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 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) (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. (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 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. 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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50732 Based on observation, record review and interviews the facility failed to ensure Minimum Data Set (MDS) Assessments were completed in a timely manner for two (#20 and #33) residents out of 20 sampled residents. Findings included: 1. On 08/29/2024 it was observed the Quarterly MDS Assessment for Resident #33 was due to be completed on 07/15/2024, however the Quarterly MDS Assessment was not completed and transmitted until 08/20/2024. Review of the Admission Record showed Resident #33 was admitted to the facility on [DATE]. 49497 Review of Resident #20 electronic medical record showed an admission to facility on 04/06/2022. Review of Minimum Data Set (MDS) dated [DATE] showed a status of finalized. Section Z assessment administration part Z0500 Verifying Assessment Completion was signed by Staff A and dated 08/20/2024. An interview was conducted on 08/28/24 at 4:05 p.m. with Staff A. She stated if an MDS assessment status showed finalized it had been completed, but has not been transmitted. She confirmed Residents #20 and Resident #33 quarterly MDS assessments scheduled on 07/15/24 both showed finalized status. She stated she did not know why they had not been transmitted within 14 days of the scheduled assessment date of 07/15/24, it was an oversight. An interview was conducted on 08/28/24 at 4:25 p.m. with Staff B. She stated Resident #20 and #33 assessments were missed. When she discovered the error, she scheduled their assessments and made sure they were completed. She confirmed Resident #20 and #33's assessments were not completed timely. She stated all assessment should be completed within 14 days of being scheduled. She stated the 07/15/24 quarterly MDS assessments for Resident #20 and #33 were completed on 08/20/24 past the 14 day expectation.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51062 Based on record review and interviews the facility failed to ensure the accuracy of the Resident Assessment Minimum Data Set (MDS) for two residents (#10, #9) of 20 residents reviewed. Findings included: 1. A review of Resident #10's Admission Record revealed she was admitted to the facility on [DATE] with diagnoses to include but not limited to obstructive and reflux uropathy and diabetes mellitus due to underlying condition with diabetic nephropathy. A review of Resident #10's physician's order dated 10/28/2023 revealed foley/supra-pubic: change catheter PRN (as needed) leakage, blockage or dislodgement. A review of Resident #10's nursing progress note dated 10/30/2023 revealed: Alert and oriented resident able to make all needs known to staff. Tolerated all medications administered no adverse effects noted. Resident advised nurse during medication pass that she had broken her catheter. Upon examination nurse found catheter bulb out. Catheter remained out. Nursing notified physician and are awaiting further instructions to either put catheter back in or leave out. A review of the resident #10's MDS assessments revealed: Admission MDS assessment dated [DATE], Section H - Bladder and Bowel A. was marked yes for indwelling catheter (including suprapubic catheter and nephrostomy tube). Quarterly MDS assessment dated [DATE], Section H - Bladder and Bowel A. was marked yes for indwelling catheter (including suprapubic catheter and nephrostomy tube). Quarterly MDS assessment dated [DATE], Section H - Bladder and Bowel A. was marked yes for indwelling catheter (including suprapubic catheter and nephrostomy tube). Quarterly MDS assessment dated [DATE], Section H - Bladder and Bowel A. was marked yes for indwelling catheter (including suprapubic catheter and nephrostomy tube). During an interview on 08/26/2024 at 3:00 PM, Staff E, Licensed Practical Nurse (LPN) stated he did not think Resident #10 had a catheter, but he is new and still in training. During an interview on 08/27/2024 at 10:10 AM, Staff F, LPN stated Resident #10 does not have a catheter. During an interview on 08/27/2024 at 10:15 AM, Staff O, Certified Nursing Assistant (CNA) stated she did not know anything about Resident #10 having a catheter. During an interview on 08/27/24 at 2:50 PM, Resident #10 stated she had a catheter a year ago when she came to the facility. It was removed right after she got to the facility, and she has not had anything since. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #10's physician's order dated 08/27/2024 revealed foley/supra-pubic: change catheter PRN (as needed) leakage, blockage or dislodgement discontinued. Discontinue note, catheter not in place as of 10/30/2023. During a phone interview on 08/28/2024 at 2:00 PM, Staff B, Regional Director of Clinical Reimbursement (RDCR) stated she works remote, so she is on the prospective payment system (PPS) calls every day and she is also on the utilization review calls. She stated she uses source documentation to complete the MDS, so she is relying on nursing notes and doctor's orders. She stated the facility does have a part-time MDS person who goes into the facility and is a Registered Nurse (RN). This person does most of the actual physical assessments. Staff B, RDCR stated she reviewed Resident #10's MDS for 11/03/2024, 02/09/2024, 05/05/2024, and 08/07/2024, section H and all indicated the resident had a catheter. Staff B, RDCR stated, I don't have a reasonable explanation to give you. During an interview on 08/28/2024 at 4:03 PM, Staff A, RN/MDS Coordinator (RN/MDSC) stated Staff B, RDCR provides her with a list of residents who need to have an MDS completed. She stated she talks to the residents and completes the assessments. Staff A, RN/MDSC reviewed the MDS assessments for Resident #10, Section H and stated, I don't know what happened with that. 49497 2. On 8/26/2024 at 2:39PM Resident #9's bed was observed to have bilateral enabler rails. Review of electronic medical record (EMR) for Resident #9 showed an admission to facility on 12/04/23 with diagnoses including lymphedema, unspecified convulsions, restless agitation, generalized anxiety, cellulitis of right lower limb, and Ichthyosis vulgaris. Review of the Minimum Data Set (MDS) dated [DATE] revealed, Section C Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment, Section GG showed resident was independent with bed mobility, transfers, upper and lower body dressing, personal and toileting hygiene and Section P P0100, Physical Restraints showed Part A Bed rails marked not used. Review of Care plan dated 06/14/2024 revealed, a problem of Urinary Incontinence, with an approach Offer assistance with toileting and incontinence care needs frequently, a problem of Resident is not independent with upper and lower body dressing, with an approach Provide assistance with dressing. Provide assistance with putting on socks and shoes on and taking them off when needed. Resident may require extensive assistance at times if he is feeling fatigued or weakness. Review of Resident #9's side rail assessment completed on 06/14/24 revealed it was incomplete. It showed medical reason for side rail box filled in no side rail. Section Risks and Benefits part date the risks/benefits were explained and to who was blank. Sections Signatures part Informed consent and Nurse signature and date were blank. During an interview conducted on 08/28/24 at 9:17 a.m. with Resident #9 he stated he used the enablers all the time to help him roll in the bed and pull himself up in the bed when he slides down. He stated when he sits on the edge of bed for staff to put on my shoes he must hold on the rail to keep my balance. He stated sometimes he can do it by himself, but it takes a long time and needs the enabler for support, so I don't fall. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated Nursing Home Side Rail Policy revealed Section 5.1 Assessments showed A comprehensive assessment of each resident will be conducted to determine the need for side rails. Review of section P of MDS dated [DATE] Section GG shows Resident #9 is independent with dressing and hygiene.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50732 Based on record review and interviews, the facility failed to ensure the Level I Pre-Admission Screening and Resident Review (PASRR) for residents with a mental disorder and individuals with intellectual disability following qualifying mental health diagnoses were accurate for nine residents (#25, #27, #24, #26, #7, #4, #35, #28, #39) out of 20 residents sampled. 1. Review of Resident #4's Admission Record showed Resident #4 was originally admitted on [DATE] with a readmitted [DATE] after returning to the facility from a hospitalization . Resident #4's Admission Record showed he was admitted to the facility with diagnoses to include Psychoactive Substance Dependence and Alcohol Dependence. Review of the Level I Preadmission Screening and Resident Review Process (PASRR) for Resident #4 dated 04/12/2024 revealed an incomplete PASRR with the qualifying diagnosis of Substance Abuse not checked in Section I: PASRR Screen Decision-Making. A 04/17/2024 psychiatric evaluation completed in the facility revealed the resident was diagnosed with major depressive disorder and generalized anxiety disorder. Record review of Resident #4's medical chart revealed an updated PASRR was not completed by the facility to include the new qualifying psychiatric diagnoses. 2. Review of Resident #27's Admission Record showed Resident #27 was admitted to the facility on [DATE] with diagnoses to include Depression. Review of the Level I PASRR for Resident #27 dated 06/06/2024 revealed an incomplete PASRR with the qualifying diagnoses of depression not checked in Section I: PASRR Screen Decision-Making. 3. Review of Resident #39's Admission Record showed Resident #39 was admitted to the facility on [DATE] with diagnoses to include anxiety disorder. Review of the Level I PASRR for Resident #39 dated 09/19/2023 revealed an incomplete PASRR with the qualifying diagnosis for anxiety disorder not checked in Section I: PASRR Screen Decision-Making. 4. Review of Resident #35's Admission Record showed Resident #35 was admitted to the facility on [DATE] with diagnoses to include diffuse traumatic brain injury, depression, nightmare disorder and generalized anxiety disorder. Resident #35 was admitted during the 1135 Waiver Period, which ended on 05/11/2023. Providers must resume compliance with normal rules and regulations as soon as they are able to do so after the end of the waiver period. Review of Resident #35's medical record revealed no PASRR was completed for this resident after the 1135 Waiver Period concluded. An interview was conducted with the Social Services Director (SSD) on 08/29/2024 at 9:03 a.m. The SSD said he is not responsible for completing the PASRRs. He said there is currently no Admissions Director (AD) and the Nursing Home Administrator (NHA) has been responsible for ensuring the completion of the PASRRs. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	51062 5. A Review of Resident #25's resident census report revealed Resident #25 was admitted to the facility on [DATE]. A review of Resident #25's Admission Record revealed diagnoses to include but not limited to cognitive communication deficit, other psychoactive substance abuse, delusional disorders, auditory hallucinations, and schizoaffective disorder. A review of the resident #25's Electronic Medical Records revealed no PASRR documentation in the resident's records. A request for Resident #25's PASRR from the Nursing Home Administrator (NHA) revealed the resident did not have a completed PASRR. 39866 6. Review of Resident #7's Face sheet revealed he was admitted to the facility on [DATE] with medical diagnoses of Schizophrenia, auditory hallucinations, major depressive disorder, dementia with psychotic disturbance, generalized anxiety disorder, and sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced anxiety disorder. Review of Resident #7's medical record did not reveal a PASRR was completed. Review of Resident #7's Annual minimal data set (MDS), dated [DATE], section I, Active Diagnoses, revealed Psychiatric/Mood Disorder diagnoses of anxiety disorder, depression, and schizophrenia. Review of Resident #7's admission MDS, dated [DATE], section I, active diagnoses revealed psychiatric/mood disorder diagnoses of anxiety disorder and depression. 46498 7. Review of an Admission Record dated 8/29/2024 showed Resident # 24 was admitted to the facility on [DATE] with diagnosis to include but not limited to bipolar disorder, unspecified, Depression, Unspecified, Suicidal Ideations, Generalized Anxiety. Review of a Minimum Data Set (MDS) dated [DATE] showed Resident # 24 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated cognitively intact. Review of the Preadmission Screening and Resident Review (PASRR) Notice of the Need for Further Evaluation dated 5/27/2024 showed Resident # 24 had a level I PASRR screen completed, with evidence of a serious illness were found. Further review showed Resident # 24 required to have a Level II screen completed but the facility did not obtain the Level II screen. 8. Review of an Admission Record dated 8/29/2024 showed Resident # 28 was admitted to the facility 12/01/2023 with diagnosis to included but not limited to Schizophrenia, unspecified, Unspecified lack of coordination, mood disorder due to known physiological condition, unspecified, anxiety disorder, unspecified, adjustment disorder with depressed mood. Review of a Minimum Data Set (MDS) dated [DATE] showed Resident # 28 had a Brief Interview for Mental Status (BIMS) score of 06, which indicated severely impaired. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Electronic Medical Record (EMR) showed no evidence of a level I PASRR for Resident # 28. 49497 9. Review of electronic medical record (EMR) for Resident #26 showed an admission to facility on 02/13/24 with diagnoses including mood disorder due to known physiological condition, depression, cognitive communication disorder, and unspecified dementia. Review of Resident #26's Minimum Data Set (MDS) dated [DATE] revealed, Section C Brief Interview for Mental Status (BIMS) score of 1 indicating severe cognitive impairment. Review of the care plan for Resident #26 dated 03/08/24 with last revised date of 08/16/24 revealed, a problem of Resident takes antipsychotic medication putting him/her at risk of complications. Dx {diagnosis] of Mood d/o [disorder], with a goal of Resident will not have any adverse side effects from antipsychotic medication through the review date, and a problem of Resident takes antidepressant medication putting him/her at risk of developing complications with a goal of Resident will not experience complications from use through the review date. Review of physician orders for Resident #26 revealed, Aricept tablet 10mg 1 tablet at bedtime, Depakote delayed release 125mg every 12 hours, Lexapro 10mg tablet once a day, Namenda 10mg tablet once a day. Review of the medical record showed no Preadmission Screening and Record Review (PASARR) uploaded. Request made for Resident #26 PASARR on 08/26/24, facility unable to provide by exit on 08/29/24. An interview conducted with the Nursing Home Administrator (NHA) on 08/27/24 at 10:04 a.m. She stated residents that were admitted to facility during time of COVID did not require a PASARR because they had the COVID waiver. She confirmed the COVID waiver ended on 05/11/2023. She stated the facility did not complete any PASARR's for residents that were admitted under the COVID waiver and remained in the facility. She stated, I didn't know we were supposed to. The NHA provided a list of three residents (Residents #25, #7, #36) that were admitted without PASRR's during COVID 1135 waiver that are current residents at facility. She stated she was still looking for Resident #26's PASARR. She confirmed Resident #26 was not admitted during the COVID waiver. An interview was conducted on 08/29/24 at 9:15 a.m. with NHA. She stated the admissions department typically completes PASRRS. She stated we do not currently have an admissions director. She stated she is covering until facility gets position filled. She stated she is ensuring PASRRs are completed prior to admission, until the new admission director is hired and trained. Review of facility undated PASRR Policy provided by NHA revealed the policy statement The Center will a [grammatical error] make sure that all admissions have the appropriate Patient Assessment and Resident Review (PASRR) completed. The NHA provided a copy of the COVID 1135 waiver that revealed: Level one assessments may be performed post-admission. On or before the 30th day of admission, new patients admitted to nursing homes with a mental illness (MI), or intellectual disability (ID) should be referred promptly by the nursing home to state PASARR program for Level two Resident Review. Updated 10/13/2022

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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** 50732 Based on observation, record review and interviews the facility failed to develop and/or implement an effective care plan for two (#35 and #24) residents out of 20 sampled residents. Findings included: 1. On 08/26/2024, 08/27/2024, 08/28/2024 and 08/29/2024 at various times of the day Resident #35's bed was observed to be in the high position. Review of the Admission Record showed Resident #35 was admitted to the facility on [DATE]. The record revealed diagnoses not limited to diffuse traumatic brain injury, nightmare disorder, depression, generalized anxiety disorder, postconcussional syndrome. Review of the Annual Minimum Data Set (MDS) Quarterly Assessment, dated 07/29/2024, Section C-Cognitive Patterns, showed Resident #35 had a Brief Interview for Mental Status (BIMS) score of 9, showing he has moderate cognitive impairment. Section GG-Functional Abilities and Goals, showed Resident #35 needs Partial/Moderate Assistance to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. Section GG also showed the Resident needs Partial/Moderate Assistance to transfer to and from a bed to his wheelchair. Review of the Care Plan for Resident #35 revealed the following: The Resident is at risk for falling related to traumatic brain injury (TBI) with impaired cognition with poor decision making, weakness, urinary incontinence, use of psychotropic medication daily. The Resident will remain free from injury. Keep bed in lowest position with the brakes locked. During an interview on 08/29/2024 at 9:54 a.m. with Staff L, Certified Nursing Assistant (CNA), she said Resident #35 always raises the bed on his own and he gets mad if it is lowered. Staff L said is was not aware of the Care Plan stating the bed should always be in the low position. During an interview on 08/29/2024 at 12:26 p.m. with the Director of Nursing (DON), she said she does not know why Resident #35's bed is in the high position. The DON also stated she was not aware of the Care Plan stating the bed should be in the low position or why the bed should be in the low position. 46498 2. On 08/27/2024 at 2:22 p.m., Resident #24 was observed sitting outside smoking a cigarette without supervision. She showed no signs of distress. Resident was dressed and well-groomed with a latex glove on her right hand while smoking. She stated that she wears the latex glove because she has a staph infection all over her body, so she has to wear the glove on her right hand. Review of an Admission Record dated 8/29/2024 showed Resident # 24 was admitted to the facility on [DATE] with diagnosis to include but not limited to bipolar disorder, unspecified, Depression, Unspecified, Suicidal Ideations, Generalized Anxiety. (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 a Minimum Data Set (MDS) dated [DATE] showed Resident # 24 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated cognitively intact. Review of the observation for safe smoking evaluation dated 6/10/24 showed an incomplete smoking evaluation created by Staff U, the Social Services Director. On 08/29/2024 at 5: 30 pm., an interview was conducted with Staff U, the Social Services Director. He stated he completes all the smoking evaluation in the facility on all residents. He was told by the administrator that he did not have to complete the whole smoking evaluation just section 1 and the sensory section on the evaluation. After you interviewed me yesterday, I went back and completed the smoking observation. He stated he only does the smoking observations and not the care plans. On 08/29/24 at 11:05 am., an interview was conducted with Staff B, the Regional Director of Clinical Reimbursement. She stated typically nursing or the social worker would do the resident smoking observation to see if they are a safe smoker. The nursing or the social services director is responsible for creating the smoking care plan after the observation is complete. Social Service or the Minimum Data Set (MDS) nurse would create a smoking care plan on the resident. If there is not one in the system, then a care plan was not created. She reviewed the resident care plan and stated that she did not see a smoking care plan for Resident # 24. She should have had a smoking care plan completed. I don't know why the social worker would do the observations and not create a smoking care plan. I have to come to the facility and do some education with staff regarding care plans. Review of the facility policy, titled, Care Plans and Care Plan Meetings, date revised on 10/4/18 showed, It Is the responsibility of the Interdisciplinary Team to: Conduct an assessment of the resident's strengths and needs. Incorporate the resident's personal and cultural preferences in developing goals of care. Comprehensive Care Plan - A comprehensive care plan must be developed within seven days after the completion of the comprehensive assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39866 Based on observations, interviews, and record review the facility failed to ensure one resident (#7) out of one sampled residents received assistance to maintain good grooming and personal hygiene. Findings included: Review of Resident #7's Face Sheet revealed he was admitted to the facility on [DATE] with medical diagnoses of cerebral palsy, lack of coordination, dysphagia, dementia, major depressive disorder, and abnormalities of gait and mobility. An observation and interview were conducted on 08/26/24 at 10:09 AM with Resident #7 he was observed to be lying in bed with his facial hair grown out and his fingernails on both hands grown out past his fingertips with black and brown substance under the majority of his nails on both hands. Resident #7 said he gets a bed bath, and they will shave him but he has not been shaved for about two weeks and he likes to be clean shaven. He looked at his nails on both of his hands and said he wanted his nails trimmed he does not like them long. An observation was conducted on 08/27/24 at 8:48 AM. Resident #7 was observed in bed, eyes closed, with his facial hair grown out and his nails extended past his fingertips with black and brown substances under his nails bilaterally. An observation was conducted on 08/29/24 at 8:55 AM. Resident #7 was observed to be in bed eyes closed, hair disheveled, facial hair was grown out, and nails were extended past his fingertips with brown and black substances under his nails. An interview was conducted on 08/29/24 at 9:00 AM with Staff K, Certified Nursing Assistant (CNA). She said she was taking care of Resident #7 today. She said she thinks he gets a shower on the 3:00 PM-11:00 PM shift because she had not given him a shower and she noticed yesterday his hair needed to be washed, and his nails were long and dirty. She said she doesn't like to clip nails because her eye sight is not good. She confirmed his facial hair was grown out. She said on the assignment board they put who gets a shower for each shift and they document on paper shower sheets and they put them in the shower book. She said they document when a resident is shaved in the computer but they had changed the documentation and it only asks how much assistance the resident needs for shaving and the documentation does not ask if shaving was performed. She exited the room and returned with several wash cloths in her hand and said to Staff D, Licensed Practical Nurse (LPN), there are no towels I only have hand towels, I could ask laundry or I could use a sheet to clean him up. She told Staff D, LPN I don't want to clip his nails because my eye sight is bad. Staff K, CNA then looked at Resident #7's roommate and asked the roommate if Resident #7 had an electric razor and the roommate said he did not know. An interview was conducted on 08/29/24 at 09:05 AM with Staff D, LPN. She observed Resident #7's nails and said his nails needed to be cleaned and trimmed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #7's Care plan with a start date of 7/18/2022 and a revised date of 5/30/24 revealed Problem: Resident has functional limitations and weakness r/t [related to] chronic health conditions and staff must assist to ensure care needs are met. The goal included Will continue to tolerate assistance with care without daily discomfort through the review date. The intervention revealed Approach: .Provide supervision to extensive assistance for care and report changes if any are noted. Review of the Shower Schedule revealed Resident #7 is scheduled to receive showers on the 3:00 PM-11:00 PM shift on Tuesdays and Fridays. Review of the point of care CNA documentation for August revealed Resident #7 was dependent or needed maximum assistance for How did the resident maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene)? Review of Resident #7's August shower sheets revealed he refused a shower on 8/2/24 and 8/9/24. He received a shower on 8/6/24, 8/23/24, and 8/27/24. There was no documentation Resident #7 received a shower from 8/10/24 through 8/22/24 Review of Resident #7's medical record did not revealed documentation Resident #7's nails were trimmed or he was shaved for the month of August. An interview was conducted on 08/29/24 at 11:15 PM with the Director of Nursing (DON) she said Resident's should be receiving their showers on their scheduled days and if they want a shower in between they are to receive showers whenever they want one. She said residents should be clean, shaved, and nails trimmed and cleaned if they want them. She said staff should be documenting when showers are performed on the shower sheets and those are stored in the shower book and uploaded into the resident's medical record. Review of the facility's Bath, Shower/Tub policy, undated, revealed, Purpose, The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of resident's skin .

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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** 39866 Based on observations, interview, and record review 1. The facility failed to provide oxygen according to physician's orders for one resident (#7) out of 2 sampled residents, and 2. the facility failed to ensure flammable products (petroleum jelly) were not used during oxygen use for one resident (#25) out of 2 sampled residents. Findings included: 1. Review of Resident #7's Face Sheet revealed he was admitted to the facility on [DATE] with medical diagnoses of chronic obstructive pulmonary disease, (COPD), cerebral palsy, lack of coordination, dysphagia, oropharyngeal phase, and dementia. An observation and interview were conducted on 8/26/24 at 10:09 AM with Resident #7. He was observed to be lying in bed, with an oxygen concentrator on and set to 3.5 liters per minute (LPM). The nasal cannula was located behind his head and not in his nares. Resident #7 said he was breathing fine and was not sure why he had the oxygen, but he had been on it for a while, and he was not sure how much oxygen he was supposed to be receiving. (Photographic evidence obtained). An observation was conducted on 08/27/24 at 8:48 AM Resident #7 was observed in bed, eyes closed, with his nasal cannula in his nares. The oxygen concentrator was on and set to administer 3.5 LPM. An observation was conducted on 08/29/24 at 8:50 AM Resident #7 was observed to be in bed eyes closed. The nasal cannula was in his nose with the oxygen concentrator on and set to 3.5 LPM. Review of Resident #7's physician orders revealed an order with a start date of 5/19/24 and no end date for O2 [oxygen] via NC [nasal cannula] continuous up to 5 liters to maintain 02% 90 and above every shift. Further physician order review revealed an order with a start date of 3/25/24 and no end date for Oxygen 2 Liters PRN [as needed] special instructions: via nasal cannula sats [oxygen saturation level] below 92% as needed. An interview was conducted with Resident #7's nurse, Staff D, Licensed Practical Nurse (LPN) she reviewed Resident #7's medical record and said he was supposed to be on oxygen, 2 LPM as needed to maintain oxygen saturations above 93%. she entered into Resident #7's room, looked at the oxygen concentrator and said it looks like the resident is on 3LPM of oxygen. She turned the oxygen level down to 2LPM and checked his oxygen saturations and said he is at 93%. Review of Resident #7's treatment Administration record (TAR) revealed the physician's order 02 via NC continuous up to 5 liters to maintain 02% 90 and above every shift was documented every day as administered with documented oxygen saturations of 90% and above for the month of August. Review of the physician order Oxygen 2Liters PRN via nasal cannula sats below 92% revealed no documentation for the month of August. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 08/29/24 at 11:48 AM. The DON reviewed Resident #7's physician orders and confirmed he had a 5LPM oxygen order and an as needed 2L oxygen order. She said she did not know why he has two oxygen orders but said if his oxygen was set to 3.5 LPM that does not follow either of the physician's orders. 51062 2. A Review of Resident #25's resident census report revealed Resident #25 was admitted to the facility on [DATE]. A review of Resident #25's Admission Record revealed diagnoses to include but not limited to Chronic respiratory failure with hypercapnia and chronic obstructive pulmonary disease. A Review of Resident #25's physician's order dated 07/03/2024 revealed oxygen at 4 liters per nasal cannula continuous. On 08/26/2024 at 9:49 AM Resident #25 was observed in bed. She was wearing a nasal cannula with an oxygen concentrator on the floor to the left of her bed. The concentrator was set at 4 liters. A container of petroleum jelly was on the bedside table next to the resident. Resident #25 stated she uses it like lotion because it works well. Photographic Evidence Obtained. On 08/27/2024 at 9:28 AM Resident #25 was observed in bed. She was wearing a nasal cannula, and the oxygen concentrator was set at 4 liters. The container of petroleum jelly was on the bedside table. On 08/28/2024 at 9:30 AM Resident #25 was observed in bed. She was wearing a nasal cannula, and the oxygen concentrator was set at 4 liters. The container of petroleum jelly was on the bedside table. During an interview on 08/28/2024 at 3:05 PM, Staff N, Licensed Practical Nurse (LPN) stated if a resident has an oxygen concentrator, they take it with them to activities then plug it in wherever they are. She stated there should be nothing flammable in the area where someone is using oxygen to include lighters and petroleum products. During an interview on 08/29/2024 at 10:49 AM, the Director of Nursing (DON) stated oxygen should be on the correct liters, the tubing should be changed every seven days, and it should be secured appropriately. She stated there should not be anything flammable in the area to include lighters and candles. She was shown the section of the oxygen policy pertaining to removing all potentially flammable items. She stated, I didn't know lotions were flammable. She was asked about petroleum products. She stated, I hadn't thought about that. The DON was informed Resident #25 had a petroleum product in her room. She stated, That's not good. During an interview on 08/29/2024 at 11:05 AM, the NHA stated she did not know how the staff were trained on the oxygen policy, and the nursing staff that takes care of training. A review of the facility's Oxygen Safety form found in the DON's employee file and signed by the DON on 07/09/2024 revealed: Oxygen can be dangerous if not used correctly. Oxygen makes things burn more easily and can even explode. While oxygen is in the room do not use: Oil-based face cream or lotion on the nose and face. Petroleum-based products such as [product name]. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the American Lung Associations website (https://action.lung.org/pf/OX3-Using_Oxygen_Safely/files/OX3-Using_Oxygen_Safely_Option2-2020-v2.pdf) revealed: Using oxygen safely: Don't Use Aerosols, Vapor Rubs or Oils, Avoid flammable creams and lotions such as vapor rubs, petroleum jelly or oil-based hand lotion. Use water-based products instead. A review of the facility's policy titled Oxygen Administration, undated, revealed: Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. General Guidelines: 1. Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter. b. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head. Steps in the procedure: 4. Remove all potentially flammable items (e.g., lotions, oils, alcohol, smoking articles, etc.) from the immediate area where the oxygen is to be administered.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 51062 Based on observations, interviews, and record review, the facility failed to ensure the medication error rate was less than 5.00%. Twenty-five medication administration opportunities were observed, and twelve errors were identified for two residents (#35, #25) out of three residents observed. These errors constituted a 48. 00% medication error rate. Findings included: 1) On 08/28/2024 at 9:41 AM a medication administration observation was conducted with Staff M, LPN for Resident #35. Staff M, LPN dispensed the following medications: -Ativan (lorazepam) 1 mg (Milligram) 1 tablet -Famotidine 20 mg 1 tablet -Lactulose 20 gram/30 mL (milliliter) solution 25 mL -Sodium chloride 1 gram 1 tablet -Valproic Acid 250 mg 1 tablet Staff M, LPN stated she did not have the other ordered medications in her cart, and she would have to find them or order them. The missing medications included: -B complex vitamin C-folic acid 400 mcg (Microgram) 1 tablet -Potassium citrate 10 mEq (milliequivalent) extended release 1 tablet Staff M, LPN was observed administering the medications to Resident #35. When Staff M, LPN returned to her cart, she was asked about the Lactulose administration and the fact she had only administered 25 mL instead of the ordered 30 mL. Staff M, LPN responded that she was not aware she had administered the incorrect dosage. A review of Resident #35's physician orders revealed the following: Lactulose solution; 20 gram/30mL; amount 30 mL oral; twice a day 09:00 PM, 09:00 AM; ordered 07/01/2024 - open ended. Famotidine OTC (Over the Counter) tablet 20 mg; amount 1 tablet oral; special instructions: I tablet every 12 hours; twice a day 09:00 AM, 09:00 PM; ordered 04/21/2023 - open ended. B complex-vitamin C-folic acid tablet 400 mg; amount 1 tablet oral; once a day 09:00 AM; ordered 04/22/2023 - open ended. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Valporic acid capsule 250 mg; amount 1 tablet oral; twice a day 09:00 AM, 09:00 PM; ordered 12/21/2023 - open ended. Ativan (lorazepam) - schedule IV 1 mg tablet; amount 1 tablet oral; twice a day 09:00 AM, 09:00 PM; ordered 01/24/2024 - open ended. Sodium chloride oral I gram tablet; amount 1 tablet; special instructions: for hyponatremia; once a day 09:00 AM; ordered 02/28/2024 - open ended. Potassium citrate tablet extended release 10 mEq (1,080 mg); amount 1 tablet oral; once a day 09:00 AM; ordered 07/23/2023 - open ended. A review of Resident #35's medication administration history report dated 08/01/2024 - 08/29/2024 revealed Staff M, LPN signed off on the Potassium citrate 10 mEq extended release 1 tablet on 08/28/2024 at 10:22 AM for Late administration: charted late, Comment: late chart administered on time. 2) On 8/28/2024 at 11:01 AM a medication administration observation was conducted with Staff M, LPN for Resident #25. Staff M, LPN dispensed the following medications: -Flecainide 100 mg 1 tablet -Aspirin 81 mg chewable 1 tablet -Ferrous Sulfate 325 mg 1 tablet -Furosemide 20 mg 2 tablets -Magnesium Oxide 400 mg 1 tablet -Metoprolol succinate extended release 50 mg 1 tablet -Multivitamin 1 tablet -Olanzapine 15 mg 1 tablet Staff M, LPN stated she did not have the other ordered medication in her cart, and she would have to find it or order it. The missing medication included: -Ascorbic Acid vitamin C 250 mg 1 tablet Staff M, LPN was observed entering Resident #25's room and taking Resident #25's blood pressure prior to administering the Metoprolol and the other medications. Staff M, LPN stated, I'm running late then exited the room. A review of Resident #25's physician orders revealed the following orders: Aspirin tablet chewable 81 mg; amount 81 mg oral; once a day 09:00 AM; ordered 07/02/2024 - open ended. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ferrous sulfate tablet 325 mg (65 mg iron); amount 1 tablet oral; once a day 09:00 AM; ordered 07/02/2024 -open ended. Flecainide tablet 100 mg; amount 1 tablet oral; twice a day 09:00 AM, 09:00 PM; ordered 07/02/2024 - open ended. Magnesium oxide OTC 1 tablet 400 mg (241.3 mg magnesium); amount 1 tablet oral; once a day 09:00 AM; ordered 07/02/2024. Metoprolol succinate 1 tablet extended release 24-hour 50 mg; amount 1 tablet oral; twice a day 09:00 AM, 09:00 PM; ordered 07/02/2024 - open ended. Multivitamin tablet; amount 1 tablet oral; once a day 09:00 AM; ordered 07/02/2024 - open ended. Olanzapine tablet 15 mg; amount 1 tablet oral; once a day 09:00 AM; ordered 07/02/2024 - open ended. Furosemide tablet 20 mg; amount 2 tablets oral; once a day 09:00 AM; ordered 07/31/2024 - open ended. A review of Resident #25's Medication Administration Record (MAR) revealed: Ascorbic acid (vitamin C) tablet 250 mg; amount to administer 250 mg oral; twice a day 09:00 AM, 09:00 PM; ordered 07/02/2024 discontinued 08/28/2024. During an interview on 08/29/24 at 9:03 AM, Staff D, LPN stated passing medications on the North unit is a very heavy medication pass and if anything goes wrong or she is needed for an emergency there is no way to complete the medication pass in time. During an interview on 08/29/2024 at 10:35 AM, the Director of Nursing (DON) was informed of the medication observations. She stated timeliness was already on her radar as she had noticed how long nurses were spending on the medication carts. She was then asked what her expectations were for medication administration. She stated her expectations are that medications are administered correctly and on time. She stated the nurses are having a hard time with their Electronic Medication Administration Record (EMAR) system and with getting medications completed in a timely manner. She stated the nurses are responsible for ordering resident medications. She requests that if the medications are in a five-day window, the nurses should order the medications. A review of the facility's policy titled, Administering Medications, undated, revealed a policy statement of: Medications shall be administered in a safe and timely manner, and as prescribed. Policy interpretation and implementation: 3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39866 Based on observations, interviews, and record reviews the facility failed to prevent multiple significant medication errors for 1 resident (#347) out of 4 residents reviewed. Resident #347 was admitted to the facility on [DATE] for intravenous antibiotic administration due to intracranial abscesses and with diagnosis of opioid abuse with withdrawals. She was transferred to the facility with orders to treat the opioid abuse with withdrawals with buprenorphine and naloxone 8-2 mg (Suboxone) sublingually three times a day. The facility failed to provide Resident #347's her Suboxone medication for two and a half days. Resident #347 arrived at the facility with hospital orders to take buprenorphine and naloxone (Suboxone) 8-2mg sublingually film three times a day. The medication was ordered as buprenorphine 2mg sublingually twice day. This failure resulted in Resident #347 being sent back to the hospital two times for opioid withdrawal symptoms and each time the resident returned with orders to administer buprenorphine and naloxone (Suboxone) 8-2mg sublingually three times a day. The facility continued to give Resident #347 buprenorphine 2mg despite the resident telling nurses on all shifts on different days and physicians she was not receiving the correct dose of her Suboxone. It was not until Resident #347's second readmission to the hospital for severe withdrawals did the hospital physician end up calling the facility's pharmacy on 8/26/24 to order the correct medication, Suboxone. The facility also failed to provide Resident #347 her with her antibiotic (vancomycin) per her discharge instruction from the hospital. The vancomycin was ordered on admission under the physician orders with a stop date of 8/26/24. Review of the hospital record revealed the stop date of the vancomycin was to be 9/21/24. This failure resulted in Resident #347 missing two of her vancomycin doses. Resident #347 was readmitted to the hospital for a third time for nausea, seeing halos, shortness of breath, chest pain, feeling hot, and skin was clammy. Findings included: 1. Review of Resident #347's Face Sheet revealed she was admitted to the facility on [DATE] at 2:23 PM with medical diagnoses, not limited to, intracranial abscess and granuloma, endocarditis, pain, opioid abuse with withdrawal, bipolar disorder current episode manic without psychotic features, and psychoactive substance abuse with unspecified psychoactive substance-induced disorder. An observation and interview were conducted on 8/26/24 at 10:46 AM with Resident #347. She was observed to be sitting on her bed eating her breakfast. She was observed to have an intravenous (IV) line in her upper right arm. She said she was receiving intravenous antibiotics for endocarditis. She said she is not getting the right dose of her Suboxone. She said she is only getting two milligrams (mg) three times a day and she is supposed to be getting eight milligrams three times a day. She said the dosing got screwed up when the hospital wrote their paperwork. I have been admitted here since Friday or Saturday and I have been back to the hospital for withdrawals, and the hospital gave me sixteen milligrams of Suboxone to make up for the missed dosing. I told the doctor this morning that I need eight milligrams and she said she was going to have to talk to someone above her because she said she couldn't prescribe the medication, that a substance abuse physician might have to prescribe it. (continued on next page)

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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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #347's Census Records revealed she was admitted to the facility on [DATE] at 2:23 PM and had been readmitted to the hospital three times from 8/24/24 through 8/28/24. Review of Resident #347's hospital record dated 8/23/24 at 2:57 PM revealed Medication List TAKE these medications CONTINUE buprenorphine-nalOXone 8-2MG [milligram] SL [sublingual] film, Commonly known as: Suboxone, Place 1 Film under the tongue in the morning and 1 Film at noon and 1 Film before bedtime. Last time this was given: August 23, 2024 10:29 AM. There was a handwritten check mark next to the medication with morning, noon, and bedtime underlined. Review of Resident #347's physician orders revealed an order created by Staff C, RN Supervisor with a start date of 8/24/24 and an end date of 8/25/24 for Buprenorphine HCL (hydrochloric acid)-Schedule III tablet, sublingual; 2mg; Amount to Administer: 1 film; sublingual twice a day for psychoactive substance abuse with unspecified psychoactive substance-induced disorder. Review of the internet revealed, Suboxone Film .generic name: buprenorphine-naloxone. This medication contains 2 medicines: buprenorphine and naloxone. It is used to treat opioid use disorder. Buprenorphine belongs to a class of drugs called mixed opioid agonist-antagonists. Buprenorphine helps prevent withdrawal symptoms caused by stopping other opioids. Naloxone is an opioid antagonist that blocks the effect of opioids and can cause severe opioid withdrawal when injected. Withdrawal is less likely when naloxone is taken by mouth, dissolved under the tongue, or dissolved on the inside of the cheek. It is combined with buprenorphine to prevent abuse and misuse (injection) of this medication, according to https://www.webmd.com/drugs/2/drug-64741-1356/suboxone-sublingual/buprenorphine-naloxone-film-sublingual/details, viewed on 8/29/2024. Review of Resident #347's August medication administration record (MAR) revealed she was administered 2mg of buprenorphine twice a day on 8/24/24 at 9:00 p.m. and on 8/25/24 the 9:00 a.m. the dose documentation revealed the medication was charted late for a documented date and time of 8/25/24 at 12:44 p.m. Review of Resident #347's progress notes revealed the following notes: -Progress note dated 8/24/23 at 6:15 PM revealed Resident medications will be here with the early morning pharmacy run. Resident is displayings [sic] withdrawal symptoms awaiting the Buprenorphine 2 mg SL, film. Resident has Ativan 0.5 mg ordered and Staff D, LPN [Licensed Practical Nurse] obtained from the EDK [Emergency Drug Kit] box to administer to resident. Pharmacy called to request the Buprenorphine 2 mg SL, film to be sent STAT. [Staff G, Medical Doctor] notified re [regarding]: the need to order the Buprenorphine 2 mg SL, film electronically. -Progress note dated 8/24/24 at 6:42PM revealed Pharmacy called to check on STAT run for Buprenorphine 2 mg SL, film. Pharmacy informed RN Supervisor that STAT is with four hours. Pharmacy did let me know that the Buprenorphine 2 mg SL, film .will be enroute as soon as possible . (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-Progress note dated 8/24/24 at 8:47 PM revealed .C/o [complain of] pain scale of 6 @ [at] this time. Alert & oriented x 4. Very anxious, especially concerning meds [medications]. Resident c/o having withdrawals from not having Suboxone since leaving hospital in am [morning]. Visibly shaking. Staff C, RN Supervisor called On [sic] call MD [Medical Doctor] to get orders for all scripts. Called pharmacy, stated they will send Suboxone and Ativan via [Delivery Company] . -Progress note dated 8/25/24 at 9:32 AM revealed Resident became combative during the night due to medication administration not being to her liking regarding pills dosage and amount administered. The resident was sent out to the hospital via 911 around 1045p[sic] due to severe withdrawal symptoms. The resident was returned from the hospital around midnight and rested throughout the night . Review of Resident #347's Hospital record Admission/Registration dated 8/24/24 at 11:04 PM revealed Resident #347 had a Principle Admitting Diagnosis/ Reason for Visit of SUBOXONE WITHDRAWAL. Review of Resident #347's Patient Visit Information dated 8/24/24 revealed You were seen today for: Opiate withdrawal .Medication Dose and Instructions Buprenorphine/Naloxone (Suboxone 8-2mg SL) 8mg-2MG tab. SL 1 tab Sublingual THREE TIMES DAILY #12 TAB [tablet] REF[refill] 0 dated 8/24/24 11:49 pm Status: PRINTED Review of Resident #347's physician order, created by Staff C, RN Supervisor, with a start date of 8/25/24 and an end date of 8/26/24 revealed buprenorphine HCL-Schedule III tablet, sublingual; 2mg; Amount to Administer: 1 film; sublingual three times a day for psychoactive substance abuse with unspecified psychoactive substance-induced disorder. Review of Resident #347's August MAR revealed her order for 2 mg of Buprenorphine HCL three times a day was administered at 3:00 p.m. on 8/25/24. The 8/25/24 at 9:00 p.m. dose, the medication administration note revealed the medication had a charted date of 8/25/24 at 10:39 p.m. with a reason/comment of Late Administration: Charted late The medication was documented as administered on 8/26/24 at 9:00 a.m. and 3:00 p.m. Review of Resident #347's progress notes revealed the following: -A progress note dated 8/25/24 at 6:42 PM revealed .pt [patient] was upset throughout the day because she wants an increase to her Buprenorphine Dosage. Supervising RN went over orders with her to try and help her understand her current dosage. during [sic] the afternoon, resident was calm. around [sic] 2pm prn [as needed] ativan given for anxiety. Tolerated well. Around 5pm pt continued to c/o dosage of Buprenorphine and wanted it increased. She stated she wants to go to the ER to have them fix: her orders to increase medication. VSS [vital signs stable]. MD and supervisor aware. MD gave permission to send pt to ER [emergency room] if she still wanted to go. pt states she'll wait and see if she wants to go later, she states she is currently ok. no apparent distress noted. will continue to monitor resident. -Progress note dated 8/26/24 at 3:54 AM revealed Resident states she is not receiving [sic] the right dosage for her narcotic so she wants to go to the hospital so she can be given the right dose. This nurse verbalized understanding. Spoke with 911 operator @ 2210 [10:10 PM]. EMT [Emergency Medical Technician] staff arrived at 2215 [10:15 PM]. Updated them on resident. Proper paperwork sent with resident. Resident left facility awake, alert and oriented x3 @ 2230 [10:30 PM] via stretcher; accompanied by EMT staff. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-Progress note dated 8/26/24 at 3:47 AM revealed Resident returned from hospital via stretcher; accompanied by EMT staff on 8/26/24 @ 0045 [12:45 AM], awake alert and oriented x3. Review of Resident #347's hospital record dated 8/25/24 at 10:57 a.m. revealed Patient Visit Information You were seen today for: Drug abuse. Review of Resident #347's hospital physicians prescription revealed an issue date of August 24, 2024 for Suboxone 8-2mg SL (8 MG-2 MG TAB. SL) Dispense 12 (twelve) TAB. SIG: 1 TAB SL TID [three time's a day] No refills. handwritten on the paper was Faxed 8/26/24 745am Review of Resident #347's progress note revealed a note dated 8/26/24 at 3:36 PM Resident complaining that Buprenorphine order in hospital was 8 mg TID [three times a day], says it was decreased to 2 mg TID upon admission to this facility without her prior knowledge. She is asking again if [Staff G, MD] will increase med. [Staff C, MD's Nurse Practitioner] in to assess her this am. Made resident aware that she cannot make changes to Buprenorphione [sic] order and would make [Staff G, MD] aware, who already stated he would not increase dose. Called [Staff G, MD]. Left message about resident wanting to increase Buprenorphine. Review of Resident #347's progress note dated 8/26/24 at 4:00 p.m. revealed [Staff G, MD] contacted. He stated [Staff H, MD] will be in tomorrow. He stated he will not make changes to Buprenorphine over the phone. N.o. [new order] Ibuprofen 200 mg PO Q 6 hours as needed for pain. Resident stated no hx [history] of GI bleed. N.o. Benadryl 25 mg PO 30 minutes prior to each dose of IV Vancomycin. Resident made aware. Sent controlled refill sheet for Buprenorphine this am. Made him aware. He stated to have [Pharmacy] call him. Called [Pharmacy] and asked Pharacist [sic] to call [Staff G, MD]. Called back to have med drop shipped for PM dose. Resident very anxious. PRN [as needed] Ativan given @ 08:15 [AM] and 14:10 [2:10 PM]. Gave Buprenorphine SL @ 15:40 [3:40PM]. Stating she will keep requesting to go to hospital if her Buprenorphine is not increased. No s/s [signs/ symptoms] of withdrawals noted. VS [vital signs] stable. Gave IV [intravenous] Vanco [vancomycin] @ 12:00, tolerated well. Review of Resident #347's progress note dated 8/26/24 at 4:49 PM revealed [Hospital] called into [Pharmacy] n.o. Buprenorphine 8/2 mg SL TIS [sic] x 4 days. Will f/u with [Staff H, MD] tomorrow. Review for the August MAR revealed a physician's order with a start date of 8/26/24 and an end date of 8/29/24 for buprenorphine-naloxone - Schedule III tablet, sublingual; 8-2 mg; Amount to Administer: 1 tab; sublingual Three times a day for Opioid abuse with withdrawal. Review of Resident #347's MAR documentation revealed the medication was administered on 8/26/24 at 9:00 PM. On 8/27/24 the documentation revealed she received the medication at 9:00 AM, 3:00 PM, 9:00 PM as ordered, and on 8/28/24 She received the medication at 9:00 AM. An observation and interview were conducted on 08/27/24 at 10:15 AM. Resident #347 was observed to be lying in bed with her hand on her head. She said she is not doing well today. She said she feels hot, has a terrible headache right where her brain abscesses are, and she said she is shaking. She said the nurse just gave her, her suboxone, Xanax, lacosamide, and ibprophen. She said the nurse took her vitals and her temperature was low. She said the suboxone was still dissolving under her tongue, but she said she wanted to go to the hospital. She said she had not told the nurse she wants to go to the hospital. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 08/27/24 at 10:18 AM with Staff F, Agency, Licensed Practical Nurse (LPN) she said Resident #347 just received her medications and she obtained her vitals, and they were normal. She said the resident is on vancomycin and is expected not to feel well. An interview was conducted on 8/27/24 at 4:45 PM with Resident #347. She said she had not received her Vancomycin and was not sure why. She said she has been back to the hospital twice because the facility was not giving her the correct dose of Suboxone, and she was having withdrawal symptoms. She said the facility is currently using the suboxone prescription from the hospital but that is only for four days. She said she feels better than she did this morning. Review of Resident #347's physician orders revealed a discontinued order with a start date of 8/24/24 and an end date of 8/26/24 for Vancomycin in 0.9% sodium chloride solution 1gram/250ml; amount to administer 750mg intravenous every 8 hours (x7) at 8:00 PM, 4:00 AM, 12:00PM. Review of Resident #347's August MAR revealed Resident #347 only received one dose of vancomycin on 8/27/25 at 5:00 p.m. Review of Resident #347's hospital record dated 8/23/24 revealed Vancomycin 750mg in sodium chloride 0. 9% 250ml IVPB [Intravenous piggy back]. Infuse 750mg into a venous catheter every 8 (eight) hours for 7 doses. hand written on the vancomycin order was stop date 9/21 see attached orders. Review of the attached orders revealed Vancomycin 750mg q. [every] 8 hours till 9/21 . Review of Resident #347's progress note dated 8/27/24 at 6:10 PM revealed [Staff H, MD] was in to see resident this morning. Informed that resident is a hospital contract resident that falls under the medical director . notified of Vancomycin medication administration time change, states will be in at 11 am tomorrow to see resident. An interview was conducted with Resident #347 on 08/28/24 at 09:14 AM she was observed to be in her wheelchair, self-propelling in the hallway. She said she was not feeling well and wanted to be sent out to the hospital. She said she couldn't explain what is wrong she just felt off and worse than she did when she was in the hospital. She said she did end up getting her vancomycin last night around 5:00 PM and again around 1:00 AM. but she had not gotten any Vancomycin during the day on 8/27/24. Review of Resident #347's progress note dated 8/28/24 at 10:34 AM Resident complaint of feeling nauseated, seeing halos, sob, and chest pain, vitals obtain BP 149/104, HR 82 regular, 99%RA unlabored, stated feels hot, skin is clammy, refused 9am Vanco infusion and other meds, stated she wanted to go to hospital instead. 911 operator called; EMS arrived within 5 minutes at 10:30 am . DON, MD, Admin [administration] aware, attempted both emergency contact #s on file and both are invalid numbers. Review of Resident #347's progress note dated 8/28/24 at 10:32 PM revealed Resident returned from hospital @ 1925. Ativan 0.5mg PO given @ 1930. Resident awake, alert and oriented x3. Sitting in wheelchair. No complaints voiced or distress noted at this time. Resident continues on IV Vanco. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A phone interview was conducted on 08/27/24 at 06:00 PM with Staff G, MD he said he has not seen Resident #347 but he got a call yesterday (8/26/24) saying the resident was not getting the correct pain medication, and they also said oh by the way she says she wants her suboxone increased. I said I'm not going to increase suboxone when I have not seen the resident, but I am happy to reorder the dose the hospital recommended she have. He said he called the pharmacy on 8/26/24 to reorder the medications and the pharmacy said a [Hospital Physician] had sent in a script for suboxone 8-2mg and the pharmacy told him the doctor who sent in the script was the residents pain physician therefore Staff G, MD approved for pharmacy to fill the medication. Staff G, MD said his Physician Assistant (PA-C) saw Resident #347 on Monday (8/26/24) and Staff H, MD was supposed to see her today but he had not seen her because it turns out she under the care of the Medical Director because Resident #347 is under a hospital contract. He said Suboxone is a medication that is made up of 2 medications, buprenorphine and nalOXone. He said if the hospital admitted her with an order to receive buprenorphine-nalOXone 8-2mg three times a day then she should have been getting that dose from the beginning and that is not fair to Resident #347 if she did not receive it. He said if the hospital record said she needed 8-2mg of suboxone three times a day and the facility only ordered buprenorphine 2mg then the resident did not get the correct medication, and it sounds like there might have been a transcription error. He said hopefully the Medical Director comes to see the resident tomorrow (8/28/24), so the resident does not run out of the medication. A phone interview was conducted on 08/27/24 at 06:21 PM with Staff C, RN Supervisor. She said she started at the facility on 8/23/24 as a weekend supervisor. She said she had worked at the facility prior as an agency nurse. She said on 8/24/24 Resident #347 was admitted to the facility. She said she was still training on the day Resident #347 was admitted but she stayed late to learn how to do admissions. She said her and her trainer entered in the orders from hospital into the computer and sent the orders over to the pharmacy to be filled. She said she entered Suboxone 2mg three times a day into the computer She said the pharmacy called her and they needed a prescription for the Suboxone so she called Staff G, MD's, Physician Assistant but she was not on call so she called Staff G, MD and told him the order for Suboxone 2mg three times a day and he called the pharmacy and ordered it. Staff C, RN Supervisor said when the resident first arrived to the facility, Resident #347 said she was having withdrawal symptoms but then she went outside and smoked a cigarette and when she came back in she said she was still having withdrawal symptoms. Her medications had not shown up from the pharmacy so we gave her, her ordered Xanax from the emergency drug kit (EDK). Resident #347 was upset because she said we were not giving her the correct dose of suboxone, and everyone explained to her we were giving her the right dose because the order from the hospital said 8-2mg three times a day which is 2mg of suboxone three times a day. We even showed her the hospital paperwork and explained to her the hospital ordered her to have 2mg. She ended up going out to the hospital because she said we were not giving her the right dose and she returned the same night. Staff C, RN Supervisor said, when I came back the next day, the pharmacy had sent Suboxone 2mg in tablet form even though the ordered said film. Staff C, RN Supervisor said for new admissions the resident arrives, the hospital medications are entered into the computer, the pharmacy gets the orders that are in the computer, and they deliver the medications. For narcotics there has to be a paper prescription, or the doctor has to talk with the pharmacy to get the medication ordered. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 8/28/24 at 8:36 AM with the Director of Nursing (DON). She said Resident #347 came into the facility over the weekend. She came in while the nurse supervisors were here. Staff C, RN Supervisor was the training nurse supervisor. The DON said Resident #347 is a hospital contract patient we are keeping her here to administer IV Vancomycin . The DON said it came to her attention yesterday morning (8/27/24) there was a transcription error related to her suboxone. She said she was not notified Resident #347 had gone out to the hospital. The DON said Resident #347 was complaining about withdrawal symptoms since she had not received her suboxone on 8/24/24 and the nurses were trying to get the suboxone delivered stat. On 8/24/24 at 6:00 PM she got 0.5mg of Ativan and she went out to the hospital around 10:45 p.m. for severe withdrawal symptoms. She returned from the hospital around midnight and rested through the night. The DON reviewed Resident #347's hospital records dated 8/24/24 and confirmed the hospital recommend the resident received suboxone 8-2mg sublingual three times a day. The DON said the resident should have received 8mg of buprenorphine and 2mg of naloxone three times a day. The DON confirmed Resident #347 should have gotten that order upon admission. The DON said then on 8/25/24 a new order was put in for buprenorphine 2mg three times a day and the resident received 4 doses. Then on 8/25/24 at about 10:30 PM the resident was sent back out to the hospital because resident stated she is not receiving the right dosage for her narcotic so she wants to go to the hospital so she can be given the right dose. Then she goes back to the hospital at 10:30 PM and returns on 8/26/24 at 12:45 AM with a paper script for suboxone 8-2mg three times a day and the script was faxed on 8/26/24 at 7:25 AM and she received her first dose of suboxone 8-2mg on 8/26/24 at 9:00 PM. The DON said she initially thought this was a transcription error until she spoke with Staff C, RN Supervisor and realized it was a miss understanding of what the hospital order was. She said normally with a new admission the nurses would input the orders from the hospital and if there was confusion on an order the nurse would ask the supervisor, and in this case the nurse was the supervisor, so she should have called me, the doctor, or sent the pharmacy the hospital order and had them explain what the order meant. The DON also said Staff C, RN Supervisor put in Resident #347's Vancomycin order and when she did, she put in a stop date that was not the correct stop date. It was put into stop on 8/26/24 and the stop date should have been 9/21/24. So, the DON said she called the doctor had it reordered to start at 5:00 PM on 8/27/24. The DON said yesterday (8/27/25) she had not seen Resident #347 in her room getting her vancomycin, so she asked the nurse when was Resident #347 ordered to get her vancomycin? The nurse told the DON she did not have vancomycin ordered. Then the DON reviewed the chart and noticed the vancomycin was not ordered because the order was put in wrong. A phone interview was conducted on 08/29/24 at 10:18 AM with the facility's Pharmacy and spoke to Staff R, Pharmacist, she said suboxone is prescribed for opioid dependency. Staff R, Pharmacist said Suboxone is a combination of buprenorphine and naloxone that helps to treat withdrawal symptoms and opioid dependence. The Naloxone portion of Suboxone aids to stopping the withdrawals symptoms and the buprenorphine portion of suboxone addresses the cravings of opioids. Suboxone is a stronger drug than just buprenorphine because the two medications that make up Suboxone work together to address the craving of opioids and the withdrawal symptoms of not taking opioids. The pharmacist reviewed Resident #347's pharmacy record and said initially the resident was ordered buprenorphine 2mg sublingual tablet and they delivered a three-day supply on 8/24/24. She said this order was received via telephone with [Staff G, MD] and our pharmacist. Staff R, Pharmacist said 2mg of buprenorphine was not suboxone. Staff R, Pharmacist said on 8/26/24 the pharmacy delivered a four-day supply of Suboxone 8-2mg sublingual. Staff R, Pharmacist said they received the suboxone order via fax from the facility. It looks like the patient went out to the hospital and the hospital physician ordered the suboxone prescription and we filled it off of that prescription. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's policy Reconciliation of Medications on Admission, undated, revealed Purpose The Purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility. Preparation: 1. Gather the information needed to reconcile the medication list: a. approved medication reconciliation form; b. Discharge summary from referring facility; c. Admission order sheet; d. Most recent medication administration record (MAR), if this is a readmission. General Guidelines 1. Medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care. 2. Medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages and routes, during the admission/transfer process. 3. Medication reconciliation helps to ensure that all medications, routes, and dosages on the list are appropriate for the resident and his/her condition, and do not interact in a negative way with other medications/supplements on the list. 4. Medication reconciliation helps to ensure that medications, routes and dosages have been accurately communicated to the Attending Physician and care team. Steps in the Procedure 1. Using an approved medication reconciliation form or other record, list all medications from the medication history, the discharge summary, the previous MAR (if applicable), and the admitting orders (sources). 2. List the dose, route and frequency for all medications. 3. Review the list carefully to determine if there are discrepancies/conflicts. For example: a. The dosage on the discharge summary does not match the dosage from the resident's previous MAR; (continued on next page)

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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 0760 Level of Harm - Actual harm Residents Affected - Few	b. There is a potential medication interaction between a medication form the admitting orders and a supplement form the resident's medication history; or c. There is a medication listed on the discharge summary for which there is no diagnosis or condition to support the use of the medication. 4. if there is a discrepancy or conflict in medications, dose, route or frequency, determine the most appropriate action to resolve the discrepancy. For example: a. Contact the nurse from the referring facility; b. Contact the physician from the referring facility; c. Discuss with the resident or family; d. Contact the admitting and/or Attending Physician. 5. Notify the Director of Nursing or her Designee of any medication discrepancies. The Director of Nursing or her designee will provide guidance for documentation and resolution. 6. When a resident is transferred to another facility, or within the organization, the reconciled medication list will be sent to the receiving care provider and the communication will be documented.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39866 Based on observation, interview, and record review the facility failed to 1. Maintain an infection prevention and surveillance program for 6 out of 6 months reviewed. 2. The facility also failed to ensure their infection control guidelines policy was reviewed yearly and was revised with current evidence-based practices. 3. The facility also failed to ensure hand hygiene was performed during lunch meal service for one out of three meal observations. 4. The facility also failed to ensure enhanced barrier precautions were in place for two residents with intravenous lines (#347 and #31) out of two residents sampled for intravenous lines. Findings included 1. An interview was conducted on 08/26/24 at 10:41 AM with the Nursing Home Administer (NHA). She said the facility does not have any staff who have completed or started the infection prevention training. She said the current Director of Nursing (DON) started her position the last week of July of 2024 or first week of August 2024 and there has not been any infection surveillance and the NHA was unsure when the last time any infection surveillance had been conducted. An interview was conducted on 08/29/24 at 11:10 AM with the Director of Nursing (DON) she said she started at the facility mid-July as the Unit Manager and became the interim DON two weeks after she started and two weeks ago, she said she would accept the DON position. She said she does not have any formal training in infection control, and she is not certified in infection prevention. She said no one else in the facility is certified. She said she is registered to take the certification, but she is not sure what course to take because there are so many options, so she has not started. She said she had not started gathering infection control documentation until after survey entry and the last infection control documentation she could find was from October of 2022. She said she tried to run antibiotics reports for July but with the electronic medical record system they have it seemed the antibiotic information was incomplete, so she tried to pull the antibiotic information from their pharmacy system and that also seemed incomplete. She said she told the NHA she was not sure what she even needed or what she was even looking for because she had never run an infection prevention program. Review of the facility's Surveillance for Infections policy, revised September 2017, revealed Policy Statement The Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. Policy Interpretation and Implementation 1.The purpose of the surveillance of infections is to identify both individual case and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to guide appropriate interventions, and to prevent future infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2.The criteria for such infections are based on the current standard definitions of infections. 3. Infections that will be included in routine surveillance include those with: a. Evidence of transmissibility in a healthcare environment.; b. Available processes and procedures that prevent or reduce the spread of infection; c. Clinically significant morbidity or mortality associated with infection (e.g. pneumonia, UTIs, C. difficile); and d. Pathogens associated with serious outbreaks. (e.g. invasive Streptococcus Group A, acute viral hepatitis, norovirus, scabies, influenza) . Gathering Surveillance Data 1. The Infection Preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data. The Infection Control Committee and/or QAPI Committee may be involved in interpretation of the data . 2. An interview was conducted with the DON and NHA on 08/29/24 at 11:08 AM they both said they did not know when the last time the infection control policy was updated. The NHA said it may have been reviewed at a regional level but in the facility, it has not been reviewed for over a year. Review of the facility's Infection Control Guidelines for All Nursing Procedures policy, with a revision date of August 2012 revealed Purpose To provide guidelines for general infection control while caring for residents. Preparation 1. Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on general infection and exposure control issues, including: a. The facility protocols for isolation (standard and transmission-based) precautions; b. The location of all personal protective gear; . .3. Employees must wash their hands for ten (10) to fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: a. Before and after direct contact with residents . 3. A lunch meal administration was conduncted on the North unit on 8/26/24 from 12:03 PM to 12:27 PM. Staff L, Certified Nursing Assistant (CNA) was observed to provided 8 residents their meal trays in their rooms and did not sanitize her hands in between residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was conducted with Staff L, CNA on 8/26/24 at 12:29 PM she said she is supposed to sanitize or wash her hands in between passing meal trays to the residents and she may not have. She said she tries to wash her hands in the resident's room but there's not always soap in there and she said there is hand sanitizer at the front of the facility. 4. Review of Resident #347's Face Sheet revealed she was admitted to the facility on [DATE] with medical diagnoses, not limited to, intracranial abscess and granuloma, endocarditis, pain, bipolar disorder current episode manic without psychotic features, and psychoactive substance abuse with unspecified psychoactive substance-induced disorder. An observation and interview were conducted on 08/26/24 at 10:46 AM with Resident #347. She was observed to be sitting on her bed eating her breakfast. She was observed to have an intravenous (IV) line in her upper right arm. She said she is receiving intravenous antibiotics for endocarditis, and she had a one-on-one staff member in the room, because she is an IV drug user and has an IV. An observation was conducted at the time of the interview and there were no precaution signs on her door and there were no Personal protective equipment (PPE) outside of her room or immediately available. Review of Resident #347's physician orders revealed an order with a start date of 8/27/24 and an end date of 9/21/24 for Vancomycin 750 milligrams (mg); intravenous special instructions: Infused Q8Hhrs [every 8 hours] via PICC [peripherally inserted central catheter] through 9/21/24 for a diagnosis of intracranial abscess and granuloma. An interview was conducted with the DON and NHA on 08/29/24 at 11:08 AM. The DON said the facility does use enhanced barrier precautions for residents who have candida aureus and methicillin resistant staphylococcus aureus (MRSA). The NHA said she will try and find an enhanced barrier policy. The policy was not provided. Review of the Centers for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 4/2/2024, revealed For Awareness Updates as of July 12, 2022 3. Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. 4. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. 5. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: 1. Wounds or indwelling medical devices, regardless of MDRO colonization status 2. Infection or colonization with an MDRO. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. 7. Standard Precautions, which are a group of infection prevention practices, continue to apply to the care of all residents, regardless of suspected or confirmed infection or colonization status. https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html. 49497 On 08/26/24 at 10:30 a.m. an Intravenous (IV) pole was observed with Resident #31 receiving an active treatment. There was no PPE supplies, other than surgical gloves in or around the resident's room. No enhance barrier precautions signage was displayed on door, door frame or outside of Resident #31's door. Review of electronic medical record (EMR) for Resident #31 showed an admitted [DATE] with diagnoses including generalized anxiety, major depressive disorder, adjustment disorder with mixed anxiety and depressed mood, unspecified atrial fibrillation, spondylosis lumbar region. Review of physician orders revealed Daptomycin intravenous injection; 600mg; amt: 1; intravenous once a day at 9:00 a.m. Flush with normal saline prior and after administering medication, Rocephin injection 2g intravenous. Flush with normal saline prior to administering medication and after administering medication. Once a day at 12:00 p.m. and Provide standard/universal precautions. Review of the MDS dated [DATE] revealed Section C Brief Interview for Mental Status score of 15 indicating no cognitive impairment and Section O showed resident receiving IV antibiotic medication through a central line. Review of Resident #31's progress notes revealed the following: On 08/28/24 at 7:20 p.m. Resident currently on ABT [antibiotics] has had no adverse reactions PICC [peripherally inserted central catheter] line dressing intact and clean and functioning properly. On 08/28/24 at 3:15 a.m. IV ABX [antibiotics] continued. No s/s [signs or symptoms] of infection. Post-op [post-operative] sling in place. Safety precautions in place. On 08/27/24 at 7:47 p.m. Resident PICC line is intact dressing was changed yesterday and is functioning properly. Resident has had no adverse reactions to ABT therapy and is compliant with current plan of care. On 08/26/24 at 3:38 a.m. Right arm IV line dressing clean and intact. No s/s of infiltration, irritation, redness or edema. No complaints noted by the resident. Continue to monitor. An interview was conducted on 08/28/24 at 9:25 a.m. with Resident #31. He stated when the nurse comes to change his Intravenous (IV) dressing and/or start his IV antibiotics she always wears gloves. He stated she has never worn a gown or mask, just gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was conducted on 08/29/24 at 11:49 with Staff P. She stated when she completes Resident #31's Intravenous (IV) treatment or IV dressing change her process is to perform hand hygiene, gather her medication and dressing supplies for performing the treatment, complete hand hygiene again, then dons her surgical gloves. She stated she the completes the treatment, removes gloves and disposes of them, then performs hand hygiene again. She stated she was not aware of enhance barrier precautions at facility. She stated she had not received any training or educational in-service regarding enhance barrier precautions. Review of facility infection control policy dated 2012 showed no reference or documentation regarding enhanced barrier precautions.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 39866 Based on interview and record review the facility failed to have a qualified infection Preventionist who was qualified by education, training, experience or certification for one of one staff member acting as the infection Preventionist. Findings include: An interview was conducted on 08/26/24 at 10:41 AM with the Nursing Home Administer (NHA). She said the facility does not have any staff who have completed or started the infection prevention training. She said the current Director of Nursing (DON) started her position the last week of July of 2024 or first week of August 2024 and there has not been any infection surveillance and the NHA was unsure when the last time any infection surveillance had been conducted. An interview was conducted on 08/29/24 at 11:10 AM with the Director of Nursing (DON) she said she started at the facility mid-July as the Unit Manager and became the interim DON two weeks after she started and two weeks ago, she said she would accept the DON position. She said she does not have any formal training in infection control, and she is not certified in infection prevention. She said no one else in the facility is certified. She said she is registered to take the certification, but she is not sure what course to take because there are so many options, so she has not started. She said she had not started gathering infection control documentation until after survey entry and the last infection control documentation she could find was from October of 2022. She said she tried to run antibiotics reports for July but with the electronic medical record system they have it seemed the antibiotic information was incomplete, so she tried to pull the antibiotic information from their pharmacy system and that also seemed incomplete. She said she told the NHA she was not sure what she even needed or what she was even looking for because she had never run an infection prevention program. Review of the facility's infection prevention documentation did not reveal a completed infection prevention education, training, experience or certification for the Director of Nursing. Review of the facility's Surveillance for Infections policy, revised September 2017, revealed Policy Statement The Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. Policy Interpretation and Implementation 1.The purpose of the surveillance of infections is to identify both individual case and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to guide appropriate interventions, and to prevent future infections .

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49497 Based on observation, record review and interview the facility failed to ensure bed rails were secure for 1 resident (#9) of 5 sampled. Findings included: On 8/26/24 at 2:39PM bilateral enabler rails were observed installed on Resident #9's bed. An interview and observation were conducted on 08/26/24 at 2:43p.m. with Resident #9. He stated his bed rail is loose as he physically shook the rail laterally. The right enabler rail was observed to be loose and could be moved out from the side of the bed and back easily. The resident stated he notified the NHA and maintenance multiple times, and nothing has been done to fix it. He stated he used the rail all the time to aid in his mobility but was fearful to use due to the rail not being secure. Review of electronic medical record (EMR) for Resident #9 showed an admission to facility on 12/04/23 with diagnoses including lymphedema, unspecified convulsions, restless agitation, and cellulitis of right lower limb. Review of the Minimum Data Set (MDS) dated [DATE] revealed, Section C Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. Review of a Work History Report for Beds & Mattresses: Inspect Bed Rails revealed the Maintenance Director (MD) signed off on 08/13/24, 07/30/24 and 06/27/24 that beds, mattresses and bed side rails had been checked during audit. Review of maintenance log for last three months showed no work order completed for Resident #9's bed rails. An interview was conducted on 08/29/24 at 11:12 am with the MD. He stated he performs bed, mattress and bed rail audits every month since he started last June. He stated he checks the bed rails to make sure they are functioning properly and safe for resident use. He stated he tightened Resident #9 bed rail when the surveyor brought it to the NHA's attention on 08/26/24. He stated it was not discovered during prior audits. Review of undated Nursing Home Side Rail Policy revealed: Section 5.4 titled Safety and Maintenance showed inspection of side rails must be inspected regularly to ensure they are functioning properly and safely. Any damaged or malfunctioning equipment should be reported immediately and repaired or replaced.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observation, record review and interview the facility failed to ensure call lights were functioning properly in resident rooms and bathrooms for one resident (# 24) out of six residents sampled Findings include: On 08/26/2024 at 2:00 p.m., an observation was conducted in room [ROOM NUMBER] with Resident # 24. She was observed in her bathroom turning on the call light which did not turn on to alert staff to come to her room. During the observation Resident # 24 stated her call light has not worked for a long time. Every time she turns on her call light in her room or in her bathroom it turns on in the resident room next door. She stated sometimes she has to wait for an hour to get assistance due to her call light not working properly. Review of an Admission Record dated 8/29/2024 showed Resident # 24 was admitted to the facility on [DATE]. On 08/26/2024 at 2:30 p.m., an interview was conducted with Staff S, the Receptionist. Staff S was observed knocking on Resident # 24's door. She stated she is a certified nursing assistant/administrative assistant. The facility had a new call light system installed in the beginning of the year which was not installed properly. Staff were told that the wiring in the call light system is crossed and that's why room [ROOM NUMBER]'s call light turns on in room [ROOM NUMBER]. Staff are aware that they must check on both residents' rooms whenever their call light comes on. On 08/29/2024 at 5:00 p.m., an interview was conducted with the Maintenance Director. He stated he was told the facility installed a new call light system in the beginning of the year. He was told some of the wires are crossed and that's why room [ROOM NUMBER] and 22 call lights are not functioning properly. He said he reached out to his corporate office today to try to contact the company that installed the system so they can come back out to fix the problem. He said he conducts call light audits monthly that's how he knows rooms [ROOM NUMBERS] are the only rooms with this problem. On 08/29/2024 at 5:30 p.m., an interview was conducted with the Nursing Home Administrator. She stated she is aware of the call light system wiring problem. The new maintenance director has corrected a lot of things around the facility and that's one of the things he will be adding to his list to fix. The facility did not have a call light policy to provide for this citation

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 39866 Based on observations, interviews, and record review the facility failed to maintain an effective pest control program to prevent flying insects in resident rooms and resident common areas for four of four days. Findings included: An observation was conducted on 08/26/24 at 10:05 AM, Resident #22 was observed to be sitting on the side of his bed, dressed in day clothes. There were four flying insects observed flying around the resident and landing on his jacket. Resident #22 said the flying insects come and go and they have been that way for months. He said he does not see anyone coming to spray for pests. (Photographic evidence obtained) An observation was conducted on 08/26/24 at 11:56 AM of a bedframe in the resident hallway with 2 fly insects flying around and landing on the bedframe. An observation was conducted on 08/27/24 at 9:13 AM of Resident #22 in bed, eyes closed with two flying insects flying around the resident and landing on his arm and shirt. An observation and interview were conducted on 08/28/24 at 11:00 AM. A bedframe was outside Resident #11's room in the hallway. The resident said she wants the bedframe away from her room because flies are on it and the fly's come into her room and keep her up at night and fly around her food so she can't eat. An observation was conducted on 08/29/24 at 12:50 PM of Resident #22 walking the halls with his walker with flying insects around him and landing on his shirt. Staff D, Licensed Practical Nurse (LPN) was observed to swat the flies off Resident #22's shirt. An interview was conducted on 08/28/24 at 11:38 AM with the Maintence Director. He said the pest control company comes every month and as needed. He said he has been at the facility for about a month and a half, and he reviewed the pest log every week and will call the pest control if he needs to and they will come out and sign the pest control log. He said the last time the pest control company was here was on 8/23/24. Review of the facility's pest control log dated January 2024 through August 2024 revealed on 7/7/24 there were fly, fruit flys, mosquitos, gnats, roaches all over the facility. There was illegible documentation on the Pest control Person sign off portion of the document for 7/7/24. On 8/24/24 the documentation revealed Continue to have multiple flying bugs all over residents and resident food through out the facility. There was no documentation the facility had been treated for the flying bugs. Review of the pest control Completed Service documentation, dated 8/23/24 revealed Issues Targeted: Mice/Rats Locations Treated: Bait Station (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Technician Notes: Today I serviced (12 of bait boxes) rodent bait boxes. I filled each rodent bait box with new rodent bait. I marked the appropriate date on the service cards. In addition, I checked that the rodent bait boxes were securely anchored. Thank you for allowing me to service your rodent bait boxes today!