STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105467	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williston Care Center and Rehab	300 NW 1st Ave Williston, FL 32696

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49846 Based on observation and interview, the facility failed to maintain dignity for a resident who needed assistance with feeding for 1 of 6 residents, Resident #5, reviewed for dining. Findings include: During an observation on 3/31/2025 at 2:58 PM Staff D, Certified Nursing Assistant (CNA) was observed standing while feeding Resident #5 at bedside. During an observation on 4/02/2025 at 12:51 PM Staff D, CNA, was standing by Resident #5's bedside feeding Resident #5. During an interview on 4/02/2025 at 12:51 PM Staff D, CNA stated, I have a bad back. The CNA then quickly sat down in the chair that was beside her. During an interview on 4/02/2025 at 12:56 PM Staff C, Unit Manager stated, Staff are supposed to sit while assistive feeding. During an interview on 4/03/2025 at 9:16AM the Director of Nursing (DON) stated, There should be good lighting, set the resident up, and sit down to feed the resident. The policy and procedure were requested for assistive dining. The DON stated she did not have a policy on feeding residents, but the standard of care is for staff to sit at eye level to feed residents.

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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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** 51447 Based on record reviews and interviews, the facility failed to accurately assess the resident status for 3 of 9 residents, Residents #31, #54, and #367) reviewed for accuracy of assessments. Findings include: 1) Review of the annual Minimum Data Set (MDS) dated [DATE] section C for Resident #54 read, BIMS (Brief Interview for Mental Status as a score of 00, indicating severe cognitive impairment. Review of annual Minimum Data Set (MDS) dated [DATE] section J for Resident #54 read, Current tobacco - Yes. During an interview on 4/1/2025 at 4:06 PM Staff H, MDS Nurse stated, The resident [Resident #54] is not a smoker and the documentation in the MDS in section J, was documented in error. 2) Review of the medical diagnosis for Resident #31documented a diagnosis of acute respiratory failure with hypercapnia (a condition where there's an abnormally high level of carbon dioxide in the blood). Review of a physician order for Resident #31 read, Continuous O2 (oxygen) at 3 Liters per Minute (L/min) via NC (nasal canula) q (every) shift. Review of the annual (MDS) dated [DATE] section O for Resident #31 read, oxygen therapy-no. Review of the most recent Care Plan for Resident #31 read, (Resident #31's first name) has a potential for complications of respiratory distress. Interventions: Administer O2 as order. During an interview on 4/3/2025 at 1:20PM Staff G, MDS Nurse, stated, The resident [Resident #31] is on continuous oxygen therapy and the documentation in the MDS in section O, was documented in error. 50695 3) Review of Resident #367's Census Data revealed the Resident was admitted to the facility on [DATE]. Review of Resident #367's medical diagnoses included the following relevant information: Type 2 Diabetes Mellitus without complications; immunodeficiency due to drugs, other fracture of the first lumbar vertebra, subsequent encounter for fracture with routine healing; pyoderma gangrenosum; unspecified protein-calorie malnutrition; rheumatoid arthritis, unspecified; generalized anxiety disorder; brief psychotic disorder; major depressive disorder, single episode, spinal stenosis, lumbar region without neurogenic claudication; fusion of spine, lumbar region; (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #367's MDS Evaluation, dated 3/18/25 documented the following relevant information: Section C: BIMS Score 15, Section I: The resident's primary medical condition category: Metabolic - Diabetes Mellitus (DM) - No, Section N: N0300. Injections - Record the number of days that injections of any type were received during the last 7 days or since admission/entry or reentry if less than 7 days. - 6; N0350. Insulin - A. Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days. - 6 Review of Resident #367's physician orders documented an order dated 3/21/25 at 11:17 PM that read, Insulin Aspart FlexPen 100 unit/ml Solution pen-injector Inject subcutaneously two times a day for DM Notify MD [Medical Doctor] for BS [blood sugar] under 70 or above 450 - Inject as per sliding scale: if 0 - 59 give sugar containing beverage if able or glucagon; 60 - 199 = 0 units; 200 - 224 = 3 units; 225 - 249 = 4 units; 250 - 274 = 5 units; 275 - 299 = 6 units; 300 - 324 = 7 units; 325 - 349 = 8 units; 350 - 374 = 9 units; 375 - 399 = 10 units; 400 - 424 = 11 units; 425 - 449 = 12 units; 450 - 700 = 14 units. Call MD for 450 and above, subcutaneously two times a day for diabetes. During an interview on 4/3/2025 at 10:27 AM, the Director of Nursing (DON) stated she expects to see that residents' Minimum Data Set (MDS), specifically Section I, would document Diabetes Mellitus as an active diagnosis. During an interview on 4/3/2025 at 1:10 PM, Staff G, MDS Coordinator, stated that she would expect to see diabetes documented in Section I and under Section I the resident's primary medical condition category: Metabolic - Diabetes Mellitus (DM) It says 'no,' and it should say, 'yes.' During an interview on 4/3/2025 at approximately 3:30 PM, Staff G, MDS Coordinator stated that they do not have a specific policy related to the completion of MDS Evaluations, that they use the Resident Assessment Instrument (RAI) Manual, and that it has everything they need.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51447 Based on record reviews and interviews, the facility failed to develop and implement a comprehensive person-centered care plan that addressed the residents' medical, physical, mental and psychosocial needs for 4 of 9 residents, Resident numbers #31, #33, #66, and #367, reviewed for comprehensive care plans. Findings include: 1) Review of medical diagnosis for Resident #31 revealed a diagnosis of major depressive disorder, generalized anxiety disorder and persistent mood disorder. Review of the [Name of the organization that provides behavioral health/psychiatric and psychotherapy services] progress note dated 3/19/2025 for Resident #31 read, Chief Complaint: depression, anxiety, insomnia and mood disorder. During an interview on 4/2/2025 at 11:22 AM, APRN (Advanced Practice Registered Nurse) #2 stated, The Resident does have diagnosis and receives treatment for major depressive disorder, generalized anxiety disorder and persistent mood disorder. During an interview on 4/2/2025 at 12:20 PM Resident #31 stated, I have been diagnosed with anxiety and depression for about 12-[AGE] years. Review of Resident #31's care plan did not contain a focused plan of care with goals and interventions related to the resident's diagnosis and treatment of major depressive disorder, generalized anxiety disorder and persistent mood disorder. During an interview on 4/2/2025 at 12:47 PM the DON stated, I am aware of [Resident #31 name] has a diagnosis of major depressive disorder, generalized anxiety disorder and persistent mood disorder and would expect that the resident would be care planned for those diagnosis. 50695 2) Review of Resident #367's Census Data documented the resident was admitted to the facility on [DATE]. Review of Resident #367's medical diagnoses included Type 2 Diabetes Mellitus. Review of Resident #367's physician orders documented an order dated 3/21/25 at 11:17 PM that read, Insulin Aspart FlexPen 100 unit/ml Solution pen-injector Inject subcutaneously two times a day for DM Notify MD [Medical Doctor] for BS [blood sugar] under 70 or above 450 - Inject as per sliding scale: if 0 - 59 give sugar containing beverage if able or glucagon; 60 - 199 = 0 units; 200 - 224 = 3 units; 225 - 249 = 4 units; 250 - 274 = 5 units; 275 - 299 = 6 units; 300 - 324 = 7 units; 325 - 349 = 8 units; 350 - 374 = 9 units; 375 - 399 = 10 units; 400 - 424 = 11 units; 425 - 449 = 12 units; 450 - 700 = 14 units. Call MD for 450 and above, subcutaneously two times a day for diabetes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #367's care plan did not contain a focused plan of care with goals and interventions related to the resident's diagnosis and treatment of Diabetes Mellitus. During an interview on 4/3/25 at 10:27 AM, the Director of Nursing (DON) stated that she expected to see Diabetes Mellitus as an active diagnosis, and be reflected on the resident's care plan. During an interview on 4/3/25 at 1:10 PM, Staff H, Minimum Data Set (MDS) Coordinator stated It's not there [the diagnosis of Diabetes Mellitus]. Somehow, we missed it for [Resident #367's name's] care plan. During an interview on 4/3/25 at 1:12 PM, Staff H, MDS Coordinator stated that a focus, goal, or intervention related to Diabetes Mellitus was not on Resident #367's Care Plan. 46523 3) During an observation on 3/31/2025 at 10:02 AM Staff F Registered Nurse (RN) was speaking to Resident #33 in Spanish. During an interview on 4/1/2025 at 3:56 PM with Staff G, Minimum Data Set (MDS) Coordinator stated, [Resident #33's name] speaks some English but he is not fluent in English. The best language to communicate with him would be Spanish. During an interview on 4/1/2025 at 2:30 PM with Staff C, License Practical Nurse (LPN) Unit Manager stated, In the afternoon [Resident #33's name] is a bit more confused and will reply in Spanish. During an interview on 4/2/2025 at 9:57 AM with Staff D Certified Nursing Assistant (CNA) stated, [Resident #33's name] can speak some English but if we cannot understand him. I will go get a therapist that speaks Spanish or even use a phone that will translate. Review of Resident #33's care plan did not document for focus, goals, or interventions for communication in Spanish. Review of Resident #33's Nursing Admission assessment dated [DATE] read, F. Communication: 1. Communication: g. interpreter needed-foreign language .2. Primary Language: b. Spanish. 4) During an observation on 3/31/25 at 10:02 AM Resident #33 was wandering the hall of the unit and was cleaning the floors with a paper napkin. Resident #33 was repeatedly observed walking the hallway. During an observation on 4/1/2025 at 8:44 AM Resident #33 was cleaning the floor with a white paper napkin. Review of Resident #33's care plan did not document for focus, goals, and interventions related to the resident's behavior of cleaning the unit and collecting trash. During an interview on 4/2/2025 at 11:23 AM with APRN #2 stated, [Resident #33's name] likes to clean and keep active. The behaviors he is having are his preferences and not causing distress to himself or any resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/3/2025 at 9:26 AM the Director of Nursing (DON) stated, [Resident #33's name] overall is helpful and likes to keep busy by picking up trash and cleaning, no negative behaviors. The staff will redirect the residents due to safety. I do not see Resident #33 care plan for these behaviors, and it should be. During an interview on 4/3/2025 at 1:17 PM with Staff G MDS Coordinator stated, I do not see a focus for [Resident #33's name] for interpreter services due to language preferences at times and for his behaviors of cleaning due to safety. 5) Review of Resident #66 progress note dated 3/3/2025 read, Resident signed out of facility and was found at gas station near facility intoxicated. Slurred speech and alcohol smell noted. Review of Resident #66's progress note dated 3/6/2025 read, Resident was out returned to facility drunk. Resident admitted drinking. Review of Resident #66's progress note dated 3/15/2025 read, Resident was out, returned he had been drinking MD [Medical Doctor] called. To hold Pregabalin this evening, as per MD's orders. Review of Resident #66's progress note dated 3/20/2025 read, Resident returned to facility very drunk, slurred speech, walking unsteady, [Medical Doctor #1's name] called, wants meds held. Resident lying in bed at this time. During an interview on 4/2/2025 at 7:41 AM the Director of Nursing stated, [Resident #66's name] for the last month or two has started getting drunk. He is coming back with that haze with that drunk look, and you can kind of smell it but does not bring the alcohol into the facility. We reached out to the doctor, and he addressed it with him. [Resident #66's name] is denying he is drinking. I would expect this behavior to have been care planned. During an interview on 4/2/2025 at 11:21 AM the Advance Practice Registered Nurse #2 stated, The facility notified me that [Resident #66's name] was drinking and has had increased depression. He denied he was drinking, and he did not want to make changes. Resident #66 was not suicidal or raised any concern. I offered psychotherapy and every time he denied issues with drinking. During an interview on 4/3/2025 at 1:18 PM Staff G, MDS Coordinator stated, [Resident #66's name] should be care planned with a focus for his behaviors regarding drinking. I do not see that as part of his focus. Review of the policy and procedure titled Comprehensive Assessments and Care Plans with a last review date of 1/31/2025 read, Standards: It will be the standard of this facility to make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS [Centers for Medicare and Medicaid]. Guidelines: 1. The facility will conduct initially and periodically a comprehensive, accurate standardized reproducible assessment of each resident's functional capacity.

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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. 51447 Based on observations, interviews and record reviews, the facility failed to provide nail care services for dependent residents for 1 of 5 residents, Resident #54, reviewed for activities of daily living (ADL). Findings include: During an observation on 3/31/2025 at 10:05 AM Resident #54 was observed to have a large amount of a brown substance under the fingernails of both of her hands. During an observation on 4/1/2025 at 10:51 AM Resident #54 was observed to have a large amount of a brown substance under the fingernails of both of her hands. During an observation on 4/2/2025 at 9:20 AM Resident #54 was observed to have a large amount of a brown substance under the fingernails of both of her hands. During an interview on 4/2/2025 at 11:12 AM Staff O, Certified Nursing Aide (CNA) stated, Her (Resident #54) nails are dirty and do not look like they have been cleaned recently. During an interview on 4/2/2025 at 12:37 PM the DON (Director of Nursing) stated, My expectations are a dependent resident should have their nails cleaned with their ADL care. Review of medical diagnosis on 4/2/2025 at 2:04 PM for Resident #54 included but not limited to diagnoses of muscle weakness, dementia and osteoarthritis. Review of the annual Minimum Data Set (MDS) section C dated 2/15/2025 for Resident #54 read, Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. Review of the annual MDS section E dated 2/15/2025 for Resident #54 read, Rejection of care - Behavior not exhibited. Review of the annual MDS section GG dated 2/15/2025 for Resident #54 read, that the Resident is dependent for showers/bathing and personal hygiene. Review of Resident #54's Care Plan dated 2/26/2025 read, Focus: [Resident #54's first name] has self-care deficits with dressing, grooming, bathing related to cognitive deficit as a result of dementia. Review of policy and procedure P&P Nail Care dated 4/1/2022 read, Policy: It will be the policy of this facility to provide nail care to residents per resident preference and to maintain dignity. Procedure: 3. Nail care includes regular cleaning and trimming.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 46523 Based on observation, interview and record review the facility failed to ensure it is free of medication errors of five percent or greater for 2 of 33 observations of medication administration, the error rate was 6.06%. Findings include: During an observation on 4/2/2025 at 8:18 AM of Staff B License Practical Nurse (LPN) for Resident #416's medication administration, Staff B removed one tablet of Amiodarone 100 mg (milligrams), one tablet empagliflozin 10 mg, one tablet Ferex 150 plus, half a tablet of spironolactone 12.5 mg, two tablets of Bumex 2mg, one tablet of Eliquis 5 mg, on tablet of Entresto 49-51mg, and one tablet of metoprolol 25 mg placing the medications into a clear medication cup. Staff B entered Resident #416's room and administered all the medications in the medication cup. Staff B returned to the medication cart and signed off the administration of the medications as listed. Review of Resident #416's physician order dated 3/25/2025 read, Amiodarone HCl Tablet 100 mg (Amiodarone HCl) give 200 mg by mouth one time a day for htn [hypertension]. During an interview on 4/3/2025 at 8:24 AM with Staff B LPN stated, I should have given two tablets instead of just one because each tablet is 100 mg and the order reads to give 200 mg. During an interview on 4/3/2025 at 9:00 AM the Director of Nursing (DON) stated, Not giving the correct dosage amount is a medication error and staff would need to contact the doctor because she should have given two tablets instead of one. The admitting nurse copies the orders; calls the doctor who approves or makes changes. Staff are to compare the medication to the medication administration record and do the three checks and compare multiple times and compare it is the right dose and medication. The staff are expected to follow physician orders. During an interview on 4/3/2025 at 10:42 AM Medical Doctor #1 stated, Medication is for rate control. We try to tamper down due to the toxicity of the medication half a dose or even missing one dose will not cause his heart rate to spike. Anytime they do not give a medication, it is a medication error. Nurses should follow the physician orders. During an observation on 4/3/2025 at 8:40 AM Staff E, LPN was administering medication to Resident #67. Staff E, LPN placed one tablet of Vitamin D 1000 unit into a medication cup. Review of Resident #67's physician orders dated 9/4/2024 read, Vitamin D3 Tablet 5000 Units, give 1 tablet by mouth one time a day for supplement. Give w/ [with]1000 iu [international unit] to equal 6000 iu. During an interview on 4/3/2025 at 8:49 AM with Staff E LPN stated, It should be 1000 unit of Vitamin D3 not Vitamin D. We don't use a lot of Vitamin D3 so I was not sure. During an interview on 4/3/2025 at 9:13 AM the DON stated, The nurse should have pulled a Vitamin D3 1000 unit not a vitamin D 1000 unit it is not equivalent. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy and procedure titled Medication Errors with a last review date 1/31/2025 read, Policy: It will be the policy of this facility that the staff and practitioner shall try to prevent medication errors and adverse medication consequences and shall stive to identify and manage them appropriately when they occur. Review of the policy and procedures titled Medication Administration with a last review date of 1/31/2025 read, Policy: It will be the policy of the facility to administer medications in a timely manner and as prescribed by the physician, unless other wised clinically indicated or necessitated by other circumstances such as lack of availability of medication or refusals of medication by resident.

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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. 49846 Based on observations, interviews, and record review the facility failed to ensure drugs and biologicals used in the facility were stored and labeled in accordance with accepted professional principles for 2 of 4 medication carts and 1 of 4 hallways reviewed for unattended medication and labeling. Findings include: 1) During an observation on 3/31/25 at 11:20 AM of Resident #318 it showed the resident had a PICC (peripherally inserted central catheter) line to the upper left arm. There was IV (intravenous) tubing that was not dated and an IV-cefriaxone (used to treat bacterial infections) solution medication bag that was not labeled with the date and time. During an interview on 3/31/2025 at 12:52 PM Staff F, Registered Nurse (RN) stated, The IV tubing hanging from the I/V pole for [Resident #318's name] should have a label with a date and time it was hung. During an interview on 4/03/25 at 09:16 AM the Director of Nursing (DON) stated, Staff should have labeled the medication bag and the IV tubing. Review of the policy and procedure titled IV Infusions with a last review date 1/31/2025 read, 6. Administer IV medications, fluids and flushes per physician orders. Applicable labeling of resident identifier and date(s) of administration should be present on the IV medication and tubing, as is appropriate. 46523 2) During an observation on 3/31/2025 at 10:23 AM with Staff F Registered Nurse (RN) of [NAME] -1 Medication Cart there was one open bottle of glucose strips that did not have an open date and one insulin aspart pen with an expiration date of 3/29. During an interview on 3/31/2025 at 10:27 AM with Staff F stated, Glucose strips should be labeled when opened with an open date and any expired medications should be removed from medication cart and disposed of. 3) During an observation on 3/31/2025 at 10:38 AM with Staff L, License Practical Nurse (LPN) of the Medication Cart North-2 there were three loose medications in the medication drawer and an expired Fluticasone inhalation powder with an expiration date of 3/30. During an interview on 3/31/2025 at 10:39 AM Staff L, LPN stated, There should not be any loose medication in the medication cart if they fall when pouring medication they should be disposed. Any expired medication should not be kept in the mediation cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4) During an observation on 3/31/2025 at 2:00 PM of Resident #51's room it showed the resident was sitting at bedside. On top of the resident's bedside table there was a medication cup containing white powder. During an interview on 3/31/2025 at 2:00 PM Resident #51's spouse stated, The nurses apply that [white powder in the medication cup] to her groin area for redness. 5) During an observation on 4/2/2025 at 4:24 PM with Staff M, RN and Staff N, LPN the medication room on the North wing could be observed. There was a small backpack, a large tumbler, and a large bag containing a coca cola bottle that was visible. During an interview on 4/2/2025 at 4:24 PM Staff N, LPN stated, Medication rooms should not be used to store personal ideas or food. The staff have a staff lounge where they can keep those items. During an interview on 4/3/2025 on 9:17 AM the Director of Nursing stated, When opening glucose strip bottles they should be labeled with an open date. Any expired medication should be disposed and not be in the medication cart. I normally like to remove the medication from the cart a day before expiring because staff might forget and give it. Medication rooms should not store any personal items, no drinks or food and medication should not be left unattended in the room. Review of the policy and procedure titled Medication/Biological Storage with a last review date of 1/31/2025 read, Policy: It will be the policy of this facility to store medications, drugs and biologicals in a safe, secure, and orderly manner. Procedure: 2. The nursing staff shall be responsible for maintaining mediation storage and preparation areas in a clean, safe, and sanitary manner.

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	105467	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williston Care Center and Rehab	300 NW 1st Ave Williston, FL 32696

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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 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. 46523 Based on observation, interview and record review, the facility failed to maintain complete and accurately documented medical records for 1 of 6 residents, Resident #66 reviewed for medication review and 1 of 3 residents, Resident #31 reviewed for weights. Findings include: 1) Review of Resident #66's physician order dated 3/1/2025 read, Insulin Apart FlexPen 100 unit/ml [100 unit per milliliter] solution pen-injector inject as per sliding scale. Review of Resident #66 Medication Administration Record for the month of March 2025 documented Insulin Apart at 0630 [6:30 AM] on 3/27/2025 was blank, at 1630 [4:30PM] on 3/15/2025 and 3/28/2025 the entry was blank, on 3/12/2025 at 2100 [9:00 PM] the entry was blank, and no blood sugar levels or insulin coverage was documented. Review of Resident #66's progress note dated 3/28/2025 read, Resident went out today. Returned drunk slurred speech, unsteady gait. Meds held per md's [Medical Doctor's] orders. Review of Resident #66 Release of Responsibility for leave of absence form documented on 3/15/2025 at 2:04 PM Resident #66 signed himself out of the facility and returned on 3/15/2025 at 6:51 PM. During an interview on 4/1/2025 at 4:30 PM Staff P, Licensed Practical Nurse (LPN) stated, [Resident #66's name] came back to the facility and he had been drinking. I contacted the provider, and he said to hold Resident #66's medications. On 3/12/2025 I think I was not able to wake him up and I called the provider. I should have documented something in the progress notes I don't know if I did. I should have also coded the medication record accordingly instead of leaving it blank. During an interview on 4/1/2025 at 4:47 PM Staff Q, LPN stated, When I work with [Resident #66's name] he always gets his insulin. I do not know why the entry for 3/7/2025 is blank, it might not have saved, but I always give him his insulin. During an interview on 4/1/2025 at 4:42 PM Medical Doctor #1 stated, Nursing staff have contacted me when [Resident #66's name] has come back to the facility and they suspect he is intoxicated. I expect nurses to do blood sugars if they are able to. I do not think it is critical if they are not able to check his blood sugars. During an interview on 4/2/2025 at 7:45 AM the Director of Nursing stated, [Resident #66's name] had signed out on 3/15/2025 during the time of administration. The nursing staff are expected to accurately document on the medication record and use the appropriate code. The nurse should not leave blank entries on the medication record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy and procedure titled Charting and Documentation with a last review date of 1/31/2025 read, Policy: It is the policy of this facility that services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's clinical record as is needed. Procedures: 1. Observations, medication administration, services performed, ect., should be documented in the resident's clinical records. 51447 2) Review of the medical diagnosis for Resident #31 documented a diagnosis of diastolic (congestive) heart failure. Review of Resident #31's physician order dated 10/21/2024 read, Check weight every other day related to diastolic heat failure. Review of documented weights for March 2025 for Resident #31, did not contain documentation for weights on the following days, March 10, 12, 16, 18, 20 and 24. During an interview on 4/2/2025 at 3:24 PM Staff K, Certified Nursing Assistant (CNA) stated, I recall having (Resident #31's name) and weighing her but I must of forgot to document it. During an interview on 4/2/2025 at 12:47 PM the DON stated, My expectations are that the CNA's would weigh the residents as order.

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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. 46523 Based on observation, interview and record review the facility failed to prevent the possible spread of infection for failing to perform hand hygiene for 2 of 7 residents, Residents #15 and #29, reviewed activities of daily living and for 1 of 7 residents, Resident #416, reviewed during medication administration. Findings include: 1) During an observation on 4/2/2025 at 8:03 AM Staff B License Practical Nurse (LPN) did not perform hand hygiene and began to retrieve Resident #416's ceftazidime (used to treat bacterial infections) intravenous solution, normal saline flush, alcohol wipes and IV (intravenous) tubing. Staff B, LPN did not perform hand hygiene, donned a gown, gloves, and entered Resident #416's room. Staff B, LPN placed the supplies on the resident's bedside tablet without sanitizing or placing a barrier on the table, opened the IV tubing bag, untangled the tubing, removed a blue cover top from the connector site of the IV tube placing the cap on top of Resident #416's bedside table. Staff B, LPN connected the tubing to the IV medication bag and primed the tubing (to fill the tubing with fluid to remove the air bubbles). Staff B, LPN reconnected the cap to the end of the tubing. Staff B, LPN removed the Curos cap (a single-use device containing a foam pad impregnated with 70% isopropyl alcohol) from Resident # 416 needleless connector and proceeded to connect the IV tubing to the needless connector. During an interview on 4/2/22025 at 8:18 AM Staff B, LPN stated, I should have done hand hygiene before starting to remove the medication from the medication cart. I also should have placed a barrier on top of [Resident #416's name] bedside table and sanitized the tubing before connecting it to the Residents PICC [peripherally inserted central catheter) line. During an interview on 4/02/2025 at 9:24 AM the Director of Nursing stated, Typically when you pull the medication you will document immediately when you come out of the room and not prior to because they might refuse. The medication should be given an hour before and hour after. She should have done hand hygiene and she should have had a barrier down and sanitize and cleaned with alcohol. Review of the policy and procedure titled Hand Hygiene with a last review date of 1/31/2025 read, Policy: This facility considers hand hygiene the primary means to prevent the spread of infections. Procedure: 5. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; e. Before and after handling an invasive device (e.g. urinary catheters, IV access sites). 50695 2) During an observation on 3/31/25 at 9:55 AM, Resident #29 was lying in a bariatric bed; dressed in a hospital gown and wearing a brief. Both of the resident's feet were propped up on pillows, and there was a Podus Boot (designed to support and position the ankle and foot) on his right foot. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/31/25 at 9:55 AM, Resident #29 stated that he wore briefs and that he required assistance from the staff for his Activities of Daily Living (ADL) needs. During an observation on 4/2/25 at 9:25 AM, Staff A, Certified Nursing Assistant (CNA) performed peri-care for Resident #29. Staff A did not remove her gloves and perform hand hygiene. Staff A opened a drawer in Resident #29's dresser, pulled out a tube of ointment, and applied some to Resident #29's sacrum and buttocks. After applying the ointment for Resident #29, while still wearing her soiled gloves, Staff A picked up the wash basin, emptied the water out of the basin and placed the basin, soap and ointment in the drawers of the resident's dresser. During an interview on 4/2/25 at 9:38 AM, Staff A, CNA stated, I should have changed my gloves and washed my hands after I dumped the basin, before putting away the ointment and soap. During an interview on 4/2/25 at 9:42 AM, the Director of Nursing (DON) stated that she would expect the staff member to remove their gloves after completing the catheter and/or peri-care, wash their hands, and don new gloves before cleaning the area or touching and/or putting away supplies. Review of the policy and procedure titled Perineal/Incontinence Care, issued 4/1/22, and last reviewed/revised 1/31/25, read, Policy: It will be the policy of this facility to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition and provide appropriate care and services required to maintain functional levels while providing perineal/incontinence care. 3) During an observation on 3/31/25 at 2:55 PM, Resident #15 was sitting up in a wheelchair next to her bed. A urinary drainage bag was observed hanging off of the side of her wheelchair. During an observation on 4/2/25 at 8:18 AM, Staff A, CNA performed catheter care for Resident #15. After completing catheter care, the CNA did not remove her gloves, did not perform hand hygiene, and while still wearing her soiled gloves, she picked up the wash basin, wiped Resident #15's overbed table, emptied the water out of the basin and placed the basin in a drawer of the resident's dresser. During an interview on 4/2/25 at 9:38 AM, Staff A, CNA stated, I should have changed my gloves and washed my hands after I dumped the basin, and before putting away the soap. During an interview on 4/2/25 at 9:42 AM, the DON stated that for residents with a catheter they would be on Enhanced Barrier Precautions, and for catheter care the expectation would be for the staff member to wash their hands, don a gown and gloves, and have all necessary supplies available. She stated that she would expect the staff member to remove their gloves after completing the catheter and peri-care, wash their hands, and don new gloves before cleaning the area, touching and/or putting away supplies. Review of Resident #15's physician order documented Enhanced Barrier Precautions when providing Direct Care to resident (Gown and Gloves) - every shift for infection prevention (indwelling catheter); Catheter care with soap and water daily and as needed every evening shift for prophylaxis. (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 #15's Care Plan documented Focus - [Resident #15's name] is at risk for infection and enhanced barrier precautions (EBP) are indicated due to: indwelling medical devices (specify - urinary catheter). Goals - Risk of infection will be reduced through use of enhanced barrier precautions daily through next review date. Interventions - Educate resident/family on the need for enhanced barrier precautions to reduce risk of infections. Employ enhanced barrier precautions when performing high contact resident care (dressing, bathing, transferring in room/shower/therapy, personal hygiene assist, changing linens, changing briefs, toileting, device care, wound care, therapy services) Review of the policy and procedure titled Indwelling Catheters, issued 4/1/22, last reviewed on 1/31/25, read, Policy It will be the policy of this facility to provide appropriate documentation for the use and care for indwelling catheters of the residents that have the indication for use beyond 14 days. Procedure: 8. Staff will provide daily catheter care or as ordered by the physician and/or needed. Catheter care should be provided in a manner that promotes infection control and maintenance of the insertion site.