| Agency f | or Health Care Adminis | tration | | | PRINTED: 11/2 FORM APPE | |
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| STATEMENT | F OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | (|
| | | 55114 | B. WING | | R-C 10/27/202 | 21 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | ATE, ZIP CODE | | |
| HEADTI A | ND OF ZEPHYRHILLS | 38220 H | ENRY DR | | | |
| HEARILA | IND OF ZEPHTRHILLS | ZEPHYR | HILLS, FL 3354 | 0 | | |
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| (N 000) | INITIAL COMMENTS | | {N 000} | | Angelon grade grade | |
| | for complaint number 2021011084, was cor at Heartla | educted on and and of Zephyrhills. The ected deficiency cited. The | | | one de la companya de | |
| (N 201) SS=E | 400.022(1)(I), FS Rigi Appropriate Health Ca | | (N 201) | | | |
| | health care and prote including social servic if available; planned r therapeutic and rehat with the resident care recognized practice s | dequate and appropriate ctive and support services, ess; mental health services, ecreational activities; and slittative services consistent plan, with established and landards within the rules as adopted by the | | | and the state of t | |
| | Based on observation review the facility faile and adequate health 1) staff providing assis timely manner for fou #25) of six dependent and one additional redependent on staff for requested during the behavior monitoring if residents reviewed for medications (#12, #1, 49 facility residents re | r an additional food item lunch meal, 2) or seven of seven sampled or the use of #13, #11, #2, #6, #8) out of | | 1. R9 was evaluated by , on 11.2.21 and the plan of care was upd R12 kardex was updated and reflects need for assistance with meats. R22 longer resides at the facility. R25 no longer resides at the facility. R24 was evaluated by the IDT team and is independent with meats. R12 no long receives , medications. For care plan was updated to include monitioning for behaviors associated with use of the , medication R 13 care plan was updated to include monitoring for behaviors associated with use of the , medication R 13 care plan was updated to include monitoring for behaviors associated with the second process of the care of t | the no s er R1 with ns. e | |

AHCA Form 3020-0001

an

4) following professional standards of practice for LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

() line for one (#15) of three residents reviewed for treatment and services,

(X6) DATE TITLE Electronically Signed /21

the use of the , , , medications.

monitoring for behaviors associated with

R11 care plan was updated to include

| | | | | | | : 11/29/202 APPROVE |
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| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | | | COMPLE | TED |
| | | | / Boilbinto. | | | |
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| | | 55114 | B. WING | | 10/2 | 7/2021 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | ATE, ZIP CODE | | |
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| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | 1D | PROVIDER'S PLAN OF CORRECTION | | (X5) |
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| | | | | DEFICIENCY) | | |
| {N 201} | Continued From page | 1 | {N 201} | | | |
| ` ′ | , , | | 1 | | | |
| | | rders related to care and | | the use of the , . , , . medication | 18. | |
| | | on the , access | | R2 care plan was updated to include | | |
| | | treatment for two (#15, #1) | | monitoring for behaviors associated w | | |
| | | ents reviewed, and 5) | | the use of the , , , medication | 18. | |
| | | reatment and services | | R8 care plan was updated to include | | |
| | | g measurements and | | monitoring for behaviors associated w | | |
| | | or three of three sampled | | the use of the , , medication | is. | |
| | residents (#15, #16, # | | | R6 care plan was updated to include | | |
| | of seven total facility | esidents with | | monitoring for behaviors associated w | | |
| | | | | the use of the , , , medication | ıs. R | |
| | | | | 15 no longer has an access device | | |
| | Findings Included: | | | R15 & R1 order was obtained to remo | ve | |
| | | | | the post days. R15 | | |
| | | ion of the lunch meal on the | | was assessed on 11.10.21 with | 1 | |
| | 200 half on | beginning at 11:50 a.m., | | measurements obtained and the plan | of | |
| | two meal carts and or | ne beverage cart were noted | | care updated. R16 no longer resides | in | |
| | to be parked at the to | p of the hall. Two aides | | the facility. R13 were assess | ed | |
| | began to pass trays to | independent diners at | | on 11.10.21 with measurements obtain | ned | |
| | 11:55 a.m. On | . at 12:00 p.m., Aide A, | | and the plan of care updated. | | |
| | commented that there | were many residents on | | | | |
| | the 200 hall that need | led assistance, and they | | 2. Utilizing the patient response ana | lyzer | |
| | passed meal trays to | the independent diners first. | | report in the electronic health record | the | |
| | | eal trays for dependent | | Interdisciplinary team reviewed reside | nt s | |
| | diners remained in the | e closed cart until a staff | | requiring assistance with meals and | | |
| | member was ready to | provide assistance. After | | validated the plan of care. Utilizing the | | |
| | Aide A obtained a tray | for a resident and left the | | Dining Observation QAPI tool : a | | |
| | | ched the meal cart and | | comprehensive review of meal service | | |
| | | vo independent residents. | | was completed by the Nursing Home | | |
| | | and returned to the nurse's | | Administrator, A comprehensive review | v of | |

food usually wasn't very good, no variety and was

station.

at 12:15 p.m., two of the unit's three

aides were each sitting with a resident assisting

them with eating. The third aide was observed

painting her nails. After the aide finished polishing

the resident's nails, the resident was ask about

the meal service. Resident #25 reported that the

providing nail care to Resident #25. The aide

was pushing the resident's cuticles

STATE FORM caso C7S212 If continuation sheet 2 of 34

residents receiving ,

medications was completed by the Quality

medications have care plans that include

monitoring for behaviors associated with

comprehensive review of current residents

Quality Assurance Consultant/designee to

validate appropriate physician orders were

the use of , , medications. A

with access was completed by the

Assurance Consultant to validate

residents receiving , . , . . . , .

| Agency fo | or Health Care Adminis | tration | | | | : 11/29/2021 I APPROVED |
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| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MOLTIPLE | CONSTRUCTION | (X3) DATE S | URVEY |
| | OF CORRECTION | IDENTIFICATION NUMBER: | | | COMPLE | |
| | | | A. BOILDING. | | | |
| | | | 1 | | R- | |
| | | 55114 | B. WING | | 10/2 | 7/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | ATE, ZIP CODE | | |
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| {N 201} | Continued From page | 2 | {N 201} | | | |
| | | daughter was bringing lunch | | in place. A comprehensive review of | | |
| | | ported that she would have | | current residents receiving . , | | |
| | | mething to drink though as | | treatments was completed by the Dire | ctor | |
| | | er daughter for another half | | of Nursing/designee to validate | | |
| | | at she often had to wait for | | orders and removal schedules if need | | |
| | | sked for as there didn't | | were in place. A comprehensive review | | |
| | | o. It was noted at this time | | current residents with | was | |
| | that only three aides | | | completed on 11.2.21 by the Quality | | |
| | | building during lunch | | Assurance Consultant to validate | | |
| | directly assisting with | | | descriptions and measurements were | | |
| | approximately 26 resi | | | documented in the medical record. | | |
| | | two nurses assigned to the | | | | |
| | | e not observed assisting the | | The Director of Nursing/designee | | |
| | residents with the lun | ch meal. | | educate the nursing and interdisciplin | | |
| | | | | department team members on the | | |
| | | p.m., the Administrator was | | Meal Service procedure; on the Behav | | |
| | | ting pizza while talking with | | Practice Guide; on | | |
| | | or. The Administrator was | | Flushing, / , | , | |
| | | hall UM could be found. | | | | |
| | | orted that she did not know, | | Change; on the nursing | | |
| | but she would find he | r. | | procedure; on the Skin Practice Guide | on : | |
| | | | | or before the date of compliance. | | |
| | | p.m., the surveyor returned | | | | |
| | to the 200 hall after s | | | 4. Utilizing the Dining Observation (| JAPI | |
| | | served a call light was | | tool :: the Nursing Home | | |
| | | lo staff were present to | | Administrator/designee will randomly | | |
| | | After five minutes without | | 5 meal times/week x 4 weeks and mo | | |
| | any staff response, th | | | x2. Results will be reviewed and tren | bet | |
| | | ng call light (Resident #24) | | by the QAPI committee for continued | | |
| | | e resident reported that her | | compliance. Utilizing the Unnecessary | | |
| | | eded sauce on it. She | | Medications Behavior | | |
| | nointed to her roomm | ate's nasta and commented | 1 | Monitoring OAPI tool the DON/design | 00 | |

that the roommate had gravy on it. The Certified

Dietary Manager was notified of the request and within another five minutes, the resident was

observed assisting three residents with eating to

at 12:30 p.m., all three aides were

provided with some brown gravy.

include Resident #22.

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will audit 5 residents that receive

, , medications weekly x4

weeks and monthly x2 to validate the care

plans include behaviors associated with the medications. Results will be reviewed

and trended by the QAPI committee for

QAPI tool : the director of

continued compliance. Utilizing the

| Agency for Health | NCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | E CONSTRUCTION | FORM (X3) DATE S | |
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| AND PLAN OF CORRECT | TION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLE | ETED |
| | | 55114 | B. WING | | R 10/2 | C 7/2021 |
| NAME OF PROVIDER OF | SUPPLIER | STREET AD | DRESS, CITY, STA | ATE, ZIP CODE | | |
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| HEARTLAND OF ZE | PHYRHILLS | | IILLS, FL 3354 | n | | |
| | CURRANTYCT | ATEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF CORRECTION | | |
| | ACH DEFICIENC | YEMBEN OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETE DATE |
| {N 201} Continue | d From page | 3 | {N 201} | | | |
| for resident obtained resident On standing her mea the resident #9 to be observat was goo On in her off was call just retur they nee time, two waiting to On trays arr | If noted walkier ents that still a meal tray with eating. at 12:40 and 12:4 | p.m., the Activity Aide was ng down the hall and looking needed assistance. She and began to assist a p.m., Aide B was observed dent #12, who was refusing to ask Resident #12 about evealed no response from ide B left Resident #12, she al tray and sat with Resident with eating. During the meal t #9 reported that her meal p.m., the UM was observed the computer screen. She rand reported that she had ch. She asked the slaff if the lunch meal. At that quiring assistance were still ir funch meal. | | nursing/designee will audit residents access weekly x4 and monthly x2 validate appropriate physician orders obtained. Results will be reviewed an trended by the OAPI committee for continued compliance. Utilizing the QAPI tool if the Director of Nursing/designee will audit residents orders weekly times 4 week and monthly x2. Results will be review and trended by the OAPI committee for continued compliance. Utilizing the QAPI tool if the Direct unursing/designee will audit residents veekly x4 and monthly Results will be reviewed and trended the QAPI committee for continued compliance. | o were id s wed or tor of with ly x2. | |

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at 1:50 p.m., the Administrator reported that the UM should be providing oversight during the meal process. The Administrator reported that everyone on the hall that was needed was present so the UM probably thought she was able to go to lunch. The Administrator was not aware of who was on the hall and was informed that only three aides were on the hall to assist up to six residents with their meals, one of the three aides was painting

PRINTED: 11/29/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B MING 55114 10/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 38220 HENRY DR HEARTLAND OF ZEPHYRHILLS ZEPHYRHILLS, FL 33540 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 201} Continued From page 4 (N 201) approximately 20 additional residents needed their trays delivered and set-up. at 2:35 p.m., the Administrator provided a plan for residents to be assisted at meals. She reported that aides and other nursing staff would be assigned to residents who needed assistance so there would be adequate staff and no resident would need to wait for their meal. A review of the Minimum Data Set (MDS) Assessment for Resident #9, dated revealed the resident's ... status was . She was assessed as requiring with one staff member at meals.

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aware.

as requiring

physical assistance at meals.

a nurse's note, dated

A review of Resident #25's MDS completed on revealed a _____ of 14 indicating intact cognition and required supervision with one person physical assistance with meals. Review of

10:29 a.m. revealed that Resident #25's daughter requested her nails to be painted because it was her birthday. The note, written by the Unit Manager (UM), indicated the aide was made

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with one person

..... and written at

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the medication and her diagnosis of for its use. Interventions included evaluating the effectiveness and the side effects of the medication for possible decrease or elimination of the , , medication. Also, the physician was to be notified of a decline in the resident's ADL (activities of daily living) abilities or decline in/behavior related to a dosage change. The physician was to be notified of signs of adverse reactions as well. The care plan included no interventions related to

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The resident was observed taking a small bite of fish out of her ... and placing it ... on her plate. The aide commented that the resident usually did that and didn't usually eat anything. An observation of Resident #12 on during the lunch meal revealed she was accepting bites of the fruit cocktail from her lunch tray. The aide confirmed that she refused the meal but seemed to be enjoying the sweet fruit. A review of the resident's _ _ revealed upon admission on the resident had . On

the resident

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being at risk for behavior symptoms related to ..., ..., and ..., as well as noncompliance with the ordered diet and lab draws initiated . . . and revised on Interventions included observations for mental status/behavior changes when new medications are started or with changes in dosages. The Physician's order for monitoring side effects was not included as an intervention in the care plan for at risk behaviors and there was no guidance given in the care plan for what behaviors should

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dinner, when observed resident, she was crying. The resident cries often and stated she was tired of being sick and does not like to be touched. The Nurse Practitioner was informed. Review of physician orders, Treatment Administration Record (TAR), and Medication Administration Record (MAR) for showed Resident #13 received _____ 15 mg at bedtime for . / . . . Monitor for side effects related to use of medication, ... My initials indicate absence of signs and symptoms of side effects. monitor every shift for side effects of , medications. The physician orders and / or MAR lacked orders and monitoring of behaviors for , . , . . . , . medications.

Review of the care plans showed a care plan for resistive / noncompliant with treatment / care

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receiving . . . , medication. Record review of active physician orders and the MAR showed Resident #11 received

Check every shift as of .

medications.

showed a

...... 50 mg by ... at bedtime for as of . Monitor for side effects related to the use of medication. . My initials indicate absence of signs and symptoms of side effects.

adverse reactions. The care plan included no interventions related to monitoring for behaviors associated with the use of

**Record review of Resident #11's quarterly Minimum Data Set (MDS) dated

.) score of 08 (moderately). Section N. Medications, showed she was

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| Agency for Health Care Adminis | stration | | |
| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY |
| AND PLAN OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | COMPLETED |
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| | 55114 | B. WING | 10/27/2021 |
| | | | |

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

| HEARTLAND OF ZEPHYRHILLS | | 38220 HENRY DR | | | | |
|--------------------------|-----------------------------------|----------------|---------------|-------------------------------|-------|--|
| | | ZEPHYRHII | LLS, FL 33540 | | | |
| (MALIE) | SUMMARY STATEMENT OF DESICIENCIES | | 4D | PROVIDER'S PLAN OF CORRECTION | (250) | |

| HEARTLA | ND OF ZEPHYRHILLS ZEPHY | RHILLS, FL 33540 | | |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | COMPLETE |
| | resident was an exit seeking / elopement risk related to initiated and revised Interventions included but were not limited to calmly redirect to an appropriate area, alert bracelet, and check for placement and function daily. Care plan for risk for adverse effects related to use of medication, initiated on medication, initiated on included but were not limited to evaluate effectiveness and side effects of medications for possible decrease / elimination of , drugs; notify physician of decline in ADL ability or / behavior related to a dosage change. | | | |

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10/27/2021

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WING _____

55114

| HEARTLAND OF ZEPHYRHILLS 33220 HENRY DR ZEPHYRHILLS, FL 33540 | NAME OF P | ROVIDER OR SUPPLIER STREET AS | DDRESS, CITY, STATE | E, ZIP CODE | |
|--|-----------|---|---------------------|--|----------|
| PREFIX TAG REGULATORY OR LSC IDENTIFY ING INFORMATION) (N 201) Continued From page 11 provide patient teaching of risks and benefits of medications as needed, report to physician signs of adverse reactions. No care plan was present related to "*On at 1:40 p.m., Resident #2 was sitting at bedside watching TV. She was dressed and groomed for the day and had her personal possessions in her room. No behaviors were noted. Record review of the annual Minimum Data Set (MDS) dated | HEARTLA | ND OF ZEPHYRHILLS | | | |
| provide patient teaching of risks and benefits of medications as needed, report to physician signs of adverse reactions. No care plan was present related to ***On at 1:40 p.m., Resident #2 was sitting at bedside watching TV. She was dressed and groomed for the day and had her personal possessions in her room. No behaviors were noted. Record review of the annual Minimum Data Set (MDS) dated showed a () score of 15 ()). Section N, Medications, showed she was receiving an Record review of active physician orders and | PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | COMPLETE |
| symptoms of side effects, monitor every shift. 5 on gaje 0.5 tablet by at bedtime on Tuesday, Wednesday, Thursday, Friday, Saturday, Sunday for with Monitor for side effects related to use of medication, My initials indicate absence of signs and symptoms of side effects, monitor every shift. Monitor for side effects related to use of medications. Check every shift as of medication defects related to use of medication, effects related to use of medication effects rel | (N 201) | provide patient teaching of risks and benefits of medications as needed, report to physician signs of adverse reactions. No care plan was present related to "On at 1:40 p.m., Resident #2 was sitting at bedside watching TV. She was dressed and groomed for the day and had her personal possessions in her room. No behaviors were noted. Record review of the annual Minimum Data Set (MDS) dated showed a showed | (N 201) | | |

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| NAME OF P | ROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE | , ZIP CODE | |
|--------------------------|--|-----------------------------|--|--|
| HEADT! | ND OF ZEPHYRHILLS | 38220 HENRY DR | | |
| HEARTLA | ND OF ZEPHYRHILLS | ZEPHYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATIC | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| {N 201} | Continued From page 12 | {N 201} | | |
| (N 201) | Continued From page 12 absence of signs and symptoms of side effect monitor every shift. The physician orders and MAR lacked orders and monitoring of behavior, medications. Review of the care plans showed resident on medications related to medications of the provide non-pharmacological interventions for symptom management suct provide quiet environment, decrease stimuli, monitor for thirst / hunger, and provide fluids snacks of resident's preference, redirection. Monitor for signs and symptoms of adverse effects related to medication us and report to physician as indicated. Resider risk for behavior symptoms related to | ots, 1/ or ors n d on | | |
| | , recurrent and history scratches self-picks scabs revised Interventions included but were no limited to attempt drug reduction physician orders, for behaviors / offer dim the lights, soft music, snacks, or TV; pro | t n per to | | |
| | for comfort by allowing resident to validate he feelings, offer support, use consistent approaches when giving care. Resident had maniputative behavior that was related to ina to adjust to loss of past roles revised Interventions included but was not limited to acknowledge moods in 1:11 interaction with | bility | | ontonomic managements and postported to the contract of the co |
| | resident and assist in identifying positive cop mechanisms; administer medications per physician orders and observe for effectivener and signs and symptoms of side effects; assidentifying positive coping mechanisms. Resided in the force of the comment of the co | es sist in ident | | *************************************** |

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| Agency fo | or Health Care Adminis | tration | | | |): 11/29/202 1 APPROVE |
|--------------------------|---|---|---------------------------|---|-----------------------|---|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | CONSTRUCTION | (X3) DATE S COMPLI | |
| | | 55114 | B. WING | | R- 10/2 | -C 27/2021 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STAT | E, ZIP CODE | | |
| HEARTLA | ND OF ZEPHYRHILLS | 38220 HE ZEPHYRI | NRY DR HILLS, FL 33540 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) | BE | (X5) COMPLETE DATE |
| {N 201} | orders and observe it and symptoms of side / environmental chang change in ; elicit TV or movies, read bit for mental status / medication is started choices to enhance s feelings of loss. The cinterventions related it associated with the usedications. **Observed Resident watching TV on eaten his lunch. No b | medications per physician or effectiveness and signs or effectiveness and signs o effects, assess for physical pes that may precipitate I family for support, watch noks or magazines; observe state changes when new or with dose changes: offer end of control and validate are plan included no monitoring for behaviors se of , , | (N 201) | | | |
| |).Section N, Mer receiving | | | | | Vendar pour pour pour pour pour pour pour pou |

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My initials indicate absence of signs and symptoms of side effects, monitor every shift. 7.5 mg three times a day for , , , medication, , . My initials indicate absence of signs and symptoms of side effects, monitor every shift. The physician orders and/or MAR lacked orders and monitoring of behaviors for , , medications. Record review of the care plans showed the

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| Agency for Health Care Adminis | tration | | FORM APPROVEL |
|---|---|---|-------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | (X3) DATE SURVEY COMPLETED |
| | 55114 | B. WING | R-C 10/27/2021 |

| | | | | 10,21,2021 |
|--------------------------|--|--|--|--------------------------|
| NAME OF PI | ROVIDER OR SUPPLIER ST | TREET ADDRESS, CITY, S | TATE, ZIP CODE | |
| HEARTLA | ND OF ZEPHYRHILLS | 8220 HENRY DR EPHYRHILLS, FL 335 | 540 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| {N 201} | Continued From page 14 | {N 201} | | |
| (N 201) | Continued From page 14 resident was at risk for adverse effects related tuse of medication, revised in the continuation of the continuation of medication interventions included but were not further than the continuation of medications for possible decrease? I eliminations of, drugs. Provide resident with teaching of risks and benefits of medications as needed. Report to physician sign adverse reactions. The care plan included not interventions related to monitoring for behavior associated with the use of, medications. Record review of progress notes for the month did not show any documentation related to behavior monitoring. "Observed Resident #6 lying in bed on at 1:48 p.m. watching TV. She would not answer any interview screening questions. Record review of the quarterly Minimum Data S (MDS) dated showed a howed a | to d d d d d d d d d d d d d d d d d d d | | |
| | . My initials indicate absence of signs and symptoms of side effects, monitor every sh | | | |
| | 25 mg daily for , . | | 1 | No. |

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PRINTED: 11/29/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B WING 55114 10/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 38220 HENRY DR HEARTLAND OF ZEPHYRHILLS ZEPHYRHILLS, FL 33540 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 201} Continued From page 15 (N 201) Monitor for side effects related to use of , medication. . My initials indicate absence of signs and symptoms of side effects, monitor every shift. The physician orders and/or MAR lacked orders and monitoring of behaviors for , , medications. Record review of progress notes for the month of do not show any documentation related to behavior monitoring. Record review of the care plans showed the resident was at risk for behavior symptoms related to , , and coprophagia (ingestion of feces) revised Interventions included but were not limited to offer dim lights, TV. snacks, soft music: toilet after meals and at bedtime; use consistent approaches when giving care. The resident had inappropriate behavior, attempting to be overly affectionate with male residents related to ..., ...,

revised

...,, and revised . Interventions included but not limited to administer medications per physician orders and observe for effectiveness and signs and symptoms of side effects. Elicit family support, watching TV, reading books/ magazines; validate feelings of loss. Episodes of . . . , related to diagnoses of initiated Interventions included but not limited to administer medications per physician orders. identify and decrease environmental stressors. At risk for adverse effects related to use of

included but were not limited to distract, if possible, explain and explore effects of behavior on others, offer dim lights, TV, snacks, soft music; remain calm and avoid angry reactions if exhibits behavior, set limits for acceptable behavior. At risk for changes in

. Interventions

related to

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PRINTED: 11/29/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B MING 55114 10/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 38220 HENRY DR HEARTLAND OF ZEPHYRHILLS ZEPHYRHILLS, FL 33540 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 201} Continued From page 16 (N 201) medications. . revised . Interventions included but was not limited to evaluate effectiveness and side effects of medications for possible decrease / elimination of ..., drugs; notify physician of decline in ADL ability or / behavior related to a dosage change; report to physician signs of adverse reactions. At risk for adverse effects related to use of . . . , / . . . , . medication. revised Interventions included but was not limited to evaluate effectiveness and side effects of medications for possible decrease / eliminations of drugs; notify physician of decline in ADL ability or / behavior related to a dosage change: report to physician signs of adverse reaction. At risk for adverse effects related to use of medication, revised . Interventions included but was not limited to evaluate effectiveness and side effects of medications for possible decrease / eliminations of , drugs; notify physician of decline in ADL ability or . . . / behavior related to a dosage change; report to physician signs of adverse reaction. **During an interview on at 1:57 p.m. the

that specific resident.

new interim DON entered, Staff G. She stated that today was her first day in the position of DON. She stated that all the other nurses, Unit Managers and MDS coordinator would be going to their assigned jobs. She stated that they were looking through the electronic medical records today. She stated that they have been seeing some issues. She stated that she recognized that the behavior monitoring was not there. She stated that she was going to do audits with the UM and the MDS coordinator and put in behavior monitoring related to specific issues for

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| | | | | | | D: 11/29/202 II APPROVE |
|--------------------------|--|--|-----------------------------|--|-----------------------|----------------------------|
| STATEMENT | or Health Care Adminis TOF DEFICIENCIES OF CORRECTION | tration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO | | (X3) DATE S COMPLI | ETED |
| | | 55114 | B. WING | | R- 10/2 | -C 27/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE | , ZIP CODE | | |
| HEARTLA | AND OF ZEPHYRHILLS | | ENRY DR RHILLS, FL 33540 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETE DATE |
| {N 201} | Continued From page | 17 | {N 201} | | | |
| | consultant pharmacis document by exceptil He stated." this was the sheavior document behavior notes, progr notes. If the resident then they will not list or there was a documentation. He st then no behaviors." I anybody on looks at the notes and documentation of befor gradual reduction documentation in the for gradual reduction documentation in the monitor for behaviors there are behaviors. I notes. If new why on medications, successful." | on for behavior moniforing, the facility's corporate rules." entation will be found in the ess notes, or physician was not having behaviors, anything. If a dose increases, initiated, they should have ated. "No documentation le stated that he looks at medications and he of looks for behaviors." Iff no haviors, then will see notes in dosages. Should be electronic medical record increased . My effects. They have to but not document unless 20 not put in MAR just in the monitor the behaviors, and Iff no behaviors med is | | | | |

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individual if they are: socially unacceptable, stressful to others, interfering with care, presenting safety risk. . . . is defined as the way that someone is feeling. Alterations in an individual's and, or behavior may be triggered by a wide variation of antecedents. . AND BEHAVIOR the Interdisciplinary process surrounding and behavior identification is accomplished through recognition of symptoms that commonly arise with adjustment , . . . , and : The experience of

| Agency for Health Care Adminis | tration | | JOHNAFFROVEL |
|---|---|---|-------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | (X3) DATE SURVEY COMPLETED |
| | 55114 | B. WING | R-C 10/27/2021 |

| | STREET ADDRESS, CITY, STATE | E, ZIP CODE | |
|--|---|--|--------------------------|
| HEARTLAND OF ZEPHYRHILLS | 38220 HENRY DR ZEPHYRHILLS, FL 33540 | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| {N 201} Continued From page 18 | {N 201} | | in the second |
| is highly individualized. The factors contributing an trigger fears that escalate into an exagerated. response when not addressed. is a comprised of affective. sa a common to coexists with sa associated functional the deferty paties as associated functional the deferty patie exhibits the greater the likelihood of INITAL PLAN OF CARE: Upon completing a evaluation, the interdisciplinary team (IDT) develops a patient specific, or person centered care plan including goals to prevent and mane behavioral symptoms. Any new behavior symptoms suggests a need to reevaluate the pl of care. Pharmacological interventions may be indicated. COMPREHENSIVE CARE PLAN: Based upon the findings of the MDS and other evaluations, the patient's comprehensive care plan is developed, or initial plan of care is updated to include individualized patient interventions that focus on the patient's specifirisk factors. Interventions are continually evaluated for effectiveness and updated as the patient's condition and needs change. INTERVENTIONS FOR CONSIDERATION. Selection of the most appropriate interventions dependent on accurate identification of the behavior, possible root causes and ruling out interventions based on narrowing of possible trigger (s) to the behavior. Begin by evaluating patient for any unmet physical need. If the behavior continues, evaluate for possible unmet in a possible contributic problem-solving patient's environment for a possible contributic patient's environment for a possible contrib | g to d n and ent n ge an c c a s is | | |

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| Agency for Health Care Administration | | | | | |
|---------------------------------------|-----------------------------|----------------------------|------------------|--|--|
| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY | | |

| TATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | (X3) DATE SURVEY |
|--------------------------|-----------------------------|---|-------------------|
| IND PLAN OF CORRECTION | IDENTIFICATION NUMBER: | | COMPLETED |
| | 55114 | B. WING | R-C 10/27/2021 |

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| NAME OF PI | ROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STA | ITE, ZIP CODE | |
|--------------------------|---|--|--|--------------------------|
| HEADTI A | ND OF ZEPHYRHILLS | 38220 HENRY DR | | |
| HEARTLA | ND OF ZEPHTRHILLS | ZEPHYRHILLS, FL 3354 | 0 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| | | (N 201) (N 201) d in ss the on. d a so of G, d, da on | CROSS-REFERENCED TO THE APPROPRIATE | |
| | medication administration twice a day as of | | | ALCOHOL: |
| | ine change ever | ery | | |
| | Sunday as of to start on line insertion site to be | | | - |
| HCA Form 3 | | | | |

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| Agency for Health Care Adminis | tration | | FORM APPROVE |
|---|---|---|-------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | (X3) DATE SURVEY COMPLETED |
| | 55114 | B. WING | R-C 10/27/2021 |

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| HEARTLA | ND OF ZEPHYRHILLS | 1220 HENRY DR EPHYRHILLS, FL 33540 | | |
|--------------------------|--|---------------------------------------|--|--|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIGIENCY) | (X5) COMPLETE DATE |
| PREFEX | (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 Changed every 72 hours from the original placement time as of to start on the start on second attempt with 22-gauge anglocath. On at 21:12 (9:12 p.m.) Resident returned from the start on th | PREFIX TAG {N 201} 4 | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | COMPLETE |
| | change by physician order and as needed if soiled or wet; flush line per physician orders; report to physician any signs and symptoms of /infiltration. On at 1:57 p.m., the Nursing Home | | | no de la composition della com |

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PRINTED: 11/29/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: P.C B MING 55114 10/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 38220 HENRY DR HEARTLAND OF ZEPHYRHILLS ZEPHYRHILLS, FL 33540 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 201} Continued From page 21 (N 201) Administrator (NHA) and Staff E, interim Director of Nursing /MDS Coordinator (DON/MDS) and Staff F, Regional Nurse, reviewed the medical record and verified that Resident #15 did not have a physician's order to place a Review of the facility's policy, "Medication and Treatment Administration Guidelines," updated on showed MEDICATION AND TREATMENT ORDERS: A complete treatment order includes: date and time; name of the patient; site of application; cleansing agent if indicated; frequency, including end date orders if applicable; directions for use, if applicable; primary and secondary , if applicable; name of the medical practitioner giving the order; signature of medical practitioner if the order is written; name, title and signature of nurse transcribing the order.

4. On at 9:00 a.m., Resident #15 was observed lying in bed with a clean and dry on his upper left arm. He stated that he went to . . , . . yesterday and that was the , they applied at , . He stated that nursing staff get around to removing the , from his arm.

Resident #15 revealed an admission date of with diagnoses that included . . Record review of the admission Minimum Data Set (MDS) dated showed a (.....) score of 12 (moderately ,).

Review of the Admission Record Report for

A review of the physician's orders related to the resident's . . , . . care, dated and , included a high protein diet.

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A review of the resident's 12 page care plan, initiated upon admission revealed no additional care plans related to the access site. A review of the resident's Nursing Notes from

..., after the ..., treatment.

until did not reveal documentation that the , had been removed, only that the site had been observed and the and was noted.

**On at 10:10 a.m., Resident #1 was observed lying in bed on his left side, watching a video. A access site was observed on the upper left arm.

A review of Resident #1's Admission Record

Report revealed an original admission date of with diagnoses that included with dependence on . . . A review of the physician's orders related to the resident's , care, revealed orders for the resident's , . . at the . . , . . center at 12 p.m., every Monday, Wednesday, Friday for , check the (_ ... -) ... site / ... every

shift, and ___ site observation every shift, site observation as needed. There was no additional orders for the care of the

access, including when to remove the after the treatment. Review of the nurse's notes revealed documentation that the and

PRINTED: 11/29/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C 55114 10/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 38220 HENRY DR HEARTLAND OF ZEPHYRHILLS ZEPHYRHILLS, FL 33540 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 201} Continued From page 23 (N 201) were present after treatment on (, site clean and dry, positive and noted). In an interview with the Administrator and the acting Director of Nurses on beginning at 2:00 p.m., it was confirmed that there should be an order for care of the site to include when to remove the applied after the site had been accessed for The Administrator confirmed during that interview that the document , Guidelines was the document used to train staff and also used as reference for care for the _____ residents. Review of the ".... Guidelines" dated revealed: Both the center and the . . , . . facility are responsible for shared communication regarding patients receiving services... Collaborative communication included information regarding physician and treatment orders, and adverse reactions or complications and recommendations for follow up observations

and monitoring including those related to the

issues, including color, temperature,, moisture status, integrity,

Record review of the facility's policy. "Phase 1: Assess, Prevention Pathway" dated 2013 showed the tool can be used by the team as a training tool for frontline staff and as an ongoing clinical reference tool. Patient is admitted or readmitted, do both a-to-. skin evaluation and

. Document skin

to document

access site.

a current or healed.

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PRINTED: 11/29/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B WING 55114 10/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 38220 HENRY DR HEARTLAND OF ZEPHYRHILLS ZEPHYRHILLS, FL 33540 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 201} Continued From page 24 (N 201) the , : location, length, width, depth, PUSH tool. The team stages the , . Obtain order for treatment from physician and obtain consultations needed. Daily body audits performed. . . . performed. **Review of Resident #15's admission Minimum Data Set (MDS) assessment dated showed a () score of 12 (moderate . , . . .). Continued review of the MDS revealed the resident required of two for bed mobility, transfers, and toileting and had one on admission due to coverage of ... bed by and/or eschar. Record review of the physician orders showed a ... culture of the to be performed on : cleanse and apply [... care product] . . . , and apply foam , every day as needed as of and increased to every 8 hours on

Review of the Admission Evaluation dated revealed under Clinical Evaluation of Skin: , open . with foam The medical record lacked the " Healing Chart," (PUSH) form or any other documentation of a ... description or measurements upon admission on Record review of the progress notes showed the following notes related to the: at 1:39 a.m. ... on his bottom with a wet to dry and foam jin

STATE FORM caso C7S212 If continuation sheet 25 of 34

10/27/2021

Agency for Health Care Administration
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION
STATEMENT OF CORRECTION
OF CORRECT

B. WING

55114 B. WING _____

| NAME OF P | ROVIDER OR SUPPLIER S | STREET ADDI | RESS, CITY, STA | TE, ZIP CODE | |
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| HEARTLA | ND OF ZEPHYRHILS | 38220 HENRY DR ZEPHYRHILLS, FL 33540 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| {N 201} | Continued From page 25 | | {N 201} | | and the same of th |
| | place to cover the bed. On at 11:37 a.m. Resident was complaining of of the the as needed was given and repositioned for comfort. Resident's provider was in to assess resident and orders received for treatment of On at 12:44 p.m. resident reported nor change with of after or Registered Nurse (RN) notified Nurse Practitioner (NP) of resident concerns of no relief. NP thinks he just needs the changed. RN to change On at 22:20 7 (10:70 p.m.) nurse documented care performed. On at 22:20 7 (10:70 p.m.) to area noted to have an odor and the was saturated with a large amount of drainage. Area noted to have in the middle of bed. Area cleansed and new treatme applied. Writer educated resident to leave in place and to turn onto their side whin bed. On at 13:15 (1:15 p.m.), Resident had one at 13:15 (1:15 p.m.), Resident had one measured 9.0 cm x 5.0 cm x 3 cm. and had moderate drainage. The 75% and 25% eschar. The score was 16. The was recently treated write 1 are product] and foam padding. Resident had a diagnosis of left and Resident was currently doing three times a week Resident's nurtitional intake currently included high protein diet with [brand name] Liquid Nutritional Supplements, and additional nutritional supplete vas 6 (1) of 31, and appetite had been normal. Recent lebas shower elevated (1) of 31, and | ddle ent dd d t k a onal d | | | |
| | of 5.39 also showed a low total prote | tein | | | 1 |

STATE FORM 699 C75212 If continuation sheet .26 of .34

| | | | 7 OTHER THOUSE |
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| Agency for Health Care Adminis | stration | | |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | (X3) DATE SURVEY COMPLETED |
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55114 B. WING_ 10/27/2021

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 38220 HENRY DR

| HEARTLA | ND OF ZEPHYRHILLS 38220 HE ZEPHYRI | NRY DR HILLS, FL 33540 | | |
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| {N 201} | Continued From page 26 of 5.6 and Hemoglobin at 8.9 and at 27.3. Resident denied , during , change. culture was pending. Treatments will continue as ordered pending culture. Resident updated on plan of care and status of The care plan was updated on status. Staff D. Registered Nurse (RN) On at 23:00 (11:00 p.m.) resident returned from in stable condition. The care was rendered, and he tolerated it well. | {N 201} | | |
| | Record review of the Culture Results dated showed (1) heavy growth of (2) moderate growth of and (3) heavy growth of The organism one and two was sensitive to | | | |
| | additional progress notes related to the | | | |
| | Resident's nutritional intake included a high protein diet, with [name brand] Liquid Nutrition with additional nutritional snacks. Nutritional intake has been adequate with a good appetite. culture completed; results sent to MD awalting new orders from culture results. changed per MD orders; resident reports no with reatment. Resident updated on plan of care and status of | | | оположивания в положивания |

AHCA Form 3020-0001

STATE FORM 6550 C7S212 If continuation sheet 27 of 34 Agency for Health Care Administration

STATEMENT OF DEFICIENCIES (XT) PROVIDERSUPPLIERCILIA DO MULTIPLE CONSTRUCTION DO JOHE SURVEY DEFICIENCY DEPOSITE CATION NUMBER:

DENTIFICATION NUMBER:

| ATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | (X3) DATE SURVEY |
|-------------------------|-----------------------------|--|------------------|
| D PLAN OF CORRECTION | IDENTIFICATION NUMBER: | | COMPLETED |
| | 55114 | B. WING | R-C |

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE
38220 HENRY DR

| HEARTLA | ND OF ZEPHYRHILLS | 0 HENRY DR HYRHILLS, FL 33540 | | | |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE | |
| {N 201} | Continued From page 27 | {N 201} | | and the same of th | |
| | Staff D, Registered Nurse (RN) On at 01:10 a.m. Resident on for | | | | |
| | **Review of Resident #16's admission record report revealed an admission date of and diagnoses to include, COVID-19, and and Record review of the admission | | | | |

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STATE FORM 699 C75212 If continuation sheet .28 of .34

PRINTED: 11/29/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B WING 55114 10/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 38220 HENRY DR HEARTLAND OF ZEPHYRHILLS ZEPHYRHILLS, FL 33540 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMBLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 201} Continued From page 28 (N 201) Minimum Data Set (MDS) dated showed a (__) score of 15 (___, ___). Section G Functional Status showed she required of two for bed mobility, transfers, and toileting. Record review of physician orders showed cleanse ..., , right and left with normal and apply [care product] gel and foam , daily and as needed as of through . A new order on to cleanse, ., right and left with normal and apply xeroform gauze and cover with foam .. daily and as needed. Treatment Administration Record (TAR) showed orders performed as given. Review of the Admission Evaluation dated showed under Clinical Evaluation of Skin, , , , right , left Record review of the Healing Chart (PUSH) forms times three dated showed Resident #16 had a

on her right and the form lacked sizes or healing graph, Had a PUSH form for the Left and it lacked sizes or healing graph. Had a PUSH form for which had a dated section of showing showing was 1.5 x 0.8, with light, and J. tissue. No additional measurements of could be located in the clinical record

Review of care plans showed a risk for alteration in skin integrity related to , mobility initiated Interventions dated included encourage to reposition as needed:

STATE FORM case C7S212 If continuation sheet 29 of 34

| Agency for Health Care Adminis | tration | | FORM APPROVE |
|---|---|---|-------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | (X3) DATE SURVEY COMPLETED |
| | 55114 | B. WING | R-C 10/27/2021 |

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TREET ADDRESS CITY STATE ZIP CODE

| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | |
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| HEARTLAND OF ZEPHYRHILLS | | 38220 HENRY DR ZEPHYRHILLS, FL 33540 | | | | |
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| (N 201) | Continued From page 29 pressure redistributing device on bed/chair. A second care plan showed resident had a | ions in ies of ins ies of ins iered ies ies ies ies ies ies ies ies ies ie | (N 201) | | | |
| | interim DON/MDS Coordinator and the Regic Nurse verified that Resident #16 had admission on They also verified that there were no sizes taken on admission | on | | | ************************************** | |

AHCA Form 3020-0001

STATE FORM 699 C75212 If continuation sheet 30 of 34

Agency for Health Care Administration
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION
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(X2) MULTIPLE CONSTRUCTION
(X2) MULTIPLE CONSTRUCTION
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 55114
 B. WING
 10/27/2021

 NAME OF PROVIDER OR SUPPLIER
 STREET ADDRESS, CITY, STATE, ZIP CODE

EADTI AND OF TERMYDHILLS

38220 HENRY DR

| HEARTLAND OF ZEPHYRHILLS | | 220 HENRY DR PHYRHILLS, FL 33540 | | |
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| {N 201} | Continued From page 30 | {N 201} | | |
| | The interim DON/MDS coordinator stated that the sizes are to be documented in the progress notes. She stated, "I thought they were getting done, but they were not", (related to sizing). The DON/MDS coordinator and Regional Nurse verified that only one of the three Resident #16 had been measured since admission. Staff D. Registered Nurse. Unit Manager (RNUM) entered the interview and stated that starting sizes, during weekly rounds. Staff D stated that sizes on admission are to track and see if the was getting better or not. **Clinical record review for Resident #13 reveals she was initially admitted on with readmissions after hospital stays on and a hospital stay from until . Review of the resident's diagnoses included a of the right heel, unspecified stage and of the region, unspecified stage. | e e | | |
| | A readmission assessment for Resident #13 wa completed upon return to the facility from the hospital on . The section of the hassessment for the clinical evaluation of the skinculded skin issues at the right heel and the but contained no description of either site including neither measurements nor stage. A review was conducted of the resident's MDS Quarterly Assessment completed on which identified the resident as having no . Score of 15). The resident was assessed as having one and one and one admission. The resident upon admission. The resident was assessed as | ₽, | | |

PRINTED: 11/29/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: P.C B WING 55114 10/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 38220 HENRY DR HEARTLAND OF ZEPHYRHILLS ZEPHYRHILLS, FL 33540 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMBLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 201} Continued From page 31 (N 201) needing with two staff members for bed mobility and transferring, having an . . , . . . and always . of . . A review was conducted of the Physician's orders and was noted to include an order to cleanse the right heel with normal apply [... care product] to the ... bed and cover with gauze and tape, every day. A second order was noted for negative , 125 mm Hg (millimeters of mercury) to ..., every day shift on Monday, Wednesday, and Friday, for the Wound vac (vacuum) to, , change Monday, Wednesday Friday, every day shift related to A record review of the Skin notes revealed only two notes documenting weekly rounds for On the weekly rounds documented the resident's as: length 6.7 cm x width 7.0 cm x depth 1.2 cm. The ___ bed had 90% __

Further review of the

10% necrosis on the edges. The PUSH (scale for healing) score was 12. The peri- ... was blanchable without redness. The resident had a , ate less than 25% or refused meals and received nutrition support. The resident also had a , , , to her right heel. The length measured 2.5 cm and the width measured 1.5 cm. The PUSH score was 6.

reveal another weekly ... round until 19 days later, on . The size of the ... was documented as: length 5.8 cm x width 6.4 cm x depth 1.2 cm. The

described as pink, with 100% The PUSH score was a 16. The peri-

Skin notes did not

bed was

STATE FORM C7S212 If continuation sheet 32 of 34

PRINTED: 11/29/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B WING 55114 10/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 38220 HENRY DR HEARTLAND OF ZEPHYRHILLS ZEPHYRHILLS, FL 33540 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES 10 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 201} Continued From page 32 (N 201) blanchable without redness and the vacuum was in place and is changed

included that the resident had a was receiving an beginning for a : she ate 25-50% of her meals and received other nutrition support. She had a , , , to her right heel which measured as 2.4 cm and the width 1.5 cm. The PLISH score for the heel was 6. During an interview on that began at 2:00 p.m. with the NHA and interim DON, it was

Monday/Wednesday/Friday. The note also

confirmed that the nurses documented their daily care on the Treatment Administration Record and once a week rounds by the Unit Managers would document measurements and observations of the . This documentation would be located under the section entitled Skin in the Progress Notes section of the resident's electronic medical

During this interview, at approximately 2:35 p.m., the NHA confirmed that in mid- there was a problem with the Registered Nurses being able to cover all tasks and for some tasks there was no follow through. She reported that had been delegated to the floor nurses to do the treatments and the Unit Managers were to conduct the documentation on the weekly evaluations, but she confirmed she was just made aware that the documentation had not been made.

healing Chart used to monitor trends in the PUSH score over time for Resident #13 revealed that there were entries dated and then no entries until

record.

Review of the

STATE FORM caso C7S212 If continuation sheet 33 of 34

| Agency f | or Health Care Adminis | tration | | | |): 11/29/2021 1 APPROVEC |
|---|------------------------|--|---|---|------------|-----------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | |
| | | 55114 | B. WING | | R- 10/2 | C 7/2021 |
| NAME OF F | ROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, STAT | TE, ZIP CODE | | |
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| {N 201} | Continued From page | 33 | {N 201} | | | |
| | CLASS III | | | | | |

AHCA Form 3020-0001

| | | ID HUMAN SERVICES | | | FORM | M APPROVED |
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| | | MEDICAID SERVICES | T | | | 0. 0938-0391 |
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| | | | A. BOILDING | ' ——— | | t-C |
| | | 105599 | B. WING | | | 27/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 10/ | 27/2021 |
| TOOLL OF T | CONDEN ON OUT DEN | | 1 | 38220 HENRY DR | | |
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| TAG . | TEODEN ON ON | 200 IOCHTH THO IN CHMATION | iAd | DEFICIENCY) | TOPAL S | |
| {F 000} | INITIAL COMMENTS | | {F 000 | 0} | | |
| | A revisit to the recert | ification and complaint | | | | |
| | | number 2021001891 and | | | | |
| | 2021011084, was cor | nducted on and | | | | |
| | | and of Zephyrhills. The | | | | |
| | | npliance with 42 CFR 483, | | | | |
| | | ng Term Care Facilities. The | | | | |
| | facility had uncorrected and new deficiencies | | | | | |
| | | s been out of compliance | | | | |
| /E 0771 | since . | | /F 67 | | | |
| (F 677) | | or Dependent Residents | {F 67 | (1) | | |
| SS=E | CFR(s): 483.24(a)(2) | | | | | |
| | §483.24(a)(2) A resid | lent who is unable to carry | | | | |
| | out activities of daily l | living receives the necessary | | | | |
| | services to maintain (| good nutrition, grooming, and | | | | |
| | personal and oral hyg | | | | | |
| | | is not met as evidenced | | | | |
| | by: | | | 71 | , | |
| | | n, interview with facility staff, | | The statements made on this plan of | | |
| | | nt documents the facility were properly deployed in | | correction are not an admission of a | | |
| | | stance with eating in a timely | | not constitute an agreement with the alleged deficiencies herein. To rema | | |
| | | dents #9, #12, #22, #25) of | | compliance with all federal and state | | |
| | | nts on the 200 hall and one | | regulations, the center has taken or | | |
| | | 24) who was dependent on | | take the actions set forth in the follow | | |
| | | food item requested during | | plan of correction. The following plan | | |
| | the lunch m | | | correction constitutes the centers | | |
| | | | | allegation of compliance such that al | 1 | |
| | Findings included: | | | alleged deficiencies cited have been | OF | |
| | | | | will be corrected by the date or dates | ; | |
| | | n of the lunch meal on the | | indicated. | | |
| | | beginning at 11:50 a.m., | | | | |
| | | ne beverage cart were noted | | 1 | | |
| | | p of the hall. Two aides | | R9 was evaluated by , or | | |
| | | o independent diners at | | 11.2.21 and the plan of care was upo | | |
| | | at 12:00 p.m., Aide A, | | R12 kardex was updated and reflect | | |
| | commented that there | e were many residents on | | need for assistance with meals. R22 | i no | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Electronically Signed /2021 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.

| DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | | | |
|--|---|--|---------------------|--|--------------------------------|-------------------------------|--|
| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105599 | | | | MULTIPLE CONSTRUCTION IUILDING | | (X3) DATE SURVEY COMPLETED | |
| | | 105599 | B. WING | | | R-C 10/27/2021 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 38220 HENRY DR ZEPHYRHILLS, FL 33540 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| {F 677} | the 200 hall that need passed meal trays to She confirmed that m diners remained in th member was ready to Aide A obtained a tray cart, Nurse C approapssed two trays to h She then left the cart station. On at 12:15 aides were each sittir them with eating. The providing nail care to was pushing the residents nails, at the resident's nails, it the resident's nails, it | led assistance, and they the independent dirers first, eal trays for dependent e closed cart until a staff provide assistance. After r for a resident and left the ched the meal cart and to independent residents, and returned to the nurse's p.m., two of the unit's three g with a resident assisting a third aide was observed Resident #25. The aide | {F 67 | In longer resides at the facility. R25 no longer resides at the facility. R24 was evaluated by the IDT team to independent with meals. 2. Utilizing the patient response and report in the electronic health record interdisciplinary team reviewed resident: s requiring assistance with meals and validated the plan of care. Utilizing the Dining Observation QAPI a comprehensive review of meal service was completed by the Nursing Home Administrator. 3. The Director of Nursing/designee educate the nursing and interdisciplin department team members on it Meal Service procedure and Focus or | ilyzer i the tool will arry ne | | |

the meal service. Resident #25 reported that the food usually wasn't very good, no variety and was usually cool, but her daughter was bringing lunch for her today. She reported that she would have liked to been given something to drink though as she wasn't meeting her daughter for another half hour. She reported that she often had to wait for something that she asked for as there didn't seem to be much help. It was noted at this time that only three aides were covering the east/rehab side of the building during lunch directly assisting with or ensuring that approximately 26 residents received their afternoon meal. The two nurses assigned to the area and the UM were not observed assisting the residents with the lunch meal.

On at 12:17 p.m., the Administrator was found in her office eating pizza while talking with the staffing coordinator. The Administrator was asked where the 200 hall UM could be found.

Administrator/designee will randomly audit 5 meal times/week x 4 weeks and monthly x 2. Results will be reviewed and trended by QAPI committee for continued compliance.

4. Utilizing the Dining Observation QAPI

F-tag 677 on or before the date of

tool :: the Nursing Home

compliance.

PRINTED: 11/29/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | | | | | ron | MALLICATE | |
|--|--|--|---------------------|---|-----|----------------------------|--|
| CENTER | CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | | |
| TATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIERICLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED R-C | | | |
| | | 105599 | B. WING | | 10 | 27/2021 | |
| IAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| HEARTLAND OF ZEPHYRHILLS | | | 1 | 38220 HENRY DR ZEPHYRHILLS, FL 33540 | | | |
| (X4) ID PREFIX TAG | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| {F 677} | , | orted that she did not know, | {F 677} | | | | |
| | On at 12:20 | p.m., the surveyor returned | | | | | |

to the 200 hall after speaking with the Administrator and observed a call light was illuminated/ringing. No staff were present to respond to the light. After five minutes without any staff response, the surveyor asked the resident with the ringing call light (Resident #24) what she needed. The resident reported that her pasta was dry and needed sauce on it. She pointed to her roommate's pasta and commented that the roommate had gravy on it. The Certified Dietary Manager was notified of the request and within another five minutes, the resident was provided with some brown gravy.

at 12:30 p.m., all three aides were observed assisting three residents with eating to include Resident #22.

On at 12:35 p.m., the Activity Aide was observed noted walking down the hall and looking for residents that still needed assistance. She obtained a meal tray and began to assist a resident with eating.

On at 12:40 p.m., Aide B was observed

standing next to Resident #12, who was refusing her meal. An attempt to ask Resident #12 about her meal at this time revealed no response from the resident. When Aide B left Resident #12, she obtained another meal tray and sat with Resident #9 to begin assisting with eating. During the meal observation, Resident #9 reported that her meal was good.

at 12:45 p.m., the UM was observed

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| EPARTMENT OF HEALTH AN | FORM APPROVED | | |
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| ENTERS FOR MEDICARE & I | OMB NO. 0938-0391 | | |
| TEMENT OF DEFICIENCIES OPLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | (X3) DATE SURVEY COMPLETED |
| | 105599 | B. WING | R-C 10/27/2021 |

| | | 105599 | B. WING | | R-C | |
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| NAME OF P | ROVIDER OR SUPPLIER | 10000 | ī | STREET ADDRESS, CITY, STATE, ZIP CODE | 10/27/2021 | |
| MEADTLA | ND OF ZEPHYRHILLS | | | 38220 HENRY DR | | |
| HEARTLA | ND OF ZEPHTRAILLS | | | ZEPHYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | REMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | |
| {F 677} | Continued From page 3 | | {F 67 | 73 | | |
| | in her office looking a was called to the flow was called to the flow in they needed help with time, two residents re waiting to receive their waiting to receive their waiting to receive their was arrived on the her tray and received. On at 1:50 preported that the UM oversight during the notation of the three was able Administrator reported that was needed was thought she was able Administrator was not hall and was informed on the hall to assist up meals, one of the three Resident #255 nails c | ther computer screen. She and reported that she had ch. She asked the staff if the funch meal. At that quiring assistance were still r lunch meal. At that quiring assistance were still r lunch meal. p.m. (one hour after meal all) the last resident received assistance to eat. c.m., the Administrator should be providing neal process. The first that everyone on the hall present so the UM probably to go to lunch. The aware of who was on the that only three aides were to to six residents with their e aides was painting luring lunch, and litional residents needed | | | | |
| | provided a plan for re- meals. She reported t staff would be assigne assistance so there w | .m., the Administrator sidents to be assisted at hat aides and other nursing ad to residents who needed ould be adequate staff and ad to wait for their meal. | | | | |
| | , She was as | | | | | |

| DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | FORM | 0: 11/29/2021 MAPPROVED 0: 0938-0391 |
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| STATEMENT (| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 105599 | B. WING | | R-C 10/27/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | 38220 HENRY DR ZEPHYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 3E | (XS) COMPLETION DATE |
| (F 677) | Interview of Mental S moderate assessed as requiring one person physical a A review of Resident revealed complete the in as requiring | #12's MDS dated the resident had a Brief tatus score of 8 indicating , She was , She was , with assistance for eating. #22's MDS completed on she was not able to terview. She was assessed , with one person t meals. #25's MDS completed on a of 14 indicating equired supervision with one tance with meals. Review of and written at hat Resident #25's daughter be painted because it was te, written by the Unit sted the aide was made | {F 67' | 7) | | |
| F 686 SS=E | supervision and set u | p assistance at meals. event/Heal | F 68 | 36 | | |
| | resident, the facility n | hensive assessment of a | | | | |

professional standards of practice, to prevent and does not develop pressure

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 1/1/29/2021 CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO. 0938-0391 ASTAREHYLO OF DEPICHOLOGIS. USA PROVIDERSHIPHER DILA (22) MINITED E CONSTRUCTION (23) DES LISTRY

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | C | MB NO. | 0938-039 |
|--------------------------|--|---|---------------------|---|-----|--|----------------------------|
| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | LTIPLE CONSTRUCTION DING | | (X3) DATE SURVEY COMPLETED R-C 10/27/2021 | |
| | | 105599 B. WING | | | | | |
| VAME OF PR | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C | ODE | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | 38220 HENRY DR ZEPHYRHILLS, FL 33540 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR | | ID PREFIX TAG | | | | (X5) COMPLETION DATE |
| F 686 | demonstrates that the | vidual's clinical condition ay were unavoidable; and receives and services, consistent | F 68 | 36 | | | |

and prevent

Findings Included:

promote healing, prevent

new _ _ _ from developing.
This REQUIREMENT is not met as evidenced

ΔÞ

- 1. During observation and interview on at 9:00 a.m., Resident #15 was observed lying in bed. The resident was observed to have an access in his right ... with a ... __dated and a clean and dry __on his upper left arm. The resident stated that this was the __applied when he went to __the day before.
- Review of Resident #15's admission Minimum Data Set (MDS) assessment dated showed a
- showed a
 () score of 12 (moderate). Continued review of the MDS
- revealed the resident required
 of two for bed mobility, transfers, and
 toileting and had one
- on admission due to coverage of ... bed by and/or eschar.

R15 was assessed on 11.10.21 with measurements obtained and the plan of care updated. R16 no longer resides in the facility. R13 were assessed on 11.10.21 with measurements obtained and the plan of

 A comprehensive review of current residents with was completed on 11.2.21 by the Quality Assurance Consultant to validate descriptions and measurements were documented in the medical record.

care updated.

- The Director of Nursing/designee will educate the licensed nursing staff on the Skin Practice Guide and Focus on F-tag 686 on or before the date of compliance.
- Utilizing the 686-QAPI tool ⊕ the Director of nursing/designee will audit residents with weekly x4 and monthly x
- Results will be reviewed and trended by QAPI committee for continued compliance.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | 105599 | B. WING | 10/27/2021 | | | |
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| ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | (X3) DATE SURVEY COMPLETED | | | |
| CENTERS FOR MEDICARE & I | CENTERS FOR MEDICARE & MEDICAID SERVICES (| | | | | |
| DEPARTMENT OF HEALTH AN | PRINTED: 11/29/2021 FORM APPROVED | | | | | |
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| 10000 | | | | | 10/ | 27/2021 | |
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| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 38220 HENRY DR | | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | 1 | ZEPHYRHILLS, FL 33540 | | |
| | | | | _ | · · · · · · · · · · · · · · · · · · · | | |
| (X4) ID PREFIX | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREF | *** | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | | SC IDENTIFYING INFORMATION) | TAG | | CROSS-REFERENCED TO THE APPROPRIATE | | DATE |
| | | | | | DEFICIENCY) | | |
| | | | | | 1 | | |
| = 000 | 8 Ctid F 6 | | | | | | |
| F 686 | Continued From page | 6 | F | 68 | 5 | | |
| | Record review of the | physician orders showed a | | | | | |
| | culture of the | to be performed on | | | | | |
| | ; cleanse | and apply | | | | | |
| | [care product] | | | | | | |
| | foam every | | | | | | |
| | | ed to every 8 hours on | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Review of the Admiss | sion Evaluation dated | | | | | |
| | revealed under Clinical Evaluation of | | | | | | |
| | | | | | | | |
| | Skin:, open with foam | | | | | | |
| | · · · • | | | | | | |
| | The medical record lacked the " | | | | | | |
| | | | | | | | |
| | Healing Chart," (PUS | | | | | | |
| | documentation of a | | | | | | |
| | measurements upon | admission on | | | | | |
| | | | | | | | |
| | | progress notes showed the | | | | | |
| | following notes relate | d to the . | | | | | |
| | | | | | | | |
| | | on his | | | | | |
| | | dry and foam jin | | | | | |
| | place to cover the | | | | | | |
| | On at 11:37 | | | | | | |
| | complaining of , o | | | | | | |
| | as needed was given | | | | | | |
| | | rovider was in to assess | | | | | |
| | resident and orders re | eceived for treatment of | | | | | |
| | | | | | | | |
| | | p.m. resident reported no | | | | | |
| | change with, of | | | | | | |
| | , Registered N | lurse (RN) notified Nurse | | | | | |
| | Practitioner (NP) of re | esident concerns of no | | | | | |
| | relief. NP thinks he ju | | | | | | |
| | , changed. Ri | | | | | | |
| | On at 22:07 | | | | | | |
| | documented c | | | | | | |
| | | (2:47 p.m.) to | | | | | |
| | On at 14.47 | lett build | | | | | |

| XXTEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLEDICULA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED R. C. | | | ID HUMAN SERVICES MEDICAID SERVICES | | | FORM APPROVED OMB NO. 0938-0391 | |
|--|------------|--|---|-----------|--|--|--|
| 105599 R. WING 1077/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 38220 HENRY OR 2EPHYRHILLS STREET ADDRESS, CITY, STATE, ZIP CODE 38220 HENRY OR 2EPHYRHILLS, FL 33540 ZEPHYRHILLS, FL 33540 ZEPHY | TATEMENT O | F DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | | | (X3) DATE SURVEY COMPLETED | |
| HEARTLAND OF ZEPHYRHILLS DEPHYRHILLS, FL 33840 | | | 105599 | B. WING _ | | | |
| HEARTLAND OF ZEPHYRHILLS, FL 33540 DATE DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 686 Continued From page 7 area noted to have an odor and the | NAME OF PR | ROVIDER OR SUPPLIER | | | | DDE | |
| PREFIX TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DOPE CROSS-REFERENCED TO THE APPROPRIATE | HEARTLA | ND OF ZEPHYRHILLS | | | | | |
| area noted to have an odor and the , was saturated with a large amount of drainage. Area noted to have in the middle of bed. Area cleansed and new treatment applied. Writer educated resident to leave in place and to turn onto their side while | PREFIX | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T | ON SHOULD BE COMPLETION HE APPROPRIATE DATE | |
| in bed. On at 13:15 (1:15 p.m.) Resident had one to the The measured 9.0 cm x 6.0 cm x 3 cm. and had moderate drainage. The bed was 75% and 25% sechar. The score was 16. The was recently treated with [care product] and foam padding. Resident had a diagnosis of left and Resident was currently doing three times a week. Resident's autritional intake currently included a high protein diet with [prand name] Liquid Nutritional Supplements, and additional nutritional snacks. His nutritional intake was good, and appetite had been normal. Recent labs showed elevated () of 31, and of 5.3 s also showed a low total protein of 5.6 and Hemoglobin at 8.9 and at 27.3. Resident demided during culture. Resident updated on plan of care and status of The care plan was updated on status. Staff D, Registered Nurse (RN) On at 23.00 (11:00 p.m.) resident returned from in status. Staff D, Registered Nurse (RN) On at 23:00 (11:00 p.m.) resident returned from in status condition. The care was rendered, and he tolerated it well. Record review of the Culture Results | F 686 | area noted to have ar was saturate of bed. Area of applied. Writer educa in place and in bed. On at 13:15 one measured 9.0 had moderate drainay and 25% score was 16. The writer of the measured 9.0 care programmers of 5.39 also protein diet with Nutritional Supplemental S | n odor and the ad with a large amount of to have in the middle ideansed and new treatment ted resident to leave to turn onto their side while (1:15 p.m.) Resident had to the The cm x 6.0 cm x 3 cm. and ge. The bed was recently treated durel] and foam padding, tosis of left Resident three times a week, intake currently included a [brand name] Liquid nst, and additional nutritional is intake was good, and in 31, and o showed a low total protein in at 9.3 and d during cutture was pending. use as ordered pending ent updated on plan of care The care plan was updated in stable to condition. The | F6 | e6 | | |

., (2) moderate growth of

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | | APPROVED 0. 0938-0391 |
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| STATEMENT | DF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPL(ER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | | 105599 | B. WING | | | R-C 10/27/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | | 38220 HENRY DR ZEPHYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 686 | and two was sensitive Continued review of tadditional progress in at 10:26 a.n. showed resident had the 6.0 cm x 3.5 cm. and drainage. The 25% eschar. The Awaiting Medical Doc Resident curr Residincluded a high prote Liquid Nutrition with a Nutritional intake has appetite. cult to MD awaiting new cresuits. resident reports no resuits. resident reports no noted. Staff D, Registered N On at 01:10 for noted. site to right On at 11:05 wheelchair for saturated foam changed pe tolerated. Well. Residented. With strong odor, con | 3) heavy growth of The organism one to | F | 686 | | | |

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | | MAPPROVED 0. 0938-0391 |
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| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 105599 | B. WING | | | R-C 10/27/2021 | |
| | ROVIDER OR SUPPLIER | | • | 38 | FREET ADDRESS, CITY, STATE, ZIP CODE 8220 HENRY DR EPHYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 686 | | care plans related to the | F | 686 | | | |
| | /skin initiated of Interventions included | | | | | | |
| | Director of Nursing /h (DON/MDS), and the that Resident #15 did documented on admi reported that when no admission and throug can worsen, the stated that they expe- and care pla | istrator (NHA), the interim IDS Coordinator Regional Nurse, verified not have any sizes ssion. The Regional Nurse | | | | | |
| | report revealed an ad and diagnoses to incl COVID-19, as Recorn Minimum Data Set (N showed a () score of 15 (Functional Status sho | ude | | | | | |
| | product] gel and foam | | | | | | |

| | | ID HUMAN SERVICES | | | | | M APPROVED | |
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| | | MEDICAID SERVICES | _ | | | | 0. 0938-0391 | |
| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | | 105599 | B. WING | | | | -C 27/2021 | |
| NAME OF PR | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| | | | | : | 38220 HENRY DR | | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | - 2 | ZEPHYRHILLS, FL 33540 | | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID. | | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | | Y MUST BE PRECEDED BY FULL | PREF | | (EACH CORRECTIVE ACTION SHOULD BI | | COMPLETION DATE | |
| TAG | REGULATORY OR I | SC IDENTIFYING INFORMATION) | TAG | | CROSS-REFERÊNCED TO THE APPROPRIA DEFICIENCY) | UE. | DATE | |
| | | | | | | | | |
| F 686 | Continued From page | 10 | F | 686 | | | | |
| | , , | cleanse, right | , | | | | | |
| | and left | with normal and | | | | | | |
| | apply xeroform gauze | | | | | | | |
| | | needed. Treatment | | | | | | |
| | | d (TAR) showed orders | | | | | | |
| | performed as given. | . , | | | | | | |
| | | | | | | | | |
| | Review of the Admiss | ion Evaluation dated | | | | | | |
| | showed und | er Clinical Evaluation of | | | | | | |
| | Skin, , , , , | right , left . | | | | | | |
| | Record review of the | Healing | | | | | | |
| | Chart (PUSH) forms t | imes three dated | | | | | | |
| | showed Resident #16 | ihada j | | | | | | |
| | on her right | and the form lacked | | | | | | |
| | sizes or healing graph | h. Had a PUSH form for the | | | | | | |
| | Left | , and it lacked | | | | | | |
| | | h. Had a PUSH form for | | | | | | |
| | | which had a dated section | | | | | } | |
| | | was 1.5 x 0.8, with | | | | | | |
| | light , and | | | | | | | |
| | additional measurement | | | | | | | |
| | located in the clinical | record. | | | | | | |
| | Review of care plans | showed a risk for alteration | | | | | | |
| | in skin integrity relate | | | | | | | |
| | | erventions dated | | | | | | |
| | | o reposition as needed; | | | | | | |
| | | g device on bed/chair. A | | | | | | |
| | second care plan sho | wed resident had a | | | | | | |
| | , on the | right Interventions | | | | | | |
| | included to administe | r treatment per physician | | | | | | |
| | orders, daily body aud | | | | | | | |
| | | ositioning during Activities of | | | | | | |
| | | plan and all interventions | | | | | | |
| | | by Staff D, Registered | | | | | | |
| | Nurse (RN) | | | | | | } | |

Record review of the progress notes showed:

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | | M APPROVED 0. 0938-0391 |
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| TATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDI | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 105599 | B. WING | | | 10 | 27/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | | 38220 HENRY DR ZEPHYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 686 | to left her . Treatmer . Treatmer . Treatmer . Treatmer . Treatmer . On . , resident and ordered. On , progres showed no mentioned in plan. On , progres showed no mention on mentioned in plan. On , left normal . and ap gel and foam sponge . On . at 12:21 updated care, right and left . Nurse (RN) notified th all questions were an . On . at 1:57 conducted with the Ni Coordinator, and the interim DON/MDS Co Nurse verified that Re admission on there were no . The interim DON/MDS sizes are to be progress notes. She registing done, but they sizing). The D Reglonal Nurse verified. | had a | F | 6686 | 6 | | |

Manager (RN/UM) entered the interview and stated that starting , she will be

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | | DRM APPROVED NO. 0938-0391 |
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| TATEMENT (| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL' A. BUILDI | | INSTRUCTION | (X3) D | IATE SURVEY OMPLETED |
| | | 105599 | B. WING | | | | 10/27/2021 |
| | ROVIDER OR SUPPLIER ND OF ZEPHYRHILLS | | • | 3822 | EET ADDRESS, CITY, STATE, ZIP CODE 10 HENRY DR HYRHILLS, FL 33540 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION | ID PREFI TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 686 | rounds. Staff D states admission are to trac getting better or not. Record review of the Assess, dated 2013 showed to team as a trainand as an ongoing dies admitted or readmiskin evaluation and issues, including colo moisture status, integresent or known, he a current or healed, the | sizes, during weekly that sizes on k and see if the was facility's policy, "Phase 1: Prevention Pathway" he tool can be used by the ning tool for frontline staff nical reference tool. Patient tted, do both a -to Document skin r, temperature, rity, . if | F | 686 | | | |
| | until . Rediagnoses included a heel, unspecified stager region, unspector A readmission assessed. | ially admitted on er hospital stays on spital stay from view of the resident's of the right ge and of the diffed stage. | | | | | |

included skin issues at the right heel and the

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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| | | ID HOMAN SERVICES | | | | FOR | M APPROVED | |
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| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO | D. 0938-0391 | |
| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | DISTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 105599 | B. WING | | | 1 | R-C /27/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | • | • | STRI | EET ADDRESS, CITY, STATE, ZIP CODE | | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | | PHYRHILLS, FL 33540 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPT DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 686 | but contained including neither meas A review was conduc Quarterly Assessmen which identified the record of 15). To admission. The residneeding members for bed mol an of | no description of either site, surements nor stage. It ded of the resident's MDS to completed on seident as having no the resident was assessed as with two staff billity and transferring, having and always ted of the days as seed of the seed of | F | 686 | | | | |

peri- was blanchable without redness. The resident had a \hdots , ate less than 25%

Facility ID: 55114

| | | ID HUMAN SERVICES | | | | | APPROVED |
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| | | MEDICAID SERVICES | | | | | 0. 0938-0391 |
| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION G | 1 | PLETED |
| | | 105599 | B. WING | _ | | | -C 27/2021 |
| NAME OF PE | ROVIDER OR SUPPLIER | | | Г | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | | 38220 HENRY DR | | |
| | | | | L | ZEPHYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 686 | Continued From page | e 14 | F | 68 | 86 | | |
| | | received nutrition support. | | - | | | |
| | | da , , , to her | | | | | |
| | right heel. The length | measured 2.5 cm and the | | | | | |
| | width measured 1.5 c | m. The PUSH score was 6. | | | | | |
| | | | | | | | |
| | | Skin notes did not y round until 19 days | | | | | |
| | later, on . Th | | | | | | |
| | | ted as: length 5.8 cm x | | | | | |
| | | 1.2 cm. The bed was | | | | | |
| | described as pink, wit | th 100% The | | | | | |
| | | 6. The peri- was | | | | | |
| | blanchable without re | | | | | | |
| | vacuum was in place | | | | | | |
| | | Friday. The note also | | | | | |
| | included that the resid | dent had a , beginning | | | | | |
| | | ; she ate | | | | | |
| | | and received other nutrition | | | | | |
| | support. She had a | , , to her right | | | | | |
| | heel which measured | as 2.4 cm and the width 1.5 | | | | | |
| | cm. The PUSH score | for the heel was 6. | | | | | |
| | | | | | | | |
| | During an interview o | | | | | | |
| | | A and interim DON, it was | | | | | |
| | | rses documented their daily eatment Administration | | | | | |
| | Record and once a w | | | | | | |
| | | document measurements | | | | | |
| | and observations of the | | | | | | |
| | documentation would | | | | | | |
| | section entitled Skin i | n the Progress Notes | | | | | |
| | section of the residen | t's electronic medical | | | | | |
| | record. | | | | | | |
| | | | | | | | |
| | | at approximately 2:35 p.m., | | | | | |
| | the NHA confirmed th | nat in mid there was | | | | | 1 |

a problem with the Registered Nurses being able to cover all tasks and for some tasks there was

Facility ID: 55114

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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| | | MEDICAID SERVICES | | | OMB NO. 0938-0391 | | |
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 105599 | B. WING | | R-C 10/27/2021 | | |
| NAME OF PR | ROVIDER OR SUPPLIER | • | 5 | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| HEARTLA | ND OF ZEPHYRHILLS | | 1 | 8220 HENRY DR EPHYRHILLS, FL 33540 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION | | |
| F 686 | had been delegated to treatments and the U conduct the documer evaluations, but she conduct was a made aware that the made. Review of the to monitor trends in the treatment of the trends in the treatment of th | e reported that care o the floor nurses to do the nit Managers were to | F 686 | | | | |
| (F 694) SS=D | with professional star accordance with phys comprehensive persor the resident's goals a This REQUIREMENT by: Based on observatio review, the facility fail orders to insert an (#15) of three resider and services. Findings included: On at 9:00 a observed lying in bed observed in his right dated An pedeside. No medi- | on-centered care plan, and not preferences. is not met as evidenced in, interview and record ed to obtain physician () line for one its reviewed for treatment treatment #15 was | (F 694) | 1. R 15 no longer has an access device. 2. A comprehensive review of curresidents with access was comple by the Quality Assurance Consultant/designee to validate appropriate physician orders were in place. 3. The Director of Nursing/designe educate the licensed nursing staff on educate the licensed nursing staff or licensed nur | ent eted | | |

| | | ID HUMAN SERVICES | | | | | M APPROVED |
|--------------------------|--|---|------------------------|-----|---|-----------|----------------------------|
| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO | 0. 0938-0391 |
| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | | CONSTRUCTION | | PLETED |
| | | 105599 | B. WING _ | | | | -C 27/2021 |
| NAME OF PE | ROVIDER OR SUPPLIER | | | 5 | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | 1 | 38 | 8220 HENRY DR | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | Z | EPHYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION] | ID PREFII TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| (F 694) | Report revealed an a and diagram and and diagram and and diagram and and diagram and | Its's Admission Record dmission date of noses to include | {F 6 | 94) | Change and Focus F-tag 694 on or before the date of compliance. 4. Utilizing the F 694 OA and the director of nursing/designee audit residents with access weekly a and monthly x2 to validate appropriate physician orders were obtained. Resu till be reviewed and trended by QAPI committee for continued compliance. | vill 4 | |
| | Review of nursing pro | gress notes showed: | | | | | 1 |

On at 00:16 (12:06 a.m.) was started

Facility ID: 55114

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | | APPROVED 0. 0938-0391 |
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| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPL(ER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI B. WING | | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED -C |
| | | 105599 | D. WING | | | 10/ | 27/2021 |
| | ROVIDER OR SUPPLIER ND OF ZEPHYRHILLS | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 38220 HENRY DR ZEPHYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| (F 694) | angiocath. On at 21:12 returned from had no Residen no adverse reactions. On at 01:10 for noted. site to right Record review of the of /sk of survey). Interventic to administer medicat Second care plan for at insertion site: on (da on). Interventic tion on). Interventic to do not take change by physician and on take change by physician on finitiration. On at 1:57 p Administrator (NHA) a Administrator (NHA) a Treatment Administra Review of the facility. Treatment Administra | nd attempt with 22-gauge (9:12 p.m.) Resident at 5 p.m. and was alert and t continued on | {₽€ | 94 | | | |

order includes: date and time; name of the patient; site of application; cleansing agent if

Facility ID: 55114

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | FORM APP OMB NO. 093 | |
|--|--|--|---------------------------|--|------------------------------|-------------------------|
| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTII A. BUILDIN | PLE CONSTRUCTION G | (X3) DATE SURVE COMPLETED | ΕY |
| | | 105599 | B. WING | | R-C 10/27/20 | 21 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | , | |
| HEARTLA | ND OF ZEPHYRHILLS | | | 38220 HENRY DR ZEPHYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | DBE COM | (X5) PLETION MATE |
| {F 694} | applicable; directions primary and seconda name of the medical | including end date orders if for use, if applicable; ry , if applicable; practitioner giving the order; practitioner if the order is d signature of nurse | {F 69 | | | |
| (F 698} SS≃D | require receive with professional star comprehensive personal star comprehensive personal star comprehensive personal star comprehensive personal star special | on-centered care plan, and not preferences. is not met as evidenced on of access sites, staff, and review of the facility policy titled he facility ploicy titled he facility practice for obtaining led to care and removal of access site following two (#15, #1) of three lewed. 0 a.m., Resident #15 was | {F 69 | 1. R15 order was obtained to renthe | order post | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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| DEFAIL | WENT OF HEALTHAN | ID HOWAIN SERVICES | | | FORM APPROVED |
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| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | OMB NO. 0938-0391 |
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 105599 | B. WING | | R-C 10/27/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | 5 | TREET ADDRESS, CITY, STATE, ZIP CODE | |
| HEARTLA | ND OF ZEPHYRHILLS | | - 1 | 3220 HENRY DR EPHYRHILLS, FL 33540 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLETION |
| (F 698) | Review of the Admiss Resident #15 reveale with diagron with diagron on Readmission Minimum I showed a () score A review of the physic resident's car included check (- every shift for site observati a day, and Tues, Thurs, Sat. The removal of the after a finitiated upon admiss care plans related to A review of the reside intilated upon admiss care plans related to A review of the reside induced that the removed, only that the and the and the and the and the A acceuper left arm. 2. On at 10 observed tying in bed video. A acceuper left arm. A review of Resident Report revealed an o | sion Record Report for d an admission date of noses that included noses that included () with dependence scord review of the Data Set (M/DS) dated of 12 (moderately), bian's orders related to the e, dated and a high protein det,) site / check: on as needed and one time on as needed and one time pryphysician order ere was no order for that was applied to the rithe treatment. | {F 698} | audit, residents orders weekt times 4 weeks and monthly x2. Res will be reviewed and trended by the committee for continued compliance | ults QAPI |

with dependence on A review of the

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/29/2021

| CENTERS FOR MEDICARE & MEDICARD SERVICES XIVENET OF DEPICIENCES XIVENET OF DEPICE ON THE DEPICIENCES XIVENET OF DEPICE OF THE DEPICIENCES XIVENET OF DEPICIENCY MAST BE PRECEDED BY FULL MEDILATORY ON LSC IDENTIFYING INFORMATION) XIVENET OF DEPICE OF THE DEPICIENCY OF DEPICIENCES XIVENET OF DEPICE OF THE DE | DEFAILI | VICINI OF HEALTHAN | AD HOMAIN SERVICES | | | | FORM | M APPROVED |
|--|------------|---|--|-----------|------|---|--------|-------------|
| IDENTIFICATION NUMBER: 1055999 1055999 1055999 1055999 1055999 1055999 1055999 10559999 10559999 10559999 10559999 10559999 10559999 10559999 10559999 10559999 10559999 10559999 105599999 105599999 105599999 105599999 105599999 1055999999 1055999999 10559999999999 | CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO | 0.0938-0391 |
| I 105599 INAME OF PROVIDER OR SUPPLIER HEARTLAND OF ZEPHYRHILLS SUMMARY STATSHEAT OF DEFICIENCES RECULATORY OR LISC IDENTIFYING INFORMATION) REGULATORY OR LISC IDENTIFYING INFORMATION) [FF 698] Continued From page 20 physician's orders related to the resident's care, revealed orders for the resident's at the penfer at 12 p.m., every Monday, Wednesday, Friday for , check the () site every shift, and site observation every shift, site observation as needed. There was no additional orders for the care of the access, including when to remove the after the, treatment Review of the nurse's notes revealed documentation that the and were present after treatment on (site clean and dry, positive and note(). In an interview with the Administrator and the acting Director of Nurses on beginning at 2:00 p.m., it was confirmed that there should be an order for care of the site to include when to remove the spile daffer the site had been accessed for | | | | | | DISTRUCTION | | |
| HEARTLAND OF ZEPHYRHILLS DAY 10 SUMMARY STATEMENT OF DEFICIENCIES RECOLUTION OF LEFFICIENCY MUST BE PRECEDED BY PULL TAG | | | 105599 | B. WING _ | | | | - |
| CALL DEPTIMENT SUMMARY STATEMENT OF DEFICIENCIES PREFEX PROVIDER'S PLAN OF CORRECTION SHOULD BE CHOOSE-REFERENCE TO THE APPROPRIATE DOMESTICAL STATEMENT | NAME OF PE | ROVIDER OR SUPPLIER | | | STRE | EET ADDRESS, CITY, STATE, ZIP CODE | | |
| SUMMARY STATEMENT OF DEFICIENCIES DEPARTMENT OF DEFICIENCIES DEPARTMENT OF DEFICIENCY MUST BE PRECEDED BY PULL TAG PROPORTION OF LIST INFORMATION PREFIX TAG PRECENT OF A CONSECTION PREFIX TAG PRECENT OF A CONSECTION PREFIX TAG PRECENT OF A CONSECTION PREFIX TAG PREFIX TAG PREFIX TAG PREFIX PREFIX TAG PREFIX TAG PREFIX PREFIX TAG PREFIX PREFIX TAG PREFIX PREFIX TAG PREFIX | | | | 1 | 3822 | 0 HENRY DR | | |
| RECHANGE REGULATORY OR LSC IDENTIFYING INFORMATION TAG TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DEFICIENCY | HEARILA | ND OF ZEPHTRHILLS | | | ZEPI | HYRHILLS, FL 33540 | | |
| physician's orders related to the resident's | PREFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREFE | (| (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA | | COMPLETION |
| revealed: Both the center and thefacility are responsible for shared communication regarding patients receivingservices Collaborative communication included information regarding physician and treatment orders, and adverse reactions or complications and recommendations for follow up observations | (F 698) | physician's orders ret care, revealed the with the document set to relate to retaining the community of the | lated to the resident's of orders for the resident's centre at 12 p.m., every centre at 12 p.m., every f. Friday for check the site. I every observation every shift, ion as needed. and orders for the care of the en to remove the them. Review of the nurse's mentation that the and er treatment on e dean and dry, positive the Administrator and the roses on n, it was confirmed that refer for care of the to remove the had been accessed for install and sused as the first staff and also used as the first staff and the staff and | {F 6 | 98} | | | |

..... access site.

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | | M APPROVED O. 0938-0391 |
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| STATEMENT (| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | LE CONSTRUCTION | (X3) DATE COM | E SURVEY IPLETED |
| | | 105599 | B. WING | | | 10 | /27/2021 |
| | ROVIDER OR SUPPLIER | | • | | STREET ADDRESS, CITY, STATE, ZIP CODE 38220 HENRY DR ZEPHYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICENCY) | BE | (X5) COMPLETION DATE |
| {F 758} SS=E | CFR(s): 483.45(c)(3)(§483.45(e) | Drugs. | {F 7 | 58 | 3) | | |
| | §483.45(c)(3) A affects activities | drug is any drug that associated with mental ior. These drugs include, | | | | | |
| | (iii) ; and | ensive assessment of a nust ensure that | | | | | |
| | unless the medication | nts who have not used re not given these drugs n is necessary to treat a diagnosed and documented | | | | | |
| | behavioral intervention | l dose reductions, and | | | | | |
| | unless that medicatio | ursuant to a PRN order n is necessary to treat a andition that is documented | | | | | |
| | §483.45(e)(4) PRN or are limited to 14 days §483.45(e)(5), if the a | Except as provided in | | | | | |

prescribing practitioner believes that it is appropriate for the PRN order to be extended

Facility ID: 55114

| | | ID HUMAN SERVICES | | | | | APPROVED |
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| | | MEDICAID SERVICES | T | | | | 0. 0938-0391 |
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE | LETED |
| | | | A. BUILDI | NG_ | | 1 | |
| | | 105599 | B. WING | | | | -C |
| | | 103333 | D. tinito | - | | 10/ | 27/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | | 8220 HENRY DR | | |
| | | | | Z | EPHYRHILLS, FL 33540 | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | GI. | | PROVIDER'S PLAN OF CORRECTION | _ | (X5) COMPLETION |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL. .SC IDENTIFYING INFORMATION) | PREFI | | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA | | DATE |
| | | | 1 | | DEFICIENCY) | | |
| | | ****** | | | | | |
| {F 758} | Continued From page | 22 | {F 7 | 58} | | | |
| | beyond 14 days, he o | r she should document their | | | | | |
| | rationale in the reside | ent's medical record and | | | | | |
| | indicate the duration | for the PRN order. | | | | | |
| | 0.000 457 1751 7571 | | | | | | |
| | | rders for | | | | | |
| | drugs are limited to 1 | | | | | | |
| | renewed unless the a | er evaluates the resident for | | | | | |
| | the appropriateness | | | | | | |
| | | is not met as evidenced | | | | | |
| | by: | ia not met da evidenced | | | | | |
| | Based on observatio | n record review and | | | 1. R12 no longer receives , . , | | |
| | | failed to ensure behavior | | | medications. R1 care plan was update | | |
| | | or seven of seven sampled | | | to include monitoring for behaviors | | |
| | | r the use of | | | associated with the use of the | | |
| | | , #13, #11, #2, #6, #8) out of | | | medications. | | |
| | 49 facility residents re | eceiving | | | R 13 care plan was updated to include | | |
| | medications. | | | | monitoring for behaviors associated wi | th | |
| | | | | | the use of the medication | 8. | |
| | Findings included: | | | | R11 care plan was updated to include | | |
| | | | | | monitoring for behaviors associated wi | | |
| | | t #12's Physician's orders | | | the use of the , , , medication | S. | |
| | | led for the | | | R2 care plan was updated to include | | |
| | | 7.5 mg by at | | | monitoring for behaviors associated wi | | |
| | bedtime for nutritiona | | | | the use of the medication | S. | |
| | medication | is an , that petite stimulant. An order | | | R8 care plan was updated to include monitoring for behaviors associated wi | 41- | |
| | for side effect monitor | | | | the use of the medication | | |
| | | cts related to the use of | | | R6 care plan was updated to include | ъ. | |
| | | | | | monitoring for behaviors associated wi | th | |
| | , , medicat | , , | | | the use of the medication | | |
| | A review was conduc | ted of the Minimum Data Set | | | | | |
| | | onducted on for | | | 2. A comprehensive review of reside | nts | |
| | | ssessment documented the | | | receiving , medications wa | | |
| | | oderately | | | completed by the Quality Assurance | | |
| | | sment documented her use | | | Consultant to validate residents receive | ing | |
| | of no | out the use of an | | | medications have care pl | | |
| | | | | | that include monitoring for behaviors | | |

associated with the use of ...,

| DEPARTMENT OF HEALTH AN | | | | | | APPROVED |
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| CENTERS FOR MEDICARE & TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT | | CONSTRUCTION | (X3) DATE | 0. 0938-0391 SURVEY LETED |
| | 105599 | B. WING | | | | -C 27/2021 |
| VAME OF PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | 38220 HENRY DR | | | |
| HEARTLAND OF ZEPHYRHILLS | | | | | | |
| PREFIX (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | | (X5) COMPLETION DATE |
| revised on for care plan identified the the medication and he for its use. Inter evaluating the effection of the medication for elimination of the the physician was to plan included no inter monitoring for behavior of medicate which was the physician was to a plan included no inter monitoring for behavior freshmen Records did an area to document behaviors that the resonance in the medication with the initials indicate absence of side effects. There in the nurse of side effects when present in the nurse in the physician thing the physician that the nurse revealed so the plant p | developed on and r Resident # 12's use of the The Focus of the er isk for adverse effects of er diagnosis of rowntons included renease and the side effects possible decrease or medication. Also, be notified of a decline in the ties of daily living) abilities or viour related to a dosage an was to be notified of clions as well. The care eventions related to ors associated with the use rations. Also, the notified of the research of the relations as well. The care eventions related to reach a control of the relations and the presence or absence of sident might be eliciting, to monitor side effects of the clarification that "my coe of signs and symptoms even was no guidance that side needed to be documented or what specific side effects cit. Is progress notes for did the resident was followed | {F 7 | (58) | medications. 3. Licensed nursing staff will be educated by the Director of Nursing/designee on the Behavior Practice Guide and Focus on F-tag 75 on or before the date of compliance. 4. Utilizing the Unnecessary Medications □ Behavior Monitoring QAPI tool the DON/designe will audit 5 residents that receive medications weekly x4 weeks and monthly x2 months to valid the care plans include behaviors associated with the medications and the completion of behavior documentation Results will be reviewed and trended be the QAPI committee for continued compliance. | ee ate | |

documented the resident's behavior of screaming and yelling and refusing the treatment.

Facility ID: 55114

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/29/2021 FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING ___ R-C

| | 105599 | B. WING | | | 10/27/2021 | | |
|--------------------------|--|---|--------------------|-----|---|--|----------------------------|
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 31 | 8220 HENRY DR | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | z | EPHYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES * MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 758} | Continued From page | 24 | {F 7 | 58} | | | |
| DAND PREETX TAG | On during the lunch meal, Resident #12 was observed being assisted with her meal. The resident was observed taking a small bite of fish out of her and placing it on her plate. The aide commented that the resident usually did that and didn't usually eat anything. An observation of Resident #12 on during the lunch meal revealed she was accepting bites of the fruit cocktail from her lunch tray. The aide confirmed that she refused the meal but seemed to be enjoying the sweet fruit. A review of the resident's revealed upon admission on the resident had the resident was a complete that the resident had the resident was a complete that the resident had the resident h | | | | | | |
| | on The rediagnoses that include and resident's active Physorder for 100 m bedtime for major order for 15 red to bedtime for also noted to monitor the use of the and The order and The order for The order for the use of the The order for and The order for and The order for the use of the the Use o | ed major Review of the Review of the Review of the and and g, give 300 ml by at and and mg, give one cap by Current orders were the side effects related to medications er included the statement, e absence of signs and | | | | | |
| | conducted on | nnual MDS Assessment which identified the | | | | | |

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | | M APPROVED D. 0938-0391 |
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| TATEMENT (| DF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILD | | CONSTRUCTION | (X3) DATI | SURVEY PLETED R-C |
| | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | B. WING | | | 10 | /27/2021 |
| | | | | 38: | REET ADDRESS, CITY, STATE, ZIP CODE 220 HENRY DR PHYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (XS) COMPLETION DATE |
| {F 758} | assessment included and with a defended and and a defended and a defend | the diagnoses of, and, and | {F 7 | 758} | | | |

dinner, when observed resident, she was crying.

| PREFEY (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFEY (EACH CORRECTIVE ACTION SHOULD BE COMPLE | | | ID HUMAN SERVICES | | | | | M APPROVED |
|--|-----------|--|--|---------|-----|--|--------|----------------------------|
| A BUILDING R.C COMPLETED R.C 105599 B. WING 105599 B. WING 105599 B. WING 1057/2021 NAME OF PROVIDER OR SUPPLIER 105599 B. WING 2016/2016 B. WING 106/2016 B. WING 2016/2016 B. WIN | CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO | D. 0938-0391 |
| I 105599 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 38220 HEINRY OR ZEPHYRHILLS, FL 33540 (ACA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC. IDENTIFYING INFORMATION) [F 758] Continued From page 26 The resident cries often and stated she was tired of being sick and does not like to be touched. The Nurse Practitioner was informed. Review of physician orders, Treatment Administration Record (TAR), and Medication | | | | | | | COM | PLETED |
| HEARTLAND OF ZEPHYRHILLS SUMMARY STATEMENT OF DEPOSITIONS (KAL) ID PRIETIX TAG (F. 758) Continued From page 26 The resident cries often and stated she was tired of being sick and does not like to be touched. The Nurse Practitioner was informed. Review of physician orders, Treatment Administration Record (TAR), and Medication | | | 105599 | B. WING | | | - 1 | |
| ### HEARTLAND OF ZEPHYRHILLS. ZEPHYRHILLS, FL 33540 PROVIDER'S PLAN OF CORRECTION PREFIX TAG PREF | NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| CAPHYRILLS, FL. 33340 CORRECTION CORRE | | | | | ١. | 38220 HENRY DR | | |
| PREFIX TAG REGULATORY OR LSC (DENTIFYING INFORMATION) FROM TAG CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROPERTY OF LSC (DENTIFYING INFORMATION) FROM TAG CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE APPROPRIATE | HEARTLA | ND OF ZEPHYRHILLS | | | Ŀ | · · · · · · · · · · · · · · · · · · · | | |
| The resident cries often and stated she was tired of being sick and does not like to be touched. The Nurse Practitioner was informed. Review of physician orders, Treatment Administration Record (TAR), and Medication | PREFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREFI | | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP | BE | (X5) COMPLETION DATE |
| showed Resident #13 received 15 mg at bedtime for / / Monitor for side effects related to use of , medication, My initials indicate absence of signs and symptoms of side effects, monitor every shift for side effects of , medications. The physician orders and / or MAR lacked orders and monitoring of behaviors for medications. Review of the care plans showed a care plan for resistive / noncompliant with treatment / care being changed and not having vac changed related to belieff that treatment is not needed / working as of Interventions included but not limited to allow for Rexibility in Activity of Daily Living (ADL) routine to accommodate preferences and customary routine and provide education about risks of not complying with therapeutic regimen. Care plan for at risk for adverse effects related to the use of medication as of Interventions included but not limited to evaluate effectiveness and side effects of medications for possible decrease / elimination of , drugs, report to physician signs of adverse related to use of Interventions included but were not limited to loveluate but not limited to sell side of Interventions included but were not limited to love late feffects related to side of Interventions included but were not limited to love late feffectiveness and side effects | (F 758) | The resident cries of of being sick and doe ware provided in the control of the c | en and stated she was tired is not like to be touched. The is informed. orders, Treatment of (TAR), and Medication of (MAR) for | {F 7 | 758 | | | |

of drugs, report to physician signs of

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | | | APPROVED 0938-0391 |
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| STATEMENT (| OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI B. WING | | TRUCTION | | (X3) DATE S COMPL R-1 | URVEY ETED |
| | | 105599 | D. WING | | | | 10/2 | 7/2021 |
| | ROVIDER OR SUPPLIER | | | 38220 H | ADDRESS, CITY, STATE, ZIP CODE HENRY DR (RHILLS, FL 33540 | | | |
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| {F 758} | adverse reactions. Ti interventions related to associated with the us medications. 4. Record review of R Minimum Data Set (N showed a () score of 08 (n Section N, Medication receiving. Record review of acting the section of the section of the section N, Medication receiving. Record review of acting the section of th | the care plan included no or monitoring for behaviors set of | {F 7 | 58} | | | | |

call was placed to the Nurse Practitioner and received an order to check her The

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | FOR | D: 11/29/2021 M APPROVED D: 0938-0391 |
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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING | INSTRUCTION | COME | SURVEY |
| | | 105599 | B. WING | | | ⊱C /27/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | STRI | EET ADDRESS, CITY, STATE, ZIP CODE | 1 10 | 21/2021 |
| HEARTLA | ND OF ZEPHYRHILLS | | - 1 | 0 HENRY DR HYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| {F 758} | for was disco- was starte notes, physician orde documentation regare medication change. Record review of the resident was an exit s related to and revised were not limited to ca appropriate area, aler placement and functio and revised conditions of the included but were not included but were not effectiveness and sid- possible decrease /e drugs, notify physicia // behavior relat provide patient teach medications as neede of adverse reactions. related to 5. On at 1.4 stitting at bedside wat and groomed for the r possessions in her ro noted. Record review of the (MDS) dated (| ninued on and dd on The progress rs and/or MARI lacked any ling her behaviors post care plans showed the seeking! elopement risk initiated initiated initiated on the progress of the progress | {F 758} | | | |

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | | APPROVED 0. 0938-0391 |
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| | S FOR MEDICARE & | (X1) PROVIDER/SUPPLIER/CLIA | (9/2) 8/6/8 | TIO | PLE CONSTRUCTION | (X3) DATE | |
| | CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | | | | LETED |
| | | | A. BUILD | 9340 | ' | l . | -C |
| | | 105599 | B. WING | | | | |
| ALLAND OF D | ROVIDER OR SUPPLIER | 103333 | B. 111110 | Т | STREET ADDRESS, CITY, STATE, ZIP CODE | 10/ | 27/2021 |
| NAME OF P | KOVIDER OR SUPPLIER | | | ı | | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | | 38220 HENRY DR | | |
| | | | | L | ZEPHYRHILLS, FL 33540 | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | 1D | | PROVIDER'S PLAN OF CORRECTION | _ | (X5) COMPLETION |
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| .,,, | | , | | | DEFICIENCY) | | |
| - | | | | | | | |
| {F 758} | Continued From page | 20 | {F 7 | 756 | 81 | | |
| (, , , , , | , , | ve physician orders and | γ, , | , ,, | 27 | | |
| | | | | | | | |
| | MAR showed | | | | | | |
| | Monitor for side effect | y other day for | | | | | |
| | | | | | | | |
| | | ion,, My initials igns and symptoms of side | | | | | |
| | | shift | | | | | |
| | | Monitor for side effects | | | | | |
| | related to use of | . Worker for side effects | | | | | |
| | | ndicate absence of signs and | | | | | |
| | | ects, monitor every shift. | | | | | |
| | | g give 0.5 tablet by at | | | | | |
| | | Wednesday, Thursday, | | | | | |
| | Friday, Saturday, Sur | | | | | | |
| | | side effects related to use | | | | | |
| | of medic | | | | | | |
| | | igns and symptoms of side | | | | | |
| | | shift. Monitor for side | | | | | |
| | effects related to use | | | | | | |
| | medications. Check e | | | | | | |
| | | | | | | | |
| | | of , , medication, | | | | | |
| | (ileus | | | | | | |
| | | symptoms of side effects, | | | | | |
| | | he physician orders and / or | | | | | |
| | | nd monitoring of behaviors | | | | | |
| | for medi | ications. | | | | | |
| | | | | | | | |
| | Review of the care plant | ans showed resident on | | | | | |
| | , medicat | ions related to , | | | | | |
| | | on and revised on | | | | | |
| | . Interventions | s included but were not | | | | | |
| | limited to provide non | -pharmacological | | | | | |
| | interventions for symp | otom management such as | | | | | |
| | provide quiet environi | ment, decrease stimuli, | | | | | |
| | monitor for thirst / hur | nger, and provide fluids / | | | | | |
| | snacks of resident's p | reference, redirection. | | | | | |

Monitor for signs and symptoms of adverse side effects related to medication use

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | | APPROVED 0. 0938-0391 |
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| | S FOR MEDICARE & | (X1) PROVIDER/SUPPLIER/CLIA | (NOV NOTE) | TIEV | E CONSTRUCTION | (X3) DATE | |
| | CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | | | | LETED |
| | | | A. BUILU | MG. | | _ | -C |
| | | 105599 | B. WING | | | | |
| | | 103399 | D. (11110 | | | 10/ | 27/2021 |
| NAME OF PE | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | | 38220 HENRY DR | | |
| | | | | Ŀ | ZEPHYRHILLS, FL 33540 | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | 1D | | PROVIDER'S PLAN OF CORRECTION | | (X5) COMPLETION |
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| ind | | , | 1,740 | | DEFICIENCY) | | |
| | | | _ | | | | |
| (F 758) | Continued From page | 30 | {F 7 | | | | |
| \i 100} | | | (F- | 30 | } | | |
| | | in as indicated. Resident at | | | | | |
| | risk for behavior symp | | | | | | |
| | | and history of | | | | | |
| | | ff-picks scabs revised as included but were not | | | | | |
| | | | | | | | |
| | | drug reduction per behaviors / offer to | | | | | |
| | | usic, snacks, or TV; provide | | | | | |
| | | g resident to validate her | | | | | |
| | feelings, offer support | | | | | | |
| | | ing care. Resident had | | | | | |
| | | r that was related to inability | | | | | |
| | | st roles revised | | | | | |
| | | d but was not limited to | | | | | |
| | acknowledge moods | | | | | | |
| | | identifying positive coping | | | | | |
| | mechanisms; adminis | | | | | | |
| | | observe for effectiveness | | | | | |
| | | oms of side effects; assist in | | | | | |
| | | ping mechanisms. Resident | | | | | |
| | had a risk for change | | | | | | |
| | diagnoses of , | | | | | | |
| | | tory of , revised | | | | | |
| | | ns included but were not | | | | | |
| | limited to administer r | nedications per physician | | | | | |
| | orders and observe for | or effectiveness and signs | | | | | |
| | and symptoms of side | e effects, assess for physical | | | | | |
| | / environmental chang | ges that may precipitate | | | | | |
| | | t family for support, watch | | | | | |
| | | ooks or magazines; observe | | | | | |
| | | state changes when new | | | | | |
| | | or with dose changes; offer | | | | | |
| | | end of control and validate | | | | | |
| | feelings of loss. The o | care plan included no | | | | | |
| | | to monitoring for behaviors | | | | | |
| | associated with the us | se of , | | | | | |
| | medications. | | | | | | |

6. Observed Resident #8 was lying in bed

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | | APPROVED 0. 0938-0391 |
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| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | E CONSTRUCTION | (X3) DATE | |
| | | 105599 | B. WING | | | | -C 27/2021 |
| NAME OF PE | ROVIDER OR SUPPLIER | | | 8 | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 3 | 8220 HENRY DR | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | 2 | EPHYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 758} | watching TV on eaten his tunch. No b Record review of the (MDS) dated (LDS) dated (LDS). Section N, Mer receiving medication. Record review of phy MAR showed Reside at bedtime for related to use of My initials indicate ab symptoms of side effects, medicat indicate absence of seffects, mentior revery and/or MAR lacked on behaviors for Record review of the resident was at risk for use of Record review of the resident was at risk for Record review of the resident was at risk for Record review of the resident was at risk for Record review of the resident was at risk for Record review of the resident was at risk for Record review of the resident was at risk for | at 1:50 p.m. He had ehavlors were noted. annual Minimum Data Set showed a) score of 15 { lications, showed he was and the state of th | {F 3 | *58} | | | |
| | associated with the us | se or , , , | | | | | |

Record review of progress notes for the month of

| R-C 105599 B. WING R-C 10/27/2021 STREET ADDRESS, CITY, STATE, ZIP CODE 38220 HENRY DR | | | ID HUMAN SERVICES | | | | | M APPROVED |
|--|-----------|---|--|---------|-----|---|-----|------------|
| DENTIFICATION NUMBER: A BUILDING COMPLETED R.C | | | | | _ | | | |
| 105599 B. WING | | | | | | | COM | PLETED |
| ### HEARTLAND OF ZEPHYRHILLS AND SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PLUL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PLUL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG F758 Continued From page 32 | | | 105599 | B. WING | _ | | 1 | |
| ### HEARTLAND OF ZEPHYRHILLS O(4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 758) Continued From page 32 did not show any documentation related to behavior monitoring. 7. Observed Resident #6 [lying in bed on at 1:48 p.m. watching TV. She would not answer any interview screening questions. Record review of the quarterly Minimum Data Set (MDS) dated showed a (| NAME OF P | ROVIDER OR SUPPLIER | | | Τ | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| CALL DEFICIENCY CALL C | | | | | ı | 38220 HENRY DR | | |
| PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE | HEARTLA | ND OF ZEPHYRHILLS | | | | ZEPHYRHILLS, FL 33540 | | |
| did not show any documentation related to behavior monitoring. 7. Observed Resident #6 lying in bed on at 1:48 p.m. watching TV. She would not answer any interview screening questions. Record review of the quarterly Minimum Data Set (MDS) dated | PREFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREF | | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE | BE | COMPLETION |
| arithor mark takes droes and infolinting of behaviors for , medications. Record review of progress notes for the month of | {F 758} | did not show to behavior monitoring any interview screenis Record review of the (MDS) dated, Section Mark 201 si, Monitor for, medicat indicate absence of seffects, monitor every bedtime for effects related to use, My initials i and symptoms of side effect, medicat indicate absence of seffects, monitor every and/or MAR lacked or behaviors for | any documentation related g. #6 lying in bed on TV. She would not answer ng questions. quarterly Minimum Data Set showed a | {F : | 775 | .8) | | |

Record review of the care plans showed the resident was at risk for behavior symptoms

| | | ID HUMAN SERVICES | | | | APPROVED |
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| | | MEDICAID SERVICES | | | | 0. 0938-0391 |
| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILD | | LE CONSTRUCTION | LETED |
| | | 105599 | B. WING | | | -C 27/2021 |
| NAME OF PE | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| | | | | ١. | 38220 HENRY DR | |
| HEARTLA | ND OF ZEPHYRHILLS | | | ١. | ZEPHYRHILLS, FL 33540 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| {F 758} | (ingestion of feces) re included but were not TV, snacks, soft musi bedtime; use consistent has behavior, attempting in male residents relate and included but were not possible, explain and on others, offer din lie music; remain calm a exhibits behavior. At risk for common the control observe for effective symptoms of side effe watching TV, reading feelings of loss. Episc diagnoses of Interventions include administer medication identify and decrease risk for adverse effect medical includents of the control of t | , and coprophagia interventions interventions interventions. It initiated to affer dim lights, ic; toilet after meals and at net approaches when giving d inappropriate to be overly affectionate with a to vivised Interventions in the process of the properties of the propertie | (F: ; | 758 | | |
| | medication, re | vised Interventions | 1 | | | |

included but was not limited to evaluate effectiveness and side effects of medications for

| | | ID HUMAN SERVICES | | | | | RM APPROVED |
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| | | MEDICAID SERVICES | | | | | O. 0938-0391 |
| | DF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDI | | NSTRUCTION | CON | E SURVEY MPLETED |
| | | 105599 | B. WING | | | | R-C 0/27/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STRE | ET ADDRESS, CITY, STATE, ZIP CODE | | |
| HEADTI A | ND OF ZEPHYRHILLS | | | 3822 | HENRY DR | | |
| HEARTLA | IND OF ZEPHTRHILLS | | | ZEP | HYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | DBE | (XS) COMPLETION DATE |
| (F 758) | possible decrease / e drugs; notify physician is, and in the physician six in the possible of medica Interventions limited to evaluate eff of medications for poeliminations of , physician of decline in behavior related to a physician of decline in behavior related to a physician signs of ad 8. During an interview the new interim DON that today was her fire DON. She stated that Managers and MDS. to their assigned were looking through records today. She st seeing some issues. recognized that the behavior monitoring roth that the behavior monitoring that specific resident. 9. During an interview the consultant pharm document by exceptile the stated," this was the behavior mother. She stated that the behavior mother of the stated that the behavior mother of the stated that the behavior mother of the stated. The second of the stated that the properties of the resident then they will not list or there was a state of the stated that the properties of the properties of the stated that the properties of the properties of the stated that the properties of the properties of the stated that the properties of the p | iliminations of on of decline in ADL ability or ed to a dosage change; pne of a daverse reaction. At its related to use of liton, revised is included but was not ectiveness and side effects sible decrease / drugs; nolify nADL ability or / dosage change; report to verse reaction. If the other included but is a different of the content of the con | {F 7 | 58} | | | |

| A BUILDING TAGE TO PROVIDER OR SUPPLIER TAGE | | | ID HUMAN SERVICES | | | | | M APPROVED |
|--|------------|--|--|---------|-----|--|--------|--------------|
| NAME OF PROVIDER OR SUPPLIER 105599 **NAME OF PROVIDER OR SUPPLIER **NAME OF PROVIDER OR SU | CENTER | S FOR MEDICARE & | | | _ | | OMB NO | 0. 0938-0391 |
| INAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3220 HEARTY DR ZEPHYRHILLS, FL 33440 DOUBLE GRACH DEFICIENCY MUST BE PRECEDED BY FULL RECOLLATORY OR US CIDENTIFYING INFORMATION) [F758] Continued From page 35 then no behaviors. "He stated that he looks at anybody on , medications and he looks at the notes and looks for behaviors, it no documentation of he electronic medical record for the side effects, increased My initials signify no side effects. They have to monitor for behaviors but not documentation of the electronic medical record for the side effects,, monitor the behaviors, and why on medications. If no behaviors med is successful." 10. Review of the facility's "Behavior Practice Guide," dated showed behavior symptoms may become problematic for an individual fit they are: socially unacceptable, stressful to others, interfering with care, presenting safety risk. Is defined as the way that someone is feeling. Alterations in an individual's and, or behavior may be triggered by a wide variation of antecedents. AND BEHAVIOR : the Interdisciplinary process surrounding and in the properties of the process surrounding and is a comprised of affective, and is a and is a comprised of affective, and is a and comprised | | | | | | | COMP | PLETED |
| MARE OF PROVIDER OR SUPPLIER HEARTLAND OF ZEPHYRHILLS DAYLD GRAMMARY STATEMENT OF DEFICIENCIES TAG FPRENK TAG FROM PROVIDER SPLAN OF CONRECTION GRAMMARY STATEMENT OF DEFICIENCIES GRAMMARY STATEMENT OF DEFICIENCY TAG FORDS: FROM PROVIDER SPLAN OF CONRECTION GRAMMARY STATEMENT OF DEFICIENCIES GRAMMARY STATEMENT OF DEFICIENCIES GRAMMARY STATEMENT OF DEFICIENCY TAG FORDS: FROM PROVIDER SPLAN OF CONRECTION GRAMMARY STATEMENT OF DEFICIENCY TAG FORDS: FROM PROVIDER SPLAN OF CONRECTION GRAMMARY STATEMENT OF DEFICIENCY TAG FORDS: FROM PROVIDER SPLAN OF CONRECTION GRAMMARY STATEMENT OF DEFICIENCY TAG FORDS: FROM PROVIDER SPLAN OF CONRECTION GRAMMARY STATEMENT OF DEFICIENCY TAG FORDS: FROM PROVIDER SPLAN OF CONRECTION GRAMMARY STATEMENT OF COMPACT TAG FORDS: FROM PROVIDER SPLAN OF CONRECTION GRAMMARY STATEMENT OF COMPACT TAG FORDS: | | | 105599 | B. WING | _ | | | - |
| TAGE TOTAL TO A STATEMENT OF DEFICIENCIES (F 758) Continued From page 35 then no behaviors. "He stated that he looks at anybody on, medications and he looks at the notes and looks for behaviors." He notes and looks for behaviors. Through the documentation in the electronic medical record for the side effects. They have to monitor for behaviors but not document unless there are behaviors. Do not put in MAR just in the notes. If new, monitor the behaviors and individual flav years escaled behavior remains any medications and he notes. If new, monitor the behaviors, and why on medications, if no behaviors, and why on medications. If no behaviors med is successful." 10. Review of the facility's "Behavior Practice Guide," dated, showed behavior symptoms may become problematic for an individual if they are: socially unacceptable, stressful to others, interfering with care, presenting safety risk. is defined as the way that someone is feeling. Alterations in an individual's and, or behavior may be triggered by a wide variation of antecedents. AND BEHAVIOR the Interdisciplinary process surrounding and The experience of, and is highly individualized. The factors contributing to can trigger fears that escalate into an exagerated, response when not addressed is an response when not addressed is an response when not addressed is an response when not addressed | NAME OF PE | OVIDER OR SUPPLIER | | | Т | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| SUMMARY STATEMENT OF DEFICIENCIES DEPROVING PROPERTY PREFIX REACH DEFICIENCY NUST BE PRECEDED BY FILL PROVIDERS PLAN OF CORRECTION SHOULD BE COMMETTING PRECIDENTY OR US. DEPRIFYING PROFIMATION) DEPRETX REACH APPROPRIATE DAME CROSS-REFERENCED TO THE APPROPRIATE DAME DAME CROSS-REFERENCED TO THE APPROPRIATE DAME DA | | | | | 1 | 38220 HENRY DR | | |
| PREFIX TAG RECOLLATORY OR ISC IDENTIFYING INFORMATION) RECOLLATORY OR ISC IDENTIFYING INFORMATION (F 758) Continued From page 35 then no behaviors. "He stated that he looks at anybody on , medications and he looks at the notes and looks for behaviors. If no documentation in the healtwoirs medical record for the side effects, increased My initials signify no side effects, monitor for behaviors but not document unless there are behaviors. Do not put in MAR just in the notes. If new, monitor the behaviors, and why on medications. If no behaviors med is successful." 10. Review of the facility's "Behavior Practice Guide," dated showed behavior symptoms may become problematic for an individual if they are; socially unacceptable, stressful to others, interfering with care, presenting safety risk. is defined as the way that someone is feeling. Alterations in an individual's and, or behavior may be triggered by a wide variation of antecedents. AND BEHAVIOR : the Interdisciplinary process surrounding and behavior identification is accomplished through recognition of symptoms that commonly arise with adjustment and in the supplies of the suppli | HEARTLA | ND OF ZEPHYRHILLS | | | ١. | ZEPHYRHILLS, FL 33540 | | |
| then no behaviors." He stated that he looks at anybody on , medications and he looks at the notes and looks for behaviors. "If no documentation of behaviors, then will see notes for gradual reduction in dosages. Should be documentation in the electronic medical record for the side effects. , increased . My initials signify no side effects. They have to monitor for behaviors but not document unless there are behaviors. Do not put in MAR just in the notes. If new . , , monitor the behaviors, and why on medications. If no behaviors med is successful." 10. Review of the facility's "Behavior Practice Guide," dated showed behavior symptoms may become problematic for an individual if they are: socially unacceptable, stresstul to others, interfering with care, presenting safety risk. Is defined as the way that someone is feeling. Alterations in an individual's and, or behavior may be triggered by a wide variation of antecedents. AND BEHAVIOR : the Interdisciplinary process surrounding and behavior identification is accomplished through recognition of symptoms that commonly arise with adjustment . , and . , . , and | PREFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREF | IX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | COMPLETION |
| | {F 758} | then no behaviors." He anybody on looks at the notes and documentation of befor gradual reduction documentation of the for gradual reduction documentation in the for the side effects, initials signify no side monitor for behaviors. It notes, if new why on medications, successful." 10. Review of the fact Guide, "dated symptoms may beconditional in they are stressful to others, int presenting safety risk that someone is feelir individual's that someone is feelir individual's that someone is feelir individual's and triggered by a wide via AND BEHAVI https://disciplinary.och.aim. is highly individualized, can trigger feel and triggered by a wide via department of the properties of the prope | te stated that he looks at medications and he medications and he do looks for behaviors. "If no haviors, then will see notes in dosages. Should be electronic medical record in dosages. Should be electronic medical record in forespees. Should be electronic medical record in forespees. They have to be the forespeed of the forespe | ₹F 7 | 758 | , | | |

associated functional . . . , the elderly patient

| DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROV | | | | | | | | | | | |
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| CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 | | | | | | | | | | | |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | | | |
| | | 105599 | B. WING | | | | -C 27/2021 | | | | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | |
| | | | | ١. | 38220 HENRY DR | | | | | | |
| HEARTLAND OF ZEPHYRHILLS | | | | | ZEPHYRHILLS, FL 33540 | | | | | | |
| - | 0.000.00 | THE RESERVE OF BUILDING | | _ | PROVIDER'S PLAN OF CORRECTION | | | | | | |
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| {F 758} | Continued From page | 36 | {F 7 | 750 | | | | | | | |
| (1 100) | | | th. | 30 | 7 | | | | | | |
| | | e likelihood of, | | | | | | | | | |
| | | RE: Upon completing an | | | | | | | | | |
| | evaluation, the interdi | | | | | | | | | | |
| | | ecific, or person centered | | | | | | | | | |
| | | pals to prevent and manage | | | | | | | | | |
| | behavioral symptoms. Any new behavior | | | | | | | | | | |
| | symptom suggests a need to reevaluate the plan of care. Pharmacological interventions may be indicated. COMPREHENSIVE CARE PLAN: Based upon the findings of the MDS and other evaluations, the patient's comprehensive care plan is developed, or initial plan of care is updated to include individualized patient | | | | | | | | | | |
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| | | | | | | | | | | | |
| | interventions that focus on the patient's specific | | | | | | | | | | |
| | risk factors. Interventions are continually | | | | | | | | | | |
| | evaluated for effectiveness and updated as the | | | | | | | | | | |
| | patient's condition and needs change. | | | | | | | | | | |
| | INTERVENTIONS FOR CONSIDERATION: | | | | | | | | | | |
| | | appropriate interventions is | | | | | | | | | |
| | dependent on accura | te identification of the | | | | | - | | | | |
| | behavior, possible roo | ot causes and ruling out | | | | | | | | | |
| | | n narrowing of possible | | | | | | | | | |
| | | vior. Begin by evaluating the | | | | | | | | | |
| | | physical needsProvide | | | | | | | | | |
| | for any unmet physical | al need. If the behavior | | | | | | | | | |
| | continues, evaluate for | | | | | | | | | | |
| | need | Continue this individualized | | | | | | | | | |
| | problem-solving | . , by evaluating the | | | | | | | | | |
| | | for a possible contribution | | | | | | | | | |
| | to behavior. MEDICA | TIONS: Select medications | | | | | | | | | |
| | may be prescribed sp | ecifically targeting | | | | | | | | | |
| | modification of patien | t behavioral symptoms. | | | | | | | | | |
| | include | | | | | | | | | | |
| | | . DOCUMENTATION: | | | | | | | | | |
| | | mptoms are documented in | | | | | | | | | |
| | the clinical record. | - | | | | | | | | | |

F 867 QAPI/QAA Improvement Activities

F 867

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/29/2021

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | OMB NO. 0938-0391 | |
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| STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 105599 | B. WING | | R-C 10/27/2021 | |
| NAME OF PE | ROVIDER OR SUPPLIER | | 1 1 | STREET ADDRESS, CITY, STATE, ZIP CODE | 10/21/2021 | |
| HEARTLA | ND OF ZEPHYRHILLS | | - 1 | 8220 HENRY DR ZEPHYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PROVIDER'S PLAN OF COF PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE. DEFICIENCY) | | SHOULD BE COMPLETION | |
| F 867 | Continued From page 37 | | F 867 | | | |
| | §483.75(g) Quality assessment and assurance. | | | | | |
| | action to correct idem This REQUIREMENT by: Based on observatio review the facility's qu assessment committe effective OA program deployment of staff in with Activities of Daily (Residents #9, #12, dependent on staff for one additional reside on staff for an additio during the professional standard hysician orders relat the on the treatment for treatment for sampled residents rev behavior monitoring. | must: emust appropriate plans of affiled quality deficiencies; is not met as evidenced n, interview, and record usulity assurance (QA) and se falled to implement an related to: 1) proper order to provide assistance r Living (ADL's) to four 22, #25) of six residents r eating on the 200 hall and nt (#24) who was dependent nal food item requested unch meal, 2) following is of practice for obtaining ted to care and removal of | | 1. The facility implemented a new service plan in order to provide assis with meals for those residents deper on staff for meal consumption. The facility implemented a plan related to residents receiving and the professional standards of care for re of from the site. T facility implemented a plan to ensure behavior monitoring was incorporate the residents plan of care. 2. Comprehensive audits of reside requiring assistance with meals, resi receiving treatments and residents receiving medications have been completed a results reviewed with the QA&A committee. | itance indent in moval he id in | |
| | Assurance and Perfo Practice Guide," date Assurance (QA) is a standards and assuri | | | The Regional Director or Operate educated the Nursing Home Adminis on the QAPI process to prevent a re-occurrence. The facility re-implemented education for staff or following areas; residents requiring assistance with meal service, resider receiving and residents receiving and residents receiving and residents receiving and residents receiving | n the nts iving se | |

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| | ROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE 8220 HENRY DR | | |
| HEARILA | ND OF ZEPHYRHILLS | | | ZI | EPHYRHILLS, FL 33540 | | |
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| F 867 | A activities do improrequently end once to has been met. The pupro-active approach quality of care we propatients experience, to cloices and provide colinical environment. ELEMENTS: Root Ce analysis is a problem cidentifying primary cat it is predicated on the resolved by eliminating action to the underlying recourrence will be resolved by eliminating recourrence will be resolved by eliminating the process improvement implementation of the 2. Review of the facility survey ending revealed the betaken to correct the assistant of the control o | nere was a system failure. ve quality, but efforts he compliance or standard upose of QAPI is to take a o continually improve the wide, the quality of life our the ability to honor patient care in the appropriate FOUNDATIONAL uses Analysis: Root cause solving method aimed at uses of problems or issues, belief that issues are best go r correcting root causes, _ obvious symptoms or By directing corrective gr cause, it is likely minimized. The administrator aiting the environment for t supports continuous a not facilitating of QAPI process. ty's plan of correction for the with a completion date of following measures would e deficient practice which cerns with meal tray delivery e: and direct care staff were elivery of meal trays by the ese. | F | 867 | mentioned areas and was indicative of knowledge and the failure to implement a sustainable system. 4. On-going audits specific to meal service, care and residents receiving medications heen implemented and will be compleweekly x4 and monthly x2 and review and trended by the QAPI committee frontinued compliance. | ave sted | |

by the IDT (inter-disciplinary team) Team. Call

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| NAME OF P | ROVIDER OR SUPPLIER | | | Г | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | 1 | 38220 HENRY DR ZEPHYRHILLS, FL 33540 | | |
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| F 867 | Audits will be compleie then monthly for 2 mc reviews will be present meeting for review and 3. During an observative 200 hall on a.m., two meal carts noted to be parked at aides began to pass 1 at 11:55 a.m. On commented that there the 200 hall that nece passed meal trays to a confirmed that member was ready to Aide A obtained a tray cart, Nurse C approassed two trays to the varys to the passed two trays to th | pleted by the IDT Team. ted weekly x 4 weeks and onths. Results of these nted at the monthly QA | F | 86 | 7 | | |
| | aides were each sittin them with eating. The providing nail care to was pushing the resist painting her nails. Aft the resident's nails, the meal service. Re food usually wasn't veusually cool, but her of for her today. She re liked to been given so she wasn't meeting h | p.m., two of the unit's three gwith a resident assisting third aide was observed Resident #25. The aide tent's cuticles. prior to erred to the sake about sident #25 reported that the try good, no variety and was laughter was bringing funch ported that she would have mething to drikt though as er daughter for another half at she often she | | | | | |

something that she asked for as there didn't

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| NAME OF P | ROVIDER OR SUPPLIER | • | | | ET ADDRESS, CITY, STATE, ZIP CODE | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | | HENRY DR HYRHILLS, FL 33540 | | |
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| F 867 | that only three aides: east/rehab side of the directly assisting with approximately 26 atternoon meal. The area and the UM wer residents with the lun On at 12:17 found in her office ae the staffing coordinat asked where the 200 The Administrator rep but she would find he On at 12:20 to the 200 hall after s Administrator and ob- illuminated/ringing. The resident with the ringi what she needed. Th pasta was dry and the pointed to her roomm that the roommate ha pointed to her roomm that the roommate ha privated with some b On at 12:30 observed assisting th include Resident #22 On at 12:30 observed doubserved walki | p. It was noted at this time were covering the biotilion during lunch or ensuring that dents received their two nurses assigned to the e not observed assisting the ch meal. p.m., the Administrator was ting pizza while talking with or. The Administrator was hall UM could be found, orted that she did not know, r. p.m., the surveyor returned peaking with the served a call light was to staff were present to After five minutes without se surveyor asked the ng call light (Resident #24) e resident reported that her edded sauce on it. She attes pasta and commented d gravy on it. The Certified notified of the request and nutes, the resident was rown gravy. p.m., all three aides were ree residents with eating to | F | 367 | | | |

obtained a meal tray and began to assist a

Facility ID: 55114

| A BUILDING | | | ID HUMAN SERVICES | | | | | RM APPROVED |
|---|------------|---------------------------|--|---------|----|--|-------|---------------|
| IDENTIFICATION NUMBER: 10599 B. WING TOURITHEAD OF PROVIDER OR SUPPLIER HEARTLAND OF ZEPHYRHILLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY AUIST BE PRECEDED BY PULL REGULATORY OR LSO IDENTIFYING INFORMATION) F 867 Continued From page 41 resident with eating. On | CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB N | IO. 0938-0391 |
| NAME OF PROVIDER OR SUPPLIER HEARTLAND OF ZEPHYRHILLS SUMMANY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PILL REQUILATORY OR LSC IDENTIFYING INFORMATION) F 867 Continued From page 41 resident with eating. On at 12:40 p.m., Aide B was observed standing next to Resident #12, she obtained another meal tray and sat with Resident #3 to begin assisting with eating. On at 12:45 p.m., the UM was observed in her office looking at her computer screen. She was called to the floor and reported that her meal was good. On at 12:45 p.m., the UM was observed in her office looking at her computer screen. She was called to the floor and reported that she had just returned from lunch. She asked the staff if they needed help with the lunch meal. At that time, two residents requiring assistance were still waiting to receive their funch meal. On at 12:50 p.m., the Administrator reported that the UM should be providing oversight during the meal proversity during he meal provess. The | | | 1 ' ' | | | COMPLETED | | |
| HEARTLAND OF ZEPHYRHILLS SUMMARY STATEMENT OF DEFICIENCIES DEPHYRHILLS, FL 33540 | | | 105599 | B. WING | _ | | - 1 | |
| ##EARTLAND OF ZEPHYRHILLS CA1 ID SUMMARY STATEMENT OF DEFIDIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX PROVIDER'S PLAN OF CORRECTION PROPRIATE PREFIX PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY PREFIX PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY PREFIX PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY PREFIX PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFINITION OF | NAME OF PR | ROVIDER OR SUPPLIER | | | 1 | | | |
| PREETX TAG F 867 Continued From page 41 resident with eating. On | HEARTLA | ND OF ZEPHYRHILLS | | | 1 | | | |
| resident with eating. On | PREFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREF | | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP | BE | COMPLETION |
| that was needed was present so the UM probably thought she was able to go to lunch. The Administrator was not aware of who was on the hall and was informed that only three aides were on the hall to assist up to six residents with their meals, one of the three aides was painting Resident #25's nails during lunch, and approximately 20 additional residents needed | F 867 | resident with eating. On | p.m., Aide B was observed dent #12, who was refusing to ask Resident #12 about revealed no response from udde B left Resident #12 about with eating. During the meal #9 reported that her meal #9 reported that her meal #9 reported that her meal #9 reported that she had ch. She asked the staff if the lunch meal. At that quiring assistance were still if unch meal. p.m. (one hour after meal all) the last resident received assistance to eat. p.m. (one hour after meal all) the last resident received assistance to eat. p.m. (one hour after meal all) the last resident received assistance to eat. p.m. (one hour after meal all) the last resident received assistance to eat. p.m. (one hour after meal all) the last resident so the UM probably to go to lunch. The taware of who was on the d that only three aides were p to six residents with their se aides was painting Juring Junning J | F | 86 | 7 | | |

.... at 2:35 p.m., the Administrator

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| | | 105599 | B. WING | | | | -C 27/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | • | | 8 | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 3 | 88220 HENRY DR | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | 2 | ZEPHYRHILLS, FL 33540 | | |
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| F 867 | meals. She reported staff would be assign assistance so there w no resident would new hore service when the Advision of the the | sidents to be assisted at that aides and other nursing ed to residents who needed yould be adequate staff and ad to wait for their meal. ministrator on | F | 867 | | | |

food, food too tough to chew, food that was

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| | | MEDICAID SERVICES | | | | | 0. 0938-0391 |
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| HEARTLA | ND OF ZEPHYRHILLS | | | 2 | ZEPHYRHILLS, FL 33540 | | |
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| F 867 | Council minutes date continued concerns wassisting with activitie complained about to use when the wrong temperatur. When these issues of were discussed with the purchase of the property of | ding variety. The Resident of a documented of the answering call lights and so of daily living. Residents of food, and food served at e and without flavor. continued noncompliance he Administrator on view that began at 2:00 reported that is he was not store the administrator on view that began at 2:00 reported that is he was not store the administrator on the second of the sec | F | 867 | | | |
| | Review of the facil the survey ending | ity's plan of correction for with a completion date | | | | | |

of revealed the following measures would

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FORM APPROVED OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING R-C

STATEMENT OF DEFICIENCIES AND REAN OF CORRECTION 105599 R MING 10/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 38220 HENRY DR HEARTLAND OF ZEPHYRHILLS ZEPHYRHILLS, FL 33540 SUMMARY STATEMENT OF DEFICIENCIES. PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 867 Continued From page 44 F 867 be taken to correct the deficient practice which was identified for concerns with , : II. DON/Designee completed audit of current residents for . . , . . communication sheets completed and ... site observations. III. DON/Designee will re-educated licensed staff on completing and receiving the communication sheet from the . . , . . center after each visit and documentation of site observation daily. Don/Designee will conduct audits of communication sheets and site observation bi weekly X2, weekly X2, then monthly X2. Findings will be reported to QA for review and further recommendations. 5. *A revisit to the survey ending was

revealed on-going concerns with follows:

On at 10:10 a.m., Resident #1 was observed lying in bed on his left side, watching a video. A access site was observed on the upper left arm.

Report revealed an original admission date of with diagnoses that included) with dependence on . A review of the physician's orders related to the resident's care, revealed orders for the resident's . , at the , center at 12 p.m., every Monday, Wednesday,

> , check the (-) /. . . every shift, and site

A review of Resident #1's Admission Record

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | | APPROVED 0. 0938-0391 |
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| STATEMENT | DF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | E CONSTRUCTION | (X3) DATE COMP | SURVEY |
| | | 105599 | B. WING | | | | -C 27/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | | 38220 HENRY DR ZEPHYRHILLS, FL 33540 | | |
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| F 867 | as needed. There was no additio access, including whe after the treat notes revealed docur were present aft(| ft, | F | 867 | | | |
| | on his upper went to yeste they applied nursing staff get arou from his arm. | r left arm. He stated that he rday and that was the at , He stated that nd to removing the | | | | | |
| | Resident #15 reveale with diagr on Re admission Minimum I showed a V score A review of the physic resident's car included check (V every shift for site observati a day, and Tues, Thurs, Sat. Th removal of the | () with dependence scord review of the pata Set (MDS) dated of 12 (moderately ,), ian's orders related to the e, dated and a high protein diet,) site - site / check; on as needed and one time , per physician order | | | | | |

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| EPARTMENT OF HEALTH AN | ID HUMAN SERVICES | | FORM APPROVED | |
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| ENTERS FOR MEDICARE & | MEDICAID SERVICES | The state of the s | OMB NO. 0938-0391 | |
| TEMENT OF DEFICIENCIES PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | (X3) DATE SURVEY COMPLETED | |
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10/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 38220 HENRY DR HEARTLAND OF ZEPHYRHILLS ZEPHYRHILLS, FL 33540 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 867 Continued From page 46 F 867 A review of the resident's 12 page care plan, initiated upon admission revealed no additional access site. care plans related to the A review of the resident's Nursing Notes from did not reveal ... , had been documentation that the removed, only that the site had been observed and the ... and . was noted. In an interview with the Administrator and the acting Director of Nurses on beginning at 2:00 p.m., it was confirmed that there should be an order for care of the site to include when to remove the applied after the site had been accessed for The Administrator confirmed during that interview

that the document Guidelines was the document used to train staff and also used as reference for care for the . . , . . residents. Review of the " , Guidelines" dated revealed:

Both the center and the , facility are responsible for shared communication regarding , services... patients receiving Collaborative communication included information regarding physician and treatment orders, and adverse reactions or complications and recommendations for follow up observations and monitoring including those related to the access site.

6. Review of the facility's plan of correction for the survey ending with a completion date of revealed the following measures would be taken to correct the deficient practice which

AND

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| NAME OF PR | ROVIDER OR SUPPLIER | | | s | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | | 8220 HENRY DR ZEPHYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | ΒĒ | (X5) COMPLETION DATE |
| F 867 | medication monitoring III. Quality Assuranc education to the DON to reviewingnew orders and that ra as identifying the large DON/Designee will prinursing staff related to new me targeted behaviors or DON/Designee to monitoring weekly x2, biweekly vab to reported to the QA recommendations. 7. A revisit to the sur conducted on revealed on-going co medication monitoring *On at the properties of the QA to the properties of the CA Condition of the | cerns with | F | 867 | | | |
| | | shift on through | | | | | |

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| WEART AND OF | 75011110111110 | | | : ا | 38220 HENRY DR | | |
| HEARTLAND OF | ZEPHYRHILLS | | | : | ZEPHYRHILLS, FL 33540 | | |
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| On seve On On On direction of be Nurs Revi Adm Adm Adm Adm Adm Show Med Bass Mon Me | ral times. resident at 22:26 er, when observe resident cries often observe resident cries often observe resident cries often observe resident cries often observed resident observed resident observed resident makes at the extension record review of the care by the care of signs and ritor every shift for cations. The phy all of orders and medicat every shift for cations. The phy all of orders and medicat every shift for cations. The phy all of orders and medicat every shift for cations. The phy all of orders and medicate of the care by all orders and medicate of the care by all orders and medicated the care by all of the care by all o | sed a bed bath and shower t refused to be (10:26 p.m.) just before d resident, she was crying, en and stated she was tired s not like to be touched. The is informed. orders, Treatment (1 (TAR), and Medication (1 (MAR) for received | F | 867 | | | |

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| F 867 | absence of signs and Check every shift as daily for related to use of I related to use of I will not since the symptoms of side effects for physician orders and monitoring of behavior medications. Progress notes review resident had increase her normal nervous I don't think are not so the side effects for was also to supplied and resident call was placed to the received an order to call was placed to the received an order to call was placed to the received an order to call was starte notes, physician orde documentation reager medication change. Record review of the resident was an exit s related to and revised were not limited to ca appropriate area, aler placement and function or adverse effects resident con adverse effects resident con adverse of the resident and function of the resident area, aler placement and function of the resident of the res | My initials indicate symptoms of side effects of | F | 866 | 7 | | |

included but were not limited to evaluate

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| F 867 | possible decrease / e drugs; notify physicia / behavior relat provide patient teachi- medications as neede of adverse reactions: "On at 1:40 sitting at bedside wat and groomed for the t possessions in her ro noted. Record review of the (MDS) dated (MDS) dated (MDS) and the ro Section N, Me receiving an Record review of acit MAR shower 24-hour 150 mg even Monitor for side effect indicate absence of s ffects, monitor every bedtime for related to use of , | e effects of medications for limination of, not decline in ADL ability or ed to a dosage change, not decline in ADL ability or ed to a dosage change, not of decline in ADL ability or ed to a dosage change, not of the interest of the inter | F | 867 | | | |

effects, monitor every shift. Monitor for side

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| STATEMENT (| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDI | | CONSTRUCTION | (X3) DATE COMP | |
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| | ROVIDER OR SUPPLIER | | | 3 | ITREET ADDRESS, CITY, STATE, ZIP CODE 18220 HENRY DR L'EPHYRHILLS, FL 33540 | | |
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| F 867 | effects related to use absence of signs and monitor every shift. IT MARI lacked orders a for medi MRI lacked orders a for medi pelated to monitoring behaviors associated medications. *Observed Resident TV on at 1:5 lunch. No behaviors v Record review of the (MDS) dated (,), Section N, Merreceiving medication. Record review of phy MAR showed Resided to use of , why initials indicate ab symptoms of side effer 7.5 m , Monitor for si medicat indicate absence of s in medicat indicate absence of sections. | of , very shift as of | F | 867 | | | |

and/or MAR lacked orders and monitoring of behaviors for ..., ... medications.

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| F 867 | Continued From page | 52 | F | 867 | | | |
| | | care plans showed no to monitoring for behaviors se of | | | | | |
| | | gress notes for the month of any documentation related g. | | | | | |
| | | #6 lying in bed on TV. She would not answering questions. | | | | | |
| | (MDS) dated(). Section N, was receiving an | quarterly Minimum Data Set showed a) score of 09 (moderately Moderations, showed she , and ations. | | | | | |
| | MAR 2021 si 0.5 mg at bedt | physician's orders and howed Resident #6 received ime for and hold for side effects related to use of ion, My initials | | | | | |
| | indicate absence of s effects, monitor every bedtime for effects related to use My initials i | Monitor for side of medication , medicate absence of signs | | | | | |
| | 25 mg Monitor for side effect medicat indicate absence of s | e effects, monitor every shift. I daily for | | | | | |

and/or MAR lacked orders and monitoring of behaviors for , , , , , , , medications.

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| HEARTLA | ND OF ZEPHYRHILLS | | | 2 | ZEPHYRHILLS, FL 33540 | | |
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| F 867 | Continued From page | 53 | F. | 867 | | | |
| | | gress notes for the month of documentation related to | | | | | |
| | resident was at risk for related to (ingestion of feces) re did not indicate what behaviors/targeted be The resident had inarattempting to be over residents related to revise included but were not possible, explain and on others, offer dim limusic; remain calm exhibits behavior, set | and coprophagia vised | | | | | |
| | Interventions administer medicator observe for effectiven symptoms of side effe watching TV, reading feelings of loss. Episc diagnoses of Interventions includer administer medicatior identify and decrease risk for adverse effect medic interventions limited to evaluate eff | , and revised included but not limited to to sper physician orders and ess and signs and sets. Elicit family support, books/ magazines; validate des of related to initiated I but not limited to see provision orders, environmental stressors. At | | | | | |

of drugs; notify physician of decline in ADL ability or behavior related to a

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| F 867 | | e 54 rt to physician signs of risk for adverse effects | F | 86 | 37 | | | |
| | | vised . Interventions | | | | | | |
| | included but was not | limited to evaluate e effects of medications for | | | | | | |
| | | liminations of | | | | | | |
| | | n of decline in ADL ability or | | | | | | |
| | / behavior relat | ed to a dosage change; | | | | | | |
| | | gns of adverse reaction. At | | | | | | |
| | risk for adverse effect | ts related to use of tion, revised | | | | | | |
| | | s included but was not | | | | | | |
| | | fectiveness and side effects | | | | | | |
| | of medications for pos | ssible decrease / | | | | | | |
| | eliminations of , , | | | | | | | |
| | | n ADL ability or/ | | | | | | |
| | physician signs of ad- | dosage change; report to | | | | | | |
| | physician signs or au- | reise reaction. | | | | | | |
| | *Review of Resident | #12's Physician's orders | | | | | | |
| | revealed an order dat | | | | | | | |
| | | . 7.5 mg by at | | | | | | |
| | bedtime for nutritional | l enhancement. The that | | | | | | |
| | | petite stimulant. An order | | | | | | |
| | for side effect monitor | | | | | | | |
| | | cts related to the use of | | | | | | |
| | , . , , . medicat | ions:" | | | | | | |
| | (MDS) Assessment o Resident #12. The as | ssessment documented the | | | | | | |
| | resident as having mo | | | | | | | |
| | | sment documented her use out the use of an | | | | | | |
| | 01110 , , . | out trie use of an | | | | | | |

A care plan had been developed on ...

. . and

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| STATEMENT (| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL' A. BUILDI | | LE CONSTRUCTION | (X3) DATE COMP | |
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| F 867 | Continued From page | 55 | F- | 86 | 7 | | |
| | revised on for | r Resident # 12's use of the | | | | | |
| | goes plan identified th | . The Focus of the e risk for adverse effects of | | | | | |
| | the medication and he | | | | | | |
| | | rventions included | | | | | |
| | | veness and the side effects | | | | | |
| | of the medication for | | | | | | |
| | elimination of the | | | | | | |
| | | be notified of a decline in the ties of daily living) abilities or | | | | | |
| | | vior related to a dosage | | | | | |
| | | an was to be notified of | | | | | |
| | | tions as well. The care | | | | | |
| | plan included no inter | ventions related to | | | | | |
| | monitoring for behavi- | ors associated with the use | | | | | |
| | of , , medic | cations. | | | | | |
| | Review of the residen | nt's Medication and | | | | | |
| | | id not reveal guidance and | | | | | |
| | | the presence or absence of | | | | | |
| | | sident might be eliciting. to monitor side effects of | | | | | |
| | | ne clarification that "my | | | | | |
| | | ice of signs and symptoms | | | | | |
| | | e was no guidance that side | | | | | |
| | | needed to be documented | | | | | |
| | in the nurse's notes, of | or what specific side effects | | | | | |
| | the resident might elic | sit. | | | | | |
| | A review of the nurse | | | | | | |
| | | ed the resident was followed | | | | | |
| | by Hospice and had a | | | | | | |
| | medication on | . Nurses notes prior to | | | | | |
| | | ratching was noted on her which received treatment. | | | | | |
| | | which received treatment. 06 (4:06 p.m.) and | | | | | |
| | | 5:58 p.m.) the nurses note | | | | | |
| | | lent's behavior of screaming | | | | | |

and yelling and refusing the treatment.

| EPARTMENT OF HEALTH AND HUMAN SERVICES | | | | | |
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| CENTERS FOR MEDICARE & I | MEDICAID SERVICES | | | OMB NO. 0938-039 | |
| ID DI AN OF CORDECTION DESCRIPTION NUMBER | | (X2) MUL A. BUILDI | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | |
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| NAME OF P | ROVIDER OR SUPPLIER | • | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
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| | | | | | DEFICIENCY) | | |
| | | | | | | | |
| F 867 | Continued From page | 56 | F | 867 | 7 | | |
| | On during | the lunch meal, Resident | | | | | |
| | #12 was observed be | ing assisted with her meal. | | | | | |
| | The resident was obs | erved taking a small bite of | | | | | |
| | fish out of her | and placing it on her | | | | | |
| | plate. The aide comm | nented that the resident | | | | | |
| | usually did that and d | idn't usually eat anything. | | | | | |
| | An observation of Re- | sident #12 on | | | | | |
| | during the lunch meal | | | | | | |
| | | fruit cocktail from her lunch | | | | | |
| | | ned that she refused the | | | | | |
| | meal but seemed to be enjoying the sweet fruit. | | | | | | |
| | | | | | | | |
| | | ent's revealed upon | | | | | |
| | admission on | the resident had | | | | | |
| | | Onthe resident | | | | | |
| | | n the resident | | | | | |
| | a | nd on the resident | | | | | |
| | | | | | | | |
| | | | | | | | |
| | *Resident #1 was adr | nitted to the facility initially | | | | | |
| | on . The | resident had current | | | | | |
| | diagnoses that includ | ed major, | | | | | |
| | and , | . Review of the | | | | | |
| | resident's active Phys | sician's orders revealed an | | | | | |
| | order for 100 m | ng, give 300 ml by at | | | | | |
| | | and and | | | | | |
| | | mg, give one cap by | | | | | |
| | | . Current orders were | | | | | |
| | | the side effects related to | | | | | |
| | | , medications | | | | | |
| | | er included the statement, | | | | | |
| | | e absence of signs and | | | | | |
| | symptoms of side effe | ects." | | | | | |
| | Resident #1 had on A | nnual MDS Assessment | | | | | |
| | | which identified the | | | | | |
| | resident as having no | | | | | | |
| | | the diagnoses of | | | | | |
| | assessment included | tire diagnoses of | 1 | | | | |

| | | ID HUMAN SERVICES | | | | | M APPROVED |
|--------------------------|--|--|-------------------------|-----|---|----|----------------------------|
| | | MEDICAID SERVICES | | | | | D. 0938-0391 |
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | | CONSTRUCTION | | PLETED |
| | | 105599 | B. WING _ | | | 1 | ⊱C /27/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | • | | s | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| MEADTI A | ND OF ZEPHYRHILLS | | | 3 | 8220 HENRY DR | | |
| HEARTLA | IND OF ZEPHTRHILLS | | | 2 | EPHYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 867 | week. A care plan was revie being at risk for beha noncompliance with t draws initiated Interventions includes status/behavior chan are started or with ch. Physician's order for not included as an infor at risk behaviors given in the care plar | an , and istered on 7 days during the swed for the Focus area of vior symptoms related to and , as well as he ordered diet and lab | F | 367 | | | |
| | that today was her fir DON. She stated tha Managers and MDS to their assigne were looking through records today. She is seeing some issues recognized that the bithere. She stated tha with the UM and the behavior monitoring that specific resident. | ered, Staff G. She stated st day in the position of t all the other nurses, Unit coordinator would be going of jobs. She stated that they the electronic medical tated that they have been She stated that she ehavior monitoring was not t she was going to do audits MDS coordinator and put in elated to specific issues for | | | | | |
| | | on at 4:26 p.m. the at stated that that they on for behavior monitoring. | | | | | |

He stated," this was the facility's corporate rules."

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | | FORM | D: 11/29/2021 MAPPROVED D: 0938-0391 |
|--------------------------|---|--|----------------------|-----|--|--------|-------------------|--|
| STATEMENT (| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | ECONSTRUCTION | | (X3) DATE COMP | SURVEY |
| | | 105599 | B. WING | _ | | | | -C 27/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | | 5 | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | 1 | 8220 HENRY DR EPHYRHILLS, FL 33540 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD B | | (X5) COMPLETION DATE |
| F 867 | behavior notes, progr notes. If the resident then they will not list a or there was a documentation. He st then no behaviors." He anybody on looks at the notes and documentation of bet for gradual reduction documentation in the for the side effects, initials signify no side monitor for behaviors there are behaviors. | entation will be found in the ess notes, or physician was not having behaviors, anything. If a dose increases , initiated, they should have ated, "No documentation e stated that he looks at medications and he of looks for behaviors." If no laviors, then will see notes in dosages. Should be electronic medical record , increased | F | 867 | | | | |
| | the survey co >Each no effects monitoring for >Your initials indicate symptoms of side effe > Use code #9 if side write on nurses note. Signature sheets sho provided to nursing st and Th adding monitoring for | Record showed the licensed nurses following wered: nedication requires side each classification . absence of signs and cts. effects are present and wed this education was aff on education did not cover | | | | | | |

indicated in the plan of correction.

8. During an interview on ... at 5:26 p.m.

| DEPARTMENT OF REALTH AND HOWARD SERVICES | | | | | | |
|---|-------------------|----------------------|---------------------------------------|-------------------------------|--|--|
| CENTERS FOR MEDICARE & I | MEDICAID SERVICES | | | OMB NO. 0938-039 | | |
| D DI AN DE CORRECTION IDENTIFICATION NUMBER | | (X2) MUL A. BUILD | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | | |
| | | | | R-C | | |
| | 105599 | B. WING | | 10/27/2021 | | |
| IAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |

| | | | | | R-C | |
|--------------------------|--|---|---------------------|---|---------------|--|
| | | 105599 | B. WING _ | | 10/27/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | 1 | 38220 HENRY DR | | |
| HEARTLA | ND OF ZEPHYRHILLS | | | ZEPHYRHILLS, FL 33540 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION | |
| PREFIX | (EACH DEFICIENCE) REGULATORY OR I Continued From page the NHA stated that it was a summer of the New York of the New York of the New York of the Stated the us homework. The Min the action plans. SI meeting in or the survey were real next meeting was ADHOC OAPI (qualif improvement). They Improvement Plans (is reviewed to see if any changed. She stated in the New York of the Stated or all of the tags cited past, and they discorrection items. She through each tag and The NHA acknowledge for all of the tags cited past, She is each piece of the aud with most of the suidil audits, she stated, "D those next ones." In Crossing of When I go know if I got them audits were not performed in the performance of the page of the performance of the performan | IN MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) 159 ley have monthly Quality ings. She stated the rattends in person or by a the participates and gives adical Director was involved ne stated that they had a before the results of veed to the state of that they had a not succeed to the state of that they had a not succeed to the state of that they had a not succeed to the state of that they did an assurance performance inscussed the Performance PIPs) to put into place and thing needed to be that they used the PIPs to succeed they are the plan of stated that they went learn on the CMS 2567, ed that audits were missing (no audits could be located tated that they discussed its and they were on track. In response to the missing on't know how I missed we my list, maybe I was wet them out and I don't she how of the state of | PREFIX | (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION | |
| | stated that they went they focused on in the system, not the exact they did the POC the Regarding dining on t during the audits ther agreed that the audits | by the POC. This was what meetings and on the issue. She stated that when | | | | |

Facility ID: 55114

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM APPROVED MB NO. 0938-0391 | |
|--------------------------|---|---|----------------------|---|--|-----------------------------------|--|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | | 3) DATE SURVEY COMPLETED | |
| | | 105599 | B. WING | | | R-C 10/27/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIF | CODE | | |
| HEARTLA | AND OF ZEPHYRHILLS | | | 38220 HENRY DR ZEPHYRHILLS, FL 33540 | | | |
| (X4) ID PREFIX TAG | | | ID PREFI TAG | X (EACH CORRECTIVE A) CROSS-REFERENCED TO | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| F 867 | supposed to be doing The facility was using approach (related to residents). She state open the dining room meeting, was an inter included the NHA, Me person, the DON or It Control Preventionist, housekeeping, and m sometimes the Regist bousekeeping, and m sometimes the Regist thought were be morning meeting and everybody. She state | not doing what they were . The PIP was going to fix it. the all on deck thining of independent that the community yellow, so the facility may again. She stated that the disciplinary learn, which discal director, activity he UM, the MDS, Human Resources, anintenance. In addition, tered Dietician, Certified jial Services and will d, "Some of the plans were a not." She stated that they ing followed up in the someone was tracking d, "Not having the nursing d, "Not having the nursing problem. Staff G can help | F | 867 | | | |