STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106047	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center at Inverrary	4300 Rock Island Road Lauderhill, FL 33319

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38349 Based on review of policy and procedure, observation, interview and record review, the facility failed to follow physicians' orders for medication parameters for an antihypertensive medication; and for a vitamin supplement for 1 of 6 sampled residents, Resident #51, located on the [NAME] wing. The findings included: Review of the facility policy and procedure on 04/16/24 at 1:15 PM titled Administration of Medication provided by the Director of Nursing (DON) reviewed 08/24/23 documented in the Policy Statement: The facility will ensure that medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms. Review of the record revealed Resident #51 was readmitted to the facility on [DATE] with diagnoses that included Dementia, Hypertension, Atherosclerotic Heart Disease, Anxiety Disorder, Anemia, Depression and Bipolar Disorder. The record documented a Brief Interview Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Review of the April 2024 Medication Administration Record (MAR) documented a physician's orders for the following: Atenolol 25mg one (1) tablet daily for Hypertension, with parameters to hold the medication if the heart rate was less than 60 bpm (beats per minute) and notify the physician; and Multivitamin (MVI) with minerals supplement one (1) tablet daily for Anemia. On 04/15/24 at 9:45 AM, Staff C was observed preparing and administering the Atenolol 25mg one (1) tablet to Resident #51. The documented heart rate of the resident was 55bpm. There was no evidence the physician was notified until the surveyor intervened. Further observation revealed Staff C prepared and administered a 'Multivitamin without the Minerals' to Resident #51. On 04/15/14 at 11:10 AM, an interview with Staff C revealed she was not aware of the parameters for the medication Atenolol but acknowledged it should have been held due to pulse rate of 55 and the physician should have been notified. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff C further stated the Multi-Vitamin with Minerals Tablet was not administered but just a MVI was given to the resident. In review with the nurse, the eight (8) minerals that were not in the MVI included Pantothenic Acid, Iron, Iodine, Magnesium, Zinc, Selenium, Manganese and Chromium. Staff C acknowledged the MVI she gave did not have the minerals in it and there was no bottle of MVI with Minerals in her medication cart. On 04/15/24 at 11:59 AM, an interview was conducted with Staff D, Registered Nurse (RN) / Assisted Director of Nursing (ADON) / Charge Nurse for the [NAME] wing, regarding the Atenolol and MVI tablet given to Resident #51 by Staff C. Staff D added that Physician's orders should always be followed. The physician was not notified regarding the low heart rate until 2.5 hours later, after surveyor intervention. On 04/15/24 at 2:40 PM, the Director of Nursing (DON) was made aware of the above findings and acknowledged Staff C did not follow the physician orders for the administration of the antihypertensive and the multivitamin.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to initiate care plans for the use of bed rails/side rails and accurately assess 5 of 5 sampled residents reviewed for the use of side rails, (Residents #25, #46, #89, #258 and #259); failed to honor a resident's representative declining the use of bed rails/side rails for 1 of 5 sampled residents reviewed for side rails/bed rails, (Resident #258); failed to obtain orders for the use of side rails/bed rails for 1 of 5 sampled residents reviewed for side rails/bed rails, (Resident #259); and failed to assess for the potential risks associated with the use of side rails for 5 of 5 sampled residents reviewed for side rails/bed rails, (Resdents #25, #46, #89, #258 and #259). The findings included: The facility's policy titled, 'Bed Rails - Safe and Effective Use of Bed Rails, most recently revised on 12/03/22, documented: Definitions Bed Rails - Also known as side [NAME], are adjustable metal or rigid plastic bars that attach to the bed .All alternatives should be considered, and bed rails should only be used when identified need outweighs potential risks. Procedure 1. Residents will be assessed upon admission, readmission, or upon initiation utilizing the Evaluation for Use of Bed Rails Assessment (Admission/Readmission/Initial). 2. If bed rails are determined to be appropriate for use with a resident, a reassessment of bed rail(s) use will be assessed at a minimum of quarterly and potentially with a change of condition utilizing the Evaluation for Use of Bed Rails Form (Quarterly). 3. If a bed rail(s) will be utilized the risks and benefits of bed rail(s) usage will be reviewed with the resident and/or resident representative and consent will be obtained prior to installation of the bed rails or as soon as practically possible. The facility should use the Med-Pass Clnsent for Use of Bed Rails. 4. The facility will document alternatives to the use of a bed rail(s) and how these alternatives did not meet the resident's assessed needs prior to the utilization of a bed rail(s). 5. A person-centered care plan will be developed within 48 hours of admission to address the bed rail(s), if indicated. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. The interdisciplinary team will review and revise the care plan, if indicated, upon completion of each comprehensive, significant change and quarterly MDS for the need to continue the use of bed rail(s). During an interview, on 04/18/24 at 10:11 AM with Staff E, LPN, and Staff F, RN/Unit Manager, when asked about residents being assessed upon admission, Staff E replied, 'head to toe, lung sounds, head, eyes, vitals and then we listen to the bowel sounds, we assess the skin and the heel for openings. We ask why they are here, if they are alert and oriented, we ask them to sign an informed consent for treatment if they are not able to, we call the representative. If the patient is alert, we call the family member to let them know that the resident is admitted to the facility. When asked about assessments for the use of bed rails, Staff E replied, We don't assess them, the next shift does. When asked about initiating care plans for the use of bed rails/side rails, Staff F stated, most of the families and residents request a quarter rail, we call them quarter rail because they don't go all the way to the middle of the bed. MDS does the care plans for side rails. When asked about the use of side rails/bed rails, Staff E stated that the rails were being used as security and as a means to prevent residents from falling from the bed. 1). Resident #25 was admitted to the facility on [DATE]. According to the resident's most recent full assessment, a Quarterly Minimum Data Set (MDS), dated [DATE], Resident #25 had a Brief Interview for Mental Status (BIMS) score of 13 indicating that the resident was 'cognitively intact'. The assessment documented that Resident #25 had no impairments to upper and lower extremities and was independent with transfers. Resident #25's diagnoses at the time of the assessment included: Coronary Artery Disease (CAD), Hypertension, Diabetes Mellitus (DM), Hyperlipidemia, Parkinson's disease, Malnutrition, Depression, Bipolar Disorder, Chronic Lung Disease, Unsteadiness on feet, Lack of Coordination, Gastroesophageal Reflux Disease (GERD), Benign Prostatic Hyperplasia, Altered Mental Status, Acute Embolism and Thrombosis of Left Lower Extremity. Resident #25's orders dated 10/31/23 included: SIDE RAILS FOR SUPPORT AND STABILITY DURING TRANSFERS AND BED MOBILITY. Resident #25's care plan for Activities of Daily Living (ADLs), initiated on 11/06/23 revised on 02/06/24, and a target date of 05/06/24, documented, Resident has an ADL self-care performance deficit r/t (related to) functional decline. The goal of the care plan was documented as, The resident will improve current level of function in toileting and transfers through the review date. Resident will be able to: toilet self with partial/mod assist and transfer with supervision. Interventions to the care plan included: SIDE RAILS: half rails up as per doctors order for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. In the section of a 'Quarterly Evaluation for Use of Bed Rails' dated 01/30/24 the question regarding 'What were the alternatives that were attempted since last review' the facility answered 'none'. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An 'Evaluation for Use of Bed Rails', dated 10/31/23, the question, 'Were appropriate alternatives attempted prior to considering bed rails' the facility answered 'yes'. For the follow up question (If yes, describe), the form was left blank. For the question in the evaluation 'Are bed rails being considered related to medical diagnosis; the facility answered 'Yes'. The follow up question (If yes, what is the medical diagnosis), the form was left blank. Further review of the resident's care plans revealed that there was no care plan for side rails and no assessment to determine the potential risks associated with the use of bed rails/side rails. During an interview, on 04/16/24 at 9:13 AM, when asked about the use of side rails, Resident #25 replied, It keeps me from falling out of bed I guess. Resident #25 further stated that he was not able to raise and lower the rails himself. During the interview and throughout the survey, Resident #25 was noted to have side rails that were from the resident's head of bed to approximately the middle of the bed on both sides of the bed. During an interview, on 04/18/23 at 9:20 AM, with the Director of Rehabilitation, when asked about the use of side rails, the Director or Rehabilitation replied, It is an enabler to help him move from side to side in the bed. He should have a quarter rail to use as an enabler. The Director of Rehabilitation confirmed that the rails that were being used for the resident were half rails and not quarter rails/enablers. 2). Record review revealed Resident #46 was admitted to the facility on [DATE]. According to the resident's most recent annual MDS assessment, dated 01/23/24, documented Resident #46 had a BIMS score of 14, indicating the resident was 'cognitively intact'. The assessment documented that Resident #46 had no impairment to upper and lower extremity and was dependent upon staff for transfers. The MDS documented that Resident #46 required Substantial/Maximal assistance to: roll left and right, sit to lying, lying to sitting. Resident #46s diagnoses at the time of the assessment included: Heart failure, Hypertension, Hyperlipidemia, Depression, Chronic lung disease, Syncope and collapse, Muscle weakness, Lack of coordination, Osteoarthritis, Pressure ulcer of sacral region, Need for assistance with personal care, Autonomic Neuropathy, and Atrial flutter. Resident #46's orders dated 10/16/23 included: SIDE RAILS FOR SUPPORT AND STABILITY DURING TRANSFERS AND BED MOBILITY. Resident #46's care plan for activities of daily living, initiated 01/26/21 with a revision date of 04/28/22, documented, The resident has an ADL self-care performance deficit related to (r/t) history (hx) of neuropathy, chronic back pain and limited mobility. The goal of the care plan was documented was, The resident will improve current level of function through the review date. - 01/26/21 with a revision date of 02/02/23 and a target date of 07/22/24. Interventions included: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SIDE RAILS: half rails up as per doctor's order for safety during care provision, to assist with bed mobility, rolling supine to sit and self-repositioning. Observe for injury or entrapment related to side rail use. 11/12/21. Further review of the resident's care plans revealed that there was no care plan for side rails and no assessment to determine the potential risks associated with the use of bed rails/side rails. An 'Evaluation For Use of Bed Rails', dated 10/16/23 documented: Is Resident being considered for Bed Rail or assistive device for the bed? NO 'Evaluation For Use of Bed Rails', completed by Staff F, RN/Unit Manager, dated 06/21/23, documented: Bed rail(s) is/are recommended at this time due to:, the facility did not provide an answer. The evaluation documented that the rails were requested by the resident. A 'Quarterly Evaluation For Use of Bed Rails', dated 03/22/23 (most recent full assessment) documented: 1. Are bed rails still appropriate for this resident? Yes 2. What were the alternatives that were attempted since last review? There were no alternatives documented and the question was not answered. 17. Is resident taking medications that require increased safety measures? Yes 17a. If yes, describe. There were no medications listed 21. Physical limitations. Yes 21a. If yes describe. There were no limitations listed. On 04/16/24 at 8:28 AM, Resident #46 was observed in bed eating breakfast independently with half bed rails on both sides of the bed in a raised position. During an interview, on 04/16/24 10:16 AM, when Resident #46 was asked about the bad rails, Resident #46 stated, they suck. When asked why the rails were installed, Resident #46 replied, so I don't fall out (of the bed). Resident #46 further stated he has no issues with falling out of bed and he was unable to raise and lower the bed rails. During the interview and throughout the survey, Resident #46 was noted to have half bed rails in place from the head of the resident's bed to approximately the middle of the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 04/18/23 at 9:20 AM, with the Director of Rehabilitation, when asked about the use of side rails, the Director or Rehabilitation replied, it is an enabler to help him move from side to side in the bed. He should have a quarter rail to use as an enabler. The Director of Rehabilitation confirmed that the rails that were being used for the resident were half rails and not quarter rails/enablers. 3). Resident #89 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, an Annual MDS, dated [DATE], Resident #89 had a BIMS score of 12, indicating that the resident was moderately cognitively impaired. The assessment documented that Resident #89 required 'Supervision or touching assistance' for rolling left and right in the bed, 'Substantial/maximal assistance' for sitting to lying on the bed and from lying to sitting and was dependent upon staff for transfers. Resident #89's diagnoses at the time of the assessment included: Hypertension, Hyperlipidemia, Hemiplegia, Depression, Dysarthria and Anarthria, Muscle Weakness, Lack of Coordination, Pain in Left Knee, Pain in Left Shoulder, Abnormalities of gait and mobility, Need for assistance with personal care. During an interview, on 04/15/24 at 12:59 PM, with Resident #89 and the resident's ex-wife, it was noted that Resident #89 had half bed rails in place from the head of the resident's bed to approximately the middle of the bed. When asked about the bed rails, the resident's ex-wife stated that the rails had been on the resident's bed prior to a fall that occured on 01/31/24. Further review of the resident's care plans revealed that there was no care plan for side rails and no assessment to determine the potential risks associated with the use of bed rails/side rails. An 'Evaluation for Use of Bed Rails', dated 02/07/24, documented: 2. Were appropriate alternatives attempted prior to considering bed rails? No 2b. Per resident request for need for positioning 1/4 rail. A 'Quarterly Evaluation for Use of Bed Rails', dated 03/27/23, documented: 1 Are bed Rails still appropriate for this resident? No 1a. contact practitioner to d/c any existing bed rail orders. During an interview, on 04/18/23 at 9:24, with the Director of Rehabilitation, when asked about the use of the bed rails for Resident #89, the Director of Rehabilitation stated, He has one side weakness, they are for mobility and ADLs that he is able to perform. He needs moderate assist for bed mobility, I would say that he needs an enabler (1/4 rail). The Director of Rehabilitation confirmed that the rails that were being used were half rails and not quarter rails. 4). Resident #258 was admitted to the facility on [DATE]. According to an Admission/readmission assessment, dated 04/10/24, Resident #258 required 'Extensive assistance' for bed mobility, and total assistance for ADLs. It was determined that Resident #258 was not interveiwable as the resident did not respond to being greeted by name. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #258's orders dated 04/10/24 included: SIDE RAILS FOR SUPPORT AND STABILITY DURING TRANSFERS AND BED MOBILITY. Further review of the resident's care plans revealed that there was no care plan for side rails and no assessment to determine the potential risks associated with the use of bed rails/side rails. An 'Evaluation for Use of Bed Rails', dated 04/10/24 (upon admission), documented: 2. Were appropriate alternatives attempted prior to considering bed rails? No 2b. If no, then bed rails should not be placed on resident's bed. Alternatives must be attempted prior to proceeding with placement of bed rails. If alternatives are attempted and proven unsuccessful, then a new evaluation needs to be completed. A 'Fall Risk Evaluation' dated 04/10/24, documented: E. confined to chair - does not use bed rails, trunk, or limb restraints. A 'Consent for Use of bed rails' signed by the resident's representative on 04/10/24' documented I do not consent to the use of bed rail(s) recommended above and understand related liabilities. On 04/17/24 at 1:07 PM Resident #258 was observed in bed with half rails in raised position to both sides of the bed. On 04/18/24 at 9:17 AM, Resident #258 was observed in bed with half rails in raised position to both sides of the bed. During an interview, on 04/18/23 at 9:24, with the Director of Rehabilitation stated, She is a new admit, PT and OT recommended to enhance mobility. I have her scheduled today. We did a screen with her when she came and determined that she needed PT and OT, but not speech. When asked about the use of bed rails/side rails, the Director of Rehabilitation replied, Bilateral to enhance her functional mobility and ADLs while in bed and to progress to a sitting position. Right now, she is advanced in her Parkinson's. The Director of Rehabilitation confirmed that the rails were half side rails. 5). Resident #259 was admitted to the facility on [DATE]. According to an Admission/Readmission Collection Tool, dated 04/11/24 (upon admission), Resident #259 was dependent upon staff for ADLs. An Admission/Readmission Progress note, dated 04/11/24, documented, [.] admitted today from [name of hospital] to room [room #], via [name of company] transportation, accompanied by his daughter, diagnosis with RIGHT SIDED INTRAPARENCHYMAL HEMORRHAGE. Resident alert and oriented x3. Further review of the resident's care plans revealed that there were no orders for bed rails/side rails, no care plan for side rails and no assessment to determine the potential risks associated with the use of bed rails/side rails. An 'Evaluation of Use of Bed Rails' done on admission (04/11/24), documented: 2. Were appropriate alternatives attempted prior to consider int bed rails? Yes (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2a. If yes, describe: there were no alternatives listed. 8. Are bed rails being considered related to medical diagnosis? Yes 8a. If yes, what is the medical diagnosis? There were no medical diagnoses listed. Will the bed rail assist the resident in: 10. bed mobility? Yes Transfers or to prevent falls? yes 21. Physical limitations: Yes 21a. If yes, describe: there were no physical limitations listed. 25. Would the use of bed rail(s) act as a physical restraint for this resident, impeding movement or limiting their daily activities? The facility did not provide an answer. On 04/17/24 at 1:07 PM, Resident #259 was observed in bed with half rails in raised position to both sides of the bed. On 04/18/24 at 9:17 AM, Resident #259 was observed in bed with half rails in raised position to both sides of the bed. During an interview, on 04/18/23 at 9:24, with the Director of Rehabilitation, when asked about the use of the bed rails/side rails, the Director or Rehabilitation replied, He has left sided weakness, so the goal in therapy is for him to roll from side to side, when he does ADL mobility when they change and clean him, he can use his good side to roll and participate. Half side rails or quarter rails would be beneficial to him.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31746 Based on the interview, observation, and records review, the facility failed to ensure that 1 of 5 sampled residents (Resident #42) was free from unnecessary medications by failing to timely relay recommendations made by the Consulting Pharmacist to decrease Resident #42's psychotropic medication, to Resident #42's Psychiatrist. The findings included: Record review revealed the Pre-Admission Screening and Resident Review (PASARR) level I dated 1/15/2019 documented that Resident #42 had diagnoses of: Depressive Disorder; Bipolar Disorder, and Psychosis. The Resident had a primary diagnosis of Dementia. The record showed that the resident did not exhibit or have suspicion of serious mental illness or Intellectual Disability. On 4/17/2024 at 11:29 AM, Resident #42 was observed in her room. Her Private Duty Aide was present sitting a few feet away from the resident. Resident #42 had a dismissive behavior. She refused to participate an the interview. Review of the Physicians Orders revealed Resident #42 was prescribed Risperidone 0.5 MG Tablet Give 1 tablet by mouth at bedtime related to Bioplar Disorder; Sertraline HCL 50 MG Tablet, Give 1 tablet orally one time a day for Depression. Review of the Behavior monitoring sheet documented, in the month of April 2024, that Resident #42's behaviors being monitored were: Depression, Mood Swing, Sadness, Irritabilities, Aggression, and Agitation, since November 29, 2023. Review of the Medication Administration Record (MAR) from 2023 to 2024 showed that Resident # 42 routinely received Risperdal (Risperidone) Oral Tablet 1 MG. The order showed to give 1 tablet by mouth at bedtime related to Other Bipolar Disorder. This dosage was administered since Resident #42's admission to the facility. On July 12, 2023, the dosage of 0.5 mg twice daily (BID) was discontinued to 0.5 mg once daily (QD). Review of the Annual Minimum Data Set (MDS) assessment dated [DATE], section C titled, Cognitive patterns, documented Resident #42 obtained a score of 3/15 on the Brief Interview for Mental Status (BIMS). This score indicated Resident #42's significant cognitive impairment. Section N of the MDS documented that Resident #42 routinely took antipsychotic medications. The Care plan dated 4/19/2024 documented the following: Resident #42's behavior problem was psychosis. Resident #42 was deemed to be not alert or oriented to person, place, or situation. Her Guardian preferred that Resident #42 not to be seen by the facility's Psychiatrist. Interventions include: o Resident #42 would not experience behaviors that are harmful to self and others through next review date. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Administer medications as ordered. o Anticipate and meet the resident's needs. o If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. o Observe behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Also, Resident #42 was noted to be resistive to care (refused shower and nail care) o The resident will cooperate with care through next review date The resident has had an actual fall with no injury, Poor Balance, Unsteady gait. o The resident will resume usual activities without further incident through the review date. [Resident] uses psychotropic medications and is at risk for side effects. o The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction, or cognitive/behavioral impairment through review date. On 04/18/24 at 11:16 AM, the Director of Nursing (DON) confirmed that Resident #42 was prescribed antipsychotic medications. She said that Resident #42 did not exhibit any behaviors and that she had a Private Duty Aid (PDA) for nearly three years or since the Resident's admission to the facility. Resident #42's behavior has been controlled and she did not exhibit any abnormal behaviors. Review of the Pharmacy consultation records documented that from November 2023 to January 2024 Resident #42's medications had no irregularities. However, on January 31, 2024, the Pharmacist recommended that a (GDR) gradual dose reduction be considered. The Consulting Pharmacist recommended a reduction of Risperidone dosage from 0.5 mg QD to 0.25 mg QD and recommended concurrent monitoring for reemergence of target behaviors and/or withdrawal symptoms. On February 2, 2024, the Primary Care Physician (PCP) denied the recommendation and placed a checkmark on rationale #1 of the Consultation Report which stated that: Continued use is in accordance with the current standard of practice and a GDR attempt at this time is likely to impair this individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder, as documented below. Yet, the PCP did not write any additional note as indicated above. (continued on next page)

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Life Care Center at Inverrary	4300 Rock Island Road Lauderhill, FL 33319

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Primary Care Physician on 04/18/24 at 12:05 PM, he said that the resident had a guardian whom he would need to consult for changes on Resident #42's medications, and a personal Psychiatrist who sees Resident #42 on a regular basis who must authorize GDR of Resident #42's psychiatric medications. He said that any recommendation for GDR should have been discussed with the guardian and the Resident's Psychiatrist. The PCP said that he did not yet discuss the GDR recommendation with them. The PCP acknowledged that he should have already discussed the issue with them since the recommendation was made on 1/31/2024. During an interview on 04/18/24 at 12:17 PM, Resident #42's Guardian said that no one had contacted her about discontinuing or reducing the Risperidone dosages. She said that Resident #42's Psychiatrist would need to decide on it. If the Psychiatrist agreed to discontinue the medication, she would have no problem with that. On 04/18/24 at 12:24 PM, the PCP contacted Resident #42's Psychiatrist to inform him of the Pharmacist's recommendation to decrease the dosage of 0.5mg to 0.25 mg QD. The PCP stated that the Psychiatrist said he must meet with the resident to determine whether to discontinue the Risperdal altogether.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38349 Based on review of policy and procedure, observation, interview and record review, the facility failed to ensure that it secured 1) over-the-counter (OTC), prescription pill medications; and 2) one (1) Nebulizer treatment medication solution for 1 of 6 sampled residents (Resident #51) observed during a Medication Administration Observation, in 1 of 3 units; the facility's Locked Dementia Unit. The findings included: Review of the facility policy and procedure titled, Long-Term Care (LTC) Facility's Pharmacy Services and Procedures Manual 5.3 Storage and Expiration Dating of Medications, Biologicals revised on 08/07/23, documented in the Policy Statement: Applicability: This Policy 5.3 sets forth the procedures relating to the storage and expiration dates of medications, biologicals, syringes and needles. Procedure: 1. Facility should ensure that only authorized facility staff, as defined by facility, should have possession of the keys, access cards, electronic codes, or combinations which open medication storage areas. Authorized staff may include nursing supervisors, charge nurses, licensed nurses, and other personnel authorized to administer medications in compliance with Applicable Law 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 1) Resident #51 was readmitted to the facility on [DATE] with diagnoses which included: Dementia, Hypertension, Atherosclerotic Heart Disease, Anxiety Disorder, Anemia, Depression and Bipolar Disorder. She had a Brief Interview Mental Status (BIM) score of 3 (severely impaired). On 04/15/24 at 9:39 AM Staff C, a Licensed Practical Nurse (LPN) was initially observed placing Resident #51's cup with eleven (11) different OTC, prescription pill medications, and a Nebulizer treatment medication inhalation suspension on a medication tray on the over bed table, right next to Resident #51's bed, making it accessible to this resident, other wandering residents on the unit, other staff members and visitors. Staff C was then observed leaving Resident #51's bedside to go into the bathroom, beyond a solid wall, to wash her hands for 25-30 seconds leaving the eleven (11) different medications unattended and out of her line of sight, during a Medication Administration, in the facility's Locked Dementia Unit, with a total of at least four (4) residents with Dementia, that ambulate and wander throughout the locked unit. Photographic Evidence Obtained. 2) On 04/15/24 at 9:45 AM, Staff C, was again observed placing Resident #51's medication tray with one (1) Nebulizer treatment medication inhalation suspension on the bedside table. Next, Staff C was observed exiting Resident #51's room to go to her one (1) [NAME] Medication cart, to obtain some additional apple sauce for Resident #51 to take a pill that she had previously prepared to administer to the resident. Thus, leaving the Nebulizer medication inhalation suspension unattended and out of her line of sight, during the same Medication Administration Observation. Photographic Evidence Obtained. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	For April 2024, the Medication Administration Record (MAR) documented physician's orders for the following (11) different OTC, prescription pill medications, and a Nebulizer treatment medication inhalation suspension as: Aspirin chewable 81mg 1 tablet daily for Atherosclerotic Heart Disease, Tylenol ES 500mg 1 tablet twice daily (BID) for Pain, Vitamin D3 2,000 units daily for Vitamin D Deficiency, Multivitamin with vitamins supplement one (1) tablet daily for Anemia, Eliquis 5mg 1 tablet BID (twice daily) for Deep Vein Thrombosis Prophylaxis, Atenolol 25mg 1 tablet daily for Hypertension, Amlodipine 10mg 1 tablet daily for Hypertension, Sertraline 25mg 1 tablet daily for Depression, Quetiapine 25mg 1 tablet daily for Bipolar Disorder, Losartan 50mg 1 tablet daily for Hypertension, Budesonide Inhalation suspension 0.5mg-2ml inhale 1 vial BID for Asthma, and Ferrous Sulfate 7.5ml BID for Anemia. Side-by-side record review was conducted with Staff C, in which it was noted that neither Resident #51's hard copy chart nor her computerized Point-Click-Care (PCC) medical record indicated that Resident #51 had any self-assessment completed in order for her to be able to administer her own medications. On 04/15/24 at 10 AM, an interview was conducted with Staff C, in which she acknowledged that the OTC, prescription pill medications and Nebulizer treatment medication inhalation suspension should not have been left unattended at Resident #51's bedside. On 04/15/24 at 10:05 AM, an interview was conducted with Staff D, a Registered Nurse (RN)/Assisted Director of Nursing (ADON)/Charge Nurse for the one (1) [NAME] wing, regarding the unattended OTC, prescription pill medications and Nebulizer treatment medication inhalation suspension, and she also acknowledged that the medications should not have been left unattended at the Resident #51's bedside. The DON further recognized and acknowledged on 04/15/24 at 1:28 PM that the unattended eleven (11) OTC, prescription pill medications and Nebulizer treatment medication inhalation suspension, should have been secured and not left unattended at Resident #51's bedside.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews, and record review, the facility failed to clean and disinfect the glucometer per manufacturer's instructions for 4 out of 4 sampled residents reviewed for blood glucose monitoring (Resident #29, #70, #80, and #93). The facility failed to properly perform hand hygiene during medication administration observation for 4 out of 6 sampled residents reviewed for medication administration (Resident #52, #76, #77, and #78). In addition, the facility failed to implement proper signage for Contact Precautions as per Physician's orders for 1 out of 2 sampled residents reviewed for Transmission-Based Precautions (Resident #311). The findings included: Review of the facility's policy titled, Cleaning and Disinfection of the Glucometer, dated 09/20/23, included the following: To prevent the spread of infection, specifically blood borne pathogens through the use of point of care blood glucose monitoring, by cleaning and disinfecting glucometers after each resident use. Glucometer Reference Manual: To minimize the risk of transmitting blood borne pathogens, the cleaning and disinfection procedure should be performed as recommended in the instructions below. The meter should be cleaned and disinfected after use on each patient. The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfection procedure. The disinfecting procedure is needed to prevent the transmission of blood borne pathogens. Only wipes with EPA registration numbers listed below have been validated for use in cleaning and disinfecting the meter. Super Sani-Cloth Germicidal Disposable Wipe EPA #9480-4 Review of the facility's policy titled, 6.0 General Dose Preparation and Medication Administration dated 01/01/22, included the following: This Policy 6.0 sets forth the procedures relating to general dose preparation and medication administration. Procedure 2. Prior to preparing or administering medications, authorized and competent Facility staff should follow Facility's infection control policy (e.g. handwashing). Review of the facility's policy titled, Hand Hygiene, dated 06/13/23, included the following: The facility has adapted the CDC Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings for indications for hand hygiene that are generally consistent with the WHO 5 moments for hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure: 2. Associates perform hand hygiene (even if gloves are used) in the following situations: a. Before and after contact with the resident. c. After contact with objects and surfaces in the resident's environment. Handwashing: Wet your hands and wrists and apply soap from a dispenser. Vigorously rub your hands together for at least 20 seconds. Rinse your hands and wrists well. Pat your hands and wrists dry with a paper towel. Review of the facility's policy titled, Transmission-based Precautions and Isolation Procedures dated 05/24/23, included the following: The facility will implement and utilize transmission-based precautions to ensure the mitigation of infection spread and to ensure standards of infection prevention and control are followed. Procedure: 4F. When a resident is placed on transmission-based precautions, the staff should implement the following: The type or type(s) of precautions and the appropriate PPE (Personal Protective Equipment) to be used. Place type precautions signage to be initiated (may be more than one type), on the outside of the resident room in a conspicuous place such as the door or on the wall next to the doorway identifying the CDC category or categories of transmission-based precautions (e.g. contact, droplet, airborne, or enhanced), instructions for use of PPE, and/or instructions to see the nurse before entering. 1) During an observation conducted on 04/16/24 at 3:50 PM noted Staff A, Licensed Practical Nurse (LPN) walking on the 2nd floor Unit with a small box containing lancets, alcohol wipes, and one glucometer placed on top of the lancets. She headed to a resident's room. Further observation revealed Staff A entered other residents' rooms with the same small box containing the above contents. The surveyor approached Staff A and inquired about the box with the lancets, alcohol wipes, and glucometer. She stated that she checked the blood glucose level for four residents (Resident #29, 70, 80, and 93). She also stated that she cleaned the glucometer in between each resident using the alcohol wipes. Staff A also stated that she was not sure if using the alcohol wipes is per facility's policy, however, she is aware that the glucometer must be cleaned prior to each resident's use. At this time, Staff A stored the small box and its contents in the top drawer of the medication cart without cleaning and disinfecting the glucometer. (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 conducted on 04/16/24 at 5:15 PM with the Director of Nursing (DON), she stated that there are two glucometers in each of the medication carts. In addition, she stated that the reason for two glucometers is to disinfect one after checking resident's blood glucose, and then use the other glucometer for the next resident while the first one is drying. The DON also stated that every medication cart has Sani-Wipes specifically for cleaning and disinfecting the glucometers. 2) A medication administration observation was conducted on 04/16/24 between 3:56 and 4:34 PM with Staff A, LPN for Residents #76, #77, and #52. After administration of medications for Resident #76 and Resident #52, Staff A was observed entering the bathroom to wash her hands and washed her hands for five to six seconds. She then exited the resident's room and went to the medication cart to document on her computer, no hand sanitizer was utilized. Staff A moved to Resident #77's room for administration of the resident's eye drops. Upon entering Resident #77's room, Staff A did not don on gloves and proceeded to administer the eye drops to both eyes of Resident #77. She then stated that since she touched Resident #77's eyes, she would wash her hands. Staff A was observed entering the bathroom to wash her hands and washed her hands for ten seconds. A medication administration observation was conducted on 04/16/24 at 4:45 PM with Staff B, Registered Nurse (RN) for Resident #78. After administration of medications for Resident #78, Staff B was observed exiting the resident's room without performing hand hygiene. She then proceeded to document on her computer. 3) Record review for Resident #311 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Acute Osteomyelitis, Left Ankle and Foot. Methicillin Resistant Staphylococcus Aureus (MRSA) Infection as the cause of diseases classified elsewhere. Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #311 had a Brief Interview for Mental Status of 15, which indicated that he was cognitively intact. Review of Section O revealed that Resident #311 was not in isolation or quarantine for active infectious disease while at the facility. Section O also revealed that Resident #311 had an Intravenous (IV) midline access upon admission. Review of the Physician's Orders showed that Resident #311 had an order dated 04/05/24 for Contact Precautions MRSA in the wound. Review of the Care Plan dated 04/05/24 documented that Resident #311 had Infection (MRSA Left great toe). Goals were to resolve infection by review date (04/23/24). Interventions were to Encourage adequate nutrition and hydration, Enhanced Barrier Precautions (EBP), and administer medications as ordered. During an observation conducted on 04/15/24 at 11:57 AM, the surveyor noted an Enhanced Barrier Precaution sign posted on the wall by Resident #311's doorway. Resident #311 refused to speak with the surveyor. During an interview conducted on 04/15/24 at 1:45 PM, with Staff F, Licensed Practical Nurse (LPN) and Unit Manager for 2 West. She stated that Resident #311 is on Enhanced-Barrier Precautions (EBP) because he is receiving antibiotics via an IV line. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A tour of the 2 [NAME] Unit was conducted on 04/16/24 at 10:47 AM, the surveyor noted that the EBP sign was still posted on Resident #311's doorway. During an interview conducted on 04/16/24 at 2:30 PM with the DON, the surveyor inquired why Resident #311 was placed under EBP. She stated that Resident #311 has an IV midline for administration of antibiotics. She also confirmed that Resident #311 has a diagnosis of MRSA in the wound. The surveyor asked the DON to review the resident Physician's orders regarding MRSA precautions. At this time, the DON noted that the posted signage on Resident #311's room was not following the Physician's orders for Contact Precautions.