STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105658	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solaris Healthcare Lake Zephyr	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47275 Based on observations, interviews, and record review, the facility failed to implement care plan interventions related to oxygen administration for four residents (#42, #56, #60, and #71) out of 4 residents reviewed for oxygen administration. Findings include: 1. During an observation 07/15/24 at 09:38 AM, Resident #42 was lying in bed with a nasal cannula in place and the oxygen concentrator running at 1.5 liters per minute (LPM). During an observation on 7/15/24 at 1:30 PM Resident #42 was lying in bed with a nasal cannula in place and the oxygen concentrator running at 1.5 liters per minute. During an interview on 7/15/24 at 1:30 PM Resident #42 stated, I think my oxygen should be running on 3, but the nurse is the one who usually checks it. A record review of Resident #42's Physicians order reads, (ACC-OXYGEN) Oxygen 2 liter via NC [nasal cannula] every shift. A review of Resident #42's care plan, dated 6/13/24, reads, The resident has dx [diagnosis] of Heart Failure, OXYGEN SETTINGS: O2 via: nasal prongs @ 2 LPM (continuously). During an interview on 7/18/24 at 08:30 AM Staff H, Licensed Practical Nurse (LPN) stated it is her expectation for the nurses to check the oxygen concentrator levels in the morning and on each shift. 41334 2. Review of Resident # 56's admission record documented diagnoses that included transient cerebral ischemic attack, unspecified, chronic respiratory failure with hypoxia, and chronic obstructive pulmonary disease (COPD) with(acute) exacerbation. Review of physician orders, dated 2/5/2024, read Oxygen 2 L ([liters]/min [minute] via NC [nasal cannula] every shift related to chronic respiratory failure with hypoxia. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/15/2024 at 10:45 AM Resident #56 was observed resting quietly in bed with oxygen at 3.5 liters via oxygen concentrator. During an observation on 7/16/2024 at 1:41 PM Resident #56 was observed sitting up in wheelchair with portable oxygen tank set at 2.5 liters via nasal cannula. Review of Resident #56's Care Plan read Respiratory distress: Potential for respiratory distress r/t [related to] COPD, bronchitis, hx [history] of emphysema, chronic resp. [respiratory] failure. Interventions include administer Oxygen as ordered. 3. Review of Resident #60's admission record documented diagnoses that included effusion right hip, arthritis due to bacteria, right hip, acute embolism and thrombosis of unspecified deep veins of right lower extremity, and acute kidney failure unspecified. Review of Resident #60's physician orders, dated 5/23/2024, read, Continuous O2 [oxygen] at 4 L/MIN via NC q [every] shift, every shift to keep oxygen more than 92%. On 7/15/2024 at 1:05 PM Resident #60 was observed with oxygen at 5 liters via concentrator using a nasal cannula. The oxygen concentrator was on the right side of the bed at the head of the residents bed, outside the reach of the resident. On 7/16/2024 at 7:21 AM Resident #60 was observed in bed with oxygen infusing at 4.5 liters nasal cannula on concentrator. The oxygen concentrator was on the right side of the bed at the head of residents bed, outside the reach of the resident. Review of Resident #60's care plan read, The resident has altered respiratory status/difficulty breathing r/t SOB [shortness of breath]. Intervention: 4 L oxygen via nasal cannula as tolerated. 4. Review of Resident #71's admission record documented diagnoses that included sleep apnea unspecified, chronic kidney disease stage two, chronic obstructive pulmonary disease, with acute exacerbation, acute respiratory failure with hypoxia, chronic respiratory failure with hypoxia, emphysema unspecified, and chronic diastolic (congestive) heart failure. Review of Resident #71's physician orders, dated 6/22/2022, read, Oxygen at 4 liters nasal cannula. On 7/15/2024 at 9:47 AM Resident #71 was observed sleeping in bed with oxygen at 5 liters via nasal cannula. The oxygen concentrator was observed to the right side of the resident and not within the residents reach at the head of the bed. On 7/17/24 at 7:23 AM Resident #71 was observed in bed with oxygen at 5 liters via nasal cannula. Review of Resident #71's care plan read, COPD. The resident has Emphysema/COPD, interventions oxygen as ordered, oxygen at 4 L via N/C. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/17/24 at 7:24 AM Staff G, LPN stated, It (the oxygen) is on 5 liters and should be on 4 liters. We should be following doctors orders and following our care plans for oxygen. I don't know how it got changed. We should check what it is running at when we give meds (medications), or when a resident has any changes in their condition. During an interview on 7/18/2024 at 7:15 AM the Director of Nursing (DON) stated, Our nurses should check what oxygen is running at at least once a shift or when they have any shortness of breath. We should implement our care plans for oxygen use. Our staff should know what rate oxygen is running at and verify this at least once a shift. Review of the policy and procedure titled, Care Plans Comprehensive, last review date of 1/30/2024, revealed the following: Policy statement: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the residents medical, nursing, mental, and psychological needs is developed for each resident. Policy interpretation and implementation: 3. Each resident's comprehensive care plan is designed to: e. reflect treatment goals, timetables and objectives in measurable outcomes; f. identify the professional services that are responsible for each element of care; i. reflect currently recognized standards of practice for problem areas and conditions. 5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers. It is recognized that care planning individual symptoms or care area triggers in isolation may have little, if any, benefit for the resident. 6. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident are into disciplinary processes that require careful data gathering, proper sequencing events and complex clinical decision making. No single discipline can manage the task in isolation. The residence position or Primary Health care provider is integral to this process.

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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 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: (continued on next page)

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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.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49289 Based on observations, interviews, and record review. the facility 1) failed to adhere to infection control practice standards for personal protective equipment (PPE) while providing direct care for two residents (#98 and #319) out of eight residents on enhanced barrier precautions (EBP), and 2) failed to perform hand hygiene during medication administration during 3 out of 9 observations of medication administration. Findings included: 1. Review of the medical record showed Resident #98 was admitted on [DATE] with diagnoses including pressure ulcer of sacral region (unstageable), Peripheral Vascular Disease, Paroxysmal Atrial Fibrillation, Acute Kidney Failure, Chronic Kidney Disease (Stage 3B), and Sepsis. Review of the physician's order, dated 06/03/2024, for Resident#98 read, (Incontinence Indwelling Catheter Urethral every shift related to Pressure Ulcer of Sacral Region, Unstageable .16Fr [French]/10 ml [milliliters]. Review of the physician's order, dated 07/02/2024, for Resident #98 read, Enhanced Barrier Precautions every shift for catheter, wound. During an observation on 07/15/2024 at 10:15 AM, there was an Enhanced Barrier Precautions sign hanging on Resident #98's door to his room. During an observation on 07/15/2024 at 10:25 AM, Resident #98 was lying in bed wearing a t-shirt and shorts. Observed Staff C, Certified Nursing Assistant (CNA) and Staff D, CNA on each side of the resident, both wearing gloves but no gowns. While wearing gloves but no gown, Staff C, CNA proceeded to take Resident #98's shorts off his legs, threading the catheter bag and tubing up through the right pant leg to remove the shorts. Staff D, CNA removed the left pant leg from the resident and took the urinary catheter bag, while wearing gloves but no gown, hung the urinary catheter bag on the left side of the bed. During an interview on 07/15/2024 at 12:22 PM Staff C, CNA stated, I wasn't wearing a gown when I was removing [Resident #98's name] shorts and fixing his Foley catheter. I should have been wearing a gown. During an interview on 07/15/2024 at 1:53 PM Staff D, CNA stated, I didn't wear a gown when I helped with [Resident #98's name] catheter. We are supposed to wear a gown and gloves when we handle the Foley catheter. 2. 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 physician's order, dated 07/01/2024, for Resident #319 read, Enhanced Barrier Precautions every shift for mid-line, catheter. During an observation on 07/15/2024 at 10:49 AM there was an Enhanced Barrier Precautions sign hanging on Resident #319's door to her room. During an observation on 07/15/2024 at 12:00 PM Resident #319 was lying in bed in a pair of long sleeve pajamas. The urinary catheter tubing was draped out through the right lower leg of the resident's pajama pants. Observed Staff C, CNA, wearing gloves but no gown, removed the resident's right pant leg while feeding the urinary catheter tubing and bag up through the pant leg. And while wearing gloves but no gown, fed the urinary catheter tubing and bag through the right leg of a clean pair of pants and re-dressed Resident #319. During an interview on 07/15/2024 at 12:22 PM Staff C, CNA stated, [Resident #319's name] has a Foley catheter. I was supposed to wear a gown because she has a Foley, but I forgot. I don't notice the sign on the door half the time. During an interview on 7/17/2024 at 07:35 AM the Director of Nursing (DON) stated, The staff should be wearing a gown and gloves when they are handling the urinary catheter and incontinence brief. They should be looking at the sign on the door and following the policy for Enhanced Barrier Precautions. Review of the U.S. Department of Health and Human Services Centers for Disease Control and Prevention (CDC) sign attached to Resident #98's and Resident #319's room doors read, STOP. Enhanced Barrier Precautions .Providers and Staff must also: Wear gloves and a gown for the following high-contact resident care activities. Dressing .Changing Linens .Changing briefs or assisting with toileting .Device care or use: central line, urinary catheter, feeding tube, tracheostomy . Review of the policy titled Enhanced Barrier Precautions, last reviewed 1/30/2024, read, Policy Statement: This facility follows recommended CDC enhanced barrier precautions, to interrupt the spread of multidrug resistant organisms (MDROs) within the facility. For the purposes of this guidance, the MDROs for which the use of EBP applies are based on the local epidemiology. At a minimum, they should include resistant organisms targeted by CDC but can also include other epidemiologically important MDROs. Policy Interpretation and Implementation. 3. Enhanced barrier precautions is an approach of targeted gown and glove use during high contact resident care activities .6. High-contact resident care activities include a. dressing e. Changing linens, f. Changing briefs or assisting with toileting, g. indwelling medical device use. 8. Indwelling medical device examples include: b. Urinary catheters. 47275 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/15/2024 at 12:16 PM Staff E, LPN was observed exiting a residents room, removing her gloves, and placing them into a waste bin attached to the right side of the medication cart. No hand hygiene was performed. Staff E, LPN then reached into her scrub top pocket and pulled out a set of keys to unlock a medication cart to retrieve another residents medication. During an observation on 7/15/2024 at 12:17 PM Staff E, LPN was observed at the medication cart,. and without performing hand hygiene Staff E, LPN opened the medication drawer, Staff E removed a blister pack and placed the medication tablet directly into her left ungloved hand,and then placed the pill into a small plastic medication cup. Staff E, LPN then placed the blister pack back into the medication cart, locked the drawer, placed the keys in her pocket, walked over to the resident and administered the medication without performing hand hygiene. Staff E, LPN returned to the medication cart, opened the laptop computer and began to type. No hand hygiene was performed. During an observation on 7/15/2024 t 12:20 PM Staff E, LPN was observed rubbing her nose, touching her hair, and pulling her pants up by the waist band. No hand hygiene was performed and staff began to prepare medications for a resident. During an observation on 7/15/2024 at 12:22 PM Staff E, LPN did not perform hand hygiene, unlocked the medication cart, pulled out a medication blister pack, popped 2 pills into a medication cup, placed the blister pack back into the medication cart, locked the drawer, and proceeded to administer the medication to a resident. Staff E took the used medication cup and placed it into the waste bin. No hand hygiene was performed. During an observation on 7/15/2024 at 12:25 PM Staff E, LPN walked into the small kitchen area, opened the refrigerator and took out a small cup of pudding. She walked back to the medication cart, placed the cup down, and pulled the keys to the cart out of her scrub top pocket without performing hand hygiene and began preparing medications for another resident. Staff, E, LPN popped 2 medications into a cup and then placed the pills into a clear plastic pouch. Staff E crushed the medications and mixed them into the small cup of pudding with a plastic spoon, before administering them to the resident. Staff E then placed the spoon and used pudding cup into the waste bin. No hand hygiene was performed. During an interview on 7/18/24 at 8:41 AM the Infection Prevention Officer, stated, It is our expectation that hand hygiene should be performed before and after each medication pour, meaning between each residents medication pass.