STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vivo Healthcare Wachula	401 Orange Place Wauchula, FL 33873

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 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** 41837 Based on observations, interviews and record review, the facility failed to ensure residents were treated in a dignified manner when entering the resident's room and during medication administration for 2 of 5 residents observed for medication pass administration (Residents #38 and #165). The findings included: Review of the facility's policy titled, Promoting/Maintaining Resident Dignity dated 09/01/23 included in part the following: 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: 1. All staff members are involved in providing care to residents to promote and maintain dignity and respect resident rights. 12. Maintain resident privacy. Review of the facility's policy titled, Medication Administration with a revised date of 09/01/23 included in part the following: Policy Explanation and Compliance Guidelines: 5. Knock or announce presence. 7. Provide privacy. 1.) Record review for Resident #38 revealed the resident was originally admitted to the facility on [DATE] with a most recent readmission on 04/01/24 with diagnoses that included: Urinary Tract Infection, Cognitive Communication Deficit, Major Depressive Disorder, Anxiety Disorder. Review of the Minimum Data Set (MDS) for Resident #38 dated 04/05/24 revealed in Section C, a Brief Interview of Mental Status (BIMS) score of 6, indicating severe cognitive impairment. (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: 105362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During med pass observation conducted on 06/25/24 at 9:20 AM with Staff C Licensed Practical Nurse (LPN) for Resident #38, Staff C, LPN entered room without knocking and did not close door or pull privacy curtain for administration of medications to resident lying in bed. 2.) Record review for Resident #165 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Muscle Wasting and Atrophy and Type 2 Diabetes Mellitus with Hyperglycemia. Review of the MDS for Resident #165 dated 06/18/24 revealed in Section C a BIMS score of 9, indicating moderate cognitive impairment. Review of the physician's orders for Resident #165 revealed an order dated 06/20/24 for Humalog Injection Solution (Insulin Lispro), Inject intramuscularly before meals and at bedtime for DM (Diabetes Mellitus). Inject as per sliding scale: if 0 - 200 = 0 units If BS is below 70 notify MD.; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 12 units If bs (Blood Sugar) is above 450 notify MD (Medical Doctor). During an observation on 06/25/24 at 10:40 AM of blood glucose (blood sugar) monitoring for Resident #165 performed by Staff C, LPN, the LPN entered the resident's room without knocking. The LPN checked the resident's blood glucose which was 313. The LPN then administered Humalog insulin (coverage) subcutaneous (6 units) into the resident's abdomen while resident was sitting in wheelchair facing the door to the room with the door open, no privacy curtain pulled and residents/staff/visitor walking by in the hall. During an interview conducted on 06/25/24 at 10:50 AM with Staff C, LPN who stated she worked for the facility for a year. When asked about entering resident's rooms should she knock, she said no, the residents all know who she is and that she is going to be giving them their medications. When asked if she should provide privacy for the residents during medication administration, she said she should have closed the door or pulled the privacy curtain.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews and record review, the facility failed to assess the safety of smoking for 1 of 1 resident reviewed for smoking (Resident #37). The findings included: A review of the facility's policy titled, Resident Smoking, dated 09/01/23, revealed the following: The facility provides a safer and healthier environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. Residents who smoke will be further evaluated using the Resident Smoking Safety Screen to determine whether supervision is required for smoking or if the resident is safe to smoke at all. In an interview conducted on 06/24/24 at 11:00 AM, Resident #37 stated that he smokes about 1-3 cigarettes a day. The facility has its own smoking schedule, and smoking is in the back patio near the dining room. When asked about the smoking supplies, Resident #37 reported that they were located in the nurse's station in a locked box. A record review showed Resident #37 was admitted on [DATE] with diagnoses of major depressive disorder, hyperlipidemia, and hypertension. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #37 with a Brief Interview of Mental Status Score (BIMS) score of 15, which indicates he is cognitively intact. A review of the quarterly nursing evaluation dated 03/15/24, under section F1, revealed that Resident #37 was smoking. The Care plan initiated on 03/12/24 revealed the following: Resident #37 smokes cigarettes and will safely use tobacco products in designated areas through the following review. Smoking assessment on admission, quarterly and as indicated. In an interview conducted on 06/25/24 at 1:30 PM, Resident #37 stated that he smokes every day and has been smoking for the last few months in the facility. In an interview conducted on 06/25/24 at 1:39 PM with Staff D, Certified Nursing Assistant (CNA), reported that Resident #37 smokes every day and that he has been smoking for months in the facility. A review of the Smoking Safety Screen showed that a safety smoking screen was completed for the first time on 06/24/24 for Resident #37. In an interview conducted by Staff E, a Licensed Practical Nurse (LPN) she stated they do a smoking assessment on admission and will then complete a quarterly evaluation as well. The smoking assessment is titled, Smoking Safety Screen and is located under the assessment tab in the electronic system. Staff E further said that the admission and readmission nursing evaluation will determine whether the resident smokes. When asked if a Smoking Safety Screen was completed on Resident #37 before 06/24/24, she said no. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the admission/readmission nursing evaluation dated 04/25/22, under section F1, revealed that Resident #37 was not smoking. In an interview conducted on 06/27/24 at 10:30 AM with the Administrator, she was told of the findings.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 41837 Based on observation, interviews, and record review, the facility failed to obtain orders for catheter care for a resident admitted with an indwelling Foley catheter for 1 of 1 resident sampled for urinary catheter (Resident #31). The findings included: Record review for Resident #31 revealed the resident was admitted to facility on 02/04/22 with the most recent readmission on 06/21/24 that included diagnoses of Urinary Tract Infection and Neuromuscular Dysfunction of Bladder. Review of the Minimum Data Set for Resident #31 dated 04/22/24 revealed in Section C Brief Interview of Mental Status (BIMS) score of 15, which indicated a cognitive response. Review of the Admission/Readmission Nursing Evaluation for Resident #31 dated 06/21/24 documented under Section K Urinary: Does the resident have a catheter? Was answered yes. Catheter type/size? Was answered 16Fr. Reason for catheter - Neuromuscular dysfunction of the bladder. Review of Medication Administration Record (MAR) for Resident #31 from 06/21/24 to 06/24/24 for catheter care documented no catheter care was performed on 06/21/24, 06/22/24, and 06/23/24. Review of the Certified Nursing Task for Foley Care Every Shift for Resident #31 from 06/21/24 to 06/23/24 revealed no documentation of foley care provided. Review of the Physician's Orders for Resident #31 from 06/21/24 to 06/23/24 revealed no orders for foley catheter care. Review of the Care Plan for Resident #31 dated 03/04/23 with a focus on Urinary catheter r/t (related to) Neurogenic bladder. The goals were for the resident to show no s/sx (signs/symptoms) of Urinary infection and for the resident to be/remain free from catheter-related trauma through review date. The interventions included: Change catheter as needed. Monitor/document for pain/discomfort due to catheter. Monitor/record/report to MD for signs and symptoms UTI. Provide catheter care to prevent UTI. Provide privacy bag to drainage bag at all times. Secure foley catheter to thigh with securement device as tolerated. On 06/24/24 at 10:20 AM, an observation was made of Resident #31 sitting up in bed with the foley catheter drainage bag covered with privacy covering hanging from bed. During an interview conducted on 06/24/24 at 10:24 AM with Resident #31 she said she just got back from hospital, she had a bladder and blood infection. She said she was pouring blood for about 2 weeks and there were big white things in the tubing. She said she is better now and has no cramping and is receiving antibiotics. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 06/25/24 at 2:00 PM with Staff H, Certified Nursing Assistant (CNA) who was asked about documenting foley catheter care, she said it would be documented in Point of Care (Tasks) for foley care. During an interview conducted on 06/26/24 at 2:30 PM with Staff A, Licensed Practical Nurse (LPN), who was asked if a resident has a foley catheter do they need an order for the catheter and/or care? The LPN stated yes. When asked about Resident #31, she acknowledged the resident did not have any order for a foley catheter or care from 06/21/24 to 06/23/24, she said all of the orders for foley catheter for Resident #31 were written on 06/24/24. During an interview conducted on 6/26/24 at 11:30 AM with the Director of Nursing (DON) who was asked about when a resident is admitted or readmitted to the facility with a foley catheter, do they need an order for catheter care, she said yes. When asked what the expectation is for putting in the order, the DON said it should be immediately. When asked who would put the order in, she said the admitting nurse.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record reviews, the facility failed to monitor nutritional status in a timely manner for one of one residents reviewed for Dialysis (Resident #22). The findings included: The facility's policy titled, Nutritional Management, dated 09/1/2023 revealed the following: A systematic approach is used to optimize each resident's nutritional status: Identifying and assessing each resident's nutritional status and risk factors. Evaluating/analyzing the assessment information. Developing and consistently implementing pertinent approaches. Monitoring the effectiveness of interventions and revising them as necessary. A record review revealed Resident #22 was readmitted on [DATE] with diagnoses of End-Stage Renal Failure, Type 2 Diabetes, and dependency on Dialysis. The Quarterly Minimum Data Set, dated dated dated [DATE] showed that Resident #22 had a Brief Interview of Mental Status (BIMS) score of 03, which indicated the resident was severely cognitively impaired. The Physician orders revealed an order dated 02/21/24 for Dialysis every Mondays, Wednesdays and Fridays. Fluid restrictions 600 milliliters for Breakfast, Lunch and Dinner which was dated 03/28/24. Regular texture, thin consistency, double protein Portion for breakfast. Magic cup/ frozen nutritional treat 3 times a day dated 03/26/24. The Admission/Readmission Nutritional assessment dated [DATE] showed the following: Resident #22 is on Dialysis and has an unspecific protein-calorie malnutrition history. He consumes on average over 76% of his meals and receives frozen nutritional treats 3 times a day. It further showed to continue monitoring nutritional parameters and follow up as needed. The care plan, which was revised on 03/21/24, showed the following: Resident #22 is at risk for malnutrition secondary to a history of significant weight loss with Dialysis. Contact renal Dietitian, to assess labs, obtain updates, and modify nutritional intervention as appropriate. It further revealed to provide nutritional interventions as appropriate. Further review of the care plan did not address the fluid restrictions as ordered above. A review of the nutritional progress notes did not show a note addressing the order for fluid restrictions (dated 03/28/24) until 05/23/24, which was seven weeks later. An interview conducted on 06/24/24 at 1:40 PM with the Dietary Manager who stated that they had hired a Registered Dietitian to cover this facility remotely. The remote facility's Dietitian has yet to come into the facility physically to see the residents. The Dietary Manager said that for high nutritional-risk residents, the Director of Nursing would review the data and contact the newly hired dietitian. She further said that it is the Director of Nursing responsibility to contact the facility's Dietitian. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 05/24/24 at 2:20 PM, the facility's newly hired Dietitian stated he started working about 1.5 weeks ago. He said that high nutritional-risk residents are the ones who are on Dialysis, on nutritional support, have significant weight loss and pressure ulcers. The high nutritional-risk residents should be followed monthly with progress notes, and the residents on Dialysis will contact the dialysis Dietitian to discuss the residents and review labs. According to the facility's Dietitian, an admission assessment is completed on admission and is titled, Nutritional Risk Evaluation and should be done quarterly. The Nutritional Risk Evaluation looks at anthropometric data (measurements of the human body), labs, calculations for nutritional needs, evaluation, and any nutritional recommendations. When asked if he had done any quarterly assessments on any residents, he said no and that he had only been working for less than a month. Further review of the facility's electronic system did not reveal that Resident #22 had completed a quarterly nutritional risk evaluation. In an interview conducted on 06/27/24 at 9:30 AM, the Minimum Data Set Coordinator stated the facility's Dietitian will complete the nutritional care plans, but since the facility is between Dietitians, she has been trying to catch up on the dietary portions of the care plans. She said yes when asked if she completed the nutrition care plan for high-risk residents. When asked who updated the care plan on Resident #22, she stated the Dietary Manager, which was in March of 2024. In an interview conducted on 06/27/24 at 11:00 AM with the facility's Administrator she was informed of the findings.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record review, the facility failed to follow tube feeding as per the Physician ' s orders for 1 of 1 resident review for tube feeding (Resident #21). The findings included: Resident #21 was admitted on [DATE] with a diagnosis of traumatic brain injury and gastroesophageal reflux disease. A review of the Physician ' s orders revealed an order for tube feeding Jevity 1.5 (tube feeding formula) starting at 10:00 AM to run for 50 milliliters (ml) an hour for 20 hours and to turn the tube feeding off at 6:00 AM. In an observation conducted on 06/24/24 at 10:05 AM, Resident #21 was noted in bed with the tube feeding running at 50 ml an hour. The tube feeding bag was noted to have Jevity 1.5 (tube feeding formulary), which started on 06/24/24 at 10:00 AM and was at the 1000 ml level in a 1000 ml capacity bottle. In an observation conducted on 06/24/24 at 2:05 PM (about four hours later), Resident #21 was noted with the tube feeding running at 50 ml an hour. The same tube feeding bottle was observed earlier, which started on 06/24/24 at 10:00 AM and was now at the 900 ml level out of a 1000 ml capacity bottle. This showed that only 100 ml of tube feeding formulary was given in four hours. In an observation conducted on 06/25/24 at 9:00 AM, Resident #21 was noted in bed with the tube feeding off. In an observation conducted on 06/25/24 at 12:30 PM, Resident #21 was in her chair with the tube feeding running at 50 ml an hour. The tube feeding bag was noted at the 1000 ml mark out of a 1000 ml capacity bottle. In this observation, Staff C, Licensed Practical Nurse, said she started the tube feeding bottle at 10:00 AM this morning and that Resident #21 is tolerating her tube feeding well. In an observation conducted on 06/25/24 at 2:45 PM, Resident #21 was in the room with the tube feeding bottle Jevity 1.5 running at 50 ml an hour, which was started on 06/25/24 at 10:00 AM. The tube feeding was noted at the 950 ml level out of a 1000 ml capacity bottle. This showed that only 50 ml was administered in about 4.5 hours. In an observation conducted on 06/26/24 at 12:05 PM, the Resident was noted in bed, with the tube feeding Jevity 1.5 that started on 06/26/24 at 10:00 AM. The bottle was noted at the 1000 ml mark out of a 1000 ml capacity bottle. In an interview conducted on 06/27/24 at 10:55 AM, Staff C, Licensed Practical Nurse, stated she was about to hang a new tube feeding bottle for Resident #21. She further said that Resident #21 is tolerating her tube feeding well. The Quarterly Minimum Data Set, dated dated dated [DATE] revealed that Resident #21 was severely cognitively impaired. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nutrition Risk Evaluation dated 03/06/24 revealed Resident #21 tolerated the tube feeding very well and relies on tube feeding to meet 100% of nutritional needs. The care plan dated 06/10/24 showed monitoring/documentation of any residuals. Provide tube feedings as ordered and flushes as ordered. In an interview conducted on 06/27/24 at 11:00 AM with the Administrator, she was informed of the findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observations, interviews, and record review, the facility failed to provide tracheostomy care in accordance with professional standards of practice and failed to implement appropriate interventions for tracheostomy care for 1 of 1 resident sampled for respiratory care (Resident #21). The findings included: Review of the facility's policy titled, Tracheostomy Care dated 09/01/23 included in part the following: The facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. Compliance Guidelines: 2. The facility will provide necessary respiratory care and services, such as oxygen therapy, treatments, mechanical ventilation, tracheostomy care and/or suctioning. 3. Tracheostomy care will be provided according to the physician's orders, comprehensive assessment and individualized care plan such as monitoring for resident specific risks for possible complications, psychosocial needs as well as suctioning as appropriate. 4. Based upon the resident assessment, attending physician's orders, and professional standards of practice, the facility in collaboration with the resident/resident's representative will develop a care plan that includes appropriate interventions for respiratory care. Review of the Tracheostomy care: An evidence-based guide located at: https://www.myamericannurse.com/tracheostomy-care-an-evidence-based-guide-to-suctioning-and-dressing-changes/ included in part the following: Under the Section When to suction Suctioning is done only for patients who can't clear their own airways. Its timing should be tailored to each patient rather than performed on a set schedule. Start with a complete assessment. Findings that suggest the need for suctioning include increased work of breathing, changes in respiratory rate, decreased oxygen saturation, copious secretions, wheezing, and the patient's unsuccessful attempts to clear secretions. According to one researcher, fine crackles in the lung bases indicate excessive fluid in the lungs, and wheezing patients should be assessed for a history of asthma and allergies. Record review for Resident #21 revealed the resident was originally admitted to the facility on [DATE] and most recently readmitted to the facility on [DATE] with diagnoses that included: Personal History of Traumatic Brain Injury, Aphasia, and Encounter for Attention to Tracheostomy. Review of the Minimum Data Set for Resident #21 dated 06/10/24 documented in Section C a Brief Interview of Mental Status was not completed due to the resident is rarely/never understood. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Orders for Resident #21 revealed an order dated 04/26/20 for Tracheostomy care provided, change disposable inner cannula (Shiley size 4) every day shift. Review of the Physician's Orders for Resident #21 revealed an order dated 04/27/24 Tracheostomy care provided every day and evening shift related to Encounter for Attention to Tracheostomy. Review of the Care Plan for Resident #21 dated 09/16/18 with a focus on the resident has a tracheostomy r/t (related to) injury Nontraumatic brain injury Congestion. The goals were for the resident to have clear and equal breath sounds bilaterally, no s/sx (signs/symptoms) of infection, and to have no abnormal drainage around trach site through the review date. The interventions were to: Ensure that trach ties are secured at all times, Monitor/document for restlessness, agitation, confusion, increased heart rate (Tachycardia), and bradycardia. Monitor/document level of consciousness, mental status, and lethargy PRN. Monitor/document respiratory rate, depth and quality. Check and document every shift/as ordered. Provide good oral care daily and PRN (As needed). Reassure resident to decrease anxiety. Suction as necessary. Tube Out Procedures: Keep extra trach tube and obturator at bedside. If tube is coughed out, open stoma with hemostat. If tube cannot be reinserted, monitor/document for signs of respiratory distress. If able to breathe spontaneously, elevate HOB 45 degrees and stay with resident. Obtain medical help Immediately. There were no interventions for providing tracheostomy care. On 06/25/24 at 2:00 PM, an observation was made of tracheostomy care provided to Resident #21 by Staff C Licensed Practical Nurse (LPN). The LPN gathered supplies, applied gown and clean non-sterile gloves (Staff C, LPN did not wear any eye protection). The LPN then proceeded to touch the resident as well as several objects in the room before removing her gloves, and applied clean non-sterile gloves, she then opened the tracheostomy kit, did not unfold or use the sterile field located in the kit, opened the saline, removed the sterile gloves, performed hand hygiene (HH), applied sterile gloves with poor technique (touching the open end of the glove with sterile gloved hand touching her wrist as she placed the glove on the other hand, she then used both hands with sterile gloves to adjust the towel on the resident's chest, pushed the resident's hair behind her neck, with her left hand she removed the old inner canula and disposed of it, during this time the resident was making a gurgling type of sound while coughing and had copious secretions coming out of the tracheostomy spilling over and onto the LPNs gloved hand holding the tracheostomy. The LPN then removed her gloves, performed HH, applied clean non-sterile gloves, and replaced the inner canula. Staff C, LPN then placed gauze under the trach ties, around the trach, then replaced the trach ties, removed her gloves, performed HH. The LPN did not listen to breath sounds, obtain oxygen saturation, or provide suctioning any time prior to, during or after the tracheostomy care. During an interview conducted on 06/25/24 at 2:23 PM with Staff C, LPN who stated she has worked at the facility for 1 year. The LPN stated she made a mistake; she should have washed her hands before applying the PPE (Personal Protective Equipment) and she should have used a mask during the procedure. When asked if suctioning should be provided prior to or after or in conjunction with tracheostomy care, she said no, not for this resident, she does that all of the time (coughing up secretions) and if you suction her, she will just produce more secretions. When asked if replacing the inner canula is a sterile procedure, she said no. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Vivo Healthcare Wachula		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Orange Place Wauchula, FL 33873	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 06/26/24 at 12:00 PM with Staff F, Licensed Practical Nurse (LPN) who was asked about tracheostomy care for a resident, he said he would suction the resident as necessary, there should be extra supplies at the bedside such as suctioning, inner cannulas, and an Ambu bag. When asked if it is considered a sterile procedure to change the inner canula, he said yes, it is a sterile procedure, and you should wear sterile gloves. During an interview conducted on 06/26/24 at 12:45 PM with Staff, G LPN, Unit Manager of east wing she stated she has worked at the facility as a Unit Manager for 8 months. When asked about tracheostomy care for residents, she said it should be performed at least twice a day. When asked if staff should perform hand hygiene before putting on gloves and after removing them, she said yes. When asked if replacing an inner canula for a resident is a sterile procedure, she said yes, it is considered a sterile procedure. When asked about the care plan for tracheostomy for Resident #21, she acknowledged the care plan interventions should include tracheostomy care, but it did not.

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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** 41837 Based on interview and record review, the facility attending physician failed to document on irregularities identified with recommendations by the consulting pharmacist for 1 of 5 residents sampled for Unnecessary Medications (Resident #2). The findings included: Review of the facility's policy titled, Medication Regimen Review dated 08/07/22 included in part the following: The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart. Policy Explanation and Compliance Guidelines: 6. d) Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. Record review for Resident #2 revealed the resident was admitted to facility 01/10/23, the resident went out of the facility on 03/10/24 and was readmitted to the facility on [DATE] with diagnoses that included: Fracture of Unspecified Part of Neck of Right Femur, Major Depressive Disorder, and Generalized Anxiety Disorder. Review of the Minimum Data Set for Resident #2 dated 05/06/24 revealed in Section C a Brief Interview of Mental Status score of 15 indicating the resident is cognitively intact. Review of the Pharmacy Medication Regimen Review for Resident #2 dated 03/21/24 documented: Currently receiving digoxin. Daily pulse recommended with use. Please consider ordering, if appropriate. The Physician/Prescriber Response was not addressed. There was an indication on the form that documented was out to hospital with no signature or date. Review of the Pharmacy Medication Regimen Review for Resident #2 dated 03/21/24 documented: Currently receiving Cholestyramine for diarrhea without stop date. Please evaluate continued need. Consider adding stop date, if appropriate. The Physician/Prescriber Response was not addressed. There was an indication on the form that documented was out to hospital with no signature or date. Review of the Pharmacy Medication Regimen Review for Resident #2 dated 03/21/24 documented: Currently receiving Tramadol which has a potential for dizziness and drowsiness, increasing the risk of falls. Per clinical record, with recent falls. Please evaluate possible causal relationship. Consider trial discontinue Tramadol and start alternate therapy (i.e.: Ibuprofen or Acetaminophen), if necessary. The Physician/Prescriber Response was not addressed. There was an indication on the form that documented was out to hospital with no signature or date. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Pharmacy Medication Regimen Review for Resident #2 dated 03/21/24 documented: Per clinical record resident with recent falls. Recommend to check 25-hydroxyvitamin D levels in those with advanced age and recent falls. Please consider ordering and if necessary, initiating Vit D3 50,000 IU once weekly for 6 weeks then monthly thereafter. The Physician/Prescriber Response was not addressed. There was an indication on the form that documented was out to hospital with no signature or date. During an interview conducted on 06/26/24 at 9:51 AM with the Director of Nursing (DON) who was asked if the consultant pharmacist reviews the medication regiment every month for every resident, she said yes. When asked about medication review recommendation for Resident #2 for the month of March, the DON said the resident was out to the hospital. When asked when the resident went out to the hospital and returned to the facility, she acknowledged the resident was out from 3/10/24 and returned on 3/19/24. When asked why the recommendations were not addressed, she said it must have been missed.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 01948 Based on observation, interview, and record review it was determined that the facility failed to prepare food in a form designed to meet the individual needs of 5 (Residents #23, #24, #26, #36, and #41) of 5 sampled residents with physician ordered pureed diet. The findings included: *Review of the facility's policy for Pureed Food Preparation noted a Date Implemented of 09/01/23 and Reviewed by Clinical Services. Further review of the Policy Explanation and Compliance Guidelines noted: (2) Pureed foods should be prepared in such a manner to prevent lumps or chunks. The goal is a smooth, soft, homogenous consistency similar to soft mashed potatoes. (3) If the food item requires chewing, it will be excluded from the pureed diet. References: Center for Medicare & Medicaid Services, State Operation Manual (SOM), Appendix PP Guidance to Surveyors for Long Term care Facilities (November 2017 Revision) 1) During the observation of the lunch meal in the main kitchen on 06/24/24 at 11:15 AM, and accompanied with the facility's Certified Dietary Manager (CDM), pureed foods located in the serving steam table were observed by the surveyor. The observation noted that the Pureed Chicken Tenders, Pureed Baked Macaroni & Cheese, and Pureed Mixed Vegetables all were noted to be lumpy and visible pieces of foods in all 3 pureed foods. At the request of the surveyor the pureed foods were taste tested by the surveyor and the CDM. The test tasting was confirmed by the surveyor and the CDM that all 3 pureed foods were not pureed to a smooth consistency and pieces of foods could be tasted. It was discussed with the CDM that pureed food should be pureed to a smooth pudding like consistency and no food lumps be present. It was stated that the lunch cook (Staff D) was not preparing foods to a proper pureed consistency and not testing the pureed foods prior to serving. Staff D stated no training of preparation of Pureed foods for residents with physician ordered pureed diet with diagnoses of Dysphagia. The surveyor requested that the lunch pureed foods be sent back to be pureed to the proper consistency prior to be served for the 06/24/24 lunch meal. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) During the observation of the lunch meal in the main kitchen on 06/25/24 at 11:15 AM, and accompanied with the facility's Certified Dietary Manager (CDM), pureed foods located in the serving steam table were observed by the surveyor. The observation noted that the Pureed Kielbasa and Pureed Cabbage, were noted to be lumpy and visible pieces of foods in the 2 pureed foods. At the request of the surveyor the pureed foods were taste tested by the surveyor and the CDM. The test tasting was confirmed by the surveyor and the CDM that the 2 pureed foods were not pureed to a smooth consistency and pieces of foods could be tasted. It was discussed with the CDM that pureed food should be pureed to a smooth pudding like consistency and no food lumps be present. It was stated that the lunch cook (Staff E) was not preparing foods to a proper pureed consistency and not testing the pureed foods prior to serving. Staff E stated no training of preparation of Purred foods for resident's with physician ordered pureed diet with diagnoses of Dysphagia. The surveyor requested that the lunch pureed foods be sent back to be pureed to the proper consistency prior to be served for the 06/25/24 lunch meal. 3) During the review of the facility's Diet Census for 06/24/24, it was noted that there were currently 5 facility residents with physician ordered Pureed Diet, with diagnoses that included Dysphagia. The 5 residents included Sample Residents #23, #24, #26, #36, and #41. Review of the sampled resident's clinical records on 06/24-25/24 noted the following: Resident #23: Date of Admission: 06/06/24 Diagnoses: Dysphagia, Protein-Calorie Malnutrition Current Physician Order: Pureed Diet (06/20/24) Resident #24 Date Of Admission: 06/18/24 Diagnoses: Protein-Calorie Malnutrition, Failure To Thrive, and Dysphagia Current Physician Order: Pureed Diet with Nectar Thick Liquids (06/18/24) Resident #26: Date Of Admission: 8/1/23 Re-admission Diagnoses: Dysphagia Current Physician Orders: Pureed Diet with Nectar Thick Liquids (06/08/22) Resident #36 Date Of Admission: 3/28/24 (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Diagnoses: Dysphagia, Protein-Calorie Malnutrition Current Physician Orders: Pureed Diet (06/24/24) Resident #41 Date Of Admission: 01/01/23 Diagnoses: Dysphagia Current Physician Orders: Pureed Diet with Fortified Foods (07/07/23)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01948 Based on observation, interview, and record review, it was determined that the facility failed to follow physician ordered fluid restriction diet for 2 (Residents #214, and #22) of 2 sampled residents. The findings included: *Review of facility's policy for Fluid Restriction on 06/24/24 noted the following: Policy : It is the policy of the facility to ensure that fluid restrictions will be followed in accordance with physician's orders. Policy Explanation: Fluid restrictions are basically the restriction of fluid intake. This may be due to underlying medical conditions that may cause fluid build-up such as Congestive Heart Failure (CHF), or End Stage Renal Disease (ESRD), in addition to electrolyte disorders such as hyponatremia. Fluid restriction can vary according to the resident's condition and the physician judgement. Compliance Guidelines: (1) The nurse will obtain and verify the physician's order for the fluid restriction and an order written to include the breakdown of the amount of fluid per 24 hours to be distributed between the food and nutrition department and the nursing department. (2) The fluid restriction distribution will take into consideration the amount of fluid to be given at meal times, snacks, and medication passes. (3) Water will not be provided at the bedisde unless calculated into the daily total fluid restriction . 1) During the review of the clinical record of Resident # 214 on 06/24/24, it was noted a current physician's order dated 06/21/24 for a 1500 cc Fluid Restriction per day. The order further documented dietary to receive 750 cc per day and nursing to receive 750 cc per day. Routine observation conducted on 06/24/24 at 1 PM noted a 16 ounce Styrofoam container on the resident's bedside table that was full of water. The resident stated that she has been drinking from the Styrofoam cup and had no knowledge of the physician ordered fluid restriction. Interview with the Director of Nursing and Certified Dietary Manager following the observation were noted to state that fluids are not allowed at the bedside of Resident #214. Routine observations of the lunch meal on 06/25/24 at 12:30 PM noted the meal tray delivered to the room of Resident #214. Review of the meal ticket documented a Mechanical Soft diet and 1500 cc Fluid Restriction . Further review of the ticket noted no documentation of how much fluid was to be served for the lunch meal . (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the observation of the lunch meal in the main dining room on 06/26/24 at 12 :15 PM, it was noted that Resident #214 was present for the meal . Further observation noted that the resident's meal ticket that was located on the dining room table documented a Mechanical Soft - Fluid Restriction of 360 cc for the lunch meal and documented 4 ounces (120 cc)of Lemonade and 8 ounces (240 cc) - Milk to be served. Further observation noted that the resident received the 120 cc of Lemonade and 240 cc of Milk, however the resident received an additional 8 ounces (240 cc) of Coffee with the meal. The surveyor requested the Certified Dietary Manager (CDM) and Charge Nurse who was in the dining room to observe the resident's beverages that were served. Both the CDM and the Charge Nurse confirmed the surveyors findings that the fluid restriction for the meal was not followed and the resident received an additional 240 cc of fluid with the meal. It was also noted that the dietary department sent the correct amount of fluids on the tray, however nursing staff who pass beverages prior to the main meal were not aware of the fluid restriction and served the resident an additional 240 cc of coffee. It was further discussed that nursing staff working in the dining room for meal service be in-serviced on any resident with a physician's order for fluid restriction. Interview with the Certified Dietary Manager during the observation of the 06/26/24 meal noted she was unaware that the specific fluids and amounts for each meal that add up to 360 cc per meal. Interview with Director of Nursing during the 06/26/24 observation noted to state that she was not aware the meal tickets failed to document the amount of fluids to be served with all meal. 40153 2) A record review revealed Resident #22 was readmitted on [DATE] with diagnoses of End-Stage Renal Failure, Type 2 Diabetes, and dependency on dialysis. The Quarterly Minimum Data Set, dated dated dated [DATE] showed that Resident #22 had a Brief Interview of Mental Status (BIMS) score of 03, which indicated the resident was severely cognitively impaired. The Physician's orders revealed an order for fluid restriction of 960 milliliters (ml) per day: Dietary to provide 200 ml for Breakfast, Lunch, and Dinner. Nursing administers 120 ml every shift for hydration and medication, dated 03/28/24. In an observation conducted on 06/24/24 at 10:10 AM, Resident #22 was in bed. The side table was noted with three bottles of 16 ounces each of sodas and 16 ounces of water in a Styrofoam cup provided by the facility. This showed that the fluids supplied by the facility were 480 ml for Breakfast and not 200 ml as per Physicians' orders. In an observation conducted on 06/25/24 at 11:50 AM, Resident #22 was in bed. The side table was noted with three bottles of 16-ounce sodas each and 16-ounce water in a Styrofoam cup provided by the facility. A progress note dated 06/24/24 revealed Resident #22 to have a soda bottle in the room; the Resident stated that the family brought it in and was educated on fluid restriction. The Resident said, I want my Pepsi. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the care plan dated 06/18/24 showed a care plan for nutrition and dialysis that needed to document Resident #22's fluid restrictions. Further review did not show any interventions regarding fluid restrictions, nor was any education provided to the family on fluid restrictions prior to 06/24/24. In an interview conducted on 06/26/24 at 12:05 PM with Staff B, the Certified Nursing Assistant (CNA) stated that she attends staff meetings with the nurses and is told about any residents who are on fluid restrictions. She further said that she would go into residents' rooms to make sure that they were the correct residents on fluid restriction and that the appropriate fluids were provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01948 Based on observation and interview, it was determined that the facility failed to store, prepare, distribute and serve food, in accordance with professional standards for food service safety. The findings included: 1) During the initial kitchen/food service observation tour conducted on 06/24/24 at 9 AM and accompanied with the facility's Certified Dietary Manager (CDM), the following were noted: a) The entire surface of the storeroom floor (10' X 20') was noted to be in disrepair with large areas of the concrete broken, rust, and peeling paint. It was discussed with the CDM that there were areas of standing water in pockets of the missing concrete surface which house bacteria that staff transfer into the main kitchen area. Also peeling paint is also transferred in the kitchen area. b) The exterior door and entry area to the walk-in refrigerator was noted to be rust laden and build-up of a black mold type matter. It was discussed with the CDM that the entry door and door area are not cleaned properly on a regular basis. c) Observation of the entry door of the walk-in refrigerator noted that the gaskets was covered in a black mold type matter and the door gasket had a large tear (approx 2'). It was noted that the unit was not operational during tour however it was discussed that the gaskets be placed prior to restart to ensure that the unit is cooling properly. d) Observation of the Reach-in Refrigerator #1 noted that the door gasket was covered in a black mold type matter and that the gasket had a large tear (1.5'). It was discussed with the CDM that the gasket requires replacement and needs to be properly cleaned on a regular basis. The CDM stated that she has requested a gasket replacement for months. e) Observation of the Reach-in Refrigerator #1 noted that a case of fresh eggs (15 dozen) was being stored directly over individual cartons of milk (48 individual). It was discussed with the CDM that there was potential of food contamination if raw eggs spilled onto the cartons of milk. f) Observation of the Reach-in #1 refrigerator noted left over containers of food dated: Beef Stroganoff (06/21), cooked rice (06/21). The CDM stated that left-over foods are to be discard after 48 hours and further stated that the left-over foods should have been discarded. g) Observation of the wood cutting board (5') that was attached to the steam table noted that the exterior was in disrepair and covered in a black mold type matter. It was discussed that the cutting board was too heavily worn to properly cleaned and should be replaced. h) Observation of the food preparation skillet pans (5) and commercial sheet pans were covered with a black carbon build-up. It was discussed with the CDM that use of the pans could result in food contamination during preparation and should be replaced. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	i) Numerous commercial dish racks (6) were noted to be heavily worn and had a build-up of black mold type matter. It was discussed with the CDM that the dish racks be replaced. j) Observation of the 3-compartment sink noted that a heavily soiled cleaning rag was placed over the water faucet. It was discussed that cleaning rags must be stored in a sanitizing solution when not in use. A chemical test of the cleaning rag bucket noted that there was no measurable chemical sanitizer in the solution to meet the regulatory requirement (Quaternary). k) Observation of the bench mounted commercial can opener noted that the entire opening stem and cutting blade was covered in a black mold type matter. It was discussed with the CDM to replace the unit. l) Observation of the juice dispensing machine noted that the whole exterior including the top had large areas of dried juice matter. It was discussed with the CDM that the dispenser is not being properly cleaned on a regular basis. m) Observation of the commercial ice machine noted that water was continuously draining from the machine onto the floor area. It was noted that 3 large blankets were on the floor to soak up the water. It was discussed with the CDM that the wet blankets cannot remain on the floor and that the machine must be repaired. Photographic evidence obtained for Example #1 : a-m. 2) During a second observation tour of the kitchen on 06/25/24 at 11:15 AM, and accompanied with the CDM, the following were noted: n) Numerous flying insects (4) were noted to be located in the food preparation and serving area. The surveyor requested that the facility's pest control company be called for treatment on 06/25/24. o) Observation of the lunch meal noted hot foods located on the serving steam table. At the request of the surveyor the temperatures of the hot and cold foods were taken by the CDM with the use of the facility's calibrated digital food thermometer. The temperatures of the foods were noted to not be in regulatory compliance of 41 degrees F or below (cold foods) or 135 degrees F or higher(hot foods). The temperatures were recorded as follows: * Kielbasa & Noodles = 118 degrees F (surveyor requested reheating) * Pureed Buttered Noodles = 125 degrees F (surveyor requested reheating * Watermelon = 71 degrees F * Pureed Watermelon = 71 degrees F 3) During a third kitchen/food service observation conducted on 06/26/24 at 11:30 AM and accompanied with the Certified Dietary Manager (CDM), the following was noted: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	p) Staff were noted to be handling clean silverware by the eating stem resulting in contaminated silverware being placed of resident food trays. It was discussed with the CDM that silverware is not being properly washed to make sure clean silverware is stored with the handle up to ensure that it is being handled in a sanitary manner. 40153 4) A record review revealed Resident #22 was readmitted on [DATE] with diagnoses of End-Stage Renal Failure, Type 2 Diabetes, and dependency on dialysis. The Quarterly Minimum Data Set, dated dated dated [DATE] showed that Resident #22 had a Brief Interview of Mental Status (BIMS) score of 03, which indicated the resident was severely cognitively impaired. A review of the Physician's order revealed an order for dialysis at 11:30 AM pick-up and return time at 4:00 PM, dated 02/21/24. In an observation conducted on 06/24/24 at 12:01 PM, Resident #22 was noted in bed with two ham and cheese sandwiches wrapped in saran wrap with no ice packs or insulated lunch bag at the side table. In this observation, Staff A, Licensed Practical Nurse, stated that Resident #22 was offered his lunch tray and refused. Staff A further said that the two ham and cheese sandwiches were provided to Resident #22 for his snack during his dialysis treatments and that he was on his way to dialysis. Continued observation showed transportation services placing Resident #22 on a stretcher, and the two ham and cheese sandwiches were placed on top of Resident #22's medical chart underneath Resident #22's head (photographic evidence obtained). In an interview conducted on 06/24/24 at 12:10 PM with Staff B, Certified Nursing Assistant stated that Resident #22 did not want his lunch tray and that he likes the ham and cheese sandwiches when he goes to dialysis.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on interviews and record review, the facility failed to accurately document code status for 1 of 29 sampled residents (Resident #50). The findings included: Record review for Resident #50 revealed the resident was admitted to the facility on [DATE] with a readmission on 06/21/24 with diagnoses that included the following: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Generalized Anxiety Disorder, Major Depressive Disorder, and Aphasia Following Cerebral Infarction. Review of the Minimum Data Set for Resident #50 dated 04/22/24 documented in Section C, a Brief Interview of Mental status score of 0, indicating severe cognitive impairment. Review of the Physician's Orders for Resident #50 revealed an order dated 6/21/24 for Code Status: Full Code Review of the Social Services Progress note for Resident #50 dated 09/10/23 documented the following: Confirmed with Proxy that resident is a DNRO code status. Review of the Care Plan for Resident #50 dated 08/10/23 with a focus on Advance Directives-I am a DNR Code Status- Do Not Resuscitate in the event of no heartbeat and no respirations. The goal was for Advance directive will be followed per MD orders. The interventions included: If code status changes update medical record. Provide comfort measures as indicated when end of life is eminent. Provide resident and family privacy as needed. Review code status quarterly to ensure preferences are honored. Review of the Care Plan Progress Note for Resident #50 dated 08/16/23 documented the following: Care plan meeting held at this time with IDT members. Brother [NAME] requested to called for care plans but did not answer. He requested a copy of care plans. Review of current plan of care. Resident adjusting well to recent admission to facility. Will continue to follow current plan of care and adjust as needed. Copy of care plans provided for brother. Review of the Care Plan Progress Note for Resident #50 dated 01/31/24 documented the following: Care plan meeting held today with IDT and friend. Review of current plan of care. Resident stable at this time. Will continue to follow current plan of care adjust as needed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 06/24/24 at 2:08 PM with Staff A, Licensed Practical Nurse (LPN) who stated she has worked at the facility for 1.5 years. When asked how she identifies what the code status is for a resident, she stated she would check in the Electronic Medical Record (EMR) at the top of the dashboard and the code status is located there. When asked if the code status is blank, what would she do, she said she would check the order and look in miscellaneous for any documentation for code status, such as a DNR (Do Not Resuscitate) form. When asked about Resident #50, she looked for the code status in the EMR in the dashboard, and acknowledged it was blank. Staff A, LPN then checked the orders for the resident and acknowledged the resident had an order for full code. Staff A, LPN then checked in miscellaneous for the resident and located a DNR form. Staff A, LPN said she will call the family and the physician to address immediately. During an interview conducted on 06/25/24 at 1:00 PM with the Social Service Director (SSD) who was asked about advanced directives specifically code status he said when a resident comes in, the nurse will talk to resident or family to discuss code status. The SSD will confirm with resident/family what the code status is. The SSD said he is responsible to make sure code status was in orders correctly and care plan implemented and updated as needed. The resident went out to hospital on 06/18/24 and returned on 6/21/24 and upon return the nurse must have put him in as a full code status unbeknownst to him. Had he known this he would have called the family to confirm they still wanted the resident to be a do not resuscitate. The SSD said the incident of making the resident a full code was done without his knowledge and he would have addressed the code status with the family as they were adamant about the resident being a do not resuscitate given his health issues.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observations, interviews, and record review, the facility failed to practice hand hygiene while donning and doffing gloves during med administration observation for 2 of 5 residents reviewed for medication pass (Residents #165 and #38), and during tracheostomy care for 1 out of 1 resident reviewed for respiratory care (Resident #38). The findings included: Review of the facility's policy titled, Hand Hygiene dated 09/01/23 included in part the following: All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning (applying) gloves, and immediately after removing gloves. Hand Hygiene Table After handling contaminated objects Before performing invasive procedures Before applying and after removing personal protective equipment (PPE), including gloves. Before and after handling medications. Before performing resident care procedures After handling items potentially contaminated with blood, body fluids, secretions, or excretions. Review of the facility's policy titled, Medication Administration with a revised date of 09/01/23 included in part the following: Policy Explanation and Compliance Guidelines: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Wash hands or ABR (Alcohol Based Rub) prior to administering medication per facility protocol and product. 1.) Record review for Resident #21 revealed the resident was originally admitted to the facility on [DATE] and most recently readmitted to the facility on [DATE] with diagnoses that included: Personal History of Traumatic Brain Injury, Aphasia, and Encounter for Attention to Tracheostomy. Review of the Minimum Data Set (MDS) for Resident #21 dated 06/10/24 documented in Section C a Brief Interview of Mental Status (BIMS) was not completed due to the resident is rarely/never understood. Review of the Physician's Orders for Resident #21 revealed an order dated 04/27/24 Tracheostomy care provided every day and evening shift. On 06/25/24 at 2:00 PM, an observation was made of tracheostomy care provided to Resident #21 by Staff C, Licensed Practical Nurse (LPN). Staff C, LPN gathered supplies, applied gown and clean non-sterile gloves without performing hand hygiene (HH). Staff C, LPN removed her gloves, did not perform HH, applied clean non-sterile gloves, with her left hand she removed the old inner canula and disposed of it, during this time the resident was making a gurgling type of sound while coughing and had copious secretions coming out of the tracheostomy. Staff C, LPN applied clean non-sterile gloves and replaced the inner canula. Staff C, LPN then placed gauze under the trach ties, around the trach, then replaced the trach ties, removed her gloves, performed HH. This indicated Staff C, LPN did not perform HH before initially starting the procedure and applying gloves, nor did she perform HH between glove changes. During an interview conducted on 06/25/24 at 2:23 PM with Staff C, LPN who stated she has worked at the facility for 1 year. Staff C, LPN stated she made a mistake; she should have washed her hands before applying the PPE (Personal Protective Equipment). 2.) Record review for Resident #38 revealed the resident was originally admitted to the facility on [DATE] with a readmission on 03/19/24 with diagnoses that included: Urinary Tract Infection, Cognitive Communication Deficit, Major Depressive Disorder, and Anxiety Disorder. During a Medication Pass observation conducted on 06/25/24 at 9:20 AM with Staff C Licensed Practical Nurse (LPN) for Resident #38, Staff C LPN did not perform hand hygiene before or after handling medications, nor did she perform hand hygiene before applying gloves or after removing gloves. 3.) Record review for Resident #165 revealed the resident was admitted to the facility on [DATE] with diagnoses included: Muscle Wasting and Atrophy and Type 2 Diabetes Mellitus (DM) with Hyperglycemia. Review of the MDS for Resident #165 dated 06/18/24 revealed in Section C, a BIMS score of 9, indicating moderate cognitive impairment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's orders for Resident #165 revealed an order dated 06/20/24 for Humalog Injection Solution (Insulin Lispro) Inject intramuscularly before meals and at bedtime for DM Inject as per sliding scale: if 0 - 200 = 0 units If BS is below 70 notify MD.; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 12 units If bs is above 450 notify MD. During a Medication Pass observation conducted on 06/25/24 at 10:40 AM with Staff C, LPN who was administering insulin to Resident #165, the LPN applied gloves without using hand hygiene and administered Humalog insulin (coverage) subcutaneous into the resident's abdomen. Staff C, LPN then removed her gloves and did not perform hand hygiene. During an interview conducted on 06/25/24 at 10:50 AM with Staff C, LPN she stated she worked for the facility for a year. When asked if she should perform hand hygiene before and after handling medication she said yes. When asked if she should perform hand hygiene before applying and after removing gloves, she said yes, she was nervous and forgot.