STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105928	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Orange Park	2145 Kingsley Ave Orange Park, FL 32073

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 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** 38804 Based on observations, interviews, and record review, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASRR) program under Medicaid, to the maximum extent practicable, to avoid duplicative testing and effort for two (Resident #40 and #80) of four residents whose PASRRs were reviewed, from a total survey sample of 41 residents. Resident #40's diagnoses were updated upon readmission indicating a need for a Level II, but no Level II was provided for review by the facility. Resident #80's Level I PASRR indicated that a Level II was required; however, no Level II was provided for review by the facility. The findings include: 1. A review of Resident #40's medical record revealed an admitted [DATE]. The resident's last readmission was on 12/20/2023. He had diagnoses including unspecified psychosis documented on 10/1/2015 during stay; bipolar disorder documented on 12/12/2024; unspecified dementia documented on 12/12/24 and active at admission, and Alzheimer's disease documented on 03/23/2022 and active at readmission. Further review of resident's record revealed that a PASRR was completed on 05/02/2018. There were no documented Suspected Mental Illnesses (SMI), Intellectual Disabilities (ID) or Related Conditions noted. A review of the 01/21/2025 quarterly Minimum Data Set (MDS) assessment revealed that Resident #40 scored 11 out of 15 possible points on the Brief Interview for Mental Status (BIMS) screening, indicating moderately impaired cognition. A mood assessment was conducted and revealed the resident displayed social isolation sometimes. There were no behaviors reported during the review period. The medication review revealed the resident received antipsychotic and antidepressant medications 7 of 7 days during the review period. A review of the most current Care Plan revealed the following Focus Areas with interventions: Impaired cognitive ability/impaired thought process; at risk to have increased periods of acute confusional episodes related to acute disease of bipolar disorder and psychosis; Risk for changes in mood or behavior due to current diagnosis of bipolar disorder; Antidepressant medication use; (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	ADL self-care performance deficit; behaviors and being resistive to care i.e., refusing to take showers and/or allowing staff to trim/clean fingernails. An interview was conducted on 02/05/2025 at 3:04 p.m. with the Social Services Director (SSD). He stated the Director of Nursing (DON) was responsible for the PASRRs. He was responsible for logging them into the the state agency website if a Level II screening was required. He stated the nursing, social services and MDS departments all worked together on the resident reviews if a resident had new behaviors and/or diagnoses after they were admitted . He stated resident behaviors and diagnoses were reviewed on a quarterly basis. When asked if there were any residents currently in the facility receiving Level II services, he replied that there were not. He also stated there were no residents being reviewed for Level II services at the time of the interview. During an interview with the SSD on 02/06/2025 at 3:31 p.m., he stated he was not aware of a Level II or review for new diagnosis for Resident #40. He again stated that resident reviews are conducted on a quarterly basis. He added that if a review was needed, the Director of Nursing would communicate that to him, and he would then communicate it to the appropriate state agency. An interview was conducted on 02/06/2025 at 1:34 p.m. with the Psychiatric Nurse Practitioner. She stated each resident in the facility was evaluated. Resident medications were reviewed on a monthly basis. She was asked if she was familiar with Resident #40. She stated she was following the resident and referred to him as being alert to self. She stated there were no documented moods and/or behaviors. She stated the resident's anti-depressant was recently increased due to him reporting he felt down and depressed. Facility staff reported that the resident did not like to get out of bed and verbalized feeling depressed. An interview was conducted on 02/06/2025 at 4:12 p.m. with the SSD who confirmed there was no updated PASRR or resident review for Resident #40. He stated it was missed. He stated when the resident returned to the facility after a brief hospital stay, his diagnoses changed and the review for additional services was not conducted as it should have been. 48947 2. A review of Resident #80's medical record revealed an admitted [DATE] with diagnoses including unspecified symptoms and signs involving cognitive functions following cerebrovascular disease, major depressive disorder, and manic episode without psychotic symptoms. A review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed diagnoses including cerebrovascular accident (CVA), anxiety disorder, and depression (other than bipolar). It noted that the resident received antianxiety medication, antidepressant medications, opioids, and anticonvulsants during the 7-day look-back period. A review of the Care Plan revealed the following focus areas: Focus: Resident has impaired cognitive ability related CVA (cerebrovascular accident - stroke) (created 11/29/2018, revised 2/28/2019). Focus: Resident uses antidepressant medication related to: depression (created 7/9/2018, revised 7/9/2018). (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: Resident has the potential to experience signs and symptoms of depression related to her CVA (created 2/28/2019, revised 2/28/2019) There were no care plans available that addressed the resident's PASRR status. A review of the resident's active Physician's Orders revealed: Duloxetine HCl (Hydrochloride) Capsule Delayed Release Particles 30 mg every 12 hours related to Major depressive disorder (8/20/2024), and Side effects medication monitoring for Antidepressants every shift (2/6/2024) A record review revealed that a Level 1 PASRR (preadmission screening and resident review) had been completed on 10/14/2024, which indicated that a Level II screening was required. A Level II evaluation was not located in the EMR (electronic medical record). A record review revealed that the Level 1 PASRR screening completed on 10/14/2024, indicated that a Level II PASRR evaluation was indicated. There was no Level II PASRR evaluation located in the EMR. On 02/05/2025 at 1:25 PM, an interview was conducted with Social Services Director (SSD) A, who was asked where a Level 2 PASRR screening report would be located for any resident in the facility who required it. He replied, It would be located in [the EMR] if we had any, but we don't have any residents in the facility that have a Level II PASRR. He was asked if PASRR information was located in the paper charts that were on the nursing units. He stated, There might be, but most likely it would be in [EMR] if we had any. On 02/05/2025 at 2:43 PM, an interview was conducted with Social Services Assistant (SSA) B. She was asked if there was anyone in the facility qualified to conduct Level 1 PASRR screenings. She stated, Yes, [SSD A]. She was asked what the facility process was for receiving the PASRR Level 1 screening. She replied, When they are admitted from the hospital, that information is sent to the facility. She was asked who was responsible for receiving the admission documents. She stated, That depends on the time of day the patient is admitted , but it's usually the admission people. She confirmed that she was familiar with the PASRR Level I screening. She was asked to access Resident #80's PASRR Level I screening that was available in the EMR and completed on 10/14/2024. After she reviewed the document, she confirmed that the screening indicated that a Level II PASRR evaluation should have been conducted. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/2025 at 3:00 PM, an interview was conducted with Admissions Director (AD) C. She was asked who was responsible for receiving the required admission documents from the hospital. She stated, I do. She was asked who reviewed the admission paperwork from the hospital to determine whether or not the resident was appropriate for admission. She stated, I do. She was asked to review the Level 1 PASRR screening for Resident #80 that was located in the EMR and dated 10/14/2024. She was asked what the results of the Level I screening indicated. After she reviewed the document, she stated, I don't quite know what you are asking. What is it that I'm supposed to be looking for? She was asked to review the results of the screening indicating that the individual may not be admitted to an NF (nursing facility). Use this form and required documentation to requesta Level II PASRR evaluation. She stated, We don't always get the PASRR before they admit, but they usually come in their admission packet. She was asked how she concluded that the resident was appropriate for admission without reviewing the PASRR. She stated, I look through the history and physical and the hospital notes, and other documentation that might indicate that there was an issue. A review of the facility's policy titled Pre-admission Screening and Resident Review (PASRR) (issued: 06/06/2019, reviewed: 09/26/2024), revealed: The facility will ensure that potential admissions are screened for possible serious mental disorders or intellectual disabilities and related conditions. A negative Level I screen permits admission to proceed and ends the PASRR process unless a possible serious mental disorder or intellectual disability arises later. A positive Level I screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as PASRR Level II, which must be conducted prior to admission to a nursing facility.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48201 Based on observations, resident and staff interviews, and a review of resident records, the facility failed to ensure residents with pressure ulcers received necessary treatment and services consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for one (Resident #144) of three residents reviewed for pressure ulcers. The findings include: On 2/03/2025 at 12:17 p.m., Resident #114 was seated in her wheelchair with both feet (red socks in place) dangling down towards the floor. A white gauze bandage was observed protruding from her sock around her right ankle area. When asked what happened, Resident #114 reported she had a sore from a tight shoe strap that cut into her skin a couple of months ago. She reported no pain, stating staff came in to change her bandage every few days. On 2/04/2025 at 10:22 a.m., Resident #114 was seated in her wheelchair with both feet dangling down towards the floor. A red sock covered her left foot, and her right foot was partially covered by a sock. A white gauze bandage was wrapped around the middle of her right foot and up over her ankle. In black writing, 1/31 was documented on the bandage. (photographic evidence obtained) Resident #114 could not recall when staff last came to change her bandage, but stated she informed the nurse last night of foot pain and throbbing. A review of the resident's medical record revealed she was admitted on [DATE] with diagnoses including urinary tract infection, Alzheimer's disease, and peripheral vascular disease. A review of the quarterly Minimum Data Set (MDS) assessment, dated 01/15/2025, revealed that Resident #114 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 possible points, indicating intact cognition. She was documented with a stage 3 pressure ulcer and was receiving pressure ulcer/injury treatment and care. (photographic evidence obtained) A review of the resident's active, person-centered Care Plan revealed that she had a pressure injury to her right heel. Interventions included administration of treatments as ordered. (photographic evidence obtained) Active physician's orders revealed: 01/08/2025 - wound care consult, right heel. 01/10/2025 - wound care orders indicated: cleanse with normal saline, pat dry and skin prep peri wound, apply honey gel/collagen powder/calcium alginate to wound bed, cover with ABD pad and secure with rolled gauze every 2 days and as needed with start date of 1/11/2025. No end date was indicated. (photographic evidence obtained) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the wound provider's progress note dated 01/30/2025, revealed: Stage 3 pressure wound of the right heel full thickness, exudate moderate serous, 20% slough, 80% granulated tissue, primary dressing leptospermum honey apply every two days for 11 days; Collagen powder apply every two days for 11 days; Alginate calcium apply every two days for 11 days. Secondary dressing ABD pad (abdominal dressing) apply every two days for 11 days; Gauze roll apply every 2 days for 11 days. Peri wound treatment skin prep applied every two days for 11 days. A review of Resident #14's February 2025 treatment administration record (eTAR) revealed: R Heel: Cleanse with normal saline, pat dry, skin prep peri wound, apply honey gel/collagen powder/ calcium alginate to wound bed, cover with ABD pad and secure with rolled gauze every 2 days and as needed had been signed off as Administered on 2/2/2025 and 2/4/2025, despite the observation made with the wound bandage dated 1/31 on 02/04/2025. (photographic evidence obtained) On 02/06/2025 at 8:52 a.m., an interview with Certified Nursing Assistant (CNA) G revealed she had been working for the facility for two years and had been assigned to work with Resident #114. She confirmed a wound to the right heel that was covered. She could not recall how often the bandage was changed but stated if she saw an old, dated bandage she would report it to her unit manager. She denied seeing or reporting old, dated wound bandages for Resident #114 to the unit manager. She confirmed working on 2/4/2025 with Resident #114, where she got her up from bed around 9:30 a.m., placed her socks on her feet, and sat her in her wheelchair. On 02/06/2025 at 8:52 a.m., an interview with Licensed Practical Nurse (LPN) H revealed he had been working at the facility for five years, passing medication and assisting with wound care when the wound care nurse was not scheduled. He confirmed being assigned to Resident #114 and confirmed working with her on 2/2/2025. He reported offering to administer her wound care treatment, but being told by the resident to come back later. He went in another time but he was postponed again. When he came back a third time, she was in bed and his shift ended at 7:30 p.m., so he reported never completing the treatment. He further stated he never went back to unmark the treatment was administered; he never notified oncoming staff that the wound treatment wasn't provided, and he never followed up on his next scheduled shift the following day. He agreed that a missed wound treatment was dangerous and reported, Infection could happen if proper wound care is not provided. On 02/06/2025 at 1:37 p.m., an interview with the Assistant Director of Nursing confirmed the expectation when administering medications and physician ordered treatments was to follow the physician's orders. Nurses signed off after the care/medication had been provided. If a resident refused, nursing should document the refusal, and if administered/treated late, nursing should document that the treatment was completed late. A review of the facility's policy and procedure titled Skin Integrity and Pressure Ulcer/Injury Prevention and Management (revised 07/09/2024), ADL Care and Services, revealed: Provide associates and licensed nurses with procedures to manage skin integrity, prevent pressure ulcer/injury, complete wound assessment/documentation, and provide treatment and care of skin and wounds utilizing professional standards of NPIAP (National Pressure Injury Advisory Panel) and WOCN (Wound, Ostomy, Continent Nurses Society). The policy interpretation and implementation indicated: 4. Measures to maintain and improve the resident's tissue tolerance to pressure are implemented in the plan of care. 7. When skin breakdown occurs, it requires attention and change in the plan of care may be indicated to treat the resident. (photocopy obtained)

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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** 28892 Based on observations, interviews, and record review, the facility failed to ensure that residents requiring respiratory care received such care, consistent with professional standards of practice and the comprehensive person-centered care plan for one (Resident #226) of two residents reviewed for respiratory care, from a total of 21 residents receiving oxygen therapy, who was not receiving oxygen at the flow rate the physician ordered. The findings include: On 02/04/25 at 9:59 AM, Resident #226 was observed resting in bed with her eyes closed. She was wearing a nasal cannula attached to an oxygen concentrator and was receiving oxygen at a flow rate of 4 liters per minute (4L/min). (photographic evidence obtained) On 02/04/25 at 1:29 PM, Resident #226 was observed resting in her room. She did not know the appropriate setting for her oxygen flow rate and stated she did not adjust it herself. On 02/05/25 at 10:43 AM, Resident #226's oxygen flow rate was set at 3L/min. (photographic evidence obtained) A review of Resident #226's medical record revealed an admitted [DATE] and diagnoses including altered mental status, atherosclerotic heart disease (a condition where plaque builds up in the arteries that supply blood to the heart), cardiomegaly (enlarged heart with difficulty pumping blood), hypertensive heart disease (a condition that develops when chronic high blood pressure damages the heart muscle), conjestive heart failure (CHF - a condition where the heart muscle is weakened and cannot pump blood effectively), and metabolic encephalopathy (a condition where the brain does not function properly due to an underlying metabolic imbalance). A review of Resident #226's physician's orders revealed: Oxygen at 2 liters/minute continuously per nasal cannula, every shift. Order was active and written on 01/15/25 at 7:00 PM. Change oxygen tubing and nebulizer circuit every night shift every Sunday. Order active and written on 12/08/24 at 7:00 PM. Clean oxygen concentrator filter with soap and water weekly every Sunday. Order active and written on 12/08/24 at 7:00 PM. Check oxygen saturation rates every shift. Order was active and written on 12/04/24 at 7:00 PM. A review of the 01/03/25 Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 03 out of 15 possible points, indicating severe cognitive impairment. Functional abilities and goals revealed the following: Substantial/maximum assistance required for roll left and right, sit to lying, lying to sitting on side of bed, and dependent for sit-to-stand, chair/bed-to-chair transfer and toilet transfers. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the care plan (initiated on 12/05/24) revealed the following focus area: The resident has coronary artery disease (CAD) related to atherosclerosis, hypertension and hyperlipidemia. Goal: The resident will be free from signs or symptoms of complications of cardiac problems through the review date. Interventions: Oxygen settings: O2 via Nasal cannula at 2 liters continuous. Change out 02 tubing, nasal cannula weekly and as needed. A review of the February 2025 medication administration record (MAR) and treatment administration record (TAR) revealed that oxygen was administered per physician's order and signed off by facility staff on each shift. On 02/06/25 at 11:27 AM, an interview was conducted with Certified Nursing Assistant (CNA) J, who stated she had been employed by the facility for five years. She explained that as a CNA, she was not permitted to adjust a resident's oxygen flow rate. She observed the flow rate and whether or not the tank was empty. If she did not know what a resident's flow rate should be or noticed that an oxygen tank was empty, she would consult with the nurse. On 02/06/25 at 11:41 AM, an interview was conducted with Licensed Practical Nurse (LPN) K, who stated she had been employed by the facility for seven months. She explained the process for caring for residents receiving oxygen (O2) therapy. Some residents received an O2 order for as needed (prn) oxygen, and others received an O2 order for continuous oxygen. Residents' O2 orders should be discussed between the oncoming and outgoing nurse during walking rounds at shift change. During shift change, LPN K stated she would look around a resident's room and if she saw the resident was on O2, she would ask the outgoing nurse what the resident's flow rate was. She would then use a piece of paper and write the resident's name, orders, special medical condition, appointments, or any concerns noted by the outgoing nurse. Residents receiving oxygen should always have their head raised while receiving oxygen. LPN K would also use a pulse oximeter to obtain oxygen saturation levels. If a resident's oxygen level was low, she would check the oxygen cannula and tubing to ensure they weren't damaged. She would also check the water tank to ensure that the water was bubbling. She made a practice of checking oxygen flow rates at the beginning of her shift and anytime she went into a resident's room, which was usually at least three times during her shift. LPN K explained that she was familiar with Resident #226 as she checked the electronic medical record for the oxygen order, reporting that the current order for oxygen was 2L/min. The order was written on 01/15/25. She stated when she started her shift this morning, she observed Resident #226's oxygen flow rate was set at 2L/min. A review of the facility's policy for Oxygen Administration (issued 12/03/18, reviewed 09/24/24, revised 10/11/24), revealed: Respiratory care . The facility must ensure that a resident who needs respiratory care is provided such care, consistent with the comprehensive person-centered care plan . Procedure: 1. Oxygen order should be written for specified liter flow required by the resident.