STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105353	A. Building B. Wing	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solaris Healthcare Forest Lake	3355 E Semoran Blvd Apopka, FL 32703

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to ensure medications were administered according to acceptable standards of practice for 1 of 2 residents observed during a medication administration pass, of a total sample of 9 residents, (#3).Findings:Resident #3 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease, personality disorder, depressive disorder, persistent mood disorder, and hyperlipidemia. Review of the Minimum Data Set admission Assessment with an Assessment Reference date of 6/25/25 revealed resident #3 had a Brief Interview for Mental Status score of 15/15, which indicated the resident was cognitively intact. On 7/10/25 at 8:57 AM, Licensed Practical Nurse (LPN) A prepared resident #3's medications which included Divalproex capsule 125 milligrams (mg), Escitalopram 10mg, Buspirone 10 mg, Cetirizine 10 mg, and Alkums 1250/500 mg. LPN A checked the photograph on the medication administration record (MAR) for identification of resident #3 before entering the resident's room.On 7/10/25 at 9:08 AM, LPN A entered the room and proceeded to resident #3's bedside. LPN A greeted resident #3 and placed five medication cups on the resident's bedside table and informed resident #3 she was going to administer her morning medications. LPN A started to explain the name of each medication in the medication cups to resident #3. During that process, LPN A held one of the medication cups and told resident #3 that it contained her seizure medication. LPN A informed the resident that she could not remember the name of the medication so she informed the resident, and both surveyors that she would be right back. LPN A stated she was returning to the medication cart to check the name of the seizure medication. LPN A walked out of resident #3's room but left all of the medication cups that held the yet to be administered medications on the resident's bedside table. Upon return to resident #3's bedside, LPN A stated the name of the medication she forgot and proceeded to administer all the prepared medications to resident #3. Further observation during the medication pass revealed LPN A did not call resident #3 by her name, did not ask the resident to say her name or her date of birth , and she did not check an armband. LPN A did not use a second identifier to verify the resident's identity before she administrated the medications. On 7/10/25 at 9:35 AM, LPN A stated if there was a new resident who she did not know, she asked for their name or date of birth . She stated she used the picture on the MAR as identification. LPN A stated the five rights for medication administration were right patient, right dose, and right medication, but she could not recall the other two rights for medication administration. LPN A stated the residents at this facility did not wear wristbands for identification, but she knew resident #3 and checked her picture on the MAR. LPN A explained the facility practice was to use a second identifier before administrating medications, and she could have the residents say their name, their birthday or check with a second nurse. She said, I had her say her name. LPN A was informed that the resident that verbalized her name and date of birth was not resident #3, but actually another resident observed earlier for medication pass. LPN A acknowledged she left resident #3's medications unattended on the bedside table which she should not have done. On 7/10/25 at 4:18 PM, the 100 Unit's Manager (UM) stated the process of medication verification included the use of two identifiers which could include the resident's name, date of birth (DOB), or the resident could be verified with another nurse before administering medications. On 7/11/25 at 10:19 AM, the Director of Nursing stated the expectation was that nurses would know the five rights for medication administration. She stated medications were not to be left at the bedside unattended and the nurse should use two forms of resident identification during a medication pass. Review of the facility policy for Medication Administration General Guidelines revised January 2018 showed medications were administered as prescribed in accordance with good nursing principles and practices. Section four of the policy listed the five medication rights which included the, Right resident, right drug, right dose, right route, and right time. The policy indicated the five rights were to be applied for each administration of medications. The policy revealed, 8) Residents are identified before medication is administered using two methods of identification.

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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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent medication errors related to not following physicians' orders for 1 of 2 residents sampled for medication administration, of a total sample of 9 residents, (#6). There were 2 medication errors in 11 opportunities, for a medication error rate of 18.18%. Findings:Resident #6 was admitted to the facility on [DATE] with diagnoses including asthma, hyponatremia (low sodium), hypertension, gastro-esophageal reflux, osteoarthritis, and chronic kidney disease. On 7/10/25 at 9:15 AM, Licensed Practical Nurse (LPN) A prepared resident #6's scheduled morning medications. She removed Losartan 50 milligrams (mg), Meloxicam 7.5 mg, Omeprazole 20 mg, Ursodiol 300 mg, Pregabalin capsule 100 mg, Sodium Chloride 1 gram (gm), and Fluticasone Salmeterol ACT aerosol 500/50 microgram (mcg). On 7/10/25 at 9:21 AM, during medication administration pass LPN A administered Losartan 50 mg to resident #6. The nurse signed off that she administered Fluticasone Salmeterol ACT aerosol 500/50 mcg, one inhalation. LPN A said she had six pills total inside the individual medication cups and was reminded the inhalation of Fluticasone Salmeterol ACT aerosol she was holding in her hand would count as the seventh medication for resident #6. LPN A proceeded to administer resident #6 her morning medications. During the administration, LPN A administered two inhalations of the Fluticasone Salmeterol ACT aerosol 500/50 mcg to resident #6. Review of the physician orders and reconciliation with the Medication Administration Record (MAR) revealed LPN A signed for administration of Losartan 100 mg which was ordered on 7/02/25. A closer review showed the Losartan 50 mg for resident #6 was discontinued on 7/02/25. Further review of the physician orders and MAR reflected that LPN A signed off that she administered one inhalation of Fluticasone Salmeterol ACT aerosol 500/50 mcg during the medication pass, instead of the two she actually administered. On 7/10/25 at 3:44 PM, LPN A pulled up the MAR on her computer which indicated she signed off for administration of Losartan 100 mg tablet. She stated she administered the 100 mg tablet. LPN A was informed she administered Losartan 50mg one tablet instead of the physician ordered Losartan 100 mg tablet. Observation and review of resident #6's medication card/bubble packages with LPN A revealed a bubble package for Losartan 100mg give 1 tablet every day, filled by the pharmacy on 7/02/25 and out of the 30 pills the count showed there were 27 tablets left, which indicated only three tablets had been removed from the bubble package over the last eight days. Further review of other bubble packages revealed one for Losartan 50 mg give one tablet every day, filled by the pharmacy on 6/19/25. Out of the 30 tablets total, it showed 16 tablets were left. LPN A verified both Losartan bubble packages with their corresponding physician orders for start dates, stop dates and the number of tablets that remained in each bubble package. LPN A stated if the medication dosage was changed, nurses would order the new dosage of the medication from the pharmacy. She explained they would keep the Losartan 50 mg medication package and administer two 50 mg tablets until the new 100 mg dosage arrived from the pharmacy. LPN A explained the facility's process for discontinued medications was to take the discontinued medications and put them in the medication room so they could be returned to the pharmacy. LPN A elaborated that nurses must get a new label from the pharmacy which indicated the medication had been discontinued while they continued to use that medication package. LPN A acknowledged during the medication administration observation she administered two inhalations of Fluticasone Salmeterol ACT aerosol rather than one inhalation as ordered. She confirmed she did not follow the physician orders for the Fluticasone Salmeterol ACT aerosol. On 7/11/25 at 10:19 AM, the Director of Nursing (DON) stated nurses were to follow the physician orders. She stated medication information on the bubble pack should match the physician's order. The DON stated nurses were to contact the physician and put the directions on the sticker in place, so other nurses would be informed of the changes before administering the medications. She stated discontinued medications should be removed from the medication cart immediately. Review of the facility policy for Medication Administration General Guidelines revised January 2018 revealed, 5) Prior to administration of any medication, the medication and dosage schedule on the resident's medication administration record (MAR) are compared with the medication label. If the label and MAR are different and the container has not already been flagged indicating a change in directions, or if there is any reason to question the dosage or directions, the physician orders are checked for the correct dosage schedule. The policy indicated when a medication order was changed, and the current supply could continue to be used, the container should be flagged right away and the order change communicated to the pharmacy. The policy detailed that medications would be

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to adhere to proper infection control practices for 1 of 2 residents observed during medication administration, of a total sample of 9 residents, (#6). Findings: On 6/12/25 resident #6 was admitted to the facility with diagnoses of asthma, hyponatremia (low sodium), hypertension, gastro-esophageal reflux, osteoarthritis, and chronic kidney disease. On 7/10/25 at 9:15 AM, Licensed Practical Nurse (LPN) A retrieved resident #6's morning medications from the medication cart. On 7/10/25 at 9:21 AM, during medication preparation LPN A placed several medication cups on top of the medication cart. She then placed Losartan 50 milligrams (mg), Meloxicam 7.5 mg, Omeprazole 20 mg, Ursodiol 300 mg, Pregabalin capsule 100 mg, Sodium Chloride 1 gram (gm), and Fluticasone Salmeterol ACT aerosol 500/50 microgram (mcg) each into the separate medication cups. LPN A then proceeded to stack the medication cups on top of each other in order to carry all of the medications in her hands to resident #6's room. The bottom of each stacked medication cup which had been sitting directly on of the medication cart surface was in direct contact with the tablets in the cups below them. LPN A administered the contaminated tablets to resident #6.On 7/10/25 at 9:40 AM, LPN A explained she stacked the medications cups because she could not carry all the medications in her hands, and she could not leave anything behind on the medication cart. She stated the top of the medication cart was not ideal for sanitation in regard to stacking the medication cups inside each other on top of the tablets. She stated she received in-service education on proper medication administration last month.On 7/11/25 at 10:19 AM, the Director of Nursing (DON) confirmed the top of the medication cart was not considered sanitary. She stated the facility had gray trays that nurses could use to carry medications to the residents' rooms, so they did not have to stack the medication cups inside each other. The DON explained once the medication cup was on the surface of the cart it was no longer sanitary because there was no barrier between the medication tablets and the bottom of the medication cups. Review of the facility policy for Medication Administration General Guidelines dated January 2018, showed medications were administered as prescribed in accordance with good nursing principles and practices. The policy detailed that authorized personnel should administer medications only after the personnel were properly oriented to the facility for administration and an adequate supply of disposable containers, equipment, and supplies should be maintained on the medication cart for administering medications.