STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105292	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Lake Nursing and Rehab Care Center	1100 66th St N Saint Petersburg, FL 33710

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Based on observation, interview and record review the facility failed to assess with an Interdisciplinary Team approach, obtain physician orders and develop a Comprehensive Person-Centered Care Plan for two of two sampled residents (#50 and #51) related to administering their own medications. Findings included: 1. Resident #51 was admitted on [DATE]. Review of the Resident Face Sheet showed diagnoses including acute bronchitis, shortness of breath, and anxiety disorder. An observation was conducted on 10/30/2024 at 9:08 a.m. with Staff A, Licensed Practical Nurse (LPN) for Resident #51's medication administration. Resident #51 was sitting in his bed. A bottle of Normal Saline Nasal Spray was sitting on the bedside table as well as lotion. A second observation occurred on 10/30/2024 at 1:40 p.m. with the Director of Nursing (DON). The DON asked the resident where the nasal spray came from. He stated his family brought it in for him. She informed him they would need to get an order for the spray and place it in the medication cart. The resident stated he was not using it, and she could take it. During an interview after exiting the room, the DON stated the resident had not been evaluated for performing administration of his own medications. The DON stated the resident had to be evaluated, have the Interdisciplinary Team (IDT) meeting and discuss with the physician. They would also need a physician's order. The DON stated the care plan would also have to be updated. Review of the October 2024 physician's orders did not show an order for nasal spray. Review of the medical record did not reveal an evaluation for self-medicating. Review of the care plans did not show interventions to include self-medicating. 2. Resident #50 was admitted on [DATE]. Review of the Resident Face Sheet showed diagnoses including chronic pain due to trauma-facial pain, glaucoma, chronic obstructive pulmonary disease, and schizoaffective disorder. Review of the October 2024 physician orders showed: Visine tears 15 ml (milliliter) drop both eyes 4 x day, 12, 4 a.m. 8 a.m. 12 p.m., 4 p.m., 8 p.m. given late at 9:56 a.m. Review of the medical record did not reveal an evaluation for self-medicating. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plans did not show interventions to include self-medicating. An observation was conducted on 10/30/2024 at 9:34 a.m. with Staff B, LPN for Resident #50's medication administration. Resident #50 was lying in bed. Staff B, LPN entered the room with a cup of medications and eye drops in the labeled plastic bag. Staff B applied gloves and handed the resident his eye drops from the plastic bag. She laid the plastic bag on the overbed table (no barrier). The resident was observed administering his own eye drops. Staff B handed him a tissue. Staff B picked up the plastic bag from the table, she placed the eye dops under her left arm and then placed them into the plastic bag and removed her gloves. She then exited the room. During an interview on 10/31/2024 at 2:25 p.m. with the Director of Nursing (DON) she stated none of the current residents had been evaluated for self-medicating. The DON stated that Resident #50 was a new resident. The DON stated that he had not been evaluated to perform self- medication. The DON stated he should not be administering his own eye drops. Review of the facility's policy titled, Administering Medications, not dated, showed medication shall be administered in a safe and timely manner, and as prescribed. 24. Residents may self-administer their own medication only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. Review of the facility's policy titled, Self-Administering of Medications, showed the Purpose to outline the guidelines and procedures for residents who are capable of self-administering their medications safely. Scope 1. Eligibility Criteria: residents must be assessed by a qualified health care professional to determine their capability to self- administer medications. Consider factors such as cognitive function, physical ability, and understanding of medication purposes and schedules. 2. Assessment Process: Conduct a comprehensive assessment that includes: Review of medical history and current medications. Evaluation of cognitive and physical abilities. Interviews with the resident and family members, if applicable. 3. Education and Training: Residents who are eligible for self-administration must receive education on: The purpose and dosage of their medications. Proper storage and handling of medications. Recognizing side effects and when to seek help. Staff should provide ongoing support and periodic reevaluations. 4. Medication Management Plan: Develop an individualized medication plan that includes: A list of approved medications for self-administration. A schedule for medication administration. Instructions for missed doses. 5. Storage and Accessibility: Medications should be stored in a secure location, accessible to the patient. Ensure that medications are organized to prevent confusion. 6. Monitoring and Documentation: Staff must regularly monitor residents who self-administer medications for: Adherence to the medication management plan. Any adverse reactions or issues arising from self-administration. Document all observations and any changes in the residence condition.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observation, record review and interview the facility failed to ensure a clean, sanitary homelike environment for two out of two units in the facility. Findings include: On 08/26/2024 at 11:00 a.m., an observation was made in room [ROOM NUMBER] revealing a hole in the wall next to the window and the wall border trim separated from the wall. The bathroom was dirty with paint chipped off the shower stall floor, rusted grab bars and yellow staining on the walls. room [ROOM NUMBER] were observed with broken, and missing blinds on the sliding doors and broken dressers in the resident's room. room [ROOM NUMBER] was observed with cable cords unattached from the wall, hanging down in the resident's room. On 08/29/2024 at 5:00 p.m., an interview was conducted with the Maintenance Director. He stated he conducts room audits once a month, but he has not done any room audits since he has started in the position. He knows he has to do some painting. Next week he will come up with a scheduled to repair the broken blinds in resident rooms. He stated he knows he has to fix the holes in the walls in resident rooms and fix other things in the facility but he lacks the time. 49497 Initial facility tour on 08/26/24 at 9:57a.m. Observed on North hallway a one by one foot section of stained ceiling with black circular substance and bubble paint/spackle patches. Floor tiles missing at end of hallway. Two end caps missing off hallway handrail exposing sharp handrail edges. (Photographic Evidence Obtained) On 08/26/22024 at 10:05 a.m. Observed in Resident #26 room a cable wire hanging from ceiling next to the resident's bed with exposed end, bathroom door with spackle patches x 2, and ensuite bathroom floor with multicolored paint and missing paint with red speckled substance on shower ro end. (Photographic Evidence Obtained) On 08/26/24 at 2:39 p.m. observed Resident #9 room with broken window sill tile with exposed sharp edges, red/brownish substance extending the base of the bed frame and bedside table, bedside chair with worn exposed patches of missing stain and loose bed enabler rail. (Photographic Evidence Obtained) An interview was conducted on 08/26/24 at 10:15 a.m. with Resident #31. He stated he shares his bathroom with the two guys next door (referencing Resident #9). He stated, take a look at the bathroom floor, it has been that way since I got here, and nothing has been done. He stated staff were aware and he has been told by facility management it would be painted for months and nothing has happened. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/29/24 at 2:40 p.m. a tour and interview was conducted with the Maintenance Director (MD) on north hallway. The MD was shown the exposed floor tiles, ceiling patch with black substance, missing handrail end caps, Resident #26's bathroom floor with missing paint, and hanging cable cord with exposed end and bathroom door. Resident #9's broken window sill tiles, discolored bed frame and bedside table, worn bedside chair with missing stain. The MD stated this was not acceptable and was aware all items shown need to be corrected immediately. 50732 On 08/26/2024 at 10:43 a.m. during an interview with Resident #4, a flying insect was observed on the resident's bed along with three other flies in the room. Also observed under the bed an area of broken floor tiles. (Photographic Evidence Obtained) Observations made on 08/26/2024, 08/27/2024, 08/28/2024 and 08/29/2024 of Resident #27's room. There were three missing vertical slats in the vertical blinds covering the sliding glass door in the room. The room faced a courtyard and Resident #27's bed could be seen from the courtyard through the missing vertical slats. On 08/26/2024 at 10:40 a.m. an observation was made of the North Exit Door, just outside of the room for Resident #1 and Resident #4, of trash on the floor, a bed in the hallway, and a dirty mattress leaning against the wall. (Photographic Evidence Obtained) On 08/26/2024 at 11:08 a.m. an observation was made in Resident #24's room of spilled, dried tube feeding on the pole of the tube feeding machine and on the floor around the pole. (Photographic Evidence Obtained) On 08/26/2024 at 11:03 a.m. an observation was made of the bathroom in room [ROOM NUMBER] of the shower floor tiles which showed dirt and mold on the tiles. (Photographic Evidence Obtained) An interview was conducted with the Maintenance Director on 08/29/2024 at 2:37 p.m. The MD said there was no maintenance person in the facility for quite a while before he started in June. He said he does not currently have an assistant and is doing everything by himself. He said he has quite a list of things to do. The MD said he needs to do room audits in every room to see what needs to be repaired. The Maintenance Director said he doesn't have an actual policy for his job and tasks he should be doing. He said he knows he is supposed to do some painting every week and he has the painting supplies in his office, but he has been too busy to complete any painting. He makes handwritten notes of tasks he needs to do and enters it into his work order system. He stated he does not keep the handwritten notes once he enters it into his work order system. A review of the undated facility policy titled, Homelike Environment, showed: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The Policy Interpretation and Implementation portion of the policy included the following: 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. The characteristics include: a. clean, sanitary and orderly environment; e. clean bed and bath linens that are in good condition; f. pleasant and neutral scents. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the undated policy titled, Environmental Housekeeping Policy for Nursing Home, showed: 1. Purpose: To maintain a clean, sanitary and safe environment for all residents, staff and visitors. To prevent the spread of infections and ensure the overall well-being of residents. 2. Scope: This policy applies to all areas within the nursing home, including resident rooms, common areas, bathrooms, dining areas and staff workspaces. 3. Responsibilities: Housekeeping Staff: Responsible for performing cleaning tasks as per the schedule and guidelines. Nursing and Medical Staff: Assist in maintaining cleanliness and reporting any issues. Management: Ensure the availability of necessary resources and oversee the implementation of the policy. 4. Cleaning Procedures: Daily Cleaning: Resident rooms-dust, vacuum and clean surfaces. Change bed linens and towels Common areas-clean floors, sanitize high-touch surfaces, and ensure restrooms are stocked and clean. Dining areas-clean and sanitize tables and chairs after each meal, and maintain a clean floor area. Weekly Cleaning: Deep clean carpets and upholstery. Wash windows and dust high surfaces. Monthly Cleaning: Clean vents, light fixtures, and other hard to reach areas. Perform detailed cleaning of other areas. 10. Resident Considerations: Ensure that cleaning practices to not disrupt the daily lives of residents. Accommodate residents' specific needs or preferences regarding cleanliness and comfort.

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F 0867 Level of Harm - Actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on observation, record review, and interview the facility failed to ensure the Quality Assessment and Assurance (QAA) Committee developed and implemented action plans to correct deficient practices identified during an intervening complaint survey conducted on 9/18/24 and the recertification survey originally conducted on 8/26/24 to 8/29/24 as evidenced by: 1) failure to ensure discharge and readmission requirements were met and documentation in the medical record was completed (F622, F623 and F626) for two residents (#1 and #3) of two residents reviewed, 2) a safe, clean and homelike environment for two of two units (F584), 3) failure to ensure the accuracy of the Resident Minimum Data Set (MDS) Assessment for one (#3) of three residents reviewed (F641), 4) failure to develop and implement a comprehensive person-centered care plan for three of seven sampled residents (#53, #54, and #9) related to wound care and enhanced barrier precautions (F656), 5) failure to ensure oxygen was provided according to physician orders for one resident (#50) out of three sampled residents (F695), 6) failure to ensure the medication error rate was less than 5%. Twenty-four medication administration opportunities were observed, and two errors were identified for one resident (#50) out of three residents observed. These errors constituted an 8% medication error rate (F759), and 7) failure to maintain an infection prevention and surveillance program related to reviewing the infection control guidelines policy, hand hygiene, cleaning of medical equipment and ensuring enhanced barrier precautions (EBP) were in place for three residents with wounds (#9, #53, #54) out of 16 residents sampled (F880). Findings included: Review of the facility's policy titled, Quality Assurance and Performance Improvement (QAPI) Program, undated, showed: Implementation 2. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process included: a. Tracking and measuring performance; establishing goals and thresholds for performance measurement; c. Identifying and prioritizing quality deficiencies; d. Systematically analyzing underlying causes of systemic quality deficiencies; e. Developing and implementing corrective action and performance improvement activities and; Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising if needed. During an interview on 10/30/24 at 4:30 p.m. the Nursing Home Administrator (NHA) stated that she could not provide the QAPI (Quality Assurance Performance Improvement) attendance sign-in sheets for August of 2024 and October 2024. The NHA was able to provide the September 2024 QAPI attendance sign-in sheets for review. The NHA stated she would also provide a QAPI meeting agenda to be reviewed as the QAPI meeting agenda never changes. Review of the Quality Assurance Performance Improvement (QAPI) and Risk Management Attendance Sheet, dated 09/16/24, showed the staff who attended included the NHA, Business Office Manager (BOM), Unit Manager/RN (Registered Nurse), Certified Dietary Manager (CDM), Maintenance Director, Residential Services Director, and Staffing Coordinator. Review of the blank Facility QAPI & Risk Management Meeting Agenda showed a blank spreadsheet that directed the QAPI meeting to discuss the following topics: (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Few	- Census - Staffing - Resident Council - Grievances - Advance Directives - Behavioral Health - Activities - Resident Rights - Ancillary Services - Resident Discharges - Hospital Admissions - Elopements - Abuse/Reporting - Business Office - MDS - Therapies - Catheters - Contractures - Restraints - Falls - Infection Control - Weight Loss - Weight Gain - Antipsychotics (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Few	- Wounds - Tube Feedings - Special Services - Pain Needs - Pharmacy - Lab - X-Ray. During an interview on 10/30/24 at 6:00 p.m. the NHA confirmed the 09/16/2024 QAPI meeting was the only meeting the facility had regarding the deficient practices identified in previous surveys. The NHA stated the 09/16/24 QAPI meeting, we spent going over the 2567. The NHA stated the Director of Nursing (DON), who also was the facility's Infection Preventionist (IP), and the Medical Director were not present for the 09/16/24 QAPI meeting. The NHA stated the facility had not conducted another QAPI meeting in October yet, but then stated, October is not over yet, we will have a QAPI meeting tomorrow. The NHA stated the facility did not attempt to start correcting the deficient tags after the recertification survey (August 2024) because, we chose to wait to see what the 2567 said and correct from there. 1.Review of the approved plan of correction for the survey ending on 9/18/24 with a completion date of 9/29/24 revealed the following measures would be taken to correct the deficient practice which was identified at F622: The facility Interdisciplinary Team (IDT) has audited the census to determine if there were any other residents in the hospital who would not be returning based upon the facility not being able to safely care for them. The medical record of any resident identified on the audit has been reviewed to ensure that the reasons why the facility could not meet their needs is documented in the medical record by the Interdisciplinary Team. The Administrator/Designee has provided education to the facility IDT on the importance of documenting, in the medical record, the reasons why the facility cannot meet the needs of any resident identified as the facility not being able to safely meet their needs upon discharge to the hospital. The Administrator/Designee will review this documentation and document the review on the Discharge Unable to Safely Return Audit Tool as these decisions occur for the next 90 days. The Discharge Unable to Safely Return Audit Tool will be reviewed in QAPI monthly until substantial compliance is achieved. Review of the approved plan of correction for the survey ending on 9/18/24 with a completion date of 9/29/24 revealed the following measures would be taken to correct the deficient practice which was identified at F623: (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Few	The Administrator/Designee reviewed the facility census of residents who were in the hospital to determine if there were any residents in the hospital, who would not be returning due to safety reasons, and ensured that the Discharge Notice was sent to the resident representative, if applicable, and the Ombudsman. The Administrator/Designee provided education to the facility Interdisciplinary Care Team regarding the need to send a copy of the Discharge Notice to the resident representative and to the Ombudsman for residents who cannot safely return to the facility following a hospital stay. The Interdisciplinary Team will document on the Discharge Notice Audit Tool the date that a copy of the Discharge Notice, for residents unable to return due to safety reasons, was sent to the resident representative and to the Ombudsman. The Administrator will review the Discharge Audit Tool weekly for 30 days to ensure compliance. The Discharge Notice Audit Tool will be reviewed in QAPI monthly until substantial compliance is achieved. Review of the approved plan of correction for the survey ending on 9/18/24 with a completion date of 9/29/24 revealed the following measures would be taken to correct the deficient practice which was identified at F626: The facility Transfer or Discharge, Facility Initiated, has been reviewed and revised as needed. The facility Administrator educated the facility Interdisciplinary Team on the facility Transfer and Discharge, Facility Initiated policy. The Transfer or Discharge, Facility Initiated, Policy was reviewed in the monthly QAPI meeting. During the revisit survey on 10/30/24, on-going concerns were identified related to transfer and discharge notices. The NHA was asked on 10/30/24 at 9:00 a.m. to provide the Plan of Correction (POC) binder or any other evidence to the State Agency (SA) Survey Team to review the facility's attempts to correct F622, F623, and F626. During an interview on 10/30/24 at 1:09 p.m. the NHA stated she could not provide the SA Survey Team the plan of correction book to be reviewed as she needed more time get the evidence together. The NHA stated everything was just a mess because we just had two hurricanes. The NHA stated she would work on getting the POC binder together in some sort of order and bring the binder to the SA Survey team to review. During an interview on 10/30/24 at 1:39 p.m. the NHA was informed the SA Survey Team could no longer wait for the POC binder and to please provide the SA Survey Team any evidence that was available at the time. Review of the facility's POC binder and additional evidence of corrective actions provided revealed no evidence was present to show substantial compliance for F622, F623, and F626. (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Few	2.Review of the facility's plan of correction for the survey ending 8/29/24 with a completion date of 9/29/24 revealed the following measures would be taken to correct the deficient practice which was identified at F584: Repairs were made to Rooms 12, 15, 8, 3A, 6B, 5B, 26A, 26B, 29B, 20B & 28 Repairs were made to the North Hall area. The Administrator/Designees made facility rounds to identify any other physical plant concerns related to homelike environment. The results of these rounds were documented on the Room Audit Checklist and entered into the electronic maintenance system for follow up. The Administrator/Designee provided education to the facility staff regarding Homelike Environment and identifying and/or reporting concerns. To identify needed improvements related to homelike environment, the Administrator/Designees will make Homelike Environment rounds 2 x week until substantial compliance is achieved. The facility will initiate a Physical Plant Improvement Plan, based upon the outcomes of the Homelike Environment Rounds, and the identified improvements will be prioritized and reviewed by the Administrator and Maintenance Director weekly to determine tasks for the week, as well as, tasks completed from prior week. Due to the resident population that we serve in this community, the Administrator/Designee will review the Physical Plant Improvement Plan in QAPI monthly ongoing On 10/30/24 a revisit survey was conducted to ensure compliance with F584. The revisit survey revealed on-going concerns and noncompliance with F584. On 10/30/24 at 5:40 p.m. an interview and review of the Plan of Corrections (POC) binder with the NHA revealed the Maintenance Director (MD) went around and made rounds to identify the issues that needed to be addressed. The NHA stated the MD used a form to document the work that needed to be completed. She said, He [the MD] knows they have more work to do. The NHA stated facility staff were educated on a homelike environment. She stated the department heads complete rounds of the facility. The NHA stated department heads make rounds twice a week. The NHA confirmed the MD, and the part-time maintenance assistant are responsible for repairs. She stated their first Quality Assurance (QA) meeting, post survey that ended on 8/29/24, was on 9/16/24. She stated during the Quality Assurance and Performance Improvement (QAPI) meeting, held on 9/16/24, is where the CMS-2567 form was reviewed. She stated the 2567 form was received on 9/13/24. The NHA stated they discussed the 2567 form during the regular QA meeting they had for that month. The NHA confirmed the Director of Nursing (DON), and the Medical Director were not present during the QA meeting held on 9/16/24. 3.Review of the facility's plan of correction for the survey ending 8/29/24 with a completion date of 9/29/24 revealed the following measures would be taken to correct the deficient practice which was identified at F641: The Interdisciplinary Team reviewed Section H of the most recent MDS and Care Plan for in house residents for accuracy related to the coding for the use of catheters. The outcome of the audit will be documented on the Section H MDS/Care Plan Audit Tool. (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Few	The Interdisciplinary Team reviewed the Side Rail Observations, Section GG of the most recent MDS and Care Plan for in house residents for accuracy related to the coding of use of side rails. The outcome of the audit will be documented on the Side Rail Accuracy Audit Tool. The Regional MDS Nurse educated facility Interdisciplinary Team on the importance of the accuracy of assessment, coding and care planning of section H regarding the use of catheters. The DON/Designee will audit the completed MDS weekly for 30 days, or until substantial compliance is achieved, for accuracy. The results of the audit will be documented on the Section H MDS/Care Plan Audit Tool. The Regional MDS Nurse educated facility Interdisciplinary Team on the importance of the accuracy of assessment, coding and care planning of section GG regarding the use of side rails. The DON/Designee will audit the completed MDS weekly for 30 days, or until substantial compliance is achieved, for accuracy. The results of the audit will be documented on the Side [NAME] Accuracy Audit Tool. The Administrator/Designee will review the Section H MDS/Care Plan Audit Tool and the Side Rail Accuracy Audit Tool in QAPI monthly until substantial compliance is achieved. On 10/30/24 a revisit survey was conducted to ensure compliance with F641. The revisit survey revealed on-going concerns and noncompliance with F641. 4.Review of the facility's plan of correction for the survey ending 8/29/24 with a completion date of 9/29/24 revealed the following measures would be taken to correct the deficient practice which was identified at F656: The Interdisciplinary Care Team reviewed the Resident Roster to determine a listing of residents who, due to safety or medical reasons, needed to keep their bed in the lowest position. The Resident Services Director/Designee then interviewed these residents to determine their preference for the height of their bed and provided resident safety education. Residents identified as desiring to raise and lower the bed to their preferences, in spite of safety needs, had their care plans updated to reflect their preferences, and the education offered. The results of these interviews and education were documented on the Bed Height Preferences Audit Tool. The Administrator/Designee reviewed the roster of residents who smoke and audited the Smoking Observations and Care Plans to ensure that each resident had a Smoking Observation conducted in the last 60 days and a Smoking Care Plan. Any resident identified as not having a Smoking Observation in the last 60 days, had a Smoking Observation completed and a Care Plan initiated. The results of the audit were documented on the Smoking Observation & Care Plan Audit Tool. Smoking Observations will be completed upon admission for new residents and Smoking Care Plans initiated as appropriate. (continued on next page)

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	105292	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Lake Nursing and Rehab Care Center	1100 66th St N Saint Petersburg, FL 33710

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F 0867 Level of Harm - Actual harm Residents Affected - Few	The Administrator educated the facility Interdisciplinary Care Team on the importance of ensuring that residents, who need their bed in the lowest position, are provided education and that if their preference is still to raise and lower the bed to their own preference that the education and preference is noted on the care plan. The Interdisciplinary Care Team will review the Facility Activity Report 5 x week for 3 weeks, 4 x week for 2 weeks and then 2 x week monthly until substantial compliance is achieved, to identify residents with these preferences and ensure that education is provided and the care plan updated. The results of these reviews will be documented on the Bed Height Preferences Audit Tool. The Administrator educated facility Resident Services Director on the importance of the Smoking Observations and Smoking Care Plans. The MDS Nurse/Designee will review the Smoking Observations and Care Plans monthly for 90 days, until substantial compliance is achieved, to ensure timely and correct completion. The results of this audit will be documented on the Smoking Observation & Care Plan Audit Tool. The Administrator/Designee will review the Bed Height Preferences Audit Tool and the Smoking Observation & Care Plan Audit Tool in QAPI monthly until substantial compliance is achieved. On 10/30/24 a revisit survey was conducted to ensure compliance with F656. The revisit survey revealed on-going concerns and noncompliance with F656. 5.Review of the facility's plan of correction for the survey ending 8/29/24 with a completion date of 9/29/24 revealed the following measures would be taken to correct the deficient practice which was identified at F695: The Director of Nursing (DON)/Designee reviewed the Oxygen orders for residents receiving Oxygen to ensure that orders were correct and appropriate. The results of these audits were documented on the Oxygen Therapy Order Audit Tool. The DON/Designee interviewed & observed other residents receiving Oxygen therapy to identify if there were any other petroleum jelly products in use. The results of these interviews and observations were documented on the Oxygen Therapy Rounding Tool The DON/Designee has provided education to nursing staff regarding the transcribing of Oxygen orders and the use of petroleum jelly products by Oxygen recipients. The DON/Designee will monitor the Facility Activity Report 5 x week for 3 weeks. 3 x week for 2 weeks and weekly for thirty days to ensure that new orders or changes in orders for Oxygen are correct and appropriate. The results of this audit will be documented on the Oxygen Therapy Order Audit Tool. The DON/Designee will round 3 x week for thirty days or until substantial compliance is achieved to monitor for the use of petroleum products by residents using Oxygen. The results of these rounds will be documented on the Oxygen Therapy Rounding Tool. The Administrator/Designee will review Oxygen Therapy Rounding Tool and the Oxygen Therapy Audit Tool in QAPI monthly until substantial compliance is achieved. (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Few	On 10/30/24 a revisit survey was conducted to ensure compliance with F695. The revisit survey revealed on-going concerns and noncompliance with F695. On 10/30/24 at 5:40 p.m. an interview and review of the Plan of Corrections (POC) binder with the Nursing Home Administrator (NHA) revealed facility wide audits were conducted after 8/29/24. She stated the audits consisted of checking oxygen orders on residents who receive oxygen, to sure they were correct. The NHA stated the facility activity report was used to conduct the audit and is reviewed in the clinical meeting. She stated the Director of Nursing (DON) used the facility activity report to see new orders or changes to orders to follow-up on. The NHA stated the DON continues to use the facility activity report to make sure orders are correct. She stated the nursing staff should be checking orders as well. She stated the previous unit manager (UM) conducted in-services on transcription of orders, understanding reasoning, and ensuring accuracy. The NHA stated the education was provided to the facility's nurses. She stated the previous UM called agency nursing staff and provided education by phone. She stated she is not sure if new staff were educated. The NHA stated based on the education provided she expected nursing staff to look at orders, then look at the oxygen concentrator and see what number it is on. The NHA stated she expected the nursing staff to call the doctor if there was a change. The NHA provided the in-service education sheet regarding the transcription of oxygen orders, dated 9/22/24 - 9/25/24, that included Staff B, Licensed Practical Nurse (LPN) attended. 6.Review of the facility's plan of correction for the survey ending 8/29/24 with a completion date of 9/29/24 revealed the following measures would be taken to correct the deficient practice which was identified at F759: The DON/Designee conducted a medication inventory to identify any other medications that were not available. The results of the inventory were documented on the Medication Cart Inventory Audit Tool. The DON/Designee has provided education to nursing staff regarding the ordering/re-ordering of medications and the obtaining of over-the-counter medications. The DON/Designee has provided education to nursing staff on the measuring and administration of liquid medications. The DON/Designee will perform random observations of administration of liquid medications by nurses 2 x week for thirty days or until substantial compliance is achieved. The results of the audit will be documented on the Liquid Medication Measuring and Administration Audit Tool. The DON/Designee will perform a medication inventory 3 x week for 3 weeks, 2 x week for 2 weeks and 1 x week for thirty days or until substantial compliance is achieved. The results of these inventories will be documented on the Medication Cart Inventory Audit Tool. Any medication identified as not available on the medication cart will be reordered and the physician notified as appropriate. The DON/Designee has provided education to the nursing staff regarding timeliness of medication administration. The DON/Designee will perform a medication administration time management audit 3 x week for 3 weeks, 2 x week for 2 weeks and 1 x week for thirty days or until substantial compliance is achieved. The results of these audits will be documented on the Medication Administration Time Management Audit Tool. (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Few	The Administrator/Designee will review Medication Cart Inventory Audit Tool, the Liquid Medication Measuring and Administration Audit Tool and the Medication Administration Time Management Audit Tool in QAPI monthly until substantial compliance is achieved. On 10/30/24 a revisit survey was conducted to ensure compliance with F759. The revisit survey revealed on-going concerns and noncompliance with F759. Review of the Inservice Education Sheet dated 09/22/24 to 09/25/24 showed timeliness of medication administration was educated and measuring and administration of liquid medications and ensuring that nurses understand how to order/reorder medications and how to obtain OTC meds. During an interview on 10/30/2024 at 5:38 p.m. the NHA stated the DON made an inventory audit for medications not available. She audited the medication carts make sure medications were available. The NHA stated they have been doing audits 3 x week to make sure medications are available. The educated the ensuing nurses to know how to order and reorder medications and how to obtain over the counter medications on 9/22/24 to 09/26/2024. The NHA stated the timeliness of giving medication was also covered in the education. 7.Review of the facility's plan of correction for the survey ending 8/29/24 with a completion date of 9/29/24 revealed the following measures would be taken to correct the deficient practice which was identified at F880: The DON received her Infection Preventionist Certification The DON and Administrator continued to search for documentation of the Infection Control Prevention and Surveillance Program without success. The DON/Designee monitored meal service and found no other non-compliance with hand washing during meal service. The DON/Designee rounded the facility and found no other non-compliance related to IV Antibiotics and Enhanced Barrier Precautions. The DON/Designee has provided education to nursing staff regarding hand hygiene during meal service. The DON/Designee has provided education to nursing staff regarding enhanced barrier precautions during IV site care and the placement of enhanced barrier precaution supplies. The Don/Designee will monitor meal service 3 x week for 3 weeks, 2 x week for 2 weeks and 1 x week for thirty days to ensure that hand hygiene is completed appropriately. The results of this monitoring will be documented on the Hand Hygiene Observation Tool The Don/Designee will round facility 3 x week for 3 weeks, 2 x week for 2 weeks and 1 x week for thirty days to ensure that supplies for enhanced barrier precautions are maintained outside of the appropriate room doors. The results of these rounds will be documented on the Enhanced Barrier Precaution Rounding Tool (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Few	The Regional MDS Nurse/Designee will provide education to the facility staff on the Infection Prevention and Surveillance Program. The program/policy will be reviewed and approved upon the education and the review documented on the Policy Review Signature Form. The Policy Review will then be calendared for review on an annual basis. The Administrator/Designee will review the Hand Hygiene Observation Tool and the Enhanced Barrier Precaution Rounding Tool in QAPI monthly until substantial compliance is achieved. The DON/Designee will review the Infection Prevention and Surveillance data with the Administrator in QAPI monthly. On 10/30/24 a revisit survey was conducted to ensure compliance with F880. The revisit survey revealed on-going concerns and noncompliance with F880. During an interview on 10/30/2024 at 1:45 p.m. the DON stated she had been hired as the Unit Manager (UM). When the previous DON resigned five days later, she became the DON. She stated she had been employed at the facility since the end of July 2024. The DON stated she completed the Infection Control Course through the CDC (Centers for Disease Prevention and Control) on 09/06/2024. She stated she has no hands on training for Infection Preventionist. The DON stated she had no other external or internal education. The DON stated she had not been party to the QAPI meetings. She had not attended a QAPI Committee meeting since her hire dare. She had not presented anything regarding Infection Control at the QAPI Committee meetings. The DON stated the policy, and procedures have not been reviewed by the QA Committee. The DON stated her only infection control policy she had was, Implementation of the Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) (CDC policy). She reached up to a top shelf on a bookcase and brought down a notebook with the facility's Infection Control policies. She stated she used these (policies), and they had not gone to the QA Committee for review. She stated she monitors her staff, and their infection control related practices, to the best of my ability. She stated she was without a UM, and sometimes she was on a cart (medication). The DON stated they did education on hand washing and enhanced barriers. She stated the sign-in sheets for Infection Control education was in the Plan of Correction books, 100% of the staff was educated. The DON stated the last time the staff was educated on hand hygiene and donning and doffing of PPE was after the survey team left in September 2024. She stated she educated the housekeeping and dietary staff at the same time she educated her nursing staff. The DON stated they had a QAPI Committee meeting after the survey, which included only the department heads, the Medical Director was not there. At that meeting they put a plan into place for the Plan of Correction. The DON stated they had not had a surveillance plan since 2022. The DON stated they have not been using [NAME] or any evidence-based surveillance criteria to define infections. She stated they have only been gathering information at this point. They call the physician with the culture results, and he gives the orders for the antibiotics. She stated sometimes the physician puts the resident on antibiotics before the culture has returned. The DON stated, I looked for trends in September after plotting on the floor plan. I did not see a trend. She stated that our UTIs (urinary tract infections) are residents which are more non-mobile and have urinary catheters. She stated she did not see any trends for locations. She stated she did not see trends of room to room. She stated she did not have completed surveillance documentation, some were missing signs and symptoms, the diagnostic tool used and whether the criteria met, nosocomial or not, nor the organism identified. The DON stated she had no documentation for October 2024 at all, no listing was in the book. (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/30/2024 at 5:38 p.m. the Nursing Home Administrator (NHA) stated education was provided to the nursing staff regarding infection control prevention and surveillance program, understanding the program and purpose, ability to demonstrate compliance, and report non-compliance, for 100% of the staff. The NHA stated the education was done by the former Unit Manager (UM) and the DON. The NHA stated the UM talked about hand washing, no gloves in hallway, barriers on the doors, blood spills. The NHA stated all the education was done between 09/22/24 and 09/26/24. The NHA stated there was not a policy or information attached to the sign in sheets giving information as what the specific education discussed. The NHA stated they only observed hand hygiene during the meal services due to the citation. The NHA stated they checked the EBP on the following days per the audits: 09/24, 09/25, 0926, 10/1,10/ 2, 10/4, 10/7, 10/14, 10/16, 10/17, 10/21, 10/23, 10/24, 10/28, 10/30. The NHA stated they focused in on meal services and not hand hygiene as a whole due to the specifics of the citation.