STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105839	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace of Kissimmee, The	221 Park Place Blvd Kissimmee, FL 34741

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility failed to provide necessary care and services according to assessed needs, to promote the highest practicable physical and psychosocial well-being; and failed to follow required processes to prevent neglect by appropriately identifying and communicating care needs and ensuring continuity of care for 1 of 3 residents reviewed for neglect, out of a total sample of 9 residents, (#2). Findings: Review of the facility's policy and procedure for Abuse Prevention Program, dated March 2024, revealed residents had the right to be free from abuse and neglect. The policy defined neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish. or emotional distress. The document indicated the facility would develop and implement policies to prevent abuse and neglect. Review of the medical record revealed resident #2, a [AGE] year-old male, was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included prostate gland enlargement, chronic pain syndrome, and generalized muscle weakness. Review of the Minimum Data Set (MDS) Significant Change in Status assessment, with assessment reference date of 12/05/24, revealed resident #2 had adequate hearing and vision, clear speech, was able to express his ideas and wants, and had clear comprehension. The resident had a Brief Interview for Mental Status score of 9/15, which indicated he had moderate cognitive impairment. The MDS assessment revealed the resident exhibited no physical or verbal behavioral symptoms, but rejected evaluation or care on one to three days in the look back period. The document showed resident #2 was always incontinent of bowel and urine. On 1/27/25 at 10:12 AM, resident #2 was in bed and there was strong odor of urine in the room. He held the the hem of his hospital-type gown over the side rail and said, It's wet. I'm wet. The resident explained his brief had not been changed during the overnight shift, nor since the start of the day shift. Resident #2 lifted his sheet which had a round, yellow-stained, brown-bordered area at the level of his brief. A folded towel at his right side and the right edge of the drawsheet was a dark yellow to light brown color. The bed protector pad under the resident's buttocks had a large yellow-stained area with a brown border. The resident explained his gown and bed were soaked with urine. He recalled seeing a male nurse during the night shift, but no Certified Nursing Assistant (CNA). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105839	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace of Kissimmee, The	221 Park Place Blvd Kissimmee, FL 34741

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/27/25 at 10:18 AM, CNA B confirmed she was assigned to care for resident #2 for the day shift, but she had not yet had a chance to perform activities of daily living (ADL) care for him. She explained she had been busy since she arrived for the 7:00 AM shift, and was still occupied. When CNA B checked resident #2's bed linen, brief, and gown, she had a shocked facial expression and stated she had never seen him so wet. She said, Whoever was on night shift did not do it. The resident informed CNA B that he was not changed during the night, and stated the last time he received incontinence care was yesterday. The Director of Nursing (DON) entered the room and verified the resident's bed was urine-soaked. Resident #2 repeated his previous statement and told the DON he had not been changed on the overnight shift. On 1/27/25 at 11:03 AM, CNA B stated she usually did walking rounds with off-going staff at the change of shift, but she did not do so this morning. CNA B said, I did not know who worked with him last night. I did not see anyone. She explained this was her regular assignment and she knew the residents well. She stated she did not provide care for this resident earlier as he was usually clean and dry in the morning. CNA B said, If I was told that there was a problem, I would have checked him. The nurse, nobody, said anything to me. She acknowledged she had been at work for almost four hours, since about 7:00 AM, but would not have checked resident's brief or provided care until almost 11:00 AM if she had not been prompted to do so by State Survey Agency staff. On 1/27/25 at 11:13 AM, the Staffing Coordinator explained night shift CNAs were scheduled from 10:45 PM to 7:15 AM, and the day shift CNAs were scheduled from 6:45 AM to 3:15 PM to facilitate a 30-minute overlap of both shifts to conduct shift change activities. She reviewed punch clock times and stated resident #2's night shift CNA clocked out at 7:01 AM this morning, and the day shift CNA clocked in at 6:44 AM. The Staffing Coordinator stated she could not explain why CNA B did not see or receive report from CNA D, as they were both in the building for approximately 15 minutes at the change of shift. On 1/27/25 at 11:20 AM, the DON provided an activities of daily living (ADL) flow sheet that showed at 6:25 AM, CNA D documented resident #2 had no urine output for the shift. He was informed the resident's assigned CNAs did not communicate or conduct walking rounds at the change of shift. He said, When staff come in the morning they should do walking rounds with off-going shift to verify residents' status and condition. The DON confirmed the expected interval related to provision of incontinence care was at the start of every shift and every two hours thereafter. He acknowledged resident #2 did not receive ADL care for almost four hours after the start of the day shift. On 1/27/25 at 11:32 AM, the Social Services Director (SSD) confirmed she interviewed resident #2 and he informed her that he had not been changed on the 11:00 PM to 7:00 AM shift. She explained the resident was alert and had experienced a decline in his physical health status recently. The SSD verified she was the facility's Abuse Coordinator and the resident's report of not being changed for an entire shift in conjunction with the condition he was found in, met the criteria for reporting and investigation of an allegation of neglect. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105839	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace of Kissimmee, The	221 Park Place Blvd Kissimmee, FL 34741

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/27/25 at 12:03 PM, in a telephone interview, CNA E stated he was one of the three CNAs assigned to resident #2's unit last night. He described the shift as a regular night. CNA E denied knowledge of any issues including shouting or aggressive, combative residents. He stated the other CNAs never mentioned not being able to care for a resident and nobody asked him for assistance. He did not recall what time CNA D left the unit in the morning, and he stated he did not receive report from her on her assigned residents before she left. CNA E stated staff were expected to make rounds at least every two hours, check and change incontinent residents during those rounds, and before leaving at the end of the shift, they should walk from room to room with the oncoming staff. On 1/27/25 at 12:22 PM, the DON stated his expectation was nursing staff would follow residents' individualized care plans and professional standards which included rounding every two hours and at the change of shift. He confirmed it was essential for all nursing staff to do walking rounds to ensure all residents were alive and appropriately cared for at shift change. The DON explained walking rounds provided staff an opportunity to identify any issues, ask questions, and explain or clarify residents' care needs. On 1/27/25 at 1:34 PM, the MDS Coordinator stated resident #2 was assessed as having a significant change in status after a recent hospitalization due to a decline in his ADL abilities. She explained the resident used to walk, but not anymore. On 1/27/25 at 2:06 PM, in a telephone interview, CNA D confirmed she was assigned to resident #2's hallway last night. She explained it was not her regular assignment as she worked in different areas throughout the building. She was informed resident #2 reported he did not see her on the night shift and did not receive incontinence care. She verified none of her assigned residents refused care last night. CNA D said, I have not been over there for a while, not really sure if that resident walks. He used to be independent. I think I cleaned all of them.I went into all the rooms and maybe I was mixed him up and thought he was independent. She recalled on arrival for her shift last night, the off-going evening shift CNA did not do walking rounds with her. When asked how she knew what type and level of care each resident on her assignment required, CNA D stated she knew the residents who were heavy wetters and needed to be changed often. She explained she usually asked the residents if they needed staff to change them or if they went to the bathroom themselves. CNA D was asked how she would obtain information on the care needs for residents who were confused or non-verbal. She stated she could possibly look at the electronic medical record to see what the previous CNA documented. CNA D said, I think there is a care plan in there, not sure though. I did not use the computer to do that last night. CNA D stated she did not know what time the day shift staff arrived, but she usually saw them standing in a huddle at the nurses' station for a while. She explained she did not always do walking rounds at the change of shift and said, I think some people do it and some don't. I am not sure if it is a requirement here to do rounds. When asked why she did not remain on the unit to give report to CNA C and conduct walking rounds, CNA D said, I had to leave to take my daughter to school. On 1/27/25 at 3:49 PM, the DON confirmed it was significant concern that the night shift CNA left her assigned residents and went home without giving a change of shift report. He validated it was unacceptable that the CNAs did not do rounds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105839	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace of Kissimmee, The	221 Park Place Blvd Kissimmee, FL 34741

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at 10:29 AM and 1:29 PM, the DON confirmed if any resident refused ADL care, he expected the CNA to return and try again. He explained if that method was not effective, the assigned CNA should ask another CNA to assist or re-approach, and if unsuccessful, then the nurse should be informed. The DON stated CNAs should report repeated refusal of care to the nurse as he/she would intervene, document, and report to the UM, family, DON, and/or physician as appropriate. Review of Resident Progress Notes revealed no nursing progress notes between 1/22/25 an 1/27/25. There was no documentation regarding resident #2 refusing ADL care and no documentation of the resident's status by the off-going night shift nurse. On 1/28/25 at 11:20 AM, the Regional Nurse Consultant (RNC) explained the facility interviewed CNA D yesterday and she informed them she offered to care for resident #2 and he declined. The RNC said, The resident is in his right mental capacity and he can either refuse or accept care. She stated she did not expect the CNA to force care upon the resident. The RNC did not respond when asked if resident #2 was his own person and in his right mental capacity, why would the facility decline to accept his report of not seeing the CNA during the night shift and not being changed. The RNC provided a written statement from CNA D which contained information that contradicted resident #2's statements to the State Survey Agency staff, the SSD, the DON, CNA B, and CNA C. The RNC was informed the written statement also conflicted with CNA D's verbal statement obtained in a telephone interview. On 1/28/25 at approximately 11:24 AM and 2:20 PM, the DON stated the facility reviewed camera footage and observed CNA D enter resident #2's room every two hours during the night shift. He acknowledged there were no cameras inside the resident's room and she might have given care to the resident's incontinent roommate. The DON stated he could not say where CNA D was at the end of her shift yesterday between 6:45 and 7:00 AM. He acknowledged she left the unit and her assigned residents without giving report or doing change of shift rounds to ensure residents had no acute needs, and to discuss any concerns, behaviors, or accidents that occurred during the shift. The DON validated CNA D failed to follow the accepted standard of practice for nursing professionals by leaving her assigned residents without endorsement to another staff member.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105839	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace of Kissimmee, The	221 Park Place Blvd Kissimmee, FL 34741

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility failed to provide adequate activities of daily living (ADL) care for a dependent resident related to incontinence care, fingernail care, and shaving facial hair for 1 of 3 residents reviewed for ADL status, out of a total sample of 9 residents, (#2). Findings: Review of the medical record revealed resident #2, a [AGE] year-old male, was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included prostate gland enlargement, chronic pain syndrome, and generalized muscle weakness. Review of the Minimum Data Set (MDS) Significant Change in Status assessment, with assessment reference date of 12/05/24, revealed resident #2 had a Brief Interview for Mental Status score of 9/15, which indicated he had moderate cognitive impairment. The MDS assessment revealed the resident exhibited no physical or verbal behavioral symptoms, but rejected evaluation or care on one to three days in the look back period. The document showed resident #2 was always incontinent of bowel and urine. Resident #2 had a care plan for bowel and bladder function, initiated on 7/03/20, that indicated he was at risk for functional incontinence and associated skin breakdown. The goal was he would remain .clean, dry, and odor free with staff assistance. The care plan approaches instructed nursing staff to assist the resident with toileting needs and incontinence care on routine rounds and as needed, provide assistance with toileting hygiene and skin care, and assist with changing his incontinence garments. A care plan for ADLs Functional Status, dated 7/03/20, revealed resident #2 required staff assistance with ADLs. The goal was he .will have ADL needs met with staff assistance, will be clean, neat, odor free and appropriately dresses. An approach instructed nursing staff not to force care if the resident resisted; instead, staff should re-approach at a later time to complete care. The document was updated on 1/27/25 to include provide assistance with nail care as needed. On 1/27/25 at 10:12 AM, resident #2 was in bed and there was strong odor of urine in the room. He held the the hem of his hospital-type gown over the side rail and said, It's wet. I'm wet. The resident explained his brief had not been changed during the overnight shift, nor since the start of the day shift. Resident #2 lifted his sheet which had a round, yellow-stained, brown-bordered area at the level of his brief. A folded towel at his right side and the right edge of the drawsheet was a dark yellow to light brown color. The bed protector pad under the resident's buttocks had a large yellow-stained area with a brown border. The resident had a Biliary drainage tube with no leakage noted from the insertion site or the collection bag. He explained his gown and bed were soaked with urine and confirmed his drainage bag did not have a leak. Resident #2's fingernails were long, uneven, and dirty, and there was a brown substance noted under all nails. The resident had unshaved facial hair on his cheeks and chin and had an unkempt appearance. He stated staff had not cut his fingernails for a while, and he could not remember when he was last shaved. The resident rubbed his chin and face and said, They are supposed to shave me. They don't give a [expletive]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105839	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace of Kissimmee, The	221 Park Place Blvd Kissimmee, FL 34741

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/27/25 at 10:18 AM, Certified Nursing Assistant (CNA) B, resident #2's assigned day shift staff, confirmed she had not yet had a chance to perform ADL care for him. She explained she had been busy since she arrived for the 7:00 AM shift, and was still occupied. When asked if she had a few minutes to check resident #2, she pointed to another resident in the hallway and stated she had to assist that resident with breakfast first, and then planned to check resident #2. The resident in the hallway informed CNA B that he would wait. When CNA B checked resident #2's bed linen, brief, and gown, she had a shocked facial expression and stated she had never seen him so wet. She said, Whoever was on night shift did not do it. The resident informed CNA B that he was not changed during the night, and the last time he received incontinence care was yesterday. The Director of Nursing (DON) entered the room and verified the resident's bed was urine-soaked. Resident #2 repeated his previous statement and told the DON he had not been changed on the overnight shift. On 1/27/25 at 10:27 AM, the North Wing Unit Manager (UM) stated none of the off-going night shift or oncoming day shift nursing staff reported any concerns to him regarding resident #2. He stated to his knowledge, the resident had no behavioral issues or rejection of care during the night shift. The North Wing UM was informed of the condition of the resident's fingernails and he verified nail care should be done whenever necessary. He explained resident #2 was scheduled for showers three times weekly, but he was not sure if CNAs were required to do nail care on shower days. On 1/27/25 at 10:41 AM, Licensed Practical Nurse (LPN) A stated the night shift nurse did not inform her of any issues regarding resident #2 refusing care last night. On 1/27/25 at 10:43 AM, CNA B stood at resident #2's bedside. She explained she had just washed his face and needed to complete a bed bath and change all the sheets. She stated she shaved the resident last week and his facial hair was also heavy then. She verified his fingernails were long and dirty and explained all CNAs were responsible for cleaning his fingernails, and the nurses should cut them as he was diabetic. Resident #2 interjected to clarify that most times when his nails were cut, staff provided the clippers and he cut them himself. CNA C entered the room and CNA B asked her to assist as resident #2 was crying out when she tried to roll him from side to side to perform care. When resident #2 was turned to his right side, closer observation of the drawsheet revealed it was stained yellow to the level of the base of his neck. Both CNAs removed all urine-soaked bedding and placed a clean incontinence brief and sheets. CNA C spoke to resident #2 in English and Spanish and he reiterated that he never saw the night shift CNA, and had not received incontinence care since yesterday. CNA C explained the resident refused care at times but said, It's our job to give care. If he says no, we have to go back. It is our job. CNAs B and C validated resident #2 was incontinent and depended on staff for incontinence care. Both CNAs confirmed the expectation was staff would check and/or change residents at least every two hours and when necessary. On 1/27/25 at 11:20 AM and 12:22 PM, the DON provided an ADL flow sheet that showed earlier this morning at 6:25 AM, CNA D noted resident #2 had no urine output during the night shift. There was no documentation on the flow sheet regarding refusal of ADL care. He explained the resident was care planned for refusing care and showers, and required constant re-education. The DON stated his expectation was nursing staff would follow residents' individualized care plans and adhere to professional standards which included checking and changing residents every two hours. He was informed in addition to the resident's report of no incontinence care during the 8-hour night shift, the day shift CNA had not provided ADL care during the almost 4-hour period after the start of her shift, until she was prompted to do so. When asked about the resident's ADL status this morning, the DON said, I cannot say I am satisfied with his condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105839	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace of Kissimmee, The	221 Park Place Blvd Kissimmee, FL 34741

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident Progress Notes for January 2025 revealed nursing documentation that showed resident #2 was alert, oriented, and able to make his needs known. Although there was documentation regarding refusal medications and insulin, there was no evidence the resident refused ADL care. On 1/27/25 at 2:06 PM, in a telephone interview, CNA D confirmed she was assigned to resident #2's hallway last night. She explained it was not her regular assignment as she worked in different areas throughout the building. She was informed resident #2 reported he did not see her on the night shift and did not receive incontinence care. CNA D said, I have not been over there for a while, not really sure if that resident walks. He used to be independent. I think I cleaned all of them.I went into all the rooms and maybe I was mixed him up and thought he was independent. CNA D was not aware resident #2 had a Biliary drain tube and bag and stated to her knowledge the only resident on her assignment with a tube was a female resident with a Foley catheter. On 1/28/25 at 10:29 AM, and 1:29 PM, the DON confirmed if any resident refused ADL care, including nail care, shaving, and incontinence care, he expected the CNA to return and try again. He explained if that method was not effective, the assigned CNA should ask another CNA to assist or re-approach, and if unsuccessful, then the nurse should be informed. The DON stated CNAs should document refusal of care on shower sheets, and nurses should be told about repeated refusal of care as he/she would intervene, document, and report to the UM, family, DON, and/or physician as appropriate. Review of the facility's policy and procedure for Supporting Activities of Daily Living , dated December 2023, read, residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. The document indicated if residents with cognitive impairment resisted care staff would not just assume the resident is refusing or declining care. The policy instructed staff to re-approach the resident in a different way or at a different time, or ask another staff member to speak with the resident. Review of the job description of Certified Nursing Assistant (undated) revealed the primary purpose of the job was was to provide assigned residents with routine nursing care and services in accordance with assessments and the care plan. The document listed job functions including assist residents with bath functions, shave male residents, and assist with clipping, trimming, and cleaning fingernails

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105839	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace of Kissimmee, The	221 Park Place Blvd Kissimmee, FL 34741

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility failed to provide appropriate pharmaceutical services to prevent administration of a prescription ointment by unlicensed nursing staff, for 1 of 1 resident reviewed for medication administration, out of a total sample of 9 residents, (#2). Findings: Review of the medical record revealed resident #2, a [AGE] year-old male, was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included dermatitis (skin inflammation), pruritis (itching), psoriasis, xerosis (dry, scaly skin), and bacterial skin infection of his left leg. Resident #2 had a care plan, started on 9/19/24, for impaired skin integrity related dermatitis. The goal was the resident's skin would exhibit signs of healing or resolution. The approaches instructed nurses to provide medications as ordered, observe for improvement or decline in condition for the possible need for change in treatment, and obtain/provide treatment as ordered by physician. Review of the Physician Order Report revealed resident #2 had an order dated 1/16/25 for Triamcinolone Acetonide 0.1% cream for psoriasis, to be applied to his arms, chest, abdomen, and legs twice daily, after the areas were washed and dried. Triamcinolone Acetonide is a potent steroid cream used to reduce itching and inflammation and calm an overactive immune system (retrieved on 2/13/25 from www.drugs.com/triamcinolone-acetonide-cream.html). On 1/27/25 at 10:12 AM, resident #2 waited in bed for his assigned Certified Nursing Assistant to provide incontinence care. A small plastic medicine cup on the resident's tray table, at the right side of his bed, was approximately one-third full of a white ointment or cream. On 1/27/25 at 10:41 AM, Licensed Practical Nurse (LPN) A was informed there was a cup with a white ointment or cream at resident #2's bedside. She confirmed she gave the cup with the cream to CNA B earlier that morning for the CNA to apply to the resident's skin. On 1/27/25 at 10:43 AM, CNAs B and C gave resident #2 a bed bath and changed his bed linen. Throughout the procedure, as CNA B washed and dried his body, the resident continuously scratched his arms and torso and described the itching as so severe that it was driving him crazy. CNA B explained the nurse gave her the cream and told her to put it on the resident. When asked where on the resident's body the cream was supposed to be applied, CNA B said, Wherever it is itching. CNA C picked up the medicine cup and while resident #2 vigorously scratched his arms and upper body, she applied the white cream to his shoulders, upper back, and buttocks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105839	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace of Kissimmee, The	221 Park Place Blvd Kissimmee, FL 34741

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/27/25 at 11:10 AM, LPN A stated CNA B came to her that morning, told her resident #2 complained of itching, and asked her to provide the cream. LPN A retrieved the tube of medication from the treatment cart and showed a tube of Triamcinolone Acetonide 0.1% cream, labeled for resident #2. She was informed CNA C applied the cream to the resident's shoulders, upper back, and buttocks. LPN A reviewed the medication administration record and explained the ointment was prescribed for use on resident #2's arms, chest, abdomen, and legs. She acknowledged the cream was ordered by a physician, dispensed by the pharmacy, and should not have been administered by CNAs. On 1/27/25 at 1:43 PM, the North Wing Unit Manager verified only licensed nurses had keys to the medication and treatment cart. He confirmed CNAs should not be instructed or permitted to apply medicated ointment or cream. On 1/28/25 at 10:29 AM, the Director of Nursing discussed LPN A's decision to provide a prescription cream to a CNA for application to resident #2's skin. He stated it was unacceptable as medications and treatments should managed by a licensed nurse. Review of the job description for Licensed Practical Nurse/Floor Nurse (undated) revealed drug administration functions that included prepare and administer medications as ordered by the physician in accordance with federal, state and local laws and regulations and facility policy. The document indicated LPNs would comply with established regulatory and professional standards and guidelines. Review of the policy and procedure for Administering Medications, dated February 2024, revealed medications would be administered in a safe manner, as ordered. The document read, Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so [and] medications must be administered in accordance with the orders.