STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105812	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Care of Avon Park	1213 W Stratford Rd Avon Park, FL 33825

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 37999 Based on observation, record review, and interview the facility failed to maintain dignity and a homelike dining experience in one (West) of two dining/common areas related to staff not removing dinnerware from trays when serving residents. Findings included: On 5/6/24 at 12:38 p.m. the noon meal service was observed on the [NAME] unit. The observation revealed two tables in the dining/common area with two residents sitting at one table and three residents sitting at the second table, one female resident was sitting in front of the television with an overbed table next to her and one male resident was sitting nearby with an overbed table next to him. The observation revealed one out of three residents at one table was served and the female resident sitting in front of the television was served. The observation revealed on 5/6/24 at 12:40 p.m., the second of the three residents sitting at the table was served and at 12:41 p.m., the male resident sitting in front of the television was served. The continued observation, at 12:42 p.m. showed the third resident was served with the dinnerware being left on the food tray. The observation revealed four out of the five residents sitting at the dining tables had their dinnerware remain on the serving trays and four out of five plate covers remained on the table with the residents while dining. On 5/9/24 at 12:25 p.m. an observation showed one male and one female resident sitting at a table on the [NAME] unit with dinnerware still on the serving trays. One resident was sitting in front of the television on the [NAME] unit with the Director of Nursing (DON) standing over her, cutting up food with the dinnerware sitting on the serving tray. On 5/9/23 at 2:13 p.m. an observation was made of a female resident sitting in front of the television, eating a meal with the dinnerware on the serving tray. During the Quality Assurance interview on 5/9/24 at 7:02 p.m. Staff J, Assistant Director of Nursing /Risk Manager (ADON/RM), the observation of staff not removing the residents' dinnerware from their trays when served was disclosed and Staff J did not respond other than nod their head. Review of the policy titled, Quality of Life - Dignity, revised August 2009, revealed: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, individuality. The interpretation and implementation of the policy showed: (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	1. Residents shall be treated with dignity and respect at all times. 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. 01800 The Dietary Director was asked during an interview on 5/9/24 at 3:13 p.m. about the facility's policy about removing the residents' plates from their meal trays in the dining room. She said she would have to check to see what the facility policy was. During an interview with the Director of Nursing (DON) on 5/9/24 at 4:46 p.m. the concern about the staff not removing the residents' plates from the meal trays was discussed. The DON stated they should remove the plates from the trays. The facility policy was requested at that time.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01800 Based on observation and interview, the facility failed to provide a clean and homelike environment, in that the facility was not free from offensive odors. This involved the front lobby area, the area in front of the [NAME] nurses' station, and four resident rooms (Rm103, Rm107, Rm109 and Rm110) out of 18 resident rooms on the [NAME] unit. Findings included: On 5/6/24 at 9:00 a.m. the lobby smelled of old urine when the survey team entered the facility. At 11:10 a.m. the area in front of the [NAME] nurses' station smelled of old urine. On 5/6/24 at 2:31 p.m. room [ROOM NUMBER] had a very offensive odor in the room, that was not urine. On 5/7/24 at 10:03 a.m. room [ROOM NUMBER] had an offensive odor that was not urine. On 5/7/24 at 10:38 a.m. room [ROOM NUMBER]'s bathroom had a strong urine odor in it. On 5/8/24 at 7:43 a.m. room [ROOM NUMBER] had a strong odor of urine. On 5/8/24 at 8:21 a.m. room [ROOM NUMBER] room had a strange offensive odor that was not urine, but it was improved from the day before. On 5/9/24 at 5:51 p.m. an interview with the Environmental Services Director revealed that he conducted a monthly room check, such as gaps between the mattress and the beds, call lights functioning, etc. His audit doesn't include checking for offensive odors in rooms. He said, if they notice an odor they do a deep clean. They cleaned room [ROOM NUMBER]B recently. They replaced the whole bed in 110B the day before (5/8/24). If the staff observe environmental concerns, the nurses can put in an IT ticket into a computer and then the Environmental Services Director receives the ticket. After that, he prioritizes the ticket and addresses the concern. When Environmental Services responds to the concern and resolves it, an email is sent to the person who submitted it to let them know that the concern has been resolved. The system alerts him when tickets are overdue. The Environmental Services Director was informed about the urine odor on the first day in front of the [NAME] nurses' station, the front lobby, and resident rooms. He said he would take care of it.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01800 Based on observation, interview and record review, including resident assessments, the facility failed to accurately reflect the resident's dental status for one of one resident (#17) reviewed for dental status and services. Findings included: During an observation on 5/6/24 at 1:18 p.m., Resident #17 was observed to have several broken, chipped teeth and dental caries (cavities/tooth decay). On 5/8/24 at 8:40 a.m. Resident #17 was observed during breakfast with multiple chipped teeth, one front tooth was a sliver. She said she fell backwards with a shopping cart and it hit her mouth. She had black gums around several teeth. She was on a regular diet. Review of the Face Sheet revealed Resident #17 was admitted to the facility on [DATE]. Her pertinent diagnoses included hypothyroidism; local infection of the skin and subcutaneous tissue; Vitamin D Deficiency; contracture, left hand; encounter for attention to colostomy; and essential hypertension. The Annual Minimum Data Set (MDS) with an Assessment Reference Date of 4/26/24 documented the resident's Brief Interview for Mental Status (BIMS) score of 14, indicating she was cognitively intact with no indicators of delirium. This assessment coded Resident #17 as requiring set up or clean up assistance with eating and oral hygiene and that she had no pain, no fever, no vomiting, and no dehydration. Resident #17 had no swallowing disorder, her height was 61 (inches), and she weighed 10# (pounds) with no weight loss or gain or unknown. She was coded as being prescribed a therapeutic diet. The Dental status section of the MDS was coded as none of the above. The Quarterly MDS with an ARD of 2/9/24 documented the resident's BIMS score of 3, indicating she had severe cognitive impairment, and no indicators of delirium. This assessment coded Resident #17 as requiring set up or clean up assistance with eating and oral hygiene and that she had no pain, no fever, no vomiting, and no dehydration. Resident #17 had no swallowing disorder, her height was 61, and she weighed 108# with no weight loss or gain or unknown. She was coded as being prescribed a therapeutic diet. Dental status is not coded on quarterly MDSs. The Annual MDS with an ARD of 5/19/23 documented the Resident #17's dental status as none of the above. None of the MDSs reflected the resident's obvious or likely cavities or broken natural teeth and abnormal mouth tissue. Resident #17 did not have a care plan for dental status. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The resident had a small gradual weight loss from 11/01/23 of 114.6 lbs. and a Body Mass Index (BMI) (A person's weight in kilograms divided by the square of height in meters. A high BMI can indicate high body fatness) of 21.65 (normal weight) to 106.5 lbs on 5/1/24 and a BMI of 19.93 (lower range of normal weight). Meal intake for April 2024 averaged 76 to 100%. The Social History assessments, dated 4/26/24 & 11/23/23, did not document any oral/dental issues and indicated No referrals necessary. The Speech Therapy Screens, dated 4/26/24 & 5/16/23, did not document any oral/dental issues. The Nutritional Evaluations, dated 11/21/23 and 4/26/24, marked dental status as none of the above. Review of the current physician orders included multivitamin with minerals, Stress Formula with zinc, offer 8 oz. (ounces) fortified milkshake by mouth twice daily, at 10 AM and 2 PM, document amount of fluid consumed (include bedside water, activities, hydration cart and snacks) every shift, document food at dinner, and Regular diet, fortified foods. Progress Notes revealed the following: 3/25/22 Advanced Practice Registered Nurse note - Lips, teeth, gums - normal dentition. 12/11/23 Physician note - Normal dentition (the development of teeth and their arrangement in the mouth). 4/29/23 Physician note - Normal dentition. There was no documentation in the medical record to indicate the resident had been referred for a dental consult or received any dental services. On 5/9/24 at 4:37 p.m. the Director of Nursing was informed that Resident #17's MDSs were inaccurate for her oral/dental status.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49497 Based on record review, interview, and review of the facility's policy the facility failed to ensure the Level I Preadmission Screening and Resident Review (PASARR) was accurate for four residents (#15, #26, #28, #38) of 17 residents sampled for PASARR review. Findings included: Review of the electronic medical record (EMR) revealed Resident #15 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included vascular dementia severe, bipolar disorder, and major depressive disorder. Review of the Level I PASARR, dated 7/31/23, showed qualifying diagnoses were not checked or indicated, and that no Level II PASARR was required. Review of the EMR revealed Resident #26 was initially admitted to the facility on [DATE] with diagnoses that included major depressive disorder, bipolar disorder, and anxiety disorder. Review of the Level I PASARR, dated 7/28/20, showed qualifying diagnoses of depressive disorder and anxiety were checked, bipolar disorder was not checked and that no Level II PASARR was required. Review of the EMR revealed Resident #28 was admitted to the facility on [DATE] with diagnoses that included post-traumatic stress disorder (PTSD), epilepsy, unspecified intracranial injury with loss of consciousness of unspecified duration (TBI), unspecified mood disorder, schizoaffective disorder, and anxiety disorder. Review of the Level I PASARR, dated 10/05/18, showed Part A qualifying diagnoses (anxiety, schizoaffective, depressive disorder) were not checked, and Part B Intellectual Disability conditions (epilepsy, PTSD, and TBI) were not checked and that no Level II PASARR was required. An interview was conducted on 05/09/24 at 5:10 p.m. with the Director of Nursing (DON). She stated their process for PASARR is to receive it prior to admission from the hospital. She said it is part of the resident preadmission paperwork the facility requires. She stated the facility will review the PASARR and if incorrect they will contact the hospital to complete a new one. She stated Residents #15, #26 and #28 PASARRs were all incorrect, as diagnoses should have reflected the diagnoses in their medical record and not left blank. It should have been corrected at admission to determine if a Level II PASARR was warranted. Review of the facility policy titled, Admission Information: Reference - PASSR [PASARR], undated, revealed: All persons needing admission to a nursing facility must first be screened (Preadmission Screening) for possible mental illnesses (Level I). If a mental illness or intellectual disability appears to exist, the person must be referred for further evaluation (Level II) before admitted to a nursing facilty . Review if there is a substantial change in their mental status. This warrants a referral for an evaluation (Level II) to either the [state agency A] contracted PASRR provider, or the [state agency B]. 01800 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/07/24 at 1:20 p.m. Resident #38's Level I PASARR was reviewed in the electronic medical records. The Level I PASARR screening (to screen for suspected serious mental illness and/or intellectual disability) was completed on 3/4/19 prior to Resident #38's admission on 3/7/19. The PASARR form only listed depressive disorder on the form, therefore no Level II PASARR was needed (copy obtained). According to the medical record, on 3/7/19, there was a new diagnosis of schizoaffective disorder (a chronic mental illness that causes a person to experience dramatic changes in their thoughts, moods, and behaviors) added for Resident #38. Resident #38's Level I PASARR was not revised to reflect this new diagnosis, which is a serious mental illness that would trigger a Level II review (An in-depth evaluation that results in the determination of need, the determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care). On 5/9/24 at 3:04 p.m. during an interview with the Social Services Director (SSD), she was informed that Resident #38's Level 1 PASARR was not revised after her new diagnosis of schizoaffective disorder. The SSD agreed that Resident #38 needed a revision of the PASARR. The SSD was asked if she or any other facility staff audit records to ensure that resident PASARRs are accurate, she replied that she couldn't speak to any audits.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based observations, interviews, and record reviews, the facility failed to provide wound care and treatment in accordance with professional standards of practice for four (#67, #328, #177, and #36) of five residents sampled for skin conditions, and failed to ensure physician's orders were obtained for application of splints for one (#41) of one resident sampled for range of motion. Findings included: 1. A review of Resident #67's medical record revealed Resident #67 was admitted to the facility on [DATE] with diagnoses of sepsis and arthroscopic surgical procedure converted to open procedure. An interview was conducted on 5/7/2024 at 12:07 PM with Resident #67 in the resident's room. Resident #67 stated he had a procedure done on his right knee prior to his admission at the facility, which resulted in a wound infection to the area and required dressing changes to the wound. An observation of Resident #67's wound dressing to the upper right leg revealed no documented date on the wound dressing. A review of Resident #67's physician's orders showed an order, dated 4/30/2024, to cleanse Resident #67's right upper leg wound with normal saline, pat dry, insert silver rope dressing, cover with an abdominal pad, and secure with a (brand name) transparent dressing. Change every other day and as needed. A review of Resident #67's 5-Day Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/31/2024 showed under Section C - Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #67 was cognitively intact. 2. A review of Resident #328's medical record showed Resident #328 was admitted to the facility on [DATE]. Resident #328 had diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and cellulitis of the right finger. A review of Resident #328's physicians orders showed an order, dated 5/3/2024 to clean the resident's right middle finger wound with [brand name] solution, paint with betadine, and cover with a dry dressing once daily. An interview was conducted on 5/7/2024 at 11:48 AM with Resident #328 in the resident's room. Resident #328 stated he had a bad infection on his right middle finger, which was previously treated with antibiotics. Resident #328's right middle finger was observed with no dressing and appeared slightly red in color with minimal swelling. A follow up interview was conducted on 5/8/2024 at 4:25 PM with Resident #328 in the resident's room. Resident #328 stated the wound on his right middle finger previously had a dressing on it, but he did not think he needed it anymore and took the dressing off. Resident #328 was not able to state when he removed the dressing from his right middle finger but stated the facility staff had stopped putting a dressing on his right middle finger. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A review of Resident #328's 5-day MDS assessment, with an ARD of 4/8/2024 revealed under Section C - Cognitive Patterns, a BIMS score of 14, which indicated Resident #328 was cognitively intact. The MDS assessment also revealed under Section E - Behavior, Resident #328 did not exhibit behaviors of rejection of care at any time during the assessment period. A review of Resident #328's progress notes with a date range of 5/3/2024 to 5/8/2024 did not show documentation related to Resident #328 refusing wound treatment or removing wound dressings from his right middle finger wound. An interview was conducted on 5/9/2024 at 12:39 PM with Staff G, Registered Nurse (RN) and Unit Manager (UM). Staff G stated Resident #328 had cellulitis of his right middle finger and the wound to the area was nearly healed but the resident kept squeezing it and messing with it so they wanted to keep the wound covered. Staff G reviewed Resident #328's wound treatment orders and addressed the resident had physicians orders for wound dressing changes to the right middle finger. Staff G reviewed Resident #328's medical record and was not able to find documentation related to Resident #328 removing the wound dressing or refusing to have the wound treatment done. Staff G stated if a resident refused to have a wound dressing treatment completed, the refusal should be documented in the resident's medical record. Staff G said nursing staff should attempt to reapply a wound dressing if a resident took dressing off or compromised the integrity of the dressing. Staff G stated when a wound treatment was done, the nurse completing the wound dressing change should label the dressing with the date and their initials. An observation was conducted on 5/9/2024 at 3:37 PM of Resident #328 in the resident's room. Resident #328 was observed resting in bed. No wound dressing was observed to Resident #328's right middle finger. An interview was conducted on 5/9/2024 at 6:58 PM with the facility's Director of Nursing (DON). The DON stated she would expect nursing staff to document completion of wound care treatments in the residents Treatment Administration Record (TAR) and any refusals of wound care treatments should be documented in the resident's medical record. The DON also stated if a resident removed a wound dressing or the dressing was not present as ordered, she would expect the nurse to find out why the wound dressing was not there and offer to reapply the wound dressing. The DON stated wound dressings should be labeled with the date the dressing change was completed and nursing staff should notify the resident's physician if the wound dressing was no longer needed. A review of the facility policy titled Wound Care, last revised in October 2010 revealed under the section titled Documentation the following information should be recorded in the resident's medical record: - The type of wound care given. - The date and time the wound care was given. - The name and title of the individual performing the wound care. - All assessment data when obtained when inspecting the wound. - Any problems or complaints made by the resident related to the procedure. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	The observation showed Staff K had removed the 4 x 4 squares of gauze from 2 packages with bare hands, then used scissors previously utilized to cut off the previously applied dressings to cut off the ends of the rolled gauze without cleaning the scissors between removing the dirty dressing and applying the clean gauze. An interview was conducted with Staff K on 5/9/24 at 2:14 PM, the staff member confirmed the scissors should have been cleaned in between cutting the old dressing and cutting the end of the new one. Review of the policy - Dry/Clean Dressings, revised October 2010, revealed the purpose of the procedure was to provide guidelines for the application of dry, clean dressings. The steps of the procedure included: 4. Position resident and adjust clothing to provide access to affected area. 5. Wash and dry your hands thoroughly. 6. Put on clean gloves. Loose tape and remove soiled dressing. 7. Pull glove over dressing and discard into plastic or biohazard bag. 8. Wash and dry your hands thoroughly. 9. Open dry, clean dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface. 10. Label tape or dressing with date, time and initials. Place on clean field. 11. Using clean technique, open other products (i.e., prescribed dressing; dry, clean gauze). 12. Wash and dry your hands thoroughly. 13. Put on clean gloves. 5. On 5/6/24 at 12:55 PM, a therapist was observed setting up Resident #41 at a dining table on the East wing. During an interview on 5/6/24 after the meal, the resident was wearing bilateral hand splints with Velcro very loosely attached along top of the resident's hands. On 5/9/24 at 8:48 AM, Resident #41 was observed lying in bed and the person feeding him was going to tell the nurse about a cramp in the resident's right foot . The resident reported receiving therapy and therapy was putting splints onto bilateral hands after each session. The resident showed three fingers on each hand was contracted. On 5/9/24 at 2:17 PM, Resident #41 was observed playing a board game with his daughter while wearing bilateral hand splints. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Physician Orders for Resident #41 did not reveal an order for the use of bilateral hand splints. The orders did reveal an order, 3/18/24 - open ended for clarification Occupational Therapy (OT) to evaluate and (&) treat as indicated: 3 times/week (x/wk) x 8 wks skilled services: Activities of Daily Living (ADL)/Self-Care Training, Thera Exercises & Thera Activities in order to facilitate increase in independence; improve client performance skills of strength, coordination, functional activity tolerance, & balance in order maximize/improve efficiency & safety during ADL performance & functional mobility. Long Term Goal (LTG): Assisted Living Facility (ALF) setting placement. Review of a Physician order, dated 3/18/24 and discontinued on 5/8/24, revealed clarification Occupational Therapy (OT) to evaluate and (&) treat as indicated: 3 times/week (x/wk) x 8 wks skilled services: Activities of Daily Living (ADL)/Self-Care Training, Thera Exercises & Thera Activities in order to facilitate increase in independence; improve client performance skills of strength, coordination, functional activity tolerance, & balance in order maximize/improve efficiency & safety during ADL performance & functional mobility. Long Term Goal (LTG): Home setting placement. Review of Resident #41's physician orders revealed an order, dated 5/1/24 to end on 6/14/24, which showed the physician had reviewed and approved the physician orders, care plan, activities, and discharge plans to continue for 45 days. I have reviewed all diagnosis, and they are all active at this time. Review of the treatment orders revealed the resident was to wear Heel Protectors when in bed. Review of Resident #41's care plan revealed the following problems: - ADL Functional Status/Rehabilitation Potential: Mobility, Strength, Endurance, (and) Balance. OT 3x wk for 8 wks. Started 3/18/24 and last reviewed and revised by Staff S, Occupational Therapist (OT). The approaches included Adapted equipment as needed and did not show the type of adaptive equipment utilized or if any equipment was being used. - Risk for skin impairment/pressure ulcers related to (r/t) impaired mobility, weakness, and needs assist with ADL. Hands are partially contracted and is at risk of skin impairment to palms of hands. He has bowel/bladder (b/b) incontinence. The approaches included Heel protectors per orders. The interventions did not include the use of bilateral hand splints. An interview was conducted with Staff S, Occupational Therapist (OT) on 5/9/24 at 2:18 PM Staff S reported putting splints on Resident #41, to gradually increase tolerance, looked for redness, and trims nails. Staff S reported the resident was wearing splints up to 7 hours a day and if the OT was not at the facility other staff roll a towel and place it in the palm of hand. (Review of orders and care plan did not show an order or a care plan for staff to do this). Staff S reviewed physician orders and confirmed not putting the verbiage of splints in the order and the resident should be care-planned for splints also. Staff S confirmed (hand) splints were not part of the care plan. Review of Resident #41's OT Evaluation and Plan of Treatment, certification period of 3/18/24 to 5/14/24, revealed the Treatment Approaches May Include: Initial Encounter: Orthotic Management and training. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	- A new goal - short term goal (STG) showed the resident would increase compliance with orthotic management instructions to partial/moderate assistance in order to maintain joint integrity, facilitate joint mobility, prevent contractures, achieve proper joint alignment, and improve skin integrity and hygiene. Target date 3/31/24. The baseline, 3/18/24 revealed the resident was dependent for orthotic management. - A new goal - STG revealed the Patient will increase ability to donn/doff splint to Partial/Moderate Assistance using wearing schedule of during daily tasks in order to improve skin integrity and hygiene, achieve proper joint alignment, maintain joint integrity, and prevent contractures. Target: 3/31/24. The resident's baseline, 3/18/24, was dependent. The OT Evaluation revealed the goals were for OT interventions to improve client performance skill deficits for balance, strength, and endurance in order to increase level of (I) and safety for ADL performance and functional mobility. Staff S signed the document on 3/18/24, the Director of Rehab signed the revision on 3/27/24 and the physician certified I certify the need for these medically necessary services furnished under this plan of treatment while under my care from 3/18/204 through 5/14/24 on 4/2/24. The therapy Initial Assessment/Current Level of Function & Underlying Impairments, with a start of care 3/18/24 revealed the Musculoskeletal System Assessment revealed the Current Orthotic Device = Hand roll. The management revealed tolerance was N/A, Donn/Doff = Dependent; Orthotic Hygiene = Dependent; Functional Use = Dependent; Orthotic Compliance = Dependent. The Assessment Summary revealed a Splint/Orthotic Recommendations: BMI Slim Grip Hand Splints for both hands. The summary of Daily therapy notes showed on 5/6/24, pt's two set of BMI Slim Grip Hand Splints were adjusted for fit and applied to both hands. The note on 5/7/24, revealed pt's two set of BMI Slim Grip Hand Splints were adjusted for fit and applied to both hands, and on 5/9/24 at 3:49 PM, Staff S documented The pt's two sets of BMI Slim Grip Hand Splints were adjusted for fit and applied to both hands. Pt tolerated 5 hours with no complaints of pain/discomfort. Review of the policy Comprehensive Care Plans, revised September 2010, showed An Individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident. The interpretation and implementation of the policy revealed: 1. Our facility's care planning/ interdisciplinary team, in coordination with the resident, his/ her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems; c. Build on the resident's strengths; d. Reflect the residents expressed wishes regarding care and treatment goals; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	e. Reflect treatment goals, timetables, and objectives in measurable outcomes; f. Identify the professional services that are responsible for each element of care; g. Aid in preventing or reducing declines in the resident's functional status and/ or functional levels; h. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and i. Reflect currently recognized standards of practice for problem areas and conditions. 5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers. It is recognized that care planning individual symptoms or care area triggers in isolation may have little, if any, benefit for the resident. 6. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that required careful data gathering, proper sequencing of advance, and complex clinical decision making. No single discipline can manage the task in isolation. The residence physician (or Primary Health care provider) is integral to this process. 8. Assessments of residents are ongoing in care plans are revised as information about the resident and the resident's condition change. 40775 49497

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01800 Based on observations, resident and staff interviews, and record review, the facility failed to identify a new area of skin impairment, until it was an advanced stage pressure ulcer for one resident (#58) of two residents reviewed for pressure ulcers. This failure resulted in actual harm because a facility-acquired unstageable pressure ulcer, which is an advanced stage of skin breakdown that is full-thickness tissue loss is difficult to heal, at increased risk for infection, and disfiguring. The findings included: On 5/7/24 at 10:45 AM, Resident #58 was cycling in the therapy gym. He said that he got a Stage 4 pressure ulcer on his back because the facility didn't do anything after they discovered the pressure ulcer. When they first discovered a wound, they just told him to lie on his side. He said the facility didn't give him any treatment, and then the wound became a stage 4. They sent a photo to the doctor and he immediately sent him to the hospital because the wound had an infection. Now the wound still hasn't healed and he has a wound vac. He said he didn't get a special mattress until a few weeks ago. He felt the pressure ulcer was the facility's fault. On 5/8/24 at 7:59 AM, Resident #58 was sleeping in bed. He is positioned on his back. He had a special mattress on his bed. At 8:50 AM Resident #58 was finishing his breakfast. He said that his food was okay. He was positioned in bed with the head of the bed elevated. On 5/8/24 at 1:25 PM Resident #58 was up in his wheelchair and just finished his lunch. He said his wound bothers him sometimes, but he wasn't having any pain. Observation of the wound on 5/09/24 at 09:52 AM by a nurse surveyor revealed the following: Staff K, Registered Nurse (RN), entered room, she had just finished changing the wound (facility was unaware of the team wanting to see wound dressing change). Her and a Certified Nursing Assistant undressed the resident. Resident #58 informed the surveyor that the wound clinic changed visits to every 3 weeks. Staff K stated the wound had no slough, looks good. The resident stated that Staff K had washed her hands during the treatment. A black sponge was observed with duoderm (a brand name for a form of dressing that contains a gel-forming agent and a flexible outer layer to seal wounds and prevent bacteria) around it, Staff K stated the resident had some excoriation. The nurse surveyor pointed out 2 open areas outside of clear adhesive dressing, both approximately 1 cm x 0.2 cm. The wound vac [a treatment that applies gentle suction to a wound to help it heal] suction tubing had serosanguinous [containing or consisting of both blood and serous fluid] fluid at the beginning and the end of it. The wound vac was running at 125 mm/Hg. The wound area appeared to be (and approximation confirmed by Staff K) 5 cm L x 3 cm W. No depth observed as black sponge was covering wound bed. Resident #58 was originally admitted on [DATE] and readmitted on [DATE]. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #58's pertinent diagnoses included Type 2 Diabetes Mellitus without complications; generalized muscle weakness; difficulty in walking, no elsewhere classified; need for assistance with personal care; diarrhea; insomnia; Vitamin D deficiency; dermatitis (skin irritation and rashes); iron deficiency anemia; hypokalemia (below normal blood potassium level); hypotension (low blood pressure); pressure ulcer of sacral region (a bone at the base of the spine), stage 4; acute respiratory failure, unspecified whether hypoxia (low oxygen in body tissues) or hypercapnia (presence of higher than normal level of carbon dioxide in the blood); obstructive and reflux uropathy (a blockage in the urinary tract, preventing urine from flowing properly and the backward flow of urine from the bladder into the kidneys); essential hypertension; pain; hyperlipidemia (high blood cholesterol); spinal stenosis (a narrowing of the space around the spinal cord or nerves), lumbar region (lower back) without neurogenic claudication (a narrowing of the space around the lower spine, which can put pressure on the spinal cord directly) (L5-S1); fusion of spine, lumbar region (TLIF/decompression 9/29); and polyosteoarthritis (arthritis that affects multiple joints), unspecified (right shoulder/C3-7). Resident #58's Significant Change in Status Assessment MDS with an ARD of 12/24/23 revealed that the resident had a Brief Interview for Cognitive Status (BIMS) score of 14, which mean his cognition was intact and had no indications of delirium. The resident did not exhibit any rejection of care behaviors. He was dependent in toileting and bathing and required substantial assistance from staff for personal hygiene and to roll left/right. He was dependent on staff to sit to lying and lying to sit, sit to stand, chair/bed-to-chair transfer, toilet transfer, and walking 10 feet. The assessment indicated that the resident had an indwelling urinary catheter, was always incontinent of bowel. The resident did not have any conditions or chronic diseases that may result in a life expectancy of less than 6 months. Resident #58 had no swallowing disorders, his height was 71 and he weighed 201 lbs. He had no weight loss or gain or unknown and was prescribed a therapeutic diet. The assessment indicated Resident #58 had a pressure injury and that he was at risk for pressure ulcers. He had an unhealed pressure ulcer, one at stage 4 and one unstageable Deep Tissue Injury (persistent non-blanchable deep red, maroon or purple discoloration). He had one unstageable pressure ulcer upon admission. He used a pressure reducing device for the bed, received pressure ulcer care and surgical wound care. He had application of nonsurgical dressings, and the application of ointments/medications. The Discharge, Return Anticipated MDS with an ARD of 12/12/23 revealed that he had a pressure injury and was at risk for pressure ulcers. He had an unhealed pressure ulcer, one unstageable. The Admission MDS with an ARD of 10/11/23 indicated that Resident #58 had no pressure ulcers. The resident did not exhibit any rejection of care behaviors. The resident did not have any conditions or chronic diseases that may result in a life expectancy of less than 6 months. The 10/6/23 Braden Scale for Predicting Pressure Sore Risk had a score for Resident #58 of 18 points, which is at risk (there are a total of 23 points, with a higher score meaning a lower risk of developing a pressure ulcer and vice versa. A score of 23 means there is no risk for developing a pressure ulcer while the lowest possible score of 6 points represents the severest risk for developing a pressure ulcer). Resident #58 had a mild risk of developing a pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The facility developed a care plan for Resident #58 for pressure ulcer prevention and pressure ulcer treatment. The pressure ulcer care plan for pressure ulcer prevention included had a problem statement that the resident was at risk for skin impairment/pressure ulcers related to impaired mobility and has bowel incontinence. The resident will at times decline to be repositioned off his sacrum or wear heel protectors (see self-determines care plan). Note: pressure injury to sacrum (see wound care plan). Care plan start date 10/06/23 and last reviewed on 3/27/24. This care plan included a goal that the resident will not develop any further areas from pressure through next review. The care plan approaches included the following: Heel protectors, starting on 10/20/23. Air mattress, starting on 11/16/23. Check and change every 2 hours and as needed, pericare for incontinent episodes, started on 10/12/23. Turn and reposition every 2 hours and as needed, started on 10/06/23. Report changes in skin to Primary Care Physician, starting on 10/6/23. Observe for redness during Activities of Daily Living skin care and report to nursing, starting on 10/6/23. Skin assessment weekly and as needed, starting on 10/6/23. There was no care plan for self-determination. The care plan for wound treatment included the problem statement that the Resident #58 was receiving treatment to pressure ulcer sacrum, start date was 12/20/23 and was last reviewed on 4/24/24. This care plan included a goal that the resident's ulcer will not increase in size. The ulcer will not exhibit signs of infection. The resident's ulcer will heal without complications. Target date 05/12/24. The approaches included the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Wound vac per orders; heel protectors; air mattress (started on 12/20/23); use lift sheets as indicated to reduce friction/shearing; obtain consults as needed. Physical Therapy and Occupational Therapy, Dietary; supplements as ordered; provide diet as ordered; encourage good nutritional and fluid intake; keep clean and dry as possible; minimize skin to exposure to moisture; use barrier cream as needed; keep linens clean and dry, wrinkle free as possible; turn and reposition every 2 hours and as needed; keep responsible party/resident informed of treatment progress and interventions; assess for pain related to ulcer and dressing changes; notify nurse if pain reported; provide treatment as ordered by Primary Care Physician (PCP); nurse to report to PCP any signs and symptoms of infection (excessive drainage, foul smelling, temp); nurse to conduct a skin inspection weekly report to PCP any signs of any further skin breakdown (sore, red, broken areas); Certified Nursing Assistant to observe skin daily during care; will report any noted changes in skin condition to nurse; and observe the pressure ulcer for location, size (length, width, and depth), presence/absence of granulation tissue and epithelization, and condition of surrounding skin - document findings. Physician Orders included the following: Diet order Reduced Concentrated Sweets/No Added Salt Diet. Multivitamin with minerals 1 tablet orally once a day. Appointment at Wound Care Center on 5/24/24 at 1:45 PM - please send wound vac dressing change with supplies with patient. House supplement - give one of the following and document amount consumed: Med Pass 120 ml, Ensure 240 ml, Boost Plus 120 ml, Vital cuisine 120 ml;, Boost VHS, or other approved supplement three times a day. Sacrum: Ensure wound vac is functioning properly at 125 mmHg Continuous suction. If unable to suction, may remove and apply wet to dry dressing twice a day. Enhance Barrier Precautions for catheter and wound. Weekly skin check on Wednesday 7 AM to 7 PM. Resident received Vancomycin IV on 12/18/23 for a wound infection. There was no order for the air mattress. The following Weekly Skin Checks revealed the following: 11/8/23 Weekly Skin Check - no open areas, no skin impairment noted. 11/22/23 Weekly Skin Check - No open areas 11/29/23 Weekly Skin Check- Dressing buttock, lower leg. The 10/5/23 Nursing Admission Observation 2 documented no pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The 10/6/23 Initial wound care documentation identified a surgical wound mid back, but no pressure ulcers. Skilled Nursing notes dated 10/11/23 and 10/15/23 documented, No new open areas or skin issues, not checked for pressure reducing device in bed or chair. There were no progress notes or skilled nursing notes prior to 11/16/23 from the resident's 10/18/23 admission to identify the development of the pressure ulcer at a lower stage. A progress note dated 11/16/23 documented, Unstageable pressure ulcer noted sacral area. This nurse notified MD [Medical Doctor] verbal order for Santyl and calcium alginate daily received and placed. Resident does not complain of pain to site. Air mattress to be applied to bed this AM. Resident wife at facility and notified of wound and treatment in place. Resident and his wife request to be seen by [Name of] Wound Care here at facility. Foley catheter in place. Resident educated on frequent reposition. Resident states he is not able to turn. A progress note dated 12/8/23 documented that the resident received a dose of Cefepime (an antibiotic) IV (intravenous) for wound infection [to the sacrum]. The Hospital History and Physical dated 12/12/23 documented Septic shock secondary to sacral ulcer Stage III, respiratory failure, mild moderate hypokalemia. A progress note dated 12/13/23 documented that the resident was admitted to ICU for treatment of wound. The resident returned to the facility on [DATE] with a wound vac according to progress notes. A progress note dated 12/19/23 documented that the resident had a Stage IV wound with wound dimensions of 9.5 cm length x 6.5 cm width x 3.5 cm depth. A progress note dated 1/11/24 from the Wound Physician documented [AGE] year old white male, with DMII (Type 2 Diabetes Mellitus, hypertension, coronary artery disease, status post myocardial infarction [heart attack], COPD, off tobacco for 8 year, wheelchair bound due to spinal stenosis, seen for a sacral ulcer. The patient moved in to [name of nursing facility] and within a few weeks, developed a sacral ulcer with osteomyelitis [bone infection], urinary tract infection, sepsis [life-threatening complication of infection] requiring ICU hospitalization . The patient is on IV Vancomycin [antibiotic], and comes to WCC (wound care clinic) for management of his ulcer. The wound measures 9 cm L x 5 cm W x 3.4 cm D. 35.343 cm^2 area and 120.166 cm^2 volume . A progress note dated 2/7/24 by the wound care physician documented that the wound was stable, ESR (erythrocyte sedimentation rate, is a blood test that can show inflammatory activity in the body) still elevated, continue current plan of care, culture sent today. If negative, we will consider wound vac. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A progress note dated 2/7/24 from the Wound Physician documented, Wound #1 status is open. Original cause of wound was Pressure Injury. The date acquired was 10/5/23. Wound has been in treatment 3 weeks. The wound is currently classified as a Unstageable/Unclassified wound with etiology of pressure ulcer and is located on the sacrum. The wound measures 9 cm L x 6 cm W x 4 cm D. 42.412 cm^2 area and 169.646 cm^2 volume. There is no tunneling noted, however, there is undermining starting at 9:00 and ending at 3:00 with a maximum distance of 2 cm. There is a medium amount of serosanguinous drainage noted. The wound margin is flat and intact. There is medium (34-66%) pink, pale granulation within the wound bed. There is a medium (34-66%) amount of necrotic tissue within the wound bed including adherent slough. This note indicated that Resident #58's wound was debrided and the character of wound improved. A progress note dated 5/3/24 documented the wound as a Stage IV with dimensions at 6 cm L x 3 cm W x 2. 6 cm D. Interview with LPN, Staff M, on 5/9/24 at 2:15 PM revealed that the resident was on a wound vac. She said his wound had been a lot better; however, she didn't have him as a resident when he first came in the facility. Interview with CNA, Staff N on 5/9/24 at 2:37 PM revealed that she had taken care of him for 2 months. She said he rotated in bed and went into the chair, but he needed assistance with turning in bed. She was asked about heel protectors - she said that she hadn't seen them. CNA Staff N said that Resident #58 ate well. He had skin on the dry side and had a wound. She said that the CNAs did skin checks every day when they got residents up in the morning and during showers. They would tell the nurses if there were skin issues. During an interview with the Director of Nursing on 5/9/24 at 4:24 PM, she stated that the resident developed a pressure ulcer on 11/16/23 and that it was unavoidable because he didn't turn and reposition. They use [brand name] mattress [a non-powered self-adjusting immersion surface with optional alternating pressure therapy] for pressure ulcers - this is an air mattress without the pump. She wasn't sure that Resident #58 had that before he developed the pressure ulcer, but that's what they use for the pressure ulcer prevention. During a telephone interview with the facility Medical Director on 5/9/24 from 4:47 PM to 4:54 PM, he was asked about Resident #58's pressure ulcer. He responded that he was relying on his memory. He said that the resident's pressure ulcer was improving. The Medical Director stated that it was discovered at Stage I. The surveyor explained to the Medical Director that the record documented that the resident's pressure ulcer was discovered at an unstageable pressure ulcer, explained the resident's course of his stay with the wound infection and sepsis, and was now on a wound vac. The Medical Director stated that this was an unavoidable pressure ulcer because of Resident #58's general debility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Care of Avon Park	1213 W Stratford Rd Avon Park, FL 33825

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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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a call back telephone interview with the facility Medical Director on 5/9/24 at 5:25 PM, he stated that the facility had had a low rate of infection at this facility. He apologized that the information that he stated before in the previous interview was not correct because he thought that this was a patient he had a year ago. He stated that Resident #58 was not his patient, so he did not know anything about this patient. The facility had a wound care doctor who came in for residents who had wounds. The Medical Director stated that he participated in Quality Assurance and they discussed infections and all wounds. He said that he did not look at resident wounds when he visited the facility. The facility policy on Prevention of Pressure Ulcers, revised September 2013 included the following: Purpose: The purpose of this procedure is to provide information regarding identification of pressure ulcer risk factors and interventions for specific risk factors. Preparation: Review the resident's care plan to assess for any special needs of the resident. General Guidelines: 1. Pressure ulcers are usually formed when a resident remains in the same positron for an extended period of time causing increased pressure or a decrease in circulation (blood flow) to that area and subsequent destruction of tissue. 2. The most common site of pressure ulcer is where the bone is near the surface of the body, including the back of the head around the ears, elbows, shoulder blades, backbone, hips, knees, heels, ankles, and toes. 3. Pressure can also come from splints, casts, bandages, and wrinkles in the bed linen. If pressure ulcers are not treated when discovered, they quickly get larger, become very painful for the resident, and often times become infected. 4. Pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on the residents skin (i.e., perspiration, feces, urine, wound discharge, soap residue, etc.), decline in nutrition and hydration status, acute illness and/or decline in the resident's physical and/or mental condition. 5. Once a pressure ulcer develops, it can be extremely difficult to heal. Pressure ulcers are a serious skin condition for the resident. 6. The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family and addressed .

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40775 Based on observations, interviews, and record reviews, the facility failed to provide administration of intravenous medication in accordance with professional standards of practice for one (#54) of one resident sampled for intravenous medication administration. Findings included: A review of Resident #54's medical record revealed Resident #54 was admitted to the facility on [DATE] with diagnoses of Parkinson's Disease and infection and inflammatory reaction due to internal left knee prosthesis. A review of Resident #54's physician's orders revealed an order, dated 5/5/2024, for vancomycin 1 gram per 250 milliliters (ml), infuse 250 ml intravenously (IV) over 90 minutes at a rate of 166 ml per hour every other day for a diagnoses of infection and inflammatory reaction d/t internal left knee prosthesis. An observation was conducted on 5/6/2024 at 4:00 PM of Resident #54 in the resident's room. Resident #54 was observed resting in bed, positioned on his right side. An IV pole was observed in Resident #54's room. A 250 ml bag of vancomycin was observed hanging from the IV pole with IV tubing attached to it. The IV tubing was not observed to be labeled with the date it was hung. Approximately 75 ml of fluid was observed inside of the bag of vancomycin. During the observation, Staff H, Registered Nurse (RN) and Unit Manager (UM) entered Resident #54's room and an interview was conducted. Staff H, RN UM stated nursing staff would normally label IV tubing with the date it was hung and was not able to state why so much of the IV medication remained in the IV bag. Photographic evidence was obtained. An interview was conducted on 5/6/2024 at 4:13 PM with Staff I, Licensed Practical Nurse (LPN). Staff I, LPN stated Resident #54 received IV vancomycin every other day for cellulitis. Staff I, LPN was not able to state when the IV vancomycin and IV tubing in Resident #54's room was hung and stated nursing staff would usually label the line and medication with the date it was hung. An interview was conducted on 5/9/2024 at 12:50 PM with Staff G, RN UM. Staff G, RN UM observed the photographic evidence of Resident #54's IV vancomycin medication and tubing captured on 5/6/2024 and stated there's about half a bag left in there when referring to the amount of medication left in the bag. Staff G, RN UM was not able to state why the IV tubing was not labeled with a date or why the IV vancomycin bag contained left over medication. Staff G, RN UM stated if the medication was not administered fully, it would be considered a medication error. An interview was conducted on 5/9/2024 at 7:04 PM with the facility's Director of Nursing (DON). The DON stated IV tubing and medication should be labeled with the date it was hung and could remain hung for 24 hours. The DON also stated IV medications should run via IV pump or a manual flow regulator until the medication is fully administered. The DON stated if a medication was not fully administered to a resident, it would be considered a medication error.

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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 Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01800 Based on observations, interviews, and record reviews, the facility failed to ensure respiratory care was provided in accordance with professional standards related to 1.) failed to ensure proper storage of respiratory equipment for one (#54) of two residents sampled for oxygen therapy, 2.) failed to ensure physician's orders for oxygen therapy were obtained for one (#54) of two residents sampled for oxygen therapy, 3.) failed to ensure oxygen tubing was changed in accordance with physician's orders for one (#126) of two residents sampled for oxygen therapy, and 4.) failed to ensure signage indicating oxygen was in use outside of resident rooms for one (#126) of two residents sampled for oxygen therapy. Findings included: A review of Resident #54's medical record revealed Resident #54 was admitted to the facility on [DATE]. Resident #54's diagnoses included Parkinson's Disease and need for assistance with personal care. An interview was conducted on 5/6/2024 at 4:00 PM with Resident #54 in the resident's room. Resident #54 was observed resting in bed at the time of the interview. An oxygen concentrator was observed next to Resident #54's bed with an oxygen nasal cannula and tubing set bundled on top of the concentrator. The oxygen tubing was not observed to be dated and was not stored in a storage bag. Resident #54 stated he used oxygen on an as needed basis. During the interview, Staff H, Registered Nurse (RN) and Unit Manager (UM) entered Resident #54's room. Staff H, RN UM stated nursing staff were to label oxygen nasal cannula and tubing with the date the set was changed. An observation was conducted on 5/8/2024 at 12:10 PM of Resident #54 in the resident's room. Resident #54 was observed resting in bed with oxygen being administered via nasal cannula at 2 liters per minute. A review of Resident #54's physician's orders revealed an order, dated 5/9/2024 for oxygen via nasal cannula at 2 liters per minute as needed for shortness of breath. Review of Resident #54's discontinued physician's orders did not reveal an oxygen order previous to 5/9/2024. An interview was conducted on 5/9/2024 at 12:50 PM with Staff G, Registered Nurse (RN) and Unit Manager (UM). Staff G, RN UM stated respiratory equipment should be stored in the plastic bag provided in the resident's room when not in use and should be thrown away and replaced if not stored properly. Staff G, RN UM also stated Resident #54 should have had an order for oxygen as needed prior to 5/9/2024. An interview was conducted on 5/9/2024 at 7:11 PM with the facility's Director of Nursing (DON). The DON stated a physician's order is required to administer oxygen to a resident. The DON also stated when respiratory equipment is not in use, it should be stored in a plastic bag and labeled with the date the equipment was changed out, which is done every week in accordance with the resident's order. If respiratory equipment is not stored correctly, it should be discarded and replaced. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility policy titled Oxygen Administration, last revised in December 2017 revealed, under the section titled Preparation staff are to verify that there is a physician's order for oxygen administration prior to administration of oxygen. The policy also revealed under the section titled Equipment and Supplies the following equipment and supplies will be necessary when performing oxygen administration: - Portable oxygen cylinder or concentrator. - Nasal cannula, nasal catheter, or mask (as ordered). - No Smoking/Oxygen in Use signs. - Regulator. Review of the facility policy titled Storage of oxygen and respiratory equipment, last revised in November 2020, revealed under the section titled Infection Control Considerations Related to Oxygen Administration staff are to change the oxygen cannula and tubing every seven (7) days, or as needed and staff are to keep the oxygen cannula and tubing used as needed (PRN) in a plastic bag when not in use. On 5/06/24 at 4:26 PM, Resident #126's oxygen tubing that was attached the standard oxygen concentrator (a machine that uses room air to make oxygen for people who need supplemental oxygen) in her room, had a date of 4/21/24 on a bright pink label. Photographic evidence obtained. There were no cautionary and safety signs indicating the use of oxygen posted outside the resident's room. On 5/07/24 at 10:37 AM, Resident #126's oxygen tubing had a date of 4/21/24 on it. There were no cautionary and safety signs indicating the use of oxygen posted outside the resident's room. On 5/08/24 at 07:19 AM, There were no cautionary and safety signs indicating the use of oxygen posted outside the resident #126's room. Photographic evidence obtained. On 5/08/24 at 07:45 AM, Resident # 126 was in her room sitting in her wheelchair. She was dressed for the day and her oxygen tubing was connected to her portable oxygen tank on the back of her wheelchair. The tubing with the bright pink label with the date of 4/21/24 was not present. Resident #126 was admitted on [DATE]. Her pertinent diagnoses included, Allergic rhinitis (inflammation of the nose), Abnormal posture, Muscle weakness, Chronic Obstructive Pulmonary Disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs), Acute respiratory failure with hypoxia (low oxygen in body tissues), Pneumonitis (lung inflammation) due to inhalation of food and vomit (aspiration pneumonia), and Candidal sepsis (a life-threatening condition that arises when Candida fungi contaminate the bloodstream and spread throughout the body, causing severe infection) (aspiration pneumonia). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #126's Admission Minimum Data Set (MDS) with an Assessment Reference Date of 4/24/24 documented the resident's Brief Interview for Mental Status score as 9, which meant the resident had moderate cognitive impairment and there were no indicators of delirium. The assessment revealed that the resident needed substantial assistance with almost all Activities of Daily Living and the resident experienced shortness of breath when lying flat. The MDS also coded the resident was using oxygen while a resident. There was a Baseline care plan, dated 4/23/24, which identified the resident was at risk for respiratory distress. The resident's comprehensive care plan included a focus area that the resident was at risk for respiratory distress related to the diagnoses of COPD and recent respiratory failure. The care plan goal included that the resident would not exhibit signs and symptoms of respiratory distress. The care plan interventions included oxygen per orders, listen to lung sounds every shift and as needed, make Primary Care Physician aware of changes, provide rest periods as needed, oxygen saturations via pulse oximetry (measures the amount of oxygen in the blood) as ordered as needed, and observe and report signs of respiratory distress. Resident #126's Physician Orders included oxygen at 2 liters/minute via nasal cannula (flexible tubing that sits inside the nostrils and delivers oxygen) twice a day and change oxygen tubing and cannula weekly once a day on Sundays. There were no issues identified in the medical record progress notes regarding the resident's oxygen use. During an interview with Licensed Practical Nurse, Staff M on 5/09/24 at 2:20 PM, she stated that the nurses change the oxygen tubing every Monday. During an interview with the Director of Nursing on 5/9/24 at 4:46 PM, she was informed about Resident #126's oxygen tubing not being changed weekly and the lack of cautionary and safety signs indicating the use of oxygen. She said the oxygen tubing should be changed weekly. 40775

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Post nurse staffing information every day. 37999 Based on observations and record review the facility failed to post nursing staff information daily and include the total number and actual hours worked by licensed and unlicensed nursing staff per shift. Findings included: On 5/9/24 at 8:13 a.m., an observation was made of the daily staffing information posted in the front lobby. The posting was dated 5/9/24, revealed a census of 79 and showed during the 7 a.m. to 7 p.m. shift the facility was staffed with 3 Registered Nurses (RN) and 5 Licensed Practical Nurses (LPN), and during the 7 a. m. to 3 p.m. shift there was 9 Certified Nursing Assistants (CNA) and 1 Patient Care Assistant (PCA). The posting did not show the number of licensed staff scheduled for the 7 p.m. to 7 a.m. shift or the number of CNA's or PCA's scheduled for the 3 p.m.- 11 p.m. or 11 p.m. - 7 a.m. shifts. Photographic Evidence was obtained. Review of the daily staffing information, dated 5/8/24, showed no CNA or PCA information for the 3 p.m. - 11 p.m. or 11 p.m. - 7 a.m. shifts.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, record reviews, and interviews the facility failed to provide medications for one (#178) out of five residents sampled for unnecessary medications related to antihypertensive medications. Findings included: Review of Resident #178's Face Sheet revealed the resident was admitted on [DATE] and included diagnoses Type 2 Diabetes Mellitus with hyperglycemia, Unspecified cirrhosis of liver non-alcoholic, and essential (primary) hypertension. Review of Resident #178's May Medication Administration Record (MAR) revealed the following: - Losartan 25 milligram (mg) oral tablet once a day. Hold for systolic blood pressure (SBP) under 120, pulse under 60. The medication was administered on 5/5 for a documented blood pressure of 113/62 and on 5/7 for a blood pressure of 96/60. - Diltiazem 30 mg oral tablet three times a day. Hold for SBP less than 110 or pulse less than 60. The medication was administered on 5/1 at 9:00 p.m. for a blood pressure of 98/62 and held on 5/2 at 9:00 p.m. for blood pressure 110/69. - Spironolactone 100 mg oral tablet once day. Give one 50 mg tab and one 100 mg tablet. 150 mg daily. Hold if SBP less than 100. The MAR showed one 100 mg tablet was administered on 5/2 and the 50 mg tablet was held, the dose of 150 mg was held on 5/3 for a blood pressure of 108/60. During an interview on 5/9/24 at 5:55 p.m., the Director of Nursing (DON) reviewed Resident #178's MAR and confirmed the nurses had administered the antihypertensive medications outside of parameters. The DON stated the expectation was to administer (meds) per parameters. The staff member shook head when reviewing Losartan and the blood pressure taken for Diltiazem.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 37999 Based on observations, record reviews, and interviews, the facility failed to ensure that the medication error rate was less than 5.00%. Twenty-eight medication administration opportunities were observed and six (6) errors were identified for two (#8 and #126) of five residents observed. These errors constituted a 21.43% medication error rate. Findings included: 1. On 5/8/24 at 8:11 a.m., an observation of medication administration with Staff R, Registered Nurse (RN), was conducted with Resident #8. The staff member obtained a blood pressure of 119/70 and a radial pulse of 65. Staff R returned to the medication cart parked in the hallway and dispensed the following medications: - Vitamin D3 50 microgram (mcg) (2000 international units) - 2 over the counter (otc) tablets - Vitamin D 25 microgram (mcg) otc tablet - Eliquis 5 milligram (mg) tablet - Metoprolol Succinate Extended-Release 25 mg tablet - Multi-Vitamin otc tablet - Oxybutynin Extended-Release tablet - ClearLax mixed with approximately 4 ounces of water. - Tramadol 50 mg tablet Staff R confirmed dispensing 8 tablets, placing all in a plastic envelope and manually crushing them all together. Staff R placed in 2 spoonfuls of applesauce in the medication cup, stirring the concoction, entered the resident room and administered the medications. Review of Resident #8's Medication Administration Record (MAR) revealed the resident was ordered: - Multi Vitamin with minerals tablet - Metoprolol Succinate Extended Release 24 hour - 25 mg tablet once a day, hold for systolic blood pressure below 110 or pulse below 60 beats per minute. - Oxybutynin Chloride Extended Release 24 hour - 5 mg once a day. Review of Resident #8's physician orders revealed the following order: - May crush medications within pharmacy guidelines. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility provided pharmacy list of DO NOT CRUSH MEDICATIONS included the medications: Metoprolol (extended release) - Toprol XL and Oxybutynin (extended release) - Ditropan XL. During an interview on 5/9/24 at 12:52 p.m., the issues regarding crushing extended-release medications and the Multi Vitamin tablet dispensed did not contain minerals was discussed with the Director of Nursing (DON), the DON confirmed Metoprolol Succinate and Oxybutynin should not have been crushed. 2. On 5/8/24 at 11:26 a.m., an observation of medication administration with Staff R, Registered Nurse (RN), was conducted with Resident #126. Staff R obtained a blood glucose level of 229 prior to dispensing the following medications: - Senna 8.6 milligram (mg) otc tablet - Aspirin 325 mg otc tablet - Metformin 500 mg tablet - Humulin R 4 units Staff R mixed applesauce in the medication cup holding the three tablets then injected the insulin into Resident #126's left lower quadrant. Staff R stated the resident could take the medications whole but due to safety the tablets needed to be crushed. Staff R sat the medication cup on the in-room sink vanity, left the room and re-dispensed the Senna, Aspirin, and Metformin, crushing the medications together, re-entered the resident room and administered the medications. Review of Resident #126's MAR revealed the resident was to be administered Aspirin once a day at 10:00 a.m., Senna was scheduled for 10:00 a.m., and Metformin twice a day scheduled for 9:00 a.m., and 5:00 p.m. The review showed the Aspirin and Senna was administered approximately one hour and half after the scheduled time and the Metformin was administered approximately 2.5 hours after the scheduled time. During an interview on 5/9/24 at 1:00 p.m., the DON was notified of the lateness of Resident #126's medications. Review of the policy - Administering Oral Medications, revised October 2010, revealed The purpose of this procedure is to provide guidelines for the safe administration of oral medications. The policy instructed staff to Check the label on the medication and confirm the medication name and dose with the MAR. Review of the policy - Administering Medications, revised December 2017, showed Medications shall be administered in a safe and timely manner, and as prescribed. The interpretation and implementation of the policy revealed: 3. Medications must be administered in accordance with the orders, including any required time frame. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40775 Based on observations, interviews, and record reviews, the facility failed to ensure one (#54) of one resident sampled for intravenous medication administration was free from significant medication errors. Findings included: A review of Resident #54's medical record revealed Resident #54 was admitted to the facility on [DATE] with diagnoses of Parkinson's Disease and infection and inflammatory reaction due to internal left knee prosthesis. A review of Resident #54's physician's orders revealed an order, dated 5/5/2024, for vancomycin 1 gram per 250 milliliters (ml), infuse 250 ml intravenously (IV) over 90 minutes at a rate of 166 ml per hour every other day for a diagnoses of infection and inflammatory reaction d/t internal left knee prosthesis. An observation was conducted on 5/6/2024 at 4:00 PM of Resident #54 in the resident's room. Resident #54 was observed resting in bed, positioned on his right side. An IV pole was observed in Resident #54's room. A 250 ml bag of vancomycin was observed hanging from the IV pole with IV tubing attached to it. The IV tubing was not observed to be labeled with the date it was hung. Approximately 75 ml of fluid was observed inside of the bag of vancomycin. During the observation, Staff H, Registered Nurse (RN) and Unit Manager (UM) entered Resident #54's room and an interview was conducted. Staff H, RN UM stated nursing staff would normally label IV tubing with the date it was hung and was not able to state why so much of the IV medication remained in the IV bag. Photographic evidence was obtained. A review of Resident #54's progress notes dated 5/5/2024 at 6:20 AM revealed Resident #54's IV vancomycin was infused with no adverse reactions. The progress not did not show documentation related to the amount of medication left in the bag of vancomycin after the administration. An interview was conducted on 5/9/2024 at 12:50 PM with Staff G, RN UM. Staff G, RN UM observed the photographic evidence of Resident #54's IV vancomycin medication and tubing captured on 5/6/2024 and stated there's about half a bag left in there when referring to the amount of medication left in the bag. Staff G, RN UM was not able to state why the IV tubing was not labeled with a date or why the IV vancomycin bag contained left over medication. Staff G, RN UM stated if the medication was not administered fully, it would be considered a medication error. An interview was conducted on 5/9/2024 at 7:04 PM with the facility's Director of Nursing (DON). The DON stated IV tubing and medication should be labeled with the date it was hung and could remain hung for 24 hours. The DON also stated IV medications should run via IV pump or a manual flow regulator until the medication is fully administered. The DON stated if a medication was not fully administered to a resident, it would be considered a medication error. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the facility policy titled Medication Errors, with no effective date, revealed under the section titled Definitions types of medication errors include wrong dose and omission (not administered before next scheduled dose due.) The policy also revealed under the section titled Policy residents shall remain free of any significant medication errors.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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. 37999 Based on observations and interviews, the facility failed to ensure proper storage of drugs and biologicals related to 1.) failing to ensure treatment carts remained locked and secured when not in use on one (South) of three units of the facility on two of four days during the survey and 2.) failing to ensure medications were stored in facility medication carts and not inside of resident rooms for one (#26) of five residents observed during medication administration. Findings included: During a tour of the South unit on 5/7/2024 at 9:29 AM, a treatment cart was observed unlocked in the unit hallway without staff present at the treatment cart. Staff U, Registered Nurse (RN) was observed conducting medication administration in the unit hallway. Staff U, RN stated she just unlocked the treatment cart because items from pharmacy were delivered that morning, which she put in the treatment cart. Staff U, RN addressed she left the treatment cart unlocked and stated she was going to lock the cart. Staff U, RN was observed locking the treatment cart before continuing with medication administration. During a tour of the South unit on 5/8/2024 at 9:26 AM, a treatment cart was observed unlocked in the unit hallway without staff present at the treatment cart. The facility's Infection Preventionist (IP) and Assistant Director of Nursing (ADON) was observed walking up to the treatment cart and closing the trash can lid on the cart. The IP ADON did not lock the treatment cart before walking away from it. An interview was conducted with the IP ADON following the observation. The IP ADON stated she did not see the treatment cart was unlocked and stated the carts should be kept locked at all times. The IP ADON was observed locking the cart before walking down the unit hallway. 2. On 5/8/24 at 11:26 a.m. an observation of medication administration with Staff R, Registered Nurse (RN), was conducted for Resident #126. The staff member obtained a blood glucose level of 229 from the resident's right thumb, the observation showed a bottle of store brand nasal spray sitting on the bedside dresser next to the bed. Staff R left the room and dispensed three tablets of oral medication and drew up 4 units of Humulin R insulin from a vial. The staff member injected the 4 units into the left lower quadrant of the resident and stated, as stirring applesauce with the oral medications, the resident could take the medications whole in applesauce however due to safety the tablets needed to be crushed. Staff R placed the medication cup containing the 3 oral tablets and applesauce on the in-room vanity and left the room. The staff member dispensed the oral medications prior dispensed, crushed the medications together, mixed them with applesauce, re-entered Resident #126's room, and administered the medications before leaving the room, leaving the nasal spray at bedside. An interview was conducted with Staff R on 5/8/24 at 11:46 a.m., regarding Resident #126 having nasal spray at bedside. The staff member entered Resident #126's room for a fourth time and removed the nasal spray from the bedside dresser reporting not knowing who put it there and it must have been a family member. The staff member, again, stated it must have been a family member and did not answer if the medication was supposed to be kept at bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 5/9/24 at 1:00 p.m., the Director of Nursing (DON) stated the nurse had informed her about the nasal spray and no one in the facility was allowed to self-administer (medications). An interview was conducted on 5/9/2024 at 6:54 PM with the facility's Director of Nursing (DON). The DON stated she would expect medications and biologicals to be stored inside of the medication and treatment carts and the carts should be kept locked when not in use. The DON also stated if a resident wishes to administer their own medications, they would provide education to the resident and assess them to ensure they are able to properly administer the medications to themselves, but the medication would still be stored in the facility medication cart. The DON stated if the resident or the resident's family wished to have an over-the-counter medication that was brought in, they must have a physician's order for the medication. Review of the facility policy titled Storage of Medication, last revised in April 2007, revealed under the section titled Policy Statement the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The policy also revealed under the section titled Policy Interpretation and Implementation compartments (including but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. 40775

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01800 Based on observation, interview, and record review, the facility failed to assist one (Resident #17) of one resident in obtaining routine dental care. The findings included: During an observation on 5/6/24 at 1:18 PM, Resident #17 was observed to have several broken, chipped teeth and dental caries. On 5/8/24 at 8:40 AM, Resident #17 was observed during breakfast with multiple chipped teeth, one front tooth was a sliver. She said she fell backwards with a shopping cart and it hit her mouth. She had black gums around several teeth. She was on a regular diet. Resident #17 was admitted to the facility on [DATE]. She was [AGE] years old. Her pertinent diagnoses included Hypothyroidism; Local infection of the skin and subcutaneous tissue; Vitamin D Deficiency; Contracture, left hand; Encounter for attention to colostomy; and essential hypertension. The Annual Minimum Data Set (MDS) with an Assessment Reference Date of 4/26/24 documented the resident's Brief Interview for Mental Status (BIMS) score of 14, indicating she was cognitively intact with no indicators of delirium. This assessment coded Resident #17 as requiring set up or clean up assistance with eating and oral hygiene and that she had no pain, no fever, no vomiting, and no dehydration. Resident #17 had no swallowing disorder, her height was 61, and she weighed 108# with no weight loss or gain or unknown. She was coded as being prescribed a therapeutic diet. The Dental status section of the MDS was coded as none of the above. The Quarterly MDS with an ARD of 2/9/24 documented the resident's BIMS score of 3, indicating she had severe cognitive impairment, and no indicators of delirium. This assessment coded Resident #17 as requiring set up or clean up assistance with eating and oral hygiene and that she had no pain, no fever, no vomiting, and no dehydration. Resident #17 had no swallowing disorder, her height was 61, and she weighed 108# with no weight loss or gain or unknown. She was coded as being prescribed a therapeutic diet. Dental status is not coded on quarterly MDSs. The Annual MDS with an ARD of 5/19/23 documented the Resident #17's dental status as none of the above. None of the MDSs reflected the resident's obvious or likely cavities or broken natural teeth and abnormal mouth tissue. Resident #17 did not have a care plan for dental status. The resident had a small gradual weight loss from 11/01/23 of 114.6 lbs. and a Body Mass Index (BMI) (A person's weight in kilograms divided by the square of height in meters. A high BMI can indicate high body fatness) of 21.65 (normal weight) to 106.5 lbs. on 5/1/24 and a BMI of 19.93 (lower range of normal weight). (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Meal intake for April 2024 averaged 76 to 100%. The Social History assessments dated 4/26/24 & 11/23/23 did not document any oral/dental issues and indicated that No referrals necessary. The Social services note dated 4/26/24 for Annual review included, She is alert and oriented and pleasant to speak with. She resides at Royal Care as a long term care resident. She is DNR (Do Not Resuscitate) Status. The Speech Therapy Screens dated 4/26/24 & 5/16/23 did not document any oral/dental issues. The Nutritional Evaluations dated 11/21/23 and 4/26/24 marked dental status as none of the above. Physician Orders included multivitamin with minerals, Stress Formula with zinc, offer 8 oz. fortified milkshake by mouth twice daily, at 10 AM and 2 PM, document amount of fluid consumed (include bedside water, activities, hydration cart and snacks) every shift, document food at dinner, and Regular diet, fortified foods. Progress Notes revealed the following: 3/25/22 Advanced Practice Registered Nurse note - Lips, teeth, gums - normal dentition. 12/11/23 Physician note - Normal dentition (the development of teeth and their arrangement in the mouth). 4/29/23 Physician note - Normal dentition. There was no documentation in the medical record to indicate that the resident had been referred for a dental consult or received any dental services The medical record documented that Resident #17's payer source was a Medicaid Health Maintenance Organization since 3/1/22. An interview with the Social Services Director on 5/9/24 at 2:56 PM revealed that residents were referred for a dental consult if there was a concern. The facility had a dental service that came to the facility monthly. Once the dentist saw a resident, the dental service would see the resident on subsequent visits. The SSD said they had 8 residents who had just seen the dental hygienist recently. The Social Services Director was informed that Resident #17 dental status and that the resident had not been referred to the dentist. On 05/9/24 at 4:37 PM, the facility Director of Nursing (DON) was asked how residents were referred to the dentist. She responded that If the staff saw or heard that a resident had a dental problem they told the social worker and the social worker would make a referral to their contract dental service that came to the facility. She said the contract dental service had a dental hygienist and dentist who came to the facility, but she could not say how often. The DON was informed about the resident's dental status and that the resident's MDSs were inaccurate for her oral/dental status.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 01800 Based on observation, interview, and record review, the facility failed to maintain food safety standards, such as maintaining clean floors and walls; not store ready-to-eat refrigerated Time/Temperature Control for Safety (TCS) food too long; thawing frozen TCS food (meat) properly under cold running water; and maintaining equipment in good condition. These findings have the potential to cause foodborne illness for 74 out of 76 residents who consume the facility's food. Findings included: During the initial brief tour of the kitchen on 5/06/24 at 9:29 a.m., the perimeter of the floor in the walk-in refrigerator had black soil. In addition, at 9:46 a.m., the perimeter of the floor in the walk-in freezer had black soil. (Photographic Evidence Obtained) Also, during the kitchen tour at 9:51 a.m. there was a quart container of egg salad in the [vendor name] double door reach-in refrigerator in the food preparation area. The container of egg salad had a label with a date that was written use by 5/4/24. The egg salad was made on the premises. (Photographic Evidence Obtained) The Kitchen Manager discarded the egg salad on her own volition. A continued observation revealed, in the dry storage area at 9:59 a.m., a black substance that appeared to be biogrowth on one wall. (Photographic Evidence Obtained) Additionally during the kitchen tour, at 10:03 a.m., a 10 pound log of frozen ground beef was being thawed in the prep sink. The frozen meat was floating in water in the sink. Staff O, Dietary Aide turned off the faucet to the sink, so that there was no water flowing over the meat in the sink. (Photographic Evidence Obtained) The Dietary Director was told about this and she turned the water back on and drained the sink. While observing the frozen meat in the sink, it was noted there was a large spatula with burnt edges hanging from the rack above the prep sink. (Photographic Evidence Obtained) During a follow up visit to the kitchen on 5/08/24 at 11:17 a.m., the wall in the dry storage area was cleaned and painted. (Photographic Evidence Obtained) In addition at 11:38 a.m., the same spatula with burnt edges was observed again hanging from a rack. (Photographic Evidence Obtained) There were three scoops in which the plastic handles were a rough surface, which was no longer easily cleanable. One was just washed and the other two were stored in a drawer. (Photographic Evidence Obtained) The Dietary Director disposed of these on her own volition. On 5/8/24 at 12:16 p.m. the facility dietitian stated that Staff P, Dietary Aide put the date she made the egg salad on the label. An observation of the [NAME] unit resident nourishment mini refrigerator on 5/08/24 at 12:59 p.m., revealed two thermometers present in the refrigerator. One was an analogue dial thermometer and the other was a hanging analogue liquid filled tube thermometer, which was broken. The hanging tube thermometer was filled with water. (Photographic Evidence Obtained) (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 5/9/24 at 3:25 p.m. to 3:47 p.m., the kitchen observation findings were discussed with the facility's Dietitian and the Dietary Director. The facility's Dietitian stated that Staff O, Dietary Aide had previously been trained in thawing frozen food. He further stated the Food and Nutrition Service staff had been trained in food storage, which he provided a copy of the in-service education report, dated 4/21/24. He stated the eggs used in the egg salad that was labeled as use by 5/4/24 were pasteurized shell eggs. The facility's Dietitian added that they have purchased a new spatula and scoops. He says he looks at kitchen sanitation during his consultation visits and documents them on his consultation reports which are given to the Nursing Home Administrator. The facility's Dietitian provided the consultation reports dated 3/4/24 and 4/21/24, which included various food safety concerns, but did not include any of the concerns identified during this survey. He provided documentation of employee training on food storage and thawing on 5/7/24 and equipment maintenance and cleaning floors and walls on 5/8/24. He also provided documentation of Performance Improvement Plans (PIPs) for the identified kitchen concerns. These PIPs included dating prepared food with a target date of 7/21/24; cleaning floors and wall with a target date of 8/6/24; and equipment maintenance with a target date of 10/8/24. The Kitchen Weekly Cleaning Schedule showed that one staff is responsible for sweeping and mopping the walk-in refrigerator and the another to sweep and mop the walk-in freezer. The Weekly Cleaning Schedule included sweep and mop storage room. The facility policy on Sanitization, revised on October 2020, included the following: Policy Statement: The food service area shall be maintained in a clean and sanitary manner. Policy Interpretation and Implementation: 1. All kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies, and other insects . The facility policy on Food Storage, revised on 10/1/20, included the following: Policy: Food and supplies shall be received and stored in proper areas . Ready-to-eat food shall be marked with a discard dated at the time of opening or preparation. The discard date shall be seven (7) days after the food has been opened if the food has been refrigerated at 41 degrees F [Fahrenheit] or less .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40775 Based on observations, interviews, and record review, the facility failed to develop and maintain an effective infection prevention and control program to control the spread of infection by 1.) failing to ensure staff donned appropriate personal protective equipment (PPE) before entering the rooms of residents under transmission based precautions for four residents (#326, #64, #328, and #67) of seven residents with COVID-19 infection in the facility, 2.) failed to ensure staff doffed PPE before exiting the rooms of residents under transmission based precautions for two residents (#328 and #67) of seven residents with COVID-19 infection in the facility, 3.) failed to ensure residents were assisted with hand hygiene before meals during observation of meal service, and 4.) failed to ensure urinary catheters were stored in a sanitary manner for one resident (#30) of one resident sampled for urinary catheter use. Findings included: During a tour of the South unit on 5/6/2024 at 11:30 AM, a call light was observed on for the room of Resident #326 and Resident #64. An observation of the room door revealed signage indicating the residents were on transmission based precautions for contact and droplet isolation. Staff B, Certified Nursing Assistant (CNA) and Staff D, CNA were observed donning isolation gowns and glove in preparation to enter the room. Staff B, CNA was observed wearing a surgical mask with an N95 mask over it and did not don eye protection before entering the resident's room. Staff D, CNA donned an N95 mask but did not don eye protection before entering the resident's room. An interview was conducted following the observation at 11:41 AM with Staff B, CNA. Staff B, CNA stated Resident #326 and Resident #64 were under contact and droplet isolation precautions and staff were to don an isolation gown, N95 mask, and gloves before entering the room. Staff B, CNA stated eye protection was not required to enter the room. Staff B, CNA read the signage posted to the door and addressed eye protection was required to enter the resident's room. Staff B, CNA stated she was not aware eye protection was needed to enter the room of a resident on contact and droplet isolation precautions and stated I don't even know if we have goggles. A review of Resident #326's medical record revealed Resident #326 was admitted to the facility on [DATE]. A review of Resident #326's physician's orders revealed an order dated 5/5/2024 for droplet isolation related to the resident being positive for COVID-19. A review of Resident #64's medical record revealed Resident #64 was admitted to the facility on [DATE]. A review of Resident #64's physician's orders revealed an order dated 5/5/2024 for droplet isolation related to the resident being positive for COVID-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	An observation was conducted on 5/6/2024 at 12:11 PM during lunch meal tray pass on the facility's South unit. Staff E, CNA was observed entering the room of Resident #328 wearing an isolation gown, gloves, an N95 mask, and goggles. An observation of the room door revealed signage indicating the resident was on transmission based precautions for contact and droplet isolation. Staff E, CNA was observed exiting Resident #328's room carrying the goggles in her left hand, using a paper towel as a barrier between her hand and the goggles. Staff E, CNA placed the goggles on top of the isolation cart outside of Resident #312's room, not using the paper towel as a barrier. Staff E, CNA donned clean gloves, picked up the goggles, and used a cleaning product to sanitize the goggles for approximately one minute. Staff E, CNA then placed the goggles back on top of the isolation cart. An interview was conducted with Staff E, CNA following the observation. Staff E, CNA stated the facility was previously utilizing face shields as eye protection, which were disposed of after each use, and she was not sure what the facility protocol was for using goggles as eye protection. Staff E, CNA also stated the facility reused the goggles and stored them in paper bags at one point in time, but she was not sure if the process was the same or if the facility was reusing PPE. A review of Resident #328's medical record showed Resident #328 was admitted to the facility on [DATE]. A review of Resident #328's physician's orders revealed an order, dated 5/5/2024 for droplet isolation related to the resident being positive for COVID-19. An observation was conducted on 5/6/2024 at 12:31 PM in the South hall of the facility. Staff D, CNA was observed entering the room of Resident #328. An observation of the room door revealed signage indicating the resident was on transmission based precautions for contact and droplet isolation. Staff D, CNA was observed donning an isolation gown, goggles, gloves, and an N95 mask. Staff D, CNA was observed donning the N95 mask over 2 surgical masks before entering the resident's room. When Staff D, CNA exited the room, she was observed carrying the N95 mask out of the room, using a piece of plastic as a barrier, and had 2 surgical masks donned. An interview was conducted with Staff D, CNA following the observation. Staff D, CNA was not able to state why she donned her N95 mask over the 2 surgical masks and was not able to explain the facility process for doffing PPE appropriately, stating I'm new. An observation was conducted on 5/8/2024 at 12:12 PM on the facility's South unit during the lunch tray pass. Staff F, CNA was observed exiting the room of Resident #328 and Resident #67 wearing an N95 mask, which was donned over a surgical mask, and a face shield. An observation of the room door revealed signage indicating the residents were on transmission based precautions for contact and droplet isolation. Staff F, CNA was observed entering the unit's soiled utility room to dispose of the N95 mask and face shield. Staff F, CNA was observed exiting the room wearing a surgical mask. An interview was conducted following the observation with Staff F, CNA. Staff F, CNA stated when entering the room of a resident on contact and droplet isolation precautions, staff are to don an isolation gown, gloves, eye protection, and an N95 mask. Staff F, CNA also stated when she exits a room of a resident on contact and droplet isolation precautions, she doffs the isolation gown and gloves, but keeps the eye protection and N95 mask on, then disposes of the PPE in the soiled utility room. Staff F, CNA was not able to state why she donned an N95 mask over a surgical mask but stated it was her normal process to do so. A review of Resident #67's medical record revealed Resident #67 was admitted to the facility on [DATE]. A review of Resident #67's physician's orders revealed an order, dated 5/7/2024 for droplet isolation related to the resident being positive for COVID-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	An interview was conducted on 5/9/2024 at 5:34 PM with the facility's Infection Preventionist (IP). The IP stated residents who are diagnosed with COVID-19 are placed on droplet isolation precautions. Personnel entering the resident's room should don an isolation gown, N95 mask, eye protection, and gloves before entering the resident's room. The IP also stated staff had the option to don a surgical mask over their N95 mask, but donning an N95 mask over a surgical mask would not be appropriate because it would not provide a proper fit for the N95 mask. The IP stated staff should doff all PPE before exiting the resident's room and should not be reusing any PPE. An interview was conducted on 5/9/2024 at 7:15 PM with the facility's Director of Nursing (DON). The DON stated when entering the room of a resident on contact and droplet isolation precautions, staff should don an isolation gown, N95 mask, gloves, and eye protection before entering the resident's room. Staff should also be doffing all PPE before exiting the room. The DON also stated the N95 mask would not be effective if a surgical mask was worn underneath and stated the facility does not reuse PPE. A review of the facility policy titled Infection Prevention and Control Program, last revised in January 2021, revealed under the section titled Policy the facility's Infection Prevention and Control Program shall ensure that this organization develops, implements, and maintains an active, organization wide program for the prevention, control, and investigation of infections and communicable diseases in order to reduce the risks of endemic infections in residents, visitors, and healthcare workers, and to optimize use of resources. The Infection Prevention and Control Program shall be conducted in accordance with all applicable federal and state rules and regulations, accrediting body standards, as well as nationally recognized infection prevention and control practices and guidelines. All staff shall participate and support the Infection Prevention and Control Program through compliance with infection prevention and control practices, policies and procedures, reporting infection prevention and control concerns, and cooperation with the Infection Preventionist/Infection Prevention and Control Committee. 37999 On 5/8/24 at 8:11 a.m., an observation of medication administration was conducted with Staff R, Registered Nurse (RN), for Resident #8. The staff member removed a manual blood pressure (BP) cuff from the bottom drawer of the medication cart, entered the resident room and placed it on the resident's right arm. Staff R obtained a BP of 119/70 and with the use of a non-contact thermometer a temperature of 97.4. The staff member used a pulse oximeter to obtain a heart rate of 70 and a oxygen saturation of 100%. Staff R, RN removed the cuff from the resident and left the room. The staff member used a disinfecting wipe to clean the BP cuff and another to clean the thermometer and pulse oximeter. Staff R did not remove the stethoscope used for BP measuring from around the neck to clean it. The staff member prepared Resident #8's medications and administered them. On 5/6/24 at 12:45 p.m., Resident #30 was observed sitting in the East Dining Room with the urinary drainage bag attached to the underside of the wheelchair, and the catheter tubing lying on the floor. On 5/6/24 Resident #8 was observed in the resident room with the catheter tubing lying on the floor. Staff T, Licensed Practical Nurse (LPN) confirmed the tubing was on the resident room floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 5/7/21 at 5:01 p.m., Resident #30 was observed lying in bed with the catheter tubing lying on the floor next to the bed. Review of Resident #30's clinical record showed the resident was admitted on [DATE] and readmitted on [DATE]. The Minimum Data Set (MDS), dated [DATE], revealed diagnoses not limited to uropathy and urinary tract infection (UTI). Review of Resident #30's care plan showed the resident had a problem involving increased potential for complications/infection related to has a urinary catheter in place. Diagnosis (Dx) urinary retention with obstruction, start date 5/2/24. The goal was the resident will not have complications or infection related to catheter during review. The approaches included Keep drainage bag below waist and free of kinks in tubing and off floor. Review of the policy - Indwelling Urinary Catheter Insertion and Maintenance - Male Resident, effective 2010, revealed the goal was to Promote single or continuous bladder elimination by insertion of a sterile catheter into the urinary bladder and provide a sterile closed receptacle system. The policy revealed The facility shall ensure that a licensed nurse catheterized male residents, preferably a licensed male nurse. The procedure instructed staff to Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. 01800 During the Dining Observation at lunch on 5/6/24 at 12:30 PM in the [NAME] unit common area, none of the 7 residents present were offered hand hygiene before eating. These resident's eating assistance varied from supervision to feeding. During an interview with the Director of Nursing on 5/9/24 at 4:46 PM, the concern about the staff not offering hand hygiene before eating was discussed. The facility policy was requested at that time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105812	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Care of Avon Park	1213 W Stratford Rd Avon Park, FL 33825

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 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40775 Based on observations, interviews, and record review, the facility failed to equip corridors with securely affixed handrails on 2 of 3 units of the facility (West and South). Findings included: During a tour conducted on 5/6/2024 at 9:48 AM on the facility's [NAME] unit, a handrail between rooms [ROOM NUMBERS] was observed to be loose and not firmly secured to the wall. A tour conducted on 5/6/2024 at 10:59 AM on the facility's South unit revealed the following: - A handrail between rooms [ROOM NUMBERS] was observed to be loose and not firmly secured to the wall. - A handrail between rooms [ROOM NUMBERS] was observed to be loose and not firmly secured to the wall. - A handrail between rooms [ROOM NUMBERS] was observed to be loose and not firmly secured to the wall. An interview was conducted on 5/6/2024 at 11:11 AM with Staff I, Licensed Practical Nurse (LPN) on the facility's South unit. Staff I, LPN stated if a maintenance concern was identified on the unit, she would communicate the concern to the Unit Manager, who would then relay the concern to facility maintenance staff. Staff I, LPN observed the unsecured handrails on the South unit and addressed the rails were loose and not firmly secured to the wall. Staff I, LPN stated she did not notice the handrails were loose and unsecured and stated the handrails were not safe. An interview was conducted on 5/6/2024 at 11:19 AM with the facility's Director of Environmental Services (DES). The DES stated he conducted inspections of the facility's handrails at least weekly and any staff member can document a maintenance concern in the electronic maintenance system. The DES addressed the handrails on the South unit were loose and not firmly secured to the wall. A review of the facility's Weekly Hand Rail Checks for 5/6/2024 revealed no issues with handrails on the facility's [NAME] unit. During a tour conducted on 5/8/2024 at 11:03 AM on the facility's [NAME] unit, the handrail between rooms [ROOM NUMBERS] was observed to be loose and not firmly secured to the wall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105812	A. Building B. Wing	05/09/2024

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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 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A review of the facility policy titled Maintenance Service, last revised in December 2009, revealed under the section titled Policy Statement maintenance service shall be provided to all areas of the building, grounds, and equipment. The policy also revealed under the section titled Policy interpretation and Implementation the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personnel include, but are not limited to: maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines, maintaining the building in good repair and free from hazards, and providing routinely scheduled maintenance service to all areas.