

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105544	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2025
NAME OF PROVIDER OR SUPPLIER Solaris Healthcare Bayonet Point		STREET ADDRESS, CITY, STATE, ZIP CODE 7210 Beacon Woods Dr Hudson, FL 34667	

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 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41334</p> <p>Based on review of pharmacy recommendations and interviews, the facility failed to ensure the attending physician documented in the residents medical records the rationale for not acting on and following pharmacy recommendation for two (#2 and #19) of three residents reviewed for pharmacy recommendations.</p> <p>Findings included:</p> <p>Review of Resident #2's medical record documented an admitted [DATE] and included the following diagnoses: depression, anxiety disorder, pulmonary hypertension a type of high blood pressure that affects the arteries in the lungs), emphysema (a disorder that affects the tiny air sacs in the lungs), and pulmonary fibrosis (scarring of the tissue around the airs sacs in the lungs).</p> <p>Review of the document titled, Consultant Pharmacist's Report for Resident #2 recommendation date of 2/23/2024 reads, Findings/Recommendations: New admission medication regimen review. Admission summary: This 77 y/o (year old) resident was readmitted on [DATE]. #1) Beers drug/potentially inappropriate medication: Xanax 0.25 mg (Milligrams). Older adults have increased sensitivity to benzodiazepines and decreased metabolism of long-acting agents: Concomitant use with opioids may result in profound sedation, respiratory depression, coma, and death. In general, all benzodiazepines increase risk of cognitive impairment, delirium, falls and fractures in older adults. Consider deprescribing by gradually tapering by 25% every 2 weeks in partnership with patient. Disagree was checked.</p> <p>The review showed there was no rationale documented from the attending physician on the recommendation form or within the medical record.</p> <p>Review of Resident #19's medical record documented a readmitted [DATE] and included the following diagnoses: urinary tract infection, traumatic subarachnoid hemorrhage (bleeding in the space between the brain and the membrane that covers the brain) without loss of consciousness, weakness, repeated falls, and essential primary hypertension (high blood pressure).</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 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the document tiled, Consultant Pharmacist's Report for Resident #2 recommendation date of 3/2/2025 reads, Findings Recommendations: New admission Medication Regime review. Admission summary : This 80 y/o resident was readmitted on [DATE]: #1 Duplication in therapy Concomitant use of the following medications represents a duplication in therapy:#1) Bupropion XL 300 mg and Fluoxetine 40 mg for depression Please attempt a dose reduction to: Bupropion XL 150 mg po (by mouth) once daily documented disagree, no rationale was provided. The review showed, *Note*: This resident has a history of falls. The current medications listed below may have contributed to the fall. Concurrent use of these medications may increase side effects such as dizziness, drowsiness, confusion, falls, impaired judgment motor coordination and difficulty concentrating. Bupropion XL 300 mg(milligrams), Fluoxetine 40mg, Gabapentin 300 milligrams, Hydrocodone 5-325 mg.</p> <p>The review showed there was no rationale documented from the attending physician on the recommendation form or within the medical record.</p> <p>During an interview on 4/28/2025 at 1:10 PM the Director of Nursing (DON) stated, I didn't realize the pharmacy recommendations needed to include a rationale when the doctors or nurse practitioners disagreed with the recommendations. I guess we need to do that.</p> <p>During a telephone interview on 4/29/2025 at 8:45 AM, the Medical Doctor (MD) stated, I will always review all pharmacy recommendation and either agree or disagree, that has always been my practice. I did not document reasons.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>41334</p> <p>Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were stored in a secured manner to limit unauthorized access to medications for one (#14) of three residents reviewed for medication storage.</p> <p>The findings included:</p> <p>During an observation on 4/25/2025 at 5:51 AM Resident #14 had one tube of Ease-Z Diabetics dry skin therapy foot cream containing Zinc on her bedside table and one bottle of ActivICE pain reliever gel roll on.</p> <p>During an interview on 4/25/2025 at 6:05 AM Staff A, Licensed Practical Nurse(LPN) stated. I don't know what those lotions are on her nightstand. Her family brings those in for her. She does not need an order for those.</p> <p>During an observation on 4/25/2025 at 6:07 AM Staff A, LPN verified that one was a bottle of ActivICE and one was Ease Z diabetics dry skin therapy foot cream with Zinc.</p> <p>During an observation on 4/25/2025 at 10:10 AM the Director of Nursing (DON) and Regional Nurse Consultant (RNC) verified that Ease Z diabetics with Zinc and ActivICE bottle with barrier cream were unsecured on the resident's bedside dresser.</p> <p>During an interview on 4/25/2025 at 10:14 AM the DON stated, All medications should be secured. Her family brings these things in for her. They should not be on her dresser, they should be in the drawer. We should have orders for all creams available to the resident. I can't tell you what the risk of having these is. I don't know.</p> <p>Review of a policy and procedure titled Medication Labels read Policy: Medications are labeled in accordance with facility requirements and state and federal laws.Procedures: Resident-specific non-prescription medications (not floor stock) that are not labeled by a pharmacy are kept in the manufacturer's original container and identified with resident's name. Facility personnel may write the resident's name on the container .</p> <p>(Photographic Evidence Obtained)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>41334</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and policy and procedure review, the facility failed to maintain an infection prevention and control program designed to help prevent the transmission of communicable diseases and infection, by failing to perform hand hygiene during medication administration for three (Residents #12,#13 and #14) of six residents observed for medication administration.</p> <p>The findings included:</p> <p>During an observation of medication administration on 4/25/2025 at 5:39 AM Staff A, Licensed Practical Nurse (LPN), returned to the medication cart from a resident room, removed medication cart keys from their pocket, unlocked the medication cart, activated the computer and typed on the computer. Staff A, LPN removed medication from the medication cart, and went to Resident #12's room, entered the room without performing hand hygiene, assisted the resident to reposition in bed and administered the medication to Resident #12. Staff A, LPN exited the resident's room and returned to the medication cart without performing hand hygiene.</p> <p>During an observation of medication administration on 4/25/2025 at 5:42 AM , Staff A, Licensed Practical Nurse (LPN) returned to the medication cart from a residents room, reached into pocket for keys unlocked the medication cart and unlocked the narcotic drawer with a key, staff removed the medication card, opened the narcotic administration book, removed a pen from pocket and documented the medication in the logbook. Staff A, LPN placed the medication in a medication cup for Resident #13 without performing hand hygiene. Staff A,LPN entered Resident #13's room without performing hand hygiene, readjusted Resident #13's head of the bed with the bed controller, assisted Resident #13 to reposition in the bed, and administered medications to the resident. Staff A, LPN exited the room without performing hand hygiene and returned to the medication cart.</p> <p>During an observation of medication administration on 4/25/2025 at 5:51 AM, Staff A, LPN returned to the medication cart, reached into pocket, removed keys and unlocked the medication cart, Staff A prepared medications for Resident #14 without performing hand hygiene, Staff A, obtained an accucheck machine, removed accucheck supplies and one medication without performing hand hygiene and donned gloves. Staff A entered Resident #14's room, performed the accucheck and without removing gloves administered the oral medication to Resident #14 and exited the room returning to the medication cart and began preparing another residents medications without performing hand hygiene.</p> <p>During an interview on 4/25/2025 at 6:05 AM Staff A, LPN stated regarding hand hygiene, I need to, I thought I did use the hand sanitizer. I guess I should have used it when I got the meds(medications) and when I went in the room. I did put my gloves on before I went in her room (Resident #14), I did not wash my hands, I did not use hand sanitizer. I did not take off my gloves before I gave her the medication after I had done the accucheck. There could have been blood from the accucheck on my gloves. I should taken the gloves off and washed my hands.</p> <p>During an interview on 4/25/2025 at 8:05 AM, the Director of Nursing (DON) stated, I expect all staff will follow our infection control policies for hand washing when they administer any medications.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the policy and procedure titled, Medication Administration-General Guidelines reads, Procedures: A. Preparation: 2). Handwashing and Hand sanitization: The person administering medications adheres to good hand hygiene which includes washing hand thoroughly: before beginning medication pass, prior to handling any medication, after coming into direct contact with a resident. B. Hand sanitization is done with an approved sanitizer between hand washings, when returning to the medication cart or preparation area (assuming hands have not touched a resident or potentially contaminated surface), at regular intervals during the medication pass such as after each room, again assuming handwashing is not indicated.</p> <p>Review of the policy and procedure titled, Handwashing/Hand Hygiene reads, Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. 7. Use an alcohol-based hand rub containing 62% alcohol; or, alternatively, soap and water for the following situations: b. Before and after direct contact with residents: before preparing or handling medications, m. after removing gloves, p. Before and after assisting residents with meals.</p>		