| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 105262 | A. Building<br>B. Wing | 04/10/2026 |

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| Blue Lake Post Acute | 991 E New York Ave<br>Deland, FL 32724 |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>Based on interviews and record review, the facility failed to designate a fullˆtime Director of Nursing (DON) as required, leaving the position vacant from 1/19/26 through 4/5/26. The findings include:During the entrance conference on 4/6/26 at 9:40 a.m., the Administrator was asked to identify the facility's DON. He named the current DON and stated that today, 4/6/26, was her first day back. He confirmed she had resigned in January 2026 and returned to the position on 4/6/26.On 4/7/26 at 8:00 a.m., the DON was interviewed and was asked who had been designated as the facility's DON from the time she resigned in January 2026 until her return on 4/6/26. She stated she did not know who was designated during that period.On 4/7/26 at 11:10 a.m., the Administrator was interviewed again and was asked whether anyone had been designated as the DON from the current DON's resignation in January 2026 through 4/5/26. He stated he was not sure and believed the DON at a sister facility was overseeing things but confirmed he had only been in his role for two weeks.On 4/7/26 at 2:00 p.m., Rehabilitation Director K was interviewed. He stated he had worked at the facility for a little over a year. When asked who the DON was from January 2026 until the current DON returned on 4/6/26, he stated he did not know. When asked who he collaborated with during that time, he stated he reported concerns to the Unit Manager, Licensed Practical Nurse (LPN) D.On 4/7/26 at 2:20 p.m., the Regional Registered Nurse Consultant was interviewed. She stated the DON at a sister facility had been overseeing things. When asked if that individual had been formally designated as the DON for this facility, she stated no.On 4/9/26 at 10:34 a.m., the Consultant Pharmacist was interviewed. She stated she normally sent Medication Regimen Reviews (MRRs) to the DON and the Administrator. When asked who she sent her March 2026 reports to, she stated she sent them to LPN D/Unit Manager because she believed LPN D had been filling in as the interim DON. She stated she had not yet met the newly returned DON.On 4/9/26 at 2:00 p.m., the Advanced Practice Registered Nurse (APRN) was interviewed. She stated from January 2026 until the DON's return on 4/6/26, she coordinated resident care with the team, specifically LPN/Unit Manager D and LPN H.A review of the DON's personnel record revealed a resignation letter dated 1/18/26 stating she was resigning her position as Director of Nursing effective immediately. A second document, dated 3/30/26, was an offer of employment for the DON position with a start date of 4/6/26, signed by the DON on 3/30/26.A review of the facility's job description for the Director of Nursing position (revised 12/18/25), revealed the DON was responsible for the overall leadership, direction, and management of nursing services, including clinical oversight, staff supervision, regulatory compliance, and coordination of resident care. |

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

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

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>Based on observation, interviews, and record review, the facility failed to ensure that nurse staffing information posted for public viewing was current.The findings include:On 4/9/2026 at 9:31 AM, an observation at the reception desk revealed the posted nurse staffing information reflected a date of 4/1/2026, which was not current. There was no evidence that updated staffing information for the day of observation was available for residents, visitors or the public to review.During an interview with the facility's Scheduler on 4/09/2026 at 10:56 AM, she stated she was the only individual responsible for posting daily staffing hours and reported that she attempted to complete staffing sheets in advance for days she was not present, typically on weekends.In a separate interview on 4/10/2026 at 2:02 PM, the Administrator stated he was in the process of training the Scheduler to perform the staffing posting duties.A review of the Scheduler's job description, dated 12/18/2025, revealed that the Scheduler was responsible for creating and maintaining accurate staffing schedules for nursing and other facility departments to ensure adequate coverage. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to 1) Provide evidence of an ongoing water management program for the entire facility, 2) Ensure alcohol-based hand sanitizer dispensers were not expired on all wings of the facility, 3) Ensure enteral nutrition tubing was not exposed to potential pathogens in the environment for one (Resident #9) of one resident receiving continuous tube feeding, and 4) Ensure one (Resident #5) of one resident reviewed out of four residents with urinary catheters, received appropriate care for handling the tubing and collection bag to prevent the potential for infection in a sample of 34 active residents. The findings include:<br><br>1.In an interview on 4/08/26 at 3:15 PM with the Infection Preventionist and the Unit Manager-in-training for the Infection Preventionist role, they were asked who was responsible for the facility water management program to demonstrate measures to minimize the risk of Legionella and other opportunistic pathogens. They indicated the water management program oversight was the responsibility of the Administrator.<br><br>On 4/09/26 at 10:45 AM, the Administrator was asked about the facility's water management program. He stated he had only been in his position for a few weeks. He said the water management was a contracted service that was maintained by the previous Maintenance Director. He went on to say they did not have any documentation of the water management program because they believed that documentation was taken by the Maintenance Director when he left last week. During the same interview, the Regional Nurse indicated they were attempting to contact the water management company to retrieve evidence of the program.<br><br>On 4/10/26 at 10:00 AM, the Administrator and the Regional Nurse were asked if they retrieved any evidence of a water management program. They said they were unable to provide evidence of the water management program. Failure to maintain an effective water management program demonstrates an inability to minimize the risk of Legionella and other opportunistic pathogens in building water systems.<br><br>2.On 4/06/26 at 9:12 AM, an observation of the foaming alcohol-based hand sanitizer (ABHS) in rooms [ROOM NUMBERS] revealed an expiration date as follows: EXP 2026/03/25. Observation of the ABHS in the hallway outside of room [ROOM NUMBER] on 4/08/26 at 4:32 PM, revealed an expiration date as follows: EXP 2026/03/25. (Photographic evidence obtained)<br><br>On 4/08/26 at 3:30 PM, the IP was asked who replaced the dispensers for ABHS. The IP said the housekeeping supervisor was responsible for changing the ABHS dispensers throughout the facility. The IP further stated they had a dispenser in each resident room and others in various spots in the hallways.<br><br>In an interview with the Housekeeping Supervisor on 4/09/26 at 10:50 AM, he was asked if he was responsible for replacing the ABHS dispensers and he replied yes. He was asked to describe the process for monitoring those that needed replacement due to being empty or expired. He said he checked them during his maintenance rounds every day he was in the facility. He said he did not have a set routine for replacement and when asked if he monitored the expiration dates he replied, no. Further observation of a dispenser in the 100-wing hallway revealed the expiration date was not visible on the bottle. He acknowledged he did not note the expiration dates for the ABHS. After removing the bottle from the dispenser, he explained that some bottles had the expiration date at the<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | base of the bottle where it attached to the dispenser; therefore, the expiration date would not be visible unless the bottle was removed from the dispenser. When asked if he had any tracking for ABHS use to help determine how often the ABHS dispensers needed to be replaced, he replied that he did not keep track of usage or any timeframes for replacement based on expiration dates. The Housekeeping Supervisor performed an inventory count of all dispensers at that time. The facility had a total of 27 ABHS dispensers.<br><br>ABHS are regulated by the United States Food and Drug Administration. FDA regulations require applicants to provide a stability testing date with expiration date. Expiration dates reflected the time period for which the product retained is strength, quality, and purity. (retrieved from www.fda.gov 04/14/26)<br><br>3.Observation of the enteral nutrition tubing for Resident #9 on 4/08/26 at 9:21 AM, revealed the end of the tubing that connected directly to the tube entering the resident's abdomen was hanging over a pole with the pump, tube feeding and water flush tubing. The end of the tubing that connected to the resident's feeding tube was exposed to air and not protected with a cover or cap to prevent contamination. Licensed Practical Nurse (LPN) F was asked if the end of the tubing was intended to be left open for contamination and she said she did not think so, and There should probably be a cap for it somewhere.<br><br>A review of the resident's medical record revealed orders for indicating that she received her nutrition via enteral (tube) feeding continuously for 20 hours a day. The feeding was turned off from 8:00 AM to 12:00 PM daily. The orders also indicated that Resident #9 received medications via the tube at 9:00 AM.<br><br>A review of the care plan with a target date of 7/16/26, revealed that Resident #9 required an enteral tube feeding G (gastrostomy) tube related to dysphagia (difficulty swallowing) with late effect cerebral vascular accident (CVA - stroke). One of the goals of the care plan was that the resident be free of side effects or complications related to tube feeding.<br><br>In an interview with the IP on 4/09/26 at 11:00 AM, she was asked about expectations for infection prevention as it related to tube feeding. She stated the end of the tubing should be protected by a cap when not in use.<br><br>A review of the Infection Prevention and Control Policy and Procedure (effective 2/01/24 and reviewed 3-31-26), revealed a policy statement showing that the infection prevention and control program was established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Prevention of Infection listed important facets to include institute measures to avoid complications .<br><br>4.On 04/06/2026 at 10:35 a.m., Resident #5 was observed lying in bed with his eyes closed. He did not respond to his name being called. His indwelling urinary catheter (Foley) drainage bag was observed on the right side of the bed, resting on the floor. (Photographic evidence obtained)<br><br>On 04/06/2026 at 12:39 p.m., Resident #5 was observed sitting up in bed, awake and eating lunch. His urinary catheter drainage bag was again observed resting on the floor. (Photographic evidence obtained)<br><br>On 04/07/2026 at 10:42 a.m., Resident #5 was observed lying in bed with his eyes closed. He did not<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | respond to his name being called. The urinary catheter drainage bag was observed resting on the floor. (Photographic evidence obtained)<br><br>On 04/08/2026 at 9:47 a.m., Resident #5 was observed lying in bed with his eyes closed. He did not respond to his name being called. The urinary catheter drainage bag was observed resting on the floor. (Photographic evidence obtained)<br><br>The catheter drainage bag remained in contact with the floor across multiple observations, creating a risk for contamination and infection. These observations were not consistent with the facility's policy requiring catheter tubing and drainage bags to be kept off the floor.<br><br>During an interview with Certified Nursing Assistant (CNA) G on 04/08/2026 at 10:35 a.m., she stated her training for urinary catheter care included cleaning around the tubing, ensuring there were no kinks in the tubing, and emptying the bag typically twice per shift. When asked about infection control practices, she stated staff members wore a gown and gloves during care. When asked if a urinary catheter drainage bag should be allowed to touch or rest on the floor, she stated no.<br><br>On 04/09/2026 at 9:40 a.m., during an interview with the Director of Nursing, she stated infection control expectations included staff wearing gloves and a gown during care and performing hand hygiene before and after care. She further stated the catheter drainage bag should be maintained below the level of the bladder and should not rest on the floor.<br><br>A record review for Resident #5 revealed diagnoses including benign prostatic hyperplasia and flaccid neuropathic bladder.<br><br>A review of the quarterly Minimum Data Set (MDS) assessment revealed:<br><br>Section C: Brief Interview for Mental Status (BIMS) score of 6 out of 15 possible points, indicating severe cognitive impairment<br><br>Section E: No behaviors documented, including no refusals of care<br><br>A review of current physician orders included:<br><br>12/31/2025: Change Foley catheter as needed for leakage, blockage, or dislodgement<br><br>12/31/2025: Drain Foley catheter bag every shift and as needed<br><br>12/31/2025: Provide Foley catheter care daily and as needed<br><br>12/31/2025: Foley catheter to drainage bag for diagnosis of neurogenic bladder<br><br>A review of the person-centered care plan revealed:<br><br>Focus (09/14/2018, revised 04/06/2026): Resident has a Foley catheter related to neurogenic bladder<br><br>Goal (revised 04/06/2026): Resident will remain free from catheter-related trauma and show no signs or symptoms of urinary tract infection<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Interventions (revised 04/06/2026): Monitor and document for pain or discomfort; monitor, record, and report signs and symptoms of urinary tract infection<br><br>A review of the facility's policy titled Catheter Care, Urinary (effective 2001), revealed the purpose was to prevent urinary catheter-associated complications, including urinary tract infections. The policy directed that catheter tubing and drainage bags were to be kept off the floor. |

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| F 0638<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Assure that each resident?s assessment is updated at least once every 3 months.<br><br>Based on interview and record review, the facility failed to ensure six (Residents #7, #8, #38, #45, #52, and #59) of twentyˆfour resident records reviewed, contained evidence of a quarterly assessment completed using the Stateˆspecified instrument approved by CMS (Centers for Medicare and Medicaid Services) at least every three months. The findings include:<br><br>A review of Resident #8's medical record revealed that the minimum data set (MDS) quarterly assessment was due on 2/18/26. As of the recertification survey conducted from 4/6/26 – 4/10/26, there was no evidence the assessment had been completed.<br><br>A review of Resident #38's medical record revealed that the quarterly MDS assessment was due on 2/14/26. As of the recertification survey conducted from 4/6/26 – 4/10/26, there was no evidence the assessment had been completed.<br><br>A review of Resident #52's medical record revealed that the quarterly MDS assessment was due on 2/21/26. As of the recertification survey conducted from 4/6/26 – 4/10/26, there was no evidence the assessment had been completed.<br><br>On 4/9/26 at 1:00 p.m., Licensed Practical Nurse (LPN)/MDS Coordinator H was interviewed regarding her process for completing MDS assessments. (The MDS assessment is the Federally required clinical assessment used to determine a resident's functional status, care needs, and the facility's reimbursement rate. The MDS Coordinator is responsible for gathering interdisciplinary information, coding the assessment accurately, and submitting it within required timelines.) LPN H stated she began working as the MDS Coordinator for both this facility and a sister facility approximately two years ago. She stated when she assumed the role, assessments were already behind. She reported that another nurse had been trained to complete MDS assessments at the sister facility but left after nine months, resulting in both buildings' MDS responsibilities returning to her around January 2026. She stated she had been trying to catch up. LPN H was asked to confirm whether the quarterly MDS assessments for Residents #7, #8, #38, #45, #52, and #59 had been completed by their Assessment Reference Dates (ARDs). She confirmed they were late and had not been completed.<br><br>On 4/10/26 at 12:00 p.m., LPN H was asked to provide the Resident Assessment Instrument (RAI) Manual instructions for timing, completion, and encoding of MDS assessments. She stated she would need to locate them.<br><br>On 4/10/26 at 12:30 p.m., LPN H stated she had not located the RAI Manual instructions and did not have a facility policy regarding MDS completion or transmission. She stated she was searching online for the RAI Manual instructions and she confirmed these materials were not readily available.<br><br>A record review revealed that Resident #59's last quarterly MDS assessment was completed on 12/3/25. The facility's electronic medical record (EMR) system showed the next quarterly assessment was due by 3/5/26. As of 4/9/26, the assessment was 21 days overdue. Failure to complete assessments timely impacts the facility's ability to ensure critical indicators of gradual change in a resident's status are monitored.<br><br>A record review revealed that Resident #7's quarterly MDS assessment with an ARD of 2/16/26 remained incomplete as of 4/9/26, exceeding the required ARD +14-day completion timeframe.<br>(continued on next page) |

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| F 0638<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A record review revealed that Resident #45's quarterly MDS assessment with an ARD of 3/4/36 remained incomplete as of 4/9/26, exceeding the required ARD + 14-day completion timeframe.<br><br>On 4/9/26 at 1:00 PM, LPN H/MDS Coordinator stated she was aware of the late completion timeframe of the MDS assessments and she was trying to catch up.<br><br>According to the Resident Assessment Instrument (RAI)User's Manual, quarterly assessments must be completed no later than 14 days after the Assessment Reference Date (ARD). |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>The facility failed to ensure that drug regimen irregularities identified by the Consultant Pharmacist were reviewed and acted upon by the attending physician, Medical Director, and Director of Nursing (DON). This failure resulted in unaddressed medication irregularities for four (Residents #5, #38, #6 and #2) of seven residents reviewed for their medication regimens. This created the potential for adverse drug outcomes.<br><br>The findings include:<br><br>1.The monthly pharmacy medication reviews for the past six months were requested. On 4/8/26 at 12:45 p.m., the DON provided a binder containing the monthly pharmacy medication reviews for October, November and December of 2025. She stated she needed to request the January, February and March 2026 reviews from the pharmacy because she wasn't here those months and did not know where they were located. She later returned with three separate stacks of paper and stated these were the monthly pharmacy medication reviews for January, February and March of 2026. When asked whether these reviews had been reviewed and acted upon by the attending physician, Medical Director or DON, she replied, No, I don't think they were. I just requested these from the pharmacy representative.<br><br>During a record review for Resident #5, it was revealed that his medication regimen review was conducted by the Consultant Pharmacist on 1/7/26 and included the following irregularities: Vitamin D 5,000 units was started on 12/31/25, and the pharmacist questioned whether the 50,000ˆunit daily dose of Vitamin D, active since 12/25/25, should be discontinued. The resident had been receiving Zinc 220 milligrams (mg) (50 mg elemental zinc) twice daily since 11/5/25, and the pharmacist noted prolonged exposure above the tolerable upper intake level may suppress immunity, decrease high-density lipoprotein (HDL) cholesterol, and cause anemia and copper deficiency, recommending evaluation of continued need. A subsequent medication regimen review dated 3/12/26, again identified two active Vitamin D orders (50,000 units daily and 5,000 units daily) and recommended discontinuing the 50,000ˆunit dose. The pharmacist again noted the excessive zinc dosing and requested evaluation. The pharmacist also requested evaluation of an as needed (PRN) Ativan 0.5 mg order for anxiety, including diagnosis, behaviors, usage patterns, and continued need. Record review did not reveal any evidence that these irregularities had been reviewed or acted upon.<br><br>During a record review for Resident #38, it was revealed that his medication regimen review was conducted by the Consultant Pharmacist on 2/5/26 and included the following irregularities: the resident was receiving Zoloft (for depression) 75 mg daily, Trazodone (for depression) 100 mg at bedtime, Xanax (for anxiety/panic disorder) 1 mg at bedtime, and Buspar (for anxiety) 10 mg three times daily. The pharmacist requested evaluation of the current doses and consideration of a gradual dose reduction, with instructions to document the clinical rationale in the record or physician progress notes. Record review did not reveal any evidence that these irregularities had been reviewed or acted upon.<br><br>During a record review for Resident #6, it was revealed that her medication regimen review was conducted by the Consultant Pharmacist on 3/12/26 and included the following irregularity: Alendronate 70 mg weekly was scheduled for administration at 9:00 a.m., and the pharmacist noted that bisphosphonates should be administered in the morning with a full glass of water, at least 30 minutes before the first food, beverage, or medication, and with the resident remaining upright for at (continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | least 30 minutes after administration. The pharmacist requested clarification of the order to adjust the dosing time. Record review did not reveal any evidence that this irregularity had been addressed.<br><br>On 4/10/26 at 10:05 a.m., during an interview with Licensed Practical Nurse (LPN) O, she confirmed she was caring for Resident #6. She reviewed the resident's order for Alendronate 70 mg weekly and stated it was administered on Sundays at 9:00 a.m. She stated the medication could be given between 8:00 a.m. and 10:00 a.m. When asked about special procedures required for administering Alendronate, she stated there were none. She reported that in previous workplaces she recalled giving it on an empty stomach and having the resident remain upright for 30 minutes afterward, but confirmed this was not occurring for Resident #6, who would have already eaten breakfast by the time the medication was administered. She was not aware of any required amount of water or of any pharmacy recommendations regarding the scheduling of this medication.<br><br>On 4/9/26 at 9:40 a.m., during an interview with the Administrator and the DON, they were asked about the facility's system for receiving and acting on monthly pharmacy medication regimen review recommendations. The DON stated prior to her resignation on 1/18/26, the pharmacy emailed her the monthly review reports with recommendations, which she reviewed with the Advanced Practice Registered Nurse (APRN) and used to update resident orders. She confirmed she returned to the DON position on 4/6/26. When asked who had been reviewing the monthly pharmacy recommendations from 1/18/26 through 4/5/26, the Administrator stated the Unit Manager/LPN D has been receiving them, adding that he believed she was getting the emails or could access the reports through the pharmacy's website. When asked how the January, February, and March 2026 reports were obtained on 4/8/26, the DON stated she contacted the pharmacy representative, who emailed the reports to the Social Services Director for printing. The DON stated the January, February, and March 2026 reports were not in the facility prior to 4/8/26 and had not been reviewed by any staff member or practitioner. She stated she asked the APRN to begin reviewing them on 4/8/26, when she became aware they had not been reviewed. She stated based on her prior experience, Medication Regime Review (MRR) recommendations were typically reviewed within one week of receipt. She confirmed that the January, February, and March 2026 recommendations had not been reviewed by any staff member, APRN, or physician. She stated the facility did not have a policy regarding Medication Regimen Review.<br><br>On 4/9/26 at 10:34 a.m., an interview was conducted with the Consultant Pharmacist who stated she completed her first monthly pharmacy medication review for the facility on 3/12/26 following the retirement of the previous consultant pharmacist and she performed all monthly reviews in person. She stated she emailed the March 2026 report to LPN D/Unit Manager and the Administrator, believing LPN D was filling in for the DON. She stated she had not yet met the newly returned DON. She stated the retiring pharmacist informed her that the facility typically kept a binder of monthly reports; however, when she arrived in March 2026, staff reported they did not have the January or February 2026 reports. She explained to LPN D how to reprint the reports and reviewed the process with her. She stated LPN D also had to print the March reports during the week of the survey. She stated she was aware that the January and February 2026 reports had not been reviewed and documented this in her pending report. She stated she reviewed this with LPN D and verbally reviewed all procedures with her. She stated all January and February 2026 recommendations were pending action.<br><br>On 4/9/26 at 2:00 p.m., during an interview with the Advanced Practice Registered Nurse (APRN), she stated she had been providing care in the facility since January 2025. She stated she typically received a stack of MRRs periodically to review, but the last time she received any was from the DON<br>(continued on next page) |

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| | 105262 | A. Building<br>B. Wing | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Blue Lake Post Acute | 991 E New York Ave<br>Deland, FL 32724 |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | prior to the DON's resignation in January 2026. She stated she did not recall receiving any MRRs after that time until 4/8/26, when she received a large stack of reports for March 2026. She stated she had not reviewed any MRRs from January or February 2026 and was not aware of whether the Medical Director had reviewed them or not. She confirmed she and the Medical Director were the only practitioners in the facility, with her present five days per week and the Medical Director present two days per week.<br><br>2.Resident #2's most recent readmission was on 5/21/24 with diagnoses including cerebral atherosclerosis and unspecified dementia with agitation.<br><br>The most recent Minimum Data Set (MDS) assessment was a Significant Change in Status assessment with an Assessment Reference Date (ARD) of 3/3/2026. The Brief Interview for Mental Status (BIMS) score was 3 out of 15, indicating severe cognitive impairment.<br><br>A review of the resident's medication regimen revealed the use of psychotropic medications, including Olanzapine 10 mg one tablet at bedtime for unspecified psychosis, and Depakote 500mg, one tablet by mouth three times daily for mood disorder.<br><br>A pharmacy consultant report dated 3/31/26 recommended a gradual dose reduction (GDR) of Olanzapine. Another pharmacy consultant report, dated 3/31/26, indicated that Depakote 500 mg TID (three times daily), since 6/24/25, had still not been addressed by the facility.<br><br>There was no documented evidence verifying that the facility implemented a GDR, provided clinical justification for not attempting the GDR, or documented monitoring or supporting continued use at the current dose.<br><br>On 4/8/26 at 12:45 PM, the DON stated she could not locate evidence that the facility had addressed the pharmacy consultant's recommendations for Resident #2. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on observations, interviews, and record review, the facility failed to ensure care was provided in a manner that maintained resident dignity for one (Resident #1) of four residents reviewed for dignity, when the resident's indwelling urinary catheter drainage bag was left uncovered. This failure had the potential to affect four residents in the facility with urinary catheter bags.The findings include:On 04/06/2026 at 11:25 a.m., Resident #1 was observed lying in bed with her eyes closed. A visitor was present at the bedside and identified herself as a lifelong friend, stating she visited Resident #1 daily. Resident #1's indwelling urinary catheter (Foley) drainage bag was observed on the right side of the bed (facing the door) and was uncovered, with clear yellow urine visible in the collection bag. Resident #1 was unable to be interviewed.During an interview at that time, the visitor was asked if she believed Resident #1 would be upset if aware that the urinary catheter bag was exposed. The visitor stated, I don't think she'd like that, with all the staff and visitors that are in and out of the room and able to see it. I think she'd want it covered.On 04/07/2026 at 9:29 a.m., Resident #1 was again observed lying in bed with her eyes closed and did not respond to her name being called. The urinary catheter drainage bag was observed on the right side of the bed (door side), uncovered, with clear yellow urine visible in the collection bag. (Photographic evidence obtained)During an interview with Certified Nursing Assistant (CNA) G on 04/08/2026 at 10:35 a.m., she stated her training for residents with urinary catheters included cleaning around the tubing, ensuring there were no kinks in the tubing, and emptying the bag usually twice per shift. When asked about maintaining resident dignity related to urinary catheter care, she stated the drainage bags should be covered.During an interview on 04/09/2026 at 9:40 a.m., the Director of Nursing (DON) stated the facility's expectation was that urinary catheter drainage bags should be covered to maintain resident privacy and dignity.A record review for Resident #1 revealed diagnoses including neuromuscular dysfunction of the bladder, need for assistance with personal care, and dementia.A review of the person-centered care plan revealed:Focus (11/28/2025): Resident has an indwelling suprapubic catheter.Goal (revised 01/20/2026): Resident will remain free from catheter-related trauma through the review date.Interventions: Position catheter bag and tubing below the level of the bladder and away from the door.A review of the current physician's orders revealed:12/20/2025: Change suprapubic Foley catheter as needed for leakage, blockage, or dislodgement.11/26/2025: Drain suprapubic catheter bag every shift and as needed.11/26/2025: Provide suprapubic catheter care daily and as needed.A review of the facility's policy titled Catheter Care, Urinary (Effective 2001), revealed:The purpose was to prevent urinary catheter-associated complications, including urinary tract infections. The policy included directions to keep the catheter tubing and drainage bag off the floor; however, it did not address covering the catheter drainage bag or placement considerations related to resident dignity. |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents were assessed for safe self-administration of medication as clinically appropriate for medications left at bedside for two (Residents #59 and #55) of two residents reviewed for self-administration of medications out of 34 active sampled residents. The findings include:<br><br>1.On 4/06/26 at 1:30 PM, a white, round tablet was observed in a clear medication cup on the bedside table for Resident #59. The resident stated the nurse must have left it for him to take last night.<br><br>Resident #59 was admitted to the facility on [DATE]. His cognitive status was most recently assessed utilizing the Brief Interview for Mental Status on 12/03/25 to show a score of 15 out of 15, indicating the resident was cognitively intact. A review of the resident's assessments and care plans revealed no indication that the resident had been reviewed for the ability to self-administer medications left at the bedside.<br><br>On 4/06/26 at 1:59 PM, Licensed Practical Nurse (LPN) P was asked to identify the pill in the cup. She stated it was Simethicone. Simethicone is an over-the-counter medication used to relieve symptoms of excess gas. LPN P stated she had not noticed it earlier that day and the resident received it a few times each day.<br><br>A review of the active physician's orders revealed an order for Simethicone 80 milligrams three times a day at 9 AM, 2 PM, and 9 PM. A review of the Medication Administration Record (MAR) for 4/05/26 showed the Simethicone was documented as given for all three doses that day.<br><br>On 04/08/26 at 5:00 PM, the Director of Nursing (DON) was asked about the facility's procedure for residents to self-administer medications. She stated residents would be assessed first and would have a physician's order to self-administer medications. She stated the facility currently had no residents who self-administered their own medication, and medications should not be left at the bedside for residents to self-administer.<br><br>2.Resident #55 was admitted to the facility on [DATE] with diagnoses including encephalopathy, and acute and chronic respiratory failure with hypercapnia.<br><br>A review of the Minimum Data Set (MDS) admission assessment, with an assessment reference date of 1/14/26, revealed that Resident #55 had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating intact cognition.<br><br>On 4/6/26 at 10:48 AM, Resident #55 was observed lying in bed watching television. A bin containing personal items contained two bottles of 2.48-ounce Fluticasone Propionate 50 micrograms (mcg) allergy nasal spray on the resident's bedside table. Resident #55 stated he used the nasal spray daily for stuffiness.<br><br>On 4/6/26 at 10:54 AM, the resident's bedside table was observed with License Practical Nurse (LPN) P, the primary care nurse. She acknowledged the two bottles of nasal spray.<br><br>A review of the resident's active physician's orders with LPN P revealed no orders for the Fluticasone Propionate allergy nasal spray found on the resident's bedside table. LPN P stated there (continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was no order for the resident to self-administer medication, but she would contact the Advanced Registered Nurse Practitioner (ARNP) to inquire and possibly obtain a physician's order for administration of the nasal spray.<br><br>On 4/8/26 at 5:09 PM, the DON stated the self-administration assessment should be conducted to ensure the resident could safely self-administer medication. Residents should have orders to self-administer medication.<br><br>A review of the facility's policy and procedure for Self-Administration of Medications by Patients/Residents (dated 2/1/24), revealed:<br><br>If a resident or family member desires to self-administer medication, an assessment is conducted by the Licensed Nurse to assess the individual's cognitive, physical, and visual ability to carry out this responsibility.<br><br>On 4/8/26 at 5:00 PM, the DON was asked about the procedure for residents to self-administer medications. She stated residents would be assessed first and would have a physician's order to self-administer medications. She stated the facility currently had no residents who self-administered their medication and medications should not be left at the bedside for residents to self-administer. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>Based on observations, interviews, and record review, the facility failed to maintain a safe, clean, and comfortable environment when resident^room equipment was observed with significant dust accumulation, affecting four residents (#38, #18, #5, and #54) with the potential to affect the facility's remaining 47 residents.The findings include:On 04/07/2026 at 9:40 a.m., Resident #38 was observed lying in bed with an oscillating floor fan positioned past the foot of his bed between his bed and Resident #5's bed. While the fan was turned on and in motion, a thick layer of grey dust was observed on the back grate. During an interview, Resident #38 asked whether the fan was caked in dust and stated, Am I breathing that in? (Photographic evidence obtained) Residents #18, #5, and #54 were also observed in their beds in this room at this time.On 04/08/2026 at 9:50 a.m., Resident #38 was not in the room. The oscillating floor fan at the foot of his bed was again observed turned on and in motion, with a thick layer of grey dust on the back grate. Residents #18, #5, and #54 were present in their beds. Two housekeepers were in the room cleaning. During an interview at this time, Housekeeper E was asked who was responsible for cleaning the backs of fans when dust was present. She stated she did not clean them and that the Housekeeping Director would do that. Housekeeper M was interviewed and stated he did not know who cleaned the backs of the fans.On 04/08/2026 at 10:11 a.m., the Housekeeping Manager was interviewed and stated he was responsible for cleaning oscillating fans and cleaned them every two weeks. When asked if he had observed the fan in Resident #38's room, he stated he had and had just cleaned it. When asked if he observed the thick layer of grey dust on the back grate, he stated yes. When asked whether this supported that the fan had not been cleaned within the past two weeks, he stated he did not know but stated he had cleaned it.The Housekeeping Manager provided a document titled Housekeeping Daily Cleaning Schedule (dated 3/25/26), with checkboxes for daily tasks. A review of the document revealed no reference to a resident-specific room or area and did not specify any fan cleaning or dusting tasks. When asked what on the document indicated that fans were being cleaned on a scheduled basis, he stated the form did not indicate that but it was the daily cleaning schedule. He stated he had no other documentation showing when fans were cleaned.A review of the facility's policy titled Environmental Policy and Procedures Manual (effective 2/24/2026) revealed:The facility will maintain a clean, safe, and functional environment that prevents infection and protects residents' health.Environmental Services is responsible for cleaning, disinfection, and sanitation.Daily cleaning of resident rooms is required, and cleaning logs are to be maintained and available for survey review. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that one (Resident #54) of one resident reviewed for rehabilitation/restorative services received necessary care and services, when a physician-ordered left-hand brace was not available and had not been applied as ordered. The findings include: On 04/06/2026 at 11:30 a.m., Resident #54 was observed lying in bed with his eyes open. During an interview, he stated he wanted to start some rehab like physical therapy. He stated, it has been a while, and he felt that if he received therapy, he could improve his overall status. He was observed with left-sided upper and lower extremity deficits. No brace or splint devices were observed in place. He stated he used to have a brace for his left hand, but it had been missing for a long time. When asked how long it had been since he last wore the brace, he stated, I'm not sure, but it's been months - since last year. He was asked if staff had assisted him with applying the brace when it was available. He stated, Yes, I can't put it on myself.On 04/07/2026 at 9:45 a.m., Resident #54 was observed lying in bed with his eyes open. He indicated he would like to speak further at a later time when staff were not present in the room. No brace or splint was observed in place on his left hand.On 04/07/2026 at 10:20 a.m., during a follow-up interview, Resident #54 stated he wanted to reiterate that he felt therapy would help with the weakness on his left side related to a prior stroke. He stated he previously received therapy when he was first admitted to the facility approximately three years ago. No brace or splint was observed in place on his left hand.On 04/08/2026 at 2:00 p.m., during an interview with Certified Occupational Therapy Assistant (COTA)/Rehabilitation Director K, he stated he was familiar with Resident #54. When asked about the resident's diagnoses, he stated the resident had a stroke with left-sided weakness and contractures, with decreased range of motion in the left upper and lower extremities. When asked about the resident's therapy status, he stated the resident was not currently receiving therapy. He stated the resident had been on occupational therapy in January 2026 but was discharged when his payer source changed. He stated the resident previously had a splint during therapy; however, it went missing. He further stated the resident was placed on a restorative nursing program and had a left palmar hand guard, which had been ordered multiple times but also went missing. When asked if any specific nurse or certified nursing assistant (CNA) was responsible for restorative therapy, he stated no. When asked if the hand guard was considered a brace, he stated yes. When asked how long it had been since the resident last wore the brace, he stated it had been sometime last year, but he could not recall exactly when. When asked what the process was when ordered therapy equipment was missing, he stated they had previously notified the Administrator to order a replacement; however, it was not obtained and that Administrator was no longer employed by the facility.Rehabilitation Director K provided a document titled OT (Occupational Therapy) Evaluation and Plan of Treatment (dated 01/09/2026), which he confirmed was the most recent therapy evaluation for Resident #54. The document revealed:Short-term goal: Resident will safely wear palm guard at all times without redness or complaints of discomfort in order to reduce pain caused by joint deformity and to complete daily hygiene and skin checks. (target date: 01/22/2026)Long-term goal: Restorative nursing staff will demonstrate 100% accuracy in donning (applying) and doffing (removing) the left palm guard and completing daily hygiene and skin checks to decrease the risk of pain and injury caused by joint deformity. (target date: 03/09/2026)This document was electronically signed by Occupational Therapist (OT) I on 01/09/2026 and by the resident's physician on 01/19/2026.On 04/09/2026 at 12:35 p.m., during an interview with Resident #54, he stated he did not currently have a left-hand brace or splint. He stated, I used to have one, but I haven't seen it in ages - months. He was not observed wearing a brace or splint on the left hand. With the resident's permission, his bedside drawers and closet were searched; however, no brace or splint was located. When asked if he had ever refused to wear the brace, he stated, No, why would I refuse<br>(continued on next page) |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | to wear it if it helps me? During this interview, Licensed Practical Nurse (LPN) F entered the room and was asked if she knew the location of Resident #54's left-hand splint. She replied, I think I've seen it. She searched the resident's drawers but did not locate the item. She asked the resident if he knew where it was, and he stated it had been gone for months and that no one had been applying it. LPN F stated she would follow up with therapy. She returned a few minutes later and stated OT J indicated that the brace may have been lost or discarded with laundry and that the new Administrator was in the process of ordering another.On 04/09/2026 at 12:45 p.m., during an interview with OT I and OT J, they were asked about the status of the resident's left-hand brace. OT J stated therapy did not track these items once a resident was discharged from therapy, and that the brace may have been lost or misplaced. OT I stated the brace had been missing for over a month and therapy had requested that the previous Administrator order a replacement in approximately January 2026. She stated they had also asked the new Administrator to order a replacement. When asked if she could confirm the resident had not had the brace since at least January 2026, she stated that, to her knowledge, that was correct.On 04/09/2026 at 1:36 p.m., during an interview with the Director of Nursing, she was asked if she had knowledge of the left-hand brace ordered for Resident #54. She stated she was not aware of the order and that documentation reflected the brace was applied on some days and marked not applicable on others.On 04/10/2026 at 10:10 a.m., during an interview with LPN O, she stated she had been caring for Resident #54 since December 2025. When asked if the resident used a left-hand brace or splint, she stated no and reported that she had never seen a brace for his left hand.A record review for Resident #54 revealed diagnoses including cerebrovascular accident (CVA - stroke) with left hemiparesis (weakness on one side of the body).A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed:Section C: Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognitionSection E: No behaviors documented, including no refusals of careA review of current physician's orders revealed:06/27/2023: May participate in restorative nursing programs as indicated and tolerated01/09/2026: Occupational therapy (OT) clarification - resident to be seen three times per week for 60 days, including therapeutic activity, self-care management, manual therapy, and orthotic interventions12/24/2025: Passive range of motion (PROM) to the left arm, including elbow, digits, wrist flexion/extension, and internal/external rotation, three sets of 10 repetitions. Assist with application of left-hand splint, remove after two hours, and assess skin before and after useA review of the person-centered care plan revealed:Focus (12/24/2024): Resident is on a passive range of motion (PROM) and splinting program to the left upper extremity (LUE) to reduce risk of contractureGoal (revised 03/20/2026): Resident will maintain or improve current level of functioning through the next reviewInterventions: PROM of left arm as ordered. Assist with application of left-hand splint, remove after two hours. Nursing rehabilitation program (initiated 06/08/2025, revised 06/09/2025): apply palm guard to left hand and wear for six hours dailyA review of the facility policy titled Functional Maintenance (effective 02/01/2024), revealed:Policy Statement: Residents may be discharged from restorative programs when goals are met but may still require nursing interventions to maintain their highest practicable level of function.Procedure: Staff are to be instructed on individualized interventions and provided with specific directions and training.A review of the facility's policy titled Contracture Management (effective 02/01/2024), revealed:Policy Statement: Maintaining joint mobility promotes independence, prevents or reduces contractures, stimulates circulation, and enhances muscle strength.Procedure: Review therapy recommendations for range of motion and splint/brace use, and communicate individualized interventions to caregiving staff. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observations, interviews, and record review, the facility failed to ensure its medication error rate was not 5% or greater. The facility's medication error rate was calculated at 36%, based on 11 medication errors observed out of 30 opportunities for error.The findings include:On 04/07/2026 at 6:15 a.m., Licensed Practical Nurse (LPN) F was observed during medication administration preparing the following medications for Resident #16: Allopurinol 100 milligrams (mg), Aspirin 81 mg, Citalopram 20 mg, Cranberry Tablet 450 mg, Folic Acid 1 mg, Furosemide 20 mg, Gemtesa 75 mg, Losartan Potassium 50 mg, Metformin 500 mg, Metoprolol Succinate ER 25 mg, and Nitrofurantoin Macrocrystal 50 mg.At 6:18 a.m., LPN F entered Resident #16's room. The lights were off, and the resident was lying in bed with his eyes closed and bedcovers pulled up. LPN F called the resident's name twice; he opened his eyes on the second attempt. She stated it was time for his medications. The resident sat up on the edge of the bed, and LPN F administered the medications. The resident then laid back down, pulled the covers over himself, and closed his eyes.LPN F returned to her medication cart. When asked if she signed medications as given on the electronic medication administration record (eMAR) once administered, she stated she could not sign them because they won't pop up for another half hour, explaining the medications were ordered for 9:00 a.m. When asked why she administered medications scheduled for 9:00 a.m. at 6:18 a.m., she stated, Because that's how I was trained. She stated she normally worked 7:00 a.m. to 7:00 p.m. but came in at 6:00 a.m. that day and started early.A review of Resident #16's current medication orders revealed the following medications were ordered once daily: Allopurinol 100 mg, Aspirin 81 mg, Citalopram 20 mg, Cranberry Tablet 450 mg, Folic Acid 1 mg, Furosemide 20 mg, Gemtesa 75 mg, Losartan Potassium 50 mg, Metformin 500 mg, Metoprolol Succinate ER 25 mg, and Nitrofurantoin Macrocrystal 50 mg.On 4/9/26 at 3:15 p.m., during an interview with the Director of Nursing, she was asked about expectations for administering medications scheduled once daily. She stated daily medications scheduled for 9:00 a.m. could be given up to one hour before or one hour after the scheduled time unless otherwise specified. When asked whether 9:00 a.m. medications would be expected to be administered at 6:18 a.m., she stated they would not and should be administered between 8:00 a.m. and 10:00 a.m.A review of a document titled Medication Times, revealed: Everyday: 9:00 a.m.A review of the facility's policy titled Medication Administration Overview (effective 2/1/24), revealed the purpose was to administer medications according to the principles of medication administration, including the right medication, to the right resident, at the right time, and in the right dose and route. The procedure instructed staff to verify physician orders, read the Medication Administration Record for ordered medication, dose, route, and time, and verify the correct resident, medication, expiration date, dose, dosage form, route, and time prior to administration. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105262 | A. Building<br>B. Wing | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Blue Lake Post Acute | 991 E New York Ave<br>Deland, FL 32724 |

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) |
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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, interviews, and record review, the facility failed to 1) Ensure refrigerated medications were stored in a locked compartment, and 2) Ensure Schedule II-V controlled medications were secured within a fully protected, doubleˆlocked system. Schedule II-V controlled medications are substances with accepted medical use that have potential for abuse and may lead to physical or psychological dependence. Although the controlled medications were stored in a separately locked, permanently affixed inner compartment, the refrigerator housing that compartment was left unlocked, resulting in inadequate security. The findings include:On 04/09/2026 at 8:40 a.m., a small refrigerator was observed in the open and unsecured nurses' station area. The refrigerator had a white lock on the front; however, the lock was not engaged, as evidenced by the connector not being secured and the surveyor being able to open the refrigerator without staff assistance or intervention. (Photographic evidence obtained)On 04/09/2026 at 8:47 a.m., during an interview with Licensed Practical Nurse (LPN)/Unit Manager D, she stated the refrigerator contained insulin and inhalers requiring refrigeration. When asked whether any controlled substances were stored inside, she stated, yes, in the locked box. She retrieved a key from the Director of Nursing's office and opened the box, which contained a labeled box of liquid Lorazepam for one resident. (Photographic evidence obtained) When asked about expectations for securing medications, she stated the refrigerator should be locked when medications are stored inside and controlled substances should be doubleˆlocked. When she was asked to confirm whether the refrigerator was unlocked, she stated yes, it was unlocked and should have been locked.According to the U.S. Drug Enforcement Administration (DEA), Lorazepam is a Schedule IV controlled substance.On 04/09/2026 at 3:15 p.m., during an interview with the Director of Nursing, she confirmed that the small refrigerator in the nurses' station should be locked at all times to prevent unauthorized access to medications stored inside.On 04/10/2026 at 11:30 a.m., during an interview with the facility's Consultant Pharmacist, she confirmed the refrigerator should be locked at all times and controlled substances should be doubleˆlocked in a permanently affixed compartment.A review of the facility's policy titled Medication Labeling and Storage (effective 2001), revealed that the facility stored all medications and biologicals in a locked compartment under proper temperature, humidity, and light controls, with access limited to authorized personnel. The policy stated compartments containing medications, including refrigerators, were locked when not in use; medications requiring refrigeration were stored in a refrigerator in the medication room or other secured location; and controlled substances listed as Schedule II-V were separately locked in permanently affixed compartments. |