STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105289	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Punta Gorda	450 Shreve Street Punta Gorda, FL 33950

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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 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 25618 Based on record review, and staff interviews, the facility failed to ensure the activities program was directed by a qualified professional who was a qualified therapeutic recreation specialist or an activities professional. This had the potential to affect all current residents residing in the facility. The findings included: On 7/24/24 at 12:24 p.m., the Activity Director said the prior Activity Director's last day of employment was 5/30/24. She said she has been the facility's interim Activity Director since 6/1/24. She said she was responsible for completing the activity assessment for each resident, create and post the activity calendar for the facility and arrange when outside entertainment would come to the facility. She said she did not have a degree, and/or a certificate as an activities professional, did not have two years of experience in a social or recreational program within the last 5 years, and was not a qualified Occupational Therapist or Occupational Therapist Assistant. She said in mid-May 2024 she started but had not completed a course to receive a national certificate to become an activity professional. Review of the Activity Director job description stated under the education, experience, and licensure/certifications section the Activity Director, Must be a qualified activities professional who is licensed or registered, if applicable, by the State in which practicing, and eligible for certification as an activities professional by a recognized accrediting body and or after 10/1/1990 or has 2 years of experiences in a social or recreational program within the last 5 years, one which was full-time in a therapeutic activities program, or is a qualified occupational therapist or occupational therapist assistant or has completed a training course approved by the State. The Therapeutic Activities Program policy issued on 1/06/2020 and revised on 4/01/22, stated per federal regulation the facility's activities program would be directed by a qualified activities director. The director was responsible for directing the development, implementation, supervision and ongoing evaluation of the activities program. This included the completion and/or directing/delegating the completion of the activity's component of the comprehensive assessment. (continued on next page)

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

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

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/24/24 at 12:57 p.m., in an interview the Executive Director (ED) confirmed after reviewing the current Activity Director's employee file, their Activity Director did not have the required certification showing she had completed a training course to become a activity professional, was not a qualified occupational therapist, and/or had two years of experience in a social or recreational program with in the last 5 years prior to becoming the facility's Activity Director on 6/1/24 as required per federal regulation as noted in the Therapeutic Activities Program policy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observation, record review, review of the facility's policy and procedure, resident and staff interview, the facility failed to provide care and services in accordance with professional standards by failure to follow the physician's order for 1 resident (#114) of 1 resident reviewed with lower extremities swelling. The findings included: Review of the facility policy for Physician Orders Revised 2/26/24 noted the facility is obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines. The receiving nurse or therapist immediately enters telephone or verbal orders into the clinical software. Review of the clinical record for Resident #114 revealed an admitted [DATE]. The Admission Minimum Data Set (MDS) Assessment with a target date of 5/30/24 noted Resident #114's cognition was intact with a Brief Interview for Mental Status Score of 15. Review of the physician's order revealed on 6/13/24 to apply knee high [NAME] hose (compression stockings) to bilateral lower extremities in the morning and remove at bedtime for edema (swelling). On 7/22/24 at 2:53 p.m., Resident #114 was observed in her room sitting on the side of the bed. The resident was not wearing the [NAME] hoses on her lower legs. In an interview Resident #114 said the [NAME] Hoses are uncomfortable and she refuses to wear them. The resident said they are applying Ace bandages (elastic bandages) instead of the [NAME] hoses but they were not applied today. Resident #114 said, The aid told me they were too busy. On 7/23/24 at 12:39 p.m., Resident #114 was observed in her room sitting on the side of the bed. The resident was not wearing the [NAME] hose to her legs as per the physician's orders. In an interview Resident #114 said the nurse told her she would apply ace bandages to her lower legs after lunch. Two Ace bandages were observed on the nightstand. On 7/23/24 at 5:18 p.m., Resident #114 was observed in bed in her room. Her right lower leg was wrapped with an Ace bandage. Resident #114 said the Ace bandage to her left lower leg came off. On 7/24/24 at 9:51 a.m., Resident #114 was observed in bed with an Ace bandage to her right leg. In an interview Resident #114 said the Ace bandage was applied to her right leg the prior day and left in place all night. The clinical record did not reveal a physician's order authorizing the use of an Ace bandage instead of the [NAME] hose to the resident's lower extremities. On 7/24/24 at 10:00 a.m., Review of the Treatment Administration Record (TAR) for July 2024 revealed documentation [NAME] hose were applied to the resident's lower legs on 7/22/24, and 7/23/24 at 8:00 a.m. and removed at 10:00 p.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/24 at 12:29 p.m., in an interview Licensed Practical Nurse (LPN) Staff G verified the documentation on the TAR was not accurate for 7/22/24 and 7/23/24 since the [NAME] hose were not applied to the resident's legs at 8:00 a.m. She said she wraps Resident #114's legs with Ace bandages instead of the [NAME] hose as the resident complained the [NAME] hose hurt her legs. Staff G verified on 7/23/24 she did not apply the Ace bandages to the resident's lower legs in the morning as ordered but at 1:51 p.m., for no reason in particular. She said when she went to apply the bandages to the resident's legs this morning around 10:30 a.m., the resident's right leg was still wrapped with an Ace bandage. It appeared as though it was not removed all night. On 7/24/24 at 1:08 p.m., in an interview Unit Care Coordinator LPN Staff F said it was not acceptable to apply Ace bandages instead of the physician ordered [NAME] hose to the resident's lower legs. On 7/25/24 at 10:12 a.m., in an interview the Director of Nursing (DON) said LPN Staff G did not follow the facility's process. She said the nurses should only place their initials on the TAR after the treatment is completed. When LPN Staff G obtained a new order to use Ace bandages instead of [NAME] hose, she should have written a progress note and changed the order.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on record review, review of facility policy and procedures, resident and staff interviews, the facility failed to ensure staff followed policies and procedures and established plan of care to ensure prompt evaluation and safe transfer after a fall for 1 (Resident #31) of 4 residents reviewed for falls. The findings included: The facility policy Incident and Reportable Event Management reviewed 9/14/23 documented, The facility to the best of its ability strives to provide an environment that is free from accident hazards over which the facility has control and provide supervision and assistive devices to each resident to prevent avoidable incidents . Avoidable accident means that an accident occurred because the facility failed to . Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and if not, reduce the risk of an accident . Fall refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force . Incident/Injury. The Licensed nurse should evaluate the resident and render first aide if needed. The nurse evaluation should be completed prior to moving a resident who has fallen to determine presence of injury . Review of the clinical record revealed Resident #31 was admitted to the facility on [DATE]. Diagnoses included a left above the knee amputation and left hemiplegia and left hemiparesis (weakness or inability to move the arm and leg on one side of the body). The Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 5/7/24 documented Resident #31's cognitive skills for daily decision making were intact with a Brief Interview for Mental Status score of 14. The MDS noted the resident was dependent for chair/bed-to chair transfer (Helper does all of the effort. Resident does none of the effort to complete the activity). The CNA Kardex specified for transferring, The resident is dependent and requires [Brand name] mechanical lift with 2 staff assistance for transfers. Review of the nursing progress notes showed on 7/6/24 Resident #31 complained of new onset of left arm pain. The Advanced Practice Registered Nurse was notified and ordered an X-ray of the left arm. The X-ray result showed an acute left humeral fracture. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation revealed the X-ray obtained on 7/6/24 showed Suspect incomplete fracture in proximal shaft of the left humerus with rather severe osteoporosis [weak, brittle bones] The investigation noted Certified Nursing Assistant (CNA) Staff N said on 7/5/24 when she went to assist Resident #31 into bed, the resident was leaning to the side and bent over forward. She said while repositioning the resident in the chair, he began to slide forward out of the chair so she lowered him to the floor. CNA Staff N stated the resident's left arm did not hit the chair or the floor and he was seated upright in front of the wheelchair. Resident #31 did not complain of any pain at the time. She said she got CNA Staff J and they lifted the resident from the floor onto the bed. Staff N said she put her arms under the resident's lower extremities and Staff J put his arm around the resident's upper body and they lifted him into the bed. CNA Staff J reported that Staff N asked him to help transfer Resident #31 into bed. When he entered the room the resident was sitting on the floor in front of his wheelchair. He put one arm under the resident's right arm and the other arm around the resident's left arm as the resident told him that his left arm was paralyzed from a stroke. Staff N put her arms around the resident's lower extremities and they lifted him into bed. Staff J reported the resident did not complain of any pain or discomfort to his left arm before, during, or after the transfer. The investigation noted on 7/6/24 Resident #31 complained of pain to his left arm and told the nurse he thought something happened to his arm when he was transferred into bed on 7/5/24 without the full body mechanical lift. On 7/8/24 the primary provider assessed and diagnosed Resident #31 with a fragility fracture of the left humerus related to severe osteoporosis and ordered to continue current pain medication regime as resident reported effectiveness. On 7/9/24 Resident #31 was assessed by an orthopedic doctor. An X-ray of the resident's left arm showed a fracture in the area of the humeral neck. The X-ray noted diffuse demineralization (losing bone minerals which can cause the bones to become brittle). The facility's investigation noted the resident was inconsistent in reports of events. Staff assigned to resident reported that resident was lowered to the floor while they were repositioning him in his wheelchair. Staff reported that resident was seated on the floor in front of the wheelchair. They performed a two person transfer from the floor to the bed. On 7/22/24 at 12:05 p.m., in an interview Resident #31 said he uses a mechanical lift for transfers. He said, I remember what happened when they dropped me. It was a female and a male CNA. I was in my wheelchair and they were lifting me, the girl had my foot and he had me around the waist under my arms and just as we got close to the bed they dropped me and down I went to the floor. I don't know why they didn't use the lift with me. My left arm hurts, they said it is broken. On 7/22/24 at 12:18 p.m., in an interview Restorative CNA Staff M, said Resident # 31 required a mechanical lift for all transfers with a special sling since his left leg is amputated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/24 at 12:00 p.m., in a second interview Resident #31 said, I fractured my arm because the staff did not use a lift with me. I was in my wheelchair. They tried to transfer me to bed without the lift and they dropped me. The guy had me under the arms around my chest, I guess he didn't know I can't use my left arm at all, it does not work. They dropped me and then they picked me up and tossed me into the bed. The girl had my right leg, and down I went on the floor. They did not use the mechanical lift; I don't know why. I did not have pain right then and there because I don't always have feeling in the left arm. But the next day it really hurt. On 7/24/24 at 8:39 a.m., in an interview CNA Staff L said she was not working on 7/5/24 when the incident with Resident #31 occurred. She said a day or so after the incident Resident #31 was yelling loudly that his arm hurts so she reported it to the nurse. On 7/24/24 at 9:41 a.m., in an interview the Director of Nursing (DON) said she was notified Resident #31 complained of pain to left arm. He told the nurse he believes something happened when he was put into bed the other night. The resident said it had happened the other night when the CNA's transferred him. He went to the orthopedic physician, and they did another x-ray that showed a fracture of the left humeral neck. When she spoke with Resident #31, he confirmed he was on the floor and they lifted him into bed. I asked and he kept saying they dropped me, they dropped me. He said he was in the wheelchair and was leaning to the right. He confirmed he was lowered to the floor and picked back up. The DON said they did not know when the fracture happened, and the provider documented a pathological fracture (fracture caused by weakness of the bone structure). She said the policy specifies to notify the nurse when a resident falls or is lowered to the floor. Staff N did not notify the nurse when she lowered the resident to the floor. The resident said the pain started later in the night and he did not tell anyone until morning. He said he felt the injury was from the transfer. CNA Staff J said he had his arm over the resident's left arm, in a bear hug to get him into bed. She concluded it could have happened during the transfer. Resident #31 directly said the pain occurred after the fall and the likelihood was the fracture did happen during the transfer. The DON said, They did not call the nurse and they did not use the lift but I can't say how the fracture happened. I can't say exactly, there are different factors. I can't connect the two occurrences, the lowering to the floor and bear hug to lift him in the bed as the cause of the fracture. On 7/24/24 at 11:12 a.m., a phone call was placed to CNA Staff J. He did not answer and did not return the call. On 7/24/24 at 11:14 a.m., in a telephone interview CNA Staff N said on the night of 7/5/24, Resident #31 was in the wheelchair. She was trying to get the sling behind him which was hard to do. He could not grip the chair and started to slide out of the wheelchair. She could not stop him so she lowered him to the floor, next to the bed. She got CNA Staff J to come and help her. She grabbed the resident's buttocks and the right leg. CNA Staff J grabbed the top of the resident. Staff J had his arms wrapped around the resident like a hug. She verified they manually lifted and transferred the resident from the floor to the bed and did not use the mechanical lift as specified in the care plan and the Kardex. She also verified she did not notify the nurse of the resident's fall since he did not complain of pain at that time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/24 at 11:47 a.m., in a telephone interview Registered Nurse (RN) Weekend Supervisor Staff M said, first thing in the morning about 8:00 or 8:30 a.m., on 7/6/24 the nurse became aware the resident had pain. She went to speak with him. Resident #31 complained of pain to the left shoulder rated seven out of 10. Resident #31 told her he thought it happened the night before when they transferred him. He said the CNAs lifted him without the mechanical lift. He did not tell anyone about the incident but told the CNA and the nurse his arm was hurting. He got a pain pill. Staff M said when the X-ray revealed a fracture she notified the Director of Nursing. She spoke with CNA Staff J who said Resident #31 was sitting on the floor, slumped and leaning forward when he went in to help CNA Staff N. They lifted the resident off the floor and put him to bed. He did not know if the resident had fallen. On 7/24/24 at 5:38 p.m., in an interview the DON said if a resident is on the floor, the process is to notify the nurse who will assess for any injury, potential fracture, get a gait belt to transfer. She said it is not always feasible to use the lift to get a resident off the floor. It depends on the situation, such as the position of the resident, weight bearing status. If therapy is present they would assist with the transfer and determine if the lift is needed. She said the main error was that CNA Staff N did not notify the nurse immediately. The nurse should have assessed the resident.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on record review, and staff interview, the facility failed to assess, evaluate, and plan care to provide individualized approaches to restore as much normal bladder function as possible for 1 (Resident #114) of 3 residents reviewed for incontinence. The findings included: Review of the facility policy for Urinary Incontinence Management, Reviewed 8/23/2023 noted, Each resident who is incontinent of urine is identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal bladder function as possible . The facility must ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain . An incontinent resident typically feels frustrated, embarrassed, and hopeless. Fortunately, bladder retraining - a program that aims to establish a regular voiding pattern - can usually correct this problem. Follow these guidelines: Assess elimination patterns . Establish a voiding schedule . Record results . Clinical record review revealed Resident #114 was admitted to the facility on [DATE]. Diagnoses included fracture of the right knee and legal blindness. The Nursing Admission Collection Tool dated 5/24/24 noted Resident #114 was able to make herself understood, was oriented to person, place, time and situation. Resident #114 was continent of urine. The baseline care plan dated 5/24/24 did not include urinary incontinence as a concern requiring interventions. The Admission Minimum Data Set (MDS) assessment with a target date of 5/30/24 noted Resident #114's cognition was intact with a Brief Interview for Mental Status Score of 15. The assessment noted the resident was occasionally incontinent of urine. The assessment did not document an assessment, or interventions attempted since the urinary incontinence was noted to maintain or restore urinary continence status. The care plan initiated on 5/24/24 noted Resident #114 has bowel and bladder incontinence at times related to impaired mobility and decreased functional range of motion of the right lower extremity. The goal was to decrease the frequency of incontinence through the next review date. The interventions included to administer preventative creams as ordered (5/28/24), clean peri-area with each incontinence episode (5/24/24), observe for and document signs and symptoms of urinary tract infections (5/24/24), Provide unobstructed path to the bathroom (5/24/24), weekly skin checks and as needed (5/28/24). The Kardex (Provides instructions for care) noted the resident required limited assistance of one person for bladder and bowel. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan and Kardex did not include individualized interventions to maintain or restore urinary continence. Review of the Skilled nursing documentation for 6/25/24, 6/28/24, 7/1/24, 7/2/24, 7/5/24, 7/10/24, 7/11/24, 7/12/24 and 7/14/24 revealed abnormal genitourinary findings. The intervention was, Incontinent care provided as needed. Review of the CNA documentation for 30 days from 6/25/24 through 7/24/24 revealed Resident #114 had 28 episodes of incontinence during the day, evening, and nighttime. On 7/22/24 at 2:37 p.m., in an interview Resident #114 said she is continent and can tell when she needs to urinate. She said she needs assistance to use the bedpan to urinate. Resident #114 said she takes a water pill and wets herself when staff do not answer the call light and get to her in time. Resident #114 said today she waited 20 minutes after she activated the call light for assistance to use the bedpan. The CNA told her she was passing meal trays and would only be a minute. Resident #114 said she's been having more and more episodes of incontinence the longer she's been at the facility. She stated, When I put the call light on, I really need to go, and I told them that. Sometimes I feel as though I am being ignored. I do not need to wear an incontinence product all the time when I'm at home. She said the facility provided her incontinence brief to wear but she does not like to urinate in them. On 7/23/24 at 4:03 p.m., in an interview Certified Nursing Assistant (CNA) Staff A said Resident #114 is continent and puts her light on when she needs to use the bedpan. She said the resident prefers the bedpan. Staff A said the resident uses an incontinent brief but does not need it since she is continent. On 7/24/24 at 2:10 p.m., in an interview CNA Staff B said she finds bowel and bladder instructions for each resident on the Kardex. She said the Kardex should tell whether the resident is continent or incontinent. She said Resident #114 takes a water pill and if they don't get to her in time, she will urinate in the incontinent brief. She said she checks the resident every two hours. She said no one, including the nurse, instructed her to check on Resident #114 more frequently than every two hours. On 7/24/24 at 2:17 p.m., in an interview CNA Staff C said Resident #114 is continent and will tell staff when she needs to go. She said she was not told to put her on a schedule or offer toileting more often than every two hours. On 7/24/24 at 2:27 p.m., in an interview MDS Coordinator Registered Nurse (RN) Staff D said she completed the MDS section, and care plan addressing the continence status for Resident #114. She verified the care plan did not list interventions to restore Resident #114's urinary continence. She said the nursing staff should be checking on the resident every two hours but they should do that with all residents. She said in order to decrease Resident #114's episodes of incontinence, she would have to be placed on a scheduled voiding program. RN Staff D verified no voiding program was implemented for Resident #114. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/24 at 2:56 p.m., in an interview Unit Care Coordinator, Licensed Practical Nurse (LPN) Staff F said the Admission Skilled Nursing Assessment noted Resident #114 was continent of urine, and now the resident was having incontinent episodes. She said she did not know how the new incontinence would have triggered but the nurses should monitor for things like this. On 7/25/24 at 10:20 a.m., in an interview the Director of Nursing (DON) verified Resident #114 had been at the facility for two months. She said the MDS coordinators should be looking at the data they have available for Resident #114. She said Resident #114 should have been evaluated to determine if she was a candidate for a toileting program but the evaluation was not completed until today. Review of the Occupational Therapy progress note dated 7/24/24 noted Resident #114 participated in mock commode transfers with focus on improving hand placement, body mechanics, and balance to further improve independence with task. Despite education the resident prefers to use the bedpan due to self-limiting behaviors. The therapist documented Resident #114 actively participated in the therapy session. Encouragement and education were provided to overcome barriers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105289	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Punta Gorda	450 Shreve Street Punta Gorda, FL 33950

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41155 Based on observation, record review and staff interview the facility failed to follow the manufacturer's instruction for cleaning and disinfecting of the Blood Glucose Monitoring System (glucometer) for 2 (Residents #57 and #556) of 3 residents reviewed with physicians' orders for blood glucose monitoring. Inadequate disinfection may result in indirect contact transmission (the transfer of an infectious agent through a contaminated inanimate object) of blood borne pathogens. The findings included: Review of the Journal of Diabetes Science and Technology (March 2009): Finger-stick devices, blood glucose testing meters, or even a health care worker's hands may all become vehicles for indirect transmission of viruses if they become contaminated with blood. Since HBV (Hepatitis B virus) is highly infectious and environmentally stable, even invisible amounts of blood are sufficient to spread infection. Review of the Center for Disease Control website at https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html noted, Blood glucose meters can easily become contaminated during use. When used in healthcare or other group settings, germs and infections can spread if preventive measures are not in place . Dedicated meters should be cleaned and disinfected per the manufacturer's instructions and, at a minimum, anytime the device is reassigned to a different person. Dedicated meters should be stored in a manner that prevents cross-contamination and inadvertent use for the wrong patient. If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per the manufacturer's instructions, to prevent the spread of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected, it should not be shared . On 7/23/24 at 11:40 a.m., Licensed Practical Nurse (LPN) Staff Q was observed doing a fingerstick and using a glucometer to measure Resident #57's blood glucose level. Staff Q retrieved the glucometer from a sealed plastic bag from the medication cart. She wiped the front of the glucometer three times with an alcohol prep pad. She used a second alcohol prep pad and wiped the back of the glucometer three times. Staff Q placed the glucometer on a clean tissue on the medication cart and said she had to wait two minutes for the glucometer to dry. After measuring the resident's blood glucose, Staff Q wiped the glucometer with an alcohol prep pad, allowed it to dry. She placed the meter in a sealed plastic bag and stored it in the cart. On 7/23/24 at 11:46 a.m., in an interview Staff Q said the glucometers can be used for multiple residents but currently only used for Resident #57. She said the facility's policy was to wipe the glucometer down with an alcohol prep pad before and after using on a resident. She said she wipes the glucometer three times on the front and three times on the back and allows it dry for two minutes before placing it back into the medication cart in a sealed plastic bag. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105289	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Punta Gorda	450 Shreve Street Punta Gorda, FL 33950

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 7/23/24 at 12:00 p.m., LPN Staff P was observed doing a fingerstick and measuring Resident #556's blood glucose with a glucometer. Staff P removed the glucometer stored in a sealed plastic bag from the medication and gathered the supplies needed. Staff P performed a fingerstick and used the glucometer to measure the resident's blood glucose level. Upon completion of the task, Staff P wiped the glucometer with an alcohol prep pad, placed it on a clean tissue on the cart and allowed it to dry. She then placed the glucometer back into the sealed plastic bag and stored it in the cart. In an interview Staff P said the policy was to wipe the front and the back of the glucometer with an alcohol wipe and let the meter dry for two minutes. Staff P said currently only Resident #556 used the glucometer. On 7/23/24 at 1:08 p.m., in an interview Unit Manager LPN Staff K said she thought alcohol wipes or a (brand name) disinfecting wipes could be used to disinfect the glucometers but she would have to find out for sure. She said the facility's policy was to wipe the glucometer three times with an alcohol wipe, using one wipe for the front and one wipe for the back. On 7/23/24 at 5:22 p.m., the Director of Nursing (DON) provided a copy of the facility's policy for Cleaning and Disinfection of the Glucometer. Review of the facility's policy for Cleaning and Disinfection of the Glucometer revised on 9/28/2022 and reviewed on 9/20/2023 noted the policy was, To prevent the spread of infections, specifically blood borne pathogens through the use of point of care blood glucose monitoring, by cleaning and disinfecting glucometers after each resident use. The procedure specified the brand name of glucometers used by the facility and cleaning procedures. The instructions specified the meter should be cleaned and disinfected after use on each patient. The instructions listed four disinfectant brands with an EPA (Environmental Protection Agency) number and specified, wipes with EPA registration numbers not listed should not be used to clean and disinfect the brand name glucometer used by the facility. Alcohol prep wipes were not listed on the list of approved disinfectants to clean and disinfect the glucometer used by the facility. The DON confirmed only the approved wipes with the EPA number should be used to ensure the disinfection of the glucometers.