STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105354	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vivo Healthcare Lakeland	1919 Lakeland Hills Blvd Lakeland, FL 33805

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. During an observation from the hallway on 06/24/2025 at 9:46 a.m., Resident #146 was observed sitting up on the side of his bed with his legs hanging off, sleeping. Resident #146 was observed to have on a white T-shirt and a brief. Review of Resident #146's admission record revealed and admission date of 03/19/2025. Resident #146 was admitted to the facility with diagnosis to include Parkinson's Disease Without Dyskinesia, Without Mention of Fluctuations, Other Lack of Coordination, Major Depressive Disorder, Recurrent, Moderate, Mood Disorder Due To Known Physiological Condition with Mixed Features, Unspecified Dementia, Unspecified Severity, With Mood Disturbance. Review of Resident #146's Quarterly Minimum Data Set (MDS), dated [DATE] revealed, Section C-Cognitive Patterns had a Brief Interview Mental Status (BIMS) of 06 out of 15 indicating severe cognitive impairment. During an interview on 06/25/2025 at 5:47 p.m., Staff O, Certified Nursing Assistant (CNA), stated residents should be treated with dignity by speaking with the residents, pulling the privacy curtain and closing the door while providing care. You should not be able to see a resident's brief from the hallway. They should have bottoms on or have a blanket to cover them while they are sleeping. During an interview on 06/25/2025 at 5:13 p.m., the Director of Nursing (DON), stated You should not be able to see a residents brief from the hallway. Review of the facility's policy, dated 09/01/2023, titled Promoting/Maintaining Resident Dignity revealed the following: Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines .12. Maintain resident privacy. Based on observations, interviews, and record review, the facility failed to ensure two residents (#316 and #146) were treated in a dignified manner out of three residents sampled for dignity. Findings included: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 06/24/25 at 9:47 a.m., Resident #316 was observed from the 100 Wing hallway in her wheelchair with her night gown pulled up and briefs exposed. Resident #316 was admitted to the facility on [DATE] with a primary diagnosis of muscle wasting and atrophy. Review of Resident #316's quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Statues (BIMS) score of 12, indicating moderate cognitive impairment. Section GG-Functional abilities revealed the resident needed substantial/maximal assistance with the ability to dress and undress below the waist, including fasteners. Review of Resident #316's care plan, dated 6/23/25, revealed she is dependent on staff for meeting emotional, intellectual, physical, and social needs with Immobility and Physical Limitations. During an interview on 6/26/25 at 10:25 a.m. with Staff D, Certified Nursing Assistant (CNA), she stated, Dignity was considered ensuring the resident is treated with respect. She stated she has had training on preserving resident dignity and if she did notice a resident in an undignified situation, she would redirect the resident to their room and fix the issue. During an interview on 6/26/25 at 10:30 a.m. with Staff E, (CNA), she stated, Dignity is considering the way people are treated as well as their living circumstances. She stated she has had training on dignity and if she noticed a resident in an undignified situation, she would redirect the resident to their room and fix the issue.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observations, record reviews, and interviews, the facility failed to ensure a homelike environment for four resident rooms (Rooms # 407, 422, 429) out of eight rooms sampled and failed to store equipment appropriately in one out of two shower rooms. Findings include: During a facility tour conducted on 6/23/2025 at 11:00 a.m., room [ROOM NUMBER] was observed with pictures hanging off the wall over a resident bed. room [ROOM NUMBER] observed with a high-rise seat positioned over the toilet in the resident's bathroom with dirty tape attached to the seat. room [ROOM NUMBER] was observed with torn, unfinished dry wall behind a resident's bed. During an observation made on 6/23/2025 at 11:00 a.m., one of two shower rooms was used as a storage room to store a bed, walker, and reclining chairs. An interview was conducted on 6/26/2025 at 8:45 a.m., with Staff T, Registered Nurse, RN/ Unit Manager. Staff T stated she has worked at the facility for 4 years. She stated she did not know why equipment was stored in the shower room because the staff knew equipment cannot be stored there. She stated whenever she knows items are stored in the shower room, she would report them to the maintenance director to have the items removed. She stated she was not aware of the high-rise toilet seat with tape on it in room [ROOM NUMBER], the torn, unfinished dry wall behind the resident bed in room [ROOM NUMBER] and the hanging picture in room [ROOM NUMBER]. She stated these issues should have been reported to her or the Interdisciplinary team should have reported this during their daily room rounds so these issues could have been addressed. An interview was conducted on 6/26/2025 at 12:30 p.m., with the Director of Maintenance. He said he is made aware of repairs in the building when staff put concerns in the system. He stated he was not aware of the equipment stored in one of the shower rooms on 400 hall, the picture hanging off the wall in room [ROOM NUMBER], the high-rise chair in the bathroom in 422 with tape on it, and the dry wall hole in room [ROOM NUMBER]. He stated he would have expected staff to report these issues to the maintenance department. An interview was conducted on 6/26/2025 at 12:30 p.m., with the Nursing Home Administrator, NHA, The Maintenance Director and The Regional Director. The NHA stated all managers have room assignments they go over in their morning meetings identifying any concerns. If there is something that needs to be repaired, they put it in maintenance system. If it's something for housekeeping, they let him know by verbal communication. She stated her expectation is these things should have been taken care of. Her managers should have reported these items so these things could be fixed. They had a discussion with all staff that they have to report everything needed to be repaired. The NHA stated managers conduct rounds daily and these things should have been reported. Review of the facility policy titled, Safe and Homelike Environment Revision Date: 1/2025, showed the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the residents can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. Policy Explanation and Compliance Guidelines: 3. Housekeeping and maintenance service will be provided as necessary to maintain a sanitary, orderly and comfortable environment. 9. General Considerations: f. Report any unresolved environmental concerns to the Administrator. (Photographic Evidence obtained)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure alleged resident to resident violations were reported to the governing agency in accordance with the State law for one (Resident #28) out of two residents sampled. Findings include: On 06/23/2025 at 2:08 P.M. an observation of Resident #28 revealed she had a dark purple and bluish area around her left eye. A review of Resident #28's admission Record showed she was admitted to the facility on [DATE] with diagnoses including but not limited to Anoxic Brain Damage, Autistic Disorder, Chronic Pain Syndrome, and Aphasia. A review of Resident #28's Minimum Data Set (MDS), Section C, dated 3/30/2025 revealed a Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive impairment. A review of a Change in Condition Assessment for Resident #28 dated 6/17/2025 revealed, swelling and bruising noted around left eye with intervention of X-Ray of left side of face, ice as needed. A review of the Facial X-Ray for Resident #28 dated 6/17/2025 revealed The osseous structures are unremarkable including grossly intact orbital rims. Maxillary sinuses are unremarkable. No blowout fracture is seen. A review of a progress note titled, Incident Note dated 6/17/2025 written by the Director of Nursing (DON) for Resident #28 reads, Resident #28 was in bed when another resident mistakenly thought the bed was hers and got in Resident #28's bed. Resident #28 noted to have slight redness to left orbit area. Medical Doctor (MD) and family notified. A review of a progress note titled, Skin/Wound Note dated 6/18/2025 reads, Noted swelling and bruising noted around left eye, Resident #28 is unable to state how this happened. An interview was conducted with Staff G, Licensed Practical Nurse (LPN) on 6/25/2025 at 1:44 P.M. She stated, I was off work when it happened. I was told by the night nurse Resident #28's roommate (Resident #49) sat on her head. She said she believes the night nurse did an incident report at the time. The night shift staff moved the roommate to a different room after the incident. Staff G, LPN stated, I personally would have done an assessment on the roommate as well as a behavior progress note because I found Resident #49 in another resident's bed a few days before this happened. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on 6/26/2025 at 9:20 A.M. The DON stated, We moved Resident #49 into the room with Resident #28. Resident #49 was placed in B bed (by the window) and she is used to being in A Bed (by the door). Resident #49 mistakenly got into A bed with Resident #28. The DON said the staff witnessed Resident #49's forehead hit Resident #28's forehead/left eye area. The DON stated, it was not hard contact, but they made contact. She said the night staff separated the two residents, assessed them, and didn't see any injuries. The DON stated, I reported it to Resident #28's family member and he expressed no concerns. Staff K, LPN Unit Manager, communicated with Resident #49's family. The DON said they moved Resident #49 to an A Bed (by the door) assignment. The NHA said an incident report was created by the DON the next day. The DON said the staff witnessed Resident #49's head come in contact with Resident #28's head, but they were not able to stop it from happening beforehand. Another interview was conducted with the DON on 6/26/2025 at 1:45 P.M. The DON stated, We did not report this to the state agencies or law enforcement. We didn't consider it a resident to resident. There was no intent or physical aggression by either party. There must be intent of abuse to be reportable. A review of the facility's policy titled: Abuse, Neglect, and Exploitation implemented on 9/1/2023 and revised on 1/2025 states, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Part IV showed: Identification of Abuse, Neglect, and Exploitation, Section B: Possible indicators of abuse include, but are not limited to: physical marks such as bruises or patterned appearances such as a handprint, belt or ring mark on a resident's body. Part VII showed: Reporting/Response, Section A: The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within the specified time frames: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involves abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Section B: The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure Preadmission Screening and Resident Review (PASRR) assessments were updated for two residents (#69, #141) out of twelve residents sampled for PASRR. Findings include: 1. A review of Resident #69's admission Record revealed he was admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia. Secondary diagnoses included mood disorder, major depressive disorder and insomnia. Review of the Level I PASARR, dated 03/24/2025 showed in Section II: Other Indications for PASRR Screen Decision-Making, questions 1 through 7 were marked No. A Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease). Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASARR evaluation not required was marked. 2. A review of Resident #141's admission Record revealed she was admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia. Secondary diagnoses included mood disorder, major depressive disorder and generalized anxiety disorder. Review of the Level I PASRR, dated 04/23/2025 showed in Section II: Other Indications for PASRR Screen Decision-Making, questions 1 through 4 were marked No. Question 5: Does the resident have a primary diagnosis of dementia was marked yes. A Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease). Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required was marked. On 06/26/25 at 3:31 p.m. an interview with the Social Services Director (SSD) was conducted. She stated when an admission comes in, she looks over their diagnosis, looks at medications, then waits a few days for psychiatry to see them. She then goes into the program and completes it, and then she uploads the document into the medical record. She stated if she has to do a Level II, she will submit. She stated Gradual Dose Reduction (GDR) meetings are when she would find out a new diagnosis or if the psychiatry provider visits the resident and gives a new diagnosis, they would send an email about any changes. She stated she has begun fixing PASRR's which require a Level II once survey started on 06/23/25. She stated she would know if the resident would need a Level II from the questions in the system where she fills out the PASRR. She stated she is not familiar with the regulation. Review of the policy titled Resident Assessment - Coordination with PASRR Program revised 01/2025 revealed the following: (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: Policy Explanation and Compliance Guidelines 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASRR Level I- initial pre-screening that is completed prior to admission i: Negative Level I screen-permits admission to proceed and ends the PASRR process unless a possible serious mental disorder or intellectual disability arises later. ii. Positive Level I screen- necessitated a PASRR Level II evaluation prior to admission. 7. The Social Services Director shall be responsible for keeping track of each resident's PASRR screening status and referring to the appropriate authority.

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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** Based on observations, record review, and interviews, the facility failed to develop and implement a person-centered comprehensive care plan to meet goals and address the resident's medical, physical, mental and psychosocial needs for three residents (#363, #28, and #49) out of thirty five residents sampled. Findings include: 1. On 6/24/2025 at 9:57 A.M., Resident #363 was observed with both legs over the right side of his bed. The bed was in a high position where the resident's feet were dangling in the air. The floor on the right side of his bed contained a bedside table, an overflowing trash can, a tied-up bag full of linens, and three wheelchair footrest adapters. There were no staff around the room at this time. An unknown staff member came to the resident's room, and she stated, I left the room to find someone to help her transfer him into the wheelchair. On 6/26/2025 at 11:21 A.M., Resident #363 was observed with both legs over the right side of his bed again. The bed was in a lowered position where his right foot was touching the ground. The right side of his bed contained a bedside table and an empty trash can. The mattress on the bed was not a scoop mattress. A review of the admission Record for Resident #363 showed he was admitted to the facility on [DATE] with diagnoses including but not limited to Parkinson's Disease with Dyskinesia and Abnormalities of Gait and Mobility. A review of Resident #363's Minimum Data Set (MDS), Section C, dated 5/8/2025 revealed a Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive impairment. A review of the assessments documented for Resident #363 revealed he had twelve documented falls since his admission on [DATE]. A review of the task record labeled ADL (Activities of Daily Living) Walk for Resident #363 revealed the activity occurred six times in ninety opportunities. A review of the Comprehensive Care Plan for Resident #363 revealed a focus documenting he is at risk for falls related to decreased cognition, decreased mobility, and history of falls. The interventions of this focus are as follows: Ensure residents' bed is in lowest locked position when in bed; 2/24/2025 Dycem to Wheelchair & Anti-Tippers; 3/12/2025 Drop Seat Wheelchair; 4/26/2025 Scoop Mattress; 5/30/2025 Falls unavoidable due to poor safety awareness- Keep pathways clear; 6/11/2025 staff to offer periodic walking throughout the day. An interview was conducted with Staff G, Licensed Practical Nurse (LPN) on 6/25/2025 at 2:00 P.M. She stated, I keep Resident #363 in the day room when he's awake and redirect him to sit back down when he tries to stand up. I also make sure he is clean and dry. Staff G, LPN said, she doesn't know if the interventions in the comprehensive care plan are working, stating, I just try and keep an eye on Resident #363. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Staff H, Certified Nursing Assistant (CNA) on 6/26/2025 at 11:15 A.M. She stated, I don't know what the specific interventions are for Resident #363. I make sure he's dry, the wheelchair is locked, and he is in a safe environment. Staff H, CNA said she can look at the Kardex to find out what the interventions are, she just hasn't looked yet because Resident #363 just moved to this unit last night. Staff H, CNA stated, if the interventions were not working, I will tell my nurse. She stated, Resident #363 fell yesterday {6/25/2025}. I was cleaning another resident, and the other CNA was in the restroom. Another CNA was showering a resident, and the nurse was putting another resident in their bed. Me and the Nurse had just cleaned him and put him right next to the nursing station in his wheelchair. Next thing I know, he was on the floor at the nursing station. Staff H, CNA said nobody saw it happen, the nurse assessed Resident #363, and three staff members put him back into his wheelchair. An interview was conducted with Staff I, LPN on 6/26/2025 at 11:31 A.M. Staff I, LPN stated, I was told in report Resident #363 was a fall risk. He fell yesterday and I am doing neuro checks every 4 hours. The CNA took Resident #363 vital signs at 7:45 A.M. and I didn't write them down yet. Staff I, LPN said, she doesn't know how to access his comprehensive care plan to review it and the interventions are reported to her in the nurse-to-nurse report at shift change. Staff I, LPN stated, I was told we are putting Resident #363 near the nursing station, and we take turns watching him. 2. An observation on 06/23/2025 at 2:08 P.M. revealed Resident #28 had a dark purple and bluish area around her left eye. A review of the admission Record for Resident #28 showed she was admitted to the facility on [DATE] with diagnoses including but not limited to Anoxic Brain Damage, Autistic Disorder, Chronic Pain Syndrome, and Aphasia. A review of Resident #28's Minimum Data Set (MDS), Section C, dated 3/30/2025 revealed a Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive impairment. A review of a progress note titled, Narrative Nurses Note for Resident #28 written on 6/17/2025 reads, Note Text: nurse practitioner into visit with patient, swelling and bruising noted on left side of face, resident shows no signs or symptoms of pain, x-ray of left side of face, Family updated on care plan. A review of the Comprehensive Care Plan for Resident #28 revealed no focuses, goals, or interventions regarding treatment or monitoring of her left eye. An interview was conducted with Staff G, Licensed Practical Nurse (LPN) on 6/25/2025 at 1:44 P.M. She stated, I was off work when it happened. I was told by the night nurse Resident #28's roommate (Resident #49) sat on her head. She said she believes the night nurse did an incident report at the time. The night shift staff moved the roommate to a different room after the incident. Staff G, LPN stated, I personally would have done an assessment on the roommate as well as a behavior progress note because I found Resident #49 in another resident's bed a few days before this happened. 3. A review of a progress note dated 4/16/2025 for Resident #49 reads, Note Text: staff reported to nurse that resident had placed hands around another resident neck in choking manner. Resident separated from other resident, vitals checked resident checked for injuries, Medical Doctor (MD) family and Psych notified of incident, order for Urinalysis (UA) received, resident placed on one-on-one supervision. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a progress note dated 6/16/2025 for Resident #49 reads, Note Text: Resident #49 confused and crawled into bed with roommate Resident #28, thinking/insisting that was her bed. Resident #49 was redirected to her own bed by the window. Resident #49 will be moved to a bed by the door. Family notified and is okay with the move. A review of the admission Record for Resident #49 showed she was admitted to the facility on [DATE] with diagnoses including but not limited to Insomnia and Anxiety Disorder. A review of Resident #49's Minimum Data Set (MDS), Section C, dated 3/29/2025 revealed a Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive impairment. A review of the Comprehensive Care Plan for Resident #49 revealed a focus of, exhibits the following behaviors: crying, refuses dental care at times, will make inappropriate comments to staff at times; 4/16/2025 Resident was the aggressor in altercation with another resident in which residents were separated to de-escalate the situation. The goal is, will exhibit a decrease in the number of behavior episodes by the next review date. The intervention is, 4/16/2025 Psych to eval, urinalysis ordered, Resident put on 1:1. Further review of Resident #49's comprehensive care plan revealed no other behavior focuses, goals, or interventions. An interview was conducted with Staff J, Minimum Data Set (MDS) Coordinator on 6/26/2025 at 11:42 A.M. She said she updates the care plan as she reads the order listing report every day. She stated, If it's not from the order listing, it's word of mouth from the nursing staff on changes needing to be made. At our clinical meeting every morning, the interdisciplinary team discusses the falls and then we decide which interventions would be appropriate for each fall. There is an intervention for every fall incident. There always must be a new intervention; even if we've chosen everything, we must write something. Staff J, MDS Coordinator said, the comprehensive care plans must be individualized, or they don't work. Staff J, MDS Coordinator stated, we leave the intervention in the comprehensive care plan even if it's not working. We just need to add something as an intervention when an incident happens. She said she updates the interdisciplinary team in the morning, but not the nursing staff. An interview was conducted with the Director of Nursing (DON) on 6/26/2025 at 1:54 P.M. The DON said any change with a resident is discussed in the morning clinical meeting. The MDS Coordinator updates the comprehensive care plan every day. The DON said the nurses make a progress note in the medical record with possible interventions as well as putting it in the incident report. Updates to the comprehensive care plans are made as needed, quarterly, annually, and after meetings with the family. The DON stated, The CNA's can look in task record on the computer and nurses should be able to open and adjust the comprehensive care plan as needed. I think most of them know how to do that, but I'm sure some do not. The DON stated, when there is an incident with a resident, there should be a new intervention that is geared based on the root cause analysis of why the incident happened. This is done every incident. If the interventions are not working, the interdisciplinary team would reevaluate and determine a new intervention. The DON said the interventions are not dated in the comprehensive care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Comprehensive Care Plan implemented on 9/1/2023 and revised on 1/2025 showed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Under section titled, Policy Explanation and Compliance Guidelines: 3): The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being. 6): The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the residents' progress. Alternative interventions will be documented, as needed. 8): Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

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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** Based on observation, interviews and record review, the facility failed to provide Activities of Daily Living (ADL) for two residents (#154) related to removal of facial hair and (#367) related to showers out of four residents sampled for ADL. Findings Included: 1. During an interview on 06/23/25 at 11:10 a.m., Resident #154 was observed with long white strands of hair on her lip and chin. Resident #154 stated I wish they would help me pluck this hair off of my face. Review of Resident #154's admission record revealed an admission date of 05/21/2025. Resident #154 was admitted to the facility with diagnosis to include Need for Assistance with Personal Care, Neuromuscular Dysfunction of Bladder, Unspecified, Colostomy Status, Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites and Multiple Sclerosis. Review of Resident #154's Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section C. Cognitive Patterns, a Brief Interview Mental Status (BIMS) of 14 out of 15 showing intact cognition. Review of Section GG. Functional Abilities revealed for oral hygiene Resident #154 needs supervision or touching assistance, where helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently for oral hygiene. For shower/bathe Resident #154 was dependent, where helper does all the effort. Residents do none of the effort to complete the activity. Or the assistance of two or more helpers is required for the residents to complete the activity. During an interview on 06/25/2025 at 5:47 p.m., Staff O, Certified Nursing Assistant (CNA), stated she assists residents with bathing, eating, or any daily activities they cannot do on their own. This includes trimming nails and shaving. She stated she had not asked Resident #154 if she would like assistance with removing her facial hair. During an interview on 06/25/2025 at 5:13 p.m., the Director of Nursing (DON) stated when staff are providing residents with their showers/baths staff should offer to help remove any unwanted facial. 2. On 06/24/2025 at 9:51 A.M. Staff L, Certified Nursing Assistant (CNA) was observed in Resident #367 room and stated, Lord have mercy, maybe I'll give you a shower today. There was a foul odor coming from Resident #367 side of the room. At 9:57 A.M., Staff M, Registered Nurse (RN) and Staff L, CNA, were observed speaking to each other at the nurses cart. Staff M, RN advised Staff L, CNA not to give Resident #367 a shower because it would be too difficult to cover his neck. Staff M, RN said to Staff L, CNA the foul odor was coming from Resident #367's clothes and not from the resident himself. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Staff L, CNA and Staff M, RN on 6/25/2025 at 2:28 P.M. Staff L, CNA said Resident #367 is dependent on bathing and showering and he requires someone to help him. Staff L, CNA said she doesn't know what Resident #367's preferences are because he is only alert to himself. Staff L, CNA stated, he normally doesn't refuse a shower, but I gave him a bath in bed the other day. Staff L, CNA stated, if Resident #367 refuses, I wait and him ask again, and then I let the nurse know. Staff L, CNA said the nurse is supposed to chart it on the computer. Staff M, RN stated, I will only notify the doctor if it starts to affect Resident #367's health. An interview was conducted with the Director of Nursing (DON) on 6/26/2025 at 3:00 P.M. The DON stated, the facility provides handwritten shower sheets to the CNA's and the nurses are supposed to sign the sheets after they review them. After the nurse reviews the sheet, the sheet go to the Unit Manager (UM) for review and then the sheets are filed somewhere in the UM's office. A review of the admission Record for Resident #367 showed he was admitted to the facility on [DATE] with diagnoses including but not limited to Muscle Wasting and Atrophy and Immunodeficiency. As of 6/25/2025, Minimum Data Set (MDS), Section C, was not completed. A review of the task record titled, bathing for Resident #367 revealed the activity did not occur four out of five opportunities. A review of the facility issued shower sheet for Resident #367 dated 6/20/2025, revealed a note reading, Refused Shower, Resident was picky and didn't want shower. The shower sheet was not signed by a nurse or unit manager. A review of the Baseline Care Plan for Resident #367 dated 6/19/2025 revealed his preference is to receive a shower and the bathing support required is a one-person physical assist. Review of the facility policy titled, Activities of Daily Living (ADL's), implemented on 9/1/2023 and revised on 1/2025 states, The facility will, based on the resident's comprehensive assessment and consistent with the resident's need and choices, ensure a resident's abilities in ADL's do not deteriorate unless deterioration is unavoidable; Care and services will be provided for the following activities of daily living: Bathing, dressing, grooming, and oral care. Under the paragraph titled, Policy Explanation and Compliance Guidelines, Section 3 states, A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to provide nursing care and services related to 1) failure to schedule appointments for one (Resident #134); and 2) failure to administer medications in a timely manner for two (Resident #106 and Resident #90) out of 35 residents sampled. Findings Included: 1. During an interview on 06/25/2025 at 9:13 a.m., Resident #134 stated he had a catheter, but they recently removed it. He stated he had not seen a Urologist. During an interview on 06/25/2025 at 9:56 a.m., Resident #134's Family Member (FM) and emergency contact stated Resident #134 was referred to see a Urologist at the beginning of June, but has never been told if it was scheduled. The FM stated, the resident saw a Neurologist because he recently started having what she believed to be seizures when he sits up in bed. The Neurologist ordered a imaging exam (MRI) and the test has not had done. I have asked the doctor and the nurses about scheduling the MRI with sedation because he is claustrophobic several times and no one has followed up with me. Review of Resident #134's admission record revealed an admission date of 05/23/2025. Resident #134 was admitted with diagnosis to include Unspecified Sequelae of Cerebral Infarction, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Mood Disorder Due To Known Physiological Condition with Mixed Features, Major Depressive Disorder, Recurrent, Moderate and Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. Review of Resident #134's Quarterly Minimum Data Set (MDS), dated [DATE], Section C- Cognitive Patterns revealed a Brief Interview Mental Status (BIMS) of 06 out of 15 showing severe cognitive impairment. Review of Section H. Bladder and Bowel revealed Appliances, Indwelling Catheter. Review of Resident #134's orders revealed: 06/05/2025 Urology Consult stat (emergent) for Urinary Retention related to benign prostatic hyperplasia with lower urinary tract symptoms. No order for Magnetic Resonance Imaging (MRI) was found. Review of Resident #134's progress notes revealed: 3/24/25: The patient was seen for a follow-up on therapy. He was sent to the hospital on 3/22/25 due to increased altered mental status and returned without new orders. His FM reported consulting with the patient's neurologist, who recommended an MRI. The order has been placed. The patient is calm, resting in bed without complaints. No additional reports from staff. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/9/25: Follow up patient on therapy and overall health. FM was there and expressed concerns about an MRI to be done to diagnose or know how advance is the patients dementia. Patient is unable to get an MRI because he is unable to stay still, and it was suggested that the patient be put to sleep to have the MRI done. FM requested to speak to the physician personally and information was relayed to the physician. 5/27/25: Patient seen today for follow up on status post hospitalization. Patient was also accompanied with FM. FM stated that the hospital made an attempt to remove the catheter and do a voiding trial but failed. FM expressed concern about patient dementia diagnosis and needing an MRI to determine future care. Expressed to FM will forward information to the physician. 6/2/25: Patient was seen today for overall care and therapy. Patient FM stated that he is much better today. Spouse states that she would like to know cognitively where the patient is at mentally. Patient needs an MRI and needs to be sedated to do so. FM requests to speak to physician so she will be able to know how to move forward in patient care. 6/5/25: Patient was seen today for follow up on therapy and overall health. Staff stated that patient removed the Foley catheter and voiding trial was in process. Stated to staff that if patient does not void to straight cath again and in six hours if patient has not voided insert Foley but use a leg bag. Staff has stated that the since the patient has been restless that the meatus has been slightly split. Will order urology consult. During an interview on 06/25/2025 at 9:45 a.m., Staff R, Driver/Transportation stated she sets up all the appointments for residents. When residents need an appointment the nursing staff fills out a form and puts it into a folder outside of her door. She then arranges transportation and schedules the appointments. I was not aware Resident #134 needed an appointment to see a Urologist. He saw a Neurologist, who ordered an MRI, but his wife wants him to be sedated for the MRI, but I am not sure what happened with that. During an interview on 06/25/2025 at 11:03 a.m., Staff P, Registered Nurse (RN) stated she was not aware of Resident #134 needing an MRI. I believe he was supposed to see a Urologist but cannot remember why. The physician will notify the nurse of any new orders. The nurses put the order in and then a form is filled out and given to the appointment Transportation and she sets the appointments up for the residents. During an interview on 06/25/2025 at 11:15 a.m., Staff N, Licensed Practical Nurse (LPN) and Unit Manager (UM), stated if residents need an appointment only the Transportation person schedules the appointments. The nurses fill out a form and put it in a folder. She reviewed Resident #134's chart and found an order for Resident #134 to see a Urologist. The order was put it in on 06/05/2025 for stat. I don't see any notes from the Urologist, and I don't see an order for an MRI. During an interview on 06/25/2025 at 5:13 p.m., the Director of Nursing (DON), stated transportation facilitates the appointments and transportation. A stat order would mean the resident needs to be seen quickly. I know we were having an issue with Resident #134's insurance and that is why he has not had his MRI or seen the Urologist. This should be documented in a note in the residents' chart. We will talk with the physician and offer for the resident go to the hospital since he has not been seen by the Urologist. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not have a policy for review. 2. A review of Resident # 90's admission Record revealed she was admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, and hypokalemia. A review of Resident #90's Quarterly Minimum Data Set (MDS) dated [DATE] Section C-Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) summary score of 15 indicating she was cognitively intact. A review of the Medication Admin Audit Report for 06/23/25 revealed the following medications were not administered in a timely manner: -Losartan Potassium oral tablet 50 milligram (mg), Give 1 tablet by mouth one time a day for hypertension: Schedule time-9:00 a.m.; administration time-1:02 p.m. -Tradjenta 5 mg oral tablet, Give 1 tablet by mouth one time a day for DM {diabetes mellitus): Schedule time-9:00 a.m.; administration time-1:06 p.m. -Lasix oral tablet 40 mg, Give 1 tablet by mouth two times a day for edema: Schedule time- 9:00 a.m.; administration time-1:02 p.m. -Prednisone oral tablet, give 1 tablet by mouth one time a day for inflammation .: Schedule time- 9:00 a.m.; administration time-1:03 p.m. -Pantoprazole sodium oral tablet delayed release 40 mg, Give 1 tablet by mouth one time a day .: Schedule time- 9:00 a.m.; administration time-1:03 p.m. -Aspirin oral tablet delayed release 81 mg, give 1 tablet by mouth one time a day: Schedule time- 9:00 a.m.; administration time-1:01 p.m. -Mucinex oral tablet extended release 12-hour 600 mg, give 1 tablet by mouth every 12 hours for cough: Schedule time- 9:00 a.m.; administration time-1:02 p.m. -Lidocaine patch, apply to left foot topically one time a day for pain On in the AM, Off in the PM: Schedule time- 9:00 a.m.; administration time-1:08 p.m. -Breztri Aerosphere inhalation aerosol, 2 puff inhale orally every morning and at bedtime: Schedule time-9:00 a.m.; administration time-1:07 p.m. 3. A review of Resident #106's admission Record revealed Resident #106 was admitted to the facility on [DATE] with diagnoses to include: Parkinson's disease, mood disorder, anemia, major depressive disorder, neurocognitive disorder with Lewy bodies. A review of the Medication Admin Audit Report for 06/23/25 revealed the following medication was not administered in a timely manner: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Gabapentin oral capsule, give one capsule by mouth 3 times a day for pain: Schedule time- 9:00 a.m.; administration time-1:29 p.m. During an interview on 06/24/25 at 10:22 a.m. with Staff M, Registered Nurse (RN) she stated her medications are late daily. Staff M stated she has help, but not always when she needs it and administration are in meetings all day. She stated it is hard to give all the medications because the residents aren't always in their room and you have to go find them, or their family will take them out for the day, so they won't get their meds. Medications are supposed to be given up to one hour before and one hour after, so if a medication is scheduled at 9 :00 a.m. I have from 8:00-10:00 a.m. to give it. It would be late after 10 a.m. During an interview on 06/25/25 at 5:00 p.m. with the Director of Nursing (DON), she stated medications should not be given late. She went on to state if nurses are having a hard time passing their medications on time, they need to be helped. A review of the policy titled Medication Administration with a revision date of 1/2025 revealed the following: Policy: Policy Explanation and Compliance Guidelines: 10. Review MAR {Medication Administration Record} to identify medication to be administered. 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route and time. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure side effect monitoring was in place for one resident (#141) out of five residents sampled for unnecessary medications. Findings include: A review of Resident #141's admission Record revealed she was admitted to the facility on [DATE] with diagnoses to include dementia, psychotic disorder with delusions, mood disorder, major depressive disorder and generalized anxiety disorder. A review of Resident #141's Order Summary Report revealed the following orders: - Divalproex Sodium Oral Tablet Delayed Release 250 milligram (MG) (Divalproex Sodium) Give 3 tablet by mouth three times a day for bipolar disorders, seizures - OLANZapine Oral Tablet 7.5 MG (Olanzapine) Give 1 tablet by mouth at bedtime for Bipolar Disorders - Lasix Oral Tablet 40 MG (Furosemide) Give 1 tablet by mouth one time a day for HTN [hypertension] - Potassium Chloride ER [extended release] Oral Tablet Extended Release 20 MEQ (Potassium Chloride) Give 1 tablet by mouth one time a day for Supplemental management - HydrALAZINE HCl Oral Tablet 10 MG (Hydralazine HCl) Give 1 tablet by mouth four times a day for HTN A review of the June 2025 Treatment Administration Record (TAR) revealed the following: -Behavior monitoring- Antipsychotic .with a start date of 01/03/25 and a discontinue date of 06/10/25. -Monitor for antipsychotic side effect .with a start date of 01/03/25 and a discontinue date of 06/10/25. A review of the Psychiatry Progress Note dated 06/16/25 revealed the following: Reason for today's visit: follow-up for medication and behavior management and lab monitoring. Assessment and Plan: Generalized anxiety disorder-will continue to monitor for improvement or worsening of the following signs and symptoms of anxiety .Will also monitor for side effects or adverse effects of the medication . Major depressive disorder: Will continue to monitor, document, and report worsening symptoms of depression . Psychotic disorder: will continue to monitor for improvement or worsening of the following signs and symptoms of psychosis: delusions, hallucinations, disorganized speech and disorganized catatonic behavior . A review of Resident #141's active care plan revealed the following: Care Plan: Focus-Resident has a mood problem related to (r/t) receives anticonvulsant for mood disorder. Intervention-administer medications as ordered. Monitor/document for side effects and effectiveness. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/26/25 at 5:00 p.m. an interview with the Director of Nursing (DON) was conducted. She stated these medications should have side effect monitoring in the medical record. She stated the admitting nurse would enter those side effects. She stated they have had a lot of education on psych medications lately and monitoring for side effects. A review of the policy titled Medication Administration with a revision date of 1/2025 revealed the following: Policy: Policy Explanation and Compliance Guidelines: 10. Review MAR {Medication Administration Record} to identify medication to be administered. 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route and time. a. Refer to drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects. 20. Report and document and adverse side effects .

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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. Based on observation, interviews and record review, the facility failed to ensure the medication error rate was less than 5.00%. Twenty-eight medication opportunities were observed, and two errors were identified for one resident (#133) out of six residents observed. These errors constituted a 7.14% medication error rate. Findings included: On 06/25/25 at 9:31 a.m. an observation was made of Staff F, Registered Nurse (RN). Staff F dispensed the following medications for Resident #133. -Losartan 100 milligram (mg) tablet -Lidocaine patch -Zonisamide 100 mg tablet -Nifedipine 60 mg capsule -MiraLAX powder Staff F began by dispensing one Losartan 100mg tablet into a small medicine cup. The staff member then poured an unidentified amount of MiraLAX into the same small medicine cup. She stated it is about a capful of MiraLAX and that's how much they give. Staff F then poured the powder and Losartan tablet from the small medicine cup into a larger drinking cup. The staff member then pulled an additional Losartan 100mg tablet and placed it into a separate empty medicine cup. The other two medications were added to the medicine cup. Staff F proceeded to pour water in the larger cup with the MiraLAX. This was stopped before administration to the resident for safety. Staff F was made aware of the additional Losartan tablet mixed with the MiraLAX powder. The staff member scooped out the tablet with a spoon and stated it should not be in there and was wondering what happened to the tablet. A review of Resident #133's Order Summary revealed the following medication orders: -Losartan Potassium oral tablet 100MG, Give 1 tablet by mouth one time a day for HTN {hypertension} -MiraLAX Powder (Polyethylene Glycol 3350), Give 1 packet by mouth one time a day for bowel On 06/26/25 at 5:00 p.m. an interview with the Director of Nursing (DON) was conducted. She stated the MiraLAX order wasn't written correctly, it should show the strength and what to mix it with. She stated MiraLAX should have been poured into the bottle cap instead of a small medication cup and should not have been mixed with another medication because MiraLAX should be given by itself. A review of the policy titled Medication Administration with a revision date of 1/2025 revealed the following: (continued on next page)

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	105354	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vivo Healthcare Lakeland	1919 Lakeland Hills Blvd Lakeland, FL 33805

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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	Policy: Policy Explanation and Compliance Guidelines: 10. Review MAR {Medication Administration Record} to identify medication to be administered. 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route and time.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on record review, observation and interviews, the facility failed to ensure food was properly stored and free of expired food(s) for residents in the kitchen. Findings included: During an observation on 06/23/2025 at 9:38 a.m., of the Walk in Freezer revealed 4 boxes with a red label and writing Tyson; A brown box with a red label, and black writing Keep frozen 0°F-10°F; 2 brown boxes with red writing Frozen Cookie Dough; A brown box with black writing; A bag of ice; A white container with green and red markings; A clear container with purple writing; Unidentifiable debris. (photographic evidence obtained) During an observation on 06/23/2025 at 9:42 a.m., of the Walk in Fridge, revealed A brown box with a clear bottle with a green liquid, a yellow rag, and white bags; A brown cardboard box with wrinkled green bell peppers with gray and black bio growth; A tan 4 wheeled cart with an open green tabbed can; A box of tomatoes with yellow string particles; A silver container labeled boiled eggs with the plastic wrap ripped; A white bucket with an open green lid labeled pickles with an expiration date of 06/16/2025. (photographic evidence obtained) During an observation on 06/23/2025 at 9:56 a.m., of the Trailer Freezer, multiple open brown cardboard boxes stacked on top of each other. (photographic evidence obtained) (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/23/2025 at 9:40 a.m., the Certified Dietary Manager (CDM) stated We are not using the walk-in freezer, because the door is not closing properly and holding the temperature. We have a freezer trailer we are using for all the frozen foods. Staff must have pulled the chicken and put it in there out of convenience. They may have pulled it to serve for tonight. During an interview on 06/23/2025 at 11:16 a.m., CDM stated the walk-in freezer should not have had anything in it. Everything has been thrown out and I did education with kitchen staff. During an interview on 06/25/2025 at 10:34 a.m., with the CDM, Kitchen Manager and Nursing Home Administrator (NHA), the NHA reviewed the photographic evidence and stated she expects the kitchen to be clean and for food to be stored properly. Food that is in poor condition should be discarded. Review of the facility's policy dated 11/2023, titled Sanitation Inspection, revealed the following: Policy: It is the policy of this facility, as part of the departments sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to follow sanitary infection control practices related to 1) proper storage and disposal of toileting items in two resident rooms (112 and 110), 2) proper nail length for three staff members (Staff P, Staff M, Staff Q), 3) and proper hand hygiene during meal service for one observed meal (6/23/25) during four days of survey. Findings Included: 1. During an observation on 06/23/2025 at 11:10 a.m., of room [ROOM NUMBER] B a plastic urinal was located opened on floor under the bed, with a wet area. During an observation on 06/23/2025 at 11:04 a.m., of room [ROOM NUMBER] bathroom an adult brief with yellow and brown markings was located in front of the toilet on the floor. (photographic evidence obtained) 2. During an observation on 06/23/2025 at 9:44 a.m., Staff P, Registered Nurse (RN), was observed with artificial nails longer than 1/4 inch. During an observation on 06/23/2025 at 9:43 a.m., Staff M, RN was observed with artificial nails longer than 1/4 inch. During an observation on 06/25/2025 at 10:50 a.m., Staff Q, CNA was observed with artificial nails longer than 1/4 inch. During an interview on 06/25/20235 at 4:00 p.m., Staff B, Assistant Director of Nursing (ADON) and Infection Preventionist (IP), stated she would expect for urinals and adult briefs to be disposed of properly and not be on the floors. On 06/19/2025 she provided education to staff who needed to have their nails cut down. She highlighted the dress code policy where it states nails should not be longer than a 1/4 an inch. There is a number of nursing staff who need to go and get them cut down as they go and get their nails done. Typically they go every 2 weeks and I am expecting for the staffs nails to be in compliance by that time frame. 3. A lunch meal observation was conducted on 06/23/25 at 12:29 p.m. Observed Staff S, CNA serve 4 separate meal trays. No hand hygiene was performed. Staff S. then sat down next to an unidentified resident and began assisting with the meal. Staff S was observed coughing in her hand and wiping her face and using the same hand to feed the resident. No hand hygiene was performed throughout the observation. On 06/25/25 at 4:12 p.m. an interview with the DON and Infection Preventionist was conducted. They stated the expectation for staff for hand hygiene is performing hand hygiene when entering or exiting a resident room. Also in between touching or caring for residents. Staff should also perform hand hygiene while feeding, and in between residents. It would not be appropriate for staff to touch their face or cough into their hand and not perform hand hygiene while feeding a resident. A Review of the facility's policy titled Infection Prevention and Control Program, last revision date 1/2025, revealed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections as per accepted national standard and guidelines. 4. Standard Precautions: a: All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. b: Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures .