STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105705	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Port Square Health Center	701 Lake Port Blvd Leesburg, FL 34748

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523 Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for 1(Resident #20) of 3 residents reviewed for nutrition. Findings include: During an observation on 2/12/2025 at 5:48 AM, Staff I, Licensed Practical Nurse (LPN), entered Resident #20's room and administered medications to Resident #20 via gastric tube. Review of Resident #20's quarterly MDS dated [DATE] showed the resident did not have a feeding tube while a resident in the facility under Section K- Swallowing/Nutritional Status. Review of Resident #20's physician order dated 12/6/2024 showed it read, G-tube [gastric tube] Enteral feedings- Monitor for adverse reactions check residuals with Bolus feedings every shift for Dysphagia. Review of Resident #20's physician order dated 12/6/2024 showed it read, Jevity 1.2 55 ml/hr x 20 hours= 1100 ML [55 milliliters per hour times 20 hours equals 1100 milliliters] total up at 4 pm (afternoon) & down at 12P [PM] or until volume is delivered in the afternoon for daily nutrition. During an interview on 2/12/2025 at 9:44 AM, the MDS Coordinator stated, [Resident #20's name] section K was coded in error. She does have a feeding tube. Review of the facility policy and procedure titled Resident Assessments with the last review date of 12/2/2024 showed it read, Policy Interpretation and Implementation . 6. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45576 Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan for 1 (Resident #26) of 5 residents reviewed for medication administration, and 2 (Resident #265 and Resident #266) of 4 residents reviewed for respiratory services. Findings include: 1) Review of Resident #26's admission record showed the resident was admitted on [DATE] with diagnoses to include atherosclerotic heart disease, cardiac pacemaker, prosthetic heart valve and atrial fibrillation (abnormal heartbeat). Review of Resident #26's physician order dated 1/18/2025 showed it read, Eliquis Oral Tablet 5 mg [milligrams] (Apixaban), Give 1 tablet by mouth two times a day for afib [atrial fibrillation]. Review of Resident #26's Medication Administration Record (MAR) for January and February 2025 showed the resident received Eliquis oral tablet 5 mg (Apixaban) as ordered. Review of Residents #26's care plan did not show a focus area or interventions for anticoagulant medication or a-fib. During an interview on 2/11/2025 at 9:26 AM, the Director of Nursing (DON) stated, [Resident #26's name] was not care-planned for monitoring of anticoagulant complications and the care plans are initiated by MDS [Minimum Data Set] Coordinator on admission. During an interview on 2/12/2025 at 9:21 AM, the MDS Coordinator stated, I do not see a care plan initiated for monitoring for complications of anticoagulants and there should be a care plan completed initially and with the comprehensive care plan. 49777 2) During an observation on 2/10/2025 at 9:10 AM, Resident #265 was sitting on the left side of the bed dressed in gown. CPAP [Continuous Positive Airway Pressure] nose piece was attached to tubing and was resting on top of the bedside table. During an interview on 2/10/2025 at 9:10 AM, Resident #265 stated, I use the CPAP to breath better at night. Review of Resident #265's admission record showed the resident was most recently admitted on [DATE] with diagnoses to include unilateral primary osteoarthritis of left hip, morbid (severe) obesity due to excess calories, sleep apnea, weakness, pain in left knee, type 2 diabetes mellitus without complications, atherosclerotic heart disease of native coronary, personal history of transient ischemic attack (TIA) and cerebral infarction. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/2025 at 10:30 AM, the DON stated, I do not see a care plan for respiratory services. The care plan is to be developed within 72 hours from admission and then MDS reviews the care plan. Review of Resident #265's comprehensive care plan on 2/12/2025 at 9:33 AM showed no focus for respiratory services. 3) During an observation on 2/10/2025 at 9:25 AM, there was an inhalation mask inside the drawer of Resident #266's bedside table. During an interview on 2/10/2025 at 9:25 AM, Resident #266 stated, I am here because I had a stroke. I do receive breathing treatments. Review of Resident #266's admission record showed the resident was most recently admitted on [DATE] with diagnoses to include sepsis, pneumonitis (swelling and irritation of lung tissue) due to inhalation of food and vomit, acute respiratory failure, obstructive sleep apnea, and emphysema (damage to air sacs in the lungs). Review of Resident #266's physician order dated 2/6/2025 showed it read, Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML [milligrams per 3 milliliters] (Ipratropium-Albuterol) 3 ml [milliliters] inhale orally every 4 hours for shortness of breath. Review of Resident #266's physician order dated 2/7/2025 showed it read, Oxygen 2 lpm [liters per minute] via nasal cannula PRN [as needed], may titrate to maintain SPO2 [oxygen saturation] greater than 90% as needed for Shortness of Breath. Review of Resident #266's comprehensive care plan on 2/12/2025 at 10:00 AM showed no focus for respiratory services. During an interview on 2/12/2025 at 10:30 AM, the DON stated, [Resident #266's name] should have care plan for respiratory services. I do not see a care plan for respiratory services. The care plan is to be developed within 72 hours from admission and then MDS reviews the care plan. Review of the facility policy and procedure titled Care planning- Interdisciplinary Team with the last review date of 12/2/2024 showed it read, Policy Statement. The interdisciplinary team is responsible for the development of resident care plans. Policy Interpretation and Implementation . 2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). Review of the facility policy and procedure titled Care Plans, Comprehensive Person-Centered with the last review date of 12/2/2024 showed it read, 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 . 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission . 7. The comprehensive, person-centered care plan . e. reflects currently recognized standards of practice for problem areas and conditions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedure titled Resident Assessment Instruments (RAI) with the last review date of 12/2/2024 showed it read, Policy: It is the policy of the facility to adhere to the following procedures related to the proper documentation and utilization of a resident's MDS to ensure a comprehensive and accurate assessment of residents will be completed in the format and in accordance with time frames stipulated by Department of Health and Human Services Center for Medicare and Medicaid Services. This assessment system will provide a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacities and assist staff to identify health problems for care plan development.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49777 Based on observation, interview, and record review, the facility failed to ensure residents received respiratory care consistent with professional standards of practice for 1 (Resident #265) of 4 residents reviewed for respiratory services. Findings include: During an observation on 2/10/2025 at 9:10 AM, Resident #265 was sitting on left side of the bed dressed in gown. CPAP [Continuous Positive Airway Pressure] nose piece was attached to tubing and was resting on top of the bedside table. During an interview on 2/10/2025 at 9:10 AM, Resident #265 stated, I use the CPAP to breath better at night. During an observation on 2/10/2025 at 9:30 AM, Resident #265 was walking with walker in her room. CPAP nose piece was attached to tubing and was resting on top of the bedside table. During an observation on 2/12/2025 at 8:25 AM, Resident #265's CPAP nose piece was attached to tubing and was resting on top of the bedside table. Review of Resident #265's admission record showed the resident was admitted on [DATE] with diagnoses to include unilateral primary osteoarthritis of left hip, morbid (severe) obesity due to excess calories, sleep apnea, weakness, pain in left knee, type 2 diabetes mellitus without complications, atherosclerotic heart disease of native coronary, personal history of transient ischemic attack (TIA) and cerebral infarction. Review of Resident #265's physician orders on 2/12/2025 at 9:32 AM showed no order for CPAP. During an interview on 2/12/2025 at 10:30 AM, the Director of Nursing (DON) stated, [Resident #265's name] should have an order in place for her to receive CPAP at the facility. Review of the facility policy and procedure titled CPAP/BiPAP [Bilevel Positive Airway Pressure] Support with the last review date of 12/2/2024 showed it read, Purpose: 1. To provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen. 2. To improve arterial oxygenation (PaO2) in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease . Preparation . 3. Review the physician's order to determine the oxygen concentration and flow, and the PEEP [Positive End Expiratory Pressure] pressure (CPAP, IPAP [Inspiratory Positive Airway Pressure], and EPAP [Expiratory Positive Airway Pressure] for the machine.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45576 Based on observation, interview, and record review, the facility failed to ensure the drugs and biologicals used in the facility were properly stored. Findings include: 1) During an observation on 2/10/2025 at 9:30 AM, there was one tube of menthol pain relieving gel lying on the bedside table in Resident #24's room (Photographic evidence obtained). During an interview on 2/10/2025 at 9:30 AM, Resident #24 stated, I use the gel for my shoulder. It really helps. I just rub it on whenever I hurt. Maybe a couple of times a week. During an observation on 2/11/2025 at 9:16 AM, there was one tube of menthol pain relieving gel lying in opened container on the bedside table in Resident #24's room. 2) During an observation on 2/10/2025 at 10:22 AM, there was one bottle of Antifungal powder with Miconazole Nitrate 2% on the bedside table in Resident #59's room. During an interview on 2/10/2025 at 10:23 AM, Resident #59 stated, I use the powder under my breast. During an interview on 2/11/2025 at 1:55 PM, Staff D, Licensed Practical Nurse (LPN), stated, Medication cannot be at the bedside unless a physician has written an order for self-administration and then the medication has to be locked in the bedside table. During an interview on 2/11/2025 at 2:05 PM, the Director of Nursing (DON) stated, All medications must be secured. Medications cannot be at the bedside unsecured. If the resident self-administers their medication, the medication has to be secured in the bedside table in their room and the physician has to place orders for self-administration. 46523 2) During an observation on 2/10/2025 at 9:18 AM, Resident #43 was sitting in his room in a chair. There was one bottle of Latanoprost 0.005% eye drops on top of the bedside table (Photographic evidence obtained). During an interview on 2/10/2025 at 9:18 AM, Resident #43 stated, Someone brought it [eye drops] one night and left it behind. I think it needs to be thrown out. During an interview on 2/13/2025 at 9:10 AM, the Director of Nursing stated, [Resident #43's name] is not able to self-administer medications and medication should not be left unattended in the residents room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedures titled Medication Labeling and Storage with the last review date of 12/2/2024 showed it read, Policy Statement: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Policy Interpretation and Implementation . 4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44571 Based on observation, interview, and record review, the facility failed to ensure food was safely and properly stored, labeled, or discarded in the areas of the kitchen walk-in cooler, and failed to ensure all areas were cleaned and free of debris. Findings include: A walk-through tour of the kitchen was conducted on 2/10/2025 at 9:12 AM with the Certified Dietary Manager (CDM)/Assistant Dining Manager. An observation was made of several containers of open food condiments [salad dressing, mustard, and sauces] in the reach-in cooler without an open date. An observation was made of numerous trash paper items and debris on the freezer floor and open box flaps exposing food items. An observation was made of a male staff member [Staff F, Dietary Aide] with no hair covering or beard guard. During an interview on 2/10/2025 at 9:28 AM, Staff F, Dietary Aide, confirmed he had not put on a hair net or beard guard when starting his job assignment. During an interview on 2/10/2025 at 9:19 AM, the CDM stated he was unaware of condiment containers in the reach-in cooler needing an open date. The CDM agreed that the freezer floor should be cleaned according to the cleaning schedule and lids should be closed. The CDM confirmed that all staff should be using hair restraints in the kitchen. During an observation on 2/11/2025 at 6:15 AM with the Food Service Director (FSD) for the campus, an observation was made of breakfast food items already placed on the tray line at 6:25 AM. An observation was made of a large buildup of food bits and dried debris on the floor mixer. An observation was made of the two convection ovens with excessive buildup of dirt and debris on the walls, door, and bottom of the ovens. An observation was made of the food/grease trap drawer on the regular stove (range) to have excessive food particles and black burnt on debris. During an interview on 2/11/2025 at 6:30 AM, the FSD confirmed that the cook at 6:15 AM had placed the food on the tray line early and should not be there until 20 minutes prior to tray service at 7:00 AM according to the facility policy. The FSD confirmed that the covered mixer was supposed to be clean before a cover was placed and was not. During an interview on 2/11/2025 at 6:42 AM, the CDM stated it was his expectation that all policies and training were followed whether he was personally in the department or not. The CDM stated that all dietary staff were required to wear hair coverings while working in the department. Review of the facility policy and procedures titled Equipment and Utensil Cleanliness with the last review date of 12/2/2024 read, 4. Deep fat fryers, ovens, slicers, ranges, mixers, and similar equipment cleaned daily. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedure titled Food Storage Areas with the last review date of 12/12/2024 read, 2. Floors should be free of .other debris. 7. Refrigerator and freezer should be cleaned regularly and free from food debris or spillage. Review of the facility policy and procedure titled Oven Cleaning with the last review date of 12/2/2024 read, Standard: The Food & Beverage Department will have a cleaning schedule for all equipment and work areas, to be completed in a timely manner as directed by the Food & Beverage Director. Purpose: Proper cleaning and maintaining ovens in order to comply with sanitation and safety standards and preserve condition. Review of the facility policy and procedure titled Employees-Personal Cleanliness with the last review date of 12/2/2024 read, The Food & Beverage Department will have a comprehensive Sanitation program to prevent the spread of infection and foodborne illness throughout all areas of the operation. 3. All staff will wear hair restraints at all times. Review of the facility policy and procedure titled Perishable Storage with the last review date of 12/2/2024 read, 5. Items such as ketchup, mustard, salad dressings, bottled sauces, etc. are dated when opened and will have a used-by date of two months if kept in the original container.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523 Based on record reviews and interviews, the facility failed to accurately document notifications of medication parameters for 3 (Resident #26, #27, and #163) of 6 residents reviewed for medication administration. Findings include: 1) Review of Resident #27's physician order dated 1/30/2025 read, Amlodipine Besylate Oral Tablet 2.5 MG (milligram) (Amlodipine Besylate) Give 1 tablet by mouth at bedtime for htn (hypertension). Review of Resident #27's physician order dated 1/30/2025 read, Metoprolol Succinate ER (extended release) Oral Tablet Extended Release 24 Hour 25 MG (Metoprolol Succinate) Give 1 tablet by mouth at bedtime for htn. Review of Resident #27's physician order 1/31/2025 read, Metoprolol Tartrate Tablet Give 12.5 mg by mouth one time a day for HTN Review of Resident #27's Medication Administrator Record (MAR) for the month of February 2025 documented Amlodipine Besylate 2.5mg was coded a 4 [vital sign outside of parameter] on 2/4 at 2100 [9:00 PM] no blood pressure or pulse documented and on 2/10/2025 no blood pressure or pulse documented. Review of Resident #27's MAR for the month of February 2025 documented Metoprolol Succinate ER 25mg was coded a 4 [vital sign outside of parameter] on 2/4/2025 at 2100 [9:00 PM] no blood pressure or pulse documented. and on 2/10/2025 no blood pressure or pulse documented. Review of Resident #27's MAR for the month of February 2025 documented Metoprolol Tartrate 12.5mg was coded a 4 [vital sign outside of parameter] on 2/9/2025 at 0900 [9:00 AM] for blood pressure 102/60 and pulse 82 and on 2/10/2025 no blood pressure or pulse documented. During an interview on 2/11/2025 at 1:14 PM, Staff H, Licensed Practical Nurse (LPN), stated, Normally I hold systolic blood pressure that is under 110. I will not give the medication and I will let the provider know. I recheck and if the blood pressure is still low I don't give them blood pressure medication. There are times with low readings they take blood pressure medications and they also have fluid pills ordered and those too can lower blood pressure. I have contacted the provider before holding the medication. I know I'm suppose to always document but I don't always document the contact to the provider in the patient record. During an interview on 2/11/2025 at 1:17 PM, Staff D, LPN, stated, Normally we have parameters for medications especially hypertension medications. I hold medication if the systolic blood pressure is 110 or the heart rate is 60. I will notify the doctor and let them know she [Resident #27's name] is running low and documented. We do a progress note the system will generate the box where you able to document the blood pressure and the notification. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/11/2025 at 1:37 PM, the Director of Nursing (DON) stated, The nurses are able to use their nursing judgment when they are administering a blood pressure medication. They should recheck the blood pressure and if it is still too low the physician should be notified. They should document the communication in a progress or skill note. During an interview on 2/11/2025 at 2:18 PM, Medical Doctor #1 stated, The nursing staff call me or text me when they are going to hold the blood pressure medication for [Resident #27's name]. I could add parameters but this way I am able to be aware of the residents vitals. I am able to determine if the patient is having constant low blood pressure and determine if I should make changes to the medication or discontinue the medication instead of waiting to do a medication review for the resident. 2) Review of Resident #163's physician order dated 2/10/2025 read, Insulin Glargine Subcutaneous Solution 100 unit/ml (Insulin Glargine) inject 15 units subcutaneously at bedtime for DM [Diabetes Mellitus]. Review of Resident #163's physician order dated 2/10/2024 read, Novolog Flexpen subcutaneous Solution Pen-injector 100 unit/ml (Insulin Aspart) inject 5 unit subcutaneously before meals and at bedtime for DM. Review of Resident #163's MAR for the month of February 2025 for Insulin Glargine documented on 2/10/2025 at 2100 (9:00 PM) a 4 [vital sign outside of parameter]. Review of Resident #163's MAR for the month of February 2025 for Novolog Flexpen documented on 2/10/2024 at 0630[6:30AM] coded 5 [Hold/see nurse notes], at 1130 [11:30 AM] coded 5, oat 1630 (4:30 PM) coded 4, and at 2100 (9:00 PM) coded 4. Review of Resident #163's progress notes did not document physician notification of holding medication. Review of Resident #163's admission record resident was first admitted on [DATE] with diagnosis including but not limited to type 2 diabetes mellitus with unspecified complications, morbid obesity and hyperlipidemia. During an interview on 2/11/2025 at 1:14 PM, Staff H, LPN, stated, I should have put a note in the system but I did not. I check blood sugar levels and don't want them to bottom out in the middle of the night so will I notify the provider that I am holding the insulin and see if he agrees. First time having him [Resident #163] was last night we were busy with admission and didn't get to document it. I know some providers say to give the long term acting they don't want them to get out of scale too much if we were to hold it. I spoke to the provider and they said it was ok to hold. During an interview on 2/11/2025 at 1:20 PM, Staff D, LPN, stated, I spoke to him [Resident #163] and he told me he had never been a diabetic. I contacted Medical Doctor #2 to notify him but I did not document it. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/11/2024 at 1:44 PM, the DON stated, If a nurse does not feel comfortable administering a medication she can contact the provider and get clarification. The staff should document the interaction in the system and code the correct information in the MAR if the resident refused. Review of the facility policy and procedure titled Charting and Documentation with the last review date of 12/2/2024 read, Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physicals, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation: .3. Documentation in the medical record will be objective (not opinionated or speculative) complete, and accurate. 45576 3) Record review of Resident # 26's clinical record documented admission to the facility 1/17/2025 with diagnosis to include type 2 diabetes mellitus. Review of Resident #26's physician order read, Basaglar Kwik-Pen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine). Inject 14 unit subcutaneously at bedtime for Diabetes Mellitus (DM). Review of Resident #26's MAR documented code (5) for insulin for 2/10/2025 at 2100. Chart code (5) = hold/see nurses note. Review of Resident #26's nurses note dated 2/10/2025 22:31 (10:31 PM) read, Basaglar KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML Inject 14 unit subcutaneously at bedtime for DM sugar too low. During an interview on 2/11/2025 at 10:37 AM, Staff A, LPN, stated, [Resident #26's name] refused her insulin last night. I did not call the doctor and should have. In error I coded a 5 which means medication are held and not given, but I should have coded a 4 which means the resident refused. The resident and her daughter refused. I will make sure that I document correctly in the future. This is a documentation error and I will correct it and make sure I chart appropriately in the future. During an interview on 2/11/2025 at 10:41 AM, the DON stated, It is my expectation if the nurse holds the insulin it is documented why the insulin is not given and the physician is to be notified. This is a documentation error and the insulin should have been documented as refused not held because of parameters. There are no parameters to hold long lasting insulin. If the nurse uses her nurses judgement to hold, she would need to call the physician. Review of the facility policy and procedure titled Documentation of Medication Administration with the last review date of 12/2/2024 read, Policy Statement: A medication administration record is used to document all medications administered .3. f. reason(s) why a mediation was withheld, not administered, or refused (as applicable).

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	105705	A. Building B. Wing	02/13/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523 Based on observations, interviews, and record reviews, the facility failed to maintain an infection control program designed to help prevent the spread and transmission of communicable diseases and follow infection control standards of practice for hand hygiene during 1 of 5 medication administration observations, 2 (Resident #265 and #266) of 10 residents reviewed for respiratory care equipment, 2 (Resident #20 and #167) of 4 residents reviewed for enhanced barrier precautions and 1(Resident #15) of 1 resident reviewed for transmission based precautions. Findings include: 1) During an observation on 2/10/2025 at 10:14 AM Resident #167's room had an enhanced barrier sign posted on the right side of the door entrance and personal protective equipment was observed upon entering the room. Staff G Certified Nursing Assistant (CNA) entered Resident #167's room with a towel and gown in her hand. Staff G donned a pair of gloves and began to assist Resident #167 to undress without donning personal protective equipment of a gown. Review of Resident #167's physician order dated 2/9/2025 read, Utilize Contact Precautions (esbl in Urine) [Extended-Spectrum Beta-Lactamase] every shift. During an interview on 2/12/2025 at 1:40 PM, Staff G, Certified Nursing Assistant (CNA), stated, I was not wearing a gown. I was helping her [Resident #167] remove her gown because she had vomited orange juice on her gown. I only need to wear a gown if the resident has an illness, and it is contagious. During an interview on 2/12/2025 at 3:00 PM, the Director of Nursing (DON) stated, Nurses will wear gloves and a gown when providing high contact care for residents on enhanced barrier precautions such a gastric tube medication administration or assisting a resident to change clothing. During an interview on 2/13/2025 at 8:37 AM, the DON stated, [Resident #167's name] is on contact precautions not enhance barrier precautions. Staff should don and doff the personal protective equipment before entering the room and when exiting the room. 2) During an observation on 2/12/2025 at 5:48 AM with Staff I, Licensed Practical Nurse (LPN), Staff I entered Resident #20's room. There was a sign on the door reading enhanced barrier precautions and personal protective equipment. Staff I washed her hand and placed medication on top of the bedside table. Staff I donned gloves but did not don a gown. Staff I placed feeding on hold and check Resident #20 for placement and residual. Staff I administered the medications via gastric tube. During an interview on 2/12/2025 at 5:48 AM, Staff I, LPN, stated, I should have worn a gown, I forgot. When administering medication via the gastric tube you should follow enhanced barrier precautions. Review of Resident #20's physician order dated 12/6/2024 read, EBP-Enhanced Barrier Precautions due to Specify G-tube every shift for Infection Prevention. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedure titled Enhanced Barrier Precautions with the last review date of 12/2/2024 read, Policy statement: Enhanced barrier precautions (EBPs)are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Policy Interpretation and Implementation: 1. Enhanced barrier precautions (EBPs) are used an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident activity (as opposed to before entering the room). 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing .g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc). 49777 3) During an observation on 2/10/2025 at 9:10 AM, Resident #265 was sitting on left side of the bed dressed in gown. CPAP [Continuous Positive Airway Pressure] nose piece was attached to tubing and was resting on top of the bedside table. During an interview on 2/10/2025 at 9:10 AM, Resident #265 stated, I use the CPAP to breath better at night. During an observation on 2/11/2025 at 9:30 AM, Resident #265 was walking in her room. Resident #265's CPAP nose piece was attached to tubing and was resting on top of bedside table. The CPAP was not in a bag. During an observation on 2/12/2025 at 8:25 AM, Resident #265 was sitting on side of bed. Resident #265's CPAP nose piece was attached to tubing and was resting on top of bedside table, it was not bagged. During an interview on 2/12/2025 at 8:28 AM, Staff B, Licensed Practical Nurse (LPN), stated, I am not sure, but I believe the CPAP nose piece should be placed in bag that is dated like another patient who is receiving inhalation treatment. I had her as a patient yesterday and should have noticed that. During an interview on 2/12/2025 at 10:30 AM, the DON stated, [Resident #265's name] CPAP nose piece should be placed in a labeled bag to store equipment between use. Review of the facility policy and procedure titled Prevention of Infection with the last review date of 12/2/2024 read, Purpose: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff 7. Store the circuit in plastic in plastic bag, marked with date and resident's name, between uses. 4) During an observation on 2/10/2025 at 9:25 AM, Resident #266's bedside table's top drawer was open with an unbagged inhalation mask lying inside the open drawer. During an interview on 2/10/2025 at 9:25 AM, Resident #266 stated, I am here because I had a stroke. I came in over the weekend. I do receive breathing treatments. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/11/2025 at 8:57 AM, Resident #266's inhalation mask was attached to the inhalation machine and not placed in a bag. During an interview on 2/12/2025 at 8:59 AM, Staff C, LPN, Unit Manager, stated, The inhalation mask for [Resident #266's name] should have been placed in bag after the treatment was completed and it should not have been left attached to the machine. Review of Resident #266's admission record documented an admitted [DATE] with diagnoses including sepsis (body's extreme response to infection), pneumonitis (swelling and irritation of lung tissue) due to inhalation of food and vomit, acute respiratory failure, hemiplegia (total or partial paralysis of one side of the body from injury or disease) and hemiparesis (muscle weakness) following unspecified cerebrovascular disease (stroke) affecting left dominant side, obstructive sleep apnea (collapse of upper airway during sleep blocking airflow), and emphysema (damage to air sacs in the lungs). Review of Resident #266's physician order dated 2/6/2025 read, Ipratropium-Albuterol Inhalation Solution 0. 5-2.5 (3) MG/3ML [milligrams per 3 milliliters] (Ipratropium-Albuterol) 3 ml inhale orally every 4 hours for Shortness of breath. 45576 5) Review of Resident#15's clinical record documented admission 1/16/2025 with diagnosis that included sepsis unspecified organism, campylobacter enteritis. Review of Resident #15's physician order dated 2/7/2025 read, Contact isolation for C. diff [Clostridium difficile]. During an observation on 2/12/2025 at 1:24 PM, contact isolation signage noted on side of Resident #15 door. Signage read, Contact Precautions everyone must: clean their hands, including before entering and when leaving the room. Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. (Photographic evidence obtained). During an observation on 2/12/2025 at 1:24 PM, observation of door to Resident # 15's room open and Staff E, CNA, observed assisting Resident #15 from bedside chair back to the bed. Staff E adjusted Resident #15's bed-covers, bedside table and water. Staff E did not have a gown or gloves on while assisting Resident #15. During an interview on 2/12/2025 at 1:24 PM, Staff E, CNA, stated, I just ran down to this wing because the call light was going off and I was helping. I did not pay attention to the signage. I should have put on a gown and gloves prior to assisting [Resident #15's name] because she is on contact isolation. During an interview on 2/12/2025 at 3:45 PM, the DON stated, I expect any staff member to don a gown and gloves prior to entering any room that is on contact precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedure titled Isolation-Categories of Transmission-Based Precautions with the last review date of 12/2/2024 read, Policy Statement. Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents . 1. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. 8. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed.