STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105999	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Ocala	2800 SW 41st St Ocala, FL 34474

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 15234 Based on observation, interviews and record reviews, the facility failed to ensure residents received an accurate assessment reflective of the resident's status at the time of the assessment for 5 of 7 residents reviewed (Resident #50, #111, #116, #118, #221). Findings include: 1). Review of Resident #50's Modification of Quarterly Minimum Data Set (MDS) Assessment, dated 5/27/2024, Section O, Special Treatments, Procedures, and Programs documented Resident #50 received tracheostomy care and used an invasive mechanical ventilator (ventilator or respirator) while a resident of the facility. Review of Resident #50's care plan, start date 7/8/2024, failed to reveal documentation Resident #50 received tracheostomy care and used an invasive mechanical ventilator (ventilator or respirator) while a resident of the facility. Resident #50 was observed on 8/6/2024 at 9:29 AM and again on 8/8/2024 at 8:26 AM. Resident #50 was not receiving tracheostomy care or using an invasive mechanical ventilator (ventilator or respirator). During an interview on 8/6/2024 at 9:37 AM, Staff D, Licensed Practical Nurse, Care Coordinator, stated that Resident #50 had not received tracheostomy care or used an invasive mechanical ventilator (ventilator or respirator) while a resident of the facility. Staff D added Never here. Maybe in hospital but never here. During an interview on 8/8/2024 at 12:36 AM, Staff E, Registered Nurse, Minimum Data Set Coordinator, stated [Resident #50's Name], Never had one [ventilator or respirator]. Staff E acknowledged Section O of Resident #50's Modification of Quarterly MDS Assessment, dated 5/27/2024, needed to be corrected. 46523 2) During an interview on 8/7/2024 at 8:59 AM, Resident #111 stated, I had motor vehicle accident and had a right shoulder fracture and some of my ribs were fracture as well. I am here for therapy. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #111's MDS Admission 5 Day Assessment, dated 7/22/2024, Section GG, Functional Abilities and Goals documented no functional limitation in her upper and lower extremities. Review of Resident #111's care plan, initiated on 7/24/2024, documented a Self-care deficit associated with right shoulder and multiple right rib fractures. PT [patient] was a pedestrian in a MVA [motor vehicle accident]. During an interview on 8/8/2024 at 12:43 PM, Staff E, Registered Nurse, MDS Coordinator stated, I need to modify Section GG of the MDS for [Resident #111's Name] since she has a right shoulder fracture. During an interview on 8/9/2024 at 8:41 AM, Staff F, Certified Occupational Therapy Assistant, stated I provide occupational therapy to [Resident #111's Name]. At the moment she is non weight bearing and non-range of motion on her right shoulder for 6 weeks. That is the standard protocol for fractures. 3) During an interview on 8/6/2024 at 9:55 AM, Resident #221 stated, I had a cardiovascular accident and I my right side was affected. I am not able to move my right hand or my right leg. Review of Resident #221's MDS Admission Assessment, dated 7/26/2024, documented in Section GG, Functional Abilities and Goals, no impairment in upper and lower extremities. Review of Resident #221's care plan, initiated on 7/25/2024, documented, Resident is at risk for fall related injury r/t (related to) impaired functional performance with ADL (activity of daily living) task, CVA (cardiovascular accident) with right hemiplegia [one-sided paralysis or weakness], incontinence and use of opioid/psychoactive medications. Review of Resident #221's care plan, initiated on 7/31/2024, documented ADL self-care performance deficit r/t CVA with right hemiplegia . Review of Resident #221's care plan, initiated on 8/1/2024, documented At risk for rehospitalization due to (Dx) [diagnosis] CVA with right hemiplegia. During an interview on 8/8/2024 at 12:42 PM, Staff E, Registered Nurse, MDS Coordinator, stated [Resident #221's Name] functional ability [assessment] has to be modified since she was admitted with right hemiplegia. 48708 4) Review of Resident #116's MDS Discharge Return Anticipated Assessment, dated 5/31/24, documented Resident #116's discharge location on Section A to home/community. Review of Resident #116's discharge nursing note, dated 5/31/24, documented Resident #116 was admitted to the hospital for altered mental status. Review of the admission/discharge report dated 2/6/24 to 8/6/24 documented Resident #116 was discharged to an acute care hospital on 5/31/24. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/8/24 at 12:44 PM, Staff E, Registered Nurse, Minimum Data Set Coordinator, confirmed [Resident #116's Name] minimum data set assessment was completed incorrectly and would need to be modified. 5) Review of Resident #118's MDS Discharge Return Not Anticipated Assessment, dated 5/7/24, documented on Section A, the resident was discharged to a short term general hospital. Review of Resident #118's discharge summary, completed on 5/7/24, documented Resident #118 was discharged to another facility. Review of the admission/discharge report documented Resident #118 was discharged to a community nursing home on 5/7/24. During an interview on 8/8/24 at 12:44 PM, Staff E, Registered Nurse, Minimum Data Set Coordinator confirmed [Resident #118's Name] minimum data set assessment was completed incorrectly and would need to be modified.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46523 Based on observations, interviews and record review, the facility failed to provide wound care and treatment in accordance with professional standards of practice for 1 of 3 residents reviewed for skin conditions, Resident #220. Findings include: During an observation on 8/6/2024 at 9:30 AM, Resident #220 was lying in bed with a dressing on her left arm dated 8/4/2024. During an interview on 8/6/2024 at 9:30 AM, Resident #220 stated, I have a skin tear in my arm; the nurse will change the dressing. During an observation on 8/7/2024 at 1:12 PM, Resident #220 was lying in bed with a dressing on her left arm dated 8/6/2024. Review of Resident #220's physician orders documented no orders for left arm wound care for skin tear. Review of Resident #220's Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form, dated 7/30/2024, documented skin tears on both arms. Review of Resident #220's Weekly Skin Integrity Data Collection, dated 8/6/2024, documented, Skin Condition: 1. Is resident available for skin inspection: yes. 2q1. Describe: abscess to abdomen, erythema [abnormal redness of the skin] to bottom skin tear to left arm. During an interview on 8/8/2024 at 9:27 AM, Staff P, License Practical Nurse, stated, I did [Resident #220's Name] left arm dressing yesterday. The resident had a right arm skin tear but that resolved. During an interview on 8/8/2024 at 1:21 PM, the Director of Nursing stated, I spoke with the nurse, and she said [Resident #220 Name] had a right arm skin tear and it resolved yesterday. There are no orders in the system for the left arm skin tear. The staff should have orders in the system in order to provide wound care. Review of the policy and procedure titled Skin Integrity & Pressure/Injury Prevention and Management with a last review date of 12/5/2023, read, Policy: 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 wound utilizing professional standards of the NPIAP (National Pressure Injury Advisory Panel) and WOCN (Wound, Ostomy, Continent Nurses Society).

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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. 46523 Based on observations, interviews, and record review, the facility failed to ensure the drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles for unattended/secured medications in 1 of 3 units. Findings include: During an observation on 8/6/2024 at 9:23 AM in Resident #89's room, there were 3 clear plastic unit doses of Sodium Chloride 0.9% of 30 milliliters each inside a bed pan on top of the resident's drawer. (photographic evidence obtained) During an observation on 8/6/2024 at 9:30 AM in Resident #219's room, there was a Wixela inhaler on top of resident's bedside table. (photographic evidence obtained) During an interview on 8/6/2024 at 9:30 AM, Resident #219 stated, The nurse brings the inhaler and leaves it here and then she will come back and pick it up after I am done. During an observation on 8/7/2024 at 8:59 AM in Resident #111's room, there were 3 clear plastic unit doses of Sodium Chloride 0.9% of 30 milliliters each on top on dresser. (photographic evidence obtained) During an observation on 8/8/2024 at 5:54 AM, Staff C, License Practical Nurse (LPN), entered Resident #68's room and after connecting intravenous tubing with medication to Resident #68, Staff C left a white foam tray with a Normal Saline syringe and an unopened Heparin lock Flush syringe in the resident room. During an interview on 8/9/2024 at 7:42 AM, the Director of Nursing (DON) stated Medication should not be left at bedside unsecured. Review of the policy and procedure titled Storage and Expiration Dating of Medications, Biological, with a last review date of 12/5/2023, read, Procedure: 3.1.1 Store all drugs and biologicals in locked compartments, including the storage of Schedule II-V medications in separately locked, permanently affixed compartments, permitting only authorized personnel to have access .3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46523 Based on observations, interviews, and record reviews the facility failed to use the appropriate infection control standards for residents with central catheters for 1 (Resident #68) of 4 residents reviewed for antibiotic medication and to sanitize reusable medical equipment. Findings include: 1) During an observation on 8/8/2024 at 8:42 AM, Staff A, Registered Nurse (RN) performed hand hygiene and donned personal protective equipment which included gown and gloves and entered Resident #68's room. Resident #68's IV (intravenous) pump was beeping. Staff A retrieved a normal saline syringe and heparin flush syringe that had been left in the room and disconnected Resident #68's IV tubing. Staff A, RN, without scrubbing the needleless connector, flushed the PICC (peripherally inserted central catheter) line with normal saline followed by the heparin lock flush. Staff A, RN, then placed a Curos (Trademark) port protector on the needleless connector hub. During an interview on 8/8/2024 at 12:14 PM, Staff A, RN, stated, I would normally clean the needleless connector at the beginning when I am first going to connect the IV tubing. When I disconnect, I do not scrub the hub again because I connect the normal saline flush right away and I consider it to be sterile when I disconnect the tubing. During an interview on 8/9/2024 at 9:09 AM, the Director of Nursing stated, The nurse should have sanitized the needleless connector after disconnecting the tubing and flushing IV [intravenous] line. Review of the policy and procedure titled IV bolus Injection, with a last review of 12/5/2023, read, For administration through an intermittent vascular access device .Perform a vigorous mechanical scrub of the needleless connector for at least 5 seconds using an antiseptic pad. While maintaining sterility of the syringe tip, attach a prefilled 10-ml syringe or a syringe specially designed to generate lower injection pressure containing preservative-free normal saline solution to the needleless connector .Perform a vigorous mechanical scrub of the needless connector for at least 5 seconds using an antiseptic pad. Allow it to dry completely. While maintaining the sterility of the syringe tip , attach the syringe containing the locking solution to the needleless connector. Inject the locking solution slowly into the venous access device. 2) During an observation on 8/8/2024 at 8:53 AM, Staff B, RN reviewed Resident #67's medication. Staff B walked over to the 200-hall equipment room, retrieved a vital machine cart outside of the room and walked into Resident #67's room to take her blood pressure. Without sanitizing the blood pressure cuff, Staff B took the resident's blood pressure. Staff B exited the room with the vital sign cart and placed the vital cart next to the medication cart. Staff B performed hand hygiene poured all medication and administered the medications to Resident #67. Staff B exited the room and, without sanitizing the blood pressure cuff, returned the vital cart to the hallway near the nursing station and plugged the cart into the wall outlet. Staff B returned to her medication cart and continued to administer medications. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/8/2024 at 1:20 PM, Staff B, RN stated, I should have sanitized the blood pressure cuff and machine after using it with [Resident #67 's name]. Normally we have the wipes with the purple top which we use to clean the machine after each use. During an interview on 8/8/2024 at 1:30 PM, the Director of Nursing (DON) stated, Staff should sanitize the equipment after each use. Review of the policy and procedure titled Cleaning and Disinfection of Non-Critical Patient Care Equipment, with a last review date of 12/5/2023, read, Policy: The following defines and establishes standards for assuring that non-critical reusable patient care equipment is cleaned daily and before and after reuse with an EPA -registered hospital disinfectant, or other approved disinfectant based on manufacturer guidelines. Examples of non-critical time include, but not limited to: a. stethoscopes, blood pressure cuffs, countertops, portable pumps, pulse oximeters, tablets used for charting or digital communication, ect.