STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105544	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solaris Healthcare Bayonet Point	7210 Beacon Woods Dr Hudson, FL 34667

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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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (continued on next page)

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

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

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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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy and procedure review the facility failed to ensure the residents rights were honored by failing to implement/follow formulated advance directives for one resident (#209) of one resident reviewed. Resident #209 had an Advanced Directive for Do Not Resuscitate (DNR) formulated, which staff did not follow. The DNR was not honored by the facility when they failed to obtain clarification of code status during the admission process, per facility policy. This failure resulted in the resident experiencing sternal and anterior chest wall pain, serious psychosocial harm by not honoring the resident's wishes for a natural, dignified death. Findings included: Review of Resident #209 medical record documented an admission date of [DATE] with medical diagnoses to include displaced bimalleolar fracture of lower leg, subsequent encounter for closed fracture with routine healing, s/p (status post) ORIF(open reduction internal fixation), sprain of tibiofibular ligament of left ankle, subsequent encounter, s/p fixation, presence of right artificial hip joint, hypo-osmolality (a condition where the levels of electrolytes, proteins and nutrients in the blood are lower than normal) and hyponatremia (a condition where the levels of sodium in the blood is low), polyneuropathy (a condition where the peripheral nerves are damaged), unspecified, and gastroesophageal reflux disease (a condition where stomach acids flows back into the esophagus causing heartburn) without esophagitis (an inflammation of the esophagus).Review of Resident #209 medical record documented a form titled State of Florida Do NOT RESUSCITATE ORDER (DNR) DH (Department of Health) form 1896, Revised [DATE], dated [DATE]. The form was signed by Resident #209 and a physician.Review of Resident #209's nursing progress note dated [DATE] at 11:30 PM read, Patient arrived per stretcher via stretch limo transportation. Alert with confusion @ (at) times word salad (a term used to describe incoherent speech that is difficult to understand), speaks loudly. Resp (respirations) non labored. Abdomen soft, non-distended, with BS (bowels sounds) x 4 quads(quadrants), had BM (bowel movement) today. With IUC (indwelling urinary catheter) Fr (French) #14/10 ml(milliliter) patent, draining well to [sic] yellow colored urine. Patients dx(diagnosis) post left ankle ORIF (open reduction internal fixation) done on 8-7/25 by [Medical Doctors name]. NWB (non-weight bearing) to LLE (left lower extremity). Wears cam boot @ all times, unable to assess fully the surgical site. Observed BUE (bilateral upper extremities) and BLE (bilateral lower extremities) has multiple bruises. RLE (right lower extremity) with edema and some bruise marks. Obtained further data/information about patient from daughter- in-law. Patient lives in ALF (Assisted Living Facility) [Name of the ALF], she's independent with everything, apparently she fell while waiting for a ride to go to her doctor's appointment, and left leg gave out causing her to fall and fracture left ankle. Patient had h/o (history of) multiple falls but this time a bad one. According to [family member] patient is a DNR (Do Not Resuscitate) and she will send it to this facility via e mail directly through ADON (Assistant Director of Nursing) email address tomorrow, @ this time patient is a full code, [family member] made aware and stated understanding. Patient does not smoke. Call light within reach. Denies of any pain @ this time. No distress noted.Review of Resident #209's physician order dated [DATE] read, Code status: Full code.Review of Resident #209's social service progress note dated [DATE] at 7:16 am read, 72 - hour note: Resident lives in an independent living apartment @ [name of ALF]. Resident was independent with functional mobility and ADL's (activities of daily living) prior to her fall. Resident utilized a 4 wheeled rolling walker. Resident's support system includes [two family members named]. Resident's discharge plan is to return home once rehab(rehabilitation) is complete. Will ask [family member] to provide copy of any advanced directives resident may have. Resident is currently a full code.Review of Resident #209's nursing progress note dated [DATE] at 2:12 PM read, Pt (patient) unresponsive in wheelchair brought to desk by Therapist. Nursing returned pt to bed as this nurse called code blue. Called 911.Review of Resident #209's nursing progress note dated [DATE] at 4:28 PM read, Shortly after 2 PM called to assess patient sitting slumped down in wheelchair nonresponsive to verbal stimuli or sternal rub. Listened for heartbeat with stethoscope and felt for radial pulse, no detected heartbeat. Called out to charge nurse to check code status, told she is full code. Grabbed wheelchair to take to room and called for someone to grab backboard. CPR chest compressions started. Opened AED (automated external defibrillator) no shock needed. Pt (patient) began to slowly respond, opened her eyes breathing on her own, faint radial pulse noted. Oxygen applied initial VS (vital signs) 96/64, HR (heart rate) 46, 84% oxygen saturation. As resident became more alert encouraged to take deep breaths, through her nose and oxygen increased to 3 liters with resulting saturation 94% the [sic] increase to 97 %. As paramedics arrived

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on record review and interview the facility failed to ensure a resident a minimum data set assessment was transmitted within 14 days after completion for one resident (#12) of two residents reviewed for resident assessment. Findings included:Review of Resident #12's electronic medical record on 9/25/2025 showed a resident assessments history that documented Resident #12's annual minimum data set assessment (MDS) was completed on 8/3/2025 with a designation of Production Batch. The review showed Resident #12's MDS assessment was not transmitted to CMS on 8/3/2025 and was past the 14-day transmittal requirement. During an interview on 9/25/2025 at 8:40 AM, the Care Plan Coordinator/Registered Nurse (RN) stated that once a minimum data set assessment is completed, the assessment is sent to the corporate office for review before submission to the Centers for Medicare and Medicaid Services (CMS). She explained the corporate office reviews the assessment and sends a validation report to the facility for corrections if needed. She specified the assessment should be forwarded to the CMS 14 days following completion. During an interview on 9/25/2025 at 8:42 AM, the Care Plan Minimum Data Set Coordinator/Licensed Practical Nurse (LPN) stated the production batch designation meant the minimum data set assessment had been completed and was ready to be submitted to the corporate office for an initial review, and had not been submitted to CMS. During interview on 9/25/25 at 10:58 AM, the Care Plan Minimum Data Set Coordinator / Licensed Practical Nurse reported the facility had not received a validation report from the corporate office because the assessment was not transmitted to the corporate office for review when completed. She verified Resident #12's minimum data set assessment had not been forwarded to the corporate office for initial review until 9/25/2025. She confirmed their failure to submit the MDS for Resident #12 to their corporate for approval resulted in their failure to meet the CMS transmittal requirement of within 14 days. Review of Resident #12's MDS record revealed it should have been transmitted to CMS by 8/17/2025.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and policy and procedure review the facility failed to honor a resident's expressed Advanced Directive for end of life for one resident (#209) of one resident reviewed, by failing to ensure life saving measures of cardiopulmonary resuscitation (CPR) were not performed when Resident #209 was found unresponsive and absent of vital signs. Resident #209 was admitted to the facility on [DATE] with a fully executed State of Florida Do NOT RESUSCITATE ORDER (DNR) DH (Department of Health) form 1896,Revised [DATE] dated [DATE]. Resident #209's representative provided a copy to the facility on [DATE] at 12:40 PM. The facility's unlicensed staff did not provide the DNR order to a licensed staff member for processing. Resident #209 was found unresponsive and absent of vital signs on [DATE] at 2:12 PM. The resident's wishes were not honored, and CPR was initiated. Resident #209 survived and was transferred to an area hospital. Findings included: Review of Resident #209 medical record documented an admission date of [DATE] with medical diagnoses to include displaced bimalleolar fracture of lower leg, subsequent encounter for closed fracture with routine healing, s/p (status post) ORIF(open reduction internal fixation), sprain of tibiofibular ligament of left ankle, subsequent encounter, s/p fixation, presence of right artificial hip joint, hypo-osmolality (a condition where the levels of electrolytes, proteins and nutrients in the blood are lower than normal) and hyponatremia (a condition where the levels of sodium in the blood is low), polyneuropathy (a condition where the peripheral nerves are damaged), unspecified, and gastroesophageal reflux disease (a condition where stomach acids flows back into the esophagus causing heartburn) without esophagitis (an inflammation of the esophagus).Review of Resident #209 medical record documented a form titled State of Florida Do NOT RESUSCITATE ORDER (DNR) DH (Department of Health) form 1896, Revised [DATE], dated [DATE]. The form was signed by Resident #209 and a physician.Review of Resident #209's nursing progress note dated [DATE] at 11:30 PM read, Patient arrived per stretcher via stretch limo transportation. Alert with confusion @ (at) times word salad (a term used to describe incoherent speech that is difficult to understand), speaks loudly. Resp (respirations) non labored. Abdomen soft, non-distended, with BS (bowels sounds) x 4 quads(quadrants), had BM (bowel movement) today. With IUC (indwelling urinary catheter) Fr (French) #14/10 ml(milliliter) patent, draining well to [sic] yellow colored urine. Patients dx(diagnosis) post left ankle ORIF (open reduction internal fixation) done on 8-7/25 by [Medical Doctors name]. NWB (non-weight bearing) to LLE (left lower extremity). Wears cam boot @ all times, unable to assess fully the surgical site. Observed BUE (bilateral upper extremities) and BLE (bilateral lower extremities) has multiple bruises. RLE (right lower extremity) with edema and some bruise marks. Obtained further data/information about patient from [family member]. Patient lives in ALF (Assisted Living Facility) [Name of the ALF], she's independent with everything, apparently she fell while waiting for a ride to go to her doctor's appointment, and left leg gave out causing her to fall and fracture left ankle. Patient had h/o (history of) multiple falls but this time a bad one. According to [family member] patient is a DNR (Do Not Resuscitate) and she will send it to this facility via e mail directly through ADON (Assistant Director of Nursing) email address tomorrow, @ this time patient is a full code, [family member] made aware and stated understanding. Patient does not smoke. Call light within reach. Denies of any pain @ this time. No distress noted.Review of Resident #209's physician order dated [DATE] read, Code status: Full code.Review of Resident #209's social service progress note dated [DATE] at 7:16 am read, 72 - hour note: Resident lives in an independent living apartment @ [name of ALF]. Resident was independent with functional mobility and ADL's (activities of daily living) prior to her fall. Resident utilized a 4 wheeled rolling walker. Resident's support system includes [two family members named]. Resident's discharge plan is to return home once rehab(rehabilitation) is complete. Will ask [family member] to provide copy of any advanced directives resident may have. Resident is currently a full code.Review of Resident #209's nursing progress note dated [DATE] at 2:12 PM read, Pt (patient) unresponsive in wheelchair brought to desk by Therapist. Nursing returned pt to bed as this nurse called code blue. Called 911.Review of Resident #209's nursing progress note dated [DATE] at 4:28 PM read, Shortly after 2 PM called to assess patient sitting slumped down in wheelchair nonresponsive to verbal stimuli or sternal rub. Listened for heartbeat with stethoscope and felt for radial pulse, no detected heartbeat. Called out to charge nurse to check code status, told she is full code. Grabbed wheelchair to take to room and called for someone to grab backboard. CPR chest compressions started. Opened AED (automated external defibrillator) no shock needed. Pt (patient) began to slowly respond, opened her eyes breathing on

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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	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on interview and record review, the facility failed to administer insulin according to professional standards of practice for two residents (#152 and #5) of four residents reviewed for insulin administration and failed to administer cardiovascular medications according to professional standards of practice for one resident (#185) of four residents reviewed for cardiovascular medication administration. Findings included: 1.Review of Resident #152’s medical record documented diagnosis that include hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, type 2 diabetes mellitus with diabetic polyneuropathy, type 2 diabetes mellitus with hyperglycemia (high blood sugar), atherosclerotic heart disease of native coronary artery (heart disease) without angina pectoris (chest pain), long term use of insulin, and hypoglycemia (low blood sugar). Review of Resident #152's physician orders dated 9/13/2025 read, Insulin Semglee (insulin-glargine-yfgn) pen 100 unit/ml(milliliter)(3ml) amount to administer: 30 units SQ (subcutaneous) at bedtime for DM (diabetes mellitus).” Review of Resident #152's physician orders dated 9/8/2025 read, Finger stick blood sugar QD (every day) notify MD (Medical Doctor) if below 60 or above 250 twice a day: 5. Monitor patients vital signs and blood sugar every 15 minutes until stable. Review of Resident #152's physician orders dated 9/8/2025 read, Hypoglycemic protocol #2:1.Check blood sugar via finger stick glucometer machine procedure if blood sugar is less than 60 notify MD and follow protocol below, 2. If patient is able to swallow, or for 4 ounces of orange juice with two packets of sugar, 3. If patient is not able to swallow, administer Glucagon or 20 to 30 CC's (cubic centimeter) of D50 (Dextrose) IV (intravenously) initially, additional amounts if no response. 4. Notify physician ASAP of crisis and for further orders. Review of Resident #152’s September medication administration (MAR) record documented that Insulin was not administered on 9/12/2025 at 9:00 PM, and on 9/13/2025 at 9:00 PM. Review of Resident #152’s MAR documented a blood sugar of 59 on 9/9/2025 at 6:00 AM. Review of Resident #152’s nursing progress notes on 9/10 /2025 document no physician notification of low blood sugar. There were no progress notes on 9/12/2025 and on 9/13/2025 for physician notification of insulin being held. During an interview on 9/25/2025 at 6:40 AM Staff T, Licensed Practical Nurse (LPN) stated, I'm not sure why I held it (the insulin). I think her (Resident #152) blood sugar was low. I don’t think I told the doctor, there are no parameters to hold it.” During an interview on 9/26/2025 at 6:40 AM the Director of Nursing (DON) stated all medications should be administered if ordered, insulin should be given as ordered and if it doesn’t have parameters, we should notify the doctor or nurse practitioner if they are hypo (hypoglycemic) or hyperglycemic. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy and procedure titled “Diabetes-Clinical Protocol” last approval date of 11/26/2024 reads, “Monitoring and Follow- Up: 4. the physician will order desired parameters for monitoring and reporting information related to diabetes or blood sugar management, a. The staff will incorporate such parameters into the medication administration record and care plan. 5. The staff will identify and report complications such as foot infections, skin ulcerations, increased thirst, or hypoglycemia. b. The physician will help staff clarify and respond to these events. “ Review of the facility policy and procedure titled “Administration Procedures for all Medications” with a last approval date of 11/26/2024 read, “Procedures: C. Review 5 Rights (3) times: d. check for vital signs, other tests to be done during/prior to medication administration. I, Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration. P. Notification of Physician/Prescriber.2) Held medication for pulse, blood pressure , low or high blood sugar, or other abnormal test results vitals signs, resulting in medication being held.” 2)Review of Resident #5's physician order dated 8/22/2025 read, “Lisinopril tablet 2.5mg [milligrams] amount to administer 2.5 mg oral once a day for HTN [Hypertension].” Review of Resident #5's Medication Administration Record (MAR) for the month of September 2025 documented Lisinopril 2.5mg was not given at 9:00AM on 9/3/2025 Not Administered: Due to Condition Comment: BP (blood pressure) 100/60, 9/6/2025 Not Administered: On Hold, 9/10/2025 Not Administered: Due to Condition Comment: hypotension 9/16/2025, 9/18/2025, 9/20/2025, 9/21/2025: Not Administered: On Hold , 9/23/2025 Not Administered: Due to Condition Comment: BP 102/59. Review of Resident #5's Medication Administration Record for the month of August 2025 documented Lisinopril 2.5mg was not given at 9:00AM on 8/11/2025 Not Administered: Due to Condition Comment: BP 99/58, 8/14/2025 Not Administered: Due to Condition Comment: BP: 85/50 , 8/18/2025 Not Administered: Due to Condition, 8/21/2025 Not Administered: On hold Comment BP Low, 8/22/2025 Not Administered: Due to Condition Comment: BP 88/50, 8/23/2025 Not Administered: On hold, 8/24/2025 Not Administered: Other Comment : BP 98/57, 8/25/2025 Not Administered: Due to Condition, 8/26/2025 Not Administered: Due to Condition Comment: hypotension, 8/27/2025 Not Administered: Due to Condition Comment: BP 97/58, 8/28/2025 Not Administered: Due to Condition Comment: BP 96/56. During an interview on 9/24/2025 at 10:02 AM with Staff O, Registered Nurse (RN), stated, I did not notify the doctor all the time I held the medication because I just used my nursing judgement and I didn’t feel it was safe to give the medication. The resident has parameters for one of the medications but not that one. I don’t want to leave a note every single day that I held the medication.” During an interview on 9/25/2025 at 11:34 AM with Staff N, Licensed Practical Nurse (LPN), stated “He [Resident #5] has blood pressure medication that has parameters and he trends low and I let the charge nurse know which is my charge nurse and with using my nursing judgment I don’t feel comfortable giving it to him. The charge nurse will let the doctor know. She is not here right now. I leave her a note sometimes she will call the doctor, she might leave it in the book and other times the doctor is here and she will hand it to the doctor.” (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/2025 at 12:25 PM Staff I, RN, stated, We would reach out to the provider right there and then if the patient is symptomatic if not symptomatic we would hold using nursing judgement. During an interview on 9/26/2025 at 8:40 AM with the Director of Nursing (DON) stated, If the nurses have to hold the medication they should let the physician know so they can review the medication. The standard is after a couple of time let the doctor know if the nurses are holding the medication. The physician review the medications. A lot of the physician come two or three times a week and most of the physicians have a binder in the station and we leave notes for them and we also have nurse practitioners that are here and they review all mediations as well. It’s hard to say if the nurses should be calling before holding the medication. The physician does get notified at some timely point maybe that day or next day. The nurses look at the full picture of the patient’s condition. Review of the facility policy and procedure titled “Administration Procedures for all Medications” with a last review date of 11/26/2025 read, “Procedures: C. Review 5 Rights (3) times: d. check for vital signs, other tests to be done during/prior to medication administration. P. Notification of Physician/Prescriber.2) Held medication for pulse, blood pressure, low or high blood sugar, or other abnormal test results vitals signs, resulting in medication being held.” 3)Review of Resident #185 physician order dated 8/14/2025 Novolin N Flex Pen 12 units Hold If Blood Sugar Less than 100. Review of Resident #185 Medication Administration Record for month of September 2025 documented Novolin N was held on 9/10/2025 at 5:00PM was 130 During an interview on 9/25/2024 at 4:29 PM Staff P, RN, stated, I might have confused it the order with the sliding scale and held the insulin when it should not have been held. Review of Resident #185 physician order dated 8/22/2025 read, Lantus Solostar U-100 Insulin amount to administer 35 units. Review of the Resident #185’s Medication Administration Record for the month of August 2025 documented Lantus Solostar on 8/27/2025 at 9:00 AM blood sugar was 98 not administer due to condition. Review of Resident #185 physician order dated 8/22/2025 read, Metformin tablet 1000mg amount to administer. Review of Resident #185’s Medication Administration Record for the month of August 2025 documented metformin on 8/27/2025 at 5:00PM not administered due to condition. During an interview on 9/25/2025 at 12:25 PM with Staff I, RN, stated, “I really don’t remember what happen [SIC] those days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/26/2025 at 8:47 AM with the Director of Nursing stated, Nursing staff should follow parameters and document accurately. The nurses should discuss the blood sugar level with charge nurse and the physicians. Depending on the doctor orders long-acting insulin should be held. Again, nurses should use their nursing judgement.” During an interview on 9/26/2025 at 10:35 AM with Medical Doctor #1 stated, Each time the nurses hold a medication they do not notify me they typically put it on a list of blood pressure, and I will review them on Friday. I rather the nurses use their nursing judgement rather than having a resident fall and injured themselves. If they were to call me every time I would call them right back. There has been no medical concerns regarding nurses and the antidiabetic medication administered to [Resident #185's name]. Review of the facility policy and procedure titled “Injectable medication Administration” with a last review date of 11/26/2025 read, “Purpose: To administer medications via subcutaneous, intradermal and intramuscular routes in a safe, accurate, and effective manner. Procedure: Check order on the medication administration record to see that an injection is currently ordered and due. Close or secure MAR to keep other from viewing it. Document administration, site, used and any unusual reactions. Notify physician if reactions occur.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to ensure physician ordered parameters were followed for blood pressure medications resulting in the administration of unnecessary medications for three residents (#157, #10 and #91) of five residents reviewed for unnecessary medications.Findings include:1. Review of Resident #157's medical record documented diagnosis that include fracture of unspecified part of the neck of right femur, subsequent encounter for closed fracture with routine healing, presence of right artificial hip joint, other sequalae of other cerebrovascular disease, urinary tract infection site not specified, sepsis due to Escherichia coli, hypothyroidism unspecified, hyperlipidemia unspecified, hypertensive chronic kidney disease with stage 1 through 4 chronic kidney disease, and orthostatic hypotension (a form of low blood pressure that happens when standing up from sitting or lying down).Review of Resident #157's physician order dated 9/5/2025 read, Midodrine tablet: 2.5 mg (milligram); amt(amount);2.5 mg; oral; special instructions: Hold if SBP (systolic blood pressure) is greater than 120 for hypotension, three times a day. Review of Resident #157's medication administration record (MAR) for September 2025 documented that midodrine was administered on 9/6/2025 at 12:00 PM for a blood pressure (B/P) of 137/69, on 9/10/2025 at 6:00 AM for a B/P of 130/73, on 9/12/2025 at 6:00 PM for a B/P of 126/75, and on 9/24/2025 at 1200 PM for a B/P of 125/70.Review of Resident #157's comprehensive care plan read, Problem Cardiac problems: at risk for as evidenced by occasional hypotension with diagnosis HTN (hypertension), CVA (cerebrovascular accident), hypothyroidism, hyperlipidemia recent hospitalization d/t (due to) AMS (altered mental status)/ febrile dx (diagnosis) acute metabolic encephalopathy 2/2 E-coli UTI, orthostatic hypotension. Goal included Patient will reduce the risk of CP (chest pain)/ SOB(shortness of breath)/complications r/t cardiac/anemia dx by taking meds/ having labs as ordered with approaches that included vital signs per protocol, some meds have B/P and/or pulse parameters administer as ordered and medications administer as ordered.2. Review of Resident #10's medical record documented diagnosis that include multiple fractures of pelvis without disruption of pelvic ring, subsequent encounter for fracture with routine healing, hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease, end stage renal disease, type 2 diabetes mellitus without diabetic neuropathy unspecified, unspecified atrial fibrillation (an irregular heart beat), other cervical disc degeneration unspecified cervical region, hemiplegia (partial paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a stroke) affecting left non dominant side, and dependence on renal dialysis.Review of Resident #10's physician order dated 7/24/2025 read, Clonidine HCL tablet, 0.1 mg (milligram), amount 0.1 mg, oral, special instructions DX (diagnosis) HTN (hypertension)hold for SBP (systolic blood pressure) less than 165 every 6 hours.Review of Resident #10's medication administration record for September 2025 documented that clonidine 0.1 mg was administered outside of the physician ordered parameters on 9/1/2025 at 12:30 PM with a blood pressure (B/P) of 160/69, on 9/3/2025 at 6:30 PM with a B/P of 160/70, on 9/6/2025 at 12:30 AM with a B/P of 125/71, and at 6:30 PM with a B/P of 152/70, on 9/10/2025 at 12:30 AM with a B/P of 152/64, on 9/11/2025 at 6:30 PM with a B/P of 133/78, on 9/12/2025 at 6:30 PM with a B/P of 157/77, on 9/13/2025 at 6:30 AM with a B/P of 149/83, and at 6:30 PM with a B/P of 137/65,on 9/14/2025 at 12:30 PM with a B/P of 161/67, on 9/17/2025 at 6:30 AM with a B/P of 164/65, on 9/18/2025 at 12:30 AM with a B/P of 148/64, on 9/21/2025 at 6:30 AM with a B/P of 163/70 and on 9/22/2025 at 6:30 AM with a B/P of 163/69 and at 6:30 PM with a B/P of 160/80. Review of Resident #10's Comprehensive care plan read, Problem Cardiac problems at risk for as evidenced by occasional HTN with dx of ESRD (end stage renal disease)/CKD(chronic kidney disease) 5 w (with)/hemodialysis, a fib (atrial fibrillation), dependent on a pacemaker, hx CVA w/L(left) hemiplegia, chronic metabolic acidosis, anemia. Goal included Patient will reduce the risk of chest pain/SOB/complications r/t cardiac /anemia/respiratory dx by taking meds/having labs as ordered with approaches that included some BP meds (medications) have parameters and medications administer as ordered.During an interview on 9/25/2025 at 6:28 AM Staff U, Registered Nurse (RN stated, I did give the clonidine and I shouldn't have based on the parameters. His pressure was under 165. I should have followed the order and held it.During an interview on 9/25/2025 at 6:40 AM the Director of Nursing (DON) stated all staff should follow orders for med (medication) administration. They should follow the orders.During an interview on 9/25/2025 at 10:40 AM Staff H, Licensed Practical Nurse (LPN) stated, I should have held the medicine, I don't know really (if I gave it or not) but my initials mean I gave it.3.Review of Resident #91's medical record documented diagnosis that include encounter for surgical aftercare following surgery on the respiratory system note status

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	105544	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solaris Healthcare Bayonet Point	7210 Beacon Woods Dr Hudson, FL 34667

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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 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. Based on observation, interview and record review the facility failed to properly store medications for two residents (#212 and #213) in one unit (200) out of 3 units observed.Findings included: 1.) During an observation on 9/22/2025 at 9:38 AM Resident #212 was sitting up on her bed. There was an Arnica cream on top of her bedside table.During an interview on 9/22/2025 at 9:38 AM Resident #212 stated, I use the cream at times for pain. I will apply it [arnica cream] to my shoulder and it helps me.During an observation on 9/25/2025 at 12:19 PM Resident #212 was sitting up on her bed. There was an Arnica cream on top of her bedside table.During an interview on 9/25/2025 at 12:32 PM Staff I Registered Nurse (RN) confirmed Resident #212 had an Arnica cream in the resident's room.Review of Resident #212's physician orders did not document the resident was able to self-administer medications.2.) During an observation on 9/22/2025 at 9:45 AM Resident #213's room was observed empty. On top of her bedside table there was a Vicks Vaporub cream. [photographic evidence obtained]During an observation on 9/25/2025 at 12:18 PM Resident #213 was resting in bed with eyes closed. There was a Vicks Vaporub cream on top of Resident #213's bedside table.During an interview on 9/25/2025 at 12:29 PM with Staff I, RN, Staff I stated In order for a resident to self-administer medication we will do a paper observation and determine if the resident meets the criteria. The resident would then be given a lock box with a key and instructed to keep medication lock. There is an order for the medication and in that order it will say patient can self-administer the medication. Staff I stated [Resident #212's name] and [Resident #213's name] do not have orders to self-administer medication. I do not have any residents on this unit at this time that are able to self-administer medication.During an interview on 9/25/2025 at 12:30 PM Staff I, RN, confirmed Resident #213 had Vicks vaporub in her room.During an interview on 9/26/2025 at 8:32 AM the Director of Nursing (DON) stated, Daily activities, is not to have the meds at bedside. Angel rounds are done on Friday and Certified Nursing Assistants do rounds on the weekends. The DON stated to determine if a resident is able to self-administer medications, an observation would be made that they do and the care plan team reviews that it is adequate. Residents would have a lock box that we give them. The DON stated, It should always be stored in locked container and not left unattended.Review of the facility policy and procedure titled Administration Procedures for all Medications with a last review date of 11/26/2024 read, Policy: To administer medications in a safe and effective manner. Procedures: A. Security: All medication storage areas are locked at all times unless in use and under the direct observation of the medication nurse/aide.Review of the facility policy and procedure titled Bedside Medication Storage with a last review date 11/26/2024 read, Policy: Bedside medication storage is permitted for residents who wish to self-administer medications, upon written order of the prescriber and once self-administration skills have been assessed and deemed appropriate in the judgement of the facility's interdisciplinary resident assessment team. Procedures: C. For residents who self-administer medications, the following conditions are met for bedside storage to occur: 1) The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if unlocked storage is deemed inappropriate.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and review of facility policy, the facility failed to ensure food was stored safely and properly labeled in one reach-in cooler out of one reach-in cooler observed in the kitchen.Findings included:A walk-through tour of the kitchen was conducted on 9/22/25 at 08:47 AM with the Dietary Manager (DM).An observation was made of several containers of food in the walk-in cooler without an identifying label or date.An interview was conducted with the Dietary Manager (DM) 9/22/2025 at 9:09AM. The DM stated all items placed in the cooler should have a label and be dated and there were no identifying labels on food that had been placed in the walk-in cooler from the breakfast meal.A policy titled Food Receiving and Storage dated 10/10/18 read, 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to accurately and adequately document medication administration for antidiabetic and cardiovascular medications for three residents (#35, #85 and #185) of seven residents reviewed for medication management. Findings included: 1.) Review of Resident #35's physician order dated 6/2/2025 read, Lantus Solostar U-100 Insulin (insulin glargine) insulin pen; 100 unit /ml [milliliters] (3ml) amt [amount] 44 units subcutaneous special instructions hold FBS <100 [fasting blood sugar less than 100].Review of Resident #35's physician order dated 9/5/2025 read, Lantus Solostar U-100 Insulin (insulin glargine) Insulin pen; 100 unit /ml (3ml) amt 46 units subcutaneous special instructions hold FBS <100.Review of Resident #35's Medication Administration Record (MAR) for the month of September 2025 for Lantus Solostar with parameters to hold if fasting blood sugar was less than 100 documented as given on 9/1/2025 at 7:30 AM blood sugar level was 80, 9/10/2025 at 7:30 AM blood sugar level was 79, 9/16/2025 at 7:30 AM blood sugar level was 95, and on 9/20/2025 at 7:30 AM blood sugar level was 88. Review of Resident #35's Medication Administration Record (MAR) for the month of August 2025 for Lantus Solostar with parameters to hold if fasting blood sugar was less than 100 documented as given on 8/23/2025 at 7:30 AM blood sugar level was 68.During an interview on 9/24/2025 at 1:04 PM with Staff K, Licensed Practical Nurse (LPN), stated, We put in the blood sugar and give her something to eat then recheck blood sugar and then give it to her. I will from now make a note that I have rechecked the blood sugar and include the new blood sugar reading. I do not always write a progress note.During a interview on 9/25/2025 at 10:52 AM with Staff L, Licensed Practical Nurse (LPN), stated, I always give her a snack and the recheck the blood sugar level and then give her the insulin, I don't recall documenting the new blood sugar level normally I will include it in the MAR under comments.Review of Resident #35's progress notes did not show documentation of staff rechecking blood sugars and documenting the blood sugar levels for dates: 9/1/2025, 9/10/2025, 9/16/2025, and 9/20/2025.Review of Resident #35's MAR did not show any documentation or additional comments on blood sugar rechecks on 8/23/2025.During an interview on 9/26/2025 at 8:35AM the Director of Nursing (DON) stated, Nursing staff should be documenting the new blood sugar level in the system. They could include it in the comments section or nurses note. Sometimes they get distracted and forget.During an interview on 9/26/2025 at 11:00 AM the DON stated, The facility did not have a policy for documentation.2) Review of Resident #85's physician order dated 7/28/2025 read, Hydralazine tablet 25 mg amount to administer 25 mg oral hypertension hold for sbp [systolic blood pressure] below 150.Review of Resident #85's physician order dated 9/3/2025 read, Hydralazine tablet 25 mg amount 25 mg oral special instructions Dx [Diagnosis]: Hypertension Hold for SBP below 150.Review of Resident #85's MAR for the month of August 2025 for Hydralazine tablet 25 mg with parameters to hold for sbp below 150, documented hydralazine was given on 8/11/2025 at 10:00 PM SBP 128, 8/14/2025 at 10:00 PM SBP 127, 8/16/2025 at 10:00 PM SBP 118, 8/18/2025 at 10:00 PM SBP 133, 8/21/2025 at 6:00 AM SBP 145, 8/22/2025 at 10:00 PM SBP 120, 8/23/2025 at 10:00 PM SBP 137, 8/24/2025 at 10:00 PM SBP 106, and on 8/26/2025 at 10:00 PM SBP 126.Review of Resident #85's MAR for the month of September 2025 for Hydralazine tablet 25 mg with parameters to hold for sbp below 150, documented hydralazine was given on 9/2/2025 at 10:0 0PM with SBP 121, 9/6/2025 at 7:00 PM SBP 123 , 9/8/2025 at 6:00 AM SBP 118, 9/12/2025 at 7:00 PM SBP 119, 9/15/2025 at 1:00 PM SBP 123, 9/19/2025 at 6:00 AM SBP 124, and on 9/23/2025 at 6:00 AM SBP 142. During an interview on 9/24/2025 at 9:37 AM with Staff M, LPN, stated, I would not be able to give it [Hydralazine] if it was out of parameters. I would not have given the medication. I am not sure why it shows as administered the system would not have allowed me completed the administration if the blood pressure was out of parameters.During an interview on 9/25/2025 at 12:09PM with Staff N, LPN, stated, I know I didn't give it to him [Resident #85] because it is rare when he gets it. I know his parameters are 150. I hate to say it like that but it could be a documentation error.During an interview on 9/25/2025 at 12:38PM with Staff L, LPN, stated I don't remember what happened. I am pretty good about holding and following parameters. Sometimes you will pull the medication separate and take the blood pressure and not administer, but I might have hit complete by mistake.3) Review of Resident #185's physician order dated 8/22/2025 read, Lantus Solostar U-100 Insulin (insulin glargine) insulin pen; 100 unit/mL [milliliters] (3 mL); amt [amount]: 35 units; subcutaneous.Review of Resident #185 Medication Administration Record for the month of August 2025 for Lantus Solostar 35 Units documented insulin was not administer on 8/23 at 9:00 PM blood sugar 107, 8/24/2025 at 7:30 AM blood sugar level was 71 not administered; Other Comment below parameter

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review and policy and procedure review, the facility failed to prevent the possible spread of infection and communicable diseases by failing to ensure staff used appropriate Personal Protective Equipment (PPE) and performed hand hygiene upon entering and exiting residents rooms while providing care to residents on enhanced barrier precautions for (Resident # 194), and contact precautions for (Resident #188) and did not perform hand hygiene upon entering and exiting resident's rooms during five observations of ten observations of medication administration. Findings included: During an observation of medication administration for Resident #41 on 9/26/2025 at 5:04 AM , Staff V, Registered Nurse (RN) approached the medication cart without performing hand hygiene, retrieved keys from their pocket, and unlocked the medication cart. Staff activated and typed on the computer. Staff prepared all medications and assembled supplies to perform an accucheck. Staff V entered Resident #41's room, without performing hand hygiene, donned gloves and performed the accucheck. Without doffing gloves or performing hand hygiene Staff V, RN administered the oral medications, doffed gloves and exited the room without performing hand hygiene and returned to the medication cart and began preparing medications for another resident.During an observation of medication administration on 9/26/2025 at 5:12 AM Staff V, RN approached the medication cart, retrieved keys from their pocket, unlocked the medication cart, activated and typed on the computer keyboard and prepared medications without performing hand hygiene and entered Resident #194's room. There was enhanced barrier precautions signage on the doorway indicating that Resident #194 was on enhanced barrier precautions. Staff W, Certified Nursing Assistant (CNA) was observed at Resident #194's beside changing an adult brief and performing incontinence care without a gown on. Staff W, CNA was observed exiting the room to obtain supplies. Staff W did doff gloves without performing hand hygiene, went to the hallway linen cart and returned to Resident #914's room. Staff W, CNA donned gloves without performing hand hygiene, did not don a gown and continued to perform incontinence care and change the resident. Staff V, RN assisted Staff W to reposition Resident #194 in bed, adjusted the linens under the resident and administered Resident #194's medications, doffed gloves without performing hand hygiene and returned to the medication cart without performing hand hygiene.During an observation of medication administration for Resident #214 on 9/26/2025 at 5:17 AM Staff V, RN approached the medication cart without performing hand hygiene, retrieved keys from their pocket unlocked the medication cart, activated and typed on the computer keyboard and prepared medication without performing hand hygiene. Staff V, RN donned gloves without performing hand hygiene, entered the residents room, administered the medications and exited the room, doffed gloves without performing hand hygiene and began to prepare another residents medications.During an interview on 9/26/2025 at 5:47 AM Staff V, RN stated,I should have used hand sanitizer after I took off my gloves. [Resident #194's name] is on enhanced barrier precautions for a wound. We should have had on gowns when we were providing care to him.During an interview on 9/26/2025 at 6:40 AM Staff W, CNA stated, Yes, he (Resident #194) was on enhanced barrier precautions, I should have a gown on, I should have washed my hands when I took off my gloves to get the pad for him.During an observation of medication administration for Resident #202 on 9/25/2025 at 5:25 AM Staff U, RN approached the medication cart, retrieved keys from their pocket, unlocked the medication cart, activated and typed on the computer and prepared medications. One medication was not available. Staff U, RN locked the medication cart and picked up the medication cup with his bare hand, Staff U's thumb and index finger were observed touching the inside of the medication cup that contained 3 medications. Staff U's fingers were observed to touch the medications as they walked to the medication room. Staff U, RN obtained the medications from the medication room, returned to the medication cart removed the keys from their pocket, unlocked the cart, unlocked the narcotic drawer and placed the medications cards in the drawer after obtaining Resident #202's medication and documenting on the narcotic record. Staff U entered Resident #202's room and administered the medication without performing hand hygiene, exited the room and returned to the medication cart and began preparing medications for another resident.During an observation of medication administration for Resident #188 on 9/26/2025 at 5:35 AM Resident #188 have contact isolation signage present on the doorway and PPE supplies of gowns and gloves. Staff U,RN retrieved keys from their pocket, unlocked the medication cart, activated and typed on computer, donned gloves, locked the medication cart, went to the medication room, unlocked the door, opened the medication refrigerator to obtain a refrigerated medication, with gloves on, Staff U,RN poured the