STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105688	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at the Bay	10300 4th St N Saint Petersburg, FL 33716

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observations, interviews, and record review, the facility failed to review and revise a care plan to reflect the nonuse of a secure door safety banner stop sign for one resident (# 54) out of ten residents sampled. Findings included: During an observations made on 05/07/24 at 9:47 a.m. and 1: 30 p.m., and on 5/8/2024 at 9: 00 a.m. and 3:00 p.m., Resident # 54 was observed sitting on the side of her bed with her call light within reach. Observation showed no stop sign across Resident # 54's room door. Review of the Admission Record Resident # 54 was admitted on [DATE] with diagnoses to include Chronic Kidney Disease, Stage 3 unspecified, need for assistance with personal care, unspecified dementia, unspecified severity, with psychotic disturbance, and unspecified mood affective disorder. Review of a Minimum Data Set (MDS), dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 03 indicating Resident # 54 was severely cognitively impaired. Review of Resident # 54's care plan, dated 3/27/2024, showed a care plan focus area as: Resident 54 is at risk for abuse and neglect due to dementia, adapting to a new environment. Interventions included a stop sign across Resident # 54's door. An interview was conducted on 05/08/2024 at 3:00 p.m., with Staff L, Certified Nursing Assistant (CNA). Staff M stated he has worked at the facility for 8 years on the secured unit. He stated he was usually assigned to Resident #54 as her nursing assistant, and she has never had a stop sign across her door. During an interview on 05/09/2024 at 8:41 a.m., with Staff M, Registered Nurse (RN/ Director of MDS), she stated she did not know why Resident # 54 has a care plan focus that shows she is at risk for abuse and neglect. She further stated she did not know why the resident had an intervention showing that she needed to have a stop sign across her door. When she reviewed the resident chart, she did not see any assessments done to show why she would need to have a care plan put in place for a stop sign. She said if Resident # 54 is care planned to have a stop sign across her door, then she should have one. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Aventura Protocol for Care Plans, Comprehensive Person- Centered, revised March 2022, showed the following: Policy statement, A comprehensive, person - centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39438 Based on observations, interviews, and record review, the facility failed to provide two residents (#3 and #9), who were dependent for Activities of Daily Living (ADLs), personal grooming related to shaving and nail care. Findings included: 1. On 05/06/24 at 11:05 a.m., Resident #3 was observed in bed in her room. Facial hair was observed above the resident's lip. On 05/08/24 at 12:32 p.m., Resident #3 was observed in bed in her room. Facial hair was observed above the resident's lip. The Admission Record showed Resident #3 was initially admitted to the facility on [DATE] with a diagnosis to include unspecified intracranial injury with loss of consciousness of unspecified duration. A review of the Minimum Data Set (MDS), dated [DATE], showed in Section C- Cognitive Patterns Resident #3 was rarely/never understood. In Section GG- Functional Abilities and Goals Resident #3 was totally dependent for personal hygiene (shaving). The care plan related to ADLS, initiated on 05/30/19, showed a focus area that revealed Resident #3 needed total assistance with ADLs because of functional quadriplegia, spastic Hemiplegia affecting her right dominant hand, traumatic brain injury, decreased range of motion on upper and lower extremities, incontinent of bowel and bladder, and unable to speak. The interventions included, assist with all ADL care to ensure daily needs are met. There was no documentation in the resident's record that indicated shaving was offered or refused. The policy provided by the facility Removal of Facial Hair, revised 09/2022, revealed the following: Residents have the right to choose their style, including facial hair. Residents have the right to refuse or comply with facial hair removal. 1. Assess the resident to ensure that there is ability to safely remove facial hair. 4. CNA [certified nursing assistant] should evaluate resident for safe facial hair removal. On 05/09/24 at 9:47 a.m., Staff O, Registered Nurse (RN)/Unit Manager (UM), stated Resident #3 was compliant with care. She confirmed Resident #3 had facial hair above her lip and staff should be attempting to shave her. On 05/09/24 at 11:46 a.m., the Director of Nursing (DON) stated shaving should be done on shower day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50570 2. On 5/6/24 at 11:28 a.m. Resident #9 was observed in her room sitting upright in bed and looking out the window to her right. An interview was attempted; however, she did not answer directed questions. Observation of her left hand, as she pointed to the window, revealed two fingers with a dark brown material underneath her nails. On 5/7/24 at 9:00 a.m. Resident #9 was observed in her room sitting up right in bed and facing forward looking at the door. Observation of her left hand, seen over the blanket covering her, revealed the same two fingers observed on 5/6/24 with a dark brown material underneath her nails. Review of Resident #9's medical record revealed she was admitted to the facility on [DATE] with diagnoses including traumatic subarachnoid hemorrhage with loss of consciousness status unknown, subsequent encounter encephalopathy, unspecified cerebral ischemia, personal history of transient ischemic attack and cerebral infarction without residual deficits, unspecified cognitive communication deficit, unspecified dementia, unspecified severity with mood disturbance, other recurrent depressive disorder, and parkinsonism unspecified. Review of Resident #9's care plan, dated 8/4/23, revealed a focus area of needing assistance with activities of daily living (ADL) because of a diagnoses of dementia with memory impairment, cerebrovascular accident (CVA), impaired balance and weakness. Interventions for the ADL focus revealed, SKIN INSPECTION twice a week on shower days and with ADL care . Resident #9's current plan did not reveal a focus or intervention specific to nail care. Review of Resident #9's Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 2, severe cognitive impairment. Section GG - Functional Abilities and Goals which included an assessment for shower and bathing revealed a score of dependent, and an assessment for personal hygiene revealed a score of substantial/maximal assistance. Review of documentation of staff tasks for personal hygiene for Resident #9, dated 5/6/24 to 5/8/24, revealed the following: - 5/6/24: At 6:51 a.m. Resident #9 required extensive assistance. At 14:47 p.m. (2:47 p.m.) Resident #9 required limited assistance. - 5/7/24: At 6:51 a.m. Resident #9 required extensive assistance. At 13:00 p.m. (1:00 p.m.) Resident #9 required total dependence on staff. At 21:35 p.m. (9:35 p.m.) Resident #9 required total dependence on staff. - 5/8/24: At 6:45 a.m. Resident #9 required extensive assistance. Review of Resident #9's progress notes, date range of 4/8/24 to 5/9/24, revealed no documentation of activities related to nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/08/24 at 9:25 a.m. an interview with Staff J, Certified Nursing Assistant (CNA) revealed she does assist with showers for Resident #9. Staff J stated the showers for B beds are done during the 3 p.m. to 11 p.m. shift. Staff J stated she assists Resident #9 with grooming and other activities such as brushing her hair and teeth. She said it is her responsibility to assist with the residents' personal hygiene every day. She said she will give the resident a shower, if needed, if there is something out of the ordinary. Staff J stated she hasn't seen anything out of the ordinary with this resident. On 5/08/24 at 9:31 a.m. an interview was conducted with Staff K, Registered Nurse/Unit Manager (RN/UM). She stated residents are provided with showers twice a week. Staff K stated during showers the residents' hair is brushed, and nails are trimmed and/or cut. She said sometimes the resident refuses. Staff K stated the expectation is the CNA should report the refusal to the nurse. She said the staff will then notify the family. She revealed the family will attempt to do the grooming. Staff K revealed documentation regarding showers is completed on the unit shower sheet, which is kept in the unit manager's office. She stated resident refusals should be documented on the shower sheet. An observation and interview on 5/8/24 at 9:33 a.m., in the presence of Staff K, RN/UM, revealed a dark brown material underneath the same two nails of Resident #9 observed on 5/6/24 and 5/7/24. Staff K confirmed Resident #9's nails should not be like that. An interview on 5/9/24 at 11:46 a.m. with the Director of Nursing (DON) revealed nail care should be done on shower day. The DON stated if the resident refused this would be documented by staff on the shower sheet or the progress note in the electronic medical record. She stated the expectation for staff is that grooming should be done every day, however, nail care would fall on shower day. She confirmed a resident should not have dark brown colored material or soiled nails for multiple days. A review of the facility's policy titled, Nail Grooming, review date of 7/24/18, included in the purpose statement, Regular fingernail care will promote cleanliness and prevent infection. The nursing staff will provide observation and care of nails for all residents daily and as necessary. The policy revealed responsible roles were, Certified Nursing Assistant, Licensed Nurse.

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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. 20311 Based on observations, interviews, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice related to unlabeled dressings for one resident (#294) out of two residents sampled for skin conditions. Findings included: An observation of Resident #294 on 05/06/24 at 03:19 PM revealed the resident was lying on his bed with his legs uncovered. The resident had a large white dressing covering his left calf below the knee and above the ankle. The dressing revealed no staff initial or a date listed on the dressing. An observations of the Resident #294 on 05/07/24 at 09:02 AM revealed the resident was lying on his bed with his legs uncovered. Resident #294 had a large white dressing covering his left calf. The dressing had no staff initial or a date listed on the dressing. Review of the residents orders revealed the following: -Cleanse L [left] medial calf with NS [normal saline], pat dry, apply oil emulsion and cover with foam dressing daily/prn [as needed], every day shift for wound care AND as needed if soiled/dislodged 5/7/24. -Cleanse L calf with n/s, apply wet to dry dressing and kerlix, as needed for Impaired Skin Integrity. complete daily and as needed until resolved, AND in the afternoon for wound care complete daily until resolved. 4/25/24. During an interview on 05/08/24 at 09:28 AM with Staff Q, CNA she reported wound care is completed by nurses or a wound care nurse. During an interview on 05/08/24 at 10:48 AM with the Director of Nursing (DON) she stated dressings should be dated and initialed following the physician orders. She reported the wound care nurse does wound rounds on Mondays, Wednesdays, and Fridays and does dressing changes. She reported floor nurses should do skin wounds. A request was made for a policy related to the standards of practice for labeling wounds, but not provide by the facility.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39866 Based on observations, interviews, and record review the facility 1) failed to ensure a resident who cares for his laryngectomy tube was assessed and deemed competent, 2) failed to ensure necessary supplies were available, and 3) failed to ensure follow-up with a specialty physician related to his laryngectomy tube was coordinated for one resident (#154) out of one resident sampled with a laryngectomy tube. Findings included: Review of Resident #154's Admission Record revealed he was admitted to the facility from an acute care hospital on 6/21/23 with diagnoses of respiratory failure, chronic obstructive pulmonary disease (COPD), tracheostomy status, malignant neoplasm of the mouth, malignant neoplasm of the larynx, and shortness of breath. An interview and observation were conducted on 05/06/24 at 09:59 AM with Resident #154. Resident #154 was observed to have a laryngectomy tube in place, with clean trach ties. He communicated well by whispering and writing his requests on paper. He said he needs an ear nose and throat (ENT) appointment because his laryngectomy tube is not long enough, and it makes it harder to breathe. He said he had an appointment but the first time there was a transportation issue and the second time there was an insurance issue. He said there is still not an appointment made. He brought the surveyor to his room, and he said he cleans his own trach six times a day because it gets clogged up with mucus. He opened his side drawer and said he uses normal saline in a bottle and rolls up paper towels located in his beside drawer and uses the normal saline and the rolled-up paper towel to clean his laryngectomy tube. He said he changes his own trach ties. He said he had asked the staff to give him extra laryngectomy tubes but they have not given him any and there was no extra laryngectomy tubes observed in his room. He pulled out his laryngectomy tube to show the side of his laryngectomy tube, where the trach ties loop into the laryngectomy tube, the hole was observed to be torn. He said he needs a new laryngectomy tube but Staff E, A-Wing Unit Manager said she can't order more until he sees the ENT doctor. The resident reinserted his laryngectomy tube and secured his own trach ties. He was not in respiratory distress when he took out his laryngectomy tube. Review of Resident #154's Quarterly Minimum Data Set (MDS), dated [DATE], Section C, Cognitive Patterns, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating no cognitive impairment. Review of Resident #154's physician orders revealed the following orders: -A start date of 5/2/24 with no end date Patient needs appointment with ENT . -A start date of 4/18/24 with no end date Send to ER for trach evaluation. -A start date of 10/30/23 with no end date Remove [NAME] [laryngectomy] tube from stoma completely and clean while awake very [sic] shift for Tracheostomy care Resident dose [sic] himself. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A start date of 6/22/23 with no end date Replace HME on tube daily or if it becomes saturated with secretions, resident changes himself every day shift for Tracheostomy Care resident dose [sic] it himself. -A start date of 6/22/23 with no end date Stoma Care every day shift for Maintenance Resident dose [sic] himself AND as needed for Maintenance. -A start date of 6/21/23 with no end date Soak laryngectomy tube with normal saline, clean with tube brush and pat dry. Every shift for Tracheostomy care Review of the Resident #154's physician note, dated 3/29/24, revealed Has appt with ENT for trach widening on 4/8/24. Review of Resident #154's progress note, dated 4/9/24 at 3:00 p.m., revealed Residents appointment with ENT was rescheduled he will be going via facility transport . Review of Resident #154's progress note, dated 4/16/24 at 1:02p.m., revealed [Company] respiratory notified in regards to coming out to eval, treat as well deliver trach cannula's .No expressions or signs of distress. O2 sats 94% on room air. He will be monitored. Review of Resident #154's progress note, dated 4/18/24 at 2:43 p.m., revealed Call placed to [Physician] in regards to Larynx tube out of place D/T [due to] clamp broken to strap it in place. Patient trach site is open and free from cannulas at this time. He has no signs of distress. he [sic] continue to ambulate around, joke and laugh with the staff. [Physician] states if he's not showing any emergent signs of respiratory distress following necessary procedures to get supply's needed. U.M. [unit manager] aware. [Company Name] respiratory notified and recommendations pending. O2 [oxygen] sats 94% roomair [sic]. He will be monitored. Review of Resident #154's progress note, dated 4/18/24 at 3:42 p.m., revealed Resident sent to ER [emergency room] for evaluation of trach, Resident shows no S/S [signs and symptoms] of distress he is in agreement with going to the ER for an evaluation. Resident is able to make needs known. An interview was conducted on 05/08/24 at 10:53 AM with Staff E, A-Wing Unit Manager (UM). She said, the reason Resident #154 needs to see an ENT physician is because he does not have extra laryngectomy tubes and we want the ENT to let us know if he needs a different size tube or if they want to remove it. Staff E, A-wing UM said Resident #154 cleans his own laryngectomy tube and he should be cleaning it with warm soapy water then letting it dry or he can clean it with normal saline and let it dry. She also said he will change his own trach ties. She said the staff will assist him sometimes with cleaning and changing the trach ties. She said Resident #154 does not have an extra laryngectomy tubes so when he cleans the tube he does not have another one to replace it with But he does well with it out he actually told me he can breathe better than he ever could before with it out. Review of Resident #154's Respiratory Assessment and Recommendation form, dated 1/31/24, revealed . Diagnosis: Resp. [respiratory] failure, COPD, Laryngectomy Tube. .Notes: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	:laryngectomy pt [patient] does self care. Pt c/o [complained of] increased SOB [shortness of breath] and dry cough since yesterday. Expiratory wheezes noted. Pt agrees breathing treatments will help him feel better . Review of Resident #154's medical record did not reveal documentation Resident #154 was assessed to care for his own laryngectomy competently. An interview was conducted on 05/08/24 at 04:33 PM with the Nursing Home Administrator (NHA). He said usually facilities don't accept residents with a laryngectomy because those tubes are $1600 each. He said the resident does all his own care related to his laryngectomy and he would have to review the record to see if the resident had competencies to ensure he knows how to properly clean and maintain his laryngectomy tube. An interview was conducted on 05/09/24 at 08:31 AM with the Director of Nursing (DON). She said Resident #154 had a laryngectomy tube and he provides his own care. She said at his bedside there should be an ambu bag, trach ties, suction kit, trach care kit with a wire brush, gauze, and he is supposed to use normal saline to clean it. He does the cleaning himself and he changes the trach ties himself, he should have an extra laryngectomy tube at the bedside, and she confirmed he does not. She said they have ordered one, but it has not come in yet. The order sheet was requested to be provided. She said her expectation is the resident uses the wire brush in the trach care kit not paper towels to clean his laryngectomy tube. She said it was her understanding he rolls up the paper towels and uses them in his nose. She said the Respiratory Therapist came in and did an assessment on Resident #154 to ensure he can competently care for his laryngectomy tube and she said it was documented on the Respiratory Assessment and Recommendation form, dated 1/31/24. She reviewed the document and said the document says Laryngectomy pt, does self care. but she will look to see if there is another assessment performed. She said she was not sure what happened with Resident #154's ENT appointment. She said the facility tries to use the resident's insurance for transportation but if the facility needs to transport a resident to an appointment, then the Maintence department is the one who does the driving. An interview was conducted on 5/9/24 at 9:23 a.m. with Staff E, A-Wing UM. She said they ordered a new laryngectomy tube for him on 4/18/24. She said The resident was sent out on 4/18/24 to the hospital because his laryngectomy tube broke where the straps attach and every time, he coughed the tube would come out because the ties couldn't attach to it. I was under the impression the hospital fixed it and that is when we contacted [Respiratory Therapy Company] to get another tube and they said it would take three to five weeks to get it. She said the laryngectomy tube has been paid for and she would provide an invoice. An interview was conducted on 05/09/24 at 09:29 AM with Staff E, A-Wing UM. She said We don't have the invoice related to Resident #154's laryngectomy tube because all orders get sent up to our corporate company and they pay them. She provided hospital documentation dated 4/18/24 and said, All the documentation says is to follow up with his primary care physician and to return to the hospital only if needed. She confirmed there is no documentation related to what the hospital did for the resident. She also said Resident #154 had two ENT appointments the first time the office canceled his appointment because Resident #154's primary physician did not approve the insurance authorization for him to go. She said they called the doctor and let him know to authorize the appointment and we made Resident #154 another appointment. She said that appointment got canceled too because the insurance authorization was never completed again. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview was conducted on 05/09/24 at 12:57 PM with Staff F, Respiratory Vendor Manager. He said he was familiar with Resident #154 and said he had a laryngectomy tube. He said an order was placed for an entire laryngectomy kit, which includes a new tube, was placed today (5/9/24) and there is a three-to-five-week delivery time. He said this is a specialty item they do not keep on the shelf so they had to special order it through a supply company and the Laryngectomy kit will be delivered to the facility as soon as it comes in. He said The facility has not paid for the laryngectomy tube yet because since the order was placed today (5/9/24) they will not be billed for it until the end of the month, and they have 60 days to pay the invoice. An interview was conducted with Staff H, Maintence Supervisor on 05/09/24 at 10:44 AM he said A-Wing told him Resident #154 made an ENT appointment and he took him but the appointment was not approved so the resident rescheduled the appointment and I brought him back. He said he has not heard or taken him to any other ENT appointment. Review of Resident #154's care plan with a creation date of 6/22/24 revealed I have impaired respiratory status or risk for related to: COPD with risk for recurrent respiratory infections. The goals included I have impaired respiratory status or risk for related to: COPD with risk for recurrent respiratory infections. The interventions included: -Administer medications as ordered by physician. Monitor/document side effects and effectiveness. -Monitor for s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. -Promote lung expansion and improve air exchange by positioning with proper body alignment when in chair and keeping head of bed elevated to resident's comfort level. -Provide rest periods during ADL's and periods of activity to prevent episodes of SOB. Review of Resident #154's care plan with a revision date of 3/1/24 revealed Resident has the potential for respiratory complications due to tracheostomy tube the goal revealed Airway will remain patent and complications will not develop secondary to having a laryngectomy site thru next review. The interventions revealed: -Monitor skin integrity under and around laryngectomy tube. Notify MD of any changes -Provide adequate hydration and nutrition -Resident provides self care to stoma/tube site -Resident teaching as needed -Trach care Q [every] shift and prn [as needed] Review of the facility's Laryngectomy Care and Suctioning Policy, undated, revealed the following: (continued on next page)

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	105688	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at the Bay	10300 4th St N Saint Petersburg, FL 33716

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: It is the policy of this facility to ensure that a resident with a laryngectomy stoma receives care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents goals and preferences. Definition: A laryngectomy is a surgical procedure to remove all or part of the larynx, or voice box. It may be indicated in persons with laryngeal cancer, laryngeal fracture, or damage to the larynx due to trauma or injury. A stoma is created, attached to the trachea, in which the person will now breathe through. .Laryngectomy Tube Care 1. Gather supplies (may be premade tracheostomy/laryngectomy care kit, or a nylon tracheostomy brush, cotton neck tape or other tube securement device, scissors, normal saline, cotton-tipped applicators, lubricating jelly, dry gauze pads). 2. perform hand hygiene and don gloves. 3. Fill one kit basin compartment or small basin with sterile water or normal saline. If needed for a harder to clean tube, another compartment may be filled with hydrogen peroxide. 4. Remove neck ties or tube securement device. 5. Remove the tube from the stoma. 6. Place the laryngectomy tube in the water or saline and use the nylon brush to gently clean the inside of the tube. The tube may be to be briefly soaked in the hydrogen peroxide if harder to clean, to loosen material in the tube (then rinse in the water or saline). 7. dry the tube with clean gauze. 8. Put clean neck tape or tube securement device into the slots on the side of the tube. 9. gently clean the skin around the stoma site with normal saline and cotton tipped applicators. 10. Lubricate the outside of the tube with lubricating jelly. 11. Have the person tilt their chin slightly toward their chest and have them hold their breath while placing the tube into the stoma. 12. Tie or secure the tape or securement device, leaving 1 finger space between the tape and the neck. 13. Discard supplies into he appropriate receptacle, remove gloves and perform hand hygiene.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 50570 Based on interviews and record review, the facility failed to ensure the drug regimen review was completed monthly, the pharmacist's report was documented in the medical record, and the pharmacist's recommendations were acted upon for one resident (#135) of nine residents reviewed for unnecessary medications. Findings included: A review of the medical record for Resident #135 revealed diagnoses to include: unspecified dementia, unspecified severity, with other behavioral disturbance, psychotic disorder with hallucinations due to known physiological condition, age-related cognitive decline, mood disorder due to known physiological condition specified, anxiety disorder, unspecified. A review of the Physician Orders, dated May 2024, revealed the following: -Dulaglutide Subcutaneous Solution Pen-injector 0.75 MG (milligrams)/0.5 ML (milliliters) Inject 0.5 ml subcutaneously every evening shift every Sunday for glucose control. Start date 8/27/23. -Glucagon Emergency Kit 1 MG. Inject 1 mg intramuscularly as needed for Hypoglycemia of less than or equal to 70 mg/dl (deciliter) who are unresponsive or cannot swallow. Start date 8/25/23. -HYDROcodone-Acetaminophen Oral Tablet 5-325 MG. Give 1 tablet by mouth every 4 hours as needed for pain. Start date 11/3/23. busPIRone HCl Oral Tablet 10 MG. Give 1 tablet by mouth three times a day for anxiety. Start date 3/26/24. -QUEtiapine Fumarate Oral Tablet 25 MG. Give 1.5 tablet by mouth in the evening for psychosis. Start date 4/11/24. -LORazepam Oral Concentrate 2 MG/ML. Give 0.25 ml by mouth every 6 hours as needed for Anxiety for 30 Days. Start date 5/6/24. -TraMADol HCl Tablet 50 MG. Give 1 tablet by mouth three times a day for moderate to severe pain. Start date 8/25/23. -QUEtiapine Fumarate Oral Tablet 150 MG. Give 1 tablet by mouth at bedtime for mood disorder. Start date 8/25/23. -QUEtiapine Fumarate Oral Tablet 100 MG. Give 1 tablet by mouth one time a day for mood disorder. Start date 8/25/23. -QUEtiapine Fumarate Oral Tablet 25 MG. Give 1.5 tablet by mouth in the evening for psychosis. Start date 4/11/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/24 the Nursing Home Administrator (NHA) provided the Drug Regimen Review reports for February 2024, March 2024, and April 2024. The February 2024 report revealed the following, Below are the residents that were reviewed this period that, assuming the record was complete, accurate, and without error, were reviewed and no new comments were made. Upon review of the report, Resident #135 was not listed as a resident reviewed. The Drug Regimen Review report for February 2024 revealed no recommendations for Resident #135 by the Pharmacy Consultant. Documentation of the pharmacy recommendations from the Pharmacy Consultant were requested from the Director of Nursing (DON). A review of Resident #135's progress notes, dated 2/7/24 to 3/8/24, revealed no documentation regarding pharmacy consultant recommendations. A review of miscellaneous documents in the medical record revealed documentation from the pharmacy with dates of 7/16/21, 8/26/21, 1/31/22, and 1/27/22. An interview on 5/09/24 at 9:38 a.m. with the NHA revealed Resident #135 was not reviewed by the Pharmacy Consultant in February 2024. The NHA confirmed there is no documentation available that Resident #135 was reviewed by the Pharmacy Consultant in February 2024. The NHA provided a second copy of the Drug Regimen Review report dated February 2024 that revealed in writing [Resident #135] - not reviewed in 2024. The NHA revealed the Pharmacy Consultant comes once or twice a month for reconciliation. He stated the expectation of the pharmacy reviews is they should be completed quarterly. An interview around 10:00 a.m. with the NHA revealed that he spoke with the Pharmacy Consultant who stated there was a glitch in their [Vendor's] system in February 2024. An interview on 5/09/24 at 11:11 a.m. with the Pharmacy Consultant revealed he started with the facility in December 2023. He stated he goes to the facility on ce or twice a week. He stated the regulation requires that he reviews the residents one time a month or every 30 days. He stated he attends the weekly Gradual Dose Reduction (GDR) meetings. He stated he reviews one building a week and does a, Clean up at the end of the month. The Pharmacy Consultant stated he has a spreadsheet he works from. He stated he compares the [Vendor name] software the facility uses to their [Vendor name] software. He stated at the end of the month he reviews all residents and, Dives in deeper for certain residents depending on the situation. The Pharmacy Consultant stated at the end of the month he participates in an exit meeting which consists of the Pharmacy Consultant, DON or the Assistant Director of Nursing (ADON). He stated there was a glitch in the system in February 2024. He stated the system the Pharmacy Consultant uses, [Vendor name], is the company's own system. The Pharmacy Consultant stated the company was doing beta testing, which caused the glitch, and the issue has been fixed. He stated he did review Resident #135 and has documentation of his recommendations from February 2024. The Pharmacy Consultant stated he sent the DON a screenshot of his recommendations. On 5/9/24, the NHA provided a third copy of the Drug Regimen Report, dated February 2024, that revealed Resident #135 on the report. Along with the third report, the NHA provided a copy of an email sent on 5/9/24 at 1:06 p.m. from the Pharmacy Consultant. The NHA stated the report in the email is the Pharmacy Consultant's recommendations from February 2024 for Resident #135. The notes from the Pharmacy Consultant were the following, .Discuss and research multiple Quetiapine orders affecting overall numbers and ratings 02/2024. Review of Resident #135's medical record to include progress notes, care plan, miscellaneous documents, and Clinical Physician Orders, revealed no evidence of the attending physician or the DON reviewing the Pharmacy Consultant's recommendations. Review of the [Vendor name] Pharmacy Services Agreement with the facility revealed the following: Responsibilities of [Vendor name]: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Maintain drug profiles on each resident in the Facility in compliance with applicable requirements of local, state and federal laws, rules, and regulations; f. Provide drug information and consultation to the Facility's licensed professional staff regarding Pharmacy Products ordered; .