STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105658	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER: Solaris Healthcare Lake Zephyr		STREET ADDRESS, CITY, STATE, ZIP CODE: 38250 A Ave Zephyrhills, FL 33542	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49227 Based on interviews and record review, the facility failed to report within two hours an injury of unknown source for one resident (# 41) of three sampled residents. Findings Included: On 7/10/2024 during the 7:00 a.m. to 3:00 p.m. shift, Staff O, Certified Nursing Assistant (CNA) observed a yellowish bruise near Resident's #41's vaginal area and did not report the observation to the nurse. On 7/11/2024 on 11:00 p.m. to 7:00 a.m. shift, Staff M, CNA said she observed a small bruise on Resident #41's left lateral thigh and did not report the observation to the nurse. Review of a Situation Background Assessment Recommendation (SBAR) form, dated 7/12/2024, showed Resident #41 had changes in skin color or condition and there were no medication changes in the past week. The blood pressure was 136/74, Pulse 82, Respiratory rate 18, Temperature 98.0 degrees and weight was 111.4 pounds. Resident #41's skin evaluation showed, Resident present bruising in the groin area and left hip, accompany by swelling of the left labia left thigh, left hip. X-ray Stat was ordered. The documentation was signed by Staff F, Registered Nurse (RN). Review of admission records showed Resident #41 was originally admitted on [DATE], with diagnoses to include metabolic encephalopathy, mood disorder, dementia, muscle wasting and atrophy, cognitive communication deficit, Alzheimer's disease, aphasia, contracture of muscles in multiple sites, and history of healed traumatic fracture. Review of Resident #41's Minimum Data Set (MDS), dated [DATE], Section G: Functional Abilities and Goals showed the resident was dependent, helper does all the effort, resident does none of the effort to complete the activity, the assistance of two of two or more helpers is required for the resident to complete the following activities: roll left and right, sit to lying, chair/bed to chair transfer, eating, oral hygiene, toileting hygiene, bathe self, dressing and personal hygiene. Review of Resident #41's Care Plan focused on extensive staff assistance with most all ADL (activities of daily living) functions. Interventions included Monitor, document, report any changes as needed . (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #41's addendum radiology report, dated 7/12/2024 at 6:46 p.m., showed comminuted (a bone that is broken in at least two places) intertrochanteric fracture left hip. No significant healing is observed involving the comminuted fracture of the left hip in the intertrochanteric location and therefore the fracture is favored to be recent. Review of the Facility's Human Resource (HR) Orientation Checklist showed Abuse, Neglect and Exploitation (ANE) prevention and reporting is discussed during orientation. Review of the facility's policy titled Change in a Resident's Condition or Status, revised on 1/30/2024, revealed the following. Policy Statement: Our facility shall promptly notify attending physician .of changes in the resident's medical/mental condition or status .1.notify the physician when there has been a discovery of injuries of unknown source . Review of facility's policy titled Resident Mistreatment, Neglect and Abuse prohibition guidelines, last review 1/24/23, revealed the following: .Training: Upon hire, annually, and additionally if determined appropriate by facility management, each employee will be trained on the following topics: what constitutes abuse, neglect, unreasonable confinement, injuries or unknown origin . employee responsibilities as a mandated reporter. .Prevention: Staff shall be regularly monitored to determine whether inappropriate behaviors are occurring. .Reporting/Response: Regulations require employees that provide services to elderly persons or dependent adults (mandated reporters) to report instances of abuse, neglect, misappropriation/ exploitation . to the state survey agency (AHCA) ,Department of Children and families (DCF) and local law enforcement agency within two hours if the alleged violation involves abuse or results in serious bodily injury or as soon as practically possible within 24 hours of detection if the alleged violation does not involve abuse and does not result in serious bodily injury. All employees are required to immediately report the facts of known or suspected instances of abuse to their direct supervisor on duty . Review of the Certified Nursing Assistant job description performance appraisal dated 3/2018, showed the following: Purpose of your job position: Provides basic nursing care to residents within the scope of the nursing assistant responsibilities and perform basic nursing procedures under the direction of a licensed nurse supervisor. .Safety- report all accidents and incidents observed on shift.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49227 Based on interviews and record review, the facility failed to prevent an injury of unknown origin for one resident (# 41) out of three sampled residents for injuries/accidents. Findings Included: Review of a Situation Background Assessment Recommendation (SBAR) form, dated 7/12/2024, showed Resident #41 had changes in skin color or condition and there were no medication changes in the past week. The blood pressure was 136/74, Pulse 82, Respiratory rate 18, Temperature 98.0 degrees and weight was 111.4 pounds. Resident #41's skin evaluation showed Resident present bruising in the groin area and left hip, accompany by swelling of the left labia left thigh, left hip. X-ray Stat was ordered. The documentation was signed by Staff F, Registered Nurse (RN). Review of admission records showed Resident #41 was originally admitted on [DATE], with diagnoses to include metabolic encephalopathy, mood disorder, dementia, muscle wasting and atrophy, cognitive communication deficit, Alzheimer's disease, aphasia, contracture of muscles in multiple sites, and history of healed traumatic fracture. Review of Resident #41's Minimum Data Set (MDS), dated [DATE], Section G: Functional Abilities and Goals showed resident was dependent, helper does all the effort, resident does none of the effort to complete the activity, the assistance of two of two or more helpers is required for the resident to complete the following activities: roll left and right, sit to lying, chair/bed to chair transfer, eating, oral hygiene, toileting hygiene, bathe self, dressing and personal hygiene. Review of Resident #41's progress notes, dated 7/9/24 at 11:37 a.m. showed a change in condition related to seizure. Nursing observations showed the Resident was observed having a seizure during breakfast this morning. Resident bit her tongue in the progress. Episode lasted about one minute. No new orders were received from the provider. There was no documentation related to bruising one week before the documented observations on 7/12/2024. Review of Resident #41's Care Plan focused on requires extensive staff assist with most activities of daily living (ADL) functions, undated. Interventions included the following: -Transfer by the Hoyer lift with two persons assist. -Bathing showering report changes to the nurse. -Totally dependent on staff for bathing. -Requires dependent assistance of two staff to turn and reposition in bed . -Requires dependent assistance of one staff to dress. -Requires total assistance to eat (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Requires dependent assistance of two staff with personal hygiene. -Monitor, document, report any changes as needed . Review of Resident #41's order summary report showed: 7/12/2024- X ray: Pelvis anterior posterior (AP) (3 view) stat (emergency) for trauma/ pain related to Alzheimer's disease. Sent Resident #41 to the hospital for further assessment and evaluation. Review of Resident #41's addendum radiology report, dated 7/12/2024 at 6:46 p.m., showed comminuted (a bone that is broken in at least two places) intertrochanteric fracture left hip. No significant healing is observed involving the comminuted fracture of the left hip in the intertrochanteric location and therefore the fracture is favored to be recent. Review of Resident #41's skin observation assessment ,dated 7/11/2024 at 7:32 a.m., showed no skin conditions were present and new skin conditions were not present. Review of Resident #41's Nursing Home Transfer and Discharge Notice, dated 7/12/23, showed: Your needs cannot be met at this facility, X-ray results abnormal with left hip fracture. An interview was conducted on 7/29/2024 at 3:28 p.m. with the Director of Nursing (DON), the Nursing Home Administrator (NHA) and the Regional Nurse Consultant. The DON said on 7/12/24 late in the afternoon Staff P, Certified Nursing Assistant (CNA) told Staff F, RN while she was providing Resident # 41's incontinence care bruising was observed. Staff F, RN, observed red and purple bruising to left hip and left inguinal area, yellow around edges, appears to be an older injury. X rays were ordered, and an internal investigation began immediately. The DON said on 7/10/2024 during the 7:00 a.m. to 3:00 p.m. Staff O, CNA said she observed a yellowish bruise on the Resident # 41's left vaginal area. She said Staff O, CNA, said the bruise looked old and she assumed it was already addressed. She stated on 7/11/2024 on 11:00 p.m. to 7:00 a.m. shift, Staff M, CNA said she observed a small bruise on the Resident #41's left lateral thigh, the bruise looked old to her, and she assumed it was already reported. During a telephone interview on 7/30/2024 at 11:30 a.m. Staff L, RN said the CNA called her to the Resident #41's bedside and showed her the bruises. She immediately reported to the Unit Manager. There was bruising and edema on the left hip and left vulvar area. The bruising was bluish, it was evident it was a bruise. A left hip X ray was completed, once the resident's Primary Care Physician, (PCP) read the radiology report. Hospital transfer orders were given. Local law enforcement was also notified. During a telephone interview on 7/30/2024 at 11:40 a.m. Staff P, CNA said transferring Resident #41 to bed using the Hoyer lift, she checked the resident's brief, and she observed bruising on the leg hip area and between her legs. She immediately notified Staff F, RN. She said the bruise was really big and she had not observed bruising on Resident #41 before. During interviews on 7/30/24 with Staff L, CNA and Staff N, RN said on 7/9/2024 while giving Resident #41 a bed bath and completing a resident assessment, no bruising or skin discoloration were observed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/30/24 at 9:55 a.m. Staff O, CNA said on 7/10/2024 she noticed a bruise on Resident #41's left pubic area, she assumed the nurses were aware of the bruise and did not report the observation. She observed the same bruising on 7/11/2024. During an interview on 7/30/24 at 11:51 a.m. Resident #41's physician said aggressive movement could have led to the type of fracture sustained. Review of the Facility's Human Resource (HR) Orientation Checklist showed Abuse, Neglect and Exploitation (ANE) prevention and reporting is discussed during orientation. Review of the facility's policy titled Change in a Resident's Condition or Status, revised on 1/30/2024, showed the following: Policy Statement: Our facility shall promptly notify attending physician .of changes in the resident's medical/mental condition or status .1.notify the physician when there has been a discovery of injuries of unknown source . Review of facility's policy titled Resident Mistreatment, Neglect and Abuse prohibition guidelines, reviewed 1/24/2023, showed the following: .Training: Upon hire, annually, and additionally if determined appropriate by facility management, each employee will be trained on the following topics: what constitutes abuse, neglect, unreasonable confinement, injuries or unknown origin . employee responsibilities as a mandated reporter. .Prevention: Staff shall be regularly monitored to determine whether inappropriate behaviors are occurring. .Reporting/Response: Regulations require employees that provide services to elderly persons or dependent adults (mandated reporters) to report instances of abuse, neglect, misappropriation/ exploitation . to the state survey agency (AHCA) ,Department of Children and families (DCF) and local law enforcement agency within two hours if the alleged violation involves abuse or results in serious bodily injury or as soon as practically possible within 24 hours of detection if the alleged violation does not involve abuse and does not result in serious bodily injury. .All employees are required to immediately report the facts of known or suspected instances of abuse to their direct supervisor on duty . Review of the Certified Nursing Assistant job description performance appraisal, dated 3/2018, showed the following: .Purpose: Provides basic nursing care to residents within the scope of the nursing assistant responsibilities and perform basic nursing procedures under the direction of a licensed nurse supervisor. .Safety: Report all accidents and incidents observed on shift.

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F 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49289

Based on observations, interviews, and record review, the facility 1) failed to provide the necessary care and services for urinary catheter care, maintaining urinary flow into the urinary catheter bag and ensuring appropriate infection control techniques during urinary catheter care for one resident (#319) out of three residents reviewed for incontinence care, and 2) failed to document consent related to insertion of a catheter for one resident (#458) out of three residents reviewed.

Findings included:

1. Review of the medical record showed Resident #319 was readmitted on [DATE] with diagnoses including neuromuscular dysfunction of the bladder, infection and inflammatory reaction due to internal right hip prosthesis, pressure ulcer of sacral region, Stage 1, anxiety disorder, depression, cellulitis of right lower limb, pyuria, and Alzheimer's Disease.

Review of the physician's order, dated 07/01/2024, for Resident #319 read, Indwelling Catheter Urethral every shift. Size 16. Dx (diagnosis) Neurogenic Bladder.

Review of the care plan, dated 6/30/2024, for Resident #319 read, The resident [Resident #319] has: Indwelling Catheter r/t [related to]: Neurogenic bladder with urinary retention. Interventions: Catheter: The resident has (16 FR [French] with 10cc [cubic centimeter] balloon) (Indwelling Catheter). Position catheter bag and tubing below the level of the bladder and away from entrance room door.

During an observation on 07/15/2024 at 10:49 AM Resident #319 was lying in bed, the urinary catheter bag was observed to be full and laying on the floor under the resident's bed. The urinary catheter had a backflow of light-yellow colored urine from the bag up the urinary catheter towards the resident's bladder, unable to drain into the full urinary catheter bag.

During an interview on 07/16/2024 at 3:54 PM Staff B, Registered Nurse (RN), Unit Manager stated, The Foley [urinary] catheter should not have been laying on the floor due to infection control and it shouldn't be that full that the urine backs up into the catheter, because it can cause a urinary tract infection.

During an interview on 7/17/2024 at 07:33 AM the Director of Nursing (DON) stated, The Foley catheter should not be laying on the floor. It should be hung below the bladder but not touching the floor. The Foley catheter laying on the floor poses a risk for infection and if the backflow in the catheter reaches the resident, it could cause pain and infection.

During an interview on 07/17/2024 at 9:54 AM Staff A, Registered Nurse (RN) stated, The urinary catheter should not have been on the floor. It looks like it was so full the hook slipped off the bed. The backflow of the urine could cause a UTI [Urinary Tract Infection], abdominal distention and cause the resident pain. I should have seen it when I was in her room that morning, but I didn't.

Review of the policy number 11.16, titled, Catheter Care, last reviewed on 1/30/2024, read:

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Purpose: the purpose of this procedure is to prevent catheter-associated urinary tract infections. Maintaining Unobstructed Urine Flow: 1. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. 3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the bladder. Infection Control: b. Be sure the catheter tubing and drainage bag are kept off the floor. d. Empty the collection bag as needed. 50570 2. A review of Resident #458's Admission Record revealed an admitted [DATE] and a discharge date of [DATE] with diagnoses including postlaminectomy syndrome, unspecified fracture of unspecified lumbar vertebra, subsequent encounter for fracture with routine healing, radiculopathy, lumbar region, spinal stenosis, lumbar region with neurogenic claudication, spondylosis, unspecified, functional urinary incontinence, need for assistance with personal care, and difficulty in walking, not elsewhere classified. A review of Resident #458's physician orders revealed orders to include: -Indwelling Catheter Urethral for Surgical wound with a start date of 6/14/24, -Urinary Catheter Anchor with a start date of 6/14/24, -Urinary Catheter Change as needed (PRN) plus or minus (+/-) one size with a start date of 6/14/24, -Bedside Drainage Bag Change as needed with a start date of 6/14/24. A review of Resident #458's Medication Administration Records (MAR) and Treatment Administration Record (TAR) revealed: -Insert Foley cath [catheter] 16fr [French]/10ml [milliliters] one time only for Surgical wound for 1 Day - Order Date 06/14/2024. -6/14/24 revealed a check mark, staff member initials and time of insertion to indicate the order was administered. A review of Resident #458's care plan revealed the following: Resident is incontinent of bladder. Date Initiated: 06/04/2024. Resident is frequently incontinent of bladder. Date Initiated: 06/12/2024. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident has behavior problems r/t [related to] resident refuses to get out of bed, staff encourages/educates resident on the importance of being OOB [out of bed]. At times refuses to participate in therapy, and refuses to be toileted, prefers to wear brief and have incontinent care provided by staff. Staff continue to encourage and educate resident on the importance of getting out of bed, participating in therapy and potential infections. Date Initiated: 06/12/2024 Revision on: 06/12/2024. Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 06/12/2024. A review of the progress notes for Resident #458 revealed no evidence of consent from the resident to re-insert the catheter on 6/14/24, as ordered by the physician. A review of the nurse's progress notes revealed the following: 6/14/24-Patient refused to get up to use the bedside commode, patient was checked frequently, remained dry until this morning. Patient did not use call light all night. Patient urinated all over in bed. Patient was medicated q4hr [every four hours] for pain with positive effect. Refused to get out of bed this morning. 6/14/24-Resident refused shower and asked to be washed up. CNA [Certified Nursing Assistant] provided resident with a bed bath. Linen and gown changed. Resident complain of Foley irritation. Foley irrigated and clear yellow urine flowing. -6/15/24-Patient was checked frequently, she repositioned to lay on left side, she repositioned herself to lay mostly on her back. She was repositioned on her left side and repositioned herself back on her back. Patient' Foley is patent draining yellow urine pergravity flow. Patient kept asking this writer what she can do about her back pain. Patient was given encouragement to up out of bed everyday and participate with PT/OT [Physical Therapy/Occupational Therapy]. Patient kept complaining about her Foley catheter and Foley is draining yellow urine. This writer offered to call the MD [Medical Doctor] and have it removed. She stated no. Patient was encouraged again about getting OOB to use the bedside commode as she is yelling at the writer about getting a UTI [Urinary Tract Infection] from the catheter. This writer again offered to get order to remove it and she started yelling no I have this so I don't have to up OOB. She then yelled wait until my daughters get her. Patient had 200c [milliliters] out this morning. On 7/30/24 at 10:13 a.m. an interview with the Director of Nursing (DON) revealed Resident #458 initially came to the facility with a catheter. She stated the catheter was placed a second time due to refusals of care. The DON stated the resident was refusing to be toileted at night. She stated those refusals should be in the progress note. She stated the resident was continent of the bladder but had behavioral issues and refused care at times. She stated the catheter was also placed due to preventive interventions to minimize the risk of infection to the incision cite on Resident #458's lower back. The DON stated the resident was her own responsible person, therefore, staff received verbal consent from the resident to place the catheter. She stated verbal consent should be documented in the progress note. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/30/24 at 12:30 p.m. an interview with the DON revealed Resident #458 had orders approved by the physician to have a Foley catheter placed on 6/14/24 due to the surgical incision. She stated the catheter was removed on 6/5/24 because, She [Resident #458] didn't have a supporting diagnoses to continue with the catheter. The DON stated urinary retention is not an appropriate diagnoses to continue with a catheter. She stated a voiding trial with a bladder scan was completed to determine the catheter was safe to remove. The DON stated the facility does not require informed consent on paper. She stated the facility, Documents by exception. The DON stated consent to place the catheter again was provided from the provider's order and the nurse received verbal consent from the resident at the bedside. She stated if the resident refused, it would have been documented in the MAR/TAR using a legend or code. The DON again stated the facility does not have anything formal that is required to document consent. She stated Resident #458's care plan demonstrated she was having behaviors, such as refusing to be toileted. The DON confirmed there is no written documentation related to the resident's consent to insert the catheter. She stated the documentation by exception to include a check mark and the staff's name is suffice for consent. A review of the facility's policy titled Foley Catheter Insertion, Female Resident, with a review date of 1/30/24, revealed the following: .Documentation 1. The date and time the procedure was performed. 2. The name and title of the individual(s) who performed the procedure. 3. All assessment date (e.g., character, color, clarity, etc.) obtained during the procedure. 4. The size of the Foley catheter inserted, and the amount of fluid used to inflate the balloon. 5. How the resident tolerated the procedure. 6. If the resident refused the procedure, the reason(s) why and the intervention taken. 7. The signature and title of the person recording the data.