STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105717	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timberridge Nursing & Rehabilitation Center	9848 SW 110th St Ocala, FL 34481

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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. 39371 Based on record review and interview, the facility failed to ensure each resident was provided an assessment which accurately reflects the resident's status for 1 of 3 residents, Resident #159, reviewed for discharge status. Findings include: Review of the Social Service's progress note for Resident #159 dated 6/7/24 read, Pt [patient] was DC [discharged] home today. Review of the MDS (Minimum Data Set) signed and dated 6/10/24 at 12:55 PM read, Section A 12105, Discharge Status 04. Short - Term General Hospital (acute hospital). During an interview on August 27, 2024, at 1:50 PM the Lead MDS Coordinator stated, It [the MDS] should be coded for the resident going home, that was incorrect. During an interview on August 27, 2024, at 1:55 PM the Director of Nursing stated, My expectation is they [the MDS] should have been coded correctly. Review of the policy and procedure titled Resident Assessment Instrument (RAI) read, Intent: It is the policy of the facility to adhere to the following procedures related to the proper documentation and utilization of a residents Minimum Data Set (MDS) to ensure a comprehensive and accurate assessment of residents will be completed in the format and in accordance with the time frames stipulated by the 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 residents functional capacities and assist staff to identify health problems for care plan development. Procedure: Completion of Minimum Data Set: 1 Resident Assessment Instrument. A facility will complete a comprehensive assessment of residents needs, functional and health status, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS [Center for Medicare and Medicaid Services]. The assessment must include at least the following: . j) Disease diagnosis and health conditions.p) Discharge planning.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46523 Based on record review and interview the facility failed to ensure pain medication was administered within parameters for 1 of 10 residents, Resident #24, failed to ensure blood pressure medication was administered within parameters for 3 of 10 residents, Residents #42, #110, and #127, reviewed for medication administration, failed to administer medications in accordance with professional standards of practice when administering crushed medications via gastrostomy tube for 1 of 1 resident, Resident #27, and failed to ensure dressing changes were completed for peripherally inserted central catheters for 1 of 4 residents, Resident #264. Findings include: 1) Review of Resident #24's physician order dated 7/25/2024 read, Oxycodone HCl Tablet 10 mg [milligrams]. Give 1 tablet by mouth every 8 hours as needed for Pain Management > [greater than] 5. Review of Resident #24's Medication Administration Record for the month of August 2024 for Oxycodone HCl 10 mg documented the medication was given on 8/05/2024 at 5:51 PM for a pain level of 4, 8/08/2024 at 3:54 PM for pain level of 4, 8/09/2024 at 3:40 PM for a pain level of 4, 8/13/2024 at 12:27 PM for pain level 3, 8/15/2024 at 9:40 AM for a pain level of 3, 8/19/2024 at 4:03 PM for a pain level of 4, 8/20/2024 at 3:46 PM for a pain level of 4, 8/21/2024 at 9:23 PM for a pain level of 4, on 8/22/2024 at 3:52 PM for a pain level of 4, on 8/26/2024 at 4:03 PM for a pain level of 4, and 8/27/2024 at 4:12 PM for a pain level of 4. During an interview on 8/28/2024 at 2:00 PM the Director of Nursing (DON) stated, After reviewing the medication administration record for [Resident # 24's name] the order was to give oxycodone when pain level was higher than five and the nurses were giving the medication out of parameters. They are expected to follow the parameters put in place by the physician. 2) Review of Resident #42's physician order dated 7/24/2024 read, Valsartan Oral Tablet 80 mg give 1 tablet by mouth one time a day for HTN [hypertension] hold if SBP [systolic blood pressure] is less than 110 or HR [heart rate] less than 60. Review of Resident #42's MAR for the month of August 2024 documented Valsartan 80 mg on 8/2/2024 at 9:00 AM given with a heart rate of 58, 8/13/2024 at 9:00 AM given with a heart rate of 57, on 8/15/2024 at 9:00 AM given with a heart rate of 57, on 8/16/2024 at 9:00 AM given with a heart rate of 52, on 8/26/2024 at 9:00 AM given with a systolic blood pressure of 106, and on 8/28/2024 at 9:00 AM given with a heart rate of 52. During an interview on 8/29/2024 at 12:14 PM APRN [Advanced Practice Registered Nurse] #2 stated, Resident #42 has been very stable and had no adverse events. Sometimes parameters are a bit lower and different. I like to put higher parameters to be on the safe side so they will not drop [blood pressure]. The parameters should be followed at all times. 3) Review of Resident #110's physician order dated 8/12/2024 read, Hydralazine HCl Oral Tablet 25 mg give 50 mg by mouth three times a day for HTN hold for SBP less than 110 or HR less than 60. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #110's MAR for the month of August 2024 for Hydralazine HCl documented medication given on 8/8/2024 at 8:00 PM with a heart rate of 54, on 8/20/2024 at 9:00 AM with a heart rate of 50, and 8/20/2024 at 8:00 PM with a heart rate of 59. During an interview on 8/29/2024 at 12:24 PM with ARNP #1 stated, [Resident #110's name] has not had any adverse effects. Hydralazine would not affect the heart rate it works more on the blood pressure. It would not cause any harm, but parameters should be followed. 4) Review of Resident #127's physician order dated 8/7/2024 read, Metoprolol Tartrate oral give by mouth two times a day for hypertension hold for SBP less than 110 & HR less than 60. Review of Resident #127's MAR for the month of August 2024 for Metoprolol Tartrate documented medication was given on 8/09/2024 at 9:00 AM with a heart rate of 58. During an interview on 8/28/2024 at 2:00 PM with the DON Residents #42, 110, and 127's medication records were reviewed. The DON stated, Nursing staff are expected to follow the parameters in place and contact the doctor if there are any questions. During an interview on 8/28/2024 at 2:04 PM the Assistant Director of Nursing (ADON) stated, Nurses were giving medications out of parameters. The nurses are expected to obtain vital signs and follow whatever the parameters may be. Review of the policy and procedure titled Administration of Drugs with a last review date of 8/22/2024 read, Policy: Residents shall receive their medications on a timely basis and in accordance with our established policies. Review of the policy and procedure titled Nursing-Medications, Oral with a last review date of 8/22/2204 read, Procedure: 2. Verify the physician's medication order for resident's name, drug name, dose, time, and route of administration. 5) During an observation on 8/28/2024 at 9:02 AM Resident #264 was lying in bed, a PICC line to the right upper arm with a single lumen was observed and the dressing was dated 8/21/2024. There was a dried dark red substance and a 2 X 2 gauze with a beige colored substance underneath the transparent dressing. Staff E proceeded to flush the IV (intravenous) line with normal saline and administered medication via the IV. During an interview on 8/28/2024 at 9:02 AM Resident #264 stated, I came in with the IV dressing from the hospital. It looks pretty disgusting, but I have no pain, it is not swollen, and it flushes without any issues. During an interview on 8/28/2024 at 9:26 AM Staff D, LPN, stated, If I would have done the admission I would have changed the dressing then. If the dressing is soiled, I would change it also. I told my relief nurse yesterday about changing the dressing due to the condition of the dressing. Today when I came in, I saw it [IV dressing] had not been changed. I was going to change the dressing, but it was breakfast time, and I was unable to change it at that time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy and procedure titled Infusion Devices and Procedures with a last review date of 8/22/2024 read, Policy: .Central vascular access device (CVAD) and midline catheter site care and dressing changes are performed at established intervals, and immediately when integrity of the dressing is compromised, if moisture, drainage, or blood is present, or for further assessment if site infection or inflammation is suspected . 39371 5) On 8/26/24 at 10:20 AM an observation of Resident #264 room door it had an enhance barrier precaution sign. Upon entering the room during the observation of the resident, her right upper arm was exposed. A peripherally inserted central catheter (PICC) had a dressing that was dated 8/21/24. The dressing site was visibly soiled with a dark red/blackish substance. (Photographic evidence was obtained). On 8/26/24 at 10:20 AM during an interview Resident 264 stated, That was put in at the hospital [PICC], I'm on a blood thinner. I know it does look bad; the bruising looked worst immediately after it was put in. Review of Pharmacy Policy title 005-O: Central Venous Catheter Dressing Changes. Policy. Central venous catheter dressing will be changed at specific intervals, or when needed, to prevent catheter related infections that are associated with contaminated, loosen, soiled, or wet dressings. Dressing must stay clean, dry, and intact. Change dressing if any contamination is suspected. Change gauze dressing or TSM [transparent semi-permeable membrane] over gauze dressings every 48 hours. General Guidelines 5. Change transparent semi-permeable (TSM) dressings every 5 to 7 days and PRN [as needed] (when wet, soiled, or not intact). 50123 6) During an observation on August 28, 2024, at 9:00 am, of Staff F, Licensed Practical Nurse (LPN), administering medication via gastrostomy tube (GT) for Resident #27, Staff F crushed the resident's medications and placed them in individual medications cups and brought the medication cups to the resident's bedside. Staff F flushed the GT with 15 milliliters of water, then the medication powder of one of the cups was poured directly into the syringe without first mixing it with water followed by 10 to 15 milliliters of water to be administered via the syringe connected to the GT by gravity. This was observed to be repeated nine times during the observation. The final medication was a powder medication that the instructions indicated to mix with 45 milliliters of water prior to administration. The medication powder was poured directly into the syringe by Staff F, followed by 15 milliliters of water, then 30 milliliters of water. During an observation on August 29, 2024, at 8:45 am, of Staff F, Licensed Practical Nurse (LPN), administering medication via GT for Resident #27, Staff F crushed the resident's medications and placed them in individual medications cups and brought the medication cups to the resident's bedside. Staff F mixed one of the powdered medications with 45 milliliters of water and administered via gravity through the syringe into the GT. A crushed powdered medication was then administered directly into the syringe by Staff F followed by 15 milliliters of water into the GT via gravity and this was repeated nine times. The syringe was observed to become clogged twice during this process and required assistance by Staff F with a plunger for administration of the medications. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on August 28, 2024, at 9:30 am Staff F, LPN stated, I administered them [the medications] separately. I flushed in between. I thought I could choose to mix or not mix [the medications]. When asked why the syringe became clogged, Staff F stated, Because the medications got stuck. During an interview on August 28, 2024, at 10:30 am the Director of Nursing stated, Medications should be mixed with water prior to administration not in the tube. Review of the policy and procedure titled Enteral Tube Medication Administration read, All medication are used in accordance with the manufacturer's recommendations or the pharmacy's directions for storage, use and disposal. Procedures: 2. Prepare mediations for administration. Ensure orders to crush medications. If a tablet is appropriate to crush, do so and dissolve in at least 5 ml [milliliters] of water. Dilute liquids with at least 5 ml of water. Empty capsule content and dilute with at least 4 ml of water. 8. Remove plunger from the 60 ml syringe and connect the syringe to the clamped tubing. 9. Flush the tube with 30 ml of water prior to medication administration. 10. Medications are never added directly to the feeding solution. Keep in mind any possible fluid restrictions and appropriate fluid requirements the resident may have and adjust accordingly. Administer liquid medications first. Allow medication to flow down tube via gravity. Administer each medication one at a time and flush 10 cc [cubic centimeter] between each medication. Give gentle boosts with the plunger (approximately 1 inch down) if the medication will not flow by gravity. Repeat if necessary. Do not push medications through the tube. 11. Flush the tube with 30 ml of water.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 15234 Based on observation, interview, and record review the facility failed to ensure 1 of 6 residents, Resident #136, reviewed for nutrition was offered a therapeutic diet as ordered by the physician and recommended by the Registered Dietician. Findings include: Review of Resident #136's admission record showed Resident #136 was admitted to the facility with diagnoses that included unspecified cirrhosis of liver, end stage renal disease, and mild protein-calorie malnutrition. Review of Resident #136's physician's orders read Liberal Renal diet Regular texture. Thin consistency. Add double protein portions. Add eggs w/ [with] breakfast when available. Review of Resident #136's care plan, revised on 4/1/2024, read [Resident #136's Name] has a nutritional problem r/t [related to] non-compliance with dialysis, CHF [congestive heart failure], ESRD [end stage renal disease], anemia in chronic disease, chronic viral Hepatitis C, therapeutic diet, abnormal nutrition related labs, fluid restriction, drug-nutrient interactions. Resident #136's care plan documented nutritional interventions that included Double protein at each meal. Review of Resident #136's complete blood count with auto differential/comprehensive metabolic profile, collection date, results showed Resident #136's hemoglobin at 6.9 and Resident #136's albumin level at 3.0. Review of Resident #136's nutrition note, dated 7/1/2024, read reports recent wt [weight] loss confirmed by nurse .would like to receive more protein portions and a supplement to complement PO [by mouth intake] . preferences are eggs for breakfast and meat for lunch/dinner. Rec: [Recommendations] Continue Liberal Renal diet, regular texture, thin consistency. Add double protein portions. On 8/27/2024 beginning at 8:13 AM, Resident #136's morning meal was observed. Resident #136 was served 1 sausage patty, 1 2-ounce scoop of eggs and one 8 ounce serving of milk. During an interview on 8/28/2024 at 12:49 PM, the Registered Dietician stated Resident #136 had requested large protein portions. He stated Resident #136 was nutritionally compromised, double protein, two scoops of eggs and two sausage patties should have been served to Resident #136.

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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. 46523 Based on record review and interview the facility failed to accurately document blood pressure medication administration and vital signs for 2 of 10 residents, Residents #42 and #110 reviewed for medication administration. Findings include: 1) Review of Resident #42's physician order dated 7/24/2024 read, Valsartan Oral Tablet 80 mg (milligrams) give 1 tablet by mouth one time a day for HTN [hypertension] hold if SBP [systolic blood pressure] is less than 110 or HR [heart rate] less than 60. Review of Resident #42 Medication Administration Record (MAR) for the month of August 2024 for Valsartan 80 mg at 9:00 AM documented on 8/7/2024 coded 9 other/see progress note, on 8/12/2024 vital signs documented NA [not applicable], and on 8/20/2024 through 8/22/2024 coded 5 hold/ see progress notes. Review of Resident #42's progress notes did not provide documentation for the coded 9 and 5 entries on the MAR for 8/7/2024, and 8/20/2024 through 8/22/2024. During an interview on 8/29/2024 at 11:48 AM the Assistant Director of Nursing (ADON) stated, In reviewing [Resident #42's name] medication record I do not see any additional documentation for those entries on the progress notes. 2) Review of Resident #110's physician order dated 8/12/2024 read, Hydralazine HCl Oral Tablet 25 mg give 50 mg by mouth three times a day for HTN hold for SBP less than 110 or HR less than 60. Review of Resident #110's MAR for the month of August 2024 for Hydralazine HCl documented on 8/05/2024 at 1:00 PM coded 9 other/see nursing note, 8/12/2024 at 9:00 AM and 1:00 PM vital signs coded NA (not applicable), and on 8/20/2024 at 1:00 PM coded 5 hold/see progress notes. Review of Resident #110's progress note revealed no documentation for the coded entries on 8/5/2024, and 8/20/2024 on the medication record. During an interview on 8/29/2024 at 11:45 AM the ADON stated, I do not see any documentation for those entries on the MAR for [Resident #110's name]. During an interview on 8/29/2024 at 11:55 AM the Director of Nursing (DON) stated, Vital signs should be inputted into the MAR. If staff code to see nursing notes than there should be a note in the system. It is a documentation issue. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy and procedure titled Documentation with a last review date of 8/22/2024 read, Purpose: The facility clinical staff will document the provision of care and services according to nursing standards and regulatory requirements. When completed, documentation will accurately reflect the clinical care and other services provided to the resident and ensure that the appropriate information is available to all interdisciplinary team members.

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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. 46523 Based on observation, interview, and record review the facility failed to maintain enhance barrier precautions to prevent the possible spread of infection during direct catheter care and intravenous medication administration and failed to prevent the possible spread of infection in failing to provide intravenous dressing change for peripherally inserted central catheter line (PICC). Findings Include: 1) During an observation on 8/26/2024 at 9:40 AM Staff C, Certified Nursing Assistant (CNA), entered Resident #127's room without gowning and inspected the urinary catheter drainage bag to see if it was leaking. Staff C exited Resident #127's room and came back with towels to place on the wet floor. Staff C without wearing a gown emptied the urinary catheter drainage bag. During an observation on 8/26/2024 at 10:02 AM Staff C, CNA was observed to be providing incontinent care for Resident #127, who has an indwelling urinary catheter, without wearing a gown. During an interview on 8/29/2024 at 8:41 AM with Staff C, CNA, stated, I know I messed up. I should have gowned when I was emptying the catheter and providing incontinent care. 2) During an observation on 8/28/2024 at 6:00 AM Staff D, License Practical Nurse (LPN) entered Resident #151's room. Resident #151's door had an enhance barrier sign posted. Staff D donned gloves and no gown. Staff D without wearing a gown connected an antibiotic medication bag to intravenous tubing and primed the intravenous tubing. Staff D cleansed the needleless connector, inserted the needless syringe to the resident's peripherally inserted central catheter (PICC) line and flushed the line to verify patency with a 10-milliliter syringe of normal saline. Staff D then re-cleansed the needleless connector and inserted the intravenous (IV) tubing to the needleless connector and began to run the medication. During an interview on 8/29/2024 at 9:00 AM Staff D, LPN, stated, You are supposed to wear gloves and gowns sometimes. To be honest they moved all the personal protective equipment [PPE], and I did not know where to get a gown from. I should have had a gown since I was administering IV medication. During an interview on 8/29/2024 at 8:55 AM the Director of Nursing (DON) stated, We have educated on enhanced barrier precautions and the staff are expected to don and doff [PPE]. The staff should wear gloves, gown, and if dealing with a urinary catheter they should wear a face mask. Enhanced barrier precautions are applied for residents with intravenous catheters, foleys, gastric tubes and wounds. (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 policy and procedure titled Enhanced Barrier Precautions with a last review date of 8/22/2024 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: 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 care 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: f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, ect.). 3) During an observation on 8/28/2024 at 9:02 AM Resident #264 was lying in bed, a PICC line to the right upper arm with a single lumen was observed and the dressing was dated 8/21/2024. There was a dried dark red substance and a 2 X 2 gauze with a beige colored substance underneath the transparent dressing. Staff E proceeded to flush the IV (intravenous) line with normal saline and administered medication via the IV. During an interview on 8/28/2024 at 9:02 AM Resident #264 stated, I came in with the IV dressing from the hospital. It looks pretty disgusting, but I have no pain, it is not swollen, and it flushes without any issues. During an interview on 8/28/2024 at 9:26 AM Staff D, LPN, stated, If I would have done the admission I would have changed the dressing then. If the dressing is soiled, I would change it also. I told my relief nurse yesterday about changing the dressing due to the condition of the dressing. Today when I came in, I saw it [IV dressing] had not been changed. I was going to change the dressing, but it was breakfast time, and I was unable to change it at that time. Review of the facility policy and procedure titled Infusion Devices and Procedures with a last review date of 8/22/2024 read, Policy: .Central vascular access device (CVAD) and midline catheter site care and dressing changes are performed at established intervals, and immediately when integrity of the dressing is compromised, if moisture, drainage, or blood is present, or for further assessment if site infection or inflammation is suspected . 39371 3) On 8/26/24 at 10:20 AM an observation of Resident #264 room door it had an enhance barrier precaution sign. Upon entering the room during the observation of the resident, her right upper arm was exposed. A peripherally inserted central catheter (PICC) had a dressing that was dated 8/21/24. The dressing site was visibly soiled with a dark red/blackish substance. (Photographic evidence was obtained). On 8/26/24 at 10:20 AM during an interview Resident 264 stated, That was put in at the hospital [PICC], I'm on a blood thinner. I know it does look bad; the bruising looked worst immediately after it was put in. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Pharmacy Policy title 005-O: Central Venous Catheter Dressing Changes. Policy. Central venous catheter dressing will be changed at specific intervals, or when needed, to prevent catheter related infections that are associated with contaminated, loosen, soiled, or wet dressings. Dressing must stay clean, dry, and intact. Change dressing if any contamination is suspected. Change gauze dressing or TSM [transparent semi-permeable membrane] over gauze dressings every 48 hours. General Guidelines 5. Change transparent semi-permeable (TSM) dressings every 5 to 7 days and PRN [as needed] (when wet, soiled, or not intact).