STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106068	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Terrace Rehab and Health Care Center	110 Lodge Terrace Dr Altoona, FL 32702

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523 Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the resident's status for 2 of 3 residents reviewed for respiratory services, Residents #3 and #23. Findings include: 1. Review of Resident #3's admission record showed the resident was most recently admitted on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, unspecified dementia, hypertensive heart and chronic kidney disease without heart failure, chronic obstructive pulmonary disease, atherosclerotic heart disease of native coronary artery, and stage 3B chronic kidney disease. Review of Resident #3's physician order dated 2/24/2023 read, Oxygen at 2.5 LPM [liters per minute] via nasal cannula PRN [as needed] for O2 sats [oxygen saturation] below 90% as needed related to facial weakness following cerebral infraction. Review of Resident #3's Weights and Vitals Summary for O2 sats summary showed the resident received oxygen via nasal cannula on 5/21/2024 at 1:47 PM and 11:48 PM, on 5/22/2024 at 2:00 PM, on 5/23/2024 at 3:34 PM, on 5/24/2024 at 11:57 PM, on 5/25/2024 at 7:27 AM and 3:33 PM, on 5/26/2024 at 7:32 AM and 3:22 PM, on 5/28/2024 at 12:00 AM, on 5/29/2024 at 4:01 PM, on 5/30/2024 at 8:21 PM and 3:15 PM, on 5/31/2024 at 7:40 AM and 3:54 PM, and on 6/2/2024 at 7:09 PM. Review of Resident #3's Quarterly MDS dated [DATE] read, Section O0110- Special Treatments, Procedures, and Programs . C1. Oxygen therapy . B. While a Resident: No. During an interview on 7/9/2024 at 1:35 PM, the MDS Coordinator stated, [Resident #3's name] has orders for oxygen and checking of saturation. I do see where it was coded no on the MDS. It should be changed to yes. 41334 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #23's admission record showed the resident was most recently admitted on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, atherosclerotic heart disease of native coronary artery without angina pectoris, chronic obstructive pulmonary disease (COPD), unspecified atrial fibrillation, cerebral infarction due to embolism of right middle cerebral artery, essential (primary) hypertension, cerebral aneurysm, other seizures, and anemia. Review of Resident #23's physician order dated 11/17/2023 read, Oxygen at 2 LPM [liters per minute] via nasal cannula continuously every shift. Review of Resident #23's care plan initiated on 11/20/2023 and last revised on 6/14/2024 read, Focus: [Resident #23's name] receives oxygen therapy r/t [related to] COPD, shortness of breath . Interventions . Oxygen Settings: O2 @ [at] 2 LPM via NC [nasal cannula] as ordered. During an observation on 7/8/2024 at 9:38 AM, Resident #23 was resting in bed, administered oxygen via nasal cannula. During an observation on 7/8/2024 at 12:08 PM, Resident #23 was resting in bed, administered oxygen via nasal cannula. During an observation on 7/9/2024 at 12:02 PM, Resident #23 was resting in bed, administered oxygen via nasal cannula. Review of Resident #23's Quarterly MDS dated [DATE] read, Section O0110- Special Treatments, Procedures, and Programs . C1. Oxygen therapy . B. While a Resident: No. During an interview on 7/10/2024 at 10:15 AM, the MDS Coordinator stated, She [Resident #23] has been on oxygen since November of last year. The MDS is not correct. It should have been documented correctly. Review of the facility policy and procedure titled Initial Assessment- MDS (Minimum Data Set) with the last review date of 1/29/2024 read, Procedures: 1. A Comprehensive assessment (MDS) will be developed for all residents based on resident needs, strengths, goals, life history and preferences utilizing the Resident Assessment Instrument. It will be developed in collaboration with the IDT [Intradisciplinary Team], resident and coordinated to include PASRR [Preadmission Screening and Resident Review] recommendations. It will include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts . 7. All staff participating in completion of this assessment must sign to certify that all above information is correct and truthful to the best of their knowledge or face monetary penalties.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39185 Based on record review and interview, the facility failed to ensure comprehensive person-centered care plans were developed for 3 of 12 residents reviewed, Residents #2, #3, #33. Findings include: Based on record review and interview, the facility failed to ensure comprehensive person-centered care plans were developed for 3 of 12 residents reviewed, Residents #2, #3, and #33. Findings include: 1. Review of Resident #33's admission record documented the resident was most recently admitted on [DATE] with diagnoses that included chronic atrial fibrillation, essential (primary) hypertension, arthritis, generalized anxiety disorder, muscle weakness (generalized), unsteadiness on feet, and major depressive disorder. Review of Resident #33's physician order dated 2/9/2024 read, Eliquis Oral Tablet 5 mg [milligram] (Apixaban), Give one tablet by mouth every 12 hours for A-fib. Review of Resident #33's care plan dated 5/16/2024 showed no focus or intervention related to anticoagulant therapy. During an interview on 7/9/2024 at 2:55 PM, the MDS Coordinator stated, I don't see she [Resident #33] was care planned for anticoagulant therapy. 46523 2. Review of Resident #3's admission record showed the resident was most recently admitted on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and allergic dermatitis of unspecified eye (onset date of 3/18/2024). During an interview on 7/8/2024 at 9:19 AM, Resident #3's Wife stated, Now that he [Resident #3] is blind, I will go with him to the activities or to participate in exercise activities and he can hear what they are saying, but I assist him in doing the actual activities. During an interview on 7/9/2024 at 12:59 PM, Staff B, Licensed Practical Nurse (LPN), stated, [Resident #3's name] has an eye condition and something happened that he lost his vision. He is able to see now a bit more, but we have to get really up close to him in order for him to recognize us. [Resident #3's name] is alert and oriented and his wife is here day and night. She is very involved. We will always let him know what we will be doing and assist him. He [Resident #3] is able to verbally communicate with us. Review of Resident #3's Quarterly Minimum Data Set (MDS) dated [DATE] read, Section B- Hearing, Speech, and Vision . B100. Vision: 3. Highly Impaired. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's physician note dated 4/26/2024 read, Assessments . 6. Encounter for examination of eyes and vision with abnormal findings. Treatment . 6. Encounter for examination of eyes and vision with abnormal findings: Notes: Opthomology [Sic.] referral to evaluate eyes as wife reports that patient is now blind from one eye. Review of Resident #3's care plan showed no focus or interventions for vision impairment. During an interview on 7/9/2024 at 1:30 PM, the MDS Coordinator stated, Based on [Resident #3's name] diagnosis and MDS coding, I should have made an entry for vision with interventions for safety. I do not see a focus for vision on [Resident #3's name] care plan and there should be a separate entry for this. 3. Review of Resident #2's admission record showed the resident was most recently admitted on [DATE] with diagnoses that included unspecified dementia, major depressive disorder, and bipolar disorder. Review of Resident #2's physician order dated 2/1/2024 read, Divalproex Sodium Capsule Delayed Release Sprinkle 125 mg [milligrams], Give 250 mg by mouth one time a day for Bipolar HX [history] of. Review of Resident #2's physician order dated 2/1/2024 read, Divalproex Sodium Capsule Delayed Release Sprinkle 125 mg, Give 375 mg by mouth at bedtime for bipolar HX of. Review of Resident #2's Quarterly MDS dated [DATE] showed bipolar disorder under Section I. Active Diagnoses. Review of Resident #2's physician progress note dated 3/5/2024 read, Assessments . 5. Bipolar disorder, current episode mixed, mild. Treatment . 5. Bipolar disorder, current episode mixed, mild. Notes: Continue current medication. Monitor for increased or new onset major depression symptoms (i.e. tearfulness, sadness, change in appetite, self-isolation), manic/hypomania episodes, decreased sleep, flight of ideas, or functional impairment- if these symptoms exacerbate or are new onset call MD/ARNP [Medical Doctor/ Advance Registered Nurse Practitioner] immediately. Psych consulted as needed. Review of Resident #2's psychiatry subsequent note dated 3/15/2024 read, Chief complaint: Depression, dementia, and bipolar disorder . History of Present Illness: This is an [AGE] years old patient with past psychiatrics history of depression, dementia and bipolar disorder. Prior to last visit, patient had mood swings. Patient had sundowning. Patient was irritable. Signs and symptoms related to depression or anxiety were not observed. Patient was sleeping and eating well without trouble. Increased Depakote to 375 mg QHS [once a day at bedtime] for behaviors/agitation. During an interview on 7/9/2024 at 1:45 PM, the MDS Coordinator stated, [Resident #2's name] has a history of bipolar disorder and should have been care planned for a separate entry for the diagnosis. During an interview on 7/10/2024 at 8:40 AM, the Director of Nursing stated, [Resident #2's name] has a diagnosis of bipolar disorder and is followed by psych. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedure titled Resident-Centered Care Planning with the last review date of 1/19/2024 read, Purpose: To provide comprehensive and Person-Centered care and services so that residents attain or maintain the highest practical physical, mental and psychological well-being. Standards . A comprehensive Person-Centered care plan must be developed for each resident that includes measurable objectives and timetables . Procedures . 5. The comprehensive care plan shall be developed collaboratively with input from the IDT [Intradisciplinary Team], including the resident or resident representative to the extent possible. It shall include the following: a. Measurable goals and time frame to meet a resident's medical, nursing, and mental and psychological needs identified in the comprehensive assessment.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41334 Based on observation, interview, and record review, the facility failed to ensure residents received oxygen as ordered by the physician for 1 of 3 residents reviewed for respiratory care, Resident #23. Findings include: Review of Resident #23's admission record showed the resident was most recently admitted on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, atherosclerotic heart disease of native coronary artery without angina pectoris, chronic obstructive pulmonary disease (COPD), unspecified atrial fibrillation, cerebral infarction due to embolism of right middle cerebral artery, essential (primary) hypertension, cerebral aneurysm, other seizures, and anemia. Review of Resident #23's physician order dated 11/17/2023 read, Oxygen at 2 LPM [liters per minute] via nasal cannula continuously every shift. During an observation on 7/8/2024 at 9:38 AM, Resident #23 was resting in bed, being administered oxygen at 4 liters per minute via nasal cannula on oxygen concentrator. During an observation on 7/8/2024 at 12:08 PM, Resident #23 was resting in bed, being administered oxygen at 4 liters per minute via nasal cannula. During an observation on 7/9/2024 at 12:02 PM, Resident #23 was resting in bed, being administered oxygen at 4 liters per minute via nasal cannula on oxygen concentrator. During an observation on 7/9/2024 at 12:04 PM, the Director of Nursing (DON) verified that the oxygen was being administered at 4 liters per minute. During an interview on 7/9/2024 at 12:05 PM, the DON stated, Her [Resident #23] order is for oxygen at 2 liters. Nurses should check oxygen when they assess the residents or when giving medications. During an interview on 7/9/2024 at 12:13 PM, Staff C, Licensed Practical Nurse (LPN), stated, We should be checking oxygen first thing in the morning. I did check her this morning, but she was on her portable tank. I did not check her when she went back on the concentrator. During an interview on 7/9/2024 at 12:41 PM, Staff D, LPN, Unit Manager, stated, Typically, we should be checking the oxygen when there is a change in a resident's condition, when we do a change over from portable to concentrator, when we are assessing their lung sounds. There are no notes that show she had a need to increase the oxygen. When we change oxygen, we should call and get orders to increase the oxygen. Review of Resident #23's nursing progress notes from 7/5/2024 through 7/9/2024 did not document notes for the need to increase the amount of oxygen being administered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedure titled Oxygen Administration with the last approval date of 1/19/2024 read, Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration . Assessment . 10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered . 13. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41334 Based on observation, interview, and record review, the facility failed to ensure staff performed hand hygiene during medication administration for 6 of 10 medication administration observations to prevent the possible spread of infection and communicable disease. Findings include: 1. During an observation on 7/10/2024 at 5:55 AM, Staff E, Licensed Practical Nurse (LPN), exited the nurses' station and went to the medication cart, removed keys from her pocket, unlocked the medication cart and prepared Resident #140's medications without performing hand hygiene. Staff E donned gloves without performing hand hygiene and locked the medication cart with her gloved hand. Staff E knocked on Resident #140's room door with her gloved hand, entered the resident's room, used the bed controls to adjust the height of the head of the bed with her gloved hands and administered Resident #140's oral medications. Staff E then pulled a syringe and alcohol swab out of her pocket with her gloved hand, cleaned Resident #140's arm with alcohol and administered medication to the resident. Staff E doffed her gloves and exited the room without performing hand hygiene and returned to the medication cart to prepare medications for another resident. During an observation on 7/10/2024 at 6:05 AM, Staff E, LPN, returned to the medication cart and began preparing medications for Resident #9 without performing hand hygiene. Staff E entered the resident's room, adjusted the overbed table and used the bed control to adjust the height of the head of the bed. Staff E administered the medications and exited the room without performing hand hygiene, returning to the medication cart to prepare medications for another resident. During an observation on 7/10/2024 at 6:15 AM, Staff E, LPN, returned to the medication cart and began preparing medications for Resident #23 without performing hand hygiene. Staff E donned gloves without performing hand hygiene, removed keys from her pocket and locked the medication cart with her gloved hand. Staff E knocked on the resident's room door with her gloved hand, entered the resident's room, adjusted the overbed table and used the bed controls to adjust the height of the head of the bed and administered the oral medication. Staff E then opened the nightstand, and removed respiratory equipment with her gloved hand, poured the medication into the passive nebulizer and adjusted the nebulizer mask on Resident #23's face. Staff E doffed her gloves and exited the room after the nebulizer was completed without performing hand hygiene. During an interview on 7/10/2024 at 6:50 AM, Staff E, LPN, stated, I should have used hand sanitizer before I put on gloves and before I did my medications. 46523 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation on 7/8/2024 at 9:54 AM, Resident #17's Wife asked Staff A, LPN, for lotion due to the resident being itchy. Staff A went to the medication cart and returned with a bottle of lotion and handed it to Resident #17's wife. Staff A returned to the medication cart and removed a nicotine patch for Resident #20 without performing hand hygiene. Staff A followed the Physical Therapist and Resident #20 into the resident's room and without performing hand hygiene, removed the nicotine patch from the package and placed the nicotine patch on Resident #20. Staff A exited Resident #20' room and returned to the medication cart and began preparing medications for Resident #15 without performing hand hygiene. Staff A entered the resident's room and administered the medications to the resident without performing hand hygiene. Staff A exited Resident #15's room without performing hand hygiene and returned to the medication cart. During an interview on 7/8/2024 at 10:10 AM, Staff A, LPN, stated, I should have done hand hygiene in between each resident. I think I did hand hygiene for one of them, but I cannot honestly remember. During an interview on 7/10/2024 at 8:47 AM, the DON stated, Staff is expected to perform hand hygiene in between each resident. Review of the facility policy and procedure titled Administering Medications with the last approval date of 1/19/2024 read, Policy Interpretation and Implementation . 25: Staff follows established infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. Review of the facility policy and procedure titled Hand Hygiene/Hand Washing with the last approval date of 1/19/2024 read, Purpose: To prevent transmissible infections and prevent contamination by bloodborne pathogens. Hand washing is the single most effective deterrent to the spread of infection . Procedure: 1. All staff shall perform hand hygiene to prevent the spread of infection. When coming on shift; Before applying and after removing gloves; Before and after each Resident contact or touching Resident surroundings (before and after resident contact, includes going between residents during dinner, activities and direct care); Before and after assisting with medications.