STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105855	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleme Center	2810 Ruleme St Eustis, FL 32726

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41334 Based on observation, interview, and record review, the facility staff failed to ensure residents were administered oxygen as per physician order for 1 of 3 residents reviewed for respiratory care (Resident #13). Findings include: Review of Resident #13's admission record showed the resident was most recently admitted on [DATE] with diagnoses that included anemia, unspecified, dysphagia following cerebral infarction (a stroke), aphasia (inability to speak) following cerebral infarction, quadriplegia, unspecified, type 2 diabetes mellitus with other circulatory complications, unspecified protein-calorie malnutrition, status gastrostomy, occlusion and stenosis of right vertebral artery, essential (primary) hypertension, and dependence on supplemental oxygen. Review of Resident #13's physician order dated 5/21/2024 showed it read, Respiratory-Oxygen: NC [nasal cannula]/mask continuous. Encourage and assist resident to us O2 [oxygen] @ [at] 2 LPM [liters per minute] via nasal cannula continuously for every shift for CVA [Cerebral Vascular Accident] related to other sequalae of cerebral infarction. During an observation on 8/19/2024 at 10:44 AM, Resident #13 was resting in bed, was being administered oxygen via nasal cannula. The oxygen concentrator was set at 4 liters per minute. The oxygen concentrator was at the head of the bed on the resident's right side, outside the reach of the resident. During an observation on 8/20/2024 at 2:16 PM, Resident #13 was resting in bed, was being administered oxygen via nasal cannula. The oxygen concentrator was set at 4 liters per minute. The oxygen concentrator was at the head of the bed on the resident's right side, outside the reach of the resident. During an observation on 8/20/2024 at 2:18 PM, Staff A, Registered Nurse (RN), verified Resident #13's oxygen concentrator was running at 4 liters per minute. During an interview on 8/20/2024 at 2:18 PM, Staff A, RN, stated, That is not correct [the oxygen rate]. It should not be on 4 liters it is ordered for 2 liters. I should check it every day when I see a resident if they are on oxygen. (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
	105855	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleme Center	2810 Ruleme St Eustis, FL 32726

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #13's progress notes from 8/14/2024 through 8/20/2024 showed no documentation indicating the need to increase oxygen or any change in Resident #13's respiratory status. Review of Resident #13's care plan showed it read, Focus: [Resident #13's name] is at risk for altered respiratory status/difficulty breathing r/t [related to] gastrostomy status, CVA, dysphagia . Interventions . Administer oxygen as ordered . Date Initiated: 05/22/2024. During an interview on 8/22/2024 at 12:19 PM, the Director of Nursing (DON) stated, I expect staff to assess residents on oxygen at a minimum daily and make sure that we are following the orders for correct oxygen administration. Review of the facility policy and procedure titled Oxygen Administration with the last revision date of 12/2023 read, Standard: The purpose of this procedure is to provide guidelines for oxygen administration . General Guidelines: 1. Oxygen therapy is administered by way of oxygen mask, nasal cannula and/or other device per physicians' orders and/or facility protocol.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105855	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleme Center	2810 Ruleme St Eustis, FL 32726

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 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. 44571 Based on observation, interview, and record review, the facility failed to ensure medications were securely stored in 1 of 2 residential halls, Hall 100. Findings include: During an observation on 8/19/2024 at 9:49 AM, Resident #9 was in her room lying in bed. There was a plastic cup lid turned up on the bedside table containing five different pills. On 8/19/2024 at 9:49 AM, an interview was attempted with Resident #9 related to the medications observed on the bedside table. Resident #9 stated, You want them? During an interview on 8/19/2024 at 9:52 AM, Staff A, Registered Nurse (RN) confirmed the medications at bedside and verified the plastic cup lid on the bedside table did contain five pills. During an interview on 8/19/2024 at 9:55 AM, Staff A, RN, stated that she passed the medications to Resident #9 at 9:00 AM, and identified the medications as Resident #9's Trazodone, Iron Pill, Clopidogrel, blood pressure medication, and Isosorbide pill. Staff A stated she did not leave the medications at bedside and pointed out that the medications were moist where evidently [Resident #9's name] had spit the pills back out. Staff A stated, I should have made sure she swallowed her pills, and I didn't do that. Review of Resident #9 medical records showed diagnoses including unspecified sequelae of cerebral infarction, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, generalized muscle weakness, type 2 diabetes mellitus with neuropathy, repeated falls, atherosclerotic heart disease of native coronary artery without angina pectoris. Review of Resident #9's Minimum data Set (MDS) showed Brief Interview for Mental Status (BIMS) summary score of 3 [indicating severe cognitive impairment]. Review of Resident #9's physician orders did not provide for a physician order for the resident to self-administer medications. Review Resident #9's MAR (medication administration record) for 8/19/24 read, 9:00AM medications were administered and initialed by Staff A. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105855	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleme Center	2810 Ruleme St Eustis, FL 32726

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #9's care plan initiated on 1/4/2023, showed it read, [Resident #9's name] has a communication problem r/t dx [related to diagnosis] of dementia, is at elopement risk/exit seeker related to episode of wandering, cognitive impairment, and impaired safety awareness, has potential for behaviors of: restlessness and getting out of bed without assistance; hitting staff, yelling at staff. She is noted not to remain in her room when on isolation. She has been noted to spit out medications, eat her food and then state another resident ate it and demand more food; knocks/pushes meal trays of other Resident's off dining table and onto floor; throwing wash cloth on face of another resident while they were sleeping, resident is resistive to care/refusing care related to dementia. She will decline administration medications and insulin checks, refusing insulin, refusal of labs, spitting out medications. During an interview on 8/22/2024 at 9:03 AM related to the residents' ability to self-administer their medications, the Director of Nursing (DON) stated that any nurse can complete an assessment for alert and oriented residents that wish to self-administer their own medications. The DON stated that Resident #9 was not able to self-administer her own medications due to her cognitive impairment and inability to do so. During an interview on 8/22/2024 at 11:14 AM, related to her expectations of nurses passing medications, the DON stated it is her expectations that all nurses passing medications apply the five rules that include, right patient or resident, right drug, right dosage, right route, and the right time. The DON stated that nurses are expected to ensure residents take the administered medications and the documentation is completed in the medication administration record (MAR). Review of the policy and procedure titled Self-Administration of Medication, last reviewed 3/11/2024, read, 1. A resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the attending physician/clinician. 2. Should the resident's attending physician/clinician permit the resident to administer his/her medication(s), the following condition should apply: a. A self-administration of medications evaluation will be completed that indicates that the resident is capable of self-administering drugs. This is to be completed quarterly and as needed with resident cognition or physical ability changes. b. Storage of medications in the resident's room must be such that it will prevent access by other residents, c. Only the medications permitted for self-administration shall be left at the bedside. Review of the policy and procedure titled Standards and Guidelines: Medication Administration, last reviewed 1/2024, read, Medications are ordered and administered safely and as prescribed. Procedure: 1. Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. 2. The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions. 21. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105855	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleme Center	2810 Ruleme St Eustis, FL 32726

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 44571 Based on observation, interview, and record review, the facility administration failed to assume full responsibility for the day-to-day operations of the facility by allowing unlicensed staff to work outside the accepted professional standards and current federal, state, and local regulations to ensure the highest degree of quality care was maintained. The facility administration failed to verify the licensure status of a nurse prior to employment who was found to not have a valid Florida license as a registered nurse. Findings include: Review of personnel records showed Staff A, Registered Nurse, was hired by the facility as a qualified Registered Nurse on 6/11/2024 and was scheduled to work in the facility as a Registered Nurse. Review of the Florida Department of Health licensure web site (https://mqa-internet.doh.state.fl.us/MQASearchServices/HealthCareProviders) revealed Staff A, RN, was not licensed as a Registered Nurse in the State of Florida. During an observation on 8/19/2024 at 9:00 AM, Staff A, RN, was working at a medication cart in the facility. Staff A had a name tag denoting a position of Registered Nurse. Review of a document from [name of an out of state university] read, Be it known that [Staff A's name] having given satisfactory evidence of the completion of professional and other requirements prescribed by law is qualified to practice as a Registered Professional Nurse in the [name of the state in which Staff A is qualified to work] in witness whereof the education department grants this license under its seal at [name of the city and state] this [date of issuance]. During an interview on 8/22/2024 at 11:30 AM, the Administrator stated, I was not the administrator at the time [Staff A's name] was hired. It is her expectation that all staff offered employment are fully qualified to perform the duties outlined in their job description. I rely on the human resources department to fully vet prospective employees to ensure that residents receive the care and services they need by a qualified individual and to notify her of any discrepancies found prior to an offer of employment. During an interview on 8/21/2024 related to expectations for nurses, the Director of Nursing (DON) stated that it is her expectation that any staff offered employment, are fully vetted by the Human Resources department before an offer for employment letter is sent out. The DON stated that it was her understanding that Staff A was a Registered Nurse and qualified to work in the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105855	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleme Center	2810 Ruleme St Eustis, FL 32726

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/22/2024 at 12:03 PM, the Human Resources Director stated that she had personally interviewed and accepted the application for Staff A, RN. The Human Resources Director stated she then went to the e-web site to check the [out of state name] license and did not see the box to check for a decision of whether the license was only for the [name of the state it was issued for] or if it was a multi-state license. The Human Resources Director stated Staff A would have had 60 days to get a Florida license and it ended August 10, 2024. The Human Resources Director verified Staff A was working in the facility beyond the expiration date of August 10, 2024. An interview was conducted via telephone on 8/22/2024 at 1:34 PM with Staff A related to her license for the State of Florida. Staff A stated, I was so confused and thought I just had to submit for a license and not have to actually have the license to be able to work [in Florida]. Staff A confirmed that she had been working through her scheduled shift on 8/19/24 in the facility as a Registered Nurse. Review of the job description titled, Administrator read, The Administrator administers, directs, and coordinates all functions of the facility to assure that the highest degree of quality of care is consistently provided to the patients. Responsibilities include, recruits and trains team members to create and maintain a highly functioning team environment and maintains high customer satisfaction. Supervises all departments within the facility. Review of the job description titled, Director of Nursing read, Executes the goals and objectives of the nursing department in regards to patient/resident rights, patient/resident care and reflects the mission statement of the facility. Serves as a role model to nursing staff while facilitating outcomes-based care delivery, cost management, and enhanced customer satisfaction within the context of an interdisciplinary framework. Provides leadership and direction for the nursing staff while being responsible for the overall management of the Nursing Department. Ensures nursing staff's compliance with all facility and nursing policies and procedures as well as compliance with regulatory requirements. Responsibilities include, interpret and execute administrative, nursing and resident/patient care policies. Ensure compliance with government and accrediting agency standards and regulations pertaining to Nursing. Ensure that all nursing personnel comply with the written policies and procedures established by the department and the facility. Establish and maintain qualifications and functions for each nursing position. Ensure resident safety in accordance with resident safety programs. Review of the job description titled, Human Resources Manager read, The human resources manager is responsible for performing HR-related duties in the following functional areas: benefits administration, employee relations, training, performance management, onboarding, policy implementation, recruitment/employment, and employment law compliance. Responsibilities include Screens and recruits job applicants to fill professional and technical job openings. Create new hire offer letters. Run exclusions, license checks and criminal background checks, employment verifications, and reference checks. Maintains compliance with federal, state and local employment and benefits laws and regulations. Review of the Florida Department of Health Division of Medical Quality Assurance a form titled Important Updates Regarding Nurse Licensed Outside of Florida dated August 8, 2021 read, Section 464.022(8), Florida Statutes, provides that a nurse who is currently licensed in another state or territory of the United States may perform services in Florida for a period of 60 days after furnishing the employer satisfactory evidence of current licensure in another state or territory and by having submitted proper application and fees to the Florida Board of Nursing for licensure prior to employment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105855	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleme Center	2810 Ruleme St Eustis, FL 32726

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41334 Based on observation, interview, and record review, the facility failed to ensure medical records were accurate and complete for 1 of 3 residents reviewed for wound care, Resident #13. Findings include: Review of Resident #13's admission record showed the resident was most recently admitted on [DATE] with diagnoses that included necrotizing fasciitis, stage 4 pressure ulcer of sacral region, anemia, dysphagia following cerebral infarction (a stroke), aphasia (inability to speak) following cerebral infarction, quadriplegia, type 2 diabetes mellitus with other circulatory complications, occlusion and stenosis of right vertebral artery, essential (primary) hypertension, and dependence on supplemental oxygen. Review of Resident #13's physician order dated 4/26/2024 read, Cleanse wound to sacrum with normal saline, pat dry, apply calcium alginate to wound bed, cover with silicone border foam every day shift for sacral wound. Review of Resident #13's Medication Administration Record (MAR) for April 2024 showed treatment was not documented as completed on 4/28/2024 and 4/30/2024. Review of Resident 13's physician order dated 5/2/2024 read, Dakins (1/4 strength) External Solution 0. 125% (Sodium Hypochlorite) Apply to sacrum topically every day shift for sacral wound. Cleanse wound to sacrum with Dakin's, pat dry, apply calcium alginate to wound bed, cover with silicone border foam. Review of Resident #13's MAR for May 2024 showed treatment was not documented as completed on 5/5/2024, 5/10/2024, 5/15/2024 and 5/16/2024. Review of Resident #13's physician order dated 5/23/2024 read, Dakins (1/4 strength) External Solution 0. 125% (Sodium Hypochlorite) Apply to sacrum topically every day shift for sacral wound. Cleanse wound with Dakin's, pat dry, apply collagen powder to wound bed, pack with Dakin's moist kerlex, cover with silicone border foam. Review of Resident #13's MAR for June 2024 showed treatment was not documented as completed on 6/21/2024. Review of Resident #13's physician order dated 6/24/2024 read, Dakins (1/4 strength) External Solution 0. 125% (Sodium Hypochlorite) Apply to sacrum topically every day shift for sacral wound Cleanse wound with Dakin's, pat dry, apply collagen powder to wound bed, pack with Dakin's moist kerlex, cover with silicone border foam. Review of Resident #13's MAR for July 2024 showed treatment was not documented as completed on 7/31/2024 and documented as 9 (other see nurses notes). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105855	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleme Center	2810 Ruleme St Eustis, FL 32726

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of medical records showed no note related to wound care on 7/31/2024. Review of Resident #13's MAR for August 2024 showed treatment was not documented as completed on 8/1/2024, 8/5/2024, 8/6/2024, 8/7/2024, 8/9/2024 and 8/13/2024. During an interview on 8/22/2024 at 9:38 AM, Staff B, Licensed Practical Nurse (LPN), stated, When wound care is done, it should be signed off on the MAR as soon as it is done. We have to document all our treatments. If they refuse, we need to document that too. During an interview on 8/22/2024 at 10:00 AM, Staff C, Registered Nurse (RN), stated, All dressing changes should be documented when they are done. During an interview on 8/22/2204 at 10:15 AM, the Director of Nursing (DON) stated, Every time a dressing is done, it should be documented. Review of the policy and procedure titled, Documentation with the last revision date of 1/2024 read, Guideline: Services provided to the resident shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Procedure . 2. The following information is to be documented in the resident medical record . c) Treatments or services performed . 8. Documentation of procedures and treatments will include care specific details, including: a) the date and time the procedure/treatment was provided; b). The name and title of the individual(s) who provided the care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105855	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleme Center	2810 Ruleme St Eustis, FL 32726

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41334 Based on observation, interview, and record review, the facility failed to ensure staff performed hand hygiene during medication administration for 6 of 9 medication administration observations to prevent the possible spread of infection and communicable disease. Findings include: During an observation on 8/20/2024 at 8:37 AM, Staff A, Registered Nurse (RN), was exiting a resident's room after administering medications to the resident. Staff A did not perform handy hygiene and returned to the medication cart. Staff A prepared Resident #86's medications, reached into her uniform pocket, removed keys and locked the medication cart. Staff A entered Resident #86's room, did not perform hand hygiene, administered the medications, exited the room without performing hand hygiene and returned to the medication cart to prepare another resident's medications. During an observation on 8/20/2024 at 8:44 AM, Staff A, RN, was returning to the medication cart after administering medications to Resident #86. Staff A reached into her pocket, removed the keys and unlocked the medication cart without performing hand hygiene. Staff A prepared Resident #54's medications, entered the resident room, administered the medications and exited the resident's room without performing hand hygiene. Staff A returned to the medication cart and began preparing another resident's medications. During an interview on 8/20/2024 at 9:00 AM, Staff A, RN, stated, I should have used the hand sanitizer when I got meds and after I got meds to the residents. During an observation on 8/21/2024 at 8:39 AM, Staff D, Licensed Practical Nurse (LPN), returned to the medication cart after administering medications to a resident, reached in her pocket, removed the keys, and unlocked the medication cart. Staff D removed a hair tie from her hair, flipped her hair, touching her hair with both hands and prepared medications for Resident #83 without performing hand hygiene. Staff D donned gloves without performing hand hygiene and entered Resident #83's room and administered the medications, doffed gloves and returned to the medication cart without performing hand hygiene. During an interview on 8/21/2024 at 9:00 AM, Staff D, LPN, stated, I should have washed my hands before and after I put on gloves. I didn't realize that I pulled out my hair tie. During an observation on 8/22/2024 at 5:02 AM, Staff E, LPN, moved the medication cart to Resident #105's doorway, reached into her uniform pocket, removed the keys, unlocked the medication cart and typed her password into the computer and began preparing medications for Resident #105 without performing hand hygiene. Staff E entered Resident #105's room without performing hand hygiene, assisted the resident by elevating the head of the bed with the bed control and administered the medications, and exited the room, returning to the medication cart without performing hand hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105855	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleme Center	2810 Ruleme St Eustis, FL 32726

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/22/2024 at 5:06 AM, Staff E, LPN, returned to the medication cart, reached into her uniform pockets, removed the keys, unlocked the medication cart, touched the computer keyboard and began preparing Resident #17's medications without performing hand hygiene. Staff E locked the medication cart, entered Resident #17's room and administered the medications without performing hand hygiene. Staff E exited the room returning to the medication cart without performing hand hygiene and began preparing another resident's medications. During an observation on 8/22/2024 at 5:11 AM, Staff E, LPN, returned to the medication cart, reached into her uniform pockets, removed the keys, unlocked the medication cart, touched the computer keyboard and began preparing Resident #83's medications without performing hand hygiene. Staff E locked the medication cart, entered Resident #83's room and administered the medications without performing hand hygiene. Staff E exited the room returning to the medication cart without performing hand hygiene and began preparing another resident's medications. During an interview on 8/22/2024 at 5:20 AM, Staff E, LPN, stated, I should have washed my hands. I just got nervous. During an interview on 8/22/2024 at 6:30 AM, the Director of Nursing (DON) stated, I expect that all nurses follow our infection control policy for hand washing. Review of the policy and procedures titled Medication Administration with the last revision date of 1/2024, read, Procedure . 19. Staff follows established infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. Review of the policy and procedure titled Hand Hygiene Infection Control with the last approval date of 1/2024 read, Standard: Hand hygiene is the single most important measure for preventing the spread of infection. Guideline: This facility shall require facility personnel use accepted hand hygiene after each direct resident contact for which hand hygiene is indicated . Procedure: The facility acknowledges the CDC (Centers for Disease Control) guidelines to improve adherence to hand hygiene in health care settings. The hand hygiene guidelines are part of an overall CDC strategy to reduce infections in health care settings to promote resident safety. These guidelines state that hand washing is necessary when healthcare personnel's hands are visibly soiled. When the hands are not visibly soiled, the CDC recommends the use of alcohol-based hand rubs by health care personnel for resident care to address the obstacles that health care professionals face when taking care of residents. Situations that require hand hygiene include, but are not limited to . Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice). Review of the policy and procedure titled General Dose Preparation and Medication Administration with the last approval date of 12/29/2023, read, Applicability: The Policy 6.0 sets forth the procedures relating to general dose preparation and medication administration. Facility staff should also refer to the facility policy regarding medication administration and should comply with Applicable Law and the State Operations Manual when administering medications. Procedure . 2. Prior to preparing or administering medications, authorized and competent facility staff should follow facilities infection control policy (e.g., hand washing).