STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105643	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Island Lake Center	155 Landover Place Longwood, FL 32750

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)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51234 Based on observation, interview, and record review, the facility failed to ensure a resident was evaluated for safe self-administration of medication and failed to obtain a physician order for self-administration of medication for 1 of 10 residents reviewed for medication, of a total sample of 40 residents, (#65). Findings: Resident #65 was admitted to the facility on [DATE] with diagnoses that included mild Neurocognitive disorder, chronic kidney disease and lack of coordination. Review of resident #65's annual Minimum Data Set assessment dated [DATE] indicated resident #65 had mild cognitive impairment. On 1/27/25 at 1:20 PM, a bottle of Vicks VapoRub was seen on the floor in resident #65's room. She explained she applied the Vicks VapoRub under her nose nightly from the jar which she had dropped on the floor. Review of resident #65's physician's order summary for January 2025 revealed no order for Vicks VapoRub or for self-administration of medication. Review of the medical record revealed no documentation of a self-administration of medication assessment. On 1/27/25 at 1:30 PM, Licensed Practical Nurse (LPN) L stated she was unaware resident #65 had the medication Vicks VapoRub in her room and applied it to herself. LPN L went to resident #65's room and saw the medication in resident #65's possession. A short time later when LPN L returned from resident #65's room, she said she had given the bottle of Vicks VapoRub to the Unit Manager (UM). On 1/27/25 at 3:00 PM, the Caribbean Cove UM acknowledged resident #65 had a bottle of Vicks VapoRub in her room that she self-administered. She verified there was no physician's order for the Vicks VapoRub, nor had there been an Interdisciplinary team assessment to determine resident #65 was safe to self-administer medication which was required before self-administration of medication.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 50401 Based on observation, and interview, and record review, the facility failed to provide a homelike environment for resident dining in the upstairs Vista View unit dayroom for 9 of 40 residents sampled. Findings: On 1/27/25 at 11:55 AM, in the Vista View dayroom nine residents were sitting around tables waiting for lunch. There were no tablecloths or centerpieces on the tables and staticky music was playing from a radio in the background. The Social Services Assistant (SSA) changed the channel several times in an attempt to find appropriate dining music but the static persisted. A short time later at 12:07 PM, lunch trays were delivered to the residents in the dayroom. The plates, cups, bowls and eating utensils were left on the trays and not set on the table for dining. On 1/30/25 at 12:00 PM, approximately eight residents were engaged in an activity in the Vista View dayroom. The meal cart with residents' lunches sat in the hall unattended. A few minutes later, the meal trays were passed to residents in their rooms and residents were guided back to their rooms to eat. No one ate lunch in the dayroom. On 1/30/25 at 12:15 PM, the Activities Director (AD) explained the upstairs Vista View unit's dayroom also functioned as a dining room. The AD stated the residents did not always eat meals in the dayroom but often ate in their rooms. On 1/30/25 at 12:34 PM, the Vista View Unit Manager (UM) stated sometimes the staff had residents eat in the dayroom, but there were often activities going on when the lunches came, so the residents ate in their rooms. She added it was different downstairs who received their meal trays on carts organized for the residents who ate in the dayroom. The Vista View UM explained they didn't use tablecloths for the dining room because some residents pulled on them. She explained staff didn't take the dishes off the meal trays because the tray provided a limitation of space for residents to know what items were theirs and to prevent them from going after other resident's food. She added for the assisted diners, the facility liked them to eat in their room because they felt there were less distractions. The Vista View UM acknowledged it was good practice to have residents dine in the dining room to promote socializing and created a more homelike environment. She explained the main dining room downstairs was larger and the residents there had better cognition. The Vista View UM acknowledged staff could prevent residents from pulling tablecloths off the tables and said the facility did not always encourage residents to eat in the dining room because it sometimes conflicted with activities. She confirmed dishes and silverware left on the trays for dining was not home-like. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/25 at 12:53 PM, the Director of Nursing (DON) stated there was no reason for dishes to be left on the trays during meals in the dining room and explained the facility encouraged residents to eat in the dining room for the social experience. The DON acknowledged residents being allowed to eat in the dining room in a home-like setting was a dignity issue. A short time later at 1:20 PM, the Vista View UM and the AD joined the DON and the AD explained that earlier, residents ate in their rooms because an activity was taking place in the dayroom and the meal trays arrived on two separate carts. The AD continued, residents whose meals came on the first cart had to eat in their room while residents whose trays were on the second cart continued with the activity until the second cart arrived. The DON, UM and AD agreed dining in their rooms or without tablecloths or trays removed was not a homelike dining experience for the residents. The facility's policy entitled Standards and Guidelines for Dining Services dates July 2023 indicated the facility should provide a pleasurable dining experience in a courteous and dignified manner. The document included that an appropriate number of nursing personnel should be stationed in the dining room to assist with eating.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on interview, and record review, the facility failed to ensure a resident was involved in developing and making decisions regarding her care plan for 1 of 1 resident reviewed for care planning, of a total sample of 40 residents, (#24). Findings: Resident #24, a [AGE] year-old female was admitted to the facility on [DATE], with a most recent readmission on 2/12/24. Her diagnoses included muscle wasting and atrophy, traumatic subdural hemorrhage without loss of consciousness, diabetes type II, repeated falls, dementia, and major depressive disorder. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was moderately impaired with a Brief Interview for Mental Status score of 11 of 15. On 1/27/25 at 2:41 PM, resident #24 stated she was not invited to her care plan meetings, and did not know if her son was invited to the care plan meetings either. Review of the Interdisciplinary Plan of Care Plan Meeting (IPOC) documents in the resident's electronic clinical record, revealed on 3/26/24, and 7/02/24, the IPOC indicated the resident's son attended the care plan meeting via telephone. There was no documentation to indicate the resident was ever invited/attended/declined or participated in her care plan meeting. On 10/01/24 documentation on the IPOC did not indicate if the resident or the resident's representative was in attendance or had participated. Documentation read, IDT attempted to call son with no answer. Left voice mail to return call. On 1/29/25 at 11:52 AM, the Vista View Unit Manager (UM) stated the facility's protocol pertaining to care plan meetings was that the MDS Coordinator provided a list of residents with scheduled care plan meetings to the Receptionist, who would then send emails to family/resident representatives regarding the scheduled care plan meetings. She stated if the resident was awake, alert, and oriented, the Receptionist or the MDS Coordinator would provide the resident with the schedule of the care plan meeting, and on the day of the care plan meeting, the UM would remind the resident of the meeting. The LPN/UM said if the resident attended the care plan meeting, it would be documented on the IPOC, and the resident's signature would be obtained. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 12:07 PM, MDS Coordinator N explained that upon completion of an MDS assessment, the next schedule would be opened and added to the care plan calendar. She stated the Receptionist received a copy of the schedule and sent an email notification of the care plan meeting schedule to the resident's family. If the resident was awake, and alert, a notification of the meeting would be provided to the resident. She verbalized if the resident's cognition was impaired, they would still be invited to the care plan meeting, and on the morning of the scheduled meeting, staff would go around to let the Certified Nursing Assistants know which residents needed to be up and ready for their care plan meeting. MDS Coordinator N said if the resident attended the care plan meeting, the resident would sign the IPOC document to indicate they attended. She stated that typically MDS would call the resident's son, and on the day of the care plan meeting they would ask the resident if they wanted to attend. She said resident #24 usually did not attend, and documentation on the IPOC document should have indicated that the resident declined. The resident's IPOC dated 3/26/24, 7/02/24, and 10/01/24 were reviewed with the MDS Coordinator. She acknowledged there was no documentation to indicate the resident was invited /attended/ or participated in her care plan meetings. MDS Coordinator N stated she would review the resident's clinical records as sometimes a progress note regarding the care plan meeting would be documented by the UM. A review of the clinical records showed no additional documentation regarding the resident's invitation/attendance or participation in her care plan meetings. This was acknowledged by MDS Coordinator N. On 1/29/25 at 2:09 PM, MDS Coordinator N stated the facility did not have a policy regarding residents' participation in the care plan meeting process, but they followed the MDS 3.0 Resident Assessment Instrument Manual . On 1/30/25 at 11:26 AM, the Director of Nursing (DON) stated residents were always invited to their care plan meetings and encouraged to participate. The resident's clinical records were reviewed with the DON. She acknowledged that there was no documentation to indicate the resident was invited/attended/declined or participated in her care plan meetings on the dates identified. The Center For Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User Manual Version 1.19.1 dated October 2024 described care planning as Establishing a course of action with input from the resident (resident's family and/or guardian or other legally authorized representative) . that moves a resident toward resident-specific goals utilizing individual resident strengths and interdisciplinary expertise; crafting the how of resident care. Chapter 4 of the Manual titled Care Area Assessment Process and Care Planning directs that care plans should be developed by Involving resident, resident's family and other resident representatives as appropriate.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51234 Based on observation, interview, and record review, the facility failed to maintain a sanitary environment by not ensuring reusable oxygen humidifier bottles were cleaned per manufacturer's guidelines for 1 of 3 residents reviewed for humidified oxygen use, of a total sample of 40 residents, (#52). Findings: Resident #52 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, heart failure, sick sinus syndrome, and COVID-19, onset date of 1/18/25. On 1/28/25 at 10:05 AM, resident #52 was observed with the Director of Nursing (DON) in his room. He had his nasal cannula connected to an oxygen concentrator with a reusable humidifier bottle. Clear liquid bubbled inside the reusable humidifier bottle. The DON verified the humidifier bottle was dated 10/31/24 as written on the reusable humidifier bottle. Review of the undated oxygen concentrator user's manual, in the section regarding cleaning of the humidifier bottle, the next step after cleaning the bottle was to disinfect the humidifier parts by immersing them in a disinfection solution, then rinse under running water, and dry. On 01/29/25 at 10:35 AM, Licensed Practical Nurse (LPN) F said he was the Weekend Supervisor. He explained that on 1/25/25 he did an audit of residents who received supplemental oxygen including cleaning resident #52's reusable humidifier bottle with soap and water. LPN F said he dried the bottle with paper towels, added sterile water to the bottle, and reconnected it to the concentrator for use. LPN F said the reusable humidifier bottles should be cleaned weekly and replaced with a new bottle once a month. He stated he did not recall seeing the date 10/31/24 written on resident #52's reusable humidifier bottle, and acknowledged he did not date the bottle himself. LPN F verified he did not document that he cleaned resident #52's reusable humidifier bottle in the resident's medical record. He confirmed he did not know the bottle should be disinfected after washing as recommended by the manufacturer. On 1/29/25 at 2:50 PM, the Assistant Director of Nursing (ADON) reviewed clinical in-service education regarding infection control for oxygen use dated 12/07/24, 12/08/24, and 12/09/24. The in-service information entitled, Standards and Guidelines: Oxygen with revision date December 2024, noted in the general guidelines that when utilizing humidified oxygen staff should follow manufacturer recommendations for guidance. The ADON could not elaborate if such guidance was discussed or what it comprised. On 1/30/25 at 10:19 AM, the DON confirmed the oxygen concentrator user's manual noted that disinfection should occur after washing. She thought the Facility Management Director and his staff completed the disinfection. The Facility Management Director confirmed he and his staff had not been completing the disinfection but preferred to replace the reusable humidifier bottle instead. The DON verified there was no documentation regarding resident #52's reusable humidifier bottle having been cleaned nor disinfected in the medical record .