STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105382	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandgate Gardens Rehab and Nursing Center	703 S 29th St Fort Pierce, FL 34947

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39167 Based on observation, interview, and record review, the facility failed to ensure that resident choices of television channels were respected for 1 of 5 sampled residents reviewed, Resident #34. The findings included: Clinical record review showed that Resident #34 was admitted to the facility on [DATE] and again on 06/02/24, with diagnoses that included anxiety disorder and depression. The quarterly comprehensive assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 15, indicating he was cognitively intact. No mood or behavior concerns were noted. According to the quarterly activity assessment dated [DATE], Resident #34 spends time reading and watching TV (television) in his room. He enjoys sports but prefers not to participate in group programs, stating that he does not want to get out of bed. On 04/14/25 at 9:31 AM, Resident #34 expressed frustration with the facility's cable system, stating, We don't have a lot of channels. He indicated that although there were supposed to be 48-49 channels, only about 35 were available. He mentioned wanting to watch the show called The Masters on CBS the previous day but could not because the TV did not include CBS. The TV lacked WTCN, NBC, and ABC channels. On 04/15/25 at 8:41 AM, the resident was observed lying in bed watching TV. He reiterated that the facility had not addressed his concerns regarding the TV channels. On 04/18/25 at 8:37 AM, the Maintenance Director was interviewed. The surveyor informed her of Resident #34's concerns about the lack of WTCN, CBS, NBC, and ABC channels. She stated that she was unaware of these issues. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Later that day, at 1:24 PM, an interview was conducted with the Maintenance Director and Resident #34. The Director presented documentation indicating that residents were supposed to have 49 channels. Upon checking, she found that ABC, WTCN, and CBS channels were not working, and NBC was stuck. These were channels preferred by Resident #34. He informed the Maintenance Director that he had previously complained about these channels to the staff, including the floor technician. When the surveyor inquired about the process for addressing environmental concerns, the Maintenance Director explained that when a resident reports an issue with the TV, staff should document it in the TELLS system, which would allow her to follow up and resolve issues. She admitted that she did not know the channels were not functioning.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on record review and interview, the facility failed to complete comprehensive assessments within 14 days of admission, or annually in a timely manner, for 4 of 21 sampled residents, Residents #14, #61, #84, and #151. The findings included: Review of the Resident Assessment Instrument (RAI) Required Assessment Summary dated October 2024, revealed the resident's admission comprehensive assessment must have an Assessment Reference Date (ARD) no later than the 14th calendar day of the resident's admission, and must be completed no later than the 14th calendar day of the resident's admission. This document also revealed the Annual comprehensive assessment must have an ARD 366 calendar days after the last comprehensive assessment and be completed no later than 14 calendar days after that ARD. Review of the records revealed the comprehensive assessments were not completed timely for the following residents: a) Resident #14 was admitted to the facility on [DATE] and the comprehensive assessment was completed on 01/02/24, 15 days late. b) Resident #61 was admitted to the facility on [DATE], and the most recent annual assessment had an ARD of 12/06/24, and was completed on 12/23/24, four days late. c) Resident #84 was admitted to the facility on [DATE] and the comprehensive assessment was completed on 04/04/25, nine days late. d) Resident #151 was admitted to the facility on [DATE] and as of 04/17/25 the comprehensive assessment had not been completed. During an interview on 04/17/25 at 11:44 AM, when asked the timeframe for completion of the comprehensive assessments, the Minimum Data Set (MDS) Director stated they should be done within 14 days of admission to the facility, and annually thereafter. When asked why these assessments were late, the Regional MDS Director, who was also present, had no answer.

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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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 25404 Based on record review and interview, the facility failed to complete quarterly assessments no less than every 3 months for 3 of 21 sampled residents, Residents #14, #21, and #61. The findings included: Review of the Resident Assessment Instrument (RAI) Required Assessment Summary dated October 2024, revealed the resident's quarterly assessment must have an Assessment Reference Date (ARD) 92 calendar days after the previous quarterly assessment, and must be completed no later than the 14th calendar day after the ARD date. Record reviews revealed the following quarterly assessments were not completed timely: a) The quarterly assessment with an ARD of 06/10/24 for Resident #14 was completed on 07/17/24. b) The quarterly assessment with an ARD of 09/10/24 for Resident #14 was completed on 10/03/24. c) The quarterly assessment with an ARD of 03/11/25 for Resident #14 was completed on 04/14/25. e) The quarterly assessment with an ARD of 05/25/24 for Resident #21 was completed on 06/21/24. f) The quarterly assessment with an ARD of 03/06/25 for Resident #21 was completed on 04/10/24. g) The quarterly assessment with an ARD of 03/09/24 for Resident #61 was completed on 03/25/24. h) The quarterly assessment with an ARD of 06/09/24 for Resident #61 was completed on 07/16/24. d) The quarterly assessment with an ARD of 09/09/24 for Resident #61 was completed on 10/03/24. During an interview on 04/17/25 at 11:38 AM, the MDS (Minimum Data Set) Coordinator and Regional MDS Director agreed with the findings.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on record review and interview, the facility failed to ensure accurate Minimum Data Set (MDS) assessments for 4 of 21 sampled residents, as evidenced by inaccurate dialysis coding for Resident #86, inaccurate medication coding for Residents #70 and #31, and inaccurate hospice coding for Resident #69. The findings included: 1. Review of the record revealed Resident #86 was admitted to the facility on [DATE]. Review of physician orders and progress notes lacked any indication the resident had received any dialysis services. During an interview on 04/14/25 at 11:15 AM, Resident #86 stated he was not receiving dialysis services, and had never received them. Review of the admission MDS assessment dated [DATE] documented the resident was receiving dialysis services. During a side-by-side record review and interview on 04/17/25 at 11:38 AM, the MDS Coordinator agreed with the inaccurate MDS for Resident #86. 39167 2 Review of the clinical records revealed Resident #31 was admitted to the facility on [DATE] and again on 02/26/24, with diagnoses that included anxiety disorder and depression. The annual comprehensive assessment, reference date 03/27/25, indicated in section N regarding medication that the resident had received an antipsychotic during the look-back period, as evidenced by a yes recorded in subsection A. Review of the medication and treatment administration records for March 2025 did not provide any documented evidence of the resident receiving an antipsychotic during that time. On 04/18/25 at 7:43 AM, both MDS coordinators were interviewed. The record for Resident #31 was reviewed side-by-side with them, and the coordinators acknowledged the findings. 3. Review of the clinical records revealed Resident #69 was admitted to the facility on [DATE] and again on 12/13/23, with a diagnosis that included a stroke. In the quarterly comprehensive assessment conducted on 02/10/25, under section O for special treatments, procedures, and programs, no was recorded for hospice services. Review of physician orders dated 11/20/24 indicated that hospice care had been initiated on 08/05/24 for the diagnosis of late effects of a cerebrovascular accident (CVA) [stroke]. Review of the progress notes dated 08/05/24 confirmed that Resident #69 was admitted to hospice services, and family members were present with the hospice team during this time. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/18/25 at 7:43 AM, both MDS coordinators were interviewed. The record for Resident #69 was reviewed side-by-side with them, and the coordinators acknowledged the findings. 52127 4. Review of records revealed Resident #70 was admitted on [DATE] with diagnosis that included Encephalopathy, unspecified, cognitive communication deficit and unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. Review of the MDS dated [DATE] documented that Resident #70 was receiving Antipsychotic medication. The Admission nursing evaluation progress note dated 01/22/25, included, in part, that the resident is receiving antipsychotic medications that require an abnormal involuntary movement scale be completed. Review of record lacked any order for Antipsychotic medication from 01/22/25-01/29/25. During an interview on 04/16/25 at 11:48 AM, when asked why the antipsychotic medication was not provided to Resident #70 when it was listed on the MDS dated [DATE], the MDS Director responded that the medication was ordered on 01/30/25. Although the MDS Director did not state that the MDS was inaccurate, further review of records revealed that the MDS was modified immediately after the interview on 04/16/25 at 11:53 AM. and changed the Yes answer to No for Antipsychotic medication for Resident #70.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51137 Based on observations, interview and record review, the facility failed to ensure communication with a resident who was unable to speak English for 1 of 2 sampled residents, Resident #60. The findings included: Review of the policy titled Standards and Guidelines: ADL [Activities of Daily Living] Care and Services issued 04/2020 and revised 01/2024, documented, 4. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: e. Communication (speech, language, and any functional communication system.) Review of the facility's current admission packet documented in the section titled Nondiscrimination & Accessibility Requirements . The facility provides the following: Free language services to people whose primary language is not English, such as: qualified interpreters; information written in other languages. Review of the record revealed Resident #60 was last admitted to the facility on [DATE] with a primary diagnosis of Chronic Obstructive Pulmonary Disease (COPD) (a lung disease that makes it difficult to breathe.) Resident #60 was actively receiving hemodialysis (a treatment to filter wastes and fluids from the blood as the kidneys did when they were healthy.) Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #60 had a Brief Interview for Mental Status (BIMS) score of 9, on a 0 to 15 scale, indicating the resident was moderately cognitively impaired. This same MDS section A Identification Information documented the resident was of Hispanic, Latino or Spanish origin. The MDS documented the resident's preferred language as Spanish and her need/want of an interpreter to communicate with a doctor or health care staff. Review of the active orders revealed an order Monitor resident for pain every shift: Start Date 07/17/24. Review of the Treatment Administration Record (TAR) for all of March 2025 and April 2025 revealed documentation of a 0 pain level on a 0-10 scale; 0 being no pain and 10 being the worst pain. Review of the last wound evaluation dated 10/21/24 documented a right diabetic wound that was being treated at that time. Review of the current weekly skin check dated 04/12/25 documented no new skin issues. Review of the most current care plan dated 03/05/25 documented The resident has a communication problem related to language barrier: Spanish. Resident is noted to have a cognitive deficit and is usually understood / understands. Interventions included, Discuss with resident / family concerns or feelings regarding communication difficulty; Ask yes/no questions if appropriate, Use simple, brief, consistent words/cues, Use alternative communication tools as needed; The resident is able to communicate by a translator; Provide translator If resident needs and or wants one to communicate with the resident. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted in Spanish on 04/14/25 at 11:26 AM, Resident #60 complained of right heel pain rated at a 10 level. Resident #60 stated that for approximately 2 months she had told staff many times about her pain but nothing had been done about it. During a follow up interview on 04/16/25 at 8:57 AM, Resident #60 stated she was in dialysis yesterday. When asked If she was in pain yesterday, she stated yes and today as well, I'm in pain everyday. When asked how she communicated with staff, Resident #60 stated I just speak but they don't speak Spanish. When asked if the resident is given any kind of translator or communication tools, she stated No, they haven't asked me but I would like a translator; that would help me communicate my needs better. Resident #60 stated it was very hard not to be able to communicate with staff. When I tell them I'm in pain, they don't understand me. When asked if any kind of pain assessment was done by the nurses taking care of her, Resident #60 stated No, I tell them my heel hurts when they get me up to the wheelchair; since they don't understand me they still get me up and I just have to deal with the pain. Resident #60 consented to have a skin check observation on 04/16/25 at 9:09 AM with Staff J, Certified Nursing Assistant (CNA). When Staff J removed the resident's sock she expressed pain; a healed wound was observed at the bottom of the right heel. Resident #60 also expressed pain when Staff J re-applied the sock back on the foot. An interview was conducted on 04/16/25 at 9:15AM with the Director of Nursing (DON) addressing the concerns regarding Resident #60's language barrier affecting her pain levels. When asked how many staff was available to speak Spanish, the DON stated she spoke Spanish herself but would get a list of Spanish speaking staff from Human Resources. This information was never provided to the surveyor. The DON stated she thought the resident spoke English. When asked what staff should normally do when a resident has a language barrier, the DON stated that the facility had a language line available they could use. Photographic Evidence Obtained. The DON agreed with the findings. During an interview on 04/16/25 at 9:24 AM, when asked how she communicated with Resident #60, Staff J stated the resident spoke English. When asked how she knew that, she stated Because she replies yes and no when I talk to her. When asked if any communication tools or communication lines were used with the Resident, Staff J replied no. During a phone interview on 04/16/25 at 10:01 AM, when asked about Resident #60's pain, the representative believed it was an arthritic pain and acknowledged being aware that the resident still complained of right heel pain and not wanting to get up due to the pain. When asked if there were any Spanish speaking staff available at the facility, Resident #60's representative stated she wasn't aware of any staff that spoke Spanish. The representative stated, It would be nice to have someone available to translate to her.

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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** 51137 Based on observation, interview, and record review, the facility failed to provide nail care for 3 of 3 sampled residents reviewed for Activities of Daily Livings (ADLs), Residents #59, #13, and #4. The findings included: 1. Review of the policy titled Standards and Guidelines: ADL Care and Services, issued 04/2020 and Revised 01/2024, documented, 4. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, mail care and oral care . Review of the record revealed Resident #59 was initially admitted to the facility on [DATE] with diagnoses that included Dysphagia (difficulty swallowing) and Aphasia (loss of ability to understand or express speech) following cerebral infarction (a serious condition where blood flow to the brain is blocked, leading to tissue damage and death.) Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #59 had a Brief Interview for Mental Status (BIMS) score of 3, on a 0 to 15 scale, indicating the resident was severely cognitively impaired. This same MDS also documented the resident had upper extremity impairment on one side of the body. Review of Resident #59's current care plan dated 1/30/25 documented, Resident has an ADL self-care deficit related to ADL needs and participation vary, chronic medical conditions, Impaired balance, Limited Mobility. Observations conducted on 04/14/25 at 9:42 AM, 04/14/25 at 2:27 PM, 04/15/25 at 9:02 AM, 04/16/25 at 8:48 AM and 04/17/25 at 9:26 AM revealed Resident #59 was found to have long, dirt-encrusted, unkempt nails on all days. During a phone interview on 04/14/25 at 2:27 PM, when asked how care was, Resident #59's representative stated she needed to tell staff to cut his fingernails as she had noticed they were long. When asked if she needed to ask staff for it to get done, she replied, yes, normally I have to ask. 2. Review of the record revealed Resident #13 was initially admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #13 had a BIMS score of 6, on a 0 to 15 scale, indicating the resident was severely cognitively impaired. Review of Resident #13's current care plan dated 02/06/25 documented, Resident has an ADL self-care deficit related to chronic medical conditions, ADL participation and needs may vary., disease process - Dementia. Observations conducted on 04/14/25 at 9:58 AM, 04/15/25 at 9:09 AM, 04/16/25 at 8:37 AM and 04/17/25 9:28 AM revealed Resident #13 was found with untrimmed and dirty nails on all days. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the record revealed Resident #4 was initially admitted to the facility on [DATE] with a primary diagnosis of senile degeneration of brain (a term that refers to the cognitive decline). Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #4 had a Brief Interview for Mental Status (BIMS) score of 4, on a 0 to 15 scale, indicating the resident was severely cognitively impaired. An observation and interview were conducted on 04/14/25 at 10:09 AM, and Resident #4 nails were observed to be long, unkempt and with chipped nail polish. When asked if she receives nail care, Resident #4 stated, Sometimes they do my nails, and sometimes they don't. My daughter usually does my nails, but she is out of town. I would like them to help me do them. Follow up observations conducted on 04/15/25 at 9:12 AM, 04/16/25 at 8:51 AM, and 04/17/25 9:30 AM revealed Resident #4's nails were still long, unkempt and with chipped nail polish on all days. During an interview on 04/17/25 at 10:01 AM, when asked who is responsible for providing nail care to residents, Staff D, Certified Nursing Assistant (CNA), stated they were not allowed to cut fingernails and could only clean nails. When asked why they were not allowed to cut fingernails, Staff D stated it was for safety reasons. When asked how nails were cleaned, Staff D stated she used a washcloth. During an interview on 04/17/25 at 10:06 AM, when asked who is in charge of providing nail care to the residents, Staff E, CNA, stated the podiatrist was in charge of cutting nails and the CNAs were in charge of cleaning nails. An interview was conducted on 04/17/25 at 10:22 AM with Staff C, Licensed Practical Nurse (LPN), and Staff A, Unit Manager. When asked who was in charge of assigning CNAs to provide nailcare, Staff C stated she was. When asked who was in charge of providing nail care to residents, Staff C stated the CNAs should be providing nail care to residents on their shower days. When asked if CNAs were allowed to cut fingernails, Staff C stated, they were allowed to cut fingernails and the only exception was to toenails. Staff C stated she didn't know where the confusion was since they had been trained to cut nails. They were made aware of the above findings regarding Residents #59, #13, and #4's fingernails. Staff C agreed with the findings.

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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** 25404 Based on observation, record review, and interview, the facility failed to ensure appropriate care and services for 2 of 6 sampled residents, as evidenced by the lack of offloading (relieve pressure) of a surgical wound for Resident #75, and failure to follow physician ordered parameters for antihypertensive (blood pressure) medications for Resident #82. The findings included: 1. Review of the record revealed Resident #75 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Further review of this assessment documented the resident had a surgical wound. Review of the wound care progress note dated 04/07/24 and written by Staff G, the wound care nurse practitioner, revealed the resident was to offload her heels as per the facility protocol. A second noted dated 04/14/25 documented, in part, to continue to reduce pressure to wound area. Offloading: Implement appropriate offloading interventions based on patient needs, utilizing standard facility practices and available support surfaces to minimize pressure on affected areas. Continue to encourage compliance and assistance with offloading and turning/repositioning. During an interview on 04/14/25 at 9:50 AM, Resident #75 was sitting up in bed. When asked what brought her to the facility, Resident #75 explained she had a wound on the outer side of her left foot. An observation of the dressing revealed shadowing was present, indicating the wound was draining. When asked if she was able to offload or relieve pressure to the wound while in bed, the resident explained that she tried to, but she purposely falls asleep on her right side, but during the night she automatically rolls over onto her left side. The resident stated, when she is on her left side the wound is directly on the mattress. When asked if they had provided any device to assist offloading, like a boot to wear in the bed, the resident stated they had not. During a wound care observation with Staff G, the Nurse Practitioner (NP), and the Wound Care Nurse on 04/14/25 at 12:28 PM, Resident #75 mentioned to the NP that when she falls asleep she automatically rolls over onto her left side. The NP stated, We have a fix for that. A foam boot for when you are in bed. During an interview on 04/17/25 at approximately 10:30 AM, Resident #75 was wheeling herself from therapy. When asked if she had received the foam boot to wear in the bed, the resident stated she hadn't seen one. Staff I, Certified Nursing Assistant (CNA), for Resident #75 was nearby and was asked if she had seen any foam boot for Resident #75 to use while in bed. The CNA stated she had not, but that the resident was usually up by the time she arrived. An observation in the resident's room with the CNA lacked any foam boot. During an interview on 04/17/25 at 10:39 AM, the Unit Manager stated she was unaware of any foam boot for Resident #75. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/25 at 2:50 PM, when asked about the provision of a foam boot for Resident #75, the Wound Care Nurse stated the NP had not entered an order for the boot. The Wound Care Nurse stated he did not hear the conversation between the NP and Resident #75 during the observed wound care. 39167 2. Review of the clinical records revealed Resident #82 was admitted to the facility on [DATE], with diagnoses that included orthostatic hypotension and fractures. The care plan, revised on 01/16/25, noted that Resident #82 had experienced falls and was at risk for further falls due to hypotension, an unsteady gait, and poor balance. Additional clinical records documented that Resident #82 had falls on the following dates: January 10, 2025; January 15, 2025; January 26, 2025; January 31, 2025; February 5, 2025; and February 13, 2025. Review of the physician's order dated 01/28/25 prescribed the administration of Midodrine 10 mg by mouth every 8 hours for low blood pressure, with a directive to hold the medication if the blood pressure exceeded 130. In the April 2025 medication and treatment administration records, it was indicated that Midodrine 10 mg was administered outside of the recommended parameters, on 04/04/25, at 6 AM, the blood pressure was recorded at 137/78, and on 04/05/25, the blood pressure was 137/72, yet the medication was still documented as administered to the resident. On 04/18/25, at 9:01 AM, an interview and a side-by-side review of Resident #82's record was conducted with the Director of Nursing (DON). The DON acknowledged the findings and agreed that Midodrine should have been withheld on those days.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on record review and interview, the facility failed to ensure appropriate and timely administration of antibiotics for 1 of 1 sampled resident, Resident #86, who had a Urinary Tract Infection (UTI). The resident was subsequently admitted to the hospital and returned to the facility with the diagnosis of sepsis secondary to the UTI, with additional orders for intravenous (IV) antibiotics. The findings included: Review of the record revealed Resident #86 was admitted to the facility on [DATE]. Urine for a urinalysis was collected by staff at the facility on 03/24/25 and the results were reported to the facility on [DATE] as positive for a Urinary Tract Infection (UTI). The culture was attached to this report and indicated, in part, that the bacteria was resistant to Cipro, an antibiotic often used to treat a UTI. This urinalysis report was not signed off as having been reviewed. Review of the orders revealed Cipro was ordered to be administered twice daily for the UTI as of 03/31/25, five days after the urinalysis report. The progress notes lacked any reference to the UTI or the use of Cipro. Record review revealed Resident #86 was sent out to the hospital on 04/01/25 related to a fever and decreased intake. The resident returned to the facility on [DATE]. The resident was treated in the hospital for sepsis secondary to the UTI. A care plan initiated on 04/09/25, upon return from the hospital, documented Resident #86 had an infection of sepsis with ESBL (extended-spectrum beta-lactamase/a multi-drug resistant organism) and E. Coli (Escherichia coli/a bacteria found in the intestines) bacteremia (bacteria in the bloodstream). Current physician orders included the intravenous (IV) administration of Ertapenem, an antibiotic, for E. coli in the blood. An interview was conducted on 04/17/25 at 11:24 AM with the Unit Manager and Director of Nursing (DON). When asked the process for reviewing lab results, the Unit Manager explained the nurses should notify the provider of any lab results, and the provider should review and check review on the lab result or document in a progress note. During a side-by-side review of the record the Unit Manager agreed the urinalysis was not marked as reviewed. The Unit Manager stated, I think he (Resident #86) was already on an antibiotic. The Unit Manager reviewed the record and stated the resident was started on Cipro on 03/31/25. When asked if the Cipro was an appropriate antibiotic to treat the infection, the Unit Manager was unsure. Review by the DON confirmed the bacteria identified was resistant to Cipro. The managers confirmed Resident #86 was treated for sepsis at the hospital.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51137 Based on observation, interview and record review, the facility failed to identify and treat pain appropriately for 4 of 4 sampled residents, as evidenced by failure to identify and treat pain for Resident #60; failure to ensure pain medication availability for Resident #84; failure to ensure appropriate indication of use of medication for Resident #86; and failure to ensure pre and post assessment for PRN (as needed) pain medication for Resident #151. The findings included: Review of the policy titled, Standards and Guidelines: Pain Evaluation and Management, issued 7/2020 and revised 2/2024, documented, Guideline: Pain Management is defined as a process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. Pain management is a multidisciplinary care process acute pain (or significant worsening of chronic pain) should be evaluated upon onset and re-evaluated as indicated until relief is obtained. For stable chronic pain the resident's pain and consequences of pain are evaluated at least daily .Recognize Pain: 1. Observe the resident (during rest and movement) for physiological and behavioral (non-verbal) signs of pain. 2. Observe for possible psychological signs of pain .5. Review the medication administration record to determine how often the individual requests and receives PRN pain medication, and to what extent the administered medications relieve the resident's pain .Evaluating Pain: 2. Evaluate pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level .3. Discuss with the resident (or legal representative) his or her goals for pain management and satisfaction with current level of pain control .Identifying the cause of pain: 1, Review the MDS(Minimum Data Set) and other documentations for indications of the onset or worsening of pain symptoms .Implementing Pain Management Strategies: 3. The physician and staff will establish a treatment plan consistent with residents condition to ensure pain management is adequate, adjustments may be made as necessary. 1. Review of the record revealed Resident #60 was last admitted [DATE] with a primary diagnosis of chronic obstructive pulmonary disease (a lung disease that makes it difficult to breathe.) Resident #60 was actively receiving hemodialysis (a treatment to filter wastes and fluids from the blood as the kidneys did when they were healthy.) Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #60 had a Brief Interview for Mental Status (BIMS) score of 9, on a 0 to 15 scale, indicating the resident was moderately cognitively impaired. Review of the last wound evaluation dated 10/21/24 documented a right diabetic wound that was being treated at that time. Review of the current weekly skin check dated 04/12/25 document no new skin issues. Review of the active orders revealed an order Monitor resident for pain every shift: Start Date 07/17/24. Review of the Treatment Administration Record (TAR) for all of March 2025 and April 2025 revealed documentation of a 0 pain level on a 0-10 scale: 0 being no pain and 10 being the worst pain. Further review of the active orders revealed there was no pain medication for Resident #60. The last documented pain medication that was ordered was Tramadol 50 mg by mouth every 8 hours as needed for pain for a total of 14 days from 02/27/25 to 03/13/25. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the current care plan dated 03/05/2025 documented, the resident has pain and/or is at risk for pain related to and general pains, arthritis. Interventions included: Administer analgesia medication as per orders; Evaluate the effectiveness of pain interventions and notify physician if interventions are unsuccessful; Monitor/record pain level as indicated. This same care plan documented, The resident has an alteration in musculoskeletal status related to arthritis. Goal: The resident will remain free from pain or at a level of discomfort acceptable to the resident through the review date. Interventions: Monitor for signs and symptoms (s/s) of pain and administer medications as ordered; Notify Medical Doctor (MD) if resident expresses or shows s/s of inadequate pain control and/or adverse side effects with current regimen; Monitor/document/report PRN s/s or complications related to arthritis: Joint pain; joint stiffness, usually worse on wakening; Swelling; Decline in mobility . During an interview conducted in Spanish on 04/14/25 at 11:26 AM, Resident #60 complained of right heel pain rated a 10. Resident #60 stated that for approximately 2 months she had told staff many times about her pain, but nothing had been done about it. During a follow up interview on 04/16/25 at 8:57 AM, Resident #60 stated she was in dialysis yesterday. When asked If she was in pain yesterday, she stated yes and today as well, I'm in pain every day. When asked how she communicated with staff, Resident #60 stated I just speak but they don't speak Spanish. Resident #60 stated it was very hard to not be able to communicate with staff. When I tell them I'm in pain, they don't understand me. When asked if any kind of pain assessment was done by the nurses taking care of her, Resident #60 stated No, I tell them my heel hurts when they get me up to the wheelchair; since they don't understand me, they still get me up and I just have to deal with the pain. Resident #60 consented to have a skin check observation on 04/16/25 at 9:09 AM with Staff J, Certified Nursing Assistant (CNA). When Staff J removed the resident's sock she expressed pain. A healed wound was observed at the bottom of her right heel. Resident #60 also expressed pain when Staff J reapplied the sock back on her foot. An interview was conducted on 04/16/25 at 9:15AM with the Director of Nursing (DON) addressing the concerns regarding Resident #60's language barrier affecting her pain levels. When asked how many staff was available to speak Spanish, the DON stated she spoke Spanish herself but would get a list of Spanish speaking staff from Human Resources. This information was never provided to the surveyor. The DON stated she thought the resident spoke English. When asked what staff should normally do when a resident has a language barrier, the DON stated that the facility has a language line available they could use. Photographic Evidence Obtained. The DON reviewed the resident's current orders and stated that she thought the resident had pain medication ordered and agreed there were no active orders after review. During a phone interview on 04/16/25 at 10:01 AM, when asked about Resident #60's pain, the representative believed it was an arthritic pain and acknowledged being aware that the resident still complained of right heel pain and not wanting to get up due to the pain. 25404 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the record revealed Resident #84 was admitted to the facility on [DATE] with diagnosis to include a right leg fracture. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented that the resident had a Brief Interview of Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. Review of the current physician orders documented that the resident should be administered Oxycodone 5 mg every 6 hours for pain. Review of the current care plan initiated on 03/14/25 documented that the resident had pain related to a right leg fracture. An intervention included to administer analgesia (pain) medication as per orders. During an interview on 04/16/25 at 5:11 PM, Resident #84 voiced concern with the availability of his pain medication, stating that a week ago the facility ran out of his Oxycodone for about 4 or 5 days, and they had run out again that morning. Review of the April 2025 Medication Administration Record (MAR) revealed the Oxycodone was scheduled for midnight, 6 AM, 12 noon, and 6 PM. This MAR revealed the Oxycodone was not administered because it was on order from the pharmacy on the following dates: a) On 04/02/25 at midnight. b) On 04/02/25 at 6 AM. c) On 04/02/25 at 6 PM. d) On 04/03/25 at 12 noon. e) on 04/04/25 at midnight. During an interview on 04/17/25 at 9:48 AM, Staff F, nurse practitioner (NP) for pain management, stated she was unaware of any issue at the beginning of the month. The NP stated she usually orders the pain medication a week at a time. Staff F volunteered that sometimes the pharmacy would only dispense a certain amount of the medication, and she was unsure as to why. During an interview on 04/17/25 at 10:46 AM, the Director of Nursing (DON) stated there was a delivery of Oxycodone for Resident #84 on 03/26/25, that lasted until 04/01/25. The DON stated it then took until 04/04/25 to get another prescription filled. When asked why it took three days to get another prescription, the DON was unsure. During a subsequent interview on 04/17/25 at 1:28 PM, the DON stated she spoke with pharmacy who explained they did not receive the prescription for the refill until 04/03/25, and that there were three tablets available for use out of the facility's emergency supply. The DON also explained that on 04/02/25 the nurse at midnight and 6 AM was unable to access the emergency system. On 04/02/25 at 6 PM and on 04/03/25 at 12 noon, the nurse was awaiting a code from the pharmacy. The DON agreed with the concerns. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the record revealed Resident #86 was admitted to the facility on [DATE]. Review of the current MDS assessment dated [DATE] documented the resident had a BIMS score of 10, indicating he had moderate cognitive impairment. A care plan initiated on 02/27/25 and revised on 04/09/25 documented the resident had pain related in part related to neck and right shoulder pain. Review of a progress note by Staff F, Pain Management NP, documented Resident #86 had been having headaches that she felt were related to his neck pain. The NP ordered Tizanidine, which she documented could also help relieve migraines. Review of subsequent orders revealed the NP ordered the Tizanidine on 04/08/25 for neck pain and on 04/09/25 for muscle spasms. During an interview on 04/14/25 at 11:11 AM, Resident #86 stated he asked the nurse for his migraine medication that morning and the nurse told him she could not find it. During an interview on 04/17/25 at 9:44 AM, when asked what she had prescribed for the migraine headaches for Resident #86, Staff F, NP, stated the Tizanidine, as she thought it was related to his neck pain. When asked how a nurse would know what to give for his complaint of a migraine, the NP stated by the order. During a side-by-side review of the record, the NP agreed the Tizanidine was not ordered for migraines. During an interview on 04/17/25 at about 10:30 AM, when asked what Resident #86 was getting for his migraine headaches, the Unit Manager was unaware. When asked how a nurse would know what to give a resident for a specific complaint, the Unit Manager stated by the order. 4. Review of the policy, titled, Pain Evaluation and Management, revised 02/2024, documented, in part, Evaluation Pain: . 2. Evaluate pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level. Review of the record revealed Resident #151 was admitted to the facility on [DATE] with diagnoses to include Endocarditis (infection of the heart) and multiple fractures. Review of the BIMS assessment dated [DATE], documented the resident was cognitively intact with a BIMS score of 15. Review of the current orders revealed the resident could have Oxycodone 10 mg every 4 hours as needed for pain. During an interview on 04/14/25 at 10:35 AM, Resident #151 stated he had a back fracture and a messed-up hip, but he was at the facility for intravenous (IV) antibiotics for an infection in his heart, before they could do surgery. The resident stated they messed up his pain medications for three days when he was first admitted to the facility. The resident stated now he has to fight for his pain meds. Resident #151 explained he has pain medications available every 4 hours as needed, and if he gets it about every 4 hours, he can maintain comfort. The resident explained that staff are not always available when it's time for his pain medication. The resident stated that one nurse told him she was going to cut him back on his pain medication. When asked if the nurses were reassessing his pain level after the administration of his medication, Resident #151 stated rarely, if ever. Review of the April 2025 MAR revealed an order was placed for the pain medication to start on 04/02/25 but was not administered until 04/03/25 at 12:32 PM. This same MAR documented with nearly every administration that the pain medication was effective. During a subsequent interview on 04/17/25 at 10:57 AM, when asked if the nurses were assessing his pain level before and after the medication, the resident again stated, rarely.

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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** 25404 Based on record review and interview, the facility failed to ensure appropriate drug regimen reviews for 2 of 5 sampled residents as evidenced by the failure to follow pharmacy recommendations for Resident #151, and failure to provide rationale for physician disagreement in a pharmacy recommendation for Resident #70. The findings included: 1. Review of the record revealed Resident #151 was admitted to the facility on [DATE]. Review of the Brief Interview for Mental Status (BIMS) assessment dated [DATE], documented the resident was cognitively intact with a score of 15. Review of the pharmacy recommendation dated 04/03/25 documented the resident was recently started on a Nicotine patch 14 mg for smoking cessation without a stop date. This pharmacy review recommended to taper to 7 mg after 6 weeks, and to evaluate and add order to discontinue the order in 6 weeks, then start 7 mg for 2 weeks, then discontinue. The physician agreed with the recommendation. Review of the current orders documented the resident was receiving a 7 mg Nicotine transdermal patch daily for smoking cessation. This order was initiated on 04/13/25 for 14 days. Further review of the physician orders revealed Resident #151 was on the 14 mg transdermal patch from 04/02/25 through 04/07/25, instead of the recommended 6 weeks. During an interview on 04/17/25 at 10:57 AM, Resident #151 stated he was not informed the Nicotine patch had been decreased. During an interview on 04/17/25 at 10:59 AM, the B-Unit Manager explained the nurse practitioners put in the new orders themselves, after a pharmacy recommendation that they or the physician agree to. The B-Unit Manager stated she had to confirm orders in the computer, but did not have access to the recommendations. 52127 2. Review of the record revealed Resident #70 was admitted on [DATE]. Further review of the record revealed a physician order dated 01/30/25 for Resident #70 for Seroquel (an antipsychotic medication) Oral Tablet 25 MG (milligrams)to be given 1 tablet by mouth at bedtime for a mood disorder. Review of the MRR [Medication Regimen Review] dated 03/01/25 had pharmacist recommendations that Resident #70 was receiving Seroquel and the pharmacist was unable to locate recent documentation of current need/effect and ability or lack of ability to taper current dose in chart and to have the prescriber please address. The prescriber response on the MRR was checked off as disagreed without a reason stated. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/25 at 12:33 PM, Staff C, A-Unit Manager, revealed that during a phone conversation on 03/07/25 with the prescriber, she told the prescriber that Resident #70 was observed to be exit seeking on 03/03/25. The prescriber then relayed to Staff C that no changes would be made to Resident #70 dose of Seroquel, but Staff C did not document the reason on the MRR form or the medical record. Staff C agreed that she had signed the form on 03/07/25 after her conversation with the provider and that this information was not added to the MRR form but it should have been.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39167 Based on observation and interview, the facility failed to secure medications in 1 of 5 medication carts B unit, and ensure medication was not found at the bedside for Resident#11. The findings included: On 04/14/25, at 11:05 AM, the surveyor observed a cup of pills on the bedside of Resident #11. One pill was yellow and oval, while the other was round and white. During an interview at 11:10 AM the same day, the surveyor asked Staff K, Licensed Practical Nurse (LPN), to check the room. She acknowledged the presence of the pills on the table. She explained that the yellow pill was Protonix, used for gastroesophageal reflux disease, and the white pill was Amlodipine, prescribed for hypertension. On 04/17/2025, at 9:07 AM, the medication cart in Unit B was found in front of room [ROOM NUMBER], with the drawers facing the room. The cart was left unlocked and unattended. The surveyor stood by the cart for about 3-5 minutes to monitor it. During this time, a nurse was observed exiting from another room across the hallway. On 04/18/25, at 8:35 AM, the same medication cart in Unit B was again observed to be unlocked and unattended by the same nurse. The Regional Nurse Consultant was called over, and the surveyor pointed out the unlocked cart. The Regional Nurse Consultant acknowledged the issue.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 25404 Based on observation, menu review, and interview, the facility failed to follow the menu for 1 of 2 observed meals (lunch on 04/16/25) affecting 96 of 99 resident who consume food orally. The findings included: Review of the menu for the lunch meal on 04/16/25 documented the following menu items. The following observations were made on the tray line in the kitchen on 04/16/25 beginning at 11:30 AM: a) The menu for the regular Philly Beef sandwich was documented to include a cheese sauce made with a cheese sauce mix and hot water. The observed sandwiches, prepared by the cook for the regular and mechanical soft diets, was topped with shredded cheese. b) The menu for the regular lunch meal was to contain a parsley sprig for garnish. The cook added finely chopped parsley to the top of the sandwich. c) The menu for the mechanically altered Philly Beef sandwich was to contain the same cheese sauce as the regular texture, along with a parsley sprig. The cook prepared the sandwiches for this diet with shredded cheese and finely chopped parsley. d) The menu for the pureed Philly Beef sandwich was to include pureed bread, cheese sauce, and powdered parsley. The cook failed to make the cheese sauce and pureed bread. There was no powdered parsley. During an interview on 04/16/25 at 12:42 PM, Staff H, Dietary [NAME] stated he forgot to make the pureed bread. When asked about the cheese sauce, the Certified Dietary Manager (CDM) stated the residents did not like the canned cheese sauce. When asked about the cheese sauce mix to make a cheese sauce, the CDM stated he did not try to obtain that item.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 25404 Based on observation and interview, the facility failed to ensure the form of food met the needs of residents who consume pureed and mechanical soft foods for 1 of 2 meals observed (lunch on 04/16/25), affecting sampled Residents #69, #31, #82, and #30 who consume pureed foods, and affecting sampled Residents #59, #2, #73, #12, and #58 who consume mechanical soft foods. This practice had the potential to affect 12 of 99 residents who consume pureed foods, and 20 of 99 residents who consume mechanical soft foods (20). The findings included: An observation of the lunch meal on 04/16/25 revealed the main entree was a Phili Beef Sandwich. Review of the recipe for the ground meat sandwich revealed the cook was to place the cooked meat into a food processor and process lightly to a coarse consistency. During the observation of the food service line beginning on 04/16/25 at 11:30 AM, the cook had a tray of cooked beef that contained large pieces of meat. The only other meat on the food service line was a pureed meat. Review of the recipe for the pureed meat documented the cook was to place the cooked beef in a food processor and process to a fine consistency. Observation of the pureed meat revealed the pureed meat was not smooth in texture. Upon tasting the pureed meat after the lunch meal service, the meat had a gritty texture. Observation was made of the lunch meal tray line on 04/16/25 at 11:30 AM and the cook prepared all Philly Beef sandwiches for the regular and mechanical soft diets, topped with shredded cheese and finely chopped parsley (not as per menu). The meat for the pureed diets was not processed to a puree form. During an interview on 04/16/25 at 12:42 PM, when asked about the mechanical soft/ground meat for the Phili sandwich, the cook stated he had prepared the regular meat in such a way as it was chopped up for the mechanically altered meal as well. Upon observation of the meat served for both the regular and mechanically altered meal, large chunks of meat, larger than a teaspoon, was noted. Photographic Evidence Obtained. When asked if that meat was coarsely ground, the CDM agreed it was not. When asked about the texture of the pureed meat, the CDM did not agree or disagree.

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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 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** 51137 Based on observation, interview and record review, the facility failed to follow infection control practices for 1 of 5 sampled residents on Enhance Barrier Precaution (EBP) and 3 of 3 sampled residents with Contact Precautions as evidenced by failure to implement Personal Protective Equipment (PPE) and EBP orders for Resident #21 who had a wound; failure to have orders and implement Contact precautions for Residents #2, #86, and #84. The findings included: Review of the policy, titled, Standards and Guidelines: Enhanced Barrier Precautions. issued 03/2024 and revised 05/28/24 documents, Definitions: Enhanced Barrier Precautions (EBP) refers ton infection control intervention designated to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities .Procedure .1.Enhanced Barrier Precautions are used for resident's with any of the following: .b. Wounds and/or indwelling medical devices even if the resident is no known to be colonized with MDRO 2. Examples of MDRO include but are not limited to: . e. Methicillin-resistant Staphylococcus Aureas (MRSA) f. ESBL-producing Enterobacteriaceae 3. Contact Precautions should be used when a resident has an active MDRO infection such as a urinary tract infection or infected wound . 9. Appropriate PPE for EBP would include: a. gowns b. gloves .15. EBP should remain in place for the duration of the resident's stay or until the resolution of the wound . Review of the policy, titled, Isolation-Categories of Transmission-Based Precautions, revised 01/2012, documented, in part, 1 .Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others . Contact Precautions 1. In addition to Standard Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment .5. Gown: a. Wear a disposable gown upon entering the Contact Precautions room or cubicle .8. Signs- The facility will implement a system to alert staff to the type of precaution resident requires a. This facility utilizes the following system for identification of Contact Precautions for staff and visitors: (left blank) b. The facility will also ensure that the resident's care plan and care specialist communication system indicates the type of precautions implemented for the resident. 1. Review of the record revealed Resident #21 was last admitted to the facility on [DATE] with a primary diagnosis of acute osteomyelitis, left ankle and foot (a bone infection, typically caused by bacteria.) Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #21 had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. Review of a wound evaluation from 04/14/25 documented the resident had a right lateral arterial wound that was currently being treated. (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 current orders revealed Resident #21 had an order of Cipro Oral Tablet 500 MG (Ciprofloxacin HCl) Give 1 tablet by mouth two times a day for wound infection for 7 Days active from 04/12/25 9:00AM and ending 04/19/25. Resident #21 also had an order of an external ointment and a wound care treatment order with dressing changes daily and as needed. Observations were conducted on 04/14/25 at 10:56 AM, 04/15/25 at 8:49 AM, and 04/16/25 at 8:41 AM, and no Enhanced Barrier Precautions (EBP) sign or Personnel Protective Equipment (PPE) was observed outside or inside Resident #21's room. During an interview on 04/16/25 at 9:30 AM, when asked if Resident #21 should have an EBP order with PPE, the Infection Preventionist confirmed the resident should have had those orders and PPE in place. Follow up observations were conducted after the Infection Preventionist interview on 04/16/25 at 1:08 PM, 04/16/25 at 2:55 PM, and 04/17/25 at 9:23 AM, and there was still no EBP sign or PPE placed for Resident #21. 2. Review of the record revealed Resident #2 was last admitted to the facility 0n 04/06/25 with a diagnosis of sepsis' (a serious condition in which the body responds improperly to an infection.) Review of the electronic medical records revealed he had ESBL (extended spectrum beta-lactamase) in the wound with a current wound treatment in place. During an observation on 04/15/25 at 11:43AM, a Contact Precaution sign was observed on his door. Review of his active orders did not reveal any Contact Precaution orders. During an interview on 04/16/25 at 9:30 AM, when asked if Resident #2 should have had a Contact Precaution order, the Infection Preventionist confirmed the resident should have had an order in place. 3. Review of the record revealed Resident #86 was last admitted to the facility 04/8/25 with a primary diagnosis of Multiple Sclerosis (a disease that causes breakdown of the protective covering of nerves). Review of Resident #86's care plan dated 02/27/25 documented, The resident has infection: Sepsis with ESBL E [Escherichia] Coli Bacteremia. Goal: Implement and follow transmission based precautions per physician orders. Review of the active orders did not reveal any current Contact Precaution orders. During an interview on 04/17/25 at 9:48 AM, when asked if Resident #86 should have Contact Precaution orders, the Infection Preventionist agreed Resident #86 should have had those orders. 4. Review of the record revealed Resident #84 was admitted to the facility 03/13/25. Review of the diagnoses revealed a diagnosis of methicillin resistant staphylococcus aureus infection [MRSA], unspecified site - MRSA in right knee, thigh, and blood. Acute infections - 3/13/2025 -Diagnosis #01. (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 Resident #84's care plan dated 03/14/25 documented, The resident has infection: cellulitis and MRSA to right knee, thigh, and blood. Goal: Implement and follow transmission based precautions per physician orders. Review of the current orders revealed an EBP order and no Contact Precaution orders. During an observation on 04/17/25 at 2:17 PM, only an EBP sign with PPE was observed at the residents room. A follow up interview with the Infection Preventionist was conducted on 04/17/25 at 2:57 PM who was made aware Resident #86 did not have a Contact Precaution order. The Infection Preventionist agreed with all findings.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on record review and interview, the facility failed to administer intravenous (IV) antibiotics timely for 1 of 1 sampled resident, Resident #151. The findings included: Review of the policy, titled, Medication Administration revised 01/2024 documented, in part, 6. Medications are administered within one (1) hour before or after their prescribed time, unless otherwise specified (for example, before and after meal orders, at bedtime). Review of the record revealed Resident #151 was admitted to the facility on [DATE] with diagnosis to include Endocarditis (infection of the heart) and multiple fractures. Review of the Brief Interview for Mental Status (BIMS) assessment dated [DATE], documented the resident was cognitively intact with a score of 15. Review of the current orders documented Resident #151 was to be administered 'ceftriaxone 2 grams intravenously (IV) every 12 hours for Endocarditis for 38 Days'. During an interview on 04/14/25 at 10:44 AM, Resident #151 explained he was on an IV antibiotic for his heart infection, and further stated he should be getting the IV every 12 hours, but the staff were not consistent, and the administration of the medication varied by several hours. Review of the Medication Administration Record (MAR) for the month of April 2025, with the nurses time-stamped administration revealed the following: a) The 8 AM dose of ceftriaxone on 04/03/25 was administered at 12:48 PM. b) The 8 AM dose of ceftriaxone on 04/05/25 was administered at 11:22 AM. c) The 8 AM dose of ceftriaxone on 04/06/25 was administered at 11:07 AM. d) The 8 AM dose of ceftriaxone on 04/07/25 was administered at 10:24 AM. e) The 8 AM dose of ceftriaxone on 04/08/25 was administered at 10:00 AM. f) The 8 AM dose of ceftriaxone on 04/09/25 was administered at 11:20 AM. g) The 8 AM dose of ceftriaxone on 04/10/25 was administered at 12:17 PM. h) The 8 AM dose of ceftriaxone on 04/12/25 was administered at 9:11 AM. i) The 8 AM dose of ceftriaxone on 04/13/25 was administered at 9:21 AM. j) The 8 AM dose of ceftriaxone on 04/14/25 was administered at 10:17 AM. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	k) The 8 AM dose of ceftriaxone on 04/15/25 was administered at 11:16 AM. l) The 8 PM dose of ceftriaxone on 04/02/25 was administered at 9:48 PM. m) The 8 PM dose of ceftriaxone on 04/05/25 was administered at 11:38 PM. n) The 8 PM dose of ceftriaxone on 04/11/25 was administered at 9:39 PM. o) The 8 PM dose of ceftriaxone on 04/12/25 was administered at 9:37 PM. p) The 8 PM dose of ceftriaxone on 04/13/25 was administered at 9:48 PM. q) The 8 PM dose of ceftriaxone on 04/14/25 was administered at 9:31 PM. During an interview on 04/17/25 in the morning, the Director of Nursing (DON) agreed with the findings.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51137 Based on interview and record review, the facility failed to provide the pneumococcal immunization for a resident with signed consent for 1 of 5 sampled residents, Resident #24. The findings included: Review of the policy, titled, Standards and Guidelines: Immunizations-Pneumonia, issued 07/2020 and revised 02/2024, documented: 1. Upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated 2. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission .4. Pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given, or refused) in accordance with Centers for Disease Control (CDC) guidelines .6 Residents who decline the vaccine will be educated on the benefits of the vaccine and the safety protocols. Residents who decline the vaccine may elect to revoke declination at any time and consent to the vaccine. They facility will continue to offer the vaccine to residents who decline as part of ongoing education and promotion of health . Review of the record revealed the resident had a re-entry admission of 03/24/25. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #24 had a Brief Interview for Mental Status (BIMS) score of 12, on a 0 to 15 scale, indicating the resident was moderately cognitively impaired. Review of the electronic medical record revealed the resident refused the pneumococcal vaccine. Review of the uploaded documents revealed an informed consent signed by the Resident for the pneumococcal vaccine dated 03/24/25, photographic evidence obtained. During an interview on 04/16/25 at 9:30 AM when asked why the electronic medical record showed Resident #24 refused the pneumococcal vaccine but also had an uploaded informed consent to the same vaccine, the Infection Preventionist stated she would find out what happened. During a follow up interview on 04/16/25 at 11:00 AM, the Infection Preventionist stated that Resident #24 should have received the vaccine. She stated she followed up with the resident who confirmed wanting the vaccine still. The Infection Preventionist stated having to verify if the resident received the vaccine on the Florida Shot Finders website which she stated she didn't have access to. The Infection Preventionist never followed up with the surveyor on Resident #24's vaccine status.