STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106049	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of New Port Richey	7400 Trouble Creek Road New Port Richey, FL 34653

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 43453 Based on interview and record review, the facility failed to ensure resident council grievances were fully and promptly acted upon, for ten of ten resident council members who regularly attend the resident council meetings. Findings included. On 3/3/25 at 11:10 a.m., a resident council meeting was held with ten participants. The group confirmed on-going complaints related to the following: - Related to call lights - Sometimes it takes a while for them to answer, depending on who's on duty. Day shift is great, second shift is good, third shift is not so great. We have told the nurses .They don't have enough staff. When one pushes the bubble, no one comes. This has been discussed in council meetings. - They keep saying they are short of help. We have reported to staff. When they are short they pull restorative staff, which means restorative is not offered that day . - Call lights take too long to answer at night. They refuse to wear name tags, so you don't identify them. _ They said they will give us more TV stations. 10 or more they said. We voted which ones we wanted . there are not enough channels, the cable cuts in and out, we spoke to maintenance about it, spoke to [NHA]. They say it comes from direct TV. It is not resolved. - Residents requested to learn Spanish because the staff don't speak English. Discussed with [NHA] at the last meeting. Review of the Resident Council meeting minutes revealed the following: On 2/27/25 the residents held a resident council meeting and addressed unresolved grievances/complaints related to staff not wearing name tags, education for diabetic diets, getting a second rod in closets for low wheelchair users, learning Spanish, and making sure someone is covering for nursing staff when they go on breaks. The review showed these grievances were not logged in the grievance log and had not been documented as addressed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/23/25 a resident council meeting was held with the following issues raised: Residents asked to be provided names of department heads and what they do. Kitchen staff not wearing name tags, visitors not wearing name tags, visitors not signing in and out. The review showed these grievances were not logged in the grievance log and had not been documented as addressed. On 12/19/24 a resident council meeting was held with the following issues raised: concerns on going outside on the patio, and nursing staff to assist. No garbage bags in restrooms, ice water on each shift, residents requested a resident council rule book. The review showed these grievances were not logged in the grievance log and had not been documented as addressed. On 11/21/24 a resident council meeting was held with the following issues raised: Staff not wearing name tags. Staff not knocking on doors. Residents raised individual concerns. DON would educate nursing staff. Other concerns noted concerns with remotes, there should be more help. The review showed these grievances were not logged in the grievance log and had not been documented as addressed. Review of resident council meting minutes dated October 2024 showed will continue to remind staff to wear their name tags, There should be more help . The review showed these grievances were not logged in the grievance log and had not been documented as addressed. Review of a 9/26/24 resident council meeting minutes revealed: Name tags - who holds staff accountable. Residents feel a member of management needed to come back at night to verify staff are wearing their name tags. No team work. Had to wait 25 minutes for assistance because a CNA (Certified Nursing Assistant) came in to check call light stated she would find her aide instead of helping, staff telling a resident they will be right back and then does not return or you are waiting for long periods of time Staff introducing themselves at the beginning of shift. The review showed these grievances were not logged in the grievance log and had not been documented as addressed. On 03/05/25 at 3:14 p.m., an interview was conducted with the Activities Director (AD). The AD stated she did not know she should initiate grievances from resident council meetings. She stated they talked about them in the meetings. The Department heads should address them. She stated they did not log them or document specific follow-up. She stated they reviewed previous' meeting minutes during council meetings. She stated some of the resident's grievances were on-going, such as name tags and staff taking too long to answer call lights. On 03/05/25 at 08:26 a.m., an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated the AD documents resident's grievances from the resident council meeting minutes. He stated by the next day, most of them were addressed. He stated the AD reviewed them with the IDT (interdisciplinary) team, and the department heads addressed the issues. He stated some of the resident's concerns were generalized, but they investigated and let the AD know to document the resolution in the resident council meeting minutes. He stated responses were reviewed at the next meeting and discussed with the residents to see if it was better. The NHA stated the outcome should be documented on the council form. The NHA reviewed on-going documented grievances and said, I see there is an opportunity for education. we should be documenting the grievances, adding to the log, and following up on resolutions. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility policy titled Resident Council, dated 09/26/24 showed the facility will assist residents all their families whenever they wish to organize the facility will provide space privacy for meetings and staff support. 3. The activities director of social services director will facilitate follow-up on all complaints, suggestions and ideas presented at the council meeting and will report results at the next meeting for the residents information. This information will be included in the minutes. 4. Each department director will be responsible for filling out a comment and concern form prior to the next meeting to provide his or her input. Review of a facility policy titled Grievance Program (Concern and Comment), revised 1/7/25 showed residents and their families have the right to file a complaint without fear of reprisal. the facility must make prompt efforts to resolve grievances the resident may have. The executive Director and / or designee is responsible for 2. Ensuring that all grievances and concerns and comment reports have been reviewed and addressed in a timely and appropriate manner and that concerned individuals feel that some type of resolution has been communicated.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on record review and interview, the facility failed to ensure the comprehensive Minimum Data Set (MDS) assessments were accurately coded for two (#108 and #110) of fifty - six sampled residents. Findings included: 1. Resident #108 was admitted to the facility on [DATE] with diagnoses to include but not limited to Type 2 Diabetes Mellitus without Complications, Acute and Chronic Respiratory Failure with hypoxia, Major Depressive Disorder, Recurrent, Moderate Review of Resident #108's Minimum Data Set (MDS) dated [DATE], Section A- Identification Information revealed section A2105- Discharge Status was coded number 01 which indicated the resident discharged to home/ community. Review of a change in condition dated 12/17/2024 revealed Resident # 108 was transferred to the hospital for further evaluation and treatment for altered mental status, increased lethargy, no urinary output. Record review revealed Resident #108 Minimum Date Set (MDS) dated [DATE] was coded inaccurately revealing the resident was coded to discharge home/ community and not the hospital. 2. Resident # 110 was admitted to the facility on [DATE] with diagnoses to include but not limited to Acute Respiratory Failure with Hypoxia, Type 2 Diabetes Mellitus without Complications, Chronic Kidney Disease, Stage 3 Unspecified. Review of Resident #110 Minimum Data Set (MDS) dated [DATE], section A - Identification Information, section A2105 -Discharge Status was coded number 04 which indicated Resident #110 was discharged to short - term general hospital. Review of Resident #110's Discharge Summary dated 1/18/2025 revealed Resident #110 discharged home in stable conditions with his daughter. Record review revealed Resident # 110 Minimum Date Set (MDS) dated [DATE] was coded inaccurately revealing the resident was coded to discharged to the hospital and not home. An Interview was conducted on 3/4/2025 at 3:00 p.m. with Staff O, the Minimum Data Set (MDS) Coordinator. Staff O stated MDS used the discharge calendar to know if a resident had a planned discharge to go back to the community or home. They also looked at the dashboard in the Electronic Medical Record, and progress notes to see if a resident had been discharged to the hospital to know how to code the MDS accurately. Staff O stated Resident 108's MDS should have been coded to show the resident went out to the hospital and Resident #110 MDS should have been coded to show the resident was discharged home or back to the community. Staff O stated both residents MDS was coded inaccurately (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Interview was conducted on 3/4/2025 at 3:30 p.m. with the Director of Nurses, DON. The DON stated that her expectation was the Minimum Data Set (MDS) should be accurate to reflect the residents' discharge locations. The facility did not have a policy to include with this citation because they use the Resident Assessment Instrument, (RAI) to ensure the Minimum Date Set (MDS) is code accurate.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on record review and interview, the facility failed to complete/update the Pre-admission Screening and Resident Reviews (PASRRs) for residents with a mental disorder and individuals with intellectual disability following qualifying mental health diagnoses for six (#12, #57, #66, #30, #73, and #84) of 23 residents reviewed for PASRRs. Findings included: 1. Review of a level I PASRR for Resident #12 dated 8/9/22, showed the resident was screened upon admission for MI (mental illness) or suspected MI. The review showed the resident had diagnoses of Anxiety disorder, Bipolar disorder and depressive disorder. The review showed diagnoses of Bipolar disorder and depressive disorder were not indicated and the level I PASRR was not revised. Review of a level II screening and determination summary report showed during the time of submission, on 06/28/23 the diagnoses of Bipolar, dementia and major depression were not included for consideration. 2. Review of a level I PASRR for Resident #57 dated 9/9/20, showed the resident was not screened upon admission for MI (mental illness) or suspected MI. The review showed a blank PASRR, and the qualifying diagnoses were not submitted for consideration. Review of a level II screening and determination summary showed during the time of submission, on 06/14/23 the diagnoses of generalized anxiety disorder and major depressive disorder were not included for consideration. 46498 49227 3. Review of the admission record showed Resident #66 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include dementia -3/12/24, psychotic disorder-3/12/24, major depressive disorder - 3/12/24 , bipolar disorder 3-12-24, and mood disorder - 3/12/24. Review of level I PASRR for Resident #66 dated 8/15/24, showed qualifying diagnoses of depressive, bipolar and mood disorders and dementia were not checked. The review showed the Level I PASRR was incomplete, and a Level II was not submitted for consideration following qualifying diagnoses. 4. Review of the admission record showed Resident #30 was admitted to the facility on [DATE] with diagnoses to include dementia-1/9/25, depressive disorder-1/9/25, and anxiety disorder-1/9/25 Review of a level I PASRR for Resident #30 dated 1/6/25 showed a blank PASRR and the qualifying diagnoses were not checked. The review showed the Level I PASRR was incomplete, and a level II was not submitted for consideration following qualifying diagnoses. 5. Review of the admission record showed Resident #73 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnose to include PTSD (Post Traumatic Stress Disorder)-12/27/24, depressive disorder-12/1/24, and anxiety disorder-12/1/24. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a level I PASRR for Resident #73 dated 11/27/24, showed the qualifying diagnosis of PTSD was not documented. The review showed the Level I PASRR was incomplete, and a level II was not submitted for consideration following qualifying diagnoses. 6. Review of Resident #84's admission record revealed an admitted [DATE]. Resident #84 was admitted to the facility with diagnosis to include Parkinson's disease without dyskinesia, without mention of fluctuations (10/23/2024), major depressive disorder recurrent (11/30/224), post-traumatic stress disorder, unspecified (11/30/2024), and generalized anxiety disorder (10/23/2024). Review of Resident #84's Level I PASRR, dated 10/22/2024, showed the Level I PASARR was incomplete, and a level II was not submitted for consideration following qualifying diagnoses. Review of the facilities policy titled Pre-admission Screening and Resident Review PASRR), reviewed 9/26/24 showed the following: Policy: The facility will ensure that potential admissions are screened for possible serious mental disorders or intellectual disabilities and related conditions. This initial pre-screening is referred to as PASARR level I, and is completed prior to admission to a nursing facility. A negative level I screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. A positive level I screen necessitates an in-depth evaluation of the individual by the state designated authority, known as PASARR level II, which must be conducted prior to admission to the nursing facility. Procedure: 1. Ensure level I PASARR screening has been completed on potential admissions prior to admission. 2. A negative level I screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. 3. A record of the pre-screening should be retained in the residence medical record. 4. A positive level I screen necessitates an in-depth evaluation of the individual by the state designated authority, known as PASARR level II, which must be conducted prior to admission to a nursing facility. God 5. When a level II PASARR Screening is warranted, it must be obtained as well as the termination letter prior to admission. The level 2 PASARR cannot be conducted by the nursing facility. 6. With respect to the responsibilities under the PASARR program, the state is responsible for conducting the screens, preparing the PASRR report, and providing or arranging the specialized services that are needed as a result of conducting the screens. a. The State is required to provide a copy of the PASARR report to the facility. This report must list the specialized services that the individual requires and that are the responsibility of the State to provide. All other needed services are the responsibility of the facility to provide. 7. The level II PASARR determination and the evaluation report specify services to be provided by the facility and/ so or specialized services defined by the State. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Recommendations from PASARR level II determination and PASARR evaluation report are to be incorporated into the person-centered care plan as well as in transitions of care. 9. As part of the PASARR process, the facility is required to notify the appropriate state mental health authority or state intellectual disability authority when a resident with a mental disorder (MD) or intellectual disability (ID) has a significant change in their physical or mental condition. This will ensure that residents with a mental condition or intellectual disability continue to receive the care and services they need in the most appropriate setting. 10. Referral to the SMH/ ID authority should be made as soon as the criteria indicative of a significant change are evident. a. Each State Medicaid Agency might have specific processes and guidelines for referral, and which types of significant changes should be referred. Therefore, facilities should become acquainted with their own state requirements. 11. Facilities should look at their state PASARR programs requirements for specific procedures. PASARR contact information for the SMH/ ID authorities and the State Medicaid Agency. 12. The State must provide or arrange for the provision of specialized services to all nursing facility residents MD or ID in accordance with S483.120, whose needs are such that continuous supervision, treatment and training by qualified mental health or intellectual disability personnel is necessary, as identified in the resident's PASARR level II. a. Specialized services provided or arranged by the State may be provided in nursing facility or through off-site visits arranged by the nursing facility, while the resident lives in the facility. 13. Any resident with newly evident are possible serious mental disorder, ID or a related condition must be referred, by the facility to the appropriate state designated mental health or intellectual disability authority for review . 14. Referral for level II resident review evaluation is required for individuals previously identified by PASSARR to have a mental disorder, intellectual disability or a related condition who experience a significant change. 50434

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observation interview and record review, the facility failed to effectively assess and revise a resident's care plan following a significant weight loss for one resident (#162) of three residents reviewed for comprehensive assessments. Findings included: Review of a facility document titled Nutrition At Risk dated 2/27/25 showed Resident #162 had the following weights recorded: -On 2/18/25 the resident weighed 114.6 lbs. (pounds). - On 2/25/25 the resident weighed 108.6 lbs. - On 2/26/25 the resident weighed 102.8 lbs. The review showed a 10.53% weight loss. Review of a care plan last updated on 2/24/25 showed resident #162 - has nutritional problem related to Advanced age, Right Femur fracture with hemi-arthroplasty, Weakness, Dysphagia on altered diet consistency, Chronic Constipation, Dementia, and variable intake with refusals at times. The goal section showed - The resident will maintain adequate nutritional status as evidenced by maintaining weight at 115# with no significant change through the review date. Interventions included: RD (Registered Dietician) to evaluate and make diet change recommendations PRN (as needed). Administer medications as ordered. Lab/diagnostic work as ordered. Report results to MD (Medical Doctor) and follow up as indicated. Invite the resident to activities that promote additional intake. Observe and report PRN (as needed) any signs/symptoms of dysphagia: Pocketing, Choking, Coughing. Review of this care plan did not show updated interventions related to the significant weight loss noted on 2/26/25 On 03/02/25 at 10:38 a.m., Resident#162 was observed in the dayroom visiting with family members. The family members stated the resident had lost a lot of weight and did not eat very much anymore. Review of the admission record for Resident #162 revealed the resident was admitted to the facility on [DATE] with diagnoses to include dysphagia, oropharyngeal phase and unspecified protein - calorie malnutrition and unspecified dementia. Review of an order summary report dated 3/5/25 showed active orders for Resident #162 included a regular diet - mechanically altered texture, thin consistency, 2 cal. (calorie) Med Pass supplement two times a day, 120 ml (milliliters) and nutrition consult. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nutritional progress note for Resident #162 dated 2/27/25 revealed CBW (current body weight) 102.8 lb reflects -10.6% wt. (weight) loss x 1 week which is significant however reflects residents previous weight range of 97.0-111.0 in 2022. BMI 20.1 WNL. Staff to encourage PO fluids per orders. Potential for weight loss/decreased appetite r/t (related to) ABT (activity based) therapy. Variable PO (by mouth) meal intake noted along with refusal of meals per % PO intake documentation. Resident at risk for weight loss/nutritional decline r/t advanced age and disease process of Dementia. Recommend 2.0 Medpass 120 cc BID (twice daily) between meals. Will monitor weekly weight and f/u (follow up) prn (as needed). On 03/03/25 at 1:10 p.m. Resident #162 was observed in bed with her eyes closed. The resident did not respond to an interview. An immediate interview was conducted with Staff Q, Certified Nursing Assistant (CNA). She stated OT (Occupational Therapy) had assisted the resident with her meal earlier. She stated the resident had had an early tray for OT observation. She said, this resident does not eat much. We set up her tray. She stated Resident #162 was not assisted with her meal. Staff Q stated the resident ate less than 25% of her meal almost all the time. On 03/04/25 at 03:15 p.m., an interview was conducted with the facility's Diet Technician, (DT). The DT stated when a resident was admitted she did nutritional assessments, got nutrition intake and the initial assessment. She stated she set up meal preferences. She stated the dietician monitored weight loss and initiated the triggers. She stated she did not know this resident had a significant weight loss. She stated if she did, it would be documented in an assessment or the plan of care. On 03/05/25 at 11:20 a.m., an interview was conducted with the facility's Registered Dietician, RD. The RD stated she saw residents once a month. She stated for Resident #162, she had documented on her weight loss last week. She said the resident was on antibiotic therapy and staff should be encouraging her to eat her meals. She stated they should be documenting if she refused. She confirmed she had reviewed the resident's weight record and identified a significant weight loss. She stated she had recommended her for supplements. She stated she had not seen the resident in person. She stated if the resident was losing a lot of weight, there should be a follow -up. She stated majority of times the IDT (interdisciplinary team) would meet to discuss a plan for the change, and it would be documented. She stated they would discuss if the resident needed 1:1 assistance. The RD stated at the time the resident only required tray set up. She stated if her intake had changed, the CNA should be letting the nurse know and possibly obtain another weight. She stated as the RD, she would see them weekly and obtain weekly weights for monitoring. The RD confirmed the resident's assessment had not been updated. She confirmed the care plan should have been updated with new interventions. She confirmed the team had not met to address this resident's significant weight loss. On 03/05/25 at 11:51a.m., an interview was conducted with Resident #162's Occupational Therapist (OT). She stated they had been working on strengthening , standing dressing and toileting. She stated related to the resident's meal intake, she was able to independently scoop the meal and drink from the cup. She stated she had not assessed the resident for meal consumption. She said, intake was not the focus, but the ability to eat independently. She stated usually the dietician would come and speak with the DOR if there were weight loss concerns. She stated it should be documented in the notes and assessments. The OT stated the Director of Rehab (DOR) had been notified of the weight loss to see if there was any trouble with feeding. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled Comprehensive Care Plans and Revisions, dated 09/11/24 showed: The facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care. Procedure: I. The facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered plan of care. 2. When these changes occur, the facility should review and update the plan of care to reflect the changes to care delivery, this can include: a. Additional interventions on existing problems, b. Updating goal or problem statements c. Adding a short-term problem, goal, and interventions to address a time limited condition.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50434 Based on observation, record review, and interview, the facility did not ensure activities of daily living (ADLs) were completed and maintained for one (#91) of three residents sampled related to meals/snacks and three (#91, #16 and #49) of 23 residents sampled for hydration. Findings included: 1. During an interview on 03/02/2025 at 10:53 a.m., Resident #91 was observed lying in bed dressed for the day. Resident #91 stated she had had some weight loss, but had lost more because she had not felt like eating. During an observation on 03/03/2025 from 10:45 a.m. to 12:45 p.m., Resident #91 was observed sitting in a wheelchair in the activities room of the 100 unit. Resident #91 was observed to have no hydration. Her lips were noted to be dry and cracked. During an observation on 03/03/2025 at 12:48 p.m., Resident #91 was observed sitting in a wheelchair in the hallway. Staff was observed telling Resident #91 that she had a doctors appointment and they needed to get her ready to leave the facility. During an interview on 03/03/2025 at 4:34 p.m., Resident #91 stated she had not eaten lunch before her appointment and was not given anything to eat while away from the facility for her appointment. Resident #91 stated she had not been offered anything to eat when she returned to the facility after her appointment and was waiting for dinner. Review of Resident #91's admission record revealed an admitted [DATE]. The resident was admitted to the facility with diagnoses to include but not limited to, Type 2 Diabetes, unspecified protein calorie malnutrition, iron deficiency, and unspecified dementia. Review of Resident #91's Admission Minimum Data Set (MDS) dated [DATE], revealed Section C. Cognitive, a Brief Interview Mental Status (BIMS) of 15 out of 15 which indicated intact cognition. Section GG. Functional limitations revealed Resident #91 needed eating set up or clean up assistance. During an interview on 03/03/2025 at 12:53 p.m., Staff A, Certified Nurses Assistant (CNA) stated she did restorative and several other things like accompanying residents to appointments. She stated she was not sure when Resident #91 had breakfast, and that Resident #91's lunch tray would be saved for her to eat when she got back. She was not sure how long they would be gone for her appointment. She stated she had not thought of getting her a snack or bringing something with them for Resident #91 to eat since she was not getting her lunch tray. During an interview on 03/03/2025 at 4:45 p.m., Staff B, CNA, stated he was told the resident did not eat lunch and might be hungry when she got back from her appointment. He stated she returned to the facility around 3:15 p.m. and he had not offered her a meal or snack. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of New Port Richey	7400 Trouble Creek Road New Port Richey, FL 34653

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/03/2025 at 5:02 p.m., the Certified Dietary Manager (CDM), stated when a resident had an appointment the nurses usually notified her so she could arrange to send the food tray early so the resident could eat before their appointments. She was not aware of a resident having an appointment for today. During an interview on 03/03/2025 at 5:10 p.m., Staff C, Registered Nurse (RN), stated she was aware that Resident #91 went out to an appointment and returned to the facility around 3:15 p.m., she stated she was not aware that Resident #91 did not receive lunch. She stated she would expect the CNA to have offered the resident something to eat when she returned to the facility. During an interview on 03/03/2025 at 5:13 p.m., Staff D, Licensed Practical Nurse (LPN) Unit Manager, stated when residents had an appointment the nurse was responsible for notifying the kitchen the day of so they could send their food tray out early. She stated she was not aware Resident #91 did not receive her lunch. She stated she would expect the nurse to share this report with the oncoming nurse. 2. During an observation on 03/03/2025 from 10:45 a.m. to 12:45 p.m., Resident #16 was observed sitting in the activities room of the 100 hall. Resident #16 was observed with no hydration during this observation. Review of Resident #16's admission record revealed an admitted [DATE]. Resident #16 was admitted to the facility with diagnoses which included but not limited to Muscle Weakness (Generalized), Other Specified Noninfective Gastroenteritis And Colitis, Major Depressive Disorder, Dysphagia Following Cerebral Infarction, Vascular Dementia, Severe, With Mood Disturbance and Unspecified Protein-Calorie Malnutrition. Review of Resident #16 MDS Section C. Cognition revealed Resident is rarely/never understood. Section GG. Functional Limitations revealed Resident #16 needs substantial maximal assistance with eating. During an interview on 03/03/2025 at 1:00 p.m., Staff F, CNA, stated she was the CNA for Resident #16, and she constantly checks on her residents. She stated Resident #16 does not drink anything but Gatorade and just got up at 10 a.m. She was not sure how often she provides hydration to Resident #16. 3. During an observation on 03/03/2025 from 10:45 a.m. to 12:45 p.m., Resident #49, was observed sitting in the activities room of the 100 hall. Resident #49 was observed to not have hydration during this observation. Review of Resident #49's admission record revealed an admitted [DATE] with an initial admitted [DATE]. Resident #49 was admitted to the facility with diagnoses which included but not limited to Dysphagia, Oropharyngeal Phase, Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Unspecified, Unspecified, Gastro-Esophageal Reflux Disease Without Esophagitis. Review of Resident #49's quarterly dated 01/21/2025 revealed Section. C. Cognitive, a Brief Mental Interview Status (BIMS) of 00 which indicated severe cognitive deficit. Section GG. Functional limitations revealed Resident #49 require substantial maximal assistance with eating. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/04/2025 at 10:50 a.m., Staff E, Registered Nurse (RN) stated residents should all have water at the bedside. She stated signs a resident needed hydration were a dry mouth and cracks in the lips. She stated if she saw a resident with any of these symptoms, she would encourage more fluids and would ask the aides to include hydration with their care of the residents. She stated, I would think the CNAs should come in and check on resident's hourly. During an interview on 03/04/2025 at 10:51 a.m., Director of Nursing (DON) stated she would expect residents to be offered hydration at least once an hour and would expect residents in the activities room to either have a cup for hydration or staff to periodically check on the residents. She stated if a resident had an appointment at mealtime or if the resident was out for a meal, Dietary should be notified to get an early tray so that they can eat before they go out. If the residents were alert and oriented, they asked them if they would like to have a snack or a bagged lunch with them so they could have something to eat while they were gone. During an interview on 03/04/2025 at 1:45 p.m., the Regional Director of Clinical services stated they do not have anything that monitors resident hydration intake unless there are physician's orders. Review of the facilities policy titled Hydration and Nutrition dated 9/10/2024 revealed: Policy: Each resident receives a sufficient amount of food and fluids to maintain acceptable parameters of nutritional and hydration status. Procedure: 2. A minimum of three meals are provided each day. If a meal or food is refused, the resident is offered a substitute or a similar nutritive value. 4. Fluid is always available to residents. A hydration cart may be utilized.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observation, record review, and interview, the facility failed to follow-up on a physician order with a black box warning for one resident (#264) of fifty-one residents sampled. Findings included: On 03/4/2025 at 9:00 am., an observation was made revealing Staff P, License Practical Nurse (LPN) on the phone with the pharmacy ordering medication for Resident #264. On 03/04/2025 at 9:21 am, an interview was conducted with Staff P. She stated Resident #264 was out of his Dronedarone Hydrochloride (HCl) 400 Milligram (MG), a medication he took for Arrhythmia. Staff P stated she believed Resident # 264 was only out of the medication today, that was why she called in a STAT (immediate) order for the medication. She stated she would fax the request over to pharmacy as soon as possible. Review of Resident #264's Admission Record revealed he was admitted to the facility on [DATE] with diagnoses to include but not limited to Paroxysmal Atrial Fibrillation, Presence of Cardiac Pacemaker. Review of the Medication Administration Record (MAR) dated 3/1/2025 - 3/31/2025, showed an order for Dronedarone Hydrochloride (HCl) Oral Tablet 400 Milligram (MG)- Give 1 tablet by mouth two times a day for Arrhythmia, order start date 2/25/2025 - discontinued on 3/4/2025. On 3/4/2025 at 3:02 p.m., an interview was conducted with the Director of Nurses, DON. The DON stated that the resident had Dronedarone ordered on admission from the hospital for Arrhythmia. She said the pharmacy did not send the medication when the facility initially put a request in for the medication on February 25th. She stated when she found out today Resident # 264 was out of his Dronedarone medication, she reached out to pharmacy to find out why they did not send the medication. She stated pharmacy responded that there was a black box warning related to this type of medication, and they were waiting for a response from the facility. The DON stated she reached out to the Primary Care Provider to notify him that Resident #264 did not receive his medication since admission. She stated she also told him what the pharmacy said about the black box warning for the medication Dronedarone. The DON stated the Primary Care Provider (PCP), stated he did not feel comfortable deciding to discontinue Resident #264's Dronedarone. The DON stated the PCP told her to reach out to the resident's Cardiologist because he or she would be more qualified to provide direction regarding whether to discontinue the use of the medication or to keep the resident on this medication. The DON stated she reached out to their Cardiology Advanced Registered Nurse Practitioner, ARNP, to explain the situation and review Resident #264's medications. She stated the ARNP instructed them to stop the medication. The DON stated she could not speak to why her nurses did not reach out to her early on to discuss the resident not receiving his medication. The DON stated the nurses kept reaching out to pharmacy, but they did not notify Resident # 264 doctor to get further instruction on whether the doctor wanted to provide the resident with an alternative medication. The DON stated the nurse should have called the pharmacy to find out why they did not send the Dronedarone medication. Then notify the physician to get further directions on what to do about the resident's medication, document why the medication was not available, and the physician's response. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/2025 at 4:00 pm, an interview was conducted with the Cardiology Advanced Registered Nurse Practitioner (ARNP). She stated she received a call from the unit manager today because Resident #264's Primary Care Provider wanted the facility to reach out to her about the resident's Dronedarone medication. The ARNP stated if the facility had reached out to her ahead of time, she would have recommended them to discontinue the medication on admission. On 03/04/2025 at 4:30 pm, an interview was conducted with the pharmacist. She stated the facility should have contacted the pharmacy to see why the medication order was not completed. She stated there are many medications with black box warnings so the nurses should have contacted the physician who prescribed the medication to see if the physician felt the resident could continue with the medication or if they would like to administer an alternative medication. Review of the facility policy titled, Medication Shortages/ Unavailable Medications, Revision date 08/01/2024, showed Applicability Policy 7.0 sets forth procedures relating to medication shortages and unavailable medication. Procedures 6. If the medication is unavailable from Pharmacy due to formulary coverage, contraindications, drug-drug interactions, drug- disease interaction, allergy or other clinical reason, Facility should collaborate with Pharmacy and Physician/Prescriber to determine a suitable therapeutic alternative.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observation, interview and record review, the facility failed to ensure competent staff were available to provide skilled nursing care and services related to (1.) Failure to monitor resident's access to food allergens for two residents (#163 and #66), 2. Failure to ensure dressings were dated for one resident (#73), 3. Failure to follow up on a physician order with a black box warning for one resident (#264), 4. Failure to provide nutrition services for one resident (#91), and 5. Failure to provide hydration for three residents (#91, #16, and #49) of 58 sampled residents. Findings included: 1. On 03/04/25 at 8:31 a.m., Resident #163 was observed in her room eating breakfast. The resident stated she was served wheat, and she was allergic. She said, this is not the first time. last night I was served milk. I am allergic. The resident stated she had requested an alternate, almond milk and had not received it. Observation of the resident's plate revealed the resident ate approximately 1/3 of pureed bread and one scoop of cream of wheat. Review of an Admission Record for Resident #163 revealed an admitted [DATE] with diagnoses to include Dysphagia. Review of the Resident Information showed under allergies: iodine, Tetracycline, milk and wheat. Review of the Resident #163's care plan revealed prior to the observation and interview, the resident did not have a focus related to food allergies. A focus initiated on 3/5/25 showed the resident has nutritional problem related to advanced age, food allergies to wheat and milk .Interventions included - detailed food preferences obtained, CDM (Certified Dietary Manager) assisting with daily menu selection. Review of physician orders for Resident #163 dated 3/5/25, showed Allergies: Iodine, tetracycline, milk, wheat. Regular diet - puree texture, nectar/mildly consistency - must use almond milk, family to supply (2/28/25) On 03/04/25 at 09:09 a.m., an interview was conducted with Staff R, Cook. He stated for breakfast this morning, the residents were served sausage gravy, biscuits, bread, scrambled eggs/boiled eggs and juice and/or milk. He reviewed the tray for Resident #163 and stated she was served pureed bread, scrambled eggs and cream of wheat. He reviewed the resident's meal ticket and confirmed the wheat allergy. He stated, she should not have been served that. He stated the dietary aides were responsible for ensuring the meal tickets were accurate. On 03/04/25 at 9:12 a.m., an interview was conducted with Staff S and Staff T, Dietary Aides. They both confirmed it was their responsibility to review meal tickets and ensure the resident's preferences were honored and allergens were prevented. The dietary aides confirmed Resident #163 was served items that she was allergic to. They stated it was an error on their part. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/04/25 at 9:14 a.m., an interview was conducted with the Certified Dietary Manager (CDM). She confirmed the resident was served cream of wheat and bread, items she was allergic to. The CDM reviewed the meal ticket and said, she is allergic to that. I know it because I spoke with her. I put the allergens down on the tickets. She stated the resident should not be served items they were allergic to. The CDM said, It can lead to anaphylactic shock. She stated she would let the nurse know. The CDM confirmed the resident was also allergic to milk. She stated they were waiting for the truck to deliver almond milk. she stated they did not have any. On 03/04/25 at 9:18 a.m., an interview was conducted with the Director of Nursing (DON). She stated the resident should not have been served items she was allergic to. She confirmed the resident was allergic to milk, wheat. She stated the family was supposed to bring Resident #163 some almond milk. On 03/04/25 at 3:15 p.m., an interview was conducted with the facility's Diet Technician (DT). The DT stated she assessed residents upon admission for meal preferences and/ or allergies. She stated she updated meal tickets if there were changes. The DT said, I ask for allergies, sometimes if it is not listed in their record, I let the DON know. The DT confirmed it was her responsibility to add the allergens to the meal profile. The DT said she heard about Resident #163 being served items she was allergic to. The DT said, I don't understand it. They should review each ticket and pay attention to allergies. Review of a progress note dated 3/4/25 showed, Writer spoke with resident regarding her food allergies. Resident stated she is allergic to milk which causes breathing difficulty. She was allergy tested for this and does not have a Lactose intolerance. Resident prefers Silk brand Almond milk in vanilla sweetened version. Resident stated she is allergic to wheat which causes breathing difficulty. She was allergy tested for this and does not have a Gluten intolerance or Celiac's disease. She reports that she purchases gluten free bread because then she knows it doesn't have wheat in it. Resident stated she does eat oatmeal regularly at home, she purchases the instant packets. On 03/05/25 at 9:46 a.m., the CDM stated she and the DT were responsible for ensuring staff competencies for dietary staff. They stated they educated the staff and observed if they were following the expectations. 49227 During an observation and interview on 3/4/25 at 9:30 a.m., Resident #66 said he ate a staff member's apple and his gums swell a little. Review of admission summary showed Resident #66 was admitted on [DATE] and readmitted on [DATE] and showed allergies to include apple, apple juice, applesauce, and apple peel. Review of Resident # 66's health status note dated 2/20/2025 at 7:33 a.m. showed, pt took Certified Nursing assistants' ([CNA's]) lunch bag and started to eat an apple a few bites. During an interview on 3/5/25 at 9:08 a.m. Staff L, CNA said on hire, she was told to store her lunch in the facility's employee lunchroom. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/04/25 at 3:15 P.M. the Director of Nursing (DON) said while Resident # 66 was in the day room he removed an apple from a staff member's lunch bag. She said during orientation staff have been instructed to keep personal items in their lockers. 2. On 3/2/25 at 11:56 a.m., during observation and interview with Resident #73, three dressings located on the left hand and both legs were undated. Photographic Evidence Obtained. Review of admission record showed Resident #73 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include cellulitis of part of limb and atherosclerosis of leg with ulcerations. Review of order summary report, active orders as of 3/5/25 showed Resident #73 had wound care orders for both feet and left hand to be changed daily and as needed. During an interview on 3/4/25 at 9:54 a.m., Staff I, Licensed Practical Nurse (LPN) said after wound dressings were changed the nurses were required to write the date and their initials on the bandage. During an interview on 3/4/25 at 3:25 p.m., the Director of Nursing (DON) said wound dressings were expected be dated and initialed, so staff knows when it was last changed. During an interview on 3/5/25 at 1:11 p.m., Staff H, Registered Nurse (RN) Wound Care Specialist said nurses were expected to date bandages when dressings were changed, that's how I know when they were put on. Review of a facility policy titled, Documentation and Assessment of Wounds, reviewed 7/9/24 showed the following: Policy-to guide the associates and licensed nurses . consistent with professional standards of practice, to promote healing, prevent infection . 46498 3. On 03/4/2025 at 9:00 am., an observation was made revealing Staff P, License Practical Nurse (LPN) on the phone with the pharmacy ordering medication for Resident #264. On 03/04/2025 at 9:21 am, an interview was conducted with Staff P. She stated Resident #264 was out of his Dronedarone Hydrochloride (HCl) 400 Milligram (MG), a medication he took for Arrhythmia. Staff P stated she believed Resident #264 was only out of the medication today, that was why she called in a STAT (immediate) order for the medication. She stated she would fax the request over to pharmacy as soon as possible. Review of Resident #264's Admission Record revealed he was admitted to the facility on [DATE] with diagnoses to include but not limited to Paroxysmal Atrial Fibrillation, Presence of Cardiac Pacemaker. Review of the Medication Administration Record (MAR) dated 3/1/2025 - 3/31/2025, showed an order for Dronedarone Hydrochloride (HCl) Oral Tablet 400 Milligram (MG)- Give 1 tablet by mouth two times a day for Arrhythmia, order start date 2/25/2025 - discontinued on 3/4/2025. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/4/2025 at 3:02 p.m., an interview was conducted with the Director of Nurses, DON. The DON stated that the resident had Dronedarone ordered on admission from the hospital for Arrhythmia. She said the pharmacy did not send the medication when the facility initially put a request in for the medication on February 25th. She stated when she found out today Resident # 264 was out of his Dronedarone medication, she reached out to pharmacy to find out why they did not send the medication. She stated pharmacy responded that there was a black box warning related to this type of medication, and they were waiting for a response from the facility. The DON stated she reached out to the Primary Care Provider to notify him that Resident #264 did not receive his medication since admission. She stated she also told him what the pharmacy said about the black box warning for the medication Dronedarone. The DON stated the Primary Care Provider (PCP), stated he did not feel comfortable deciding to discontinue Resident #264's Dronedarone. The DON stated the PCP told her to reach out to the resident's Cardiologist because he or she would be more qualified to provide direction regarding whether to discontinue the use of the medication or to keep the resident on this medication. The DON stated she reached out to their Cardiology Advanced Registered Nurse Practitioner, ARNP, to explain the situation and review Resident #264's medications. She stated the ARNP instructed them to stop the medication. The DON stated she could not speak to why her nurses did not reach out to her early on to discuss the resident not receiving his medication. The DON stated the nurses kept reaching out to pharmacy, but they did not notify Resident # 264 doctor to get further instruction on whether the doctor wanted to provide the resident with an alternative medication. The DON stated the nurse should have called the pharmacy to find out why they did not send the Dronedarone medication. Then notify the physician to get further directions on what to do about the resident's medication, document why the medication was not available, and the physician's response. On 03/04/2025 at 4:00 pm, an interview was conducted with the Cardiology Advanced Registered Nurse Practitioner (ARNP). She stated she received a call from the unit manager today because Resident #264's Primary Care Provider wanted the facility to reach out to her about the resident's Dronedarone medication. The ARNP stated if the facility had reached out to her ahead of time, she would have recommended them to discontinue the medication on admission. On 03/04/2025 at 4:30 pm, an interview was conducted with the pharmacist. She stated the facility should have contacted the pharmacy to see why the medication order was not completed. She stated there are many medications with black box warnings so the nurses should have contacted the physician who prescribed the medication to see if the physician felt the resident could continue with the medication or if they would like to administer an alternative medication. On 03/04/2025 at 4:40 p.m. an interview was conducted with the Staff Developer, SD and the Director of Nurses, DON. The SD stated he used the annual education calendar for staff education. He stated the calendar was divided into different types of topics each month. He stated he also used a nursing manual to help provide education pertaining to nursing topics. He stated he ensured staff competencies were maintained by doing chart reviews, he looked at documentation, observations, and conducted audits. He stated medication filling out orders would not be in the nursing manual he used for education. He stated filling physician orders was a standard of nursing practice. The DON stated the nurses were provided with education on their standard when it came to completing orders. The DON stated their standards were if a medication was not available the nurse would call the pharmacy, notify the physician of what the pharmacy said about the medication not being available. The nurses would document their conversation with pharmacy and the doctor and any changes that was made to the order and the follow through process. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Registered Nurse (RN) Unit Registered Nurse, Job Description Revision Date 11/10/2016, showed Position Summary, The RN Unit Registered Nurse delivers quality nursing care to patients through interpersonal contact and provides care and services to assure patient safety and attain or maintain the highest practicable physical, mental and psychological well-being of each patient in accordance with all applicable laws, regulations, and Life Care Standards. Reports to Director of Nursing (DON). Specific Requirements must perform proficiently in all applicable competency areas. Essential Functions must be able to knowledgeably and competently deliver quality nursing care to patients. Review of the License Practical Nurse (LPN) Unit License Practical Nurse Job Description Revision Date 11/10/2016, showed Position Summary, The LPN Unit License Practical Nurse delivers quality nursing care to patients through interpersonal contact and provides care and services to assure patient safety and attain or maintain the highest practicable physical, mental and psychological well-being of each patient in accordance with all applicable laws, regulations, and Life Care Standards. Reports to the Director of Nursing (DON) or other nursing supervisor. Specific Requirements must perform proficiently in all applicable competency areas. Essential Functions, must be able to knowledgeably and competently deliver quality nursing care to patients. Review of the Certified Nursing Aid (CNA) Job Description Revision Date 11/10/2016, showed Position Summary, The Certified Nursing Aid is responsible for providing routine daily nursing care to assigned patients to assure patient safety and attain or maintain the highest practicable physical, mental, and psychological well-being of each patient in accordance with all applicable laws, regulations, and Life Care standards. Specific Requirements must perform proficiently in all applicable competency areas. 4. During an observation on 03/03/2025 at 12:48 p.m., Resident #91 was observed sitting in a wheelchair in the hallway. Staff A, Certified Nurse Assistant (CNA) was observed telling Resident #91 that she had a doctor's appointment and transportation was there to get her. During an interview on 03/03/2025 at 4:34 p.m., Resident #91 stated she had not eaten lunch before her appointment and was not given anything to eat while away from the facility for her appointment. Resident #91 stated she had not been offered anything to eat when she returned to the facility after her appointment and was waiting for dinner. Resident #91's lips were observed to be pale, dry, and cracked. During an interview on 03/03/2025 at 12:53 p.m., Staff A, Certified Nurses Assistant (CNA) stated she does restorative and several other things like accompanying residents to appointments. She stated she was not sure when Resident #91 had breakfast, and that Resident #91's lunch tray will be saved for her to eat when she gets back. She was not sure how long they would be gone for her appointment. She stated she had not thought of getting her a snack or bringing something with them for Resident #91 to eat since she was not getting her lunch tray. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of New Port Richey	7400 Trouble Creek Road New Port Richey, FL 34653

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/03/2025 at 4:45 p.m., Staff B, CNA, stated he was told the resident did not eat lunch and might be hungry when she got back from her appointment. He stated she returned to the facility around 3:15 p.m. and he had not offered her a meal or snack. During an observation on 03/03/2025 from 10:45 a.m. to 12:45 p.m., Resident #91, Resident #16 and Resident #49 were observed sitting in the activities room of the 100 Hall. During the observation residents were observed not to have hydration. No staff were observed entering the room and offering hydration to the residents. 5. During an interview on 03/03/2025 at 1:00 p.m., Staff F, CNA, stated she was the CNA for Resident #16, and she constantly checks on her residents. She stated Resident #16 does not drink anything but Gatorade and just got up at 10 a.m. She was not sure how often she provided hydration to Resident #16. During an interview on 03/04/2025 at 10:51 a.m., Director of Nursing (DON) stated she would expect residents to be offered hydration at least once an hour and would expect residents in the activities room to either have a cup for hydration or staff to periodically check on the residents. She stated if a resident had an appointment at mealtime or if the resident was out for a meal, Dietary should be notified to get an early tray so that the resident could eat before they go out. If the residents were alert and oriented, they asked them if they would like to have a snack or a bagged lunch with them so they could have something to eat while they were gone. Review of the facilities policy titled, Education and Training Requirements, dated 10/3/2024 revealed: The facility will maintain an effective in service and orientation program for: a. all associates b. individuals providing direct care services under contractual arrangements c. volunteers consistent with their roles Procedure 1. The staff development coordinator or designee plans and directs an effective orientation, training, and evaluation program. 2. General orientation is required for all new or rehired associates, agency or contract staff, and volunteers. 7. Competencies and skill sets will for all new and existing staff, be consistent with their expected roles. This would include the following: a. facility associates b. Individuals providing services under contractual arrangement (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Volunteers 8. The facility will need to ensure staff are trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program. 10. In service education topics related to specific needs of the facility, its residents and associates will be determined by the facility assessment, annual skills evaluations, associate request, and other items determined by the quality assurance performance improvement committee (QAPI). 12. In service, training, competencies can be completed using various forms including: a. In person instruction b. Live training/webinars c. HCA or other learning management systems d. Lippincott procedures including associated competency checklist or skill test e. Supervised practical training 50434

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49227 Based on observation, record review, and interview, the facility failed to ensure the medication error rate was less than 5%. Twenty-nine medication opportunities and 3 errors were identified for two residents (#102 and #361) of four observations, resulting in an error rate of 10.34% Findings included: On 3/3/25 at 8:12 a.m., during medication administration observation Staff J, Licensed Practical Nurse (LPN) was observed administering the following medications to Resident #361, Bupropion ER 100MG, Sertraline HCl 100 mg, Olanzapine 5MG, Calcium Carbonate 600mg, Cholecalciferol 1000 UNIT, Lidocaine 5% patch, Losartan Potassium 50 mg, Metoprolol ER 625mg, Multiple Vitamins with Minerals 1 tablet, Vitamin B Complex with Vitamin C 1 tablet, Vitamin C 250 mg and Aspirin 81 mg low dose EC 1 tablet. A review of the order summary report dated 3/4/25 showed Resident #361 did not receive Aspirin 81 mg Delayed Release and Vitamin B Complex as ordered. On 3/3/25 at 8:49 a.m., during medication administration observation Staff E, Registered Nurse (RN) administered the following medications to Resident #102, Cholecalciferol 1000-unit, Aspirin 81 mg low dose EC 1 tablet, Carvedilol tablet 3.125 MG, Bactrim DS 800-160 mg, Potassium Chloride ER 40 MEQ, and Pyridoxine HCl 50 mg tablet. A review of the order summary report dated 3/4/25 for Resident #102 showed Aspirin 81 mg delayed release was not administered as ordered. During an interview, record review, and medication container observation on 3/4/25 at 8:27 a.m. with Staff E, RN, Unit Manager, Aspirin 81 mg delayed release and Vitamin B Complex were verified as not administered as ordered. During an interview on 3/4/25 at 12:50 P.M. the DON said Staff E, RN, UM had informed her of the medication administration concerns and it is expected for nurses to administer medications as ordered. Review of a facility policy titled, Administration of Medications, reviewed 9/16/24 showed the following: Policy-The facility ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms. Procedure- 2 Staff who are responsible for medication administration will adhere to the 10 rights of medication administration. 2a. Right Drug-Every drug administered must have an order from the provider. Compare the order with the medication administration record (MAR) for accuracy. Compare the label on the drug to the information on the MAR three times. i) Before removing the container from the drawer ii) as the drug is removed from the container and iii) At the bedside before administering it to the resident.

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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** 43453 Based on observation, interview, and record review, the facility did not ensure medications were inaccessible to unauthorized staff, residents, and visitors for five (#265, #63, #12, #164 and #18) of 58 sampled residents. Findings included: 1. On 3/2/25 at 11:32 a.m., an observation in Resident #265's room revealed a medication bottle, labeled Custom medication crafted for (Resident #265). The medication name was CA/MAG/[NAME] 8/2/12/89 %, apply to treatment area one to two times daily. The medication was observed on a table in the resident's room. Review of the Admission Record for Resident #265 showed the resident was admitted to the facility on [DATE] with a primary diagnosis of atherosclerotic heart disease of native coronary artery without angina protectors. Review of active physician orders for Resident #265 dated 3/5/25 did not show an order to administer the medication. 2. On 3/2/25 at 10:20 a.m. an albuterol inhaler was observed on Resident #63's bedside table. The resident stated it was her rescue inhaler, and she self-administered as needed. Review of the Admission Record for Resident #63 showed the resident was re- admitted to the facility on [DATE] with diagnoses to include COPD (Chronic Obstructive Pulmonary Disease). Review of active physician orders for Resident #63 dated 3/5/25 did not show an order to self- administer the medication, nor was this medication on the list. The order showed the resident received Ipratropium - Albuterol solution 0.5-2.5 MG/ML (Milligram/milliliter) inhale orally via nebulizer every 4 hours as needed for shortness of breath. 3. On 3/2/25 at 10:31 a.m., Resident #12 was observed in bed. An antifungal cream was observed on the bedside table. The resident could not answer if and when the cream was applied. Review of the Admission Record for Resident #12 showed the resident was admitted to the facility on [DATE] with a primary diagnosis of Cerebral Palsy. Review of active physician orders for Resident #12 dated 3/5/25 did not show an order to administer the medication. 4. On 3/2/25 at 11:38 a.m., an observation was made of a Miconazole nitrate antifungal cream at Resident #164's bedside table. The resident did not respond to the interview. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Admission Record for Resident #164 showed the resident was admitted to the facility on [DATE] with a primary diagnosis of unspecified intracapsular fracture of right femur. Review of active physician orders for Resident #164 dated 3/5/25 did not show an order to administer the medication. 5. On 3/3/25 at 12:59 p.m., Resident #18 was observed in her room. An observation was made of a white basket placed on her bed with a hydrocortisone cream and bio freeze. The resident stated she used the bio freeze for her hurting toe. She stated she received the itching cream from the facility, and she applied it herself due to itching. Review of the Admission Record for Resident #18 showed the resident was readmitted to the facility on [DATE] with a primary diagnosis of malignant neoplasm of unspecified site of left female breast. Review of active physician orders for Resident #18 dated 3/5/25 did not show an order to self- administer the medications, and the medications were not on the order list. On 03/05/25 at 9:25 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated medications should be stored in the treatment cart or medication cart at all times. She stated nursing staff should apply and administer all medications unless there was a self-administration assessment. The DON said, even so, they should still be locked and handed to them at the time of application or administration. The DON stated there were no residents with self-administration orders. She stated medications should not be left at bedside. Review of a facility policy titled, Storage and Expiration Dating of Medications and Biologicals, revised on 8/01/24 showed: 1. The facility should ensure that only authorized facility staff, as defined by facility should have possessions of the keys access card electronic codes or combinations which open medication storage areas. 5. Facility should ensure 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. 19.2 Facility should store bedside medications or biologicals in a locked compartment within the resident's room.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observation, interview, and record review, the facility did not ensure food that accommodates resident allergies, intolerances, and preferences was served for one (#163) of four residents reviewed for nutrition. Findings included: On 03/04/25 at 8:31 a.m., Resident #163 was observed in her room eating breakfast. The resident stated she was served wheat, and she was allergic. She said, this is not the first time. last night I was served milk. I am allergic. The resident stated she had requested an alternate, almond milk, and had not received it. Observation of the resident's plate revealed the resident ate approximately 1/3 of pureed bread and one scoop of cream of wheat. Review of an Admission Record for Resident #163 revealed an admitted [DATE] with diagnoses to include Dysphagia. Review of the Resident Information showed under allergies: iodine, Tetracycline, milk and wheat. Review of the Resident #163's care plan revealed prior to the observation and interview, the resident did not have a focus related to food allergies. A focus initiated on 3/5/25 showed the resident has nutritional problem related to advanced age, food allergies to wheat and milk .Interventions included - detailed food preferences obtained, CDM (certified Dietary Manager) assisting with daily menu selection. Review of physician orders for Resident #163 dated 3/5/25, showed Allergies: Iodine, tetracycline, milk, wheat. Regular diet - puree texture, nectar/mildly consistency - must use almond milk, family to supply (2/28/25) On 03/04/25 at 9:09 a.m., an interview was conducted with Staff R, Cook. He stated for breakfast this morning, the residents were served sausage gravy, biscuits, bread, scrambled eggs/boiled eggs and juice and/or milk. He reviewed the tray for Resident #163 and stated she was served pureed bread, scrambled eggs and cream of wheat. He reviewed the resident's meal ticket and confirmed the wheat allergy. He stated, she should not have been served that. He stated the dietary aides were responsible for ensuring the meal tickets were accurate. On 03/04/25 at 9:12 a.m., an interview was conducted with Staff S and Staff T, Dietary Aides. They both confirmed it was their responsibility to review meal tickets and ensure the resident's preferences are honored and allergens are prevented. The dietary aides confirmed Resident #163 was served items that she was allergic to. They stated it was an error on their part. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/25 at 9:14 a.m., an interview was conducted with the Certified Dietary Manager (CDM). She confirmed the resident was served cream of wheat and bread, items she was allergic to. The CDM reviewed the meal ticket and said, she is allergic to that. I know it because I spoke with her. I put the allergens down on the tickets. She stated the resident should not be served items they were allergic to. The CDM said, It can lead to anaphylactic shock. She stated she would let the nurse know. The CDM confirmed the resident was also allergic to milk. She stated they were waiting for the truck to deliver almond milk. she stated they did not have any. On 03/04/25 at 9:18 a.m., an interview was conducted with the Director of Nursing (DON). She stated the resident should not have been served items she was allergic to. She confirmed the resident was allergic to milk, wheat. She stated the family was supposed to bring Resident #163 some almond milk. On 03/04/25 at 3:15 p.m. an interview was conducted with the facility's Diet Technician (DT). The DT stated she assessed residents upon admission for meal preferences and or allergies. She stated she updated meal tickets if there were changes. The DT said, I ask for allergies, sometimes if it is not listed in their record, I let the DON know. The DT confirmed it was her responsibility to add the allergens to the meal profile. The DT said she heard about Resident #163 being served items she was allergic to. The DT said, I don't understand it. They should review each ticket and pay attention to allergies. Review of a progress note dated 3/4/25 showed, Writer spoke with resident regarding her food allergies. Resident stated she is allergic to milk which causes breathing difficulty. She was allergy tested for this and does not have a Lactose intolerance. Resident prefers Silk brand Almond milk in vanilla sweetened version. Resident stated she is allergic to wheat which causes breathing difficulty. She was allergy tested for this and does not have a Gluten intolerance or Celiac's disease. She reports that she purchases gluten free bread because then she knows it doesn't have wheat in it. Resident stated she does eat oatmeal regularly at home, she purchases the instant packets. On 03/05/25 at 9:46 a.m., The CDM stated she and the DT were responsible for ensuring staff competencies for dietary staff. They stated they educated the staff and observed if they were following the expectations. Review of a facility policy titled Food Allergies and Intolerances dated 04/30/24 showed under policy - The Director of Food and Nutrition Services obtains food preferences, including any food allergies and intolerances upon admission. Procedure: 1. The Director of Food and Nutrition Services/Designee conducts food preference interviews with all new residents on admission. 2. Food allergies or intolerances are communicated to Nursing Services and indicated on the resident tray card and resident diet profile. 3. The information is also recorded in the electronic medical record, including the nutrition assessment and care plan. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. The Director of Food and Nutrition Services identifies menu items that contain the food item(s) related to the allergy/intolerances and ensures those items are not used in foods prepared and served to identified residents. 5. Food service and nursing associates are educated on residents with food allergies and intolerances.