STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105269	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Groves Center	512 S 11th St Lake Wales, FL 33853

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 34768 Based on observation, interview, and record review the facility failed to provide privacy and confidentiality for three (#1, #4, #7) of seven sampled residents related to placing items in the trash can with resident identifiable information and leaving the medication cart unattended with resident information present and accessible in paper and electronic format. Findings included: On 10/01/2024 beginning at 9:42 a.m., Staff A, Registered Nurse (RN) entered Resident #1's room and detached the feeding tube from the (gastrostomy) g-tube site. She placed the used tube feeding bottle with resident information into the unsecured, publicly accessible trash can. Staff A, RN then went over to Resident #1's roommate, Resident #7, detached the feeding tube from the g-tube site and placed Resident #7's used tube feeding bottle with resident information into the unsecured, publicly accessible trash can. Staff A, RN left the room and opened the computer on the medication cart. Staff A, RN went to the supply room and left the computer open with Resident #4's information on the screen and a resident roster exposed on top of the medication cart. Staff A, RN returned to the medication cart approximately five minutes later and closed the computer but left the resident roster turned upward and exposed, while going back into Resident #1's room to provide care. During an interview on 10/01/2024 at 10:05 a.m. Staff A, RN confirmed she left her medication cart while Resident #4's medical information was up on her computer and the resident roster was turned upward leaving this information available to other residents, staff, and visitors in the area. Interview with the Director of Nursing (DON) on 10/01/24 at 2:38 p.m. revealed if the tube feeding bottles were placed in the trash after use, the staff should be marking off any resident identifiably information. Review of the facility's policy titled Resident Rights, dated February 2021, revealed the facility will protect and promote the rights of each resident.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 34768 Cross reference F695 and F880 Based on interview and record review the facility failed to provide care consistent with the comprehensive person-centered care plan for two (#1 and #6) of three sampled residents with tracheostomies. Findings included: 1. Review of Resident #1's admission record showed an admitted [DATE] and readmitted [DATE]. The admission record showed diagnoses to include anoxic brain damage, respiratory disorders, acute and chronic respiratory failure, bell's palsy, metabolic encephalopathy, muscle wasting and atrophy, acute kidney failure, myocardial infarction, acute and subacute hepatic failure, hypokalemia, obstructive and reflux uropathy, protein-calorie malnutrition, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/09/2024, showed a Brief Interview for Mental Status (BIMS) score of 0, indicating severe cognitive impairment. The resident was rarely or never understood, was dependent on staff for bathing and toileting, and received oxygen therapy and tracheostomy (trach) care. The following physician orders were found to be sitting in queue and not confirmed from 09/25/2024: Elevate head of bed while feeding and medication is being administered Flush tube with 30 ml of water before and after (med) medication administration and feeding for patency and hydration Enteral feed order, dilute each crushed/sprinkles/powdered med with at least 15 ML (milliliter) of water and rinse the cup with 5 to 15 ml to ensure all residue is out of the cup Flush feeding tube with 5 ml of water between meds May give meds via tube, for patency and hydration Change feeding syringe daily Tube feeding spike sets: change ready to hang every 24 hours and prn G (gastrostomy) tube site may be left open to air if clean and no drainage Evaluate for displacement of tube by observing for abdominal distress /nausea/vomiting, pain, distention. If displacement is suspected, clamp tube, call MD (medical doctor) Order description not specified: Dilute liquid enteral medications with at least 15 cc (cubic centimeter) of H2O (water) prior to administration (continued on next page)

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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	Review of the October Medication Administration Review (MAR) and Treatment Administration Review (TAR) showed: Transmission based precautions enhanced barrier precautions due to g-tube, trach, and Suprapubic catheter as of 09/16/2024, documented as performed by Staff A, Registered Nurse (RN) Additional Free water flush of G Tube as per MD order. Flush with 200 mL via flush. Deliver every 6 hours as of 09/06/2024, documented as performed by Staff A, RN Shiley size 6, care daily and as needed clean inner cannula and replace cleanse tracheostomy site with normal saline. Pat dry. Cover with drain sponge daily as of 08/21/2024, documented as performed by Staff A, RN Post Suction of trach, record amount of secretions, characteristic of secretions (color, odor, viscosity) lung sounds, heart rate, respirations, and tolerance as of 08/21/2024, no documentation by Staff A, RN Review of the September Medication Administration Review (MAR) and Treatment Administration Review (TAR) showed Pantoprazole Sodium 40 mg via g-tube in the morning for gastroesophageal reflux disease (GERD) lacked documentation as given on 09/08/24, 09/16/24, and 09/23/24 Carvedilol 12.5 mg via g-tube two times a day for hypertension lacked documented as given on 09/15/24 and 09/29/24. Enteral feed order: Jevity 1.5 Cal continuous via tube to infuse at a rate of 65 ml/hr. Total volume of 1300 ml infused in 24 hours. lacked documented as given on 09/15/24 and 09/29/24 Hyoscyamine Sulfate oral elixir 0.125 mg/5 ml give 5 ml via g-tube three times a day for increased secretion lacked documented as given on 09/08/24, 09/15/24, 09/16/24, 09/23/24, and 09/29/24 Monitor pain every shift and record pain number on a 0-10 scale, every shift lacked documented as performed on 09/07/24, 09/15/24, and 09/29/24 Side effects monitoring lacked documentation performed on 09/07/24, 09/25/24, and 09/29/24 Transmission based precautions enhanced barrier precautions due to g-tube, trach, and Suprapubic catheter every shift as of 09/16/2024, lacked documentation performed on 09/29/24 Additional Free water flush of G Tube as per MD order. Flush with 200 mL via flush. Deliver every 6 hours for nutritional supplementation as of 09/06/2024, lacked documentation as given for 2 shifts on 09/08/24, 2 shifts for 09/16/24, 09/23/24, and 09/29/24. Suprapubic catheter care daily and as needed every evening lacked documentation as performed on 09/15/24 and 09/29/24 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Shiley size 6, care daily and as needed clean inner cannula and replace cleanse tracheostomy site with normal saline. Pat dry. Cover with drain sponge daily as of 08/21/2024, lacked documentation as performed on 09/22/24 Humidified oxygen per trach continuously 4 liters every shift for shortness of breath lacked documentation as performed on 09/05/24, 09/0724, 09/15/24 for 2 shifts, 09/22/24 and 09/29/24 Maintain ambu bag at bedside and replacement trach of equal size and one size down maintained at bedside, check every shift, for preventative measure lacked documentation as performed on 09/05/24 for 2 shifts, 09/07/24 for 2 shifts, 09/15/24 for 2 shifts, 09/22/24 and 09/29/24 Maintain suction set up at bedside, check every shift lacked documentation as performed on 09/05/24 for 2 shifts, 09/07/24 for 2 shifts, 09/15/24 for 2 shifts, 09/22/24 and 09/29/24 Suprapubic catheter: drain suprapubic catheter bag every shift and prn, lacked documentation as performed on 09/04/24, 09/05/24, 09/07/24, 09/10/24, and 09/15/24 for two shifts Suprapubic catheter: drain suprapubic catheter bag every shift and prn, lacked documentation as performed on 09/15/24 on 2 shifts, 09/22/24 and 09/29/24 Leave abrasion to right wrist open to air, monitor every shift for skin lacked documentation as performed on 09/05/24 and 09/07/24 Review of Resident #1's care plans showed the resident required Enhanced Barrier Precautions related to: G-tube, suprapubic catheter, and trach initiated on 06/27/2024. Interventions included gloves and gowns to be worn when providing high touch resident care as of 06/27/2024. Review of Resident #1's care plans showed he was receiving enteral nutrition because of dysphagia as of 06/27/2024. Interventions included administration of enteral nutrition as ordered as of 06/27/2024; administration of flushes as ordered as of 06/27/2024. Review of Resident #1's care plans showed he had pain or a potential for pain, required prn (as needed) pain medication for pain management as of 06/27/2024. Interventions included observe/anticipate the residents need for pain relief and offer/provide pain treatment/intervention as of 06/27/2024; observe/report to nurse any signs and symptoms of non-verbal pain as of 06/27/2024. Review of Resident #1's care plans showed the resident had a tracheostomy related to acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia initiated as of 06/27/2024. Interventions included give humidified oxygen as prescribed revised on: 08/22/2024; maintain ambu bag and replacement trach at bedside per order revision on: 08/22/2024; monitor/document respiratory rate, depth and quality. Check and document every (q) shift/as ordered revised on 08/22/2024; suction as necessary revised as of 08/22/2024; Trach care per order revised as of 08/22/2024; tube out procedures: keep extra trach tube and obturator at bedside as of 06/27/2024. Review of Resident #1's care plans showed the resident uses a urinary catheter with risk for infection and/or complications related to suprapubic for obstructive and reflux uropathy as of 06/27/2024. Interventions included change drainage bag routinely and as needed as of 06/27/2024; provide catheter care daily as needed as of 06/27/2024 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's care plans showed he had cardiovascular problems, gastrointestinal problems as of 06/27/2024. Interventions included administer medications as ordered. 2. Review of Resident #6's admission record revealed an admitted in January of 2022 with diagnoses to include cancer of the hypopharynx, scalp and neck, chronic obstructive pulmonary disease, (COPD), acute and chronic respiratory failure, tracheostomy status. Review of the MDS dated [DATE] showed a BIMS score of 15, indicating cognitively intact. The resident needed assistance for toileting and bathing, and received oxygen therapy and tracheostomy care. Review of the September MAR and TAR and physician orders showed the following: Change feeding syringe daily for PEG (percutaneous endoscopic gastrostomy) tube label with name and date lacked documentation on 09/07/24 and 09/15/24. Humidified oxygen per trach at bedtime at 2 liters for shortness of breath lacked documentation on 09/29/24. Carvedilol 12.5 mg two times a day for hypertension lacked documentation as given on 09/29/24. Docusate Sodium 50 mg two times a day for prophylaxis, hold for diarrhea lacked documentation as given on 09/29/24. Oyster shell 500 mg two times a day for hypocalcemia lacked documentation as given on 09/29/24. Albuterol Sulfate inhalation nebulization solution (2.5mg/3 ml) 0.083% via trach three times a day for COPD lacked documentation as given on 09/29/24. Enhanced barrier precautions for MRSA, trach, check every shift lacked documentation as observed on 09/07/24, 09/15/24, and 09/29/24. Enteral Feed Order: dilute each crushed/sprinkles/powdered med with at least 15 ml of water and rinse the cup with 5 to 15 ml to ensure all residue is out of the cup lacked documentation as given on 09/07/24, 09/15/24, and 09/29/24. Enteral Feed Order: dilute liquid enteral medications with at least 15cc of water prior to administration lacked documentation as given on 09/07/24, 09/15/24, and 09/29/24. Enteral Feed Order: TwoCal HN continuous via tube to infuse at a rate of 80 ml/r total volume of 960 ml infused in 24 hours. May turn off for care/services lacked documentation as given on 09/07/24, 09/15/24, and 09/29/24. Enteral Feed Order: three times a day flush enteral tube with 200 ml water lacked documentation as given on 09/29/24. Flush tube with 30 ml of water before and after med administration and feeding for patency and hydration lacked documentation as given on 09/07/24, 09/15/24, 09/29/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	HOB (head of bed) elevated due to shortness of breath while lying flat lacked documentation as monitored on 09/07/24, 09/15/24, 09/29/24. Ipratropium Bromide Inhalation Solution 0.02% 1 vial inhale orally three times a day for COPD lacked documentation as given on 09/29/24. May give medications by mouth every shift for route lacked documentation as given on 09/07/24, 09/15/24, 09/29/24. Medpass or equivalent supplement three times a day, 180 ml lacked documentation as given on 09/29/24. Monitor pain every shift and record pain number on 0-10 scale every shift lacked documentation as performed on 09/07/24, 09/15/24, 09/29/24. Neurotin 100 mg three times a day for neuropathy lacked documentation as given on 09/22/24, 09/29/24. Post administration evaluation for Duoneb nebulization solution three times a day for prophylaxis post treatment evaluation lacked documentation as performed on 09/29/24. Side effects monitoring lacked documentation as performed on 09/07/24, 09/15/24, 09/29/24. Change suction canister every 72 hours and / or when 3/4 full every 3 days lacked documentation as performed on 09/15/24. Change trach collar, mask and oxygen weekly as well as prn every night for preventative measures lacked documentation as performed on 09/15/24. Change tubing weekly labeling with date lacked documentation as performed on 09/15/24. Clean oxygen filter weekly lacked documentation as performed on 09/15/24. Cleanse g tube site with soap and water daily and cover with dry dressing daily and prn lacked documentation as performed on 09/05/24, 09/07/24, 09/15/24. Electronic Wander Bracelet: Check function with the transponder daily on night shift. Replace electronic wander bracelet if not working correctly, lack of documentation performed on 09/05/24, 09/07/24, 09/15/24. Tracheostomy Type: shiley size 4 trach care daily and as needed. Cleanse tracheostomy with normal saline, pat dry. Change inner cannula; cover with drain sponge daily as needed, lack of documentation performed on 09/19/24, 09/22/24. Electronic Wander Bracelet: Check placement daily every shift, lack of documentation performed on 09/05/24, 09/07/24, 09/15/24, 09/29/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Evaluate for displacement of tube by observing for abdominal distress/nausea/ vomiting, pain, distention. If displacement is suspected, clamp tube, Call MD lack of documentation performed on 09/05/24, 09/07/24 for 2 shifts, 09/15/24 for 2 shifts, 09/19/24, 09/22/24, 09/29/24. G-tube site may be left open to air if clean and no drainage, skin integrity monitor for changes every shift lack of documentation performed on 09/05/24, 09/07/24, 09/15/24 x 2 shifts, 09/19/24, 09/22/24, 09/29/24. Humidified oxygen per trach prn; oxygen sat to maintain saturation (90%) or above every shift for shortness of breath lack of documentation performed on 09/05/24, 09/07/24, 09/15/24 x 2 shifts, 09/19/24, 09/22/24, 09/25/24, 09/29/24. Maintain suction set up at beside check every shift, lack of documentation performed on 09/05/24, 09/07/24, 09/15/24 x 2 shifts, 09/19/24, 09/22/24, 09/29/24. Review of Resident #6's care plans showed the resident may have a nutritional problem or potential nutritional problem related to history of anxiety, hypertension, respiratory failure, acute kidney failure, COPD, skin cancer, anemia, and hypopharynx cancer. Interventions included supplements as ordered as of 08/16/2023 Review of Resident #6's care plans showed the resident had tube feeding orders with water flushes and enteral feeding. Resident also receives a po (by mouth) diet revised on 07/25/2023. Interventions included enteral nutrition as ordered, administration of flushes as ordered, elevate HOB during administration of feeding or medication administration; observe stoma site condition and provide site care as of 01/28/2022; observe/document report to MD prn aspiration, tube dislodgement, infection at tube site as of 01/28/2022. Review of Resident #6's care plans showed the resident required enhanced barrier precautions related to MRSA carrier and trach as of 05/03/2024. Interventions included Enhanced Barrier Precautions / glove and gowns to be worn when providing high touch resident care as of 05/03/2024. Review of Resident #6's care plans showed the resident was at risk elopement. Interventions included apply electronic wander bracelet (check function after placed) as of 03/25/2024; apply electronic wander bracelet due to elopement risk as of 03/25/2024; electronic wander bracelet check placement every shift and check function with the transponder daily, replace bracelet if not working correctly as of 03/25/2024. Review of Resident #6's care plans showed the resident was at risk of pain or a potential for pain as of 01/31/2022. Interventions included administer pain medication and observe for effectiveness; observe and report to nurse any signs and symptoms of non-verbal pain as of 0/31/2022. Review of Resident #6's care plans showed the resident was on oxygen related to COPD. Interventions included oxygen; administer at ordered as of 02/11/2022; change and date respiratory equipment / tubing weekly and prn as of 11/08/2022. Review of Resident #6's care plans showed the resident has a tracheostomy related to impaired breathing mechanics as of 02/11/2022. Interventions included give humidified oxygen as prescribed as of 02/11/2022; suction as necessary as of 04/24/2023; trach care per order as of 04/24/2023. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #6's care plans showed the resident had cardiovascular problems related to hypertension and atrial fibrillation as of 01/22/2024. Interventions included administer medications as ordered. On 10/01/24 at 2:38 p.m., the Director of Nursing (DON) stated Resident #1 was on enhanced barriers. The DON verified the trach care order showed the trach was to be cleansed with normal saline and pat dry and a drain sponge applied. She stated the orders showed an inner cannula was to be cleaned daily, and they are to supposed to do it, if the resident had an inner cannula trach. The DON reviewed the TAR for Post Suction of trach, record amount of secretions, characteristic of secretions (color, odor, viscosity) lung sounds, heart rate, respirations, and tolerance as of 08/21/2024, and verified the lack of documentation. She stated she expected to see lung sounds, heart rate, respirations and tolerance documented at the time of the procedure. The DON verified there were blanks in the documentation on the September MAR and TAR for both Residents #1 and #6. The DON stated that the staff was supposed to document. Review of the facility's policy, Physician Orders, dated October 2021 showed 2. Physician's orders will include the drug or treatment and a correlating medical diagnosis or reason. 3. Medication orders to include: A. Route B. Dosage C. Frequency D. Strength E. Reason for administering F. Stop date 4. Enteral nutrition therapy orders will include the following required components: A. fluid B. Amount C. Flow rate D. Pump slash gravity bolus use E. Flush orders. Additionally a separate order to be obtained for dressing changes for this therapy, if required medications that require monitoring will need to be entered into the electronic medical records. 12. Confirm the accuracy of orders. Review orders daily in the clinical meeting to confirm accuracy and transcription and identify errors of omission. 16. When the physician changes an order that is currently in place, discontinue the original physicians order when the physician changes an order that is currently in place. Assure the new order reflects the change and order components required. The night shift nurses will verify orders received within the last 24 hours has been transcribed into the electronic record. The nurse will review each hard chart for new orders and compare to the electronic order listing report to ensure each written order has been entered into the electronic medical record. If a written physician's order is found on the chart and not on the order listing, transcribe the order and monitor and notify the resident / representative. Medication treatment variants may be completed if needed with physician notification. Review of the facility's competency, Tracheostomy Care Competency Skills Checklist, without a date showed 1. Check TAR to verify physician orders for Trach care 22. Document procedure and all observations. Review of the facility's competency, Tracheostomy Suctioning Competency Skills Checklist, without a date showed 1. Check TAR to verify orders 22 Document procedure and all observations

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Cross reference F656 and F880 Based on observation, interview, and record review the facility failed to provide tracheostomy (trach) and suctioning care consistent with professional standards of practice and the resident's comprehensive person-centered care plan for one of three sampled residents (#1). Findings included: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/01/2024 beginning at 9:42 a.m., Staff A, Registered Nurse (RN) entered Resident #1's room without a gown on and put on gloves. Resident #1 was lying in bed, had a trach with humidifier mask in place, and oxygen attached. Staff A, RN detached the feeding tube from the (gastrostomy) g-tube site for Resident #1 Staff A, RN removed her gloves and did not perform hand hygiene. She applied new gloves and went to Resident #1's roommate (Resident #7) and detached Resident #7's feeding tube from the g-tube site. She removed her gloves, did not perform hand hygiene, and exited the room. Staff A, RN went to the medication cart and started to open it. Staff A, RN then stopped and went into the resident room across from Resident #1 and #7 and washed her hands. Staff A then entered Resident #1's room again without donning a gown. She applied non-sterile gloves and opened the drawer to the resident's side table. She removed sterile gloves and a packet of drain sponges. She applied the sterile gloves over the non-sterile gloves and opened the bottle of sterile water with the sterile gloves. She removed the suction catheter from the bag on the wall. She removed the humidifying mask and suctioned the resident. She placed the suction tubing into the sterile water bottle. She removed the suction tubing from the bottle of water and suctioned the resident again. She turned off the suction machine. She replaced the suction tubing into the bag on the wall. She took off the sterile gloves and threw them away (leaving on the non-sterile gloves). She threw the bottle of water away, opened another package of sterile gloves, and applied the sterile gloves. She removed the trach dressing from around the resident's trach and threw it in the trash can. She wiped around the trach with a drain sponge and wiped the humidifier mask with the drain sponge. She replaced the humidifier mask and removed both sets of gloves. She went to the resident's bathroom and washed her hands for a short period of time. Staff A left the room, opened the computer on the medication cart, and then went to the supply room (down the hallway) to retrieve more drain sponges. When Staff A returned approximately five minutes later, she closed the computer on the medication cart and re-entered Resident #1's room. Staff A, RN did not don a gown and placed the drain sponges on the bedside table. Staff A, RN washed her hands for a short period of time in the bathroom, applied non-sterile gloves and sterile gloves over the non-sterile gloves. She opened the drain sponges and placed the drain sponges around the resident's trach. She removed her gloves and threw the paper trash for the drain sponges into the trash can. Staff A, RN washed her hands, exited the room, and went to the medication cart and computer. She returned to Resident #1's room without gowning or performing hand hygiene and applied non-sterile gloves. She retrieved a Styrofoam cup from the room and a 60-cc (cubic centimeters) syringe and entered the bathroom. She turned on the faucet with her gloved right hand, put water into the cup, and turned the faucet off using a paper towel. She opened the privacy curtain to stand next to Resident #1's bed. Staff A uncapped the g-tube, attached the 60-cc syringe and poured 60 cc of water into it. She used the plunger to gently push the 60 cc of water into the g-tube. She removed the syringe, recapped the g-tube, removed her right glove only and put the syringe back in the packaging, and then removed her left glove. Staff A, RN then washed her hands for a short time period. She touched the privacy curtain, Resident #1's bed, left the room, re-entered the room, moved the bed into a low position, moved the bed around and repositioned it into a higher position. Staff A, RN touched the resident and exited the room without performing hand hygiene. A fan on the over bed table which was previously placed away from Resident #1 was now facing towards the resident. Staff A, RN then returned to the medication cart. (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 10/01/2024 at 10:05 a.m. Staff A, RN stated the orange sign on Resident #1's door meant enhanced barrier precautions. Staff A, RN stated enhanced barrier was for a resident who had a catheter or trach or something. She stated they were supposed to wear gloves and gowns. She confirmed she did not wear a gown during care of the resident. Staff A stated, you are supposed to hand wash with soap and water when changing gloves. She stated, I did not hand sanitize between glove changes. Staff A stated when she left Resident #1's room, she went across the hall and washed her hands one time. Staff A stated, I do not like the way the blue gloves [sterile gloves] feel next to my skin; it was tight and itchy. She stated she placed the blue gloves over the clear gloves (non-sterile gloves) because of that. She stated the family put the fan in the resident's room and it does get hotter in there sometime due to the equipment. Review of Resident #1's admission record showed an admitted [DATE] and readmitted [DATE]. The admission record showed diagnoses to include anoxic brain damage, respiratory disorders, acute and chronic respiratory failure, bell's palsy, metabolic encephalopathy, muscle wasting and atrophy, acute kidney failure, myocardial infarction, acute and subacute hepatic failure, hypokalemia, obstructive and reflux uropathy, protein-calorie malnutrition, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/09/2024, showed a Brief Interview for Mental Status (BIMS) score of 0, indicating severe cognitive impairment. The resident was rarely or never understood, was dependent on staff for bathing and toileting, and received oxygen therapy and tracheostomy (trach) care. Review of physician orders showed: Post Suction of trach, record amount of secretions, characteristic of secretions (color, odor, viscosity) lung sounds, heart rate, respirations, and tolerance as of 08/21/2024 Shiley size 6, care daily and as needed clean inner cannula and replace cleanse tracheostomy site with normal saline. Pat dry. Cover with drain sponge daily as of 08/21/2024 Additional Free water flush of G Tube as per MD order. Flush with 200 mL via flush. Deliver every 6 hours as of 09/06/2024 Transmission based precautions enhanced barrier precautions due to g-tube, trach, and Suprapubic catheter as of 09/16/2024 Review of physician orders sitting in queue, not confirmed from 09/25/2024 (orders not being followed) included: Elevate head of bed while feeding and medication is being administered Flush tube with 30 ml of water before and after (med) medication administration and feeding for patency and hydration Enteral feed order, dilute each crushed/sprinkles/powdered med with at least 15 ML (milliliter) of water and rinse the cup with 5 to 15 ml to ensure all residue is out of the cup Flush feeding tube with 5 ml of water between meds May give meds via tube, for patency and hydration (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Change feeding syringe daily Tube feeding spike sets: change ready to hang every 24 hours and prn G (gastrostomy) tube site may be left open to air if clean and no drainage Evaluate for displacement of tube by observing for abdominal distress /nausea/vomiting, pain, distention. If displacement is suspected, clamp tube, call MD (medical doctor) Order description not specified: Dilute liquid enteral medications with at least 15 cc (cubic centimeter) of H2O (water) prior to administration Review of Resident #1's care plans showed the resident required Enhanced Barrier Precautions related to: G-tube, suprapubic catheter, and trach initiated on 06/27/2024. Interventions included but not limited to Enhanced Barrier Precautions / Gloves and gowns to be worn when providing high touch resident care as of 06/27/2024. Review of Resident #1's care plans showed he was receiving enteral nutrition because of dysphagia as of 06/27/2024. Interventions included administration of enteral nutrition as ordered as of 06/27/2024; administration of flushes as ordered as of 06/27/2024. Review of Resident #1's care plans showed the resident had a tracheostomy related to acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia initiated as of 06/27/2024. Interventions included give humidified oxygen as prescribed revised on: 08/22/2024; maintain ambu bag and replacement trach at bedside per order revision on: 08/22/2024; monitor/document respiratory rate, depth and quality. Check and document every (q) shift/as ordered revised on 08/22/2024; suction as necessary revised as of 08/22/2024; Trach care per order revised as of 08/22/2024; tube out procedures: keep extra trach tube and obturator at bedside as of 06/27/2024. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Director of Nursing (DON) on 10/01/24 at 2:38 p.m. revealed Resident #1 was on enhanced barriers. She stated the staff have to wear certain PPE (Personal Protective Equipment) when providing care, included gowns and gloves. She said staff should be hand sanitizing between residents, upon leaving the room. The staff should wash their hands prior to entering another resident's room. The DON stated it was not the norm, nor were the staff supposed to, place sterile gloves over nonsterile gloves. The DON stated the staff should not be opening bottles of water with sterile gloves. She stated that sterile gloves should not be put on until they are ready to provide care. The DON stated we have (trach) kits, I don't know why she used the sterile water bottle. The DON verified there were orders in the queue dated 09/25/2024, which had not been processed. She stated until they are processed the staff was not following these physician orders. The DON stated they should be following the orders. The DON verified there was not an order to flush the g-tube with 60 cc of water. The DON stated the staff should have been hand sanitizing. The DON's expectation was to make sure proper infection control protocol was followed and do education with the staff. The DON verified the trach care order showed the trach was to be cleansed with normal saline and pat dry and a drain sponge applied. She stated the orders showed an inner cannula was to be cleaned daily, and they are to supposed to do it, if the resident had an inner cannula trach. The DON reviewed the TAR for Post Suction of trach, record amount of secretions, characteristic of secretions (color, odor, viscosity) lung sounds, heart rate, respirations, and tolerance as of 08/21/2024, and verified the lack of documentation. She stated she expected to see lung sounds, heart rate, respirations and tolerance documented at the time of the procedure. During an interview on 10/01/2024 at 4:16 p.m. the Assistant Director of Nursing (ADON), who was also the Infection Control Preventionist, stated the staff was to wash their hands or hand sanitize before and after care, after removing gloves, anytime they touch anything, all the time. The staff was to wash their hands if they were visibly dirty. The staff was not to double glove. The staff had been educated before about hand sanitizing. If the staff member has sterile gloves on and they touch things, they need to remove the gloves, hand sanitize and re-glove. Enhanced Barrier Precautions was supposed to be used when providing care such as personal care. The staff member should have had a gown on when providing trach care. The ADON stated, If in doubt, put a gown on. Review of the facility's competency, Tracheostomy Care Competency Skills Checklist, without a date showed 1. Check TAR [Treatment Administration Record] to verify physician orders for Trach care 2. Gather supplies: trach care kit or gather supplies: non-sterile gloves, sterile gloves, trach ties, suction kit, disposable inner cannula, extra sterile saline and non-sterile 4 x 4s, bag to discard dressings / items in 3. Knock on resident's door for permission to enter and introduce yourself 4. Verify resident identity via arm band / resident photo or calling resident name 5. Explain procedure to resident and provide privacy 6. Wash hands and apply non-sterile gloves (soap and water or hand sanitizer) 7. Remove and dispose of trach dressing (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Wash hands and apply gloves (soap and water or hand sanitizer) 7. Open suction kit place on top of non-permeable barrier 8. [NAME] sterile gloves and other PPE (as indicated) 9. Attach the catheter to the connecting tube, keeping the sterile hand on the catheter and the clean hand on the connecting tube 10. Instruct the resident to take several breaths prior to suctioning (if patient is able) 11. Advance the suction catheter until slight resistance is felt and / or resistance is felt and /or coughs (note measurement on catheter) 12. Remove the catheter from the airway using a gentle twisting motion in conjunction with intermittent suctioning (this process should take no more than 5 to 10 seconds) 13. Observe secretions removed while monitoring residents color and reaction to procedure (obtain oxygen saturations per MD order) 14. Encourage the resident to cough up any remaining secretions 15. Suction a small amount of saline from the cup to clear the catheter tip from any remaining secretions 16. Repeat steps 10 - 15 as needed 17. Discard suction catheter and supplies 18. Clean suction tubing with remaining normal saline. Turn off suction machine and place tubing in labeled / dated setup bag 19. Wipe down area with disinfectant wipes. Remove gloves. Discard. 20. Wash hands with soap and water 21. Reposition / ensure resident comfort 22. Document procedure and all observations Review of the facility's policy, Hand Hygiene, dated October 2021 showed the facility considers hand hygiene the primary means to prevent the spread of infections. Procedure: 1. Personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. Personnel shall follow the handwashing / hand hygiene guidelines to help prevent the spread of infections to other personnel, residents, and visitors. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Employees must wash their hands for twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice); Before and after performing any invasive procedures; Before and after entering isolation precaution settings; Before and after handling peripheral vascular catheters and other invasive devices; Before and after changing a dressing; Upon and after coming in contact with a resident's intact skin; After contact with a resident's mucous membranes and body fluids or excretions; After handling soiled or used linens, dressings, bedpans, catheters, and urinals; After handling soiled equipment or utensils; After removing gloves or aprons. 6. The alternate method of hand hygiene is with an alcohol-based hand rub. 7. Hand hygiene is the final step after removing and disposing of personal protective equipment. 8. The use of gloves does not replace handwashing / hand hygiene. Review of the facility's policy, Barrier Precautions, dated April 2024 showed standard precautions are the minimum infection prevention steps to include: 1. Hand hygiene, proper washing of hands before and after patient contact. 2. Use of appropriate protective equipment (i.e. gloves) before patient care. Enhanced Barrier Precautions (EBP) refers to infection control interventions designed to reduce transmission or multi-drug resistant organisms (MDROs) that employ targeted gown and glove use during high contact resident activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfers of MDROs to staff hands and clothing. EBP is indicated for residents with any of the following: 1. Infections or colonization with a CDC (Centers for Disease Control) -targeted multi-drug resistant organism when Contact Precautions do not otherwise apply or, 2. Wounds and / or indwelling medical devices even if the resident is not known to be infected or colonized with a multi-drug resistant organism. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy, Physician Orders, dated October 2021 showed 2. Physician's orders will include the drug or treatment and a correlating medical diagnosis or reason. 3. Medication orders to include: A. Route B. Dosage C. Frequency D. Strength E. Reason for administering F. Stop date 4. Enteral nutrition therapy orders will include the following required components: A. fluid B. Amount C. Flow rate D. Pump slash gravity bolus use E. Flush orders. Additionally a separate order to be obtained for dressing changes for this therapy, if required medications that require monitoring will need to be entered into the electronic medical records. 12. Confirm the accuracy of orders. Review orders daily in the clinical meeting to confirm accuracy and transcription and identify errors of omission. 16. When the physician changes an order that is currently in place, discontinue the original physicians order when the physician changes an order that is currently in place. Assure the new order reflects the change and order components required. The night shift nurses will verify orders received within the last 24 hours has been transcribed into the electronic record. The nurse will review each hard chart for new orders and compare to the electronic order listing report to ensure each written order has been entered into the electronic medical record. If a written physician's order is found on the chart and not on the order listing, transcribe the order and monitor and notify the resident / representative. Medication treatment variants may be completed if needed with physician notification.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Cross reference F656 and F695 Based on observation, interview, and record review the facility failed to follow standard and enhanced barrier precautions when performing resident care for one (#1, #7) of seven sampled residents. Findings included: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/01/2024 beginning at 9:42 a.m., Staff A, Registered Nurse (RN) entered Resident #1's room without a gown on and put on gloves. Resident #1 was lying in bed, had a trach with humidifier mask in place, and oxygen attached. Staff A, RN detached the feeding tube from the (gastrostomy) g-tube site for Resident #1 Staff A, RN removed her gloves and did not perform hand hygiene. She applied new gloves and went to Resident #1's roommate (Resident #7) and detached Resident #7's feeding tube from the g-tube site. She removed her gloves, did not perform hand hygiene, and exited the room. Staff A, RN went to the medication cart and started to open it. Staff A, RN then stopped and went into the resident room across from Resident #1 and #7 and washed her hands. Staff A then entered Resident #1's room again without donning a gown. She applied non-sterile gloves and opened the drawer to the resident's side table. She removed sterile gloves and a packet of drain sponges. She applied the sterile gloves over the non-sterile gloves and opened the bottle of sterile water with the sterile gloves. She removed the suction catheter from the bag on the wall. She removed the humidifying mask and suctioned the resident. She placed the suction tubing into the sterile water bottle. She removed the suction tubing from the bottle of water and suctioned the resident again. She turned off the suction machine. She replaced the suction tubing into the bag on the wall. She took off the sterile gloves and threw them away (leaving on the non-sterile gloves). She threw the bottle of water away, opened another package of sterile gloves, and applied the sterile gloves. She removed the trach dressing from around the resident's trach and threw it in the trash can. She wiped around the trach with a drain sponge and wiped the humidifier mask with the drain sponge. She replaced the humidifier mask and removed both sets of gloves. She went to the resident's bathroom and washed her hands for a short period of time. Staff A left the room, opened the computer on the medication cart, and then went to the supply room (down the hallway) to retrieve more drain sponges. When Staff A returned approximately five minutes later, she closed the computer on the medication cart and re-entered Resident #1's room. Staff A, RN did not don a gown and placed the drain sponges on the bedside table. Staff A, RN washed her hands for a short period of time in the bathroom, applied non-sterile gloves and sterile gloves over the non-sterile gloves. She opened the drain sponges and placed the drain sponges around the resident's trach. She removed her gloves and threw the paper trash for the drain sponges into the trash can. Staff A, RN washed her hands, exited the room, and went to the medication cart and computer. She returned to Resident #1's room without gowning or performing hand hygiene and applied non-sterile gloves. She retrieved a Styrofoam cup from the room and a 60-cc (cubic centimeters) syringe and entered the bathroom. She turned on the faucet with her gloved right hand, put water into the cup, and turned the faucet off using a paper towel. She opened the privacy curtain to stand next to Resident #1's bed. Staff A uncapped the g-tube, attached the 60-cc syringe and poured 60 cc of water into it. She used the plunger to gently push the 60 cc of water into the g-tube. She removed the syringe, recapped the g-tube, removed her right glove only and put the syringe back in the packaging, and then removed her left glove. Staff A, RN then washed her hands for a short time period. She touched the privacy curtain, Resident #1's bed, left the room, re-entered the room, moved the bed into a low position, moved the bed around and repositioned it into a higher position. Staff A, RN touched the resident and exited the room without performing hand hygiene. A fan on the over bed table which was previously placed away from Resident #1 was now facing towards the resident. Staff A, RN then returned to the medication cart. (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 10/01/2024 at 10:05 a.m. Staff A, RN stated the orange sign on Resident #1's door meant enhanced barrier precautions. Staff A, RN stated enhanced barrier was for a resident who had a catheter or trach or something. She stated they were supposed to wear gloves and gowns. She confirmed she did not wear a gown during care of the resident. Staff A stated, you are supposed to hand wash with soap and water when changing gloves. She stated, I did not hand sanitize between glove changes. Staff A stated when she left Resident #1's room, she went across the hall and washed her hands one time. Staff A stated, I do not like the way the blue gloves [sterile gloves] feel next to my skin; it was tight and itchy. She stated she placed the blue gloves over the clear gloves (non-sterile gloves) because of that. She stated the family put the fan in the resident's room and it does get hotter in there sometime due to the equipment. Review of Resident #1's admission record revealed an admitted [DATE], readmitted [DATE], and diagnoses to include anoxic brain damage, respiratory disorders, acute and chronic respiratory failure, bell's palsy, metabolic encephalopathy, muscle wasting and atrophy, acute kidney failure, myocardial infarction, acute and subacute hepatic failure, hypokalemia, obstructive and reflux uropathy, protein-calorie malnutrition, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 0, indicating severe cognitive impairment. The resident was rarely or never understood, was dependent on staff for bathing and toileting, and received oxygen therapy and tracheostomy care. Review of physician orders showed transmission based precautions enhanced barrier precautions due to g-tube, trach, and suprapubic catheter as of 09/16/2024. Review of the October Medication Administration Review (MAR) and Treatment Administration Review (TAR) showed transmission based precautions enhanced barrier precautions due to g-tube, trach, and suprapubic catheter as of 09/16/2024 was documented as performed by Staff A, RN. Review of progress notes showed on 09/25/2024 the Interdisciplinary Team met to review Resident #1's Plan of Care and documented the resident on enhanced barriers due to g-tube and suprapubic catheter. Review of Resident #1's care plans showed the resident required Enhanced Barrier Precautions related to: G-tube, suprapubic catheter, and trach initiated on 06/27/2024. Interventions included Enhanced Barrier Precautions / Gloves and gowns to be worn when providing high touch resident care as of 06/27/2024. Interview with Director of Nursing (DON) on 10/01/24 at 2:38 p.m. confirmed Resident #1 was on enhanced barriers. She stated the staff have to wear certain PPE (Personal Protective Equipment) when providing care, included gowns and gloves. The staff should be hand sanitizing between residents and upon leaving the room. The staff should wash their hands prior to entering another resident's room. The DON stated it was not the norm for the staff to place sterile gloves over nonsterile gloves. The DON stated the staff should not be opening bottles of water with sterile gloves. She stated that sterile gloves should not be put on until they are ready to provide care. The DON stated we have (trach) kits, I don't know why she used the sterile water bottle. The DON stated the staff should have been hand sanitizing. The DON's expectation was to make sure proper infection control protocol was followed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105269	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Groves Center	512 S 11th St Lake Wales, FL 33853

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/01/2024 at 4:16 p.m. the Assistant Director of Nursing (ADON), who was also the Infection Control Preventionist, stated the staff was to wash their hands or hand sanitize before and after care, after removing gloves, anytime they touch anything, all the time. The staff was to wash their hands if they were visibly dirty. The staff was not to double glove. The staff had been educated before about hand sanitizing. If the staff member has sterile gloves on and they touch things, they need to remove the gloves, hand sanitize and re-glove. Enhanced Barrier Precautions was supposed to be used when providing care such as personal care, etc. The staff member should have had a gown on when providing trach care. The ADON stated, If in doubt, put a gown on. Review of the facility's policy, Hand Hygiene, dated October 2021 showed the facility considers hand hygiene the primary means to prevent the spread of infections. Procedure: 1. Personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. Personnel shall follow the handwashing / hand hygiene guidelines to help prevent the spread of infections to other personnel, residents, and visitors. 5. Employees must wash their hands for twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice); Before and after performing any invasive procedures; Before and after entering isolation precaution settings; Before and after handling peripheral vascular catheters and other invasive devices; Before and after changing a dressing; Upon and after coming in contact with a resident's intact skin; After contact with a resident's mucous membranes and body fluids or excretions; After handling soiled or used linens, dressings, bedpans, catheters, and urinals; After handling soiled equipment or utensils; After removing gloves or aprons. 6. The alternate method of hand hygiene is with an alcohol-based hand rub. 7. Hand hygiene is the final step after removing and disposing of personal protective equipment. 8. The use of gloves does not replace handwashing / hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy, Barrier Precautions, dated April 2024 showed standard precautions are the minimum infection prevention steps to include: 1. Hand hygiene, proper washing of hands before and after patient contact. 2. Use of appropriate protective equipment (i.e. gloves) before patient care. Enhanced Barrier Precautions (EBP) refers to infection control interventions designed to reduce transmission or multi-drug resistant organisms (MDROs) that employ targeted gown and glove use during high contact resident activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfers of MDROs to staff hands and clothing. EBP is indicated for residents with any of the following: 1. Infections or colonization with a CDC (Centers for Disease Control) -targeted multi-drug resistant organism when Contact Precautions do not otherwise apply or, 2. Wounds and / or indwelling medical devices even if the resident is not known to be infected or colonized with a multi-drug resistant organism. Review of the facility's competency, Tracheostomy Care Competency Skills Checklist, without a date showed 1. Check TAR [Treatment Administration Record] to verify physician orders for Trach care 2. Gather supplies: trach care kit or gather supplies: non-sterile gloves, sterile gloves, trach ties, suction kit, disposable inner cannula, extra sterile saline and non-sterile 4 x 4s, bag to discard dressings / items in 3. Knock on resident's door for permission to enter and introduce yourself 4. Verify resident identity via arm band / resident photo or calling resident name 5. Explain procedure to resident and provide privacy 6. Wash hands and apply non-sterile gloves (soap and water or hand sanitizer) 7. Remove and dispose of trach dressing 8, Remove gloves and wash hands (soap and water or hand sanitizer) 9. Prepare trach care kit and supplies on work surface area 10. Separate 4 x 4 gauze sponges and Q-tips (if needed) and pour sterile water or normal saline into container 11. Put on sterile gloves found in kit 12. Place protective drape over resident (continued on next page)

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