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	03/26/2026

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

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview, and record review, the facility failed to ensure the Quality Assessment & Assurance (QAA) / Quality Assurance and Performance Improvement (QAPI) committee conducted performance improvement activities to ensure prior improvement measures were sustained which had possibility to affect 113 of 113 residents in the facility.Findings: Review of the undated facility's QAPI Program revealed the objective of the program was to provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. The document indicated the components of this process included tracking and measuring performance; identifying and prioritizing quality deficiencies; developing and implementing corrective action or performance improvement activities; and monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. During the previous recertification survey conducted 1/27/25 through 1/30/25, the facility had deficiencies cited related to medications left at bedside, and for infection control issues. During the current survey, the facility was found to have noncompliance related to medications observed at bedside and infection control related to personal protective equipment use for a resident on standard precautions. As a result of the repeat deficiency, it was identified there was insufficient auditing and oversight to prevent the citation. On 3/26/26 at 1:07 PM, the Administrator stated the facility held monthly QAPI meetings. She explained the committee reviewed several areas which included infection control and prior survey results. She stated there had been several staff turnovers in management recently including the Administrator position. The Administrator explained she had only been at the facility for about 3 weeks and their monthly QAPI meeting was scheduled for the following week. The Administrator stated they had not had the chance to review the previous survey results or assess the previous plan of correction and audits related to the concerns. She explained, as a result, she unable to say what happened as she was not aware of what the previous plan was for longevity of results to ensure lasting, systemic change in the facility.

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 0578 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to honor a resident's advanced directive wishes and failed to ensure the medical record accurately reflected advanced directives related to Do Not Hospitalize for 1 of 1 resident reviewed for Advance Directives, of a total sample of 40 residents, (#49).Findings: Resident #49 was admitted to the facility on [DATE] with diagnoses including senile degeneration of brain, depression, age-related physical debility, cognitive communication deficit and vascular dementia. Review of the Minimum Data Set significant change assessment with assessment reference date of [DATE] revealed resident #49 had a Brief Interview for Mental Status score of 8/15 which indicated she had moderate cognitive impairment. The assessment revealed she required assistance with activities of daily living and received hospice care services. Review of resident #49's electronic medical record (EMR) revealed a physician order dated [DATE] for Do Not Resuscitate (DNR). This order was also displayed on the resident demographic section in the EMR. An advanced directive care plan initiated [DATE] indicated the resident/resident representative had requested DNR status which meant that cardiopulmonary resuscitation (CPR) measures were not to be performed. Resident #49's EMR contained an Advance Directive Discussion Document dated [DATE] which indicated resident #49 wished for CPR to be withheld. No other advanced directives were indicated. On [DATE] at 1:41 PM, resident #49's daughter stated her mother was admitted to the facility in [DATE]. She confirmed resident #49 currently received hospice care services. She recalled her mother was sent to the hospital a couple of months ago although she had told the staff she did not want her mother to be hospitalized . She stated they sent her anyway. Resident #49's daughter explained she was able to get to the hospital before the hospital treated her and had her mother sent back to the facility. Resident #49's daughter expressed she was upset this occurred and did not understand why her mother was sent to the hospital since her wishes not to be hospitalized were in the chart. Review of the EMR revealed a progress note dated [DATE], written by resident #49's primary physician which read, I discussed advanced care planning with the patient including advanced directives, living will, comfort care/palliative care, end of life care, and resuscitation/intubation status. The POA [Power of Attorney] does not want any heroic life prolonging measures, no tube feeds, no hemodialysis, and no mechanical life support. The patient's HCP/POA [Health Care Proxy/Power of Attorney] consents to DNR/DNI [Do Not Resuscitate/Do Not Intubate], palliative care plan, comfort care measures, and do not hospitalize orders. Review of the medical record revealed resident #49 was noted to have vomited coffee-ground emesis. The physician was contacted and gave an order to send her resident #49 to the hospital for further evaluation. The hospital transfer form documented she transferred to the hospital on [DATE] at 10:00 PM. The change in condition form indicated resident #49's daughter was notified of the transfer on [DATE] at 10:05 PM. On [DATE] at 12:40 PM, the Social Services Director (SSD) stated she discussed Advanced Directives upon admission and completed an Advanced Directive discussion form. The SSD reviewed the physician progress note in the EMR which identified the Advanced Directives for resident #49. She explained she was aware resident #49 was a DNR and acknowledged resident #49's daughter had let everyone know she did not want her mother to be hospitalized . The SSD was unable to explain why there was no order in the chart for do not hospitalize or why the Advanced Directives were not updated to reflect the resident's wishes in the EMR. On [DATE] at 12:53 PM, the Director of Nursing (DON) explained if a resident or resident's representative did not want the resident to be hospitalized , the facility would contact the physician and obtain an order which would be documented on the resident's demographic sheet in the EMR. The DON stated she was aware resident #49 was sent to the hospital. She was unable to explain why an order was not obtained to ensure the resident's Advanced Directives wishes for no hospitalization were honored.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to request a new Preadmission Screening and Resident Review (PASARR) Level I Screening for a resident later diagnosed with a new mental illness diagnosis for 1of 1 residents reviewed for PASARR, of a total sample of 40 residents, (#78).Findings: Resident #78 was admitted to the facility from an acute care hospital on [DATE] with a diagnosis of major depressive disorder. Review of resident #78's Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed she had a Brief Interview of Mental Status score of 15 out of 15, cognitively intact. Review of resident #78's PASARR Level I screening completed on 9/23/25 was negative for mental illness or intellectual disability. Review of the order summary for resident #78 dated 3/24/26 revealed she had been prescribed Mirtazapine, an antidepressant, at bedtime for poor appetite related to depression on 3/04/26. On 3/23/26 at 1:30 PM, resident #78 was in her room sitting in her wheelchair. She had her lunch tray in front of her but had not eaten. She stated she was just not really feeling hungry and did not feel like eating. She said she was having trouble adjusting to living in the facility and missed being at home. Resident #78 said she knew her son and daughter-in-law could not take care of her anymore. Review of psychology progress notes for resident #78, revealed she was last seen by the provider on 2/18/26 and reported feeling depressed, having difficulty sleeping, and poor appetite. The treatment plan was for staff to monitor changes in the resident's mood or behavior and continue antidepressants to target depression, appetite, and sleep. On 3/24/26 at 12:20 PM, the director of MDS and Social Service Director (SSD) explained the facility's PASARR process. The SSD said when a resident was admitted either she or the MDS Director were responsible for reviewing the PASARR to ensure it was complete and accurate. She said if the form was incomplete, they would alert the admission Coordinator who would request a new PASARR from the hospital. She stated that PASARRs for new admissions were also reviewed daily during morning clinical meetings, monthly during psychotropic drug meetings with the psychology department, and when there was a significant change in behavior for the resident. Both the MDS Director and SSD confirmed resident #78 had not been screened for a new PASARR Level I. They were unable to explain why a new Level I PASARR was not completed for resident #78, when she had a change in her diagnoses.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to refer a resident with identified mental illness for a Level II Preadmission Screening and Resident Review (PASARR) evaluation and determination for 1 of 3 residents reviewed for PASARR, of a total sample of 40 residents, (#106).Findings: Resident #106 was admitted to the facility on [DATE] with diagnoses including bipolar disorder, generalized anxiety disorder, major depressive disorder and adjustment disorder. Review of the Minimum Data Set admission assessment with assessment reference date of 1/13/26 revealed resident #106 had a Brief Interview for Mental Status score of 11/15 which indicated she had moderate cognitive impairment. The document indicated her active diagnoses included anxiety disorder and bipolar disorder and received antipsychotic, antianxiety and antidepressant medications. Review of resident #106's electronic medical record revealed a Level I PASARR screening form dated 1/06/26. The form indicated resident #106 had bipolar disorder and depressive disorder. Review of the Level I PASARR screening form revealed resident #106 was identified as having an indication of a serious mental illness which caused her to have serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities which occurred in school or home settings, manifested difficulties in concentration, the inability to complete simple tasks within an established time period, made frequent errors, or required assistance in the completion of these tasks. The form indicated resident #106 required a Level II Evaluation to be conducted prior to admission to the facility. The medical record did not contain a Level II PASRR Evaluation and Determination form. On 3/24/26 at 12:20 PM, the Social Services Director (SSD) stated PASRR screenings for new admissions were reviewed in daily clinical meetings. She explained the screenings were checked for accuracy and a Level II screening was submitted if indicated. The SSD reviewed the Level I PASRR screening for resident #106. She verified the form indicated a Level II screening was required. She acknowledged the required screening had not been completed. The SSD was unable to state why the facility had not submitted for a Level II screening.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an individualized on-going activity program designed to meet the interests of and support the physical, mental, and psychosocial well-being for 1 of 1 residents reviewed for activities, of a total sample of 40 residents, (#52).Findings: Resident #52 was admitted to the facility 8/30/25. admission diagnoses included arthritis of the hip, type two diabetes, total retinal detachment of the right eye, and blindness in left eye. The [NAME] Data Set assessment dated [DATE] revealed resident #52 had a Brief Interview for Mental Status score of 10/15 which indicated he had moderately impacted cognitive impairment. The assessment indicated the resident required full assistance with meals, toileting, hygiene, and transfers. His preferences included television movies, sports, classic rock and country music, audible books, sports and bingo. The setting preferences for activities reflected to take place both outside and inside the room. Review of resident # 52's medical record revealed no active care plan for activities. On 3/22/26 at 10:30 AM, resident #52 was observed lying flat in his bed with the head of bed slightly elevated. His eyes were open. The resident stated he had to wait for someone to help him with his breakfast because he was blind. At 1:30 PM, he was observed in the same position. He stated that he was never sure what time of the day it was and gauged time based on his meals. He stated he couldn't see the remote for the television and liked to listen to sports. The next day on 3/23/26 at 10:15 AM, resident #52 was observed in same position and there was no television audible. The resident revealed he was not aware that there was a dining room or that there were activities for residents. He stated no one had ever offered for him to eat in the dining room, attend activities, or bring activities to him. He stated no one asked if he wanted to sit in a chair except when physical therapy came, right before dinner. The resident stated his brother was the only person who had visited him. Later in the day at 1:45 PM, resident #52 was in same position in his room. On 3/24/26 at 9:15 AM, resident #52 was observed in same position and no audible television. He stated he had been waiting for someone to help him with his breakfast and a couple times they had forgotten him. At 1:15 PM, resident #52's brother was visiting. The television was on with sports audible. The brother stated he always brought food, turned sports on the television, and downloaded audible books when he visited. He revealed his brother was always in bed and wasn't aware of his brother participating in any activities at the facility. Resident #52 stated he would like to go to the dining room for meals and participate in some activities. On 3/25/26 at 9:10 AM, resident #52 was observed in same position and no audible television. Resident #52 stated he was going to ask to go to the dining room for dinner. He stated he never knew what his meals were going to be because no one read the menu to him. At 4:10 PM, resident #52 was observed in a wheelchair in the hallway working with physical therapy. On 3/26/26 at 1:00 PM, the Activity Director revealed resident #52's admission ?Lifestyle and Activity Preferences Evaluation' was completed on paper dated 9/02/25 but it was not scanned into the resident's medical record until that day, 3/26/26. She acknowledged there was no activity care plan for resident #52. The Activity Director stated her department was responsible for reading the daily menu and offering daily activities to resident #52 but did not explain why it had not been done. On 3/26/26 at 3:00 PM, the DON stated the facility had no activity policy.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services in accordance with professional standards of practice related to acknowledging and following the consultant dermatologist's recommendations for 1 of 2 residents reviewed for non-pressure skin concerns, of a total sample 40 residents, (#30). Findings: Resident #30 was admitted to the facility on [DATE] with diagnoses that included vascular dementia and atopic dermatitis (dry, itchy skin). On 3/22/26 at 10:00 AM, resident #30 was in her room scratching her wrists. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed resident #30 had a Brief Interview for Mental Status score of 3/15, indicating severe cognitive impairment, and she exhibited rejection of care behaviors 1 to 3 days in the lookback period. Resident #30 was dependent on toileting, personal hygiene, dressing, and mobility. Active diagnoses included atopic dermatitis and dementia. On 3/22/26 at 10:00 AM, resident #30 was in her room and was observed scratching her wrists. On 3/23/26 at 10:37 AM, resident #30 was in her room, rubbing the skin on her abdomen and thighs up and down. On 3/25/26 at 10:23 AM, resident #30 was observed scratching her right hand. She had reddened, dry cracked skin on her right hand and a scratched area on her right wrist as she turned her hands over two times to show the skin. Resident #30 said her hands itched and rubbed both of her hands together to demonstrate. Review of resident #30's progress notes revealed a dermatology consult note dated 3/02/26 at 11:58 AM. The dermatology note showed resident #30 was seen for a rash which was not a new rash. The dermatologist documented resident #30's four extremities had dry patches, dark spots and rough bumps. The consult revealed a diagnosis of dermatitis (inflammation) of the chest, back and abdomen with persistent itching. The dermatologist's note indicated an order for Permethrin 5% cream to be applied overnight and washed off in the morning. Review of resident #30's current physician orders revealed no order for the treatment recommended by the dermatologist on 3/02/26. Review of resident #30's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for March 2026 contained no treatment of Permethrin 5% as recommended by the dermatologist on 3/02/26, nor any refusal of the medication. Review of progress notes did not show resident #30's primary physician, or representative were called for an approval of the dermatologist's recommendation on 3/02/26. Review of the progress notes contained no documentation of resident #30's representative refusal of the treatment to be applied to resident #30's skin. The progress notes did not include documentation of attempt(s) made to apply the treatment to resident #30's skin, or refusal by the resident. On 3/23/26 at 10:37 AM, Certified Nursing Assistant (CNA) E said resident #30 liked to stay in her room but at times she came out to ask staff for water or snacks. CNA E said she was not aware of any skin problems for resident #30. On 3/25/26 at 10:25 AM, Licensed Practical Nurse (LPN) F said the last time she worked with resident #30 she had something on her skin but was not sure what resident #30 had on her body. LPN F verified resident #30 had a treatment order for Hydrocortisone every eight hours, as needed for itchiness which was written on 2/08/26. LPN F said resident #30 was itching the last time she worked but could not recall the day or date. The nurse said resident #30 let staff know when she needed anything. She felt resident #30 would have told the staff if she had itching. On 3/25/26 at 10:32 AM, the 200 Hall Unit Manager (UM) said resident #30 had no concerns that morning when she saw her and was not itching. The UM and LPN F said when there was a new recommendation from a consulting physician, such as a dermatologist, the resident's physician would be called by the nurse who spoke to the consulting specialist and the order would be placed in the medical record. They explained, the same nurse would call the responsible family member and inform him/her of the new order. On 3/25/26 at 10:35 AM, the 200 hall UM and LPN F entered resident #30's room and confirmed she was observed rubbing her hands together. The UM and LPN F said resident #30's hands were red, and dry and confirmed resident #30 had a scratch on her right wrist. The 200 hall UM asked resident #30 if she (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was itchy and resident #30 rubbed both her right and left hands in a circular motion from her hands to her wrists, to indicate where she itched. On 3/25/26 at 10:40 AM, the 200 hall UM and LPN F reviewed resident #30's physician orders in the computer. LPN F removed a tube of medication from the treatment cart, went to resident #30's room and applied the cream to both of her hands and wrists. Resident #30 did not refuse the treatment. On 3/25/26 at 2:58 PM, in a joint interview with the Regional Nurse Consultant (RNC) and the Director of Nursing (DON), the DON said the process when a specialty physician such as a dermatologist recommended a new order, that specialty physician will verbally communicate the recommendation to a nurse. The DON continued that the nurse was responsible for documenting the new order or recommendation in a physician's order after they had spoken to the primary physician for approval of the new order or treatment. She explained the new order would be placed in the MAR and/or TAR, then the nurse would call the resident's family to let them know of the new order then complete documentation in a progress note. The DON reviewed the dermatology note dated 3/02/25 and read the physician's recommendation aloud: Start Permethrin 5% cream applied from neck down overnight and wash off in the morning; repeat in seven days for total of two treatments. The DON and the Regional Nurse Consultant (RNC) reviewed resident #30's physician orders for the dermatology recommendation for Permethrin. The DON and the RNC confirmed there were no corresponding physician orders in electronic medical record (EMR). The DON said resident #30 refused her medications many times and her family was aware. The DON said, in the past, the resident #30's son agrees with only certain medications or treatments prescribed by the physician. The DON acknowledged a progress note should be in the medical record if the son refused the treatment recommended by the dermatologist. The medical record was reviewed by the DON and the RNC and confirmed the EMR revealed was no progress note to indicate the recommendation from the dermatologist was communicated to resident #30's physician and/or family. They confirmed there was no progress note or other documentation in resident #30's medical record to indicate her family refused the treatment recommended by the dermatologist. Review of the policy revised on January 2026 titled, 'Standards and Guidelines: Physician Orders,' revealed, that verbal orders should be recorded in the resident's chart by the authorized person who received the order and should include the prescriber's name, credentials, the date and time of the order. The policy noted the resident would be informed of medication changes as they occurred, and if the resident was incapable of making health care decisions, the resident's responsible party would be informed of medication changes as they occurred.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow physician's orders consistent with professional standards of practice for 1 out of 4 residents reviewed for respiratory care, of a total sample of 40 residents, (#92). Findings: Resident #92 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease, Alzheimer's disease, Type two Diabetes Mellitus and dementia. A review of the Annual Minimum Data Set with assessment date 1/29/26 revealed resident #92 was cognitively impaired with a Brief Interview for Mental Status of 0 out of 15. Review of the medical record revealed documentation that resident #92 had a change in condition on 3/06/26. The documented assessment revealed the resident had shortness of breath and her oxygen saturation was at 88%. Subsequent orders from the physician on 3/06/26 included delivery of continuous oxygen at 2 liters per minute (LPM) via nasal cannula, provide portable oxygen tank for 2 LPM nasal cannula, monitor oxygen saturation twice a day and to consult pulmonology. Resident #92's current plan of care indicated she was at risk for altered respiratory status or difficulty breathing related to shortness of breath. Interventions included administer oxygen as ordered and monitor oxygen saturations as ordered. The care plan most recent revision was on 3/10/26 and did not mention non-compliance with oxygen therapy and had no interventions regarding non-compliance. Review of the medical record showed oxygen saturation levels were documented on 3/13/26 but contained no documentation of the actual levels from 3/06/26 on. The nurses' progress notes contained no documentation of the resident's refusal to wear oxygen as ordered and no documentation of a pulmonary consultation on 2/17/26 and 3/06/26. Review of the medication administration record (MAR) revealed nurses checked off the task of monitoring oxygen saturation twice daily but did not record the measurement of the percentage of oxygen saturation. On 3/22/26 at 10:46 AM, resident #92 was observed sitting in the common area. She was not wearing the nasal cannula connected to oxygen, as ordered by the physician. On 3/24/26 at 4:38 PM, resident #92 was observed not wearing the oxygen as ordered. Registered Nurse (RN) A was present and said she was not aware the resident used oxygen and was ordered to be on 2 LPM of continuous oxygen. Both RN A and Certified Nursing Assistant (CNA) C, who joined the interview, verified there was neither an oxygen concentrator nor a portable oxygen tank at the resident's bedside. CNA C said she remembered the resident had a portable oxygen tank but she never used it. RN A then verified the physician's order for oxygen in the computer and said she would call the doctor to change it from continuous to as needed. RN A continued to explain that the resident would let them know if she was short of breath, that she did not complain of any shortness of breath lately and that her oxygen was fine. She said she checked the resident's oxygen saturation earlier and it was fine. On 3/25/26 at 9:45 AM, the Director of Nursing (DON) reviewed resident #92's MAR and explained the resident's oxygen was monitored by the indication of the check marks on the MAR. The DON was unable to say how anyone including the physician would know what the oxygen saturation was if the actual measurement was not documented, and no refusals were noted by the nurses. On 3/25/26 at 1:31 PM, in a telephone interview, resident #92's attending physician said if there was an order to monitor oxygen saturation, she expected the actual oxygen saturation measurement to be recorded in the medical record so it could be reviewed. She said together with her Nurse Practitioner, the facility's staff would often say that the resident was fine, but when her and the Advanced Practice Registered Nurse (APRN) did their own test, they found resident #92's oxygen saturation was low, so they placed orders for the resident to be monitored twice a day. The physician explained this situation happened again and they placed the orders in addition to a second pulmonary consult when they could not find any documentation in the record of whether the resident had the pulmonology consult or not. She said she had not been informed the resident had not been wearing her oxygen but would reach out to the APRN for more information. On 3/25/26 at 3:52 PM, in a telephone interview, the APRN for resident #92 said she (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requested the oxygen delivery to be continuous and for the oxygen saturation to be monitored once during the day and once at night. The APRN explained the resident had low oxygen saturation in the past and her order for oxygen was as needed at that time, but that situation had resolved. She continued that when she saw the resident in March, her oxygen saturation was low and placed new orders for oxygen and pulse oximetry measurements. The APRN explained staff reported the resident's oxygen saturations were not low but whenever she checked the oxygen saturation it was. She said facility staff indicated the resident was not going to be compliant with the orders when she had seen the resident not wearing oxygen. She said she explained to staff they needed to remind resident #92 to wear her oxygen. The APRN conveyed her experience was the resident understood she needed the oxygen, agreed to wear it and was given an oxygen tank. She continued that staff reported the resident would not be compliant with wearing the oxygen because she walks with a rolling walker and it's not like she had a third arm. The APRN said this was the reason we asked for the pulmonary consultation and ordered oxygen saturation checks twice daily. She said she figured the resident could have had a small portable tank she could carry around. The APRN confirmed there were two orders placed for a pulmonary consultation and the Unit Manager reported the resident was seen by a pulmonologist, but they had no documentation or paperwork from the consult. The APRN said a facility nurse called yesterday stating the resident's oxygen saturation was fine and they requested to discontinue the oxygen. The APRN explained she did not discontinue the oxygen order but changed it to as needed instead of continuous in case the resident needed it. The APRN elaborated that the order for monitoring, meant she expected the nurses to use a pulse oximeter and record the percentage of oxygen for everyone involved in her care to see in the medical record. She said, I find that they don't always do that. On 3/25/26 at 4:36 PM, the Transportation Coordinator confirmed she managed transportation and scheduling of consults at the facility. She said the pulmonary physician used by the facility was in-house. The coordinator verified she did not schedule an outside appointment with the pulmonologist and said the nurses or the Unit Managers usually took care of those consults or referrals. On 3/25/26 at 5:06 PM, Licensed Practical Nurse (LPN) D explained if a resident was ordered a consult, she would put the physician order into the computer, she would print it out and the Unit Manager would be expected to follow up and follow through. LPN D continued that for any physician's orders she followed what was ordered and if a resident refused something, she would notify the physician, write a note in the record, and wait for any new orders. On 3/25/26 at 3:56 PM, the DON confirmed that nurses monitoring oxygen saturation should include the actual numbers as measured. She explained the expectation for nurses was to monitor the oxygen saturation and document the percentage of oxygen in the medical record as ordered by the physician. The DON said for consultations, once the recommendation, referral or order was placed, the Unit Manager should communicate to the Transportation Coordinator. She continued, once an appointment was made the Unit Manager should be made aware, would discuss the appointment in morning meeting and would get back to the physician if the resident was unable to make the appointment. The DON conveyed the Unit Manager would document in the medical record all new orders obtained from the consult or the physician and if there were no new orders in the residents' chart, they would discuss that in their morning meetings. The DON was unable to provide documentation regarding resident #92's pulmonary consult. The facility's policy on physician orders issued October 2020, and revised January 2026 indicated physician orders should be followed as prescribed and if not followed it should be recorded in the resident's medical record during that shift. The policy detailed that the physician and the party responsible should be notified, if indicated. Review of the Guidelines for Oxygen Administration issued October 2019, and revised January 2026 revealed staff should notify the supervisor if the resident refused the procedure and should report other information in accordance with facility policy and professional standards of practice.

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	03/26/2026

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and accurate administration of medication to meet the needs of residents, for three of six residents reviewed for medication administration, of a total sample of 40 residents, (#41, #37, and #77).Findings: 1. Resident #41 was admitted on [DATE] from an acute care hospital with diagnoses that included Alzheimer's disease, dementia with psychotic disturbance, gastro-esophageal reflux disease (GERD) and dysphagia-oral phase. The American Speech-Language-Hearing Association says a disorder in swallowing is called dysphagia. Dysphagia oral phase is a problem with sucking, chewing and moving food and/or liquid into the throat which could lead to it going into the airway (aspiration), and pneumonia or other lung infections, (retrieved on 4/08/26 from www.[NAME].org). Review of resident #41's current physician orders revealed medications including Sucralfate one Gram tablet, by mouth, four times a day for GERD. The instructions directed the nurse to dissolve one tablet in 10 milliliters of water before meals and at bedtime for administration. Resident #41 had additional orders including the medication Pantoprazole Sodium Oral tablet Delayed Release 40 milligrams with instructions to give one tablet by mouth twice a day for GERD. The instructions for the nurse included do not crush, chew or split with a start date of 4/09/25. There were no physician orders for self-administration of medication. Resident #41 had a care plan for dated 7/20/24 for impaired cognitive function/impaired thought processes related to Alzheimer's and diagnosis of dementia with psychotic disturbance. A care plan dated 7/20/24 for risk for alteration of nutrition related to GERD included an intervention to Administer medications as ordered. Resident #41 had an additional care plan dated 8/14/24 for a risk for aspiration related to mechanically altered diet. Interventions included encourage resident to eat in an upright position, keep head of bed elevated, monitor for excessive excretions, and any signs of dysphagia including pocketing, choking, coughing, drooling, and holding food in mouth. There was no care plan for self-administration of medication. On 3/22/26 at 10:20 AM, resident #41 was in his bed by the window with his eyes closed. On the floor there was a blanket dirty with dried food stuck to it and on the floor. There was dried food on his sheets, and the room-divider curtain. On the resident's nightstand was a small plastic cup containing two white tablets. (photo evidence obtained). A few minutes later outside the room Licensed Practical Nurse (LPN) K was standing at her medication cart and confirmed she was the assigned nurse for resident #41. LPN K described resident #41's mentation as confused. She confirmed resident #41 was not able to self-administer his medications due to his confusion. The LPN said she had not left the cup of medications in the room and had not seen the cup on the nightstand when she gave him his morning medications earlier that morning. LPN K went to resident #41's bedside and retrieved the cup of medications. She said they were resident #41's Pantoprazole and Sucralfate probably left with the resident by the night shift nurse. LPN K looked in her Medication Administration Record (MAR) and said the night shift nurse erroneously signed off in the MAR they were administered at 6:03 AM that morning. LPN K explained the large white tablet was Sucralfate, which was supposed to be dissolved in water before (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration to the resident. The nurse confirmed resident #41 could not self-administer his medications and acknowledged if the medicine was left at the bedside, the nurse would not know if the resident actually took the medications or they could be taken by someone else. On 3/25/26 at 3:18 PM, in a joint interview with the Director of Nursing (DON) and the Regional Nurse Consultant, the DON explained the facility policy was that no medication should be left at the bedside unless the resident was assessed by the nurse for self-administration of medications and there was an order for self-administration from the physician. The DON confirmed resident #41 did not have an assessment or a physician order to self-administer his medications. She stated a resident with a low cognitive assessment test score like resident #41 would not be safe to take medications on their own. Review of the Standards and Clinical Guidelines: Medication Administration, with most recent revision January 2026, revealed medications should be administered in accordance with prescriber orders, and residents may self-administer their own medications only if the attending physician, in conjunction with the Interdisciplinary Care Planning Team has determined the resident had the decision-making capacity to safely do so. 2. Resident #37 was admitted to the facility from an acute care hospital on 3/05/26 with diagnoses that included osteoarthritis of the right hip, prostate cancer, muscle weakness, and chronic pain. On 3/25/26 at 1:21 PM, Registered Nurse (RN) L was observed during medication administration for resident #37. She looked at the resident's order on the computer and pulled two of his medication peel packs containing tablets and a bottle of Acetaminophen 500 milligrams (mg). From each peel pack and the Acetaminophen bottle she took one tablet and dropped them each into a medication cup for a total of three tablets. The nurse proceeded into resident #37's room with the medication and a cup of water. She told the resident what each tablet was and administered the medication. Review of resident #37's order summary dated 3/26/26 revealed an order for Acetaminophen 500 mg two tablets by mouth, three times per day for pain, which was a total of 1000 mg per administration. On 3/25/26 at 1:47 PM, RN L was notified she had administered only one tablet of the Acetaminophen instead of two as was ordered by the physician. She stated she only saw the 500 mg dosage but did not realize she was supposed to give two tablets for a total of 1000 mg. The nurse acknowledged she made a mistake and should have verified the amount of medication to be given, not just the strength of the medication to ensure the resident was not being under or over medicated. She confirmed she did not follow the physician order. 3. Resident # 77 was admitted to the facility from an acute care hospital on [DATE] with diagnoses that included systemic lupus erythematous, immunodeficiency, chronic kidney disease stage 3, cognitive communication deficit, and colostomy status. On 3/24/26 at 8:56 AM, LPN M was observed during medication administration for resident #77. She pulled up a total of eight medications including a metered dose inhaler and Cranberry 450 mg tablets. LPN M proceeded to administer the inhaler first followed by the other medications, which were all tablets. The LPN did not have the resident rinse their mouth after receiving the inhaler, which is recommended after administration of metered dose inhaled medications. A metered dose inhaler (MDI) is a small handheld device that disperses medication into the airways via an aerosol spray or mist through the activation of a propellant. A measured dose of the drug is (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	delivered with each push of a canister, and dosing is usually achieved with one or two puffs. After administration of the inhaler patient should rinse mouth and gargle with warm water two minutes after treatment. Rinsing removes residual medication from mouth and throat and helps prevent oral candidiasis, (retrieved on 4/09/26 from drugs.com). Review of resident #77's order summary dated 3/26/26 revealed an order for Cranberry oral tablet 300 mg, one tablet once per day for urinary tract infection ordered on 1/26/26. On 3/24/26 at 9:07 AM, LPN M acknowledged she did not administer the correct dose of the Cranberry and had grabbed the house stock bottle without realizing the dosage was different than what was ordered. She also acknowledged she did not have the resident rinse her mouth following the administration of the inhaler. On 3/26/26 at 1:28 PM, the Director of Nursing (DON) acknowledged the two medication errors. She stated the expectation was for nurses to ensure they verified the resident's orders prior to administering medications to ensure they were giving the correct medication and dosage.

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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** Based on observation, interview, and record review, the facility failed to ensure staff followed transmission-based precautions to prevent spread of infection and ensure residents were provided a safe, sanitary and comfortable environment by preventing the development and transmission of communicable diseases and infections for 1 out of 1 resident reviewed for transmission based precautions, of a total sample of 40 residents, (#56).Findings: On 3/22/26 at 10:15 AM, room [ROOM NUMBER]'s door was open with a Contact Precaution sign posted but nothing on the sign to identify which bed was on precautions. A nursing student completed hand hygiene and donned gloves then walked into room [ROOM NUMBER] to see resident #56 in the B bed by the window. Registered Nurse (RN) H was outside the room at her medication cart. RN H completed hand hygiene and proceeded into room [ROOM NUMBER] bed B to see resident #56 and administered oral medications. RN H did not don gloves or gown. RN H and the nursing student exited the room, and a few minutes later at approximately 10:25 AM, RN H stated resident #9 (#118A) had scabies and was on contact precautions. At 10:30 AM, RN H completed hand hygiene and donned gown and gloves, then entered room [ROOM NUMBER]. She administered inhaled medications to resident #56, in the B bed and walked into the bathroom. RN H doffed the gown and gloves, completed hand hygiene and explained she wore the gown and gloves this time when administering medications to resident #56 because resident #9 used the same bathroom and was on contact precautions for the scabies. On 3/22/26 at 10:40 AM, resident #9 was in bed watching TV and said as she pointed to her roommate, resident #56, she has scabies, not me. Review of resident #56's (room [ROOM NUMBER]B) medical record revealed a physician order for contact precautions for possible scabies to continue 14 days on 3/19/26. On 3/26/26 at 10:30 AM, the Infection Preventionist Nurse confirmed resident #56 had physician orders for contact precautions for scabies. She revealed she was aware RN H had mistakenly believed resident #9 had contact precautions instead of resident #56 and did not wear the proper protective equipment when providing care.