STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105968	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VI at Lakeside Village	2782 Donnelly Drive Lantana, FL 33462

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to maintain food in a safe and sanitary method. This had the potential to affect 49 residents on oral diets. The findings included:An initial tour of the kitchen was conducted on 02/23/26 at 9:05 AM. The surveyor was accompanied by the Registered Dietician (RD) and the Kitchen Manager. The following was observed:1. Unwrapped tongs with brown residue was on a low shelf located to the right of the salad area. A metal bin with 2 bags of chicken broth powder and a pastry cloth were also on the shelf. A rag for cleaning and 2 empty red buckets were on the same shelf. Cleaning items should not be in the same area as food and food handling items. The Kitchen Manager agreed with this finding. 2. The Southbend oven had an accumulation of dark brown residue on the inside of the oven's doors. A frayed mesh material that was visible when the oven door was open, revealed broken off pieces of the mesh that rested on silver metal. Dark black residue covered the bottom of the oven. The RD agreed with this finding. 3. Yellow/orange and brown/black residue was on the knobs that were used to set the timer and temperature on the Southbend oven. The RD agreed with this finding. 4. The Vitamix-Drink Machine Two-Speed blender had white colored particles on top of the base of the machine. A yellow-white batter-like substance was splattered on the machine. The Kitchen Manager agreed with this finding. 5. The food processor (used to mix ingredients or to make them smoother) had tan colored residue on its' center tube. The Kitchen Manager agreed with this finding. 6. A 2 Gallon plastic container of shredded Kraut had dried on bright yellow residue on the exterior top of the container. Clusters of green residue was on the exterior of the container below the lid.Photographic Evidence Obtained

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 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** Based on observation, interview, and record review, the facility failed to ensure appropriate care and services for respiratory services for 2 of 2 sampled residents as evidenced by the failure to ensure oxygen orders and a clean oxygen filter for Resident #63, and failure to ensure a clean oxygen filter for Resident #9.The findings included:1. Review of the record revealed Resident #63 was admitted to the facility on [DATE], transferred to the hospital on [DATE], and returned to the facility on [DATE]. The resident's diagnoses included congestive heart failure (CHF), and acute respiratory failure with hypoxia (a lack of oxygen).Review of the physician orders revealed Resident #63 had orders to administer oxygen continuously at 3 liters per minute from 02/06/26 though 02/16/26. The record lacked any current physician orders for oxygen use. There was also an order for staff to clean the concentrator filter weekly from 02/06/26 through 02/16/26. The record lacked any current order for filter maintenance.A current care plan initiated on 02/09/26 documented the resident had the potential for respiratory distress related to CHF and history of acute respiratory failure with hypoxia. Interventions included the use of oxygen as ordered, but lacked anything related to the filter maintenance.During an observation on 02/24/26 at 12:02 PM, the concentrator's oxygen filter was noted to be dust laden, with approximately 1/4 inch of gray dust on the black filter. Photographic Evidence Obtained.During an interview on 02/25/26 at 2:24 PM, when asked the process for maintaining oxygen equipment, the RN (Registered Nurse) Supervisor explained all oxygen equipment was changed out and cleaned by the night nurses once weekly. When asked specifically about Resident #63, the RN Supervisor stated she had heard there was an issue. The RN Supervisor was shown the photograph of the filter and agreed with the findings. During this interview a side-by-side review of the record confirmed the lack of current oxygen orders. 2. Review of the record revealed Resident #9 was admitted to the facility on [DATE] with a diagnosis of acute respiratory disease. Review of the orders revealed the resident had received oxygen since 10/12/25. The record also documented the orders to clean the concentrator filter with soap and water weekly since that date.An observation on 02/24/26 at 12:09 PM revealed the oxygen filter was dust laden. Photographic Evidence Obtained.On 02/25/26 at 2:24 PM, the RN Supervisor agreed with the findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure proper labeling of pill dispensing packets for 2 of 27 reviewed during medication administration for 2 of 4 sampled residents, Resident #7 and Resident #58.The findings included: Review of the facility's policy titled, Medication Management Protocol, dated November 2004 and revised June 2011, included the following: Administration of Medications 3. Prior to administering the medication, the label on the container is matched to the Medical Administration Record (MAR).Review of the facility's policy titled, Medication Ordering and Receiving from Pharmacy, dated March 2019, included the following: Only the dispensing pharmacy / registered pharmacist can modify, change, or attach prescription labels. Procedures G. 1) If the physician's directions for use change or the label is inaccurate, the nurse may place a change of order-check chart label on the container indicating there is a change in directions for use, taking care not to cover important label information.Review of the facility's policy titled, Preparation and General Guidelines, dated March 2019, included the following: Procedures: A. Preparation 5) .If the label and the Medical Administration Record (MAR) are different and the container has not already been flagged, indicating a change in directions, .the physician's orders are checked for the correct dosage.and the order change communicated to the provider pharmacy so that the next supply of the medication is labeled with the current directions. 1. Record review revealed Resident #7 was admitted to the facility on [DATE] with the following diagnosis: Generalized anxiety disorder.Review of the Physician's Orders showed that Resident # 7 had an order dated 02/13/26 for Clonazepam 1mg tablet to be given twice a day for anxiety.During a medication administration observation conducted on 02/25/26 at 8:58 AM with Staff B, Registered Nurse (RN), for Clonazepam 1 mg tablet, the pill pack description stated, blue round logo 2531. During a side-by-side comparison of the pill, Staff B agreed that the pill color was green and did not have a logo. Photographic evidence obtained ([NAME]). When asked how she knows if this is the correct medication, Staff B stated that she would look in the pill description guide. Staff B notified the Director Of Nursing (DON) and confirmed the medication prior to administration. 2. Record review revealed Resident #58 was admitted to the facility on [DATE] with the following diagnosis: Hypotension (low blood pressure).Review of the Physician's Orders showed that Resident #58 had an order dated 11/03/25 for Midodrine tablet 5 mg, one tablet to be given three times a day. Special instructions Orthostatic Hypotension. Hold for Systolic Blood Pressure (SBP) greater than 140.During a medication administration observation conducted on 02/25/26 9:14 AM with Staff C, RN, and during the side-by-side comparison of the electronic medical record (EMR) and the pill dispensing packet for Midodrine 5mg 1 tablet three times per day, the EMR read Hold for SBP greater than 140. The pill pack description stated, Hold for SBP less than 140. Staff C noted the difference and stated that she is aware of the SBP parameters for the medication, follows the orders in the EMR but will clarify with the provider prior administration. Photographic Evidence Obtained.During a follow up interview on 02/25/26 at 11:58AM, Staff C informed this surveyor that after speaking with the provider and verifying that the EMR order was correct, the pill pack label was covered with new instructions that read Directions changed, refer to chart per pharmacy. During an interview conducted on 02/26/26 at 3:00PM, the DON stated that she was immediately notified of the pill pack labeling issues for Resident #7 and Resident #58. She stated that she reached out to the pharmacy to confirm that the correct medication was dispensed for Resident #7 and was informed that the medication was correct and that she was instructed to place a new description label on the pill pack. When asked about the process for reconciling medication received from the pharmacy, she stated that any nurse can receive the medication from the courier, verifying the count with the inventory sheet and give the medication to the unit nurse to restock the cart.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide food in a puree form to meet the individual needs of residents for 1 of 6 residents, Resident #57, who were on puree diets; and failed to provide honey thickened fluids to 1 (one) of 7 residents, Resident #61, who were on a diet with thickened fluids. This had the potential to affect 7 residents who were on diets with thickened fluids that included 6 residents were on nectar thickened fluids and 1 resident on honey thickened fluids. The findings included: 1. Record review revealed Resident #57 was admitted to the facility on [DATE], with diagnoses that included: Muscle Weakness and Oropharyngeal Dysphagia (swallowing difficulty). Review of the physician orders documented a medical diet order was for a Regular diet with puree texture foods, and thin consistency fluids. An observation on 02/23/26 at 1:16 PM revealed Resident #57 received a plate with pureed Chicken Alfredo. The resident ate approximately 1 bite of the food. Small rectangular and square pieces of a green vegetable were on top of the pureed chicken alfredo. A square piece of a green vegetable was in the sauce on the plate. The pureed food should have been a homogenous mixture of smooth food with no distinguishable pieces or lumps in it. The Registered Dietician (RD) was made aware. Photographic Evidence Obtained. On 02/23/26 at 1:55 PM, an interview was conducted with the RD and the Kitchen Manager in the kitchen. When asked what the green pieces were, the RD showed the surveyor that the alfredo sauce had small pieces of celery in it. She said the sauce was pureed and that the puree process didn't work. Photographic Evidence Obtained. 2. Record review revealed Resident #61 was admitted to the facility on [DATE] with diagnoses that included: Pneumonia, Unspecified Protein Calorie Malnutrition, and Oropharyngeal Dysphagia (swallowing problem). Resident #61's physician's diet order specified a regular diet with mechanical soft ground texture foods, and honey thickened fluids consistency since 01/20/26. Review of the Minimum Data Set (MDS) assessment dated [DATE] showed the resident was able to understand others sometimes, and she was able to make herself understood sometimes. An observation on 02/23/26 at 12:50 PM revealed Resident #61 was served a glass of regular consistency cranberry juice. The resident should have been served honey thickened cranberry juice. The RD agreed with this finding. Photographic Evidence Obtained. An interview on 02/03/26 at 1:00 PM with the RD revealed she could just look at the juice and see that it was thin. She confirmed that the cranberry juice served to Resident #61 was not honey thickened.