned on shower days. On 3/11/20 at 3:22 PM, the resident's ADL care plan was discussed with the Care Plan Coordinator (CPC). She stated that the current care plan was a Baseline Care Plan and that nail care was done on bath/shower day and 'as necessary. The CPC explained 'as necessary' as, if you see, you take ownership and get it done. 2. Resident #73 was admitted to the facility on [DATE] and readmitted on [DATE]. Her [DIAGNOSES REDACTED]. The annual minimum data set (MDS) with assessment reference date 1/31/20 revealed that the resident's cognition was moderately impaired, with a brief interview of mental status (BIMS) score of 10/15. The resident required extensive assistance by staff for activities of daily living, (ADL) and had impairment on one side to her upper and lower extremities. The resident's care plan for ADL self-care performance deficit created on 2/02/16 with revision on 8/07/18 noted intervention that included, Provide assistance as needed to perform ADL functions including but not limited to . personal hygiene Check nail length and trim and clean on bath day and as necessary. The certified nursing assistant (CNA) care plan, or Kardex also revealed that staff were expected to check the resident's nail length, and trim and clean the nails on bath days, and as necessary. On 03/08/20 at 1:55 PM, 3/09/20 at 10:59 AM, 3/10/20 at 9:59 AM and on 3/10/20 at 12:00 PM, resident #73's fingernails to her right hand were untrimmed, with dark debris underneath her fingernails. The resident could not say when her nails were last trimmed and cleaned. On 03/10/20 at 10:20 AM, Licensed practical nurse (LPN) H stated, that nail care should be completed by the resident's CNA. Observation of the resident's nails were conducted with LPN H. The LPN acknowledged the resident's fingernails to her right hand were untrimmed, and dirty. On 03/10/20 at 10:25 AM, CNA I stated that nail care was provided as needed. She said she was off this past weekend, but resident #73 was part of her assignment on Monday 3/09/20. CNA I stated, that she was not sure when the resident's nails were last trimmed and cleaned. The resident's fingernails were observed with CNA I, and she acknowledged the resident's nails needed cleaning and trimming. 3. Resident #76 was admitted to the facility on [DATE] and readmitted on [DATE]. His [DIAGNOSES REDACTED]. The resident's MDS assessment with assessment reference date 2/05/20 revealed the resident's cognition was severely impaired, with a brief interview of mental status (BIMS) score of 04/15. The resident required extensive assistance for most activities of daily living (ADL), and had total dependence on staff for personal hygiene. Resident #76's care plan for ADL self-care performance deficit created 4/30/19, and revised on 3/09/20, revealed the resident required extensive to total staff assistance for ADL care. The goal read, Will have ADL needs anticipated and met by staff through next review. An intervention dated 2/10/20 read, Provide assistance as needed to perform ADL functions including .personal hygiene. The CNA care plan, or Kardex revealed that staff were expected to provide nail care for the resident. On 03/09/20 at 11:34 AM, the fingernails of resident #76's bilateral hands were untrimmed, with a dark substance under the fingernails of his left hand. Observation on 03/10/20 at 9:40 AM with CNA G, showed the resident's fingernails were still untrimmed, and dirty. CNA G stated that nail care was done during ADL care, and as needed. However, nail care was not done for resident #75. On 03/10/20 at 10:12 AM, LPN H stated, that nail care should be completed by the resident's CNA during ADL care. Observation of the resident's fingernails was conducted with the LPN. The LPN noted that the fingernails of the resident's bilateral hands were untrimmed and dirty, with a dark substance underneath the fingernails of his left hand. The facility did not have a policy for nail care, but followed the procedure from the National Nurse Assistant Assessment Program (NNAAP) Unit IV Assisting with activities of daily living Chapter 19 Grooming- giving nail and foot care. The procedure read, Nail and foot care prevents infection, injury, and odors .Long or broken nails can scratch skin.
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to enhance quality of life by ensuring participation in a preferred activity for 1 of 3 residents reviewed for activities, (#28). Findings: Resident #28 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) quarterly assessment with assessment reference date (ARD) of [DATE] revealed resident #28 had moderate difficulty hearing and used a hearing appliance. He was usually able to understand others if he used his hearing device, but still missed some part and the intent of messages. The MDS annual assessment with ARD of [DATE] revealed it was somewhat important for resident #28 to listen to music he liked, keep up with the news and do his favorite activities. Review of resident #28's care plan for activities, initiated on [DATE] and revised on [DATE], revealed he was independently able to pursue activities. The care plan read, Enjoys music with staff, group social events and visiting with his brother and sister-in-law. The care plan goal was to promote resident #28's quality of life and choice. The interventions were resident #28 . mostly prefers to be in his room with a preferred activity time of afternoons. The care plan did not list specific in-room activities. A care plan for communication, initiated on [DATE] and revised on [DATE] revealed resident #28 used a sound amplifier as a hearing device. The care plan goal was resident #28 would use his hearing device to communicate his needs with minimal frustration. The interventions directed staff to encourage use of the hearing device. Review of the Certified Nursing Assistant (CNA) care plan or kardex for resident #28 revealed no directions regarding provision of the hearing device, and no specific instructions regarding activities. The kardex indicated television was to be used as a diversional activity if resident was upset. On [DATE] at 2:09 PM, resident #28 lay in bed with his arms folded behind his head. He was unable participate in conversation and make himself understood. Later that afternoon he was observed in the same position with his eyes closed. On [DATE] at 5:18 PM, resident #28 remained in bed. There was a small television high up on the wall to the right side of the bed, approximately 10 feet away. The television was off and resident #28 explained the remote control did not work. On [DATE] at 9:42 AM, resident #28 was in bed with his eyes open and arms crossed behind his head. The room was dimly lit and the television was off. On [DATE] at 11:40 AM, resident #28 was in bed. In response to greeting, he pointed to his ear and said, Can't hear. Two televisions were side by side on the wall across the room, just below the level of the ceiling. Both televisions remained off. On [DATE] at 12:05 PM, Registered Nurse (RN) A stated resident #28 did not like to get out of bed to participate in activities. She explained if staff brought him out to the common area to socialize he usually quickly propelled himself back to his room. On [DATE] at 12:10 PM, resident #28 stated he did not like to get out of bed for activities. He explained he liked to stay his room and watch television. Resident #28 stated he had difficulty hearing and could not really hear the television. He stated the television was off because the remote was broken. Later that afternoon at 1:42 PM, resident #28 lay in bed on his back and stared at the ceiling. Both televisions were off. On [DATE] at 1:43 PM, CNA B stated resident #28 was alert and liked to stay in bed all day and watch television. She explained he used the remote to change the channels without assistance. On [DATE] at 2:14 PM, the Activity Director (AD) stated resident #28's preferred activity was to stay in his room and watch television. The AD was informed resident #28's television was off and had not been on during multiple observations conducted since [DATE]. Resident #28 informed the AD his television remote control was not working. The AD tested the remote and stated it needed new batteries. On [DATE] at 2:56 PM, the Activity Assistant (AA) stated he interacted with resident #28 regularly, was aware he had a hearing problem, but he did not know he used a hearing device. Resident #28 pointed towards his bedside table drawer and the AA retrieved a sound amplifier hearing device. The AA stated it was not right that resident #28 was not using his hearing device. He said, It would be helpful for him to be able to hear. On [DATE] at 3:23 PM, the AD stated during 2 years of interaction with resident #28 he was not aware he used a hearing device. The AD was asked how resident #28 participated in his preferred activity, watching television, if he could not hear it. The AD stated television was more for the effect of visual stimulation as resident #28 watched movements on the screen. On [DATE] at 11:03 AM, the AD stated resident #28 used to get out of bed more, and enjoyed visits with his brother. However, after the brother died approximately a year ago, resident #28 became less social and chose to spend most of his time in the room. The AD explained resident #28 enjoyed sports channels and murder mystery programs and could change the channels himself. He also enjoyed playing air guitar to rock and roll and country music, and socialized with his roommate. The AD was informed the specific activities he mentioned were not listed on the nursing care plan or the CNA kardex. He stated CNAs should check that the television was working, and AAs should make 1:1 room visits

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F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) twice weekly. However, the AD explained the AAs had not documented any room visits in the previous 30 days. The AD said, I believe his quality of life is good. He seems to enjoy when we go. If I knew (about) the assistive device it would have promoted better quality of life. The facility obtained and provided a signed statement from resident #28 that indicated he had social interactions and visits . on a monthly basis . However, review of task documentation related to activities revealed there was No Data Found from [DATE] to [DATE] for group activities, individual activities or self-directed activities.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to apply left hand splint, and left lower extremity splint as ordered for 1 of 6 residents reviewed for range of motion (ROM) from a total sample of 40 residents, (#73). Findings: Resident #73 was admitted to the facility on [DATE] and readmitted on [DATE] Her [DIAGNOSES REDACTED]. The annual minimum data set (MDS) with assessment reference date 1/31/20 revealed the resident's cognition was moderately impaired with a brief interview of mental status (BIMS) score of 10/15. The resident required extensive assistance for activities of daily living, (ADL) and had impairment on one side to her upper and lower extremities. The resident's current physician's orders [REDACTED]. A physician order [REDACTED]. An AFO is a brace, usually made of plastic, that is worn on the lower leg and foot to support the ankle, hold the foot and ankle in the correct position and correct foot drop. (Medicinenet.com) The resident's care plan for ADL self-care performance deficit, weakness, impaired mobility, [MEDICAL CONDITION], as evidenced by: cannot complete ADL tasks independently and requires individualized interventions to improve function. Left sided [MEDICAL CONDITION], limited range of motion to lower extremity, created on 2/02/16 with revision on 8/07/18. One of the care plan goal was: Will minimize progression of contracture(s) on L (left) hand and wrist through next review. The care plan for Range of Motion, revealed the resident had a risk or actual limitations in range of motion as evidenced by: Left hand contracture, Left Lower Extremity (LLE) contracture, was created on 9/17/18, with revision on 11/15/18. Interventions included, Apply AFO to LLE while out of bed. Left hand carrot splint to left hand, on in AM for up to 3 hours daily or as tolerated removed before lunch. The directives for the left hand splint, and the LLE AFO was also documented on the Certified nursing assistant (CNA) care plan, or Kardex. Observations on 03/08/20 at 1:55 PM, on 3/09/20 at 9:33 AM, on 3/09/20 at 10:59 AM, and 3/10/20 at 9:59 AM showed resident #73 lying in bed. Her left hand was contracted, and the resident did not have any splints on her left hand. On 03/10/20 at 10:20 AM, Licensed Practical Nurse (LPN) H stated the resident's left hand was contracted, and acknowledged the resident's left hand splint was not on the resident's left hand. On 03/10/20 at 10:25 AM, Certified Nursing Assistant (CNA) I stated the resident did not have her left hand splint on. CNA I stated that the restorative aides placed splints on the resident, and she was not sure when, or if the splints were placed yesterday or today. On 03/10/20 at 12:00 PM, resident #73 was sitting at the dining table in the atrium on Wing 2 for lunch. The resident's carrot airhead splint was applied to her left hand. Her left foot was hanging from the wheelchair. It was not on the footrest, and the AFO was not applied to left lower extremity. Resident #73 stated, that her splints were not always placed on. Review of the physician's orders [REDACTED]. On 03/10/20 at 1:33 PM, resident #73 was still sitting at the table in the atrium. The carrot airhead splint was to her left hand, and the resident's AFO was not applied to her LLE. Resident #73 was transferred to her room via wheelchair by LPN H. LPN H acknowledged that the AFO was not in place, and stated that she would look for it. The AFO was located in the resident's closet, buried under other belongings. On 03/10/20 at 1:45 PM, the Director of Rehab stated, that resident #73 was on case load, for occupational therapy and was discharged from the program on 12/19/19. The resident was changed from a resting hand splint to an air carrot splint, and was discharged to the restorative nurse program. The director of rehab stated, that all staff, restorative CNAs, CNA on the floor, and nurses, were trained to apply the resident's splint. She stated that the goal of Therapy, was to train as many members as possible. If the restorative staff was not available, other staff were trained to apply the splints. The director of rehab stated, that resident #73 was supposed to have her hand splint on in the AM for 3 hours. Staff should document when the splint was placed, and taken off. If the resident did not want the splint, or there was a concern with the splint, staff would report to therapy, and therapy would re- evaluate, screen and reassess the resident. The director of rehab said she was not aware of any issues regarding the resident not wanting the splint. On 03/10/20 at 4:35 PM, CNA J stated that resident #73, usually stayed in the atrium, and went back to bed after dinner. CNA J stated that the resident did not have her AFO on when she was out of bed. The resident was still sitting at the table in the atrium without her AFO to her LLE. On 03/11/20 at 9:54 AM, resident #73 was lying in bed on her back and indicated the carrot splint was on her left hand. Resident #73 stated that staff did not always put her splint on, and added, thank you. The resident's Medication Administration Record [REDACTED]. The CNA's plan of care (POC) response history for left hand carrot splint for question 1 Task Completed revealed that on 3/08/20 at 2:59 PM, 3/09/20 at 1:36 PM, and 8:07 PM and on 3/10/20 at 2:59 PM the column for yes was checked, indicating that the splints were placed. Observations on 03/08/20 at 1:55 PM, on 3/09/20 at 9:33 AM and 10:59 AM, and on 3/10/20 at 9:59 AM showed resident #73 in bed without her left hand splint. Response to question 1 for the AFO, I applied and removed adaptive device per instructions was checked yes on 3/08/20 at 2:59 PM, 3/09/20 at 1:36 PM, and 3/10/20 at 2:59 PM. However the resident was not out of bed on 3/08/20, or 3/09/20. The resident was out of bed on 3/10/20, but the AFO were not applied. On 03/11/20 at 9:59 AM, CNA I stated that the AFO was not placed on the resident's LLE on 3/10/20 when she was out of bed. The POC documentation was discussed with the CNA. CNA stated she had placed the AFO on, but the resident stated she did not want it. She said she documented yes before she had placed them, and did not go back to document the resident's refusal. On 3/11/20 at 4:19 PM, the concerns regarding the application of the resident's splints, and documentation indicating the splints were applied, when observations and interviews indicated that splints were not applied were discussed with the DON. The DON stated that task(s) should not be documented as completed before the task(s) was performed. The facility's policy and procedureCare plan- Interdisciplinary Plan of care from Interim to Meeting, with effective date March 2017, read, The comprehensive care plan is an interdisciplinary communication tool. It includes measurable objectives and timeframes and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.
F 0694 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide for the safe, appropriate administration of IV fluids for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide dressing change for a midline intravenous site as per physician orders, and according to current, professional standards of practice for 2 of 2 residents of a total sample of 40 residents, (#43, #404). Finding: 1. Resident #43 was admitted to the facility on [DATE], and readmitted on [DATE]. Her [DIAGNOSES REDACTED]. The Medicare 5 day minimum data set (MDS) assessment with assessment reference date 2/26/20, revealed that the resident's cognition was severely impaired, with a brief interview of mental status (BIMS) score of 02/15. Resident #43 required limited assistance with bed mobility, and transfers, and required extensive assistance with dressing, toilet use, and personal hygiene. She was independent with eating, after set-up help. The resident's current physician's orders [REDACTED]. Change IV (intravenous) dressing every 7 days as well as needed (PRN) for soiling and/or dislodgement, document IV site appearance every shift- report any change. On 03/08/20 at 1:50 PM, resident #43 was sitting in her wheelchair in the atrium of Wing II. An IV access was noted to the resident's right upper arm. The resident's sleeve was covering the date on the dressing. On 03/08/20 at 5:04 PM, the resident's midline dressing was observed with Registered nurse (RN) N. Two dates were documented on the dressing, 1/30/20, and [DATE]. The RN stated she had no idea the resident had a midline, as her IV antibiotic therapy was completed on 3/06/20 at midnight. RN N stated that the Task to change the midline dressing did not populate on her schedule, or on the treatment administration record (TAR). She stated, she did not see the IV site as the resident had on long sleeves. However at the time of the observation, the resident wore a short sleeved blouse. Review of the resident's Medication Administration Record [REDACTED]. Observation of the midline site showed dressing dated 1/30/20, and [DATE], not 2/25/20 (13 days ago). On 03/08/20 at 5:16 PM, the weekend supervisor stated, that typically, midline dressing was changed weekly, and PRN if it was dislodged or soiled. The weekend supervisor stated, that the resident's midline dressing should have been changed. 2. Resident #404 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The resident's current physician orders [REDACTED]. The Baseline Care Plan for IV medications- on IV antibiotics related to pneumonia was created on 3/08/20. One intervention was to check dressing at site

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	105539	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEALTHCARE AND REHAB OF SANFORD	950 MELLONVILLE AVE SANFORD, FL 32771

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

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F 0694 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) daily. Change per facility policy/ physician's orders [REDACTED].#404 stated she was admitted to the facility on Thursday 3/05/20. A midline was noted on the resident's right upper arm and the dressing was dated 2/28/20. On 03/09/20 at 12:49 PM, the resident's midline site was observed with Licensed practical nurse (LPN) H. LPN H stated that the policy for dressing change for the midline was every 7 days. She verbalized that the resident's midline dressing was on for 10 days without a dressing change, which could be a potential for infection. On 03/09/20 at 12:53 PM, Wing II unit manager (UM) stated that the facility's policy indicated that a midline dressing should be changed every 7 days. After a review of the physician's orders [REDACTED]. A review of the resident's Medication Administration Record [REDACTED]. On 03/09/20 at 1:24 PM, the resident's midline dressing was observed with the Wing II UM. She acknowledged the dressing was dated 2/28/20, and initialed DR. Review of MAR indicated [REDACTED]. This was again acknowledged by the UM. On 03/09/20 at 2:14 PM, the director of nursing (DON) stated there was no staff at the facility with the initial DR. The DON stated the staff should have changed the dressing to the resident's midline 7 days from the date documented on the dressing. The DON noted that the midline dressing should have been changed 3 days ago. On 03/10/20 at 2:04 PM, registered nurse (RN) M stated that resident #404 was admitted to the facility at approximately 8:30 PM, on 3/05/20. RN M stated he completed an assessment on the resident, and noted the midline to her right upper arm. RN M said, on 3/06/20 he saw the task for midline dressing change on his schedule, and he clicked off the task in the MAR. The RN stated, that a certified nursing assistant (CNA) called him regarding another resident whose dressing had dislodged. He went to change the other resident's dressing, and when he was finished with the other resident, he forgot to complete the midline dressing change for resident #404. RN M stated that he signed for the dressing change completed before he actually completed the task. The facility's policy and procedure Dressing Change For Vascular Access Devices read, Purpose: To prevent local and systemic infection related to the IV catheter .Central venous access device and midline dressing changes will be done at established intervals Transparent semi-permeable membrane dressings are changed every 7 days and PRN .Initial dressings after catheter placement will be changed PRN if saturated, and 24-48 hours post insertion of midlines.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that the attending physician reviewed pharmacy identified irregularities/recommendations for 1 of 5 sampled residents, (#21). Findings: Resident #21 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission Minimum Data Set ((MDS) dated [DATE] noted that resident #21 had received [MEDICAL CONDITION] medication in the past 7 days. A review of the medical record noted that the resident had received both the antipsychotic medication, [MEDICATION NAME], and the antidepressant medication [MEDICATION NAME]. On 12/16/19 the Pharmacist reviewed the resident's medication regimen and recommended to the attending physician to consider a trial dose reduction of the [MEDICATION NAME]. There was no evidence that the attending physician had responded to the pharmacy recommendation in a timely manner. Further record review noted a Physician's progress note dated 1/27/20 but the Physician did not respond to the Pharmacist's recommendation for dose reduction of the [MEDICATION NAME]. On 3/11/20 at 5:17 PM, the Director of Nursing (DON) acknowledged that the Pharmacist had made a recommendation for a gradual dose reduction of the [MEDICATION NAME]. The DON stated the expectation was for the Physician to respond to the pharmacy recommendation on the next facility/resident visit, which was in January 2020. The DON could not provide an answer as to why the physician did not respond timely to the pharmacy recommendation.
F 0806 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a food substitute as per resident's preference for 1 of 4 residents reviewed for choices of a total sample of 40 residents, (#26). Finding: Resident #26 was admitted to the facility on [DATE] and readmitted on [DATE]. Her [DIAGNOSES REDACTED]. The quarterly minimum data set (MDS) assessment, with assessment reference date 12/12/19, revealed that the resident's cognition was intact, with a brief interview of mental status (BIMS) score of 13/15. Her preferences were not assessed, and the resident required supervision or limited assistance for all her activities of daily living. The resident's current physician orders [REDACTED]. A care plan for Potential risk inadequate intake related to medical/mental condition .resident will change her mind daily about foods .daily food preference obtained- picks her own menu was created on 9/26/16 with revision on 3/10/20. Interventions included, 9/12/19 snacks of choice, and 9/26/19 offer substitute if refused. Food preferences obtained on 9/10/19 showed PM snacks-pudding: butter scotch/vanilla and dislikes included spinach. The resident's Nutrition Quarterly assessment dated [DATE] read, Choosing not to comply with diet/eating what she wants/orders outside facility .daily food pref (preference) honored. On 03/08/20 at 2:13 PM, resident #26 stated she had a lot of concerns with the kitchen. The resident stated that she was supposed to have butterscotch pudding daily, but she received chocolate. She could not get a meat sandwich but only got grilled cheese sandwich and was sick of it. During the interview, a staff member brought a container of chocolate pudding for the resident. Resident #26 stated, that she was not allowed to have chocolate. Her gastrointestinal physician gave her a choice between chocolate and tomatoes, and she chose tomatoes. Resident #26 stated she had told staff her preferences repeatedly. On 03/09/20 at 10:15 AM, certified nursing assistant (CNA) L came into the resident's room to obtain her lunch and dinner choices from the menus given to her. Resident #26 stated that the two (2) main entrees for lunch were apple ginger pork loin, or vegetable quiche. She stated that she could not have fruit or spinach, and her only other choice was grilled cheese sandwich. CNA L told the resident, that he would ask the kitchen for a ham and cheese sandwich, for the resident. CNA L returned to the resident's room at 10:31 AM, and stated, that he was told by the kitchen staff that they could not make a meat sandwich but could get a grilled cheese sandwich. On 03/10/20 at 9:49 AM, the consultant Registered Dietician (RD) stated, that the resident had about 200+ dislikes. The RD said she knew resident #26 had a grilled cheese sandwich yesterday as she worked the tray line. The RD could not say if the facility provided meat sandwiches. On 03/10/20 at 11:51 AM, licensed practical nurse H stated that the resident complained about her dessert, and told her she could not eat fruits. LPN H said resident #26 mentioned to her that she could not get a ham and cheese sandwich. On 03/10/20 at 1:23 PM, Cook K stated that sandwiches available for residents were peanut butter and jelly, and grilled cheese. The Cook stated that if the facility served meat sandwiches as an entree, then the resident could get a meat sandwich. Cook K said, she was aware of resident #26's request for a ham and cheese on 3/09/20 but they did not have any meat sandwiches. The facility's policy Menus read, Menus will be served as written, unless a substitution is provided in response to preference.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to wash and sanitize dishes to ensure food was distributed in accordance with standards for food service safety. Findings: On 3/8/20 at approximately 1:30 PM, staff were observed operating the facility's dishwashing machine. Staff placed two racks of dishes in the machine and the washing temperature was 100 degrees Fahrenheit. The final rinse was approximately 118 degrees Fahrenheit. The facility's Sodium [MEDICATION NAME] test strip was used to determine the sanitizer solution's concentration. The test strip indicated that the sanitizer solution's concentration was not detectable. The dish machine had a label that indicated the wash and rinse temperature should be between 120 to 140 degrees Fahrenheit. The staff ran the dishmachine again and the wash and rinse temperature was 115 & 118 degrees Fahrenheit, respectively. The sanitizer solution was still not detectible as per results of the the test strip. Review of the Dish Machine Log form noted the last time the wash/rinse water temperature and sanitizer concentration was checked was on 3/2/20 at about the breakfast meal. The kitchen staff stated the temperature and sanitizer concentration was to be checked for all 3 meals (Breakfast, Lunch and Dinner) and the results were to be documented on the log each day. The kitchen staff that were present provided no explanation as to why the dish machine

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	105539	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEALTHCARE AND REHAB OF SANFORD	**950 MELLONVILLE AVE SANFORD, FL 32771**

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

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 5) temperature and sanitizer concentration was not checked on a daily basis during each meal shift. Underneath the dishmachine were 3-5 gallon containers of Rinse Aide, Liquid Dish Detergent and Sanitizer (bleach based sanitizer). The Liquid Dish Detergent and Sanitizer containers were empty and the staff stated that they both needed to be replaced. Further kitchen observations revealed that the the sanitizer concentration (ammonium based sanitizer) in the 3 compartment sink was not at the correct level. The concentration was checked with a Quaternary Test Strip which indicated the sanitizer concentration was near zero. The kitchen staff checked the container of Quaternary Sanitizer that was under the 3 compartment sink and it was nearly empty and the staff stated that it needed to be replaced. Shortly, thereafter the Certified Dietary Manager (CDM) arrived and he was informed about the issues with both the dishwashing machine and the 3 compartment sink sanitizer. He stated that the dishes will be re-washed once the temperature and sanitizer concentration issues were resolved. On 3/8/20 at 2:49 PM, a meeting was held with the CDM and the District Manger. They stated that the dish machine wash/rinse temperature needed to be between 120 to 140 degrees Fahrenheit and that the concentration of the chlorine based sanitizer needed to be at a minimum of 150 parts per million (ppm). They also stated that the sanitizer for the 3 compartment sink was ammonium based that required a minimum concentration of 150 ppm. They added that the vendor had set calibrations for both the dish machine and the three compartment sink to be at 200 ppm so that it was above the minimum. They acknowledged that the dish machine log needed to be completed everyday for all three meals. The CDM stated he was in charge for checking the log but in his absence the cook was to ensure the log was maintained/completed. Neither the CDM or the District Manger could explain why the dish machine log was not being completed by the kitchen staff.