STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105816	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lilac at Bayview, The	161a Marine Street Saint Augustine, FL 32084

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44571 Based on interview and record review, the facility failed to ensure residents with newly evident or possible serious mental disorders, intellectual disability, or related conditions were reviewed for level II pre-admission screening and resident review (PASRR) for one (Resident #87) of two residents reviewed for PASRR. The findings include: A record review for Resident #87 was conducted on 04/08/25 at 6:30AM and read, PASRR signed by RN (registered nurse) on 7/03/24 from hospital with depressive d/o (disorder). No Level II needed. A review of the resident's medical diagnoses for the facility on 7/10/24 included anxiety d/o (disorder), psychosis and brief psychotic d/o. A review of the resident's Admission Summary, dated 7/10/24, read, Resident arrived via stretcher from [acute care hospital name] via Stat @ 1515 (3;15 PM). She is alert and oriented. Spanish speaking but understands and speaks limited English. DX CVA (Diagnosis cerebrovascular accident) She is a Full Code. POA (Power of Attorney) contacted for verbal consents via phone. She is a 2-person assist with right side and bilateral lower extremity weakness. HX (History) diabetes, HIV (human immunodeficiency virus), GERD (gastroesophageal reflux disease), dementia, HTN (hypertension - high blood pressure), HDL (hyperlipidemia), depression. Last BM (bowel movement) 7/8/24. She is on a Cardiac Puree diet/thin liquids (diet). Take pills whole. Bruising to bilateral (both) arms, abdomen. Lungs clear, abdomen soft with bowel sounds times 4 quad (quadrants). Denies pain/discomfort. Resident resting in bed at present. A Psychiatry Referral Order read, Chief Complaint: Depression, anxiety, dementia and psychosis. Reason for Today's Evaluation: I was consulted for psychiatric evaluation and treatment of depressed mood and anxiety. History of Present Illness: This is an [AGE] year-old patient with past psychiatric history of depression, anxiety, dementia and psychosis. Patient is a new admit to this facility requiring evaluation for underlying psychiatric conditions and treatment. Facility requested a consult. I was consulted for psychiatric evaluation and treatment of depressed mood and anxiety. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 4/09/25 at 9:35 AM related to PASRR. The DON stated the facility did not have any documentation that indicated Resident #87's Level I PASRR had been revised to show a diagnosis of anxiety disorder or psychosis and to initiate a Level II PASRR screening. A review of the facility's policy and procedure titled Resident Assessment-Coordination with PASRR (Preadmission Screening and Resident Review) Program (dated 11/03/20, revised 9/19/02) revealed: This facility coordinates assessments with the preadmission screening and resident review (PASRR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receive care and services in the most integrated setting appropriate to their needs. 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition, will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45576 Based on observation, interview and record review, the facility failed to stop enteral feeding as ordered by the physician for one (Resident #305) of two residents reviewed for gastrostomy tube enteral feedings. The findings include: A review of Resident #305's medical record revealed an admitted [DATE] with diagnoses including severe protein-calorie malnutrition, dysphagia (difficulty swallowing) and gastrostomy status (G-tube - feeding tube passed into a resident's stomach through the abdominal wall). A review of Resident #305's physician's orders, dated 4/7/2025, read, Enteral feed order every shift for nutritional support administer Jevity 1.5 40 ml/hr (milliliters/hour) via G-tube continuously with (200 ml) autoflush every hour for (4) hours (1200). 20 hours a day. Start infusion daily at (1400 p) and stop infusion at (10:00 a). Ensure to record amount infused to record amount infused per pump reading once a shift. During an observation on 4/8/2025 at 12:10 PM, Jevity 1.5 Cal/Fiber Oral Liquid (Nutritional Supplement) was observed infusing at 40 ml via G-tube. During an interview with Registered Nurse (RN) A, she stated, The feeding was supposed to be turned off at 10:00 AM and restarted at 2:00 PM. I'm always late giving my meds (medications) and I didn't pay attention to the time. The feeding should have been turned off at 10:00 AM. During an interview on 4/8/2025 at 12:40 PM with Licensed Practical Nurse (LPN) B/Nurse Manager, she stated, Physician's orders must be followed, and the tube feeding should have been turned off at 10:00 AM, as ordered. During an interview with the Director of Nursing on 4/8/2025 at 12:58 PM, she stated, Physician's orders must be followed and the Jevity should have been turned off at 10:00 AM as ordered. A policy and procedure for following physicians' orders was requested; however, no policy was received during the survey.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 15234 Based on interview and record review, the facility failed to ensure nutritional interventions were implemented as ordered by the physician for two (Residents #94 and #89) of nine residents reviewed for nutrition. The findings include: 1. A review of Resident #94's care plan, revised 3/9/2025, revealed the resident was at nutritional risk related to therapeutic mechanically altered diet and autoimmune gastritis weight loss in 90 days. A review of Resident #94's weight record revealed that on 3/5/2025, Resident #94 weighed 170 pounds, and on 4/1/2025, he weighed 165.5 pounds, which was a - 2.65 % weight loss. Resident #94's weight record showed that on 11/6/2024, he weighed 204 pounds, and on 4/1/2025, he weighed 165.5 pounds, which was a - 18.87 % weight loss. A review of Resident #94's physician's orders revealed that he had a physician's order, dated 3/20/2025, which read, (Name of supplement) one time a day 120 ml (milliliters) one time a day PO (by mouth), record amount consumed. A review of Resident #94's medication administration and treatment administration records, dated April 2025, failed to reveal documentation that showed the amount of nutritional supplement consumed by Resident #94 had been recorded as ordered by the physician. Further review of Resident #94's physician's orders showed the resident had a physician's order, dated 3/5/2025, which read, ST (speech therapy) consult r/t (related to) weight management hx: (history): Dysphagia. A review of the resident's medical record failed to show documentation that Resident #94 had been referred to speech therapy for evaluation related to weight management as ordered by the physician. During an interview on 4/9/2025 at 10:30 AM, the Director of Rehabilitation stated Resident #94 had not been referred to speech therapy for an evaluation related to weight management as ordered by the physician. She explained that nursing staff would complete referrals to therapy after the physician wrote an order for therapy. During an interview on 4/9/2025 at 10:37 AM, Licensed Practical Nurse (LPN) C confirmed that Resident #94 had a physician's order to document the amount of nutritional supplement consumed by the resident. LPN C confirmed that the physician's order had not been followed, and the amount of the nutritional supplement consumed by Resident #94 had not been recorded as ordered by the physician. LPN C stated she was not aware of the physician's order for Resident #94 to be referred to speech therapy related to weight management. She stated there was no system to flag new orders by the physician, and the only way to know new orders would be to check the orders or to have the new order passed on by another nurse. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/2025 at 8:54 AM, the Registered Dietician (RD) stated recording the amount of a supplement consumed would assist the provider to know whether a nutritional intervention was beneficial for a resident. 2. A review of Resident #89's care plan, revised 3/9/2025, revealed that the resident was at risk for altered nutrition related to use of psychotropic agents and significant weight loss in 30 days. A review of Resident #89's weight records showed on 3/6/2025, Resident #89 weighed 128.6 pounds, and 4/1/2025, Resident #89 weighed 127.5 pounds, which was a - 0.86 % weight loss. Resident #89's weight records showed that on 12/24/2024, Resident #89 weighed 136.8 pounds, and on 4/1/2025, Resident #89 weighed 127.5 pounds, which was a - 6.80 % weight loss. A review of Resident #89's physician's orders showed that the resident had a physician's order, dated 3/17/2025, that read (Name of Supplement) one time a day 120 ml (milliliters) one time a day PO (by mouth), record amount consumed. A review of Resident #89's medication administration and treatment administration records, date April 2025, failed to reveal documentation that showed the amount of nutritional supplement consumed by Resident #89 had been recorded as ordered by the physician. During an interview on 4/9/2025 at 10:46 AM, LPN C confirmed that Resident #89 had a physician's order to document the amount of nutritional supplement consumed by the resident. She confirmed that the physician's order had not been followed, and the amount of the nutritional supplement consumed by Resident #89 had not been recorded as ordered by the physician.

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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. 45576 Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was not 5% or greater for two (Residents #254 and #305) of seven residents observed during medication administration, resulting in a medication error rate of 6.45%. The findings include: 1. During medication administration observation for Resident #254 on 4/8/2025 beginning at 11:00 AM, Registered Nurse (RN) A verified orders, prepared and initiated Cefepime HCL (hydrochloride - antibiotic) solution 50 ml (milliliters) intravenously (IV), and initiated instillation via pump over 1 hour. Medication was due at 9:00 AM and was administered 2 hours late. A review of Resident #254's physician's orders, dated 4/8/2025, read, Cefepime HCL Solution 1 GM/50ML (grams per milliliters), Use 1 gram intravenously every 12 hours for UTI (urinary tract infection)for 7 Days. A review of the resident's April 2025 Medication Administration Record (MAR) revealed, Cefepime HCL Solution 1 GM/50ML, Use 1 gram intravenously every 12 hours for UTI for 7 days start date 4/8/2025 at 0900. During an interview on 4/8/2025 at 11:59 AM with RN A , she stated, I am always late with my medications, and this medication is due once a day. It was due at 9:00 AM. 2. During medication administration observation for Resident #305 on 4/8/2025 at 12:10 PM, RN A verified orders, prepared and initiated Daptomycin (antibiotic) Intravenous Solution Reconstituted (Daptomycin INFUSE 100 ML NS (600 MG)(milligrams) IV OVER 30 MIN AT 200 ML/HR, administered 4 hours late. A review of Resident #305's physician's orders, dated 4/3/2025, revealed, Daptomycin Intravenous Solution Reconstituted (Daptomycin INFUSE 100ML NS (600 MG) IV OVER 30 MIN AT 200ML/HR EVERY 24 HOURS FOR BACTEREMIA UNTIL 4/22/2025 at 23:59. A review of Resident #305's April 2025 MAR documented 4/3/2025, Daptomycin Intravenous Solution Reconstituted (Daptomycin INFUSE 100ML NS (600 MG) IV OVER 30 MIN AT 200ML/HR EVERY 24 HOURS FOR BACTEREMIA UNTIL 4/22/2025 at 23:59 with administration documented scheduled at 08:00 daily. During an interview on 4/8/2025 at 12:30 PM with RN A, she stated, [Resident #305's] Daptomycin is to be administered every 24 hours. It is scheduled at 8:00 AM, but I am always late giving out my medications. During an interview on 4/8/2925 at 12:40 PM with Licensed Practical Nurse (LPN) B/Nurse Manager, she stated all medications should be given no earlier than 1 hour before and no later than 1 hour after the scheduled time. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/2025 at 12:58 PM with the Director of Nursing (DON), she stated, Medications are to be administered anytime 1 hour before or 1 hour after they are scheduled. If they are not administered within that hour before or after, I consider that they are administered late. During an interview on 4/9/2025 at 9:49 AM with the Assistant Director of Nursing (ADON), the ADON stated, The timeframe for medication to be administered on time is 1 hour before and up to 1 hour after they are scheduled. If the medications can not be administered on time, the doctor is to be called and informed. A review of the facility's policy and procedure titled Medication Administration (dated 1/30/2025), revealed: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection . 11. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician .

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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 - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45576 Based on observation, interview, and record review, the facility failed to ensure that all drugs and biologicals used in the facility were properly stored in accordance with professional standards of practice. Unsecured medications were found on two of four hallways and affected three residents (Residents #55, #52, and #73). The findings include: 1. During an observation on 4/7/2025 at 10:49 AM of Resident #55's room, two bottles of medication were observed sitting at bedside unsecured. The bottles were labeled: Prevagen and Cerebral. (Photographic evidence obtained) During an observation on 4/8/2025 at 8:13 AM of Resident #55's room, two bottles of medication were observed sitting at bedside unsecured. The bottles were labeled: Prevagen and Cerebral. (Photographic evidence obtained) During an interview on 4/8/2025 at 8:13 AM, the resident stated he took Prevagen and Cerebral pills daily and had done so for months. He stated he had the pills in his room for months. 2. During an observation on 4/7/2025 at 11:19 AM of Resident #52's room, a medication cup with 7 unidentified pills was observed sitting on Resident #52's bedside table unsecured. During an interview on 4/7/2025 at 11:19 AM, Resident #52 stated, Those are pills from this morning. I will not take them until after I eat and I did not want to eat this morning. I took my blood pressure pill only. (Photographic evidence obtained) During an interview on 4/8/2025 at 12:40 PM with Licensed Practical Nurse (LPN) D, she stated, No medications are allowed in the room unsecured. I did not leave any medications in there. She (Resident #52) has refused her medications for the last two days and I threw them away this morning. During an interview on 4/8/2025 at 12:48 PM with LPN B/Unit Manager, she stated, No, medications even over the counter are not allowed in the room unless they (the residents) have been screened for self-administration, and they have a lock box then, so that they can secure their medications. During an interview on 4/8/2025 at 12:58 PM with the Director of Nursing (DON), she stated, No over the counter medications or prescription medications can be left at the bedside. The nurse should be watching the residents take their scheduled medications before leaving the room. 47275 3. During an observation on 4/8/2025 at 11:25 AM of Resident #73's room, a medication cup with an unidentifiable pink pill was sitting on the resident's bedside table unsecured. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/2025 at 11:26 AM, Resident #73 stated, That's my medication. They leave that there until I get some food to take it with. When asked if they left the medications there all the time, the resident replied, yes. During an interview on 4/8/2025 at 11:33 AM, LPN C confirmed there was medication in the cup sitting on Resident #73's bedside table and stated, No, medication should not be left at bedside. A review of Resident #73's Electronic Medical Record (EMR) revealed that the resident entered the facility on 12/24/24 with diagnoses including Interstitial Pulmonary Disease, Kidney Disease, Proximal Atrial Fibrillation, Essential (primary) Hypertension, and Rheumatoid Arthritis. Review of Resident #73's EMR revealed that the resident had no assessment for self-administration of medication. During an interview on 4/8/2025 at 1:30 PM, the Director of Nursing stated, There are no residents here that are supposed to have meds (medications) at bedside. A review of the facility's policy and procedure titled Medication Storage (dated 1/30/2025), revealed: It is the policy of this facility to ensure that all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturers' recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. 1. General guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e. medications carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls . c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45576 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program to prevent the possible development and transmission of communicable diseases and infections. Specifically, the facility failed to ensure the staff followed Enhanced Barrier Precautions (EBP) for two (Residents #254 and #305) of seven residents reviewed for infection with use of antibiotics. The findings include: 1. A review of Resident #254's medical record revealed an admitted [DATE] and diagnoses including Infection and inflammatory reaction due to indwelling urethral catheter. During an observation on 4/8/2025 at 11:00 AM, Enhanced Barrier Precautions (EBP) signage was observed on Resident #254's door that read, Enhanced Barrier Precautions - everyone must: clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: Central line, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. (Photographic evidence obtained) Personal Protective Equipment (PPE) - gloves, gown or mask) was stored beside the resident's room. During an observation on 4/8/2025 at 11:00 AM, Registered Nurse (RN) A initiated Cefepime HCL (hydrochloride) solution 50 ml (milliliters) intravenously (IV) via pump over 1 hour and did not adhere to Enhanced Barrier Precautions (EBP). She did not utilize PPE (gloves, gown or mask). During an observation on 4/8/2025 at 11:59 AM RN A discontinued IV infusing of Cefepime HCL solution and flush PICC (Peripherally inserted Central Catheter) line with 10 cc (cubic centimeters) Normal Saline (NS) solution and did not adhere to EBP. RN A did not use PPE. A review of Resident #254's physician orders dated 4/1/2025 read, Enhanced barrier precautions every shift. 2. A review of Resident #305's medical record revealed an admission on 4/1/2025 with diagnoses inlcuding endocarditis and pneumonia. During an observation on 4/8/2025 at 12:10 PM, RN A initiated Daptomycin 600 mg (milligrams)/100 ml (milliliters) NS over 30 minutes at 200 ml/hour via pump every 24 hours for bacteremia observed being initiated at 12:10 PM and RN A flushed the IV at the left AC (antecubital) with 10 cc NS prior to administration of Daptomycin IV. RN A did not adhere to physician's orders for EBP and did not utilize PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/8/2025 at 12:10 PM, RN A discontinued the G-tube (feeding tube passed into a resident's stomach through the abdominal wall) feeding and flushed the G-tube after aspiration of contents with 200 cc of tap water. RN A did not adhere to physician's orders for EBP. She did not utilize PPE. A review of Resident #305's physician's orders, dated 4/2/2025, read, Enhanced Barrier Precautions. A review of Resident #305's Physician's orders, dated 4/3/2025, read, Daptomycin intravenous solution reconstituted 600 mg one time a day everyday time code 08:00 (8:00 AM), use 600 mg intravenously one time a day for bacteremia until 4/22/2025 at 23:59 (11:59 PM) During an interview on 4/9/2025 at 12:20 PM with RN A, she stated, I should have put on mask, gloves and gown for [Resident # 254 and Resident #305] prior to administering their IV medications and stopping and flushing the G-tube for [Resident #305]. I just didn't think to do it. During an interview on 4/8/2025 at 12:40 PM with Licensed Practical Nurse (LPN) B/Nurse Manager, she stated when staff were providing direct care to residents with IV's, G-tubes, or for any reason the resident was on EBP, gowns and gloves had to be worn. During an interview on 4/8/2025 at 12:58 PM with the Director of Nursing, she stated for any resident that had an IV or G-tube, staff must use PPE when providing direct care even if an EBP sign was not posted. During an interview on 4/9/2025 at 9:49 AM with the Assistant Director of Nursing, she stated EBP was utilized when any staff member was providing direct care for any resident that had an IV or G-tube. EBP included using a gown and gloves when providing direct care. A review of the facility's policy and procedure titled Enhanced Barrier Precautions (dated 1/30/2025) revealed: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definitions: Enhanced barrier precautions refers to the use of gown and gloves during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as for those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) . 4. High- contact resident care activities include: . g. Device care or use: central lines . 7. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical device is removed.