| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 106012 | A. Building<br>B. Wing | 08/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Port Saint Lucie | 3720 SE Jennings Rd<br>Port Saint Lucie, FL 34952 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on policy review, interview, and record review, the facility failed to ensure care and services were provided in a dignified manner for 6 of 9 sampled residents reviewed with dignity concerns (Residents #26, #49, #54, #74, #3, #372).<br><br>The findings included:<br><br>Review of the policy Dignity reviewed 09/25/23 documented, Policy: Each resident has the right to be treated with dignity and respect. Interactions and activities with residents by staff, temporary agency staff, or volunteers must focus on maintaining and enhancing the resident's self-esteem, self-worth, and incorporating the resident's goals, preferences, and choices. Staff must respect the resident's individuality as well as, honor and value their input.<br><br>Review of the Grievance Log for the month of July 2024 revealed six customer service concerns. These concerns were related to inappropriate comments toward a family member, in front of residents, by a Certified Nursing Assistant (CNA) on 07/08/24; staff failing to introduce themselves at the beginning of the shift and being left in the shower alone when assistance was needed on 07/10/24; inappropriate comment by a CNA on 07/11/24; inappropriate comment and actions by the Activity Assistant on 07/18/24; a staff member grumbling in a foreign language after a resident request for care and witnessed altercation between staff and another family in the common area on 07/19/24; and complaints about a CNA during a shower on 08/08/24.<br><br>1) Review of the record revealed Resident #26 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a range of motion impairment to one arm and required substantial to dependent assistance for all Activities of Daily Living (ADLs). Although the Brief Interview for Mental Status (BIMS) score was documented as a 6, on a 0 to 15 scale, indicating some cognitive impairment, Resident #26 could hold a conversation to make her needs known and to express her feelings.<br><br>Review of the current care plan initiated on 05/01/24, and revised 06/07/24, documented Resident #26 needed ADL assistance to maintain or attain her highest level of functioning.<br><br>(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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106012 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/08/2024 |
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| NAME OF PROVIDER OR SUPPLIER Life Care Center of Port Saint Lucie | | STREET ADDRESS, CITY, STATE, ZIP CODE 3720 SE Jennings Rd Port Saint Lucie, FL 34952 | |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 08/05/24 at 1:20 PM, when asked if staff treat her with respect and dignity, Resident #26 stated about two thirds (2/3) of staff are OK and the others have an attitude, especially when they clean me up. The resident stated sometimes it's just a look. Resident #26 volunteered that she has both Tylenol and ibuprofen, and that once she asked for an ibuprofen and the nurse wouldn't go get it stating she didn't have an order, adding that the nurse was nasty, referring to the nurse's attitude. Resident #26 finally stated she told the Unit Care Coordinator for the 200 unit, who told her she gets that a lot.<br><br>During an interview on 08/08/24 at 11:27 AM, when asked if she had spoken with Resident #26 about staff having poor or nasty attitudes, the Unit Care Coordinator denied speaking with the resident about any staff concerns. When asked if she told the resident that she gets a lot of complaints about the staff, the Unit Care Coordinator stated she did not say that.<br><br>2) Review of the record revealed Resident #49 was admitted to the facility on [DATE]. Review of the current MDS assessment dated [DATE] documented the resident had a BIMS score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. Review of this same MDS documented the resident's prior functioning was independent, but upon admission needed partial to substantial assistance from staff for all ADLs except eating.<br><br>Review of the current care plan initiated on 05/03/24 and revised on 05/07/24 documented Resident #49 needed ADL assistance to maintain or attain her highest level of functioning.<br><br>During an interview on 08/05/24 at 3:15 PM, when asked if staff treated her with respect and dignity, Resident #49 stated, They are understaffed. The CNAs (Certified Nursing Assistants) are overworked and always running. When I was not as mobile, I had an accident (referring to an incontinent episode) because the CNA didn't come when I called. When I'm in bed and they ask me to turn, if I don't do it quick enough, they just push me over. Resident #49 clarified that the majority of staff are fine, but a minority are the problem. Resident #49 further volunteered, once when she returned to her room from therapy, she was in pain and asked to go back to bed. The resident stated the CNA responded with, as soon as I get back from my break.<br><br>3) Review of the record revealed Resident #54 was admitted to the facility on [DATE]. Review of the current MDS assessment dated [DATE] documented the resident had a BIMS score of 14, on a 0 to 15 scale, indicating the resident was cognitively intact. Further review of this MDS documented the resident's prior functioning was independent, but upon admission needed the partial to moderate assistance of staff for mobility.<br><br>Review of the current care plan initiated 07/19/24 documented Resident #54 needed ADL assistance to maintain or attain her highest level of functioning.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Life Care Center of Port Saint Lucie | | STREET ADDRESS, CITY, STATE, ZIP CODE 3720 SE Jennings Rd Port Saint Lucie, FL 34952 | |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 08/05/24 at 10:45 AM, when asked if staff treat her with respect and dignity, Resident #54 stated, They have an attitude, like they don't want to be here. When I ask to get back into bed they say, 'I'll be back in two hours.' When I ring the bell for help, they come in, turn it off and say, 'I'll be back' or 'I'm busy. I have 10 other patients to take care of.' Resident #54 further stated when she is trying to talk to an aide, they don't listen to her and or she can't understand them. The resident further explained when staff come in to answer the call light, as they are turning it off, her roommate gets their attention, and they ignore her. Resident #54 stated their attitude is, don't bother me. The resident stated when she asked to go to the bathroom the other night before bed, the CNA stated, Why? You've already been three times. Resident #54 stated, That's none of her (the CNA's) business . so what. Resident #54 finally stated, It's always cold in here. And when they change me, they let me lie here half naked.<br><br>4) Review of the record revealed Resident #74 was admitted to the facility on [DATE]. Review of the current MDS assessment dated [DATE] documented the resident had a BIMS score of 14, on a 0 to 15 scale, indicating he was cognitively intact. This MDS documented the resident had range of motion impairment on one side of both his upper and lower extremities and needed substantial to maximum assistance for all ADLs except eating.<br><br>Review of the current care plan initiated on 12/06/21 documented Resident #74 had an ADL self-care performance deficit related to a stroke with left sided hemiplegia, and that his left upper extremity was flaccid (unable to move independently).<br><br>During an interview on 08/05/24 at 11:31 AM, when asked if staff treat him with respect and dignity, Resident #74 stated, Staff are grumpy at night when I need to be changed. When I call for assist, staff come into my room and say, 'What do you need?' with an attitude. If I say I need to be cleaned up after a BM, they tell me they will come back later. By the time they get to it, it's hard and stuck to me, and feels like a 'grill brush on my butt.' Resident #74 also complained of the lack of fingernail care, stating he had been begging for his nails to be cut and trimmed for two weeks. An observation at that time revealed the fingernails were long and dirty. The nails to his left hand, with his fingers curled up due to his stroke, revealed the nails were nearly cutting into his palm.<br><br>On 08/08/24 at 12:53 PM, Resident #74 was sitting up at his bedside, in a wheelchair, speaking with a friend. With permission from the resident to ask questions, when asked if the issue with his fingernails was just recently, as his usual aid had been on vacation for the past two weeks, Resident #74 stated it has been an ongoing problem. The resident then stated, My aid was not happy with me. She came back in and said, why do you tell them I don't cut your nails. I cut your nails. The surveyor had questioned the aid about the nail care process earlier that day. During this interview, the friend described a time when she was trying to call Resident #74, but he was not answering. The friend stated she then called the main number, the receptionist transferred the call to the nurses' station, she waited a bit and all the nurse said was, (Name of resident) doesn't want to talk to you, and then click, the nurse hung up on her. When asked if he said he didn't want to speak with his friend at any time, Resident #74 stated, I always want to talk with her. The friend further stated, The staff should know to put his phone and tablet where he can reach it when he gets up. He shouldn't have to tell them every day to put them nearby. He can't use his left hand. An observation at that time revealed the resident's tablet and phone, with the cords entangled, was stuck in his top drawer on the opposite side of the bed. Resident #74 again stated the aides have an attitude, especially when he needs to be cleaned up.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 33103<br><br>5) Review of Resident #3's record revealed the resident was admitted to the facility on [DATE] with a diagnoses to include Major Depressive Disorder, Emphysema, and General Weakness. A review of the resident's Quarterly MDS (Minimum Data Set) assessment dated [DATE] documents her BIMS (Brief Interview for Mental Status) score of 8, which indicates she has moderate cognitive impairment. She requires Partial/Moderate assistance for toileting, upper body dressing, and personal hygiene. She requires substantial/maximum assist for lower body dressing, putting on and taking off shoes and to roll left and right. (The ability to roll from lying on back to left and right side and return to lying on back on the bed).<br><br>On 08/05/24 at 2:30 PM, Resident #3 was observed lying in bed leaning towards the right side of the bed. The Surveyor asked her if she was uncomfortable in that position. She stated, yes and attempted to straighten herself up in bed but was unable to. The Surveyor put her call light on to have an aide come to her room to assist her. At 2:55 PM Staff E, CNA (Certified Nursing Assistant) walked into the room. The Surveyor stated the Resident in Bed B needed assistance in repositioning. Staff E, CNA then stated, I have already been in here four times today and repositioned her.<br><br>39142<br><br>6) Record review revealed Resident #372 was a new admission, who was admitted to the facility on [DATE], with his comprehensive assessment still in progress. Resident #372 was assessed for his Brief Interview of Mental Status (BIMS). Resident 372 had a BIMS score of 12/15, indicating moderate cognitive impairment. Section D, Mood, revealed a score of 00, which indicated no issues with mood. Section E, Behaviors, indicated Resident #372 had no behavioral issues. Section I, Pertinent Diagnoses, revealed the resident had the following:<br><br>1. Cancer<br><br>2. Coronary Artery Disease (CAD)<br><br>3. Hypertension (HTN)<br><br>4. Multi Drug Resistant Organisms (MDRO)<br><br>5. Diabetes Mellitus (DM)<br><br>6. Stroke<br><br>7. Parkinson's disease<br><br>Resident #372 was identified to need mobility devices that included a wheelchair and walker.<br><br>On 08/06/24 at 10:32 AM, an interview was conducted with Resident #372. When the resident was asked about his care he expressed that staff took too long to respond to the call light. When asked to explain, Resident #372 stated he has to wait for help to go to the bathroom and he had an accident in his pants, multiple times. Resident #372 stated he did not remember how many times. When asked how he felt about that Resident #372 stated the staff ignores me, I feel ignored. |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on record review and interview, the facility failed to respond to and honor request for insulin sensor use for 1 of 6 sampled residents reviewed for choices (Resident #54).<br><br>The findings included:<br><br>Review of the record revealed Resident #54 was admitted from the facility's associated Independent Living (IL) facility, to the skilled nursing facility, on 07/18/24 with a diagnosis of Diabetes. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, on a 0 to 15 scaled, indicating she was cognitively intact.<br><br>Review of the current orders revealed as of 07/18/24 staff were to complete an accucheck twice daily for diabetes. This process is completed by obtaining blood via a finger stick to obtain a blood sugar level.<br><br>Review of a progress note written on 07/27/24 by the Nurse Practitioner documented, The patient is unsure about the facility's protocol for glucose monitoring and would like to have her sensor replaced and used for monitoring. (The sensor is attached to the resident's arm and is read by a monitor to obtain a blood sugar level, without having to do a finger stick, that can often be painful).<br><br>During an interview on 08/05/24 at 11:10 AM, when asked if she was receiving insulin, Resident #54 stated she was. The resident further stated she had a blood sugar sensor in her left arm, that was up two weeks ago, but that the facility would not replace it or use it.<br><br>During an interview on 08/08/24 at 9:35 AM, when asked about the insulin sensor for Resident #54, the 200 Unit Care Coordinator stated, She doesn't have her monitor. It's next door at (name of IL). When asked if someone could get it for her, the Unit Care Coordinator stated she could call over to the IL and try to get the monitor for Resident #54. The Unit Care Coordinator later informed the surveyor the items needed to do the sensor blood glucose level were on the way over from next door. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>33103<br><br>Based on observations and interviews the facility failed to provide a safe, clean, comfortable homelike environment 3 of 3 units (Unit 100, 200 and 400).<br><br>The findings included:<br><br>During observations on 08/05/24, 08/06/24 and 08/07/24, the following environmental concerns were noted in the facility:<br><br>Rooms:<br><br>103-Observations made on 08/05/24 at 9:05 AM, the ceiling vent showed rust and dust.<br><br>104-Observations made on 08/06/24 at 10:43 AM, there was a stain on the wall under the window that appeared to be liquid splashed that was dripping down on the wall.<br><br>105-Observations made on 08/05/24 at 9:45 AM, the ceiling vent showed rust and dust; The floor was scuffed and paint peeling behind the bed.<br><br>106-Observations made on 08/05/24 at 9:23 AM, there was paint peeling from the wall behind bed.<br><br>110-B Observations made on 08/06/24 at 10:55 AM, there was a hole in the wall by the window and by the dresser across from bed-B.<br><br>111-Observations made on 08/06/24 at 11:15 AM, there was paint peeling from the wall across from bed-A and at the entrance of the room; The ceiling vent was rusted.<br><br>112-A Observations made on 08/05/24 at 11:22 AM, the resident's closet door hinge was broken. The seat pad in the bathroom was torn.<br><br>113-B Observations made on 08/05/24 at 10:50 AM, the light behind the bed had no string for the resident to turn the light on; The paint on the walls were peeling.<br><br>114-B Observations made on 08/05/24 at 2:30 PM, the wheelchair pad was torn.<br><br>115 Observations made on 08/06/24 at 11:11 AM, the ceiling vent was rusted and dusty.<br><br>123-B Observations made on 08/06/24 at 12:16 PM, the ceiling vent was rusted and dusty. This was observed after Resident # 13's daughter pointed to the AC ceiling vent, which was noted with blackish/brownish discoloration.<br><br>126-B Observations made on 08/06/24 at 9:31 AM, the ceiling vent was noted with blackish/brown discoloration.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 128-B Observations made on 08/06/24 at 9:34 AM, the ceiling vent was noted with blackish/brown discoloration.<br><br>203-B Observations made on 08/05/24 at 11:44 AM, the floors were dirty, and the resident stated it rarely gets cleaned up; The walls were in disrepair; and in need of a deep clean; Observations made on 08/06/24 at 12:10 PM, the ceiling vent was dusty. The vinyl base on the bottom of the wall behind bed A was peeling away from the wall.<br><br>206-B Observations made on 08/06/24 at 12:14 PM, the ceiling vent was dusty<br><br>207-B Observations made on 08/06/24 at 12:15 PM, the ceiling vent was dusty and rusted.<br><br>400-unit rooms-Observations made on 08/06/24 at 12:10 PM, ceiling vents were dusty.<br><br>The 400-unit light by the entrance to the unit was very dusty.<br><br>Observations made on 08/05/24 at 1:05 PM, the hallway by rooms 107-116, the handrail had brown paint peeling off and exposed wood that was not smooth; and a resident may get a splinter from the wood. The vinyl at the base of the wall was peeling away from the wall.<br><br>Observations made on 08/06/24 at 12:20 PM, the ceiling vent in the laundry room, over the clean area by the dryers was dusty.<br><br>A follow-up tour was completed on 08/07/24 at 10:08 AM with Director of Environmental, the Director of Maintenance and Regional [NAME] President. The tour included the 100, 200 and 400 units. The 400 unit which has 12 rooms was toured to check the ceiling vents and found the ceiling vents were very dusty. The Director of Maintenance stated the walls are the way they are because of residents hitting their wheelchair or furniture hitting the wall. He stated they will go around to all the rooms and check all ceiling vents. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on policy review, observation, record review, and interview, the facility failed to ensure of proper nail care for 1 of 3 sampled residents reviewed for Activities of Daily Living (ADL's) (Resident #74).<br><br>The findings included:<br><br>Review of the policy Nail Care reviewed 08/23/23 documented, Policy: The resident will receive assistance as needed to complete activities of daily living (ADLs). Procedure: For general fingernail care for most residents, the following procedure will be followed: 1. Ensure fingernails are clean and trimmed to avoid injury and infection.<br><br>Review of the record revealed Resident #74 was admitted to the facility on [DATE] with a diagnosis to include hemiparesis secondary to a stroke. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, on a 0 to 15 scale, indicating the resident was cognitively intact. Further review of this MDS documented Resident #74 needed substantial to maximum assistance with bathing, showering, and personal hygiene.<br><br>Review of the current care plan initiated on 12/06/21 documented Resident #74 had an ADL self-care performance deficit related to a stroke with left sided hemiparesis with his left arm being flaccid. This care plan instructed staff to check the resident's nail length and to trim and clean them on bath days and as necessary.<br><br>Review of the Certified Nursing Assistant's (CNA's) documentation in the electronic medical record revealed the shower schedule for Resident #74 was every Monday and Thursday during the 7 AM to 3 PM shift. Further review of the documentation for the past two weeks revealed the resident received a shower on 07/29/24, 08/01/24 and 08/05/24, along with bed baths on 07/22/24, 07/25/24, 07/27/24, 08/03/24, and 08/04/24. This would have provided 8 opportunities during the past two weeks for staff to trim and clean the resident's fingernails with bathing and showering.<br><br>During an interview on 08/05/24 at 11:28 AM, when asked how he was doing, Resident #74 stated in a frustrated tone, that he had asked everyone, CNAs, nurses, and even the maintenance man, about getting his fingernails trimmed, as he held up his right hand. An observation of his fingernails revealed they were long, extending past the end of each finger, with a black substance under the nails. Observation revealed the resident's left fingers were curled up, and the fingernails were long and nearly digging into his palm.<br><br>An observation and interview on 08/06/24 at 9:50 AM, revealed the resident's fingernails had been trimmed, although some black substance was still noted under a few of the nails. Resident #74 stated he did not understand why it took so long, again stating he had been asking constantly for the past couple of weeks. The resident stated, I get my toe nails trimmed every two months like clockwork. Why can't I get my fingernails done routinely as well.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 08/08/24 at 11:13 AM, when asked the process for trimming and cleaning a resident's fingernails, Staff A, CNA, stated she trims and cleans the nails whenever they need to be done. When asked about how often she trimmed and cleaned the fingernails for Resident #74, the CNA stated about once a week. When told he had been asking for the past two weeks, Staff A stated she had been on vacation the past two weeks.<br><br>During a follow-up interview on 08/08/24 at 12:53 PM, when asked if the issue getting his fingernails trimmed and cleaned was just over the past two weeks, Resident #74 stated it had been an ongoing issue. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on policy review, record review, and interview, the facility failed to ensure care and services for 3 of 7 sampled residents reviewed for medication use, as evidenced by the failure to follow physician ordered parameters for Resident #26, the failure to ensure timely antibiotics and timely central vascular access device (CVAD) dressing change for Resident #164, and the failure to ensure timely medication administration for Resident #76.<br><br>The findings included:<br><br>1) Review of the record revealed Resident #26 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 6, on a 0 to 15 scale, indicating some cognitive impairment.<br><br>Review of the current orders revealed staff were to hold the midodrine tablet used for low blood pressure if the systolic blood pressure (SBP/upper number) was greater than 120, as of the order date of 07/20/24. This medication was ordered three times daily.<br><br>Review of the August 2024 Medication Administration Record (MAR) revealed staff failed to hold the midodrine for a SBP greater than 120 on the following dates:<br><br>a) On 08/01/24 at 1400 (2 PM) with a SBP of 121.<br><br>b) On 08/04/24 at 1400 with a SBP of 127.<br><br>c) On 08/05/24 at 1400 with a SBP of 133.<br><br>d) On 08/06/24 at 1400 with a SBP of 132.<br><br>e) On 08/07/24 at 1400 with a SBP of 128.<br><br>Review of the July 2024 MAR revealed staff failed to hold the midodrine for a SBP greater than 120 on the following dates:<br><br>f) On 07/22/24 at 1400 with a SBP of 126.<br><br>g) On 07/27/24 at 1400 with a SBP of 122.<br><br>h) On 0728/24 at 1400 with a SBP of 123.<br><br>i) On 07/29/24 at 2200 (10 PM) with a SBP of 124.<br><br>During an interview on 08/08/24 in the afternoon, the Director of Nursing (DON) was made aware of the failure to follow physician ordered parameters and agreed with the concern.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2a) Review of the record revealed Resident #164 was admitted to the facility on [DATE] with diagnosis of osteomyelitis and the need for intravenous (IV) antibiotics. Review of the transfer form from the hospital revealed an area to document the medications due near the time of transfer, with the last time the medication was administered. The area was filled as an unknown date, as the form documented start 2, and the time of 6 PM. Further review of the hospital record revealed the antibiotic daptomycin was last provided by the hospital on 07/23/24 at 5:27 PM.<br><br>Review of the current order dated 07/25/24 documented staff were to provide daptomycin 500 mg (milligrams) via IV every 48 hours beginning on 07/25/24, even though the resident was admitted during the evening hours on 07/25/24. The electronic order was rewritten to start the antibiotic on 07/26/24. The record revealed the IV antibiotic form to obtain the daptomycin from the pharmacy was completed on 07/26/24 at 11:00 AM. Pharmacy records revealed the daptomycin was delivered to the facility on [DATE] at 7:19 PM. Although the resident's IV access was thought to be infiltrated on 07/26/24, it was checked and available for use as of 3:22 PM.<br><br>Review of the July 2024 Medication Administration Record (MAR) the lack of administration of the IV antibiotic on 07/26/24 at 6:56 PM and 07/27/24 as evidenced by a large X on the MAR. The antibiotic was last provided on 07/23/24 by the hospital staff and not provided by the facility until 07/28/24. Review of the progress notes lacked any explanation of the delay.<br><br>During an interview and observation on 08/06/24 at 3:24 PM, when asked if the antibiotic daptomycin was available in house, the Unit Care Coordinator was unable to find it in the pharmacy stock. The Unit Care Coordinator and DON were made aware of the concern related to the antibiotic delayed administration. As of the exit conference, no additional information had been provided.<br><br>2b) Review of the pharmacy policy Central Vascular Access Device (CVAD) Dressing Change revised 06/01/21, that included a PICC line, documented, 1. Perform sterile dressing changes . 1.1 Upon admission. 1.1.1 If transparent dressing is dated, clean, dry, and intact, the admission dressing change may be omitted and scheduled for 7 days from the date on the dressing label. 1.2 At least weekly. 24. Documentation in the medical record includes, but is not limited to: 24.1 Date and time. 24.2 Site assessment. 24.3 Length of external catheter. 24.4 Arm circumference. 24.5 Reason for dressing change. 24.6 Patient response to procedure. 24.7 Patient/significant other teaching.<br><br>Further review of the hospital transfer form revealed the Peripherally Inserted Central Catheter (PICC) line for Resident #164 was inserted by the hospital staff on 07/16/24. Additional hospital documentation provided by the Assistant Director of Nursing (ADON) revealed the hospital staff last changed the dressing for the PICC line on 07/23/24 at the hospital.<br><br>Review of the order dated 07/25/24 documented staff were to change the transparent dressing to the PICC catheter site every 7 days. This order included staff were to measure the external catheter length and notify the physician of any change in length. The first dressing change was scheduled for 07/25/24.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Medication Administration Records (MARs) for July and August 2024 lacked any documented PICC line dressing change. Further review of the MAR revealed the scheduled date for the PICC line dressing change was 07/25/24, then changed to 07/26/24, again neither was documented as completed. The next PICC line dressing change was scheduled for 08/02/24, and again was not documented as completed. This date of 08/02/24 would represent 10 days after the documented PICC dressing change by hospital staff on 07/23/24.<br><br>Review of all progress notes lacked any documented PICC line dressing change or any type of assessment to the PICC line, that included a date on the dressing upon admission to the facility, any length of external catheter or any arm circumference, as per their policy.<br><br>An observation on 08/05/24 at 2:55 PM revealed a central line to left upper arm of Resident #164. The date on the label was difficult to read, but appeared to be 8/6/24 with the 6 having been written over another number, with permanent marker noted on the resident's arm.<br><br>During an interview and side-by-side review of the record on 08/06/24 at 1:49 PM, the Unit Care Coordinator confirmed the PICC dressing changes were to be done weekly and signed off in the computer via the eMAR. The Unit Care Coordinator looked at the dressing on the resident's arm and agreed it looked like 8/6/24. The Unit Care Coordinator stated those initials were for a nurse that she believed did not work on 08/06/24. The Unit Care Coordinator stated the initials were of Staff B, Licensed Practical Nurse (LPN) who worked night shift (7 PM to 7 AM), and that she had worked on 08/02/24, the last scheduled dressing change date.<br><br>During a phone interview on 08/06/24 at 2:20 PM, when asked the process for PICC dressing changes related to the timing and documentation, Staff B, LPN stated the dressings were changed weekly, with the date written on the dressing prior to putting the dressing on the resident's arm, and documented as completed in the eMAR. When asked if she had changed the PICC dressing for Resident #164, the LPN stated she did it last Friday (08/02/24) before she went home. When asked about the lack of documentation in the eMAR, the LPN stated she would have signed it off when completed, and had no reason for the lack of documentation.<br><br>33103<br><br>3) During an interview on 08/05/24 at 11:31 AM, Resident #76 informed the surveyor that he is not getting his medications until hours later.<br><br>A review of the Policy titled, Medication Administration Times with an issue date of 11/17/19, Revised 05/06/21 and reviewed 08/28/23 documented the following times are used for standard medication times:<br><br>Medication prescribed one time a day-0800 AM or 0900 AM<br><br>Medication prescribed in the Evening-5:00 PM or 6:00 PM<br><br>Medication prescribed at Bedtime-8:00 PM or 9:00 PM<br><br>Medication prescribed Twice a day- 0900 AM and 5:00 PM<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Medication prescribed Three times a day-0900 AM, 1:00 PM and 5:00 PM<br><br>Review of Resident #76's medical records revealed he was admitted to the facility on [DATE] with a diagnosis to include Spinal Stenosis of the Lumbar, Type II Diabetes, Muscle Spasm, Cervical Stenosis, Osteoarthritis, Chronic Pain Syndrome, Radiculopathy of the Lumbar Region, Lack of Coordination, Benign Prostatic Hyperplasia, and Muscle Weakness.<br><br>A review of the Physician Order for 07/24/24 and 08/24/24 revealed the following medications were ordered:<br><br>-Metformin HCl Tablet 500 MG Give 1 tablet by mouth two times a day for Diabetes *WITH MEALS 08:00 and 5:00 PM.<br><br>-Hydrochlorothiazide Tablet 12.5 MG Give 1 tablet by mouth one time a day for Diuretic/Edema 08:00 AM.<br><br>-Flomax Oral Capsule 0.4 MG Give 2 capsule by mouth one time a day for bph (benign prostatic hyperplasia) 5:00 PM.<br><br>-Cymbalta Oral Capsule Delayed Release Particles Give 60 mg by mouth two times a day for depression 0900 and 5:00 PM.<br><br>-Cozaar Oral Tablet 100 MG Give 1 tablet by mouth one time a day for Hypertension 08:00 AM.<br><br>-Carvedilol Tablet 25 MG Give 1 tablet by mouth two times a day for HTN 08:00 and 5:00 PM.<br><br>-Aspirin EC Tablet Delayed Release 81 MG (Aspirin) Give 1 tablet by mouth one time a day for Cardiac 08:00 AM.<br><br>-Cymbalta Oral Capsule Delayed Release Particles (Duloxetine HCl) Give 60 mg by mouth two times a day for depression 09:00 AM and 5:00 PM.<br><br>-Flomax Oral Capsule 0.4 MG (Tamsulosin HCl) Give 2 capsule by mouth one time a day for bph 5:00 PM.<br><br>Further review of the Medication Administration Audit Report reveals the following medications were not given at the ordered time in August.<br><br>08/05/24 Metformin, Cozaar, Hydrochlorothiazide, Carvedilol, Aspirin ordered for 08:00 AM and was given at 10:36 AM and Cymbalta ordered at 9:00 AM was given at 10:36 AM.<br><br>08/05/24 Metformin, Carvedilol, Flomax, Cymbalta ordered to be given at 5:00 PM and not given until 8:27 PM.<br><br>The physician's order for Metformin specifically states to give with meals. A review of the Meal Service Schedule documents Resident #76's unit to be served breakfast between 7:55 AM-8:25 PM and dinner in the dining room is 4:45 PM-5:15 PM.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Further review of the July 2024 Medication Administration Audit Report revealed that Resident #76 did not timely receive the following medications at their scheduled time.<br><br>- Metformin 8:00 AM dose, did not timely receive 10 times in 31 opportunities and did not receive his 5:00 PM dose timely 6 times in 31 opportunities.<br><br>-Carvedilol 8:00 AM did not timely receive 10 times in 31 opportunities and his 5:00 PM dose did not receive 5 times in 31 opportunities.<br><br>- Hydrochlorothiazide 8:00 AM dose, did not timely receive 10 times in 31 opportunities.<br><br>-Cozaar 8:00 AM dose, did not timely receive 10 times in 31 opportunities.<br><br>-Aspirin 8:00 AM dose, did not timely receive 10 times in 31 opportunities.<br><br>-Cymbalta 9:00 AM dose, did not receive timely 3 times in 31 opportunities and the 5:00 PM dose did not timely receive 6 times in 31 opportunities.<br><br>-Flomax 5:00 PM dose did not timely receive 6 times in 31 opportunities.<br><br>During an interview on 08/08/24 at 10:46 AM with Staff F, RN (Registered Nurse), who started employment on 04/01/24, she stated I am supposed to give the medication an hour before or an hour after. It does not happen! We have 28 patients, I can't keep up with it.<br><br>During an interview on 08/08/24 at 11:15 AM with the DON (Director of Nursing), it was revealed the census is 51 today on the 100 unit, and staffed with two nurses on both shifts. It was reported that Cart 1 is one of the heaviest med passes. The residents on that hall might have a lot of meds (room [ROOM NUMBER]-116). You may have a resident on 27 meds. What we have identified regarding the medications is we had the pharmacy look the meds for those resident's, created a plan in place for the Unit Manager to come in at 0700 AM. We are doing a trial period where she is taking one of the carts and assisting with the meds. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33103<br><br>Based on record review and interview, the facility failed to implement nutritional supplements for 1 of 3 sampled residents reviewed for nutrition (Resident #3).<br><br>The findings included:<br><br>Review of Resident #3's medical records revealed Resident #3 was admitted to the facility on [DATE] with a diagnosis to include Adult Failure to Thrive, Dementia Without Behavioral Disturbances, Mood Disturbance, and Anxiety. A review of Resident #3's quarterly MDS (Minimum Data Set) assessment dated [DATE] documented her BIMS (Brief Interview for Mental Status) score of 8, which indicates she has moderate cognitive impairment. Further review revealed under section K that the resident had a weight loss of 5% or more in the last month or 10% in 6 months and was not on prescribed weight-loss regimen. A review of the resident's weights documented on 03/23/2024, the resident weighed 119.1 lbs. On 07/08/2024, the resident weighed 108.2 pounds which is a -9.15 % weight loss. A progress note from the dietician documented a weight change on 05/02/24 with a 3% change from last weight and change over 30 days. The note further documented will add fortified foods and Med Pass 120 ML three times a day. A review of the physician's order's from May 2024, June 2024, July 2024 and [DATE] did not document any orders for Med Pass (nutritional supplement).<br><br>During an interview on 08/08/24 at 10:09 AM with the Registered Dietician, she was asked about Resident #3 and the progress note to add Med Pass 120 ml three times a day. She acknowledged that she does not find any order and was not sure why. |

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F 0693

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404

Based on observation, record review, and interview, the facility failed to properly monitor the continuous tube feeding for 1 of 2 sampled residents, resulting in the failure to administer the calculated amount of nutrition and fluids (Resident #84).

The findings included:

Review of the record revealed Resident #84 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident received all of his nutrition and fluids via a feeding tube.

Review of the current order dated 07/10/24 instructed staff to provide Resident #84 via his feeding tube Glucerna 1.5 (a specific brand of tube feed used for residents with blood sugar difficulties) at 65 milliliters (ml) per hour, for 20 hours, for a total amount of 1300 ml. This same order instructed staff to provide 30 ml of water every hour, for 20 hours, for a total amount of 600 ml. This order instructed staff to initiate the tube feeding at 1 PM each day and stop it each day at 9 AM.

The current care plan initiated on 03/13/23 documented the resident had a potential for fluid deficit related to the use of a feeding tube and diuretics. A second care plan documented the resident required tube feeding related to dysphagia (difficulty swallowing) with the intervention that the resident was dependent with tube feeding and water flushes.

An observation was made on 08/05/24 at 12:13 PM. Resident #84 out of bed and reclining in a specialty chair. An empty 1000 ml container of Jevity 1.5 with a label that documented it was started on 08/05/24 (incorrect date) at 1300 (1 PM) was noted hanging from a pole behind the resident. A water flush bag with approximately 600 ml of water remaining also documented it was initiated at the same date and time. A stack of several boxes of Jevity tube feeding was noted in the corner of the room.

A second observation on 08/07/24 at 8:20 AM revealed Resident #84 up in his specialty chair. The tube feeding pole was empty.

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 08/07/24 at 10:08 AM, when asked the process for the administration of tube feeding to a resident, Staff C, Licensed Practical Nurse (LPN), explained she puts a new canister up each day at the ordered time. The LPN volunteered that they don't routinely clear the volume on the feeding tube pump. When asked about Resident #84's tube feeding for that day, the LPN stated the night nurse was in the facility with an orientee earlier that morning, having stayed over beyond the end of her shift, and they took down an empty canister of tube feeding. When asked if it was Jevity because that was what was used earlier in the week, the LPN stated she did not see the label, but had just noticed the empty canister, and further stated Resident #84 received Glucerna. The LPN explained he used to receive Jevity, but his blood sugars were elevated, so he was changed to Glucerna. When asked about the boxes of Jevity in his room, the LPN explained that his insurance provided the tube feeding specifically for that resident, so it was stored in his room. When asked to clarify the order and total amount to be administered to Resident #84, Staff C, LPN, confirmed the order was for Glucerna 1.5 and they were to administer 1300 ml. When asked the volume of the canister, the LPN confirmed it was only 1000 ml, and further stated she always took down an empty canister each morning and had thought it was strange, as there should have been a canister with just 300 ml used. When asked if she questioned anyone about that, the LPN stated she had not, as she was fairly new to that assignment. Review of the July 2024 Medication Administration Record (MAR) revealed Staff C had worked with Resident #84 five days during the month.<br><br>During an interview on 08/07/24 at 10:14 AM, when asked about the boxes of Jevity in Resident #84's room, the Unit Care Coordinator stated she thought central supply had taken the boxes out of the room to return them. The Unit Care Coordinator was made aware of the observation of the empty Jevity canister on Monday and the LPNs comment that she always takes down an empty canister. The Unit Care Coordinator had no response.<br><br>During an interview on 08/07/24 at 4:45 PM, the Registered Dietician agreed the ordered nutritional need for Resident #84 was 1300 ml of Glucerna per day and 600 ml of water per day. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33103<br><br>Based on record review and interview, the facility failed to ensure pain medication was provided as ordered for 1 of 3 sampled residents reviewed for pain ( Resident #76).<br><br>The findings included:<br><br>A review of the Policy titled, Medication Administration Times with an issue date of 11/17/19, Revised 05/06/21 and reviewed 08/28/23 that the following times are used for standard medication times:<br><br>Medication prescribed one time a day-0800 AM or 0900 AM<br><br>Medication prescribed in the Evening-5:00 PM or 6:00 PM<br><br>Medication prescribed at Bedtime-8:00 PM or 9:00 PM<br><br>Medication prescribed Twice a day- 0900 AM and 5:00 PM<br><br>Medication prescribed Three times a day-0900 AM, 1:00 PM and 5:00 PM<br><br>On 08/05/24 at 11:31 AM Resident #76 informed the surveyor that he always has pain in his right shoulder and arm from neck surgery that occurred years ago. He further reportedthat he is not getting his pain medications/patches until hours later.<br><br>Review of Resident #76's medical records revealed he was admitted to the facility on [DATE] with a diagnosis to include Spinal Stenosis of the Lumbar, Type II Diabetes, Muscle Spasm, Cervical Stenosis, Osteoarthritis, Chronic Pain Syndrome, and Radiculopathy of the Lumbar Region.<br><br>A review of the Physician Order's revealed the following medications were ordered for pain.<br><br>-Lidoderm external patch-Apply to the right shoulder topically one time a day for pain. 0900 AM Start date 03/31/24.<br><br>-Gabapentin Capsule 300 MG, to give 1 capsule by mouth three times a day for Neuropathic Pain. 08:00 AM, 2:00 PM, 8:00 PM.<br><br>-Bio freeze Cool the Pain External Patch, apply to bilateral knees topically one time a day for knee pain Cut patch in half and apply to right and left knee 09:00 AM start date 05/23/24.<br><br>-Acetaminophen Tablet 500 MG Give 2 tablet by mouth two times a day for Pain (1000mg) 09:00 AM start date 10/12/23.<br><br>Further review of the Medication Administration Audit Report reveals the following pain medications were not given at the ordered time in August 2024:<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - 08/05/24 Gabapentin 300 MG time ordered to be given 08:00 AM given at 10:36 AM; The 2:00 PM - - dose given at 8:25 PM (documented under the 2:00 PM dose) and the 8:00 PM dose not given.<br><br>- 08/05/24 Lidoderm Patch ordered to be applied at 09:00 AM applied at 8:25 PM and<br><br>Bio freeze Patch ordered to be applied at 9:00 AM and applied at 8:27 PM.<br><br>Further review of the July 2024 Medication Administration Record) MAR and MAR Audit report revealed that Resident #76 did not timely receive the following medications at their scheduled time.<br><br>- Gabapentin 8:00 AM dose, did not timely receive 7 times in 31 opportunities and did not receive his 2:00 PM dose timely 7 times in 31 opportunities.<br><br>-Lidoderm Patch 9:00 AM did not timely receive 11 times in 31 opportunities.<br><br>-Bio Freeze Patch 9:00 AM did not timely receives 11 times in 31 opportunities.<br><br>-Acetaminophen 9:00 AM, did not timely receive 4 times in 31 opportunities.<br><br>During an interview on 08/07/24 at 10:15 AM with Staff E, LPN (Licensed Practical Nurse), it was reported this resident (Resident #76) was on Norco or something similar for his pain but he has severe constipation so the doctor took him off it. The doctor put him on Celebrex, which worked great but his B/P (blood pressure) sky rocketed so the pain doctor took him off that and he gets steroid medication every 3 months in his neck and shoulder. She further stated he is on Tylenol and gets Lidocaine patch for his shoulder/neck and bio freeze patch for his knee.<br><br>During an interview on 08/08/24 at 10:46 AM with Staff F, RN (Registered Nurse), who began on 04/01/24, it was reported I am supposed to give the medication an hour before or an hour after. It does not happen! We have 28 patients, I can't keep up with it. Sometimes for the Bio Freeze the resident states he wants it after a shower, I get it later but then I can't do it at the time he wants, and I will forget to give it to him. In the morning the residents are in their room and the 5:00 PM medication order, the residents are sometimes in the dining room.<br><br>During an interview with Resident #76 on 08/08/24 at 11:00 AM, he was asked if he refuses his meds like his Lidoderm patch? He stated he does not refuse his medications nor his Lidoderm or Bio freeze Patch, but if he takes a shower, he will ask them to put it on afterwards which he takes three times a week (Tuesday, Thursday and Saturdays). He further stated that does not always happen, they forget. He stated his Pain levels are around 8. |

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| NAME OF PROVIDER OR SUPPLIER Life Care Center of Port Saint Lucie | | STREET ADDRESS, CITY, STATE, ZIP CODE 3720 SE Jennings Rd Port Saint Lucie, FL 34952 | |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>25404<br><br>Based on record review and interview, the facility failed to ensure adequate staffing to provide nursing and related services to meet the resident's needs and in a manner that promotes each resident's rights, physical, mental and psychosocial well being for 13 of 24 sampled residents. This failure was evidenced by verbal complaints of a lack of staff by Residents #57, #54, #12, #74, #18, #26, #29, #3, #49, #40, #34, #372, #366, or their family members. This was also evidence by the lack of dignified care for Residents #3, #26, #49, #54, #74, and #372.<br><br>The findings included:<br><br>1) During interviews by the survey team on 08/05/24 and 08/06/24, the following concerns were voiced by residents and families.<br><br>a) On 08/05/24 at 10:17 AM, Resident #57, who had a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact, stated that the Certified Nursing Assistants (CNAs) rush during care to get done and go to the next resident. The resident stated they don't have enough time to get their work done, providing the example that it took them a week of the resident requesting for them to help her with a broken fingernail to get it trimmed. The resident stated she doesn't get the care that she needs as staff are too busy to get her up as she wants, and has been in bed too much the past month and is generally declining. Resident #57 explained she believes they now transfer her with the mechanical lift because they were rushing her during the sit to stand lift transfers, not allowing time for her body to adjust when going from a lying to sitting position. This led to her feeling a head rush and becoming lightheaded. The resident voiced she is terrified of the mechanical lift.<br><br>The use of a mechanical lift requires two staff. The census at the time of the survey was 108, with 52 residents on Riverwatch, the unit where Resident #57 resides. Of the 52 residents on that unit, 25 required two person assistance for either care, transfers, or both.<br><br>b) On 08/05/24 at 10:45 AM, Resident #54, who was cognitively intact with a BIMS of 14, stated sometimes staff tell her they will be back in two hours or I'm busy I have 10 other patients to take care of. The resident explained her call bell will either ring for hours or they come in and turn it off and say they will be back.<br><br>c) On 08/05/24 at 11:15 PM Resident #12, who was cognitively intact with a BIMS of 12, complained there was not enough staff to care for him timely. The resident stated it takes 30 to 60 minutes for staff to answer call lights. The resident stated when he fell on ce it took 30 minutes to help him after the fall, even with him yelling out for help.<br><br>d) On 08/05/24 at 11:42 AM, Resident #74, who was cognitively intact with a BIMS of 14, stated that staff are always running, and they tell her they never get breaks and that they are short staffed.<br><br>e) On 08/05/24 at 11:57 AM, Resident #18, who was cognitively intact with a BIMS of 15, stated it can take up to two hours for staff to answer the call light.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | f) On 08/05/24 at 1:23 PM, Resident #26, who had some cognitive impairment with a BIMS of 6, but could hold a conversation, stated she felt they could use a little more staff. The resident stated she can sometimes tell when she has to go to the bathroom, but by the time the aide arrives she has gone in her diaper. when asked how that makes her feel, Resident #26 stated, terrible.<br><br>g) On 08/05/24 at 1:51 PM, a family member of Resident #29 stated there was not enough staff on all shifts, and that the weekends are the worse.<br><br>h) On 08/05/24 at 2:30 PM, when asked if there was enough staff, Resident #3, who had some cognitive impairment, stated there was not, explaining she needed help repositioning and staff take a long time to answer the call bells.<br><br>i) On 08/05/24 at 3:15 PM, Resident #49, who was cognitively intact with a BIMS of 15, stated the facility was understaffed, the CNAs were overworked, and they were always running. Resident #49 stated she was not as mobile as she was now, she had an accident (voiding incontinence) because it took too long for the CNAs to answer the call light. The resident further explained if she does not turn quickly enough when they ask her to while in the bed, the CNAs will just push her over, and not very gently.<br><br>j) On 08/06/24 at 8:35 AM, Resident #40 who was cognitively intact with a BIMS of 15, stated there was not enough staff, and that they are under paid and over worked on all shifts. Resident #40 stated she waits an hour for staff to assist her, and by that time she has soiled my diaper.<br><br>j) On 08/06/24 at 9:56 AM, Resident #34, who was was cognitively intact with a BIMS of 15, stated there was not enough staff and stated he thought it was a corporate issue for not bringing in the staff.<br><br>k) On 08/06/24 at 10:38 AM, Resident #372, who was cognitively intact with a BIMS of 12, stated staff do not answer call bells timely and he feels ignored. The resident further stated the staff do not answer the call bell timely, so he ends up being incontinent instead of helped to the bathroom.<br><br>l) On 08/06/24 at 1:19 AM, Resident #366, who was cognitively intact with a BIMS of 14, stated he waits a long time for assistance to get out of the wheelchair and back to bed.<br><br>During an interview on 08/08/24 at 12:29 PM, the Director of Nursing (DON) stated they have plenty of CNAs, but the weekends are a challenge because they work every other weekend. The DON was made aware of the number of complaints related to staffing and agreed something needed to be done.<br><br>2) The survey process revealed the facility failed to ensure care and services were provided in a dignified manner for Residents #3, #26, #49, #54, #74, and #372 (Refer to F550). These residents stated there was not enough staff to care for the needs of residents and that the care they did receive was often in an undignified manner. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>39142<br><br>Based on interview, record review and observation, the facility failed to keep medications secured as evidenced by an observation of dispensed and open medications at the bedside for 1 of 1 sampled residents (Resident #55) and failed to ensure medication carts were free of expired medications in 1 of 3 medication carts with the potential to negatively affect 1 resident (Resident #314), who was prescribed Ferrex 150 MG, which was expired.<br><br>The findings included:<br><br>The facility's Pharmacy Services and Procedure Manual, last revised 08/07/23, under the Procedure section has requirements listed in numerical sequence. Item #2 is worded as follows:<br><br>Facility should ensure that medications and biologics are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding.<br><br>Item 3.3 is worded as follows:<br><br>Facility should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that inaccessible by residents and visitors.<br><br>Item 4 is worded as follows:<br><br>Facility should ensure that medications and biologics that: (1) have an expired date on the label; (2) have been retained longer than recommended by the manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated , are stored separate from other medications until destroyed or returned to the pharmacy or supplier.<br><br>Item 5 is worded as follows:<br><br>Once any medication or biologic package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened.<br><br>1) Record review revealed Resident #55 has a Brief Interview for Mental Status (BIMS) score of 14/15, which is considered cognitively intact.<br><br>Resident #55 has medications administered by mouth in the mornings. The following is a list of medications which is not inclusive of all medications:<br><br>- Metoprolol Tartrate Oral Tablet 25 MG Give 1 tablet by mouth two times a day for HTN (Hypertension) Hold for SBP (Systolic Blood Pressure)<110, HR (Heart Rate)<60 (Active)<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Methadone HCl Oral Tablet 10 MG Give 1 tablet by mouth two times a day for pain (Active)<br><br>- Metformin HCl Oral Tablet 500 MG Give 1 tablet by mouth two times a day for Hypoglycemia (Active)<br><br>- Lactobacillus Oral Capsule Give 1 capsule by mouth one time a day for supplement (Active)<br><br>- Apixaban Oral Tablet 5 MG Give 1 tablet by mouth every 12 hours for AFIB (Atrial Fibrillation) (Active)<br><br>- Amlodipine Besylate Oral Tablet 5 MG Give 5 mg by mouth one time a day for HTN hold for SBP <110; HR <60 (Active)<br><br>On 08/6/2024 at 9:59 AM, while interviewing Resident #55, it was noted that the resident had medications laying on a napkin. The resident explained he was waiting for the nurse to come back with a medicine cup so he could take the medications. Resident # 55 explained he had poured his medications onto a napkin because he was suspicious that one of the medications was not one he was taking before. Resident #55 stated the nurse took away the medicine cup after he poured the medications out. The nurse came into the room, while the surveyor was present, and showed Resident #55 the medication cards for the medications given to Resident #55. Resident #55 was satisfied with the nurse's explanation and took his medications at that time in the presence of the nurse.<br><br>Photographic Evidence Obtained<br><br>39167<br><br>2) On 08/07/24 at 2:13 PM the medication storage review process was started at the Ocean Unit, medication cart #2 was audited (this cart had medications for Residents in rooms 213-226). There were 3 bottles of expired medications found in the cart included: 2 bottles of Ferrex (iron) 150 mg which was open and a bottle of Ibuprofen 200 mg which was open, the medications were expired in July 2024. At 2:15 PM the Ocean Unit Manager was asked to print out a list of residents who were on those medications. It was revealed Resident #314 was on Ferrex 150 mg. Clinical record review for Resident #314 showed evidence he received Ferrex 150 mg on 08/06/24 and 08/07/24 at 8 AM. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>25404<br><br>Based on menu and recipe review, observation, and interview, the facility failed to ensure an adequate protein portion for all residents eating the regular meal for lunch on 08/07/24. Upon entrance there were 108 residents in the facility with the potential to affect the 70 residents who consume a regular diet, including sampled Residents #77, #164, #49, #34, #54, #57, #53, #74, #76, #3, #12, and #55.<br><br>The findings included:<br><br>Review of the menu for Week 2 revealed the lunch for Wednesday 08/07/24 included kielbasa with peppers and onions. The kielbasa was the meat protein for that meal. Review of the diet spread sheet for the meal documented the serving size to be 4 ounces of kielbasa with 2 ounces of the peppers and onions. Review of the production recipe instructed to serve 4 ounces of sausage (kielbasa) with 3 ounces of vegetables.<br><br>An observation of the lunch line service on 08/07/24 beginning at 11:20 AM revealed a large pan on the steam table containing sliced kielbasa mixed with onions and green peppers. Staff D, the cook for that day, used a 4-ounce ladle to portion out and serve the kielbasa and vegetables for each resident. Observations were made of the entire first and second carts that serviced the restorative and main dining room. Each portion of kielbasa and vegetables had about 6 slices of the kielbasa, give or take one slice.<br><br>At the end of the service on 08/07/24 at approximately 12:50 PM, the cook was asked to weigh 6 slices of the kielbasa, the protein served for the regular diet. The cook agreed that was the average number of slices provided to each resident. The weight of the kielbasa was 2.4 ounces (Photographic Evidence Obtained). During a side-by-side review of the diet spread sheet and recipe, both the cook and CDM (Certified Dietary Manager) agreed an inadequate protein portion was served. |