STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105655	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inn at Freedom Village, The	6410 21st Ave W Bradenton, FL 34209

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 49227 Based on observations, interviews, and record reviews the facility failed to ensure privacy of personal health information on three medication carts (Wing A and Wing C) out of four medication carts observed. Findings included: On 7/17/24 at 11:09 a.m. the facility's nursing shift report form was observed unattended on top of one of two medication carts on the Wing A hallway. The cart was assigned to Staff E, Registered Nurse (RN). (Photographic Evidence Obtained). On 7/17/24 at 11:10 a.m. the facility's nursing shift report form was observed unattended on top of one of two medications carts in the Wing C hallway. The cart was assigned to Staff J, Licensed Practical Nurse (LPN). On 7/18/24 at 11:19 a.m. the facility's nursing shift report form was observed unattended on top of the second medication cart in the Wing C hallway. The cart was assigned to Staff J, LPN (Photographic Evidence Obtained). The facility's nursing shift report form observed unattended on the three medication carts contained the following resident personal health information (PHI): -Room number -Date and shift skin check is scheduled -Resident's name -Mobility device -Blood sugar checks -Additional information such as type of diet, oxygen use, urinary catheter, etc., (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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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at 4:33 p.m. an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated nursing staff are expected to cover up or turn over their nursing report form to prevent disclosure protected health information. A review of the facilities policy titled, HIPAA Privacy and Security Safeguarding and Storing Protected Health Information, effective 8/1/2020, revealed the following: Purpose: To provide guidelines for safeguarding of protected health information . Policy: The policy of this community is to ensure, to the extent possible, that Protected Health Information (PHI) is not intentionally or unintentionally use or disclose in a manner that would violate the HIPAA privacy rule Safeguards for written PHI 1. Documents containing PHI should be stored appropriately to reduce the potential for incidental use or disclosure. Documents should not be easily accessible to any unauthorized staff or visitors .

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NAME OF PROVIDER OR SUPPLIER Inn at Freedom Village, The		STREET ADDRESS, CITY, STATE, ZIP CODE 6410 21st Ave W Bradenton, FL 34209	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223 Based on interviews, and record review, the facility failed to report an alleged violation of abuse/neglect within the required timeframe, related to elopement for two residents (#43 and #281) out of the four residents sampled. Findings included: 1. Review of the Admission Record showed Resident #43 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including atrial fibrillation, hypertension, unspecified dementia, and other co-morbidities. A review of Section C: Cognitive Patterns on the quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #43 had a Brief Interview Status (BIMS) score of 00 out of 15, indicating severely impaired cognition. Section G: Functional Status revealed Resident #43 needed the following assistance for activities of daily living: bed mobility, dressing, toilet use, and personal hygiene- being dependent; transfers- dependent; eating - supervision. A review of Resident #43's admission nursing evaluation showed the resident was not at risk for elopement. A review of a Progress Notes, dated 10/29/2023 at 2:20 PM, revealed the writer was alerted Resident #43 was in the parking lot. The nurse completed an evaluation, and the resident had no new concerns noted. The nurse completed an Elopement Risk Evaluation and determined Resident #43 was now at risk for elopement. The nurse contacted the physician and received new orders for urinalysis culture, sensitivity, and electronic monitoring device placement. All orders were carried out and the resident's care plan was updated as needed. 2. A review of the Admission Record showed Resident #281 was admitted to the facility on [DATE], with diagnoses including Congestive Heart Failure with hypertensive heart disease, prostate cancer, atrial fibrillation, hypertension, Parkinson's disease, dementia, and other co-morbidities. A review of Section C: Cognitive Patterns of the quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #281 had a Brief Interview Status (BIMS) score of 8 out of 15, indicating moderately impaired cognition. Section G: Functional Status revealed Resident #281 needed the following assistance for activities of daily living: toileting - substantial/maximal assistance; bed mobility, dressing, transfers, and personal hygiene- being partial/moderate assistance; walking - dependent; eating - supervision. A review of Resident #281's admission nursing evaluation showed the resident was not at risk for elopement. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Progress Note, dated 2/15/2024 at 3:45 PM, revealed the writer was alerted Resident #281 was in the parking lot. The nurse completed an evaluation, and the resident had no new concerns noted. The nurse completed an Elopement Risk Evaluation and determined Resident #281 was now at risk for elopement. The nurse contacted the physician and received new orders for an electronic monitoring device. All orders were carried out and the resident's care plan updated as needed. During an interview on 7/17/2024 at 10:25 AM the Nursing Home Administrator (NHA) and the Director of Nursing (DON) reviewed the elopement event of Resident #43 and Resident #281. The NHA stated elopements are not considered abuse or neglect therefore they are not reportable events for Day 1 and Day 5 abuse and neglect reporting. The facility submitted an Adverse Incident Form on 11/10/2023 for Resident #43, and 2/29/24 for Resident #281. Review of the facility's Policy and Procedures titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated revised September 2022, revealed the following: Policy Statement: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation. Reporting Allegations to the Administrator and Authorities: 1. If resident abuse, neglect, exploitation, and misappropriation of resident property or injury of unknown sources suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The residents representative; d. Adult Protective Services(where state law provides jurisdiction and long term care); e. Law enforcement officials; f. The residents attending physician; g. The facilities medical director. 3. Immediately is defined as: a. Within two hours of an allegation involving abuse or results in serious bodily injury; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Or b. Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. . Follow-Up Report: 1. Within five business days of the incident, the the chair will provide a follow-up investigation report. 2. The follow up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective action taken if the allegation was verified. 3. The follow up investigation report will provide as much information as possible at the time of submission of the report. 4. The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation. Review of the facility's policies and procedures titled Abuse and Neglect - Clinical Protocols dated revised March 2018 revealed the following: Definitions - . 2. Neglect as defined at S483.5, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49497 Based on interviews and record review, the facility failed to ensure the Level I Preadmission Screening and Resident Review (PASRR) was accurate for four Residents (#1, #6, #30, #24) out of 9 residents sampled for PASRR review. Findings included: 1. Review of the medical record for Resident #1 showed an admission to facility on 07/20/23 with diagnoses including unspecified dementia moderate with mood disturbance, dissociative and conversion disorder, major depressive disorder, and panic disorder. Review of the PASRR, dated 6/14/2023, showed on page two panic disorder not marked on section A. Mental Illness or suspected mental illness. Page 5 marked no diagnosis or suspicion of serious mental illness or intellectual disability indicated. Level II PASRR evaluation required. The box on page showed A level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder, and a suspicion or diagnosis of an Serious Mental Illness, Intellectual Disability, or both. A Level II PASRR may only be terminated by the Level II PASRR evaluator in accordance with 42 CFR [Code of Federal Regulation] 483.128(m) (2) (i) or 42 CFR 483.128 (m) (2) (ii). Resident with a primary diagnosis of dementia and secondary diagnoses including major depressive disorder, panic disorder and dissociative and conversion disorder with no Level II PASRR. Review of physician orders revealed: - Ativan oral tablet 0.5 tablet by mouth every 6 hours as needed for anxiety. - Duloxentine Hydrochloride capsule delayed release particles 20 mg (milligrams) by mouth one time a day for depression related to major depressive disorder. - Levetiracetam oral tablet 250 mg by mouth four times a day related to unspecified dementia moderate with mood disturbance, dissociative and conversion disorder. A review of the Minimum Date Set (MDS), dated [DATE], revealed: - Section C: Cognitive Patterns: showed a Brief Interview for Mental Status (BIMS) score of 12 indicating no cognitive impairment. - Section I: Diagnoses marked included non-Alzheimers Dementia, anxiety, depression, dissociative and conversion disorder. - Section N: Medications marked yes for antianxiety, antidepressant. A review of the care plan, dated 04/26/24, revealed: - A focus Has impaired cognitive function/dementia or impaired thought processes. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions included Collaborate with hospice as needed. - A focus Uses psychotropic medications. She receives antidepressant medication for depression, anxiolytic for anxiety and hypnotic for sleep. Intervention included administer medications as ordered, and monitor/document for side effects and effectiveness. 2. Review of medical record for Resident #6 showed an admission to facility on 09/20/23 with diagnoses including unspecified dementia, mood disorder due to known physiological condition with depressive features, bipolar disorder II, anxiety disorder, major depressive disorder. A review of Pre-Admission Screening and Resident Review (PASRR), dated 09/23/23, showed no mental illness or suspected mental illness marked on page two section A, all boxes were left blank. Review of the physician orders revealed: - Paroxetine Hydrochloride oral tablet 20 mg, 1 tablet by mouth one time a day related to major depressive disorder. Review of the Minimum Data Set (MDS), dated [DATE], revealed: - Section I Diagnoses included anxiety, depression, bipolar, and non-Alzheimer's dementia. - Section C a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. - Section N marked yes for antidepressant. Review of the care plan, dated 04/29/24, revealed: - A focus of Received antidepressant or dx of depression. Past attempt at GDR [gradual dose reduction] unsuccessful date initiated 12/08/22, revision on 03/28/23. Interventions including Administer medications as ordered. Monitor/document for side effects and effectiveness. Date initiated 12/08/2020. - A focus of Has depression related to disease process major depressive disorder. date initiated on 10/08/2020, revised on 12/17/2020. 3. Review of Resident #30's medical record showed an admission to facility on 07/28/17 with diagnoses including major depressive disorder, schizoaffective disorder bipolar type, vascular dementia mild with mood disturbance, and generalized anxiety disorder. Review of the physician orders revealed: - Quetiapine Fumarate oral tablet 25 mg. Give 12.5 mg by mouth at bedtime for schizoaffective disorder, bipolar type paranoia, mania symptoms, for failed dose decrease attempt. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS, dated [DATE] revealed: - Section C Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive impairment. - Section I diagnoses marked yes for anxiety disorder, depression, schizophrenia, and non-Alzheimer's dementia. - Section N marked yes for antipsychotics. Review of the care plan, dated 03/21/24, revealed: - A focus of Experiencing changes in psychosocial well-being, related to her diagnosis of schizoaffective disorder, bipolar type, psychosis. Date initiated 04/29/20, revision on 06/22/23. Interventions including clinical monitoring guidelines in the MAR to be filled out daily by nursing. - A focus of Potential to demonstrate physical behaviors related to dementia. Date initiated 10/12/20, revised on 03/22/23. Interventions including Assess and anticipate resident needs for food, thirst, toileting needs, comfort Review of PASRR, dated 07/25/17, showed no boxes marked on page 2 section A question MI [mental illness] or suspected MI. Section II on page 4, question #6 Does the individual have a secondary diagnosis of dementia, related neurocognitive disorder (including Alzheimer's disease) and the primary diagnosis is an SMI or ID marked No. Question #7 Does the individual have validating documentation to support dementia or related neurocognitive disorder (including Alzheimer's disease marked Yes. The outlined box on page 4 reveals Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder, and a suspicion or diagnosis of an SMI, ID, or both. A level II PASRR may only be terminated by the Level II PASRR evaluator in accordance with 42 CFR 483.128 (m)(2)(i) or 42 CFR 483.128(m) (2)(ii). No level II PASRR completed. 48223 4. Review of the Admission Record showed Resident #24 was admitted on [DATE] and readmitted on [DATE] with diagnoses of cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery; major depressive disorder recurrent severe with psychotic symptoms; Bipolar disorder, unspecified dementia, mood disorder due to known physiological condition; anxiety disorder, and other comorbidities. Review of Resident #24's PASRR Level I Assessment, dated 5/17/2021, did not reveal a qualifying mental health diagnosis marked in section I A. nor was the diagnosis of Dementia. A level II PASRR was not completed. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Social Service Coordinator (SSC) on 7/18/2024 at 11:47 AM. The SSC stated the Director of Social Services (SSD) completes PASRR's, and the SSD was out of the facility but was able to be reached by telephone. The SSC then proceeded to call the SSD. The SSD stated the Assistant Director of Nursing (ADON) reviews the PASRR upon resident admission, the ADON will bring PASRR to the Interdisciplinary Team (IDT) meeting if any questions arise after review. A determination is made if the PASRR needs correction. She stated the ADON will initiate the Level II PASRR if it is warranted. An interview was conducted with the ADON on 11/18/2024 at 11:58 AM. The ADON stated on admission she completes a chart review for history, medications, diagnoses, and PASRR. She stated a review of the PASRR is done ensuring the marked diagnoses match the diagnosis list and a resident warrants an updated PASRR if a diagnosis is not identified at the hospital when admitted to the facility. She stated in addition to new residents the order listing report is completed for all residents each morning to see if a new antipsychotic or antidepressant, etc was added. She stated if any are added then a review of the resident's PASRR is completed to determine if an updated PASRR is needed. The ADON stated the facility does not have a process in place to alert the staff when new diagnoses are added to a resident chart unless they receive new orders. The ADON reviewed Residents: #1, #6, #24 and #30 and confirmed 4 of 4 residents have a primary or secondary diagnoses of dementia and/or Alzheimer's, along with a mental illness or suspected mental illness that was marked yes on their PASRR's page 2 and none of the residents had Level II PASRR completed. The ADON stated, I should have put the Dementia or Alzheimer under question #7 on page 4 other, this would have prompted an update of the Level I and indicated a Level II PASRR be completed. Review of the facility's policies and procedures titled Admission Criteria, dated revised March 2019, revealed the following: Policy Statement: Our facility admits only residents whose medical and nursing care needs can be met. Policy Interpretation and Implementation: . 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per Medicaid Pre-Admission Screening and Resident Review (PASRR) process. a. The facility conducts a level 1 PASRR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD. b. If the level one screen indicates that the individual may meet the criteria for AMD, ID, or RD., he or she is referred to the state PASRR representative for the level 2 (evaluation and determination) screening process. (1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or event) MD, ID or RD. (2) The social worker is responsible for making referrals to the appropriate state designated authority. 3 c. Upon completion of the level 2 evaluation, the state PASRR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility appropriate. d. The state PASRR representative provides a copy of the report to the facility. e. The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the resident that are outlined in the evaluation. f brought back. Once the decision is made, the state PASRR representative, the potential resident and his or her representative are notified.

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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** 48223 Based on observations, interviews, and record review, the facility failed to provide nursing care according to standards related to properly dating skin care dressings one resident (#59) out of eight residents sampled. Findings included: Review of the Admission Record revealed Resident #59 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses to include metabolic encephalopathy, Rhabdomyolysis (skeletal muscle breaks down rapidly), history of falls and other co-morbidities. On 7/15/2024 at 10:58 AM, Resident #59 was observed and interviewed lying in the bed. Resident #59's feet were at the foot board of the bed with undated dressings. (Photographic Evidence was Obtained). The resident stated the dressings had not been changed for a couple of days. On 7/16/2024 at 11:31 AM, Resident #59 was observed and interviewed. Resident #59's feet were at the foot board of the bed with undated dressings. The Resident stated the dressing had been changed. A review of Resident #59's active Physician Order Summary Report, dated 6/27/2024, showed: Right inner Foot and side of 1st toe: Clean with normal saline/wound cleaner. Pat dry and skin prep peri wound. Cover open area with Xeroform and secure with Allevyn/CDD. If resident has fragile skin, secure with kerlix roll gauze and stretch net, as needed for replacement if soiled or dislodged, and every Monday, Wednesday, and Friday for wound care. A review of the Treatment Administration Record (TAR), for July 2024, revealed treatment was provided on 7/12/2024 and 7/15/2024. During an interview on 7/17/2024 at 1:39 PM Staff M, Licensed Practical Nurse (LPN) stated nursing was responsible for wound care with residents when ordered. Staff M, LPN stated if a resident is seen with a dressing not dated, then the dressing needs to be changed according to the physician orders and dated, The stated the event would be reported to the Unit Manager or Director of Nursing (DON). During an interview on 7/18/2024 at 11:20 AM the DON stated when dressings/treatments are completed the nurses are expected to date and initial the treatment. The DON reviewed Resident #59's foot treatments and stated the dressing/treatment should have been dated. A review of the facility's policies and procedures titled Wound Care, revised October 2010, revealed the following: Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Steps in the Procedure: . 13. Dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initials, time, and date and apply to dressing. Be certain all clean items are on clean field. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policies and procedures titled Dressings, Dry/Clean, revised September 2013, revealed the following: . Steps in the Procedure: 10. Label tape or dressing with date, time and initials. Place on clean field. 17. Apply the ordered dressing and secure with tape or bordered dressing per order. (Note: Use non-allergenic tape as indicated.) Label with date and initials to top of dressing.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49227 Based on observations, interviews, and record review, the facility failed to ensure the medication error rate was less than 5.00%. Twenty eight medication administration opportunities were observed, and three errors were identified for three residents (#23, #29 and #39) out of five residents observed. These errors constituted a 10.71% medication error rate. Findings included: On 7/17/24 at 8:04 a.m. a medication administration observation was conducted with Staff D, Registered Nurse, (RN), for Resident #21. Staff D, RN administered the following medications: -Amlodipine 5 mg (milligrams) for high blood pressure. -Abilify 5 mg for depression. - Plavix 75 mg for clot prevention. - Vitamin D 1000 units, 2 tablets for vitamin supplement. - Colace 100 mg to prevent constipation -Cymbalta 25 mg for depression - Loratadine 10 mg for allergy relief. - Senokot 2 tablets for constipation. - Multiple Vitamins with minerals 1 tablet for wound healing. - Metoprolol Succinate Extended Release 50 mg for high blood pressure -Potassium Chloride Extended Release 20 MEQ (milliequivalent) for hypokalemia [low potassium]. - Montelukast Sodium (Singular)10 mg for chronic obstructive pulmonary disease (COPD). - Spironolactone 12.5 mg for high blood pressure. Review of Resident #21's June Medication Administration Record (MAR) showed Staff D, RN, administered medications as ordered. On 7/17/24 at 9:00 a.m. a medication administration observation was conducted with Staff E, RN for Resident #29. Staff E, RN obtained Resident #29's vital signs and administered the following medications: -Hydrochlorothiazide 25 mg for high blood pressure. (continued on next page)

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F 0759

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

- Metformin 500 mg for diabetes mellitus type 2.

-Potassium Chloride extended release 20 milliequivalent (meq.) for supplement.

-Sertraline HCl 25 mg (1/2 tablet) for depression.

-Aspirin Tablet Delayed Release 81 mg for clot prevention.

-Calcium Carbonate 600 mg for supplement.

-Polysaccharide Iron Complex 1 capsule for anemia.

-Vitamin B12 100 micrograms (mcg) for vitamin B12 deficiency.

-Vitamin D25 (Cholecalciferol) 1000 units for Vitamin D deficiency.

- Med Pass 2.0 supplement drink 60 milliliters (mils)

Review of Resident #29's June MAR showed Vitamin D25 (Cholecalciferol) 3000 units was ordered. Staff E, RN administered Vitamin D25 (Cholecalciferol) 1000 units (Photographic Evidence Obtained). The nine additional medications was administered as ordered.

On 7/17/24 at 9:11 a.m. medication administration observation was conducted with Staff E, RN, for Resident #234. Staff E, RN administered the following medications:

-Escitalopram Oxalate 10 mg, 0.5 tablet by mouth for Depression.

-Glucerna Shake 237 mls (milliliters) for supplement.

Review of Resident #234's June MAR showed Staff E, RN administered medications as ordered.

During an interview on 7/18/24 at 8:38 a.m. the Assistant Director of Nursing (ADON) said she expects the nursing staff to administer medications one hour before and up to one hour after the scheduled time.

On 7/17/24 at 9:22 a.m. Resident #23's MAR was highlighted red Staff E, RN confirmed Ascorbic Acid (vitamin c) 250 mg was scheduled to be given at 8:00 a.m., had not been administered and would be given late.

On 7/17/24 at 5:30 p.m. Resident #23's June MAR showed an order for ascorbic acid 250 mg one time a day with breakfast. Staff E, RN initialed the MAR showing the medication was administered on time.

On 7/17/24 at 9:23 a.m. Resident #39's MAR was highlighted red Staff E, RN confirmed Metformin Hydrochloride (HCL) 500 mg was scheduled to be given at 8:00 a.m., had not yet been administered and would be given late.

(continued on next page)

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	105655	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inn at Freedom Village, The	6410 21st Ave W Bradenton, FL 34209

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at 5:23 p.m. Resident #39's June MAR showed an order for Metformin HCL 500 mg for diabetes each morning with breakfast. Staff E, RN had initialed the MAR showing the medication was administered on time. Review of the facility's Administering Medications, revised April 2019, showed the following: Policy: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: .4. Medications are administered in accordance with prescriber's orders, including required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. enhancing optimal therapeutic effect of the medication. .7. Medications are administered within one (1) hour of their prescribed time. .10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time before giving the medication. .21 If a drug is .given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose .

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NAME OF PROVIDER OR SUPPLIER: Inn at Freedom Village, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 6410 21st Ave W Bradenton, FL 34209	

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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. 51097 Based on observations, interviews, and record review, the facility failed to store medications safely and securely for one resident (#22) of thirty-two residents sampled. Findings included: An observation and interview with Resident #22 on 07/15/2024 at 11:28 AM revealed unsecured medications on Resident #22's bedside furniture including Tylenol, nasal spray and medicated powder. He said he takes Tylenol once in a while, he only takes a couple, no more than two and he lets the nurse know when he takes them. A review of Resident # 22's most recent Quarterly Minimum Data Set (MDS), with a date of 05/28/2024, revealed in section C-Cognitive Patterns: a Brief Interview for Mental Status (BIMS) score of 15 indicating he was cognitively intact. A review of Resident # 22's July 2024 physician orders revealed an order with a start date of 03/07/2024 and no end date for Acetaminophen 325 mg [milligram], Give two tablets by mouth every 4 hours as needed for mild pain NTE [not to exceed] 3 GMS [grams] 24hr [hour]. There was no order for self-administration of medications for Resident #22. A review of Resident #22's active care plans revealed no care plan indicating self-administration of medication was in place. An interview was conducted with Staff C, Licensed Practical Nurse, (LPN) on 07/18/2024 at 11:05 AM. She said if she found medications at the bedside, she would take the medications and tell the resident they are not allowed to have them. She would report it to a supervisor. An interview was conducted with the Director of Nursing (DON) on 07/18/2024 at 11:30 AM. She said the expectations for medications found at the bedside would be to get a lock box to store the medications in. She said the nurses would normally report it to her. She said if the patient were to self-administer, they would do an assessment and try to encourage the patient to give the medications to the nurse to be stored on the medication cart. A review of policy titled Self-Administration of Medications, dated February 2021, revealed the following: Policy: Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room. The facility reorders self-administered medications in the same manner as other medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of policy titled Storage of Medications, dated April 2007, revealed the following: Policy: Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals and shall be locked when not in use .

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on interviews and record review, the facility failed to ensure laboratory results were reported to the provider, and/or physician orders were followed up on for two residents (#333 and #336) out of three sampled for reporting laboratory test results. Findings include: 1. During an observation on 7/15/2024 at 11:00 a.m., Resident #333 was observed lying down in bed with his call light within reach. The resident was well-groomed with no signs of distress. A review of the medical record showed Resident #333 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including urinary tract infection, depression, unspecified, and chronic kidney disease, stage 3 B. Review of the Minimum Data Set (MDS), dated [DATE], showed the resident had a Brief Interview Mental Status (BIMS) score of 15, which indicated cognitively intact. Review of the medical record showed abnormal laboratory results for a CBC (completed blood count) and urinalysis were reported electronically to the facility on [DATE]. The medical record revealed the staff did not review the lab report, and the abnormal results had not been reported to the physician for review. 2. During an observation on 7/15/2024 at 11:20 a.m. Resident #336 was observed lying down on his bed, dressed well-groomed with no signs of distress. Review of the medical record showed Resident #336 was originally admitted to the facility on [DATE] with diagnoses to including chronic kidney disease, stage 3 A, Type 2 Diabetes Mellitus without Complications, and Depression. Review of the Minimum Data Set, dated dated [DATE], showed the resident had a Brief Interview Mental Status (BIMS) score of 15, which indicated cognitively intact. Review of the medical record showed abnormal laboratory results for a CBC were reported electronically to the facility on [DATE]. The medical record revealed the staff did not review the lab report and report the abnormal results to the physician for review. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/17/24 at 09:36 a.m., with the Assisted Director of Nurse, (ADON), she stated on admission a Complete Blood Count (CBC) and Complete Metabolic Panel (CMP) laboratory tests are ordered for each resident. Laboratory test orders are placed in the computer by the nursing staff. She stated the order is a reminder for the night shift nurse to complete the laboratory requisition form. The completed requisitions are placed in the laboratory binder used by the phlebotomist to identify residents with test orders. She stated laboratory tests results are available the following day unless the results are critical. For residents with critical lab values the laboratory staff calls the facility and notifies the nursing staff. For non-critical laboratory results the Physician Assistant (PA) reviews 80% of the test results daily. She stated for results not addressed by the PA the nursing staff notifies the resident's physician of the test results. The ADON confirmed on 7/13/2024 Resident #336's CBC results were not reviewed by the nursing staff and the staff had not notified the physician, and on 7/10/2024 Resident #333's CBC and urinalysis tests results were not reviewed by the nursing staff and the staff had not notified the physician. The ADON stated the facility has a new doctor who has remote access and the doctor may have reviewed the resident lab results and not document the test results were reviewed. She stated the facility's process for reporting laboratory test results is for the nurse to notify the doctor when the lab results are received. A review of the facility policy titled, Lab and Diagnostic Test Results- Clinical Protocol, revised November 2018, revealed the following: Option for Physician Notification: a. Facility staff should document information about when, how, and to whom the information was provided and the response. This should be done in the Progress Notes section of the medical record and not on the lab result report, because test results should be correlated with other relevant information such as the individual's overall situation, current symptoms, advance directives, prognosis, etc. b. Direct voice communication with the physician is the preferred means for presenting any results requiring immediate notification, especially when the resident's clinical status is unstable or current treatment needs review or clarification.

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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. 50570 Based on observations, interviews, and record review, the facility failed to ensure hand hygiene was offered prior to meals to residents in the dining room during one (7/15/24) of one meal observations. Findings included: On 7/15/24 at 11:51 a.m. observations of the main dining room during the lunch meal revealed no hand hygiene was offered to residents prior to eating. There were sixteen resident in the dining room at the time of the observation. Residents were observed sitting down at their table of choice. Staff were observed assisting residents with positioning at the table. Staff were observed providing beverages and condiments to residents. At 12:29 p.m. staff started to provide each resident with their lunch meal. Observations of the main dining room from 11:51 a.m. to 12:40 p.m. revealed no hand hygiene was offered to the residents by the staff. On 7/18/24 at 9:48 a.m. an interview with Staff G, Certified Nursing Assistant (CNA) was conducted. She stated she typically assists in the dining area. She stated she provides hand hygiene when giving residents a bed bath, before they go in their wheelchair, and when they go to the bathroom. Staff G stated residents are offered hand sanitizer or assistance with washing their hands before meals. On 7/18/24 at 9:57 a.m. Staff I, CNA stated he washes resident's hands with a washcloth before they eat. He stated he typically assists residents who dine in their rooms. Staff I stated he doesn't know if staff provide hand hygiene to residents in the dining area. On 7/18/24 at 10:07 a.m. Staff H, Restorative Aide, stated she typically assists in the dining area. She stated staff offer [Vendor Name] wipes to resident's before and after they eat. Staff H stated staff assist residents with sitting at the table, obtaining their requests from the dining menu, and giving them beverages. She stated after providing the residents their beverages, is when staff provide the Sani-Hands wipes. An interview conducted on 07/18/24 at 10:31 a.m. with Resident #11 revealed she eats breakfast, lunch and dinner in the dining room. She stated she was not offered hand hygiene by staff prior to eating her breakfast this morning. She stated staff offer hand hygiene prior to meals, Once in a while. Resident #11 stated yesterday, on 7/17/24, she was provided hand hygiene by staff for one of three meals. She stated the staff gave her a wipe to clean her hands. During an interview on 7/18/2024 at 10:34 a.m. the Infection Preventionist (IP) stated it is an expectation hand hygiene is provided to residents before meals. The IP stated staff have received education on completing hand hygiene for the residents prior to meals. She stated hand hygiene was discussed during the facilities recent mock survey. The IP stated the facility has ordered hand Sani-Wipes to provide to residents prior to meals. She stated she doesn't think the CNAs are providing hand hygiene to residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/18/24 at 10:47 a.m. an interview with Resident #33 was conducted. The resident stated meals were eaten in the dining room, stated staff do not ask him if he wants to wash his hands before he eats. He stated, You have to be careful with germs in here. On 7/18/24 at 10:56 a.m. an interview with Resident #235, who typically eats meals in the dining room, the resident stated staff do not ask him about washing his hands before he eats. He stated, No one has offered me wet naps. A review of the facility's policy titled, Handwashing/Hand Hygiene, revised August 2019, includes the following policy statement: This facility considers hand hygiene the primary means to prevent the spread of infection. The Policy Interpretation and Implementation includes the following: .7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: . o. Before and after eating or handling food; .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50570 Based on observations, interviews, and record review the facility failed to ensure food service equipment was maintained in a safe operating condition in two of two kitchen freezers. Findings included: On 7/15/24 at 9:44 a.m. a kitchen tour was conducted with the Director of Dining Services and the Assistant Director of Dining Services/Certified Dietary Manager (CDM). At 9:54 a.m. an observation of the large walk-in freezer revealed ice build-up on the floor upon walking in. Further observation of the large walk-in freezer revealed ice build-up and condensation throughout the freezer to include on top of racks and boxes of food items. The large walk-in freezer revealed icicles and ice build-up on the ceiling and floor. Observations of the back of the large walk-in freezer, by the blower unit, revealed icicles and ice build-up. The Director of Dining Services stated there were work orders for the large walk-in freezer and small walk-in freezer, which is inside the refrigerator. He stated the door handle of the large walk-in freezer was not working properly and does not close all the way. He stated this allows air into the freezer contributing to the ice build-up. An observation of the door revealed it did not seal and close all the way. At 9:56 a.m. an observation of the small walk-in freezer, inside the refrigerator, revealed ice build-up on the right corner of the blowing unit, as well as on the top of the rack next to the blower unit. An observation of the rack next to the blower unit revealed a small ice mound. On 7/15/24, after the kitchen tour, the CDM provided three work orders. A review of the work order for the small walk-in freezer, created on 6/27/24 by the CDM, revealed the request was completed by Staff L, Maintenance. A review of the second work order for the small walk-in freezer, created on 7/7/24 by the CDM, revealed the request was completed by the Nursing Home Administrator (NHA). A review of the work order for the large walk-in freezer, created on 7/6/24, revealed the request was completed by the Maintenance Director on 7/10/24. On 7/16/24 at 10:09 a.m. an interview with the Sous-chef regarding the work orders revealed he was told last week, by the Maintenance Director and Staff K, Maintenance, the small walk-in freezer was fixed. A second observation, with the Sous-chef present, of the small walk-in freezer revealed ice build-up on the right corner of the blower unit and a small ice mound on top of the rack next to the blower unit. The Sous-chef stated he would follow up with maintenance. A second observation of the large walk-in freezer revealed ice build-up on the floor upon walking in. Further observation of the large walk-in freezer revealed ice build-up and condensation throughout the freezer to include on top of racks and boxes of food items. The large walk-in freezer revealed icicles and ice build-up on the ceiling and floor. Observations of the back of the large walk-in freezer, by the blower unit, revealed icicles and ice build-up. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/16/24 at 2:45 p.m. an interview was conducted with the CDM. A review of the work order for the small walk-in freezer created on 6/27/24 by the CDM revealed the request was completed by Staff L, Maintenance. The CDM stated Staff L scraped the ice build-up away and applied sealant to the gaps leaking air. He stated he created another work order on 7/7/24 due to air leaking from the ceiling panel still occurring. A review of the second work order for the small walk-in freezer, created on 7/7/24 by the CDM, revealed the request was completed by the NHA. He stated the NHA closed the order by mistake. A review of the work order for the large walk-in freezer, created on 7/6/24, revealed the request was completed by the Maintenance Director on 7/10/24. For the large walk-in freezer, the CDM provided an approved estimate proposal dated 7/10/24 from [Vendor name]. The CDM stated the proposal was approved, however, the vendor was waiting for parts. At the time of the interview, he did not have documentation of the communication from the vendor regarding the delay of parts. On 7/17/24 at 12:57 p.m. an interview with the CDM revealed he did not follow-up with the vendor until today regarding the parts for the large walk-in freezer. He provided evidence of communication with the vendor, dated 7/17/24 at 9:48 a.m., to include, The needed parts will arrive within 7 days. An ETA [estimated time of arrival] will be set when they come in . For the small walk-in freezer the CDM provided evidence of communication from the vendor to include, Your technician will arrive between [DATE]:00PM and [DATE]:00PM . He stated this was a text message sent today from the vendor. A review of a service request from the vendor for the small walk-in freezer, created by Staff K, revealed a created date of 7/17/24. A review of the facility Food and Beverage Clinical Services policy titled, Equipment Maintenance, revealed under policy, It is the policy of the community to maintain equipment according to manufacturer's directions. Further review of the policy revealed under procedure, 1. All food service equipment will be operated, maintained, serviced, and cleaned according to manufacturer's directions.