STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105478	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Care Center	401 Fairwood Ave Clearwater, FL 33759

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on observations, interviews, and policy review, the facility failed to ensure resident rooms were maintained in a safe, sanitary, and homelike manner in three Zones (Zones 3, 6, and 8) out of eight facility Zones. Findings included: 1. During a facility tour of Zone 6/8 on 12/16/24 10:58 a.m. the following observations were made: - The nursing station front was covered in a textured paper, the paper had white and black stains, and a piece of trim was being held on by silver tape. - The bathroom connected to room [ROOM NUMBER] was observed to have a black ring of dirt and debris around the base of the toilet, with no caulking. The call light cord and the wall in the bathroom was also splattered with a brown substance. - In room [ROOM NUMBER], the wall, baseboard, and floor had dried liquid splattered on them. The door bed had a brown substance on the footboard. - The bathroom connected to room [ROOM NUMBER] was observed to have black marks and stains on the floor, a black ring, and cracked caulk around the base of the toilet. The widow bed had dirt, dust, hair, and debris on the bed frame and side rails. The baseboards were observed coming off the wall. - In room [ROOM NUMBER], the outlet cover on the wall next to the sink was cracked. The walls near the sink and the door to the room had previous drywall patches that were not painted and were cracked and coming apart. Above the window bed, there was a large stain on the ceiling, the texture was missing, and the drywall paper was peeling. The resident in the room said the stain had been there for a few months. She said the wall behind her bed was messed up as well and she wished her room was better. The wall behind the bed was observed to have a hole where a section of board was missing and the wall behind it was crumbling. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up tour on 12/19/24, the observations remained unchanged. room [ROOM NUMBER] was also observed to have a different resident in the door bed, however the brown substance remained on the footboard. An interview was conducted on 12/19/24 at 3:21 p.m. with the Regional Environmental Services (EVS) Director. She said when a resident moves out of a room the mattress is taken off the bed and the bed frame is cleaned. She said every room should get cleaned daily and deep cleaned once a month. She stated if a bed frame was visibly dirty it should have been cleaned. The Regional EVS Director was observed going to room [ROOM NUMBER] and looking at the foot board. She said, I could wipe that off right now. She said there is nothing she can say about it not being cleaned from one resident to the next. She said the bed should have been cleaned, especially during a terminal clean. She also stated any staff members, including nurses or certified nursing assistants (CNAs) that observed the brown substance on the bed should have cleaned it off. She said they all work together as a team. The Regional EVS Director was observed going to room [ROOM NUMBER] and looking at the window bed. She said the bed should have been cleaned on the monthly deep cleaning. The Regional EVS Director reviewed the deep cleaning schedule and said it appeared room [ROOM NUMBER] had not been deep cleaned since October. She stated room [ROOM NUMBER] had been scheduled to be deep cleaned on 12/17/24 but it did not appear to be done. An interview was conducted on 12/19/24 at 5:06 p.m. with the Director of Nursing (DON). She reviewed photographic evidence taken of the bed in room [ROOM NUMBER]. She said she would have expected staff to clean the brown substance off of the bed and she was surprised it remained even after the change of residents in the bed. She said the facility also had an ambassador program where management is assigned to do rounds, and she would have expected that to have been seen and cleaned. 43453 2. During a facility tour of Zone 3 on 12/16/24 at 9:44 a.m. environmental concerns were identified in rooms #1, #2, #3, #4, and #5. The room walls were observed to have holes, chipped paint, stains, and damaged baseboards. room [ROOM NUMBER] was observed with stained toilet base caulking with brown colored matter. On 12/17/24 at 3:45 p.m. and on 12/18/24 at 9:28 a.m., the previously identified environmental concerns were observed in resident rooms #1, #2, #3, #4, and #5. On 12/18/24 at 9:32 a.m. an interview was conducted with Staff F, Housekeeping. He stated if he observed a room in disrepair or stained toilet bases that were not cleanable, he would report it to maintenance. He said, I would tell the nurse to put it into [name of work orders management system]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/24 at 12:42 p.m. an interview was conducted with the Director of Maintenance (DOM). He confirmed he was aware the facility had damaged walls and baseboards in some of the rooms. He said, We have been tearing down walls, removing the trim, and adding new baseboards. The DOM stated some resident rooms needed to be repaired and the resident rooms were on the schedule to be repaired, but he was waiting for the census to go down. The DOM also stated if any employee saw items that needed to be repaired or replaced, they should put it into the facility's work orders management system. He said, If the toilet bases are not cleanable, they should be scheduled for us to strip and re-caulk. The DOM presented the list of current open work orders. The rooms noted with concerns were not documented in their system for pending repairs. Review of the facility policy titled Maintenance Service, revised December 2009, revealed the following: Policy Statement: Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation: 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: a. maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. b. maintaining the building in good repair and free from hazards. c. maintaining the fire alarm system and emergency generator system in good working order. d. maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order. e. maintaining lighting levels that are comfortable and assuring that exit lights are in good working order. f. establishing priorities in providing repair service. g. maintaining the paging system in good working order. h. maintaining the grounds, sidewalks, parking lots, etc., in good order. i. providing routinely scheduled maintenance service to all areas. j. others that may become necessary or appropriate. 3. The maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Photographic Evidence Obtained)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49227 Based on interviews, record review, and policy review, the facility failed to ensure a written Notice of Transfer and/or Discharge Notice was issued in writing for one resident (Resident #94) of three residents reviewed for transfer/discharge process and failed to ensure a thirty (30) day Notice of Discharge was provided one resident (Resident #94) of three residents reviewed for transfer/discharge process. Findings included: Review of Resident #94's Admission Record showed Resident # 94 was admitted to the facility on [DATE]. Review of Resident # 94's Consent to Treat, dated 10/19/24, revealed verbal consent for treatment was received from Resident #94's Emergency Contact. Review of Resident #94's Brief Interview for Mental Status (BIMS) Assessment, dated 10/19/24, showed a BIMS score of 6/15, indicating severe cognitive impairment and impaired insight and judgement. Review of Resident # 94's Social Services Notes, dated 10/21/24 at 3:03 PM, revealed Resident #94's memory is impaired related to cognitive deficit. Review of Resident #94's Minimum Data Set (MDS) assessment dated [DATE] showed under Section Q - Participation in Assessment and Goal Setting, the overall goal for discharge was to remain in the facility, with the information source documented as family. Review of Resident #94's Psychiatry Provider Physician Assistant (PA) note, dated 10/23/24, revealed the following: impaired cognition, impaired short-term memory, fair to impaired long-term memory, and impaired judgement. Resident #94 was diagnosed with dementia. The Dementia Functional Assessment Staging Test (FAST) revealed Resident #94 has stage 5 dementia. Review of Resident #94's Speech Therapy evaluation and plan of treatment note dated 10/24/24 revealed a St. Louis University Mental Status (SLUM) exam score of 10 out of 30, indicating cognitive deficits. Review of an Elder Affairs of Florida Notification of Level of Care dated 11/1/24, showed recommendations for a skilled level of care and placement in a Nursing Home. Review of Resident #94's Progress Notes dated 12/7/24 at 11:22 PM, revealed at approximately 6:15 PM, Resident #94 was standing at another resident's bedside and both residents were yelling at each other. Resident # 94 was placed on one-to-one monitoring following the incident. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #94's Psychiatry Provider evaluation note dated 12/9/24, revealed Resident #94 had a history of dementia and recommendations included psychotropic medication management and assessment. Resident stated to the provider, I am being ping-ponged back-and-forth and confirmed feeling agitated. The note also revealed Resident #94 will be evaluated by another facility .today .for potential discharge. The note revealed Resident #94's thought process is organized with confusion, short term and long-term memory are fair to impaired and staff were educated to offer non-pharmacological interventions including redirection and reassurance. Review of Resident #94's Progress Notes dated 12/10/24 at 11:57 AM revealed resident discharged to other facility. Review of Resident #94's Nursing Home Transfer and Discharge Notice revealed the notice was given on 12/10/24. The Notice revealed under Reason for Discharge or Transfer was Your needs cannot be met at this facility. The section of the form titled Notice received by, was blank and did not document the name of the person receiving the notice or a signature of the person receiving the notice. Review of Resident #94's medical record did not contain documentation indicating Resident #94 received advance notice of discharge, no documentation of Resident #94's voiced intent of transfer, nor was there documentation of the facility's attempts to meet the resident's needs or what services the new receiving facility had in order to meet the resident's needs that were not available at the current facility. During an interview on 12/18/24 at 11:20 AM with Resident #94's Psychiatric Physician Assistant (PPA), the PPA stated there were two incidents' of behaviors displayed by Resident #94, one involved another resident and the second involved a nurse. The PPA said Resident #94 was confused and on all accounts had a good rapport with staff. She said increased incidents in Resident # 94's behaviors may have been related to miscommunication and how staff approached him and he may do well in a memory unit. During an interview on 12/18/24 at 12:19 PM with the facility's Director of Nursing (DON) and the Social Services Director (SSD), the SSD said Resident # 94 was transferred to another facility because the facility was at capacity, and they found a facility to accept him. During an interview on 12/18/24 at 5:24 PM, the SSD confirmed Resident # 94's discharge was a facility-initiated discharge and discharge notification was provided to the resident on 12/10/24. During a telephone interview on 12/18/24 at 7:54 PM, Resident # 94's Emergency Contact (EC), the EC said he had not been notified of Resident #94's transfer to another facility. He also said a 30-day discharge notification didn't happen. The EC said the nurse called and told him Resident #94 was blocking the door with his wheelchair; I don't know if that caused them to push him out of the nursing home. The EC also said the last time he spoke with Resident #94, the resident thought [NAME] was president, and it was 1994. During an interview on 12/19/24 at 12:07 PM, with Staff E, Nursing Consultant (NC), Staff E, NC said Resident #94 received a 30-day discharge notice on the day of discharge, 12/10/24. Staff E, NC also stated a 30-day discharge notice could be given at any time. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 12/19/24 at 5:08 P.M., with the NHA, DON, SSD, and Staff E, NC, the SSD said there were fluctuations in Resident #94's cognition, and he was more lucid at times. Staff E, NC said Resident #94 was transferred to another nursing home that has more psychiatric services. Staff E, NC also stated onsite psych services were available more days a week at Resident #94's new facility. Review of the facility policy titled Transfer or Discharge Notice, revised March 2021, revealed the Policy Statement: Residents and/or representatives are notified in writing, and in a language and format they understand, at least 30 days prior to a transfer or discharge. The policy also revealed the following Policy Interpretation and Implementation: 1b. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility. 2. Residents are permitted to stay in the facility and an not be transferred or discharged unless: a) the transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility. 3. Except as specified below, the resident and his representative are given 30-day advanced written notice on an impending transfer or discharge form this facility. 4. Under the following circumstances, the notice is given as soon as it is practicable but before transfer or discharge: 4a. The safety of individuals in the facility would be endangered. 4b. The health of individuals in the facility would be endangered. 4d. An immediate transfer of discharge is required by the residents' urgent medical needs; and/or 4e. The resident has not resided in the facility for thirty (30) days. 5. The residents and representatives are notified in writing of the following information: 5a. The specific reason for the transfer or discharge. 5b. The effective date of the transfer or discharge. 5c. The location of which the resident is being transferred or discharged . 5d. The location to which the resident is being transferred or discharged . 5e. An explanation of the residents' right to appeal the transfer or discharge. 6. A copy of the notice is sent to the Office of State Long -Term Ombudsman at the same time the transfer or discharge is provided to the residents and representative. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Residents have the right to appeal a facility-initiated transfer or discharge through the state agency that handles appeals.

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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** 48223 Based on record review, observations, and interviews, the facility failed to ensure the comprehensive Minimum Data Set (MDS) Assessment was accurately coded for two residents (Resident #46 and Resident #38) of four residents sampled for accuracy of assessments. Findings included: Review of Resident #46's Admission Record revealed Resident #46 was admitted to the facility on [DATE], and readmitted to the facility on [DATE], with diagnoses of adjustment disorder with depressed mood, generalized anxiety disorder, schizoaffective disorder, and major depressive disorder. Review of Resident #46's Florida Preadmission Screening and Resident Review (PASRR) Level II Determination Summary Report dated 3/13/2019 revealed, Resident #46 meets the definition of Serious Mental Illness, appropriate for nursing facility placement, and does not require specialized services. Review of Resident #46's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/10/2024 revealed under Section A - Identification Information, Resident #46 did not have a serious mental illness or related condition. Review of Resident #38's Admission Record revealed Resident #38 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of major depressive disorder, generalized anxiety disorder, unspecified mental disorder due to known physiological conditions, unspecified psychosis not due to a substance or known physiological condition, and dementia. Review of Resident #38's PASRR Level II Determination Summary Report dated 1/20/2022 revealed Resident #38 meets the definition of Serious Mental Illness, appropriate for nursing facility placement, and does not require specialized services. Review of Resident #38's MDS with an ARD of 3/20/2024 revealed under Section A - Identification Information, Resident #38 did not have a serious mental illness or related condition. During an interview on 12/19/2024 at 11:35 a.m., with Staff D, Registered Nurse (RN)/MDS Coordinator, Staff D, RN stated she was responsible for completing the MDS Assessments. Staff D, RN verified Resident #46 and #38's MDS Assessments were inaccurately coded under Section A for PASRR, as both residents meet requirements for having a Level II PASRR. During an interview on 12/19/2024 at 2:18 p.m. with the Director of Nursing (DON), she stated the facility does not have a policy and procedure related MDS Assessment completion, the facility just follows the regulation.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on record review and staff interview, the facility failed to complete the Pre-Admission Screening and Resident Review (PASRR) Level II upon a new qualifying mental health diagnoses and failed to resubmit for a PASRR Level II review for five residents (Resident #1, Resident #3, Resident #98, Resident #46, and Resident #38) of 10 residents sampled for PASRRs. Findings included: 1. Review of Resident #1's Admission Record revealed an original admitted [DATE] and a readmitted [DATE]. Review showed the resident had the following diagnoses listed: - Schizoaffective disorder, bipolar type dated 1/24/24. - Unspecified dementia, unspecified severity, with psychotic disturbance dated 5/11/23. - Epilepsy, unspecified, not intractable, without status epilepticus dated 10/14/15. - Major depressive disorder, single episode, unspecified dated 10/1/15. - Unspecified mood [affective] disorder dated 10/1/15. - Anxiety disorder, unspecified dated 09/10/15. - Unspecified intellectual disabilities dated 12/17/22. Review of a Level II PASRR Determination Summary Report dated 7/20/09 showed the resident was reviewed related to history of seizure disorder, reported history of mild schizophrenia, depression and impulse control. The review did not include the newly acquired diagnoses. he review showed a Level II PASRR was not submitted for recommendation. 51097 2. Review of Resident #3's Admission Record showed Resident #3 was admitted to the facility on [DATE]. Review showed the resident had the following diagnoses listed: - Generalized anxiety disorder dated 5/31/24. - Unspecified dementia, unspecified severity, with psychotic disturbance dated 5/11/23. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Level I PASRR, dated 8/14/2024 showed in Section II: Other Indications for PASRR Screen Decision-Making, questions 1 through 7 were marked No. A Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease). Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required was marked. Review of Resident #98's Admission Record showed Resident #98 was admitted to the facility on [DATE]. Review showed the resident had the following diagnoses listed: - Generalized anxiety disorder dated 11/6/24. - Unspecified dementia, unspecified severity, with mood disturbance dated 11/6/24. - Depression, Unspecified dated 10/30/24. Review of the Level I PASRR, dated 11/5/2024 showed in Section II: Other Indications for PASRR Screen Decision-Making, questions 1 through 7 were marked No. A level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease). Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required was marked. 48223 3. Review of Resident #46's Admission Record revealed Resident #46 was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Review showed the resident had the following diagnoses listed: - Adjustment disorder with depressed mood dated 3/24/24. - Generalized anxiety disorder dated 9/25/20. - Schizoaffective disorder dated 4/13/20. - Major depressive disorder dated 7/29/20. Review of Resident #46's PASRR Level II Determination Summary Report dated 3/13/2019 revealed, Resident #46 meets the definition of Serious Mental Illness. Review of Resident #46's medical record did not reveal an updated PASRR Level II after identification of new diagnoses. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #38's Admission Record revealed Resident #38 was admitted to the facility on [DATE] and readmitted on [DATE]. Review showed the resident had the following diagnoses listed: - Major depressive disorder, recurrent, severe with psychotic symptoms dated 9/10/20. - Anxiety disorder, unspecified dated 9/10/20. - Unspecified mental disorder due to known physiological conditions dated 9/10/20. - Unspecified psychosis not due to a substance or known physiological condition dated 9/10/20. - Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety dated 6/3/16. Review of Resident #38's PASRR Level II Determination Summary Report dated 1/20/2022 revealed Resident #38 meets the definition of Serious Mental Illness. Review of Resident #38's medical record did not reveal an updated PASRR Level II after a identification of new diagnoses. An interview was conducted on 12/18/24 at 1:44 p.m. with the Social Services Director (SSD). The SSD said after admission to the facility, she meets with the nursing leadership team to review the resident's PASRR and their diagnoses to determine if a Level II PASRR evaluation is required. The SSD acknowledged the PASRRs were not updated upon acquiring new diagnoses and Level II PASRRs should have been completed. Review of the facility policy and procedure titled Resident Assessment - Coordination - Pre-Admission Screening and Resident Review (PASRR) program, not dated, revealed under Intent, it is the policy of the facility to assure that all residents admitted to the facility receive a PASRR, in accordance with state and federal regulations. The policy also revealed the following Procedure: 2. Coordination includes: a. Incorporating the recommendations from the PASRR level II determination and the PASRR evaluation report into a resident's assessment, care planning, and transitions of care. b. 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.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on record review and staff interviews, the facility failed to complete the Pre-Admission Screening and Resident Reviews (PASRR) for residents with a mental disorder and individuals with intellectual disability following identification of qualifying mental health diagnoses for three residents (Resident #36, Resident #102, and Resident #53) of 10 residents sampled for PASRRs. Findings included: Review of Resident #36's Admission Record revealed an admitted [DATE]. Review showed the resident had newly acquired diagnoses of major depressive disorder, dated 9/10/24 and Alzheimer's disease, dated 5/3/24. Review of a Level I PASRR for Resident #36 dated 5/3/24 revealed a blank PASARR and the qualifying diagnoses were not checked. 46234 Review of Admission Records showed Resident #102 was admitted on [DATE] with diagnoses including bipolar disorder, generalized anxiety disorder, adjustment disorder with anxiety, major depressive disorder, and mood (affective) disorder. Review of Resident #102's PASRR Level I Screen, dated 4/25/24, did not indicate the resident had a diagnosis of any mental illness or suspected mental illness. 51097 Review of Resident #53's Admission Record showed she was admitted to the facility on [DATE] with diagnoses to include major depressive disorder and generalized anxiety disorder. Review of Resident #53's Level I PASRR, dated 9/9/2022 showed in Section I: PASRR Screen Decision-Making: A. MI or suspected MI (check all that apply), Schizophrenia is marked. Anxiety Disorder and Depressive disorder was not marked. 48223 An interview was conducted on 12/18/24 at 1:44 p.m. with the Social Services Director (SSD). The SSD said after admission to the facility, she meets with the nursing leadership team to review the resident's PASRR and their diagnoses to determine if a Level II PASRR evaluation is required. The SSD acknowledged the PASRRs were not updated upon acquiring new diagnoses. Review of the facility policy and procedure for Resident Assessment - Coordination - Pre-Admission Screening and Resident Review (PASRR) program, not dated, revealed under Intent, it is the policy of the facility to assure that all residents admitted to the facility receive a Pre-Admission Screening and Resident Review, in accordance with State and Federal Regulations. The policy also revealed the following Procedure: (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The facility will coordinate assessments with the pre-admission screening and resident review (PASRR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. 2. Coordination includes: a. Incorporating the recommendations from the PASRR level II determination and the PASRR evaluation report into a resident's assessment, care planning, and transitions of care. b. 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. 3. Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. The facility will not admit, on or after January 1, 1989, any new residents with: a. Mental disorder, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission: i. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and ii. If the individual requires such level of services, whether the individual requires specialized services for mental retardation.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observation, interview, and record review, the facility failed to ensure treatment and care for chronic conditions were provided in accordance with professional standards of practice and failed to complete timely and thorough assessments for one resident (Resident #36) of one resident reviewed for edema. Findings included: On 12/16/24 at 9:38 a.m., Resident #36 was observed in the dining room during a morning activity session sitting in her wheelchair. The resident was noted with swelling in both of her lower legs. Review of Resident #36's Admission Record showed the resident was admitted to the facility on [DATE]. The review also revealed the resident had a newly acquired diagnosis of edema, unspecified, dated 11/7/24. Review of Resident #36's medical record revealed the following: - The Medical Certification For Medicaid Long-Term Care Services and Patient Transfer Form dated 5/2/24 did not show a documented edema diagnosis. - Review of an Admission History and Physical (H&P) dated 3/11/24 did not show a diagnosis of edema. A review of Resident #36's admission nursing comprehensive evaluation dated 9/10/24 showed the resident had suspected deep tissue injury to her left heel and sacrum but no other skin conditions were documented. Review of physician notes for Resident #36 showed from 7/31/24 to 9/17/24, there were no documented concerns related to edema diagnosis. The notes showed, skin is unremarkable with no worrisome lesions seen, color is good. No jaundice or cyanosis seen. Review of a CIC (Change in Condition) SBAR (Situation, Background, Assessment, Recommendation) Communication Form dated 10/31/24 showed Resident #36 had +3 edema to LLE (left lower extremity). There were no additional notes related to this change. Review of a physician note dated 11/1/24 showed the PCP ordered an ultrasound of left lower extremity secondary to edema. Review of Resident #36's Radiology Results Report dated 11/1/24 showed the following: - Procedure: left duplex scan, veins, extremity, unilateral /limited study - Findings: technique: Real-time ultrasonography of the left lower extremity venous vasculature was performed, and static images are presented for interpretation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Findings: the left common femoral and left proximal to mid superficial femoral veins were visualized and are noncompressible. - Impressions: Acute, deep venous thrombosis involving the left common femoral and left proximal to mid superficial femoral veins. A nursing progress note dated 11/1/24 showed an order note for Eliquis (Apixaban) oral tablet 5 mg (milligrams) mg give 1 tablet by mouth two times a day for DVT (deep vein thrombosis). Review of active physician orders dated 12/18/24 showed the Apixaban was ordered on 11/1/24 and started on 11/9/24. Review of Resident #36's physician orders also showed furosemide (Lasix) oral tablet 20 mg, give 1 tablet by mouth one time a day for edema, initiated on 11/16/24. Review of Resident #36's Minimum Data Set (MDS) assessment dated [DATE] under Section I - Active Diagnoses did not show the diagnosis of chronic edema. On 12/17/24 at 2:16 p.m. an interview was conducted with the Director of Nursing (DON). She stated Resident #36 was seen by her Primary Care Physician (PCP) earlier that day. The DON stated the original Change in Condition (CIC) was discovered on 11/7/24 and, The doctor stated there wasn't much that can be done. Her edema is chronic. We can ask her to elevate her legs as much as possible. The DON stated the resident could not get footrests to elevate her legs because she ambulates independently, and the resident was receiving Lasix. Review of an ARNP (Advanced Registered Nurse Practitioner) note dated 11/5/24 and electronically signed by the ARNP on 12/17/24 at 3:26 p.m., showed Patient has a positive DVT (Deep Vein Thrombosis) to the left common femoral and left proximal to mid superficial femoral veins. Spoke with nursing. Review of an Update Diagnosis note for Resident #36 dated 12/17/24, and with a revision date of 12/18/24, showed under Description: Localized Edema, Date: 5/2/24, Classification: During Stay, Comments: Chronic. Review of Resident #36's care plan initiated 5/17/24 showed, the resident has a potential for skin impairment/pressure ulcers related to impaired mobility, requires staff assist to turn and reposition, incontinence of bowel, incontinence of bladder, fragile skin, has a cachectic appearance, and receives steroids. On 12/17/24, the care plan was revised to include, chronic edema to BLE [Bilateral Lower Extremities]. Review of Resident #36's nursing progress notes dated from 11/1/24 to 12/7/24 revealed inconsistent monitoring and documentation of the resident's condition as follows: - 11/1/24: Edema noted to LLE. - 11/2/24: Edema present: Has edema in the following extremities: LLE non-pitting. - 11/3/24: Edema present: Has edema in the following extremities: LLE non-pitting. - 12/17/24: Resident noted with 1+pitting edema to BLE (bilateral lower extremities). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 12/18/24 at 2:02 p.m., Resident #36 was observed with swelling in both feet. Her right leg was observed more swollen than the left and the legs were mottled on the lower end of both feet. The resident stated sometimes it hurts. During the interview Staff A, Registered Nurse (RN), assigned to this resident, stated the resident had chronic edema and has had swelling to both feet, which started about 6 weeks ago. She stated when the swelling started increasing to her left foot, the resident was prescribed Lasix. Staff A, RN stated the expectation for nursing is to document in the skilled notes their daily assessment of the resident's condition, especially when there has been a change. This nurse stated sometimes this resident complains of pain, mostly during the day because she is mobile, and does not want to sit or put her feet up. She stated they should be documenting the appearance of her feet and any changes noted. On 12/19/24 at 11:30 a.m., an interview was conducted with Staff D, RN/MDS Coordinator. She stated to complete a care plan, they look at diagnosis, review orders, and history and physical. She confirmed diagnosis of edema should be listed in Section I of the MDS Assessment if the diagnosis was present on admission. Staff D, RN MDS also stated Resident #36 did not have the diagnosis when the MDS Assessment was done and if nurse's notes and wound care notes showed the concern, it would be documented, and the care plan would be updated with the skin condition of edema. Staff D, RN/MDS confirmed the care plan was not updated because they did not know she had that problem. Staff D, RN/MDS also confirmed the care plan was edited on 12/17/24 and she did not see the edema diagnosis on the Medical Certification For Medicaid Long-Term Care Services and Patient Transfer Form or the H&P. On 12/17/24 at 03:48 p.m., an interview was conducted with Staff B, Licensed Practical Nurse (LPN). She stated she worked with Resident #36 often and approximately 2 weeks ago, the resident had shown signs of edema due to a DVT and was prescribed Lasix. She stated if a resident was diagnosed with edema, they would monitor the resident daily, checking pedal pulses, swelling, and signs of infection. She also stated there should be daily skilled notes to show nursing interventions, such cueing the resident to elevate their feet. She stated she did not know if she had documented on this particular resident, and she was reminded today during change of shift to monitor the resident. On 12/18/24 at 2:06 p.m., an interview was conducted with Staff C, RN/Unit Manager. She stated Resident #36 had chronic edema issues. She stated she remembered seeing that information documented somewhere, but she could not find it at the moment. She stated on 11/1/24 the resident was noted with a DVT. She revealed two progress notes dated 11/2/24 and 11/3/24 documenting the resident's edema assessments, but no other notes. This nurse confirmed she did not see any other nurses notes and could not confirm if the resident had edema on her left, right, or both legs. She stated nurses should be documenting in the skilled notes of observations of their monitoring of the resident's condition. (continued on next page)

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