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	03/27/2025

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51023 Based on interview, and record review, the facility failed to ensure completion and accuracy of Level I Preadmission Screening and Resident Reviews (PASARRs) on admission, and/or failed to make referrals for newly evident or possible mental disorders to evaluate the need for specialized mental health services or alternate placement for 7 of 7 residents reviewed for PASARR, of a total sample of 53 residents, (#17, #199, #136, #19, #185, #9 and #72). Findings: 1. Resident #17's medical record revealed she was admitted to the facility on [DATE] from an acute care hospital with a diagnoses including diverticulitis, fibromyalgia, generalized anxiety disorder, and major depressive disorder. Review of the resident 5-day Minimum Data Set (MDS) dated [DATE] revealed the resident had a diagnosis of anxiety, and depression listed under section active psychiatric and mood disorders. The MDS assessment noted the resident was taking antianxiety and antidepressant medications. The resident's level I PASARR form dated 10/09/24 was completed prior to admission to the facility. The form indicated only the diagnosis of anxiety listed under Section IA, Mental Illness or suspected Mental Illness. A psychiatry consultation dated 10/15/24 revealed the resident had diagnoses of major depressive disorder, generalized anxiety, and dementia without behavioral, psychotic, mood disturbances. Resident's plan of action included continuing Donepezil and Memantine for dementia and Duloxetine for depression. The resident's Clonazepam for anxiety was changed from as needed (PRN) to a scheduled medication at bedtime. Review of resident #17's physician medication orders revealed the resident was ordered Clonazepam 0.5 milligrams (mg) at bedtime for anxiety with a start date of 10/15/24, Gabapentin 100 mg every 8 hours for neuropathy with a start date of 10/11/24, Memantine HCl 10 mg every morning and at bedtime for dementia with a start date of 10/09/24, Donepezil HCl 10 mg daily for dementia with a start date of 10/10/24, and Sertraline HCl 25 mg at bedtime for depression with a start date of 12/17/24. Review of resident #17's care plan revealed a focus initiated 10/10/24 regarding the use of antidepressant medication related to depression. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record revealed no updates had been made to the level I PASARR form to include this mental illness, major depressive disorder. 2. Resident #199's medical record revealed he was admitted to the facility on [DATE] from an acute care hospital with diagnoses including metabolic encephalopathy (brain dysfunction), dementia without behavioral, psychotic, or mood disturbances, and cognitive communication deficit. Review of the resident Admission MDS assessment dated [DATE] revealed the resident had no diagnosis listed under section active psychiatric and mood disorders, but the assessment indicated the resident was taking antianxiety and antipsychotic medications. The resident's PASARR form dated 1/29/25 was completed prior to admission to the facility. The form indicated no mental illness or suspected mental illness under Section IA. Review of resident #199's physician medication orders revealed the resident was ordered Rexulti 0.25 mg every day for mood disorder with a start date of 1/29/25 and was discontinued on 2/04/25 and an order for Trazodone 25 mg every 12 hours for diagnosis of depression with a start date of 2/04/25. A Psychiatry consultation dated 2/04/25 under the section 'Plan of Action' revealed the resident's medication Rexulti was discontinued and Trazodone 25mg every 12 hours for depression was started. The resident was started on this medication because non-pharmacological interventions were not sufficient to manage the symptoms of the resident. The consultation described the medication was prescribed because in general it helped with depression, anxiety, panic attacks, post trauma anxiety, irritability, agitation and sleep. Review of resident #199's care plan revealed a focus initiated 2/05/25 about the use antidepressant medications and the resident being at risk for complications from these medications. Review of resident medical record revealed no updates were made to the PASARR form to include this mental illness diagnosis. 50401 3. Resident #136 was admitted on [DATE] with diagnoses of acute respiratory failure with hypoxia (low oxygen), Parkinson's disease, type 2 diabetes mellitus, stroke, insomnia, bipolar disorder, depressive disorder, and post-traumatic stress disorder. Review of the PASARR level I screening dated 2/19/25 revealed it did not include the diagnoses bipolar disorder, depressive disorder, nor post-traumatic stress disorder. On 3/26/25 at 4:06 PM, in a joint interview the Admissions Clerk and Admissions Director stated they both reviewed admission referrals which included reviews of the hospital transfer form for patient transfers, including the PASARR form, prior to admission. They agreed they looked to see if the PASARR was complete, but stated they didn't check the assessment for accuracy. They added, the Social Services Director reviewed the PASARRs for accuracy. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/26/25 at 4:19 PM, the Director of Social Services stated she checked to see if the PASARR was accurate and then she provided the PASARR to the Regional Social Worker or the Director Of Nursing. The Director of Social Services added, during Gradual Dose Reduction (GDR) meetings for medications, she reviewed the PASARR's to ensure their accuracy, especially if any new psychiatric diagnoses were added. She did not say why resident #136's level I PASARR was not accurate. 50875 4. Resident #19 was initially admitted to the facility on [DATE] and readmitted on [DATE] from the hospital. Some of her diagnoses included acute respiratory failure with hypoxia, pneumonia, chronic obstructive pulmonary disease, heart failure, generalized anxiety disorder and major depressive disorder. Resident #19's most recent MDS assessment with an assessment reference date of 2/27/25 revealed the resident scored 15 out of 15 on the Brief Interview for Mental Status which indicated she had no cognitive impairment. The assessment indicated she felt depressed, but had no behaviors nor rejection of care and listed diagnoses of both anxiety disorder and depression. Resident #19's Order Summary Report showed the resident had an order for Sertraline HCl Oral Tablet 50 mg, 3 tablets given by mouth at bedtime for depression. Resident #19 had a Plan of Care initiated on 2/29/24 for the use of antidepressant medication related to the diagnosis of depression. On 3/26/25 at 10:31 AM, a review of resident #19's PASARR Level I Screen for Serious Mental Illness and /or Intellectual Disability or Related Conditions dated 1/04/24 incorrectly revealed no diagnoses listed in Section A for Mental Illness or Suspected Mental Illness. 5. Review of the medical record revealed resident #185 was admitted to the facility on [DATE] from the hospital. Some of her diagnoses included nontraumatic intracerebral hemorrhage, displaced intertrochanteric fracture of the right femur, dementia, major depressive disorder, generalized anxiety disorder, and Alzheimer's disease. Resident #185's Admission Minimum Data Set (MDS) with an assessment reference date of 2/24/25 revealed the resident scored 6 out of 15 on the Brief Interview for Mental Status which indicated she was cognitively impaired. The assessment indicated resident #185 felt depressed, exhibited behaviors and rejected care. She had diagnoses of anxiety disorder and depression. Resident #19's Order Summary Report showed the resident had an order for Citalopram Hydrobromide 20 mg and half tablet to be given by mouth one time a day for depression. The resident also had orders for Trazadone HCL tablet 50 mg and half tablet to be given by mouth every twelve hours for depression. Resident #185 had a Plan of Care which was initiated and revised on 3/27/25 related to the diagnosis of depression and another care plan for the use of antidepressants initiated and revised on 2/18/25. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/26/25 at 3:47 PM, review of resident #185's PASARR Level I Screen for Serious Mental Illness and /or Intellectual Disability or Related Conditions dated 2/18/25 revealed no diagnoses listed in Section A for Mental Illness or Suspected Mental Illness. 6. Resident #9 was initially admitted to the facility on [DATE] and readmitted on [DATE] from a rehabilitation hospital. Some of her diagnoses included chronic respiratory failure with hypoxia, hypotension (low blood pressure), type 2 diabetes mellitus, end stage renal disease, and bipolar disorder. Resident #9's Quarterly MDS assessment with an assessment reference date of 1/3/25 revealed the resident scored 00 out of 15 on the Brief Interview for Mental Status which indicated she was cognitively impaired. The assessment revealed resident #9 had no behaviors nor rejection of care and included bipolar disorder as an active diagnosis. Resident #9 had a Plan of Care initiated on 4/08/21 and revised on 7/09/21 for mood problems related to anxiety. Another focus in the Plan of Care revealed resident #9 had a history of being aggressive with staff, anxiety, depression, anger, and poor impulse control initiated 12/06/20. On 3/26/25 at 4:32 PM, a review of resident #9's PASARR Level I Screen for Serious Mental Illness and /or Intellectual Disability or Related Conditions dated 1/17/22 revealed no diagnoses listed in Section A for Mental Illness or Suspected Mental Illness. 7. Resident #72 was admitted to the facility on [DATE] from an acute care hospital. Some of his diagnoses included unspecified fracture of the right femur, partial paralysis following stroke, type 2 diabetes mellitus, chronic kidney disease and major depressive disorder. Resident #72's Admission MDS assessment with a reference date of 12/13/24 revealed the resident scored 6 out of 15 on the Brief Interview for Mental Status which indicated he was cognitively impaired. The assessment indicated the resident felt down, depressed and hopeless, but had no behaviors nor rejection of care and listed depression as an active diagnosis. Resident #72's Order Summary Report showed the resident had an order for Venlafaxine HCL tablet extended release 24 hour, 150 mg to be given with Venlafaxine HCL tablet extended release 75 mg to equal 225 mg given daily for depression. The Plan of care revealed resident #72 had mood problems related to depression initiated on 12/10/24. On 3/26/25 at 4:38 PM, a review of resident #9's PASARR Level 1 Screen for Serious Mental Illness and /or Intellectual Disability or Related Conditions dated 12/06/24 revealed no diagnoses were listed in Section A for Mental Illness or Suspected Mental Illness. On 3/26/25 at 4:06 PM, the Admissions Director and the Admissions Clerk explained they reviewed PASARRs for potential residents prior to admission. They ensured the form was completed, then given to the Social Services Department who further reviewed them and would determine if a Level II PASARR was needed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/26/25 at 4:19 PM, the Social Services Director (SSD) explained she would review the level I PASARR forms and if necessary, would let the Regional Social Worker or the Director of Nursing (DON) know of any updates or discrepancies. She said most times, she would learn of updated PASARRs or add new diagnoses during the Interdisciplinary Team meetings with the Psychiatrist when they addressed Gradual Dose Reductions for residents on psychotropic medications. The SSD and DON acknowledged and confirmed the list of seven residents, (#17, #199, #136, #19, #185, #9 and #72) whose PASARRs were inaccurate and noted the missing diagnoses in Section A of the form. On 3/27/25 at 9:52 AM, the DON stated that her expectation was accurate diagnoses were listed in Section A of the PASARR screening forms. The Facility's Policy on Preadmission Screening and Resident Review reviewed December 2024 stated A complete and accurate PASARR is required upon admission of each resident. Residents who may need Level II will not be admitted until the review has been completed and that the determination has been made to ensure that placement in a nursing facility is appropriate. The admissions department is responsible for assuring that each resident has a complete and accurate PASARR screening upon admission. If new information has been discovered, facility should complete a Level I or review if applicable. Social Services is responsible for any referral of an in-house resident in need of a level II.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50401 Based on interview, and record review, the facility failed to ensure pharmacy reports of irregularities with medication regimens were reviewed, including actions taken to address the discrepancies, and their rationale for 1 of 5 residents reviewed for medication review, (#151). Findings: 1. Resident #151 was admitted on [DATE] with the diagnoses of fibromyalgia, severe obesity, acute respiratory failure, osteoarthritis, polyneuropathy, anxiety, anemia, hypothyroidism, depression, migraine, and chronic kidney failure, unspecified. On 12/08/24, the consulting pharmacist recommended the side effects of the anxiolytic (antianxiety) medication Buspirone be monitored along with the behaviors related to the antidepressant medication Bupropion Extended Release (XL), which included target behaviors, interventions, adverse effects, and effectiveness of the antidepressant. Review of the medical record revealed no evidence the recommendations were reviewed or addressed by the attending physician as no changes to the residents' orders were made and no rationale for not adding them were provided. Review of the medical record revealed on 1/19/25, the pharmacist recommended a change in the order for potassium 10 milliequivalents (mEq) tablet to Potassium Chloride 10% oral solution (20 mEq/15 milliliters (ml)), 7.5 ml daily with at least 120 ml cold water, because the pharmacist noted, solid sources of potassium chloride were contraindicated for patients with delayed gastric emptying. Review of the medical record revealed no evidence that the pharmacy recommendations were reviewed or addressed; no changes to the orders were made and no rationale was provided. Review of the medical record revealed on 2/07/25, the pharmacist repeated the recommendation for side effect monitoring of the anxiolytic (antianxiety) medication Buspirone, along with monitoring behaviors for the antidepressant Bupropion XL. Review of the medical record revealed no evidence these recommendations were ever reviewed or addressed by the attending physician. On 3/11/25, for the third month the recommendations to monitor the side effects for Buspirone and to monitor behaviors related to the antidepressant Bupropion XL were given by the consulting pharmacist. Review of the medical record revealed no evidence the recommendations were reviewed or addressed. On 3/17/25, an order to monitor behaviors for the antidepressant Bupropion XL was added, but did not include to document for target behaviors, interventions, adverse effects, or effectiveness, as was recommended by the pharmacist, nor a rationale for not adding these recommendations. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25 at 1:53 PM, the Director of Nursing (DON) stated the pharmacist reviewed resident medications monthly for appropriateness and for irregularities, then emailed their reports with any recommendations to the DON. The DON stated she then distributed the recommendations to the appropriate Unit Managers who then contacted the doctors. She explained the process must be completed before the end of the month. The DON verified there was an 'order set' available for antianxiety medication side effects, but confirmed it was not added to resident #151's orders anytime between December 2024 and March 2025 as recommended. She confirmed the antidepressant behavior monitoring was not added in December 2024 through February of 2025 as recommended, and when added on March 17, 2025, it did not include the specific recommendations of the pharmacist, but just to monitor behaviors. The DON stated it was important to follow up on pharmacist recommendations because the facility must follow physician orders, and address pharmacy recommendations to provide appropriate care for the residents. The DON added, the January recommendation in January for the change from the Potassium tablet to the liquid form was addressed with the physician with the resident refusing. However, she acknowledged there was no evidence of this until a late entry progress note was added after the interview on the afternoon of 3/27/25. The facility policy entitled Medication Regimen Review, dated 2006, with most recent revision of January 2018, indicated pharmacist recommendations were to be acted upon and documented by the facility staff and/or the prescriber. The policy described that the prescriber either accepted and acted upon the recommendations or rejected them with an explanation.