STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105849	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wrights Healthcare and Rehabilitation Center	11300 110th Ave N Seminole, FL 33778

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39866 Based on observations, interviews, and record review, the facility failed to protect the residents' right to be free from abuse by an agency staff member, for one resident (#1) out of 3 residents sampled for abuse. On 11/04/2024 a physical altercation was witnessed to occur between Staff A, Agency Certified Nursing Assistant and Resident #1. Resident #1 suffered injuries to include: purple discoloration of the left eye on the eye lid and under the eyebrow, purplish discoloration along his left jaw line, and a swollen right forearm with redness near his elbow extending down to his mid forearm. Resident #1 was transferred to a higher level of care for evaluation and treatment as a result of the altercation. Findings included: Review of Resident #1's Admission Record revealed he was admitted to the facility on [DATE]. His diagnoses included dementia without behavioral disturbances, glaucoma, Type 2 Diabetes Mellitus without complications, personal history of transient ischemic attack, cerebral infarction without residual deficits, hypertension, hyperlipidemia, retention of urine, anemia, benign prostatic hyperplasia without lower urinary tract symptoms, and cerebral vascular disease. Review of Resident #1's Admission Minimum Data Set (MDS), dated [DATE], Section C, Cognitive Patterns, revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severe cognitive impairment. Review of Resident #1's Determination of Incapacity form, dated 8/30/24, revealed he was deemed incapacitated as of 8/30/24. An observation was made on 11/12/24 at 9:45 AM of Resident #1. He was observed to be lying in bed on his right side with his eyes closed. His left forearm was observed to be larger than his right forearm with redness near his elbow extending down to his mid forearm. He was observed to have a bandage on his left wrist and a discolored area to his left and right hand. There was no bruising observed on the left side of the residents face. The right side of his face was not visible. (continued on next page)

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.

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

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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 0600 Level of Harm - Actual harm Residents Affected - Few	An observation was conducted on 11/4/24 at 12:00 PM of Resident #1. He was observed to be in his wheelchair in the dining room being assisted by staff eating his ice cream. There was no facial bruising observed. His left forearm arm was observed to be larger than his right with a red area from his mid forearm to his elbow. Review of Resident #1's late entry incident note, dated 11/4/24 at 7:10 AM, revealed: Staffing coordinator [sic] responded to a female voice yelling from behind the closed door of resident' room. Upon entering room to investigate she observed assigned agency CNA [Certified Nursing Assistant] involved in a physical and verbal altercation with the resident. Resident was naked and lying on his back in his bed. The staffing coordinator [sic] directed the agency CNA to exit the room/facility and summoned the nurse to evaluate resident. Another CNA assisted staffing coordinator [sic] in applying brief and covering resident for comfort pending [sic] action by abuse prevention coordinator. Review of Resident #1's late entry incident note, dated 11/4/24 at 8:00 AM, written by the Director of Nursing (DON), revealed: This writer rec'd [received] call from staffing coordinator [sic] at approximately 7:10 a [AM] reporting that she had witnessed a physical altercation between the resident and the CNA assigned to him. She had already directed the CNA to exit the facility and the nurse on duty had completed an initial evaluation of the resident. Upon arriving at the facility, this writer approached resident at his bedside where he was observed lying on his right side in reverse direction (head towards footboard) in his bed resting quietly. This writer immediately noted purplish-red discoloration of resident's left eye orbit/lid extending corner to corner and around the outside, as well as purplish-red discoloration along his lower left jawline. Resident initially attempted to push this writer away, but calmed with soothing verbal reassurance and touch. This writer lifted the sheet that was covering him and noted that resident's left forearm was swollen, red and warm to touch. Resident would not allow the writer to assess further. No additional acute injuries were apparent. Resident known to have multiple other areas of bruising, skin tears and abrasions of various sizes and healing stages to bilateral upper and lower extremities, as well as left forehead/upper eyebrow prior to this incident. This writer notified the APRN [Advanced Practical Registered Nurse] of the event and requested a bedside visit ASAP [as soon as possible]. Additional notifications and reports were made to the resident's daughter, law enforcement, and regulatory agencies as required. Review of Resident #1's late entry Transfer to Hospital Summary, dated 11/4/24 at 10:12 AM, revealed: At the direction of [Sheriff's Office] resident transferred to [emergency room] via [Emergency Medical Services (EMS)] for further evaluation and treatment r/t [related to] incident that occurred earlier this morning. Resident was assisted from bed to stretcher w/o [without] incident by EMS and facility staff. Resident somnolent but responsive at the time of transfer. VSS [vital signs stable]. [Family]aware of transfer. Review of Resident #1's Admission Note, dated 11/4/24 at 7:51 AM, revealed: Resident readmitted with a red area to left arm and ecchymosis noted to left eye and left [NAME] [sic] Discoloration noted to upper and lower extremities Sitting [sic] up in bed at present eating dinner NO [sic] s/s [signs/symptoms] of respiratory distress Call [sic] bell in reach. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Incident note, dated 11/6/24 at 11:10 PM, revealed: Resident continues to be monitored following incident on 11/4. Resident out of bed in main common area. Today seating was changed to gerichair per therapy to improve comfort and reduce restless behaviors when out of bed with good results. Resident rested quietly for most of the day. Monitoring of injuries ongoing. Left eyelid and inner canthum remain dark purple in color - fading bruising of outer canthum and left lower jaw line. Swelling and redness of left forearm improved, but elbow remains swollen andtender [sic] to touch. Resident also has multiple areas of bruising, skin tears and abrasions of multiple sizes at various stages of healing r/t other events (e.g. falls), including nearly resolved area of discoloration above left eyebrow. Seen today by medical director during rounds. Resident exhibiting no obvious adverse response to 11/4 incident. Will continue to monitor. Review of Resident #1's Hospital Transfer Form, dated 11/4/2024 at 9:38 AM, revealed: Other Reason for Transfer: pain and swelling left arm, pain and bruising jaw. .Skin/Wound Care .2. Other wounds or bruises present (describe): Left eye bruised Left jaw bruised Review of Resident #1's Trauma/Stressful Event Screening Tool, dated 11/8/24 at 4:59 PM, revealed: Indicate which individual participated in the interview 1. Other (explain below) 1a. Explain other Staff-Director of Nursing 2. Instructions: Say to the resident: Sometimes things happen to people that are unusual or especially frightening, horrible or traumatic. For example: a serious accident or fire, physical or sexual assault or abuse, an earthquake or flood, a war, seeing someone killed or seriously injured or having lost a love through homicide, suicide or an unusual accident or event? 2a. Have you ever experienced this kind of event? Yes 2aa. Information on the traumatic event as per residents choice to share details (explain below). Resident experienced physical and verbal abuse by a caregiver on 11/4/24. As of 11/8/24 - resident demonstrates baseline behaviors with no obvious indicators of residual psychological distress related to the incident. Resident has severe cognitive deficits secondary to dementia diagnosis and may have no recall/memory of event. Ongoing monitoring. 2b. Ask the Resident or Representative: In your life, have you ever had any experience that was so frightening, horrible or upsetting that I the past month you/they have experienced: NONE of the above experienced, no further intervention required. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's care plan with a creation date of 9/19/24 revealed; [Resident #1] has cognitive deficits R/T a diagnosis of dementia. On 11/8/24 the care plan was updated to include He is at increased risk for adverse interactions due to dementia-related behaviors that include resistance to care, verbal outbursts and physical defensiveness. The goal revealed [Resident #1] will be safe, free of distress and will maintain current cognitive function for as long as possible through next review date. The interventions revealed Administer medications as ordered. Monitor resident response in regard to need, effectiveness and side effects. Attempt to identify specific stressors and educate staff to what they are so they can be minimized if possible. Ensure safety then leave and reapproach when demonstrating care resistance. Explain all care prior to starting and talk to resident throughout care. Identify things resident[sic] enjoy (e.g. music, preferred TV show, etc.) that can be played during care. If able, plan care during time of day/shift when resident is more approachable and allow rest periods if necessary to complete task. If resistive, seek out caregivers that resident is familiar with and trusts to assist with care. Reorient resident as needed and provide TLC [tender loving care] and reassurance. Speak clearly and slowly in a calm voice using short, simple sentences. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 11/12/24 at 12:05 PM with the Staffing Coordinator. She said at 6:40 AM she was looking for a broom. Resident #1' s room and her office share a wall. She walked out of her office to get a broom from the housekeeper and as she was walking back she heard a female voice, screaming, yelling, and cursing coming from Resident #1's room so she entered his room, his bed was near the window and the dividing curtain was not drawn so she saw Resident #1 on his back completely nude, his head was at the foot of the bed and his feet were at the head of the bed with his legs bent and together. Staff A, Agency, CNA, was between the window and his bed standing towards the middle of the bed where his knees were bent. Staff A, Agency, CNA's back was to the window and when the Staffing Coordinator opened the door her and Staff A, Agency, CNA made eye contact. The Staffing Coordinator said to Staff A, Agency, CNA What the [expletive] are you doing, get out of here! as the Staffing Coordinator was saying that, Staff A, Agency, CNA looked at Resident #1 and said, You're piece of [expletive] and she was shoving his legs and arms pushing him away from her and when she would push his legs and his arm on his left side he would recoil back because he does not move that way. The Staffing Coordinator repeated herself and said Get out of here! As Staff A, Agency, CNA was walking out of the residents room she threw a pile of sheets, Resident #1's clothing for the day, and a folded up unused brief at his face. The Staffing Coordinator called out for help and Staff B, Agency, CNA came in as Staff A, Agency, CNA was exiting. Resident #1 was swinging his fists at that time and He was scared and reactive, I talked softly to him, got a sheet on him, and pillow under his head. Then the Staffing Coordinator said she called out for Staff C, LPN Supervisor and he came in and then the Staffing Coordinator exited the room. She saw Staff A, Agency, CNA was gathering her belongings in the small dinning room and the Staffing Coordinator followed behind her until she was out of the building. The Staffing Coordinator said there were no other altercations with Staff A, Agency, CNA with staff or other residents as she was exiting the facility, There was not even a word spoken from her. She exited the facility and the doors were locked. The Staffing Coordinator said she went back to Resident #1's room, Staff C, LPN Supervisor was assessing Resident #1 and The Staffing Coordinator called the Director of Nursing (DON) and put her on speaker phone so the Staffing Coordinator and Staff C, LPN Supervisor could tell her what they saw. Staff C, LPN Supervisor told the Staffing Coordinator 20 minutes prior to the incident he did not notice any facial bruising or swelling to the residents' left forearm. The Staffing Coordinator said she saw Resident #1 had bruising on his left eye and under his left jaw. On his left hand, the first knuckle was red from where he swung at Staff A, Agency, CNA and she hit his hand away. His left forearm was red, hot, and swollen from about his mid forearm up to his bicep area. When the staff member pushed him the second time, the Staffing Coordinator said she noticed Resident #1 had a bandage on his left bicep, from a previous skin tear, had attached to Staff A, Agency, CNA's glove and completely removed it off his skin. The Staffing Coordinator said Resident #1 was very scared. She sat with him until he calmed down and he said to her Let's just all be nice to each other, and he ended up going back to sleep with no further incident. By then the DON came in and she started her assessment and he was still a little skittish with her but then calmed down and she was able to finish her assessment. The Staffing Coordinator said Resident #1 enjoyed music and was a very sweet man. She said she did not provide him with personal care but from what she knew he was not resistive to personal care or had any behaviors. The Staffing Coordinator said Staff A, Agency, CNA had abuse and neglect training with an 88% passing rate through her agency in July of 2024. She said Staff A, Agency CNA used to work at the facility through a different agency company and the only concern was she was not reliable, she had a lot of call outs. The Staffing Coordinator said Staff A, Agency, CNA had worked with Resident #1 a total of five times including the day of the event. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A phone interview was conducted on 11/4/24 at 1:16 PM with Staff C, LPN Supervisor. He said, on 11/4/24, he was giving report to the oncoming nurse. The staff coordinator went into Resident #1's room because she heard something and that's when he heard the Staffing Coordinator tell Staff A, Agency, CNA she had to leave. Then he saw Staff A, Agency, CNA exit the room and Staff B, Agency, CNA went in the room with the Staffing Coordinator to finish providing care. Staff C, LPN Supervisor said when Staff A, Agency, CNA exited the room she told him Resident #1 was resisting care and she was leaving and probably won't be able to come back. Staff C, LPN, Supervisor said Oh okay what happened? but she just left. Then the Staffing Coordinator called him into the room to assess Resident #1 and he said, Why what's wrong and [Staffing Coordinator] said to me something happened in here with [Resident #1]. Staff C, LPN, Supervisor said he assessed Resident #1, and saw his left arm was swollen and red. Staff C, LPN Supervisor, said Resident #1 doesn't really feel pain but he was acting like it was hurting him. Then when the resident looked at him, he saw Resident #1 had a blue area under his eye and above his eye and he said What happened in here because he did not have that when I was in his room less than an hour before that. He said he told the DON what he saw and gave a statement. Staff C, LPN Supervisor said his interactions with Resident #1 were minimal because he did not get any medications on the night shift, but he would get restless at night and Staff C, LPN Supervisor would talk with him and get him in his chair But he was a very pleasant person. I did not know him to be resistive to care. A family phone interview was conducted on 11/12/24 at 1:56 PM. She said she was told One of the other nurses or someone from agency slapped [Resident #1]. She said the police and the Nursing Home Administrator had told her that his arm was really swollen, and they were going to order a mobile X-ray but it was going to take too long so they recommended to have him sent out to the hospital. The family member said they called the deputy a couple days after the event and the deputy said Staff A, Agency, CNA was cooperative with the investigation and is denying she hurt him and saying the person who reported her does not like her. The family member said But I can't see someone making up a story like that. The family member said they saw his left arm was red and swollen but the hospital told them they took X-ray's, and it wasn't broken or fractured. The hospital also said he had a bruise under his jaw. I just don't see how someone could do that to [Resident #1]. He's cooperative and such a nice person I don't know how someone could do that. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 11/12/24 at 2:04 PM with the DON. She said she received a phone call at home about 10 minutes after 7:00 AM on 11/4/24. The Staffing Coordinator called and said she had witnessed Staff A, Agency, CNA slapping at Resident #1. Staff C, LPN Supervisor was at the bedside so she asked about Resident #1's condition and the DON had asked the Staffing Coordinator where Staff A, Agency, CNA was and she said the CNA had left the building and Staff C, LPN Supervisor was in the middle of evaluating Resident #1 and the DON said she got dressed and came to the facility. Then she got to the facility and immediately went into Resident #1's room and did an assessment and found purple discoloration of the left eye on the eye lid and under his eyebrow. There was also purplish discoloration along his left jaw line. She said Resident #1 was covered with the sheet at the time so she removed the sheet, and she noticed his left arm was red and swollen but he would not let her assess it any further. At first when she assessed Resident #1, he was comfortable, in bed, and quiet. It wasn't until she went to assess his arm he tried to push her away with his other arm and started to move about in the bed but, she reassured him by kneeling down next to him and rested her hand on his head and let him know it was okay they were going to take care of him and he calmed right down, nodded his head, and closed his eyes, and went back to sleep. The DON said that was when she started making the notifications to the authorities, Resident #1's family, and Resident #1's ARNP and asked her to do an urgent onsite visit. Law Enforcement came out and they took over and they said it was their protocol for the resident be taken to the hospital. So, EMS came and the ARNP showed up, but she was not able to see the resident before he left. Resident #1 was evaluated in the emergency room and they did numerous X-ray's and cat scans and they didn't find any acute fractures and he returned to the facility. He returned to the facility and his injuries and behaviors were monitored. The DON said she did training with the staff related to abuse neglect and exploitation. Dementia training was done in January for all staff which included managing difficult behaviors. 100% of staff have completed the abuse and neglect training which included a post test. She said she was not sure how many of the staff have received dementia training because they had newly hired staff but she plans to do the training with all her staff. The DON said Resident #1 can be very, very sweet but when it comes to personal bedside care, he can be resistive and push you away, Kind of like what he did when I went to assess his arm. But if he does not want to be bothered, he'll push you away. The DON said they had not had any previous concerns with Staff A, Agency, CNA. The DON said after their 5-day investigation they determined Staff A, Agency, CNA's actions did meet the definition of abuse and due to Resident #1's injuries the facility believe abuse did occur. A phone interview was conducted on 11/12/24 at 4:44 PM with Resident #1's APRN she said on the day of the event (11/4/24) the resident went out to the hospital to be assessed. The APRN said she came to the facility and the sheriff's office had been notified and they said it was their protocol to have the resident evaluated in the emergency room . In the emergency room they took X-ray's and there were no fractures present. She said she was able to see the resident yesterday (11/11/24) and upon her exam the resident's left arm was red and swollen and there was some old bruising around the eye. She said Resident #1 was at his normal baseline, tired after lunch and pleasantly confused. She said she has heard from the staff Resident #1 can have some periods of combativeness with care, but he has not been combative or resistive to care during her exams. Review of Staff A, Agency, CNA's Agency credentialing documentation revealed FL. Alzheimer 's Disease & Dementia Awareness was missing. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 11/12/24 at 4:34 PM. With the Staffing Coordinator, she said the facility has a binder of all of the facility's policies and procedures and when the Agency staff accept the position on the agency portal they acknowledge they know where the binder is but they are not required to review the binder of policy's prior to starting their shift, it is just used as a reference. If we were to go over all the contents in the book, that would be an hour that they would not be caring for the residents. I cannot force them to read the book. Review of the facility's Abuse, Neglect, and Exploitation Policy with a revision date of June 20, 2024, revealed Purpose: Wrights Healthcare and Rehabilitation Center has developed operational polices and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property; to include the use of physical and/or chemical restraints. The Administrator, Director of Nursing and Risk Manger in the facility are responsible for ensuring the implementation and ongoing monitoring of these requirements. Definitions: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, physical pain, mental anguish. .physical abuse includes, hitting, slapping, pinching, pulling, and kicking. It also includes controlling behavior through corporal punishment. .The facility's abuse prevention officer is the Director of Nursing or designee. The Risk Manger is the Assistant Director of Nursing or Designee. Residents of this facility shall be protected from occurrences of abuse, neglect, exploitation, misappropriation of property, mistreatment of neglect. Staff and other relevant parties as determined by management shall be trained at least annually on abuse, neglect and exploitation, procedures for reporting incidents of this nature, dementia management, and abuse prevention. .II Training: Train employees through orientation and on-going sessions on issues related to abuse prohibition practices such as: 1) Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents. .5) In addition to the freedom from abuse, neglect, and exploitation, requirements in 483.12, facilities must also provide training to their staff that at a minimum educates all staff on: 483.95(c) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at 483.12. 483.95(c) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property. (continued on next page)

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