STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105196	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge Healthcare and Rehabilitation Center	635 SE 17th Street Ocala, FL 34471

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 51447 Based on observation, interviews, and record reviews, the facility failed to notify the provider and resident representative of a change in condition for 1 (Resident #397) of 5 residents reviewed for intravenous therapy. Findings include: During an observation on 2/23/2025 at 10:30 AM, Resident #397 was observed lying in bed with the head of bed elevated. She had a single lumen peripherally inserted central catheter (PICC) line in her right upper arm with a transparent dressing dated 2/9/2025. The dressing was intact around the insertion site but was noted to be partially lifted on the bottom right inside corner and brownish stains on the outside of the dressing. Review of the physician's order for Resident #397 dated 2/13/2025 read, Discontinue IV line right upper extremity [RUE] one time only for dc [discontinue]. Review of the Medication Administration Record (MAR) for Resident #397 documented the PICC line was discontinued on 2/13/2025 by [Staff O's initials] at 1358 [1:58 PM]. During an interview on 2/26/2025 at 9:19 AM, Staff O, Licensed Practical Nurse (LPN) stated, When I documented that the PICC line was discontinued it was a mistake by me. I typically don't check off a task until I have completed the task. During an interview on 2/24/2025 at 2:41 PM the Director of Nursing (DON) stated, [Resident #397's name] had an order for the PICC line to be removed but she refused. I would expect nursing staff to call the doctor and notify him of the refusal and document the information accurately in the residents chart. I did not see any notification in the system [electronic record system] made to the provider or [Resident #397's name] family. Review of Resident #397 progress notes from 2/11/2025 through 2/14/2025 did not document any notification of refusals of PICC line removal to the physician or resident representative. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/2025 at 2:53 PM, Resident #397's daughter stated, The only time I have ever been notified by the facility about my mother was when the facility had sent my mother to the hospital or if they had a billing question. I have not had any calls about my mother refusing care regarding her PICC line. During an interview conducted on 2/26/2025 at 1:51 PM, the Advanced Practice Registered Nurse (APRN) #2 stated, I am very familiar with [Resident #397's name]. I am at the facility two to three times a week. I do not recall any communication from the facility staff about any refusals of care for the resident. It would be my expectation that if one of my resident's refused care like the removal of a PICC line, I would be called by the facility so that I can make sure the appropriate orders are in for maintenance. Review of the policy and procedure titled Change in Condition with a last review date of 1/28/2025 read, Policy: It will be the policy of this facility to notify the physician, family, resident, and/or responsible party/resident representative (as is applicable) of significant changes in condition and providing treatment(s) according to the resident's wishes and physician's orders. Procedure: 7. Contact the primary physician to update him/her to the change in condition. In the event the primary physician cannot be notified, attempt to contact the facility's medical director. 11. Notify the family or responsible party/resident representative regarding the resident condition change .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51504 Based on observations, interviews and record reviews, the facility failed to develop and implement a comprehensive care plan for 2 (Resident #63 and #71) of 4 reviewed for respiratory services. Findings include: Review of Resident #71's admission record documented an admitted [DATE] with diagnosis that included chronic obstructive pulmonary disease, shortness of breath, acute respiratory failure with hypoxia, and pleural effusion (fluid around the lungs). An observation on 2/23/2025 at 9:40 AM, Resident #71's oxygen concentrator was set on 3 liters. An observation on 2/24/2025 at 2:15 PM, Resident #71's oxygen concentrator was set on 3 liters. Review of Resident #71's physician's order dated 9/22/2024 read, Oxygen at 2 liters/minute via nasal cannula with humidification when on the concentrator. May be without humidification when on a tank. Review of Resident #71's care plan dated 7/25/2024 read, [Resident #71's name] has a potential for complication of respiratory distress related to a diagnosis of COPD. Goals included resident will be able to maintain patent airway and will not exhibit signs of respiratory distress daily thru next review. Interventions include administer medication as ordered, O2 sats [Oxygen saturations] as order, Administer O2 as ordered. During an interview on 2/25/2025 at 6:00 AM, the Director of Nursing (DON) stated, It is my expectation that all nursing staff read and follows the care plan and follow the interventions regarding oxygen settings and respiratory care protocols. 46523 2) During an observation on 2/23/2025 at 9:49 AM, Resident #63 was lying in bed in a hospital gown. Oxygen was being administered at 1 liter per minute via nasal cannula. Review of Resident #63 physician's order dated 1/19/2025 read, Change oxygen/nebulizer tubing weekly and prn [as needed]. Review of Resident #63's physician's order dated 1/19/2025 read, Oxygen at 2 liters/minute via nasal cannula with humidification when on the concentrator. May be without humidification when on a tank as needed related to Chronic Obstructive Pulmonary Disease. Review of Resident #63's care plan initiated on 1/11/2025 documented Resident #63 had a potential for complications of respiratory distress r/t [related to] s/s [signs and symptoms] of: SOB (Shortness of breath), COPD (Chronic Obstructive Pulmonary Disease) was cancelled on 2/14/2025. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/2025 at 3:00 PM, the Director of Nursing (DON) stated, The oxygen focus [care plan] was cancelled and not reinstated into the care plan. I am not sure what happened. During an interview on 2/27/2025 at 8:36 AM, the DON stated, I received a text message from the Regional MDS (Minimum Data Set) Consultant that oversees care plans and she stated that during the 8/2 modification it [oxygen focus] was canceled from her [Resident #63] care plan. Review of the policy and procedure titled Respiratory Care with a last review date of 1/28/2025 read, Policy: It is the policy of this facility to provide respiratory care and safe oxygen administration to meet the needs of the residents. Procedure: 15. The use of oxygen, respiratory conditions/medications or trach [tracheostomy] needs should be reflected in the resident's plan of care. Review of the policy and procedure titled, Comprehensive Assessments and Care Plans with a last review date of 1/28/2025 read, Standard: It will be the standard of this facility to make a comprehensive assessment of a resident's needs, strength, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS (Centers for Medicare & Medicaid Services). Guidelines: 1. The facility will conduct initially and periodically a comprehensive, accurate, and standardized reproducible assessment of each residents functional capacity.8. The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights .that includes measurable objectives and timeframe to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51447 Based on observations, interviews, and record reviews, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for 3 (Resident #2, #301, and #397) of 7 residents reviewed for intravenous lines, medication administration and unnecessary medications. Findings Include: 1) During an observation on 2/23/2025 at 10:30 AM, Resident #397 was observed lying in bed with the head of bed elevated. She had a single lumen peripherally inserted central catheter (PICC) line in her right upper arm with a transparent dressing dated 2/9/2025. The dressing was intact around the insertion site but was noted to be partially lifted on the bottom right inside corner and brownish stains on the outside of the dressing. During an interview conducted on 2/23/2025 at 10:30 AM, Resident #397 stated, I have an IV (intravenous line) for my antibiotics because I have an infection. Review of the admission record documented that Resident #397 was admitted to the facility on [DATE] with diagnosis that included metabolic encephalopathy, dysphagia, oropharyngeal phase, unspecified combined systolic (congestive) and diastolic (congestive) heart failure, morbid (severe) obesity due to excess calories, muscle weakness, anxiety disorder, unspecified, major depressive disorder, recurrent, moderate, acquired absence of kidney, essential (primary) hypertension, chronic kidney disease, unspecified, personal history of other venous thrombosis and embolism, peripheral vascular disease. Review of Resident #397's physician's order dated 1/21/2025 read, Insert/maintain PICC line IV. Review of Resident #397's Medication Administration Record (MAR) documented a physician's order with a start date of 1/21/2025 that read, Meropenem solution reconstituted 1 GM (gram), Use 1 gram intravenously every 8 hours for ESBL (Extended-Spectrum Beta-Lactamases, a bacteria that is resistant to most antibiotics) for 10 days. Review of Resident #397's MAR documented a physician's order with a start date of 1/21/2025 that read, Change transparent dressing. Measure external catheter length, every night shift every wed (Wednesday). Observe site for signs and symptoms of infection, infiltration, and/or extravasation and as needed for leakage, loosening or soiling of dressing. Review of Resident #397's MAR documented a physician's order with a start date of 1/30/2025 that read, Saline Flush Solution (Sodium Chloride Flush), use 10 ml (milliliters) intravenously every 8 hours for line patency [free of blood clots, free flowing] until 2/1/2025 23:59 [11:59 PM] flush with 10 ml normal saline before and after medication administration. Review of Resident #397's MAR documented a physician's order with a start date of 1/30/2025 that read, Monitor IV (Intravenous) Site - RUE (right upper extremity). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's order for Resident #397 dated 2/13/2025 read, Discontinue IV line right upper extremity [RUE] one time only for dc [discontinue]. Review of the Medication Administration Record (MAR) for Resident #397 documented the PICC line was discontinued on 2/13/2025 by [Staff O's initials] at 1358 [1:58 PM]. During an interview on 2/26/2025 at 9:19 AM, Staff O, Licensed Practical Nurse (LPN) stated, When I documented that the PICC line was discontinued it was a mistake by me. I typically don't check off a task until I have completed the task. Review of Resident #397 MAR for the month of February 2025 did not document any saline flushes after 2/1/2025 or any monitoring of the IV site every shift since 2/13/2025. During an interview conducted on 2/26/2025 at 1:04 PM, Staff N License Practical Nurse (LPN) stated, I charted that the dressing was changed on 2/12/2025 because when I went to change it, I realized that it had been changed on 2/9/2025 and the dressing would still be good for 7 days from when it was changed. Central line dressings are supposed to be changed every 7 days. If a dressing is not changed on a central line the resident would be at increased risk for getting an infection. During an interview on 2/26/2025 at 8:00 AM with the Medical Director stated, The risk associated with not flushing a central line when it is not in use would be potential of a blood clot and possibly infection. Risk associated with not changing a central line is infection to the resident. When asked about how frequently a central line should be flushed and what is the frequency for dressing changes, he stated, central lines should be flushed at least once a shift and dressing changes for central lines are determined by the facility. During an interview conducted on 2/26/2025 at 1:51 PM with ARNP #2 stated, I do not recall any communication from the facility staff about any refusals of care for the Resident. It is facility protocol for how frequently a PICC is flushed and dressings are changed, I would expect that minimally the PICC would need to be flushed daily to maintain patency. I believe in the facility setting dressing changes for PICC is every 7 days. Infection would be the biggest risk if a central line dressing was not changed as ordered. Not flushing a PICC would likely result in the PICC not staying patent. During an interview on 2/24/2025 at 2:41 PM, the Director of Nursing (DON) stated, (Resident #397's name] had an order for the PICC line to be removed but she refused. As a result of the DC (discontinue) order for the PICC line, all of the other associated orders with the PICC line were also discontinued. I saw the dressing on her arm it was dated in purple, but I can't recall the date that was written. When the PICC line stayed in after the 13th [February], there should have been orders placed in the system to flush the IV. Nursing staff should change the dressing every 7 days. Review of the policy and procedure titled PICC/Midline IV Line with a last review date of 1/28/2025 read, Policy: It will be the policy of this facility to adhere to IV/PICC/Midline administration guidelines as set forth by infection control, state, and federal regulations. Licensed nurse shall provide care according to state and federal law. Dressing Changes: 1. Sterile dressing change using transparent dressings is performed: At least weekly, if the integrity of the dressing has been compromised (wet, loose, or soiled). 46523 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Review of Resident #301's admission record documented an admitted [DATE] with the following diagnoses: type 2 diabetes mellitus with ketoacidosis (a life threatening complication of diabetes that occurs when the body doesn't have enough insulin) without coma, osteomyelitis (a bone infection) of vertebra, thoracic region, severe sepsis with septic shock, atherosclerotic heart disease of native coronary artery (heart disease) without angina pectoris (chest pain), and essential (primary) hypertension. Review of Resident #301's physician's orders for February of 2025 did not include orders for intravenous normal saline flushes. Review of Resident #301's Medication Administration Record (MAR) for the month of February 2025 did not document intravenous normal saline flushes. Review of Resident #301's physician's order dated 2/3/2025 read, Cefepime HCl (Hydrochloride Hydrogen) Solution 1 GM/50ML (1 gram/50 milliliters) use 1 gram intravenously every 8 hours for osteomyelitis until 3/06/2025. Review of Resident #301's physician's order dated 2/3/2025 read, Vancomycin HCl in NaCl (Sodium Chloride) Intravenous Solution 750-0.9 MG/250 ML -% (Vancomycin HCl-Sodium Chloride) use 750 mg (milligrams) intravenously every 12 hours for osteomyelitis until 3/06/2025. Review of Resident #301's physician's order dated 2/3/2025 read, Change dressing post PICC (peripherally inserted central catheter) insertion and routinely every day shift every 7 day(s) for PICC line placement. Observe site for signs/symptoms of infiltration/extravasation/infection. Review of Resident #301's physician's order dated 2/8/2025 read, Change transparent catheter site dressing every night shift every 7 day(s). Measure external catheter length on admission, with each dressing change and PRN (as needed). Observe site for signs/symptoms of infiltration/extravasation with each dressing change. During an interview on 2/25/2025 at 7:33 AM, Staff L ,Registered Nurse (RN), stated, I do not see any orders in the system [electronic medical record] for saline flushes for [Resident #301's name]. The orders will usually be in the system. During an interview on 2/27/2025 at 8:15 AM, the Director of Nursing (DON) stated, I do not know what happened to the order; at some point it fell off. We would not be able to track if nurses are actually doing the flushes unless the order is in the system. 3) Review of Resident #2's admission record documented an admitted [DATE] with diagnosis that included essential primary hypertension, unspecified combined systolic and diastolic heart failure, unspecified heart failure, and pulmonary hypertension unspecified. Review of Resident #2's physician's order dated 1/19/2025 read, Midodrine HCl Tablet 10 mg give 1 tablet by mouth three times a day for hypotension hold for SBP (systolic blood pressure) above 140. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's Medication Administration Record (MAR) for the month of February 2025 documented Midodrine 10 mg was given at 0900 [9:00AM] on 2/3 for a systolic blood pressure (SBP) of 142, on 2/5 for SBP of 150, on 2/7 for a SBP of 143, on 2/8 for a SBP of 147, on 2/11 for a SBP of 142. At 1300 [1:00PM] on 2/3 for a SBP of 142, 2/5 for a SBP of 150, on 2/7 for a SBP of 143, 2/11 for SBP of 142. At 1700 [5:00PM] on 2/3 for SBP of 187, 2/4 for a SBP of 150, 2/5 for a SBP of 143, on 2/7 for a SBP of 143, on 2/10 through 2/12 for a SBP of 142 and on 2/15 for a SBP of 154. During an interview on 2/26/2025 at 10:53 AM the Director of Nursing (DON) stated, The nurses should follow parameters and if they have any questions they should call the doctor to get clarification. During an interview on 2/27/2025 at 11:01 AM the Advance Practice Registered Nurse (APRN) #3, stated, I was not aware staff were administering medication out of parameters. I expect nursing staff to follow my orders and parameters. 41334 4) Review of Resident #301's admission record documented that Resident #301 was admitted to the facility on [DATE] with the following diagnoses: type 2 diabetes mellitus with ketoacidosis (a life threatening complication of diabetes that occurs when the body doesn't have enough insulin) without coma, osteomyelitis (a bone infection) of vertebra, thoracic region, severe sepsis with septic shock, atherosclerotic heart disease of native coronary artery (heart disease) without angina pectoris (chest pain), and essential (primary) hypertension. Review of Resident #301's physician's order dated 2/3/2024 reads, Perform accuchecks before meals and at bedtime for type 1 diabetes. Review of Resident #301's Medication Administration Record (MAR) documented blood glucose levels of greater than 400 on 2/4/2025 at 1630 (4:30 PM) of 476, on 2/5/2025 at 1630 of 434, on 2/5/2025 at 2100 (9:00 PM) of 427 and on 2/7/25 at 2100 of 447. Review of Resident #301's nursing progress notes from 2/2/2025 until 2/24/2025 showed no documentation that the physician or nurse practitioner were notified of blood glucose greater than 400. During an interview on 2/24/2025 at 1:47 PM, Resident # 301 stated, My blood sugars are high and low, they have been checking them. When I was first here they were monitoring my accuchecks but not covering them with my normal short acting insulin. I told them and the nurse practitioner. I have been a diabetic for a long time, and I know when my sugars are low and when they are high. I told them I needed to have my short acting insulin, and they didn't call the doctor. During an interview on 2/26/2025 at 8:19 AM, the Director of Nursing stated, I expect staff will document that they have notified the provider when blood sugars are elevated above 400, it is a standard to do this to determine if the resident will need any additional coverage of insulin. The nurse should have called the provider and documented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/2025 at 12:35 PM, Staff G, Licensed Practical Nurse (LPN), stated, I do recall this resident, he [Resident #301] at one time did have accuchecks that were without SSIC (sliding scale insulin coverage). I recall that he [Resident #301] did have several times that his blood sugar was over 400. I did not notify the nurse practitioner or doctor about it. I should have notified them usually they have orders to notify them if the blood sugar is above 400, but this order didn't say that. I just assumed that the doctor didn't want any coverage. I should have called and notified them. A policy and procedure for insulin administration was requested but not received.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 51504 Based on observations, interviews and record reviews, the facility failed to ensure residents received the correct oxygen flow rate for 3 (Resident #63, #65, and #71) of 4 residents reviewed for respiratory services. Findings include: During an observation on 2/23/2025 at 9:40 AM, Resident #71's oxygen concentrator was set on 3 liters. During an observation on 2/24/2025 at 2:15 PM, Resident #71's oxygen concentrator was set on 3 liters. During an interview on 2/24/2025 at 2:18 PM, Resident #71 stated that she does not operate or have knowledge of how to adjust the oxygen concentrator. Review of Resident #71's physician's order dated 9/22/2024 read, Oxygen at 2 liters/minute via nasal cannula with humidification when on the concentrator. May be without humidification when on a tank. During an interview on 2/24/2025 at 2:30 PM, Staff A, License Practical Nurse (LPN), stated the prescribed order calls for the O2 (oxygen) was for 2 liters. Staff A confirmed that the oxygen was set at 3 liters and should have been 2 liters per the physician's order. During an interview on 2/25/2025 at 6:00 AM, the Director of Nursing (DON), stated, My expectation is that all nursing staff read and follows the physician's orders regarding oxygen settings and respiratory care protocols. 46523 2) During an observation on 2/23/2025 at 9:49 AM, Resident #63 was lying in bed in a hospital gown. Resident had oxygen running at 1 liter per minute via a nasal cannula attached to an oxygen concentrator. There was oxygen tubing dated 2/8 hanging from the back of Resident #63's wheelchair which was not bagged. (photographic evidence obtained) Review of Resident #63's physician's orders dated 1/11/2025 read, Change oxygen/nebulizer tubing weekly and prn [as needed], every night shift every sat (Saturday). Review of Resident #63's physician's order dated 1/10/2025 read, Change oxygen/nebulizer tubing weekly and prn, as needed. Review of Resident #63's physician's order dated 1/19/2025 read, Oxygen at 2 liters/minute via nasal cannula with humidification when on the concentrator. May be without humidification when on a tank as needed related to Chronic Obstructive Pulmonary Disease. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/2025 at 3:35 PM, the Director of Nursing stated, [Resident #63's Name] has oxygen orders for 2 liters not for 1 liter per minute. The nursing staff should be checking the resident's flow rate to make sure it is correct when they go into the room to check the oxygen saturation. Tubing is to be changed every 7 days or as needed. Review of the policy and procedure titled Respiratory Care with a last review date of 1/28/2025 read, Policy: It is the policy of this facility to provide respiratory care and safe oxygen administration to meet the needs of the residents. Procedure : 1. Verify that there is a physician's order for respiratory procedures or oxygen use. Review the physician order for oxygen administration, nebulizer treatments, inhalers, trach care, chest tube/PleurX [pleural catheter care], BiPAP [Bilevel Positive Airway Pressure], CPAP [Continuous Positive Airway Pressure] or medication administration. 10. Oxygen, trach [tracheostomy], and nebulizer tubing is changed weekly and dated as verification that the tubing was changed. 41334 3. During an observation on 2/24/2025 at 3:17 PM, Resident #65 was observed resting in bed with oxygen at 4 liters via nasal cannula. The oxygen concentrator was on the right side of the residents bed between the bedside nightstand and the head of the bed outside of the residents reach. During an observation on 2/25/2025 at 8:24 AM, Resident #65 was observed with oxygen at 4 liters via nasal cannula. The oxygen concentrator remained outside of the residents reach. Review of Resident #65's admission record documented a diagnosis of chronic obstructive pulmonary disease (a group of lung diseases that cause difficulty breathing), chronic respiratory failure with hypoxia (a serious condition where the body doesn't get enough oxygen and the lungs can't remove enough carbon dioxide), and atherosclerotic heart disease of native coronary artery (heart disease) without angina pectoris (chest pain). Review of Resident #65's physician's order dated 1/19/2025 read, Oxygen at 3 liters/minute via nasal cannula with humidification when on the concentrator. May be without humidification when on a tank every shift related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED. During an interview on 2/24/2025 at 3:17 PM, Resident #65 stated, I never change the amount of oxygen I am getting, I can't reach the machine, the nurses would if I needed it, but I'm at my normal for breathing. During an interview on 2/24/2025 at 3:18 PM, Staff H, Licensed Practical Nurse (LPN) stated, That is wrong [while observing the concentrator oxygen setting]; her oxygen should be at 3 liters.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 46523 Based on observations, interviews, and record reviews, the facility failed to ensure the medication error rate was not 5 percent or greater. The medication error rate was 6.98 percent. Findings include: During an observation on 2/25/2025 at 8:44 AM, Staff H, Registered Nurse (RN), without hand hygiene began to pour Resident #58's medication. Staff H entered Resident #58's room and without hand hygiene handed Resident #58 his medication cup. Staff H handed Resident #58 his Styrofoam cup which contained water. Staff H handed Resident #58 his nasal spray. Resident #58 self-administered two nasal sprays on each nostril. Staff H performed hand hygiene before exiting Resident #58's room. During an interview on 2/25/2025 at 8:52 AM, Staff H, RN, stated, [Resident #58's Name] should only do one spray per nostril not two sprays in each nostril. We did not follow the physician order. I should have reminded him [Resident #58] he was to do one spray per nostril before handing him the nasal spray. Review of Resident #58's physician's order dated 12/5/2024 read, Fluticasone Propionate Nasal Suspension 50 MCG/ACT (micrograms/actuation nasal spray) 1 spray in both nostrils one time a day for allergy symptoms. During an observation on 2/25/2025 at 9:12 AM, Staff I, License Practical Nurse (LPN), exited Resident #67 's room and did not perform hand hygiene. Staff I was holding a blood pressure machine which she place on top of the medication cart without sanitizing. Staff I entered Resident #247's room and without performing hand hygiene or sanitizing the blood pressure machine took Resident #247's blood pressure. Staff I returned to the medication cart and began to pour Resident #247's medication. Staff I did not have Cetirizine in the medication cart. Staff I entered Resident #247's room and without hand hygiene administered the medication. Staff I, without hand hygiene walked to central supplies to look for Cetirizine and was unable to find it. Staff I walked to another station and asked the nurse if she had the medication. Staff I was handed keys to the 300 medication cart. Staff I opened the 300 hall medication cart and was unable to find the medication. Staff I returned the keys that were given to her. Staff I return to her medication cart and without hand hygiene removed a nicotine patch from the medication cart. Staff I, without hand hygiene entered Resident #247's room and removed a clear nicotine patch from Resident #247 left arm. Staff I placed a 7 mg (milligram) nicotine patch on Resident #247 right arm. During an interview on 2/25/2025 at 9:47 AM, Staff I, LPN, stated, [Resident #247's Name] order for the nicotine patch is 14 mg. I did not pay attention. That was on me. I should have contacted the provider if I see we do not have the correct dose. Review of Resident #247's physician's order dated 2/21/2024 read, Nicotine Patch 24 hour 14MG/24HR [14 milligrams per 24 hours] apply 1 patch transdermal in the morning for nicotine and remove per schedule. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/2025 at 12:39 PM, the Pharmacist Consultant stated, If a resident has an order of a dose of nicotine and is given another dose in a patch it is considered a medication error. During an interview on 2/25/2025 at 3:39 PM, the Director of Nursing (DON) stated, I expect nursing staff to follow the physician order and if the medication is not in the medication cart the staff should go and look for the medication in central supply or in the medication room. If the medication is not available, she should contact the provider and notify them the medication is not on hand and get further directions. The nurse should be informing the resident how many sprays to administer before giving him the nasal spray and if she sees that he did the first administration incorrectly stop the resident. Review of the policy and procedure titled Medication Administration with a last review date of 1/28/2025 read, Policy: It will be the policy of this facility to administer medications in a timely manner and as prescribed by the physician, unless otherwise clinically indicated or necessitated by other circumstances such as lack of availability of medication or refusals of medication by the resident. Procedure: 3. Medications should be administered in a timely manner and in accordance with the physician orders. 11. Established facility infection control procedures (e.g., handwashing, antiseptic techniques, gloves isolation precautions, etc.) must be followed during the administration of medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523 Based on observations, interviews, and record reviews, the facility failed to ensure that drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional principles for 2 of 6 medication carts and 2 of 6 hallways reviewed for unsecured medications. Findings include: 1) During an observation on [DATE] at 9:43 AM, Resident #47 was lying in bed. There was a white oval tablet with numbers 112 on top of the nightstand. (photographic evidence obtained) During an interview on [DATE] at 9:43 AM, Resident #47 stated, I do not know what that medication is. During an interview on [DATE] at 3:21 PM, the Director of Nursing stated, The medications should not have been unattended in her [Resident #47] room. 2) During an observation on [DATE] at 10:24 AM, Resident #43 was sitting up in bed. There was a bottle of Aspercreme Lidocaine Cream on top of nightstand. (photographic evidence obtained) During an interview on [DATE] at 10:24 AM, Resident #43 stated, The cream is for my pain. 3) During an observation on [DATE] at 10:26 AM, Resident #48 was lying in bed. There was an unlabeled medication cup with a white cream on top of the bedside table. (photographic evidence obtained) During an interview on [DATE] at 10:26 AM, Resident #48 stated, That is cream that the nurse applies to my back area. During an interview on [DATE] at 3:29 PM, the Director of Nursing (DON) stated, Medication should not be left in resident rooms unattended. 4) During an observation on [DATE] at 11:01 AM with Staff D, Licensed Practical Nurse (LPN), of the 100 Hall medication cart, there was an opened Fluticasone Propionate and Salmeterol inhaler with no open or expiration date, an open Humalog vial with no open or expiration date, an open bottle of Dorzolamide 2% eye drops with no open or expire date, and a bottle of Timolol Maleate 0.5% eye drops with no open or expired date. During an interview on [DATE] at 11:03 AM, Staff D stated, Medication should be labeled once it is open and dated with the expiration date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5) During an observation on [DATE] at 11:17 AM with Staff K, LPN, of the 500 hall medication cart, there was an opened Incruse Ellipta inhaler that was not dated with the open or expire date, there was an opened Albuterol inhaler with no open or expiration date and an opened Lantus Solostar insulin pen with no open or expiration date. During an interview on [DATE] at 11:25 AM, Staff K stated, Medication should be dated once it is open. During an interview on [DATE] at 10:58 AM, the DON stated, Nursing staff should be labeling the medication when it is opened with the open date and follow manufacturer guidelines for the expiration date in order to discard the medication. Review of the policy and procedure titled Medication/Biological Storage with a last review date of [DATE] read, Policy: It will be the policy of this facility to store medications, drugs and biologicals in a safe, secure and orderly manner. Procedure: 4. The facility shall not use discontinued, outdated up to including (7-Days) or deteriorated medications, drugs or biologicals. 7 Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes) containing medications, drugs and biologicals shall be locked when not in use.

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49777 Based on interview and record review, the facility failed to ensure residents with allergies were provided foods that were free from allergens for 1 (Resident #297) of 12 residents sampled who had food allergies. Resident #297 had a peanut allergy. On 2/23/2025 at 7:00 PM, Resident #297 was provided with a [NAME] Buddy snack by Staff G, Certified Nursing Assistant. Staff G did not review Resident #297's meal ticket or Resident #297's electronic medical record to determine her allergies. At approximately 10:00 PM Resident #297 consumed several bites of the cookie and began to experience a burning and itching sensation in her throat. Resident #297 notified facility staff and was treated with medication for an allergic reaction. A peanut allergy is a condition that causes the body's germ-fighting immune system to react to peanuts. An allergic response to peanuts usually occurs within minutes after exposure. Peanut allergy signs and symptoms can include skin reactions, such as hives, redness or swelling. Itching or tingling in or around the mouth and throat. Digestive problems, such as diarrhea, stomach cramps, nausea or vomiting. Tightening of the throat and shortness of breath or wheezing. It's one of the most common causes of a life-threatening allergic reaction to food. This life-threatening reaction is known as anaphylaxis. Anaphylaxis is a severe, life-threatening allergic reaction. It can happen seconds or minutes after you've been exposed to something you're allergic to. In anaphylaxis, the immune system releases a flood of chemicals that can cause the body to go into shock. Blood pressure drops suddenly, and the airways narrow, blocking your breathing. The pulse may be fast and weak, and you may have a skin rash. If it is not treated right away, it can be deadly. (Mayo Clinic/Mayoclinic.org) The facility failure to ensure residents with allergies were provided foods that were free from allergens led to the determination of Immediate Jeopardy at a scope and severity of isolated, (J). The facility's actions placed Resident #297, who had a known allergy to peanuts at a likelihood of serious harm, such as difficulty breathing, swelling, anaphylaxis and/or death. The Nursing Home Administrator was notified of the Immediate Jeopardy on February 27, 2025, at 9:22 AM. The Immediate Jeopardy began on February 23, 2025, and was removed on site on February 26, 2025. Findings include: During an interview on 2/24/2025 at 8:20 AM, Resident #297 stated I ate peanuts last night around 10:00 PM and had an allergic reaction. I felt burning in my throat and reported it to nursing. I did not taste the peanuts. The snack was chocolate covered. I received medication for the allergic response. (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/26/25 at 7:44 AM, Resident #297 stated, I ate something the other night with peanut butter in it. I can't see very well in the dark and I opened it, I thought it was a chocolate bar. The aide did not tell me what snacks she gave me. She handed me 2 snacks, a long one and a round one. After 2 bites, I tasted the peanut butter, and I got so scared I would swell up again. I first had this happen a couple of months ago. I had a peanut butter and jelly sandwich, and I had my face and tongue swell up. I did go to the emergency room , and they gave me medicine. They put in an IV (intravenous line) and gave me medicine in that. They told me I shouldn't eat peanuts or peanut butter, anything with peanuts in it. I was very frightened that it was going to happen again, so I got my cane, and I got out of bed and found the nurses, I know I should not have tried to walk on my own, but I was just so afraid that I would swell up again. I told them what happened, that I ate something with peanut butter, they helped me back to bed and called the doctor and gave me Benadryl. I had some itching in my throat, but I didn't have any swelling in my face like the last time it happened. I was really frightened, and I just couldn't see the wrapper. It was dark and it looked like chocolate. The nurse got upset and told me I should have looked at the wrapper myself, maybe I should have. I know it's serious and they told me [in the emergency room] it might get worse the next time. Review of the Admission Record for Resident #297 documented an admitted [DATE] with diagnosis that include major depressive disorder, solitary pulmonary nodule (a small mass of dense tissue on the lung), generalized anxiety disorder, atherosclerotic heart disease of native coronary artery (heart disease) without angina pectoris (chest pain), essential (primary) hypertension (high blood pressure), type 2 diabetes mellitus (high blood sugar), chronic obstructive pulmonary disease (a group of lung diseases that cause breathing difficulty), emphysema (a chronic lung disease making it harder to breathe), and asthma (a chronic lung condition that causes inflammation and narrowing of the airways, making it difficult to breathe). A review of the [electronic medical record name] dashboard for Resident #297 read, Allergies: Peanuts, special instructions: Peanut allergy. Review of Resident #297's progress notes dated 2/23/2025 at 2240 (10:40PM) Interact SBAR (situation, background, assessment, recommendation) read, Situation: The Change In Condition/s reported on this CIC (change in condition) Evaluation are/were: Other change in condition. Nursing observations, evaluation, and recommendations are: Patient stated that she ate half cookie [pre-packaged snack labeled [NAME] Buddy] that contains peanuts and didn't realize it. Patient is not presenting with any s/s (signs and symptoms) of an allergic reaction. Patient states that she feels fine. Benadryl administered per orders. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: New order from [Advanced Registered Nurse Practitioner name], NP (Nurse Practitioner), for Benadryl 25 mg (milligrams) every 6 hrs. (hours) as needed to prevent allergic reaction. Review of Resident #297's physician orders dated 2/23/2025 read, diphenhydramine HCL (Hydrochloride Hydrogen) oral capsule 25 mg (Diphenhydramine HCL) give 1 capsule by mouth every 6 hours as needed for allergies for 14 days. Review of Resident #297's medication administration record (MAR) documented that diphenhydramine HCL oral capsule 25 mg (diphenhydramine HCL) give 1 capsule by mouth every 6 hours as needed for allergies was administered on 2/23/2024 at 2245 (10:45 PM) and 2/24/2025 at 0445 (4:45 AM) (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #297's meal ticket dated 2/24/2025 reads, [Resident #297's Name] Diet: MS (mechanical soft), CCHO (consistent carbohydrate), please send house shake with meal, Food dislikes: ALLERGIC: PEANUTS. During an interview on 2/24/2025 at 2:50 PM, Staff D, Licensed Practical Nurse (LPN) stated 'I worked from 6:45 am to 11:40 PM and Resident [Resident #297's last name] came down the hall walking with her cane to where [Staff E's Name] and I were in the other hallway and said she (Resident #297) had eaten part of a [NAME] buddy and stated. I am allergic to peanuts. We asked what happens when you eat peanuts and the resident stated, I get swelling. [Staff E's name] went to get the Resident's nurse [Staff F's name]. I told the Resident to wait there for the wheelchair. [Staff F's name] brought a wheelchair to her. During a telephone interview on 2/24/2025 at 3:10 PM, Staff E, LPN stated, [Resident #297's name] with a cane was walking down the hallway where [Staff D's name] and I was and stated that she ate a snack that had peanuts in it, and she is allergic to peanuts. I went to get [Staff F's name], the resident's nurse. [Staff F's name] brought a wheelchair to the resident and brought her to her room. During an interview on 2/24/2025 at 3:28 PM, Resident #297, when shown a [NAME] Buddy [a snack that consists of four wafers sandwiched together in a peanut butter mixture and covered with a chocolatey coating] confirmed that was what she ate last night. Review of the Fieldstone Bakery [NAME] Buddy package showed ingredients that included peanut butter and allergy information: Contains wheat, peanuts, soy, milk, egg. May contain tree nuts. [photographic evidence obtained] During an interview on 2/24/2025 at 3:30 PM, the Certified Dietary Manager (CDM) stated A tray ticket is printed for each resident with the diet order, consistency and food allergies listed. Assorted snacks individually wrapped, including cookies and crackers, are placed on a tray and then put on the top of the food carts and delivered to each hallway for the nursing staff to offer residents each evening. During a telephone interview on 2/24/2025 at 4:08 PM, Staff G, Certified Nurse Assistant (CNA) stated, The meal cart comes, and the snacks are on the top of the cart. I will pick up the trays and offer a snack and ask the residents what they want. I gave her (Resident #297) a snack. If a resident has allergies there is a place in the computer that we look at. It will have the allergies listed. I don't recall her having allergies. I did not look over her meal ticket when I picked up her tray. I know close to end of shift {Staff F's name] told me you gave her a [NAME] Buddy. She told me she could not have peanuts. It would have been nice if someone told me. I don't always have time to check on the computer. During a telephone interview on 2/24/2025 at 4:17 PM, Staff F, LPN stated, The meal tray is reviewed by the nurse to make sure the resident is getting the right meal, and the CNA will distribute the snacks. We check if it is a regular diet, mechanical soft, any specifics like allergies to make sure they are not included in the tray. Diet tickets have allergies listed. A nurse came and told me my patient was saying she ate a cookie with peanuts. The resident stated she took a couple of bites and figured it had peanuts. She said it was a [NAME] Buddy. It is our responsibility to know what allergies residents have and not the resident to know what is given to them. (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/25/2025 at 8:27 AM, the Director of Nursing (DON) stated, Everyone, all disciplines are responsible for checking allergies of residents. My expectation is for staff to always verify the resident's diet. The ticket does have allergies listed on the ticket as well as dislikes. For snacks when the CNA or staff give out snacks, they should check the diet on the computer to verify if they have a pureed diet, diet texture, allergies or give someone something that they dislike. During a telephone interview on 2/25/2025 at 8:53 AM, Advanced Practice Registered Nurse #1 (APRN), stated I received a call from the nurse stating [Resident #297's name] had eaten a snack with peanuts and the resident is allergic to peanuts. I was told [Resident #297's name] was not having problems. I ordered Benadryl every 6 hours and to call me if there were any problems. My expectation is for staff to be mindful of allergies to safeguard residents from eating food they are allergic to. During an interview on 2/25/2025 at 9:13 AM, the Administrator stated, Everyone in the facility is responsible to be sure a resident's diet order is followed. The CDM (Certified Dietary Manager) visits the resident and documents any allergies and dislikes. The meal ticket lists allergies. My expectation is for staff from top to bottom to follow the facility's policies and procedures. Allergies need to be checked for meals and snacks. During a telephone interview on 2/25/2025 at 9:48 AM, the Medical Director stated My expectation is the physician orders are followed. Diet orders should be followed for meals and snacks. If an allergen is provided to a resident, the physician needs to be notified and 911 called if the resident is emergent as in anaphylaxis reaction which is life threatening. If a resident does receive an allergen then we should be notified so actions can be taken to make sure residents are kept safe. During a telephone interview on 2/25/2025 at 12:06 PM, APRN #1 stated, Allergic reactions are based on the level of severity to the allergen. The reaction can be from mild, hives and itching up to anaphylaxis, a severe, life-threatening allergic reaction that can occur rapidly after exposure to an allergen. During an interview on 2/26/2025 at 8:25AM, the Registered Dietician (RD) stated There should be a mechanism in place to ensure and monitor food allergies are addressed for each resident. But we do not have a list of resident allergies that go with snacks. There are a whole host of problems that can be a potential issue for food allergies. Peanuts and peanut allergies can affect the immune system causing a reaction for the resident and can result in a life-threatening issue of anaphylaxis which can include dizziness, lightheadedness, constriction of airways, drop in blood pressure, rapid pulse. For some people there could also be a skin reaction such as hives, redness, swelling, itching and tingling; also, for some people it could result in a digestive problem such as diarrhea, stomach cramps, nausea and vomiting. It could also be shortness of breath, runny nose, or tightness of the throat. We should have systems to monitor this. During a telephone interview on 2/26 2025 at 8:35 AM, Medical Doctor #1 stated Peanut allergies can result in facial swelling and anaphylaxis which means closure of her airway. I cannot tell you how long she had the allergy. During an interview on 2/26/2025 at 8:37 AM, the Certified Dietary Manager (CDM) stated There was no snack listing. (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 2/26/2025 at 9:19 AM, APRN #2 stated Peanut allergies can be fatal especially if there is a history of facial swelling. Review of the facility policy and procedure titled Provide Diet to Meets Needs of Each Resident with a last review date of 1/28/2025 read, Policy: The purpose of the food and nutrition services (FNS)/dietary department is to provide high quality, nutritious, palatable and attractive meals in safe, sanitary manner. Food will be prepared in a form to accommodate resident allergies, intolerances, and personal, religious, and prescribed by the attending physician or their designee. The Immediate Jeopardy (IJ) was removed onsite on 2/26/2025 after the receipt of an acceptable IJ removal plan. The facility has completed the following steps to remove the immediate jeopardy. On 02/25/2025, an Ad Hoc [Latin meaning for this] Quality Assurance and Performance Improvement (QAPI) meeting and completed a root cause analysis (RCA) related to the provision of the snacks for Resident #297. The RCA yielded that the facility failed to conduct validation of accuracy of provision of snack/diets. On 2/25/2025, the Director of Nursing, Assistant Director of Nursing and Nurse Consultant completed an audit of 97 of 97 residents for accuracy of prescribed diet and allergies. On 2/25/2025, the Director of Nursing and Dietary Consultant completed an audit of resident allergies listed in the electronic medical record with resident and resident representative interviews to confirm accuracy of allergies listed for 97 of 97 residents. On 2/25/2025, the facility initiated the use of a Diet Type Report from the Electronic Health Record during the provision of snacks and meals to ensure the accuracy of diet order, texture and allergies. On 2/25/2025, the facility initiated the use of an Alternative Diet Tool in the dietary department to ensure residents received diets as ordered by the physician or snacks in the correct form and ensuring resident are not allergic to food items when requestion food items form the kitchen. On 2/25/2025 , the facility initiated the use of a Supervisory Monitoring Tool got facility leadership to validate staff are providing appropriate meals and snack per physician orders and validation of allergies using the Diet Type Report. On 2/26/2025, the facility initiated printing meal tickets in color to highlight the red allergies noted on the tickets. On 2/26/2025, residents with food allergies have snacks labeled by the dietary department for them specifically to ensure allergy requirements are maintained. On 2/26/2025, Director of Nursing ad Assistant Director of Nursing/designee educated staff on: Provide Diet to Meet Needs of Each Resident - Policy and Procedure; Allergies-types of allergies, how they effect individuals, emergency response, the medications commonly used to manage allergic reaction and protecting residents from allergic reactions and accuracy of Diet/Snack education. On 2/27/2025, a review of the facility audits documented the DON/designee and dietary consultant conducted a full house audit of 97 residents to determine accuracy of diets and allergies. On 2/27/2025, review of the facility audit tool titled Diet Type Report documented audits were completed for 2/25/2025 and 2/26/2025. On 2/27/2025, review of the resident meal tickets for 12 of 12 residents with allergies were reviewed and allergies were printed in red. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge Healthcare and Rehabilitation Center	635 SE 17th Street Ocala, FL 34471

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/27/2025, a review of the training and education documented 53 of 53 Certified Nursing Assistants, 23 of 23 Licensed Practical Nurses, 5 of 5 Registered Nurses, 23 of 23 rehabilitation therapy staff, 2 of 2 social services staff, 3 of 3 activities staff, 13 of 13 dietary staff, 11 of 11 housekeeping staff and 10 of 10 administrative staff received education on mechanically altered diets/ allergies, emergency response for allergic reactions, medications for allergies, common allergy symptoms in Long Term-Care Residents, and verifying the correct diets/snacks for patients. During staff interviews conducted 2/26/2025 through 2/27/2025, 5 Licensed Practical Nurses, 2 Registered Nurses, 9 Certified Nursing Assistants, 8 rehabilitation therapy staff, 5 dietary staff, 6 environmental staff, the Social Service Assistant, the Activities Director, Registered Dietician, and the Admissions Director all verified receiving the training and verbalized understanding of mechanically altered diets, resident allergies, allergic reactions and verifying allergies and diet prior to providing meals and snacks.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44571 Based on observations, interviews, and record reviews, the facility failed to ensure food was safely and properly stored and labeled in the walk-in cooler and freezer and that all equipment was clean, in good repair, or disposed of properly. Findings include: A tour was conducted of the kitchen on 2/23/25 at 9:07 AM. An observation was made of the hand washing sink with no paper towels available and of a live roach on the overflowing trash can located at the hand washing sink. A walk-through tour of the kitchen was conducted on 2/23/2025 at 9:12 AM with Staff M, the morning cook. An observation was made of a large pan of raw meat product in the walk-in cooler with no label or date. An observation was made of two large boxes on the floor in the walk-in freezer. An interview was conducted with Staff M, morning cook on 2/23/2025 at 9:15 AM. Staff M stated that the pan of raw meat was pork and that she had not dated or labeled it yet. Staff M stated that the boxes should not have been on the floor in the freezer. A follow-up tour was made to the kitchen on 2/24/2025 at 6:30 AM with the Certified Dietary Manager (CDM). There was an observation of a reach-in cooler located next to the cooking range with an out of order handwritten sign dated 8/29/23. An observation was made of food splashes, a buildup of dirt, and spills located on the sides of the reach-in cooler, the wall behind the cooking range, on the bottom and front of the cooking range, on the interior and exterior of the convection oven, on the storage racks located throughout the kitchen and on the floor area. An out of order handwritten sign was observed on a two-compartment sink. There were two dirty rags observed to be draped over the 3-compartment sink. An interview was conducted with the Certified Dietary Manager (CDM) on 2/24/2025 at 6:37 AM related to pest, equipment ,and food splashes and spills. The CDM stated that pest sighting are reported to maintenance, and she confirmed the spills and splashes on the equipment and walls. The CDM confirmed the out of Order signs were placed on unusable equipment in the kitchen. The CDM stated that she acquired the dirty equipment when she started working approximately three weeks ago. The CDM stated it is her expectation that all policies are followed whether she is personally in the department or not. Review of the policy and procedure titled Food Delivery and Storage, last reviewed on 1/28/2025, read, Policy: It will be the policy of this facility that foods shall be received and stored in a manner that complies with safe food handling practices. Procedure: 6. Food in designated dry storage areas shall be kept off the floor and clear of sprinkler heads, sewage/waste disposal pipes and vents. 8. All foods stored in the refrigerator or freezer will be covered, labeled and dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy and procedure titled Refrigerated Storage, last reviewed on 1/28/2025, read, Policy: Foods and Nutrition Services (FNS) staff should maintain safe refrigerated storage areas. Refrigerated items should be properly stored, labeled and maintained by dietary staff. Procedure: 4. Dietary staff will label, date, and monitor refrigerated food, including, but not limited to leftovers to ensure use by use-by dates, or frozen (where applicable) or discarded.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51447 Based on observations, interviews and record reviews, the facility failed to maintain complete and accurately documented medical records for 3 (Resident #2, #301, and #397) of 7 residents reviewed for intravenous lines, medication administration and unnecessary medications. Findings include: Review of the admission record documented that Resident #397 was admitted to the facility on [DATE] with diagnosis that included metabolic encephalopathy, dysphagia, oropharyngeal phase, unspecified combined systolic (congestive) and diastolic (congestive) heart failure, morbid (severe) obesity due to excess calories, muscle weakness, anxiety disorder, unspecified, major depressive disorder, recurrent, moderate, acquired absence of kidney, essential (primary) hypertension, chronic kidney disease, unspecified, personal history of other venous thrombosis and embolism, and peripheral vascular disease. Review of Resident #397's Medication Administration Record (MAR) documented a physician's order with a start date of 1/21/2025 that read, Change transparent dressing. Measure external catheter length, every night shift every wed (Wednesday). Observe site for signs and symptoms of infection, infiltration, and/or extravasation and as needed for leakage, loosening or soiling of dressing. Review of Resident #397's MAR for the month of February 2025 documented a dressing change for central line was done on 2/12/2025. During an observation on 2/23/2025 at 10:30 AM, Resident #397 was observed lying in bed with the head of bed elevated. She had a single lumen peripherally inserted central catheter (PICC) line in her right upper arm with a transparent dressing dated 2/9/2025. The dressing was intact around the insertion site but was noted to be partially lifted on the bottom right inside corner and brownish stains on the outside of the dressing. During an interview on 2/23/2025 at 10:30 AM, Resident #397 stated, I have an IV (intravenous line) for my antibiotics because I have an infection. During an interview on 2/26/2025 at 1:04 PM, Staff N, License Practical Nurse (LPN), stated, I charted that the dressing was changed on 2/12/2025 because when I went to change it, I realized that it had been changed on 2/9/2025 and the dressing would still be good for 7 days from when it was changed. A checkmark in PCC (point click care), would indicate that the medication was given or the task was done. I should not have documented that the dressing was changed but should have made a progress note about why it wasn't done so that my documentation would be accurate. Review of the physician's order for Resident #397 dated 2/13/2025 read, Discontinue IV line right upper extremity [RUE] one time only for dc [discontinue]. Review of the Medication Administration Record (MAR) for Resident #397 documented the PICC line was discontinued on 2/13/2025 by [Staff O's initials] at 1358 [1:58 PM]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/2025 at 9:19 AM, Staff O, Licensed Practical Nurse (LPN) stated, When I documented that the PICC line was discontinued it was a mistake by me. I typically don't check off a task until I have completed the task. During an interview on 2/24/2025 at 2:41 PM, the Director of Nursing (DON) stated, I saw the dressing on her arm it was dated in purple, but I can't recall the date that was written. I would expect nursing staff to document the information accurately in the residents chart. Review of the policy and procedure titled Charting and Documentation with a last review date of 1/28/2025 read, Policy: It is the policy of this facility that services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's clinical record as is needed. Procedure: 1. Observations, medications administered, services performed, etc., should be documented in the resident's clinical records. 3. Entries into the clinical record should be made by the appropriate staff members. Staff providing care and services to the resident may contribute to the overall documentation in the clinical record in accordance with state and federal laws. 46523 2) Review of Resident #2's physician's order dated 1/19/2025 read, Midodrine HCl (Hydrochloride Hydrogen) Tablet 10 mg (milligram) give 1 tablet by mouth three times a day for hypotension hold for SBP (systolic blood pressure) above 140. Review of Resident #2's Medication Administration Record (MAR) for the month of February 2025 for Midodrine 10mg did not include blood pressure readings for the following days at 0900 [9:00 AM] 2/4/2025, 2/6/2025, 2/10/2025, 2/12/2025, 2/13/2025, 2/15/2025, 2/18/2025, 2/19/2025, 2/20/2025, 2/21/2025, 2/22/2025. At 1300 [1:00PM] 2/1/2025, 2/4/2025, 2/6/2025, 2/8/2025, 2/10/2025, 2/12/2025, 2/13/2025, 2/15/2025, 2/18/2025, 2/19/2025, 2/20/2025, 2/21/2025. At 1700 [5:00PM] 2/1/2025 and 2/8/2025. Review of Resident #2's physician's order dated 12/12/2024 read, Isosorbide Mononitrate ER (extended release) Tablet Extended Release 24 Hour 30 MG give 1 tablet by mouth one time a day related to essential (primary) hypertension Hold for SBP <120 (systolic blood pressure less than 120). Review of Resident #2's MAR for the month of February 2025 for Isosorbide Mononitrate ER 30 mg did not include blood pressure readings for the following days at 0900 2/4/2025, 2/6/2025, 2/10/2025, 2/12/2025, 2/13/2025, 2/15/2025, 2/18/2025, 2/19/2025, 2/20/2025, 2/21/2025 and 2/25/2025. During an interview on 2/25/2025 at 12:39 PM, Staff H, Registered Nurse (RN), stated, Normally we will document the blood pressure, and it will show on the MAR. During an interview on 2/26/2025 at 10:53 AM, the Director of Nursing stated, Nursing staff was asked why she just put NA (not applicable) instead of the blood pressure and she said she took the blood pressure just didn't show on the MAR. If the system is asking for blood pressure then it should be included in the MAR. 41334 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #15's admission record documented diagnoses that included non-st elevation (nstemi) myocardial infarction (heart attack), chronic obstructive pulmonary disease, atrial fibrillation (an irregular heartbeat), type 2 diabetes mellitus without complications, chronic systolic (congestive) heart failure, major depressive disorder, and anxiety disorder. Review of Resident #15's physician's order dated 2/02/2025 reads, Alprazolam Tablet 0.25 MG (milligrams): Give 1 tablet by mouth at bedtime for restlessness related to anxiety disorder, unspecified. Review of Resident #15's physician's order dated 2/20/2025 reads, Alprazolam Tablet 0.25 MG (milligrams): Give 1 tablet by mouth as needed for restlessness related to anxiety disorder, unspecified) for 14 Days One tablet every HS (hour of sleep) as needed. . Review of Resident #15's February Medication Administration Record (MAR) documented behavior monitoring as n/a (not applicable) on 2/2/2025, 2/4/2025, 2/5/2025, 2/6/2025, 2/7/2025, 2/11/2025, 2/13/2025, 2/14/2025, 2/15/2025, 2/18/2025, 2/19/2025, 2/20/2025 and 2/24/2025 under the behavior code for the day shift and on 2/3/2025, 2/4/2025, 2/5/2025, 2/7/2025, 2/11/2025, 2/17/2025, 2/18/2025, 2/19/2025, 2/21/2025, 2/22/2025, and 2/23/2025 on the evening shift. Review of Resident #15's February MAR reads, Behavior Code - 0 = No behaviors. There is no code n/a. During an interview on 2/25/2025 at 7:00 PM, Staff F, Licensed Practical Nurse (LPN), stated, I do monitor behaviors, documenting NA was a mistake, that was supposed to be no behaviors; that's what I meant. I should have used the numbers and not put that [n/a]. It would be incorrect documentation; I should have documented this correctly. During an interview on 2/26/2025 at 7:10 AM, Staff H, LPN, stated, NA for behavior monitoring, did I do that? Well, I guess that is not what I'm supposed to do, I see I should put 0 in that line. It was not documented correctly, it should be. During an interview on 2/26/2025 at 1:10 PM, the DON stated, All behaviors should be monitored and documented correctly. The nurses should put 0 which means no behaviors, not n/a. This would be incorrect documentation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46523 Based on observations, interviews, and record reviews, the facility failed to follow infection control standards during for hand hygiene for 4 of 7 residents reviewed during medication administration and follow enhanced barrier precautions for 1 (Resident #78) of 2 for enteral medication administration. Findings include: During an observation on 2/25/2025 at 8:39 AM, Staff H, Registered Nurse (RN), exited a resident room and without performing hand hygiene and began to pour medications for Resident #36. Staff H entered Resident #36's room and without performing hand hygiene handed Resident #36 her medication cup. Staff H handed Resident #36 her Styrofoam cup which contained water. Staff H exited Resident #36's room without performing hand hygiene and returned to the medication cart. Staff H, without hand hygiene, began to pour Resident #58's medication. Staff H entered Resident #58's room and without hand hygiene handed Resident #58 medication cup. Staff H handed Resident #58 his Styrofoam cup. Staff H handed Resident #58 his nasal spray. Staff H performed hand hygiene before exiting Resident #58's room. During an interview on 2/25/2025 at 8:52 AM, Staff H, RN, stated, I perform hand hygiene between every two residents. During an observation on 2/25/2025 at 9:12 AM, Staff I, License Practical Nurse (LPN), exited Resident #67's room and did not perform hand hygiene. Staff I was holding a blood pressure machine which she placed on top of the medication cart without sanitizing it. Staff I entered Resident #247's room and, without performing hand hygiene or sanitizing the blood pressure machine, took Resident #247's blood pressure. Staff I returned to the medication cart and began to pour Resident #247's medications. Staff I did not have Cetirizine in the medication cart. Staff I entered Resident #247's room and, without hand hygiene, administered the medications. Staff I, without hand hygiene walked to central supply to look for Cetirizine and was unable to find it. Staff I walked to another station and asked the nurse if she had the medication. Staff I was handed keys to the 300 medication cart. Staff I opened the 300 hall medication cart and was unable to find the medication. Staff I returned the keys that were given to her. Staff I return to her medication cart and, without hand hygiene, removed a nicotine patch from the medication cart. Staff I, without hand hygiene, entered Resident #247's room and removed a clear nicotine patch from Resident #247's left arm. Staff I placed a 7 mg nicotine patch on Resident #247 right arm. Staff I performed hand hygiene when exiting Resident #247 room. During an interview on 2/25/2025 at 9:47 AM, Staff I stated, I should have done hand hygiene between residents and when coming back from the supply room. I should have sanitized the blood pressure cuff between uses. 2) During an observation on 2/25/2025 at 10:08 AM, Staff J, LPN, entered Resident #78's room which had an enhanced barrier sign posted on his room door and a bin with personal protective equipment outside of the room. Staff J donned gloves but did not don a gown. Staff J administered Resident #78's medications via the gastric tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/2025 at 12:19 PM, Staff J, LPN, stated, I forgot to do one step. I should have donned a gown before coming into contact with the gastric tube. I was nervous. Review of Resident #78's physician's order dated 1/28/2025 read, Requires enhanced barrier precautions every shift for dialysis and g-tube related end stage renal disease. During an interview on 2/25/2025 at 3:38 PM, the Director of Nursing stated, Staff is expected to perform hand hygiene in between each resident. If the nursing staff is coming into close contact with a resident on enhanced barrier precautions they should wear gloves and gown when providing care. Blood pressure machines should be wiped down and sanitized between each use. Review of the policy and procedure titled, Hand Hygiene with a last date of 1/28/2025 read, Policy: This facility considers hand hygiene the primary means to prevent the spread of infections. Procedure: 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 5. Use an alcohol-based hand rub containing at least 62% alcohol or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents. Review of the policy and procedure titled, Enhanced Barrier Precautions with a last review date of 1/28/2025 read, Policy: It will be the policy of this facility to implement enhanced barrier precautions for preventing transmission of novel or targeted multidrug-resistant organisms. Definitions: Enhanced barrier precautions (EBP) refers to the use of gown and gloves for certain residents during specific high-contact resident care activities. Procedure: 4. For residents for whom EBP are indicated, EBP is employed when performing the following High contact resident care activities. g. Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. Review of the policy and procedure titled Infection Prevention and Control Program with a last review date of 1/28/2025 read, Policy: The primary mission is to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections.