STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106138	A. Building B. Wing	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewalk on Harden Health and Rehabilitation, LL	3110 Oakbridge Blvd E Lakeland, FL 33803

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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** 43192 Based on observation, interview, and record review, the facility failed to safeguard a resident's personal property which included lower dentures for 1 of 2 residents reviewed for personal property of a total sample of 44 residents, (#55). Findings: Review of resident #55's medical record revealed she was initially admitted to the facility on [DATE] with diagnoses that included dementia, anxiety, and bipolar disorders. Review of resident #55's quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 0 out of 15 which indicated severely impaired cognition. On 1/23/24 at 2:18 PM, resident #55's daughter and Power of Attorney stated her mother was admitted to the facility with upper and lower dentures. She explained her mother wore the dentures all the time, and they were only removed for cleaning and mouth care. She recalled the lower dentures went missing sometime last fall and she reported it to several staff members more than once. She indicated she was told they searched but did not find them. She explained she went personally to the laundry to search for the bottom dentures but did not find them. Review of a Dental Exam note dated 6/09/23 revealed presence of full upper and lower removable appliances. The note included, No concerns, eats well. Dentures fit well. Dentist cleaned dentures . Review of a dental hygienist note dated 7/06/23 revealed, Patient was seen for upper and lower denture cleaning bedside. The note included instructions for staff to, Please assist with brushing denture 2 times daily and removing over night to soak in clean water. Review of a dental hygienist note dated 10/30/23 revealed, . Patient is not wearing upper and lower denture, as per CNA (Certified Nursing Assistant) her dentures are missing. I did not find her F/F (complete dentures) in her room. Review of a Care Conference - Multidisciplinary note dated 10/31/23 revealed attendees included resident #55's daughter and the Social Services Director. The form included, Expectation/Concerns from the family and read, . Dental to eval for new lower dentures. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Dental Exam note dated 11/30/23 revealed, Patient is edentulous and has no removable prosthetics. Review of the Grievance Log for 2023 did not reveal a grievance was filed from resident #55 for the missing denture. There was no evidence of an inventory log in resident #55's medical record. On 1/25/24 at 2:36 PM, the Social Services Director stated she did not recall a denture concern for resident #55. After reviewing the Care Conference note dated 10/31/23, she stated she sent a referral directly to the dental group during the care conference meeting. She stated she was not able to find the message she sent to the dental group requesting a visit to replace the missing denture. She explained the facility's procedure for missing dentures included offering reimbursement for the dentures if the family paid out of pocket for them. She indicated if the family was not able to provide a receipt she would discuss with the facility's Administrator for further direction and resolution. She stated she did not have evidence of any follow up or conversation with resident #55's daughter regarding the status of the missing lower denture. On 1/25/24 at 3:27 PM, the Administrator explained when someone reported missing personal belongings, staff began searching immediately. She indicated if the item was not found, it would be documented in a grievance form and discussed during their meeting to ensure all department heads were aware. She stated the facility would notify the resident or family of their efforts and status. She explained they would not assume they were at fault for missing items, especially for residents with dementia, because the residents tend to wrap around dentures and put them in pockets, or trays. She noted if she knew they were at fault for the missing item, they would evaluate whether the resident needed it, but they would not reimburse if they were not at fault. She looked through a copy of the admission packet given to new residents and stated it did not include information on how the facility addressed missing personal items. Review of the facility's Personal Property policy and procedure revised on August 2022 read, Residents are permitted to retain and use personal possessions . The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary. Review of the Facility Assessment Tool updated on 12/20/23 revealed the facility provided person-centered care which included, Support resident having familiar belongings.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13252 Based on observation, record review, and interview, the facility failed to revise the care plan to reflect the resident's eating ability for 1 of 5 residents sampled for Activies of Daily Living (ADL) in a total sample of 44 residents, (#82). Findings: Resident #82 was admitted to the facility on [DATE] with diagnoses of Metabolic Encephalopathy, Altered Mental Status, Hemiplegia and Neoplasm of Brain. On 1/2324 at 11:48 AM, resident #82 stated she received tub feedings but also received foods to eat by mouth. She explained the facility staff did not always assist her meals and added the Certified Nursing Assistant did not assist her with eating dinner last night. Review of the resident's medical record revealed physician orders that read, Jevity 1.5 through tube feed and regular mechanical soft diet. the The annual Minimum Data Set (MDS) assessment dated [DATE] noted a Brief Interview of Mental Status score of 15 out of 15 that indicated the resident's cognition was intact. The assessment showed the resident was dependent on staff to help with meals. The resident's Behavior Care Plan noted the resident refused tube feedings and fabricated stories. Resident #82's ADL care plan showed the resident received tube feedings but could feed herself an oral diet, requiring only set up help. On 1/25/24 at 3:27 PM, the MDS Coordinator and the Assistant MDS Coordinator reviewed resident #82's medical record and care plans. They reviewed the ADL care plan that indicated the resident could feed herself, the Assistant Coordinator stated the resident could not feed herself. The MDS Coordinator stated the residents' care plans were revised on 12/27/23 and the ADL Care Plan should have been revised to indicate the resident's current status for eating, requiring staff assistance with meals.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35086 Based on observation, interview, and record review, the facility failed to follow physician's orders to ensure wound care was provided per standards of nursing practice for 1 of 3 residents reviewed with pressure ulcers out of a total sample of 44 residents, (#46). Findings: Resident #46 was admitted to the facility on [DATE] and readmitted from home/community on 12/21/23. Her diagnoses included unstageable pressure ulcer to the left heel, Type II diabetes, fractured left fibula post fall, non-pressure chronic ulcer right foot, and coronary artery disease. Unstageable pressure injuries are widely understood to be full-thickness pressure injuries in which the base is obscured by slough and/or eschar. (Retrieved on 1/26/24 from https://pubmed.ncbi.nlm.nih.gov) The quarterly Minimum Data Set (MDS) assessment with assessment reference date of 11/12/23 revealed resident #46 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated she was cognitively intact. She required moderate assistance from facility staff with bathing, toileting, dressing and turning in bed. The assessment indicated resident #46 was always incontinent of urine and had an unstageable pressure ulcer that was present at admission to the facility. On 1/24/24 at 9:37 AM, resident #46 was observed with an overbed table across the middle of her bed and was eating breakfast from tray on the overbed table. Review of the resident's current physician orders dated 1/23/24 read, to cleanse left heel with Betadine, pat dry, skin prep to peri wound, apply sterile gauze sponge and ABD (abdominal) pad, wrap with Kerlix, secure daily, and as needed for unstageable pressure ulcer left heel. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A wound care observation was conducted on 1/24/24 at 9:05 AM, with Licensed Practical Nurse (LPN) A. Prior to entry to resident #46's room LPN A was observed at the treatment cart in the hall as he placed supplies on a small foam tray that included saline, blue incontinent pad, ABD pad, Kerlix, Betadine solution packet, 2 packs of sterile 2 inch (in.) by 2 in. gauze, roll of Kerlix, skin prep, and non-sterile gloves. LPN A took scissors from his right pant pocket and cut piece of tape off roll approximately 3 to 4 in. and placed the tape on the foam tray with other supplies. The LPN then proceeded into the resident's room with tray of supplies and bottle of hand sanitizer taken from the treatment cart. He placed all supplies onto the resident's overbed table and placed an incontinent pad under the resident's left foot and heel. LPN A did not clean the overbed table nor did he apply drape on the table prior to placing the dressing supplies, hand sanitizer and scissors directly onto the table. The LPN did not sanitize his scissors before, during or after the procedure. Resident #46 was lying on specialty mattress, alert and oriented. The nurse performed hand hygiene, donned gloves, and proceeded to use his scissors to cut off the soiled dressing from the resident's left foot/ankle. The dressing was stuck to the wound bed and the nurse used his 2 packs of sterile gauze and saline to loosen and remove the old dressing. The wound on the left heel had moderate amount of serous drainage. The LPN then disposed of the soiled dressing, performed hand hygiene, and donned clean gloves. The dressing supplies were now off the foam tray and lying directly on the resident's bedside table with the resident's personal items. LPN A then used the unclean scissors from which he had cut off the soiled dressing and proceeded to cut a piece of the Kerlix gauze off the roll approximately 3-4 in. and poured the Betadine solution onto the cut Kerlix which he used to clean the wound on the left heel. He then used dirty scissors to cut another piece of Kerlix roll approximately 2-3 in. folded it and placed it directly onto the heel wound with frayed edges of cut Kerlix noted on wound bed. The nurse then covered the dressing with an ABD pad and secured it with Kerlix. He then placed the soiled scissors into the front pocket of his scrubs shirt. LPN A then placed the hand sanitizer in the treatment cart without first sanitizing it. On 1/24/24 at approximately 9:30 AM, LPN A acknowledged he did not clean his scissors pre, post or during wound care procedure. He took the dirty scissors out of his front scrub shirt pocket and acknowledged the dirty scissors were placed in his pocket with other supplies. He stated he should have cleaned the hand sanitizer bottle prior to returning it to the treatment cart. Review of resident #46's care plan revised on 1/23/24 for unstageable left heel pressure ulcer noted goal that wound will show signs of healing and remain free from infection. The interventions included following policies/protocols for prevention/treatment of skin breakdown and administer treatments as ordered. On 1/24/24 at 12:50 PM, an interview was conducted with LPN A and the Director of Nursing (DON). The DON read resident #46's physician order and acknowledged that LPN A should have applied gauze and not piece of Kerlix to the left heel wound. The DON explained LPN A should not cut the Kerlix because frayed pieces could get into the wound bed. LPN A explained he used all sterile gauze with saline to loosen the old dressing and did not have more gauze with him or in the treatment cart. The DON said, LPN A should have obtained more gauze from the medication storage room or another treatment cart. The DON acknowledged LPN A should have cleaned his scissors pre/post procedure with sanitizing wipes or bleach, and should have cleaned the resident's overbed table and placed the supplies on a barrier. The DON stated cleaning re-useable resident equipment was important to reduce chance of cross contamination. She verified she had not done competency wound check with LPN A as he started working at the facility less than 2 months ago. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Wound Care policy and procedure revised October 2010 read, The purpose of this procedure is to provide guidelines for care of wounds to promote healing. Preparation 1. Verify that the physician's order for this procedure Steps in Procedure 1. Use disposable cloth [paper towel is adequate] to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field .19. Use clean field saturated with alcohol to wipe overbed table. 20. Return the overbed table to its proper position. 21. Wipe reusable supplies with alcohol as indicated [i.e., outside of containers that were touched by unclean hands, scissors blades, etc.]. Return reusable supplies to resident's drawer in treatment cart

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 43192 Based on interview, and record review, the facility failed to submit staffing data through the Center for Medicare/Medicaid (CMS) Payroll-Based Journal (PBJ) system for the Fiscal Year Quarter 4 of 2023. Findings: Review of the Certification and Survey Provider Enhanced Reports for Quarter 4 of 2023 revealed the facility failed to submit data for the quarter. On 1/24/24 at 4:22 PM, the Scheduling Coordinator stated she and the Human Resources Director were responsible for completing and submitting the PBJ report. She explained she attempted to submit the Quarter 4 report but received many error messages which she attempted to correct but did not complete on time. She indicated the report was due on 11/14/23 and stated the Administrator was aware of the issue. On 1/25/24 at 10:46 AM, the Administrator stated she was ultimately responsible for ensuring PBJ reports were submitted timely. She explained they completed the PBJ report but received multiple errors when submitted. She indicated they attempted to correct the errors and made calls to CMS. She said they tried before 11/14 but were having lots of problems and went down to the wire because nothing we tried worked. She stated the purpose of the PBJ report was to show they had the required staffing and met the required staffing ratios to service their residents. The Administrator stated they did not have a policy for PBJ reporting.