

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Cypress Cove Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 SE Dr Martin Luther Jr Ave Crystal River, FL 34429	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>50695</p> <p>Based on interview and record review the facility failed to administered physician ordered medications in accordance with professional standards for 2 of 6 residents, Residents #10 and #18, reviewed for medication administration.</p> <p>Findings include:</p> <p>Review of Resident #10's Medication Administration Record (MAR) for November of 2024, the physician's order read, Insulin Glargine Subcutaneous Solution: 100 UNIT/ML (Insulin Glargine) Inject 12 unit subcutaneously at bedtime for diabetes mellites (DM). Start Date 09/19/2024 9:00 PM (2100).</p> <p>Review of Resident #10's physician orders did not provide parameters to hold the Glargine long-acting insulin.</p> <p>Review of the Resident #10's MAR for November 2024 documented the physician ordered Glargine Insulin was held on 11/15/2024 and 11/17/2024 and documented 4: Vitals outside of parameters for administration.</p> <p>Review of Resident #10's Care Plan documented Focus Area - [Resident #10's name] has a physician's order for insulin or hypoglycemic r/t [related to] DM. Goal - Resident will be free of adverse drug reactions from insulin administration through the next review date. Interventions - administer insulin as ordered. Monitor/document for side effects and effectiveness. Monitor and report blood glucose levels per physician's order. Date Initiated: 09/19/2024.</p> <p>Review of Resident #10's Progress Notes did not provide documentation on 11/15/2024 or 11/17/2024 of the blood sugar values at bedtime, notification to the physician when not administering the physician ordered Glargine long-acting insulin, and the reason for not administering the insulin.</p> <p>During an interview on 11/20/2024 at 2:15 PM, the Director of Nursing (DON) stated, For medications that do not have parameters, such as long-acting insulin, the expectation is that if they hold the medication, they notify the doctor.</p> <p>During an interview on 11/21/2024 at 8:40 AM, Physician A stated, I don't recall getting any calls about [Resident #10's name] or giving any orders to hold the long-acting insulin. Usually, we don't hold the long-acting insulin. It's the short-acting [insulin] that's usually the culprit [for dropping blood sugar levels]. If it was just a couple of days, there wouldn't be any significant harm.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/21/2024 at 8:50 AM, Physician B stated, I haven't gotten any calls about [Resident #10's name] insulin, and I did not give any orders to hold her long-acting insulin. If it was held a couple of times, it shouldn't have caused any harm.</p> <p>Review of Resident #18's Medication Administration Record (MAR) for October 2024 documented a physician order which read, Metoprolol Tartrate Tablet 25 MG [milligrams] - Give 1 tablet by mouth two times a day for HTN [hypertension] HOLD for SBP [systolic blood pressure] <110 [less than] OR HR [heart rate] <60 - Start Date 05/23/2020 1700 [5:00 PM]. Review of the documentation of the administration of the Metoprolol documented the medication was held, with a 4: vitals outside of parameters for administration, on 10/19/2024 at 9:00 AM, 10/23/2024 at 5:00 PM, and 10/26/2024 at 9:00 AM. On 10/26/2024 at 5:00 PM documented was 9. 9. Other/See progress notes.</p> <p>Review of Resident #18 vital signs when the medication was held documented on 10/19/2024 the B/P was 110/54; the HR/pulse was 73, dated 10/23/2024 at 4:10 PM B/P 110/50; HR/pulse 88, dated 10/26/2024 at 7:58 AM B/P 110/54; HR/pulse 73 and on 10/26/2024 at 3:33 PM B/P 119/69; HR 76.</p> <p>During an interview on 11/20/2024 at 1:15 PM, Staff C, RN stated, The aids do vital signs at the beginning of the shift. If the blood pressures are low, like with [Resident #18's name] they will let me know. If the reading is off, I will re-take it myself. The certified nursing assistants will tell me all of the vital signs. If [Resident #18's] blood pressure was 112/54 and her pulse rate was 64, I would hold her Metoprolol. I know her and know that she bottoms out. I would check her vital signs again. If it starts getting to be a routine, like three days in a row, I would go ahead and tell the doctor.</p> <p>During an interview on 11/20/2024 at 2:15 PM, the DON stated, The expectation for medications with parameters for metoprolol for example, that would have an order to hold for a [systolic] blood pressure of less than 110, if the blood pressure was below 110, they would hold the medication. If they are holding the medication [outside of the parameters] they will let the doctor know.</p> <p>During an interview on 11/21/2024 at 8:40 AM, Physician A stated, I don't recall getting any calls about [Resident #18's name]. I think we need to do some education with the nurses about Beta Blockers. For Beta Blockers we go with the heart rate, not the systolic blood pressure. We don't hold for B/P, it is the heart rate. If it was just a couple of days, there wouldn't be any significant harm.</p> <p>Review of the policy and procedure titled Medication Administration, last reviewed on 01/17/2024, read, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: . 8. Obtain and record vital signs, when applicable or per physician's orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters . 10. Ensure that the six rights of medication administration are followed: . c. Right dosage . f. Right documentation .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15234</p> <p>Based on observation, interview, and record review the facility failed to ensure food was stored in a safe and sanitary manner in the main kitchen and in 2 of 2 nourishment rooms.</p> <p>Findings include:</p> <p>A tour of the main kitchen was conducted on 11/18/2024 beginning at 9:44 AM with the Certified Dietary Manager. There was a case of individual serving ice cream containers stored below meat products in the meat freezer. There was a plate of thawed nutritional drinks stored in the walk in refrigerator with no thawed on date inscribed on the individual supplement cartons. There was an undated bag of corn and an undated/unlabeled plastic bags of cookies stored in the walk in freezer.</p> <p>During an interview on 11/18/2024 beginning at 9:44 AM, the Certified Dietary Manager confirmed the individual serving ice cream containers should not be stored below meat products. She confirmed all food products should be dated and labeled. She acknowledged there was no thawed on date inscribed on the thawed nutritional supplements.</p> <p>A tour of Nourishment room [ROOM NUMBER] was completed on 11/18/2024 beginning at 9:59 AM with the Certified Dietary Manager. There were brown and black substances spattered on the interior upper surface of the microwave. There were brown and red substances pooled on the bottom of the refrigerator bins.</p> <p>During an interview on 11/18/2024 beginning at 9:59 AM, the Certified Dietary Manager stated the microwave oven and refrigerator bins needed cleaning.</p> <p>A tour of Nourishment room [ROOM NUMBER] was completed on 11/18/2024 beginning at 10:04 AM with the Certified Dietary Manager. There were brown and black substances spattered on the interior upper surface of the microwave. There was a yellow substance pooled on the bottom shelf of the refrigerator.</p> <p>During an interview on 11/18/2024 beginning at 10:04 AM, the Certified Dietary Manager stated the microwave oven and refrigerator needed cleaning.</p> <p>Review of the policy and procedure titled Food Receiving and Storage, last reviewed 1/17/2024, read 1. Food Services, or other designated staff, will maintain clean food storage areas at all times .8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date) .13. Uncooked and raw animal products and fish will be stored separately in drip proof containers and below fruits, vegetables and other ready to eat foods.</p>		