STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106069	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Wales Wellness and Rehabilitation Center	730 N Scenic Hwy Lake Wales, FL 33853

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on observations, interviews, and record review, the facility failed to ensure residents were free from neglect related to 1.) not providing physician ordered tube feeding and not providing assistance to get out of bed for 13 days, leading to a decline in functionality for one resident (#7) out of 12 sampled residents and 2.) failing to administer medications in accordance with physician orders for two residents (#7 and #4) out of twelve sampled residents. Findings included: 1. An observation and interview was conducted on 4/30/25 at 10:47 a.m. with a family member of Resident #7. The family member said she was concerned because the resident's tube feeding was supposed to be running all day, and she had been in a few times and it was not running. She said she was worried he was not getting the nutrition he needed. The family member said she talked to staff a few times and was told the pump for the tube feed was broken. She said the tube feed had not been running when she got to the facility that day and the day prior it ran for a while, then the pump broke. She said after a little bit, someone got it running again. The family member also stated Resident #7 had not been out of bed in the almost two weeks. She said when the resident came to the facility he was able to transfer and walk with assistance, but now he had gotten so much weaker. She said he was supposed to be there for rehab and then go home. The family member said she is now concerned Resident #7 won't be able to improve and go home. Review of Admission Records showed Resident #7 was admitted on [DATE] with diagnoses including sepsis, unspecified organism, pneumonitis due to inhalation of food and vomit, acute respiratory failure with hypoxia, and protein-calorie malnutrition. Review of Resident #7's Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (Form 3008), dated 4/17/25, showed the resident ambulates with assistive device, transfers with 2 assistants, and is partial weight-bearing on the left and right sides. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #7's Care Plan showed a focus area of Resident requires assist with ADLs [activities of daily living] R/T [related to] impaired mobility, dated 4/18/25. Interventions included substantial/maximum assistance with bed mobility and lying to sitting on the side of the bed and dependent for chair to bed and bed to chair transfers. Another focus area was PEG [percutaneous endoscopic gastrostomy] tube is utilized for all medications/nutrition and fluids, dated 4/18/25. Interventions included feeding/water flushes per doctor orders. Review of Resident #7's orders showed: #1 Nutren Renal Oral Liquid. Give 250 ml (milliliters) via g-tube four times a day for Nutritional Supplement. Start date 4/17/25. Discontinued 4/18/25. #2 Enteral Feed Order. Every shift for dysphasia. Nutrin 2.0 60 ml/hr (hour) x 20 hrs. Up at 6 a.m. and down at 2 a.m. Start date 4/18/25. Discontinued 4/19/25. #3 Enteral Feed Order. Every shift for dysphasia. Nutrin 2.0 60 ml/hr x 20 hrs. Up at 6 a.m. and down at 2 a. m. Start date 4/19/25. Discontinued 4/21/25. #4 Enter Feed Order. Five times a day. Nutren 2.0 bolus 1 can 5 times a day with 75 cc (cubic centimeters) water bolus. Start date 4/21/25. Discontinued 4/24/25. #5 Enteral Feed. In the morning for dysphasia Nutrin 2.0 60 ml/hr x 20 hrs up at 6 a.m. and one time a day for dysphasia Nutrin 2.0 60 ml/hr x 20 hrs down at 2 a.m. Dated 4/24/25. Review of Resident #7's progress notes showed the first note was entered into the medical record at 5:19 p. m. on 4/17/25, indicating the resident arrived prior to that time. Review of Resident #7's April 2025 Medication Administration Record (MAR) showed the resident did not receive enteral feeding on 4/17/25. The feeding at 9:00 p.m. on 4/17/25 was documented as 5 meaning Hold/See Progress Notes. The progress notes did not have any documentation as to why the enteral feeding was not provided. According to the MAR, the resident received his first enteral feeding at 9:00 a.m. on 4/18/25, over 15 hours after admission to the facility. The resident received another feeding at 1:00 p.m. on 4/18/25, and order #1 for bolus feeding was discontinued. Order #2 for continuous feeding to hang at 6 a.m. and take down at 2 p.m. was signed off for the night shift on 4/18/25, and it was discontinued. The MAR showed order #3 for continuous feeding was signed off for all shifts on 4/19/25 and 4/20/25 and for the morning shift on 4/21/25, but was not signed off on the evening shift of 4/21/25. Order #3 was discontinued on 4/21/25. Order #4 was documented as completed twice on 4/21/25 and five times each on 4/22/25 and 4/23/25. The order was discontinued the morning on 4/24/25. There is no order in place or documentation to show the resident received any tube feeding on 4/24/25. Order #5 began on the morning of 4/25/25 and was signed off as the tube feed being hung at 6:00 a.m. on 4/25/25, 4/27/25, 4/28/25, 4/29/25, and 4/30/25. On 4/26/25, the tube feed was not signed off as being hung and there is no documentation stating why it was not administered as ordered. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 4/30/25 at 11:16 a.m. with Staff F, Licensed Practical Nurse (LPN). She stated she cared for Resident #7 on 4/29/25 starting at 7:00 a.m. She said when she came on shift, Resident #7's tube feed was not hanging. She confirmed it was supposed to be hung at 6:00 a.m. and didn't know why it wasn't hung up and why it was signed off. She said she did not notify anyone she just hung the tube feed around 10:00 a.m. and turned it on. Staff F, LPN said she did not know why the resident had been switched back and forth between continuous and bolus feedings. She said she did not think the pump was broken, she just didn't think the staff knew how to use it correctly. An observation was conducted on 4/30/25 at 10:47 a.m. of Resident #7 lying in bed. The tube feed pump was next to the bed and there was no tube feed hanging and the pump was turned off, although it was documented it had been hung at 6:00 a.m. on 4/30/25. An interview was conducted on 4/30/25 at 5:41 p.m. with the facility's Registered Dietician (RD). She said from her understanding, Resident #7 has switched from continuous pump feeding to bolus feeds and back again because the facility had issues with the pump. She said they do weekly weights on tube feed residents and Resident #7 was 145 pounds on admission 13 days ago and 142 pounds on 4/30/25. She said he was on a medication for edema, but in general, tube feed residents should never lose weight. The RD said not getting the required food intake can lead to a lot of problems. She said Resident #7 looks worse now than when she saw him after admission. She said the resident not getting the proper amount of nutrition and possible missing tube feedings could have led to the weakness he had been having, it certainly doesn't help. The RD said Resident #7 had gone down since he had been at the facility. An interview was conducted on 4/30/25 at 2:49 p.m. with the facility's Director of Nursing (DON). She said the facility was not notified of the type of tube feed Resident #7 was on until he arrived and it was a less common type. She said they did not have a tube feed pump available at the time he arrived due to an influx of tube feed residents. She said they found a pump in the back for the resident, but it was an older type. She said they also found a case of Nutrin renal containers in the facility after he arrived and that is why they were doing bolus feedings instead of continuous feed. She said the bags of tube feeding arrived and he began continuous tube feeding on the second day. An interview was conducted on 4/30/25 at 11:42 a.m. with Staff H, Occupational Therapy Assistant (OTA). Staff H, OTA said there is not a reason Resident #7 cannot get out of bed. She said he used a full body mechanical lift and the nursing staff should have been getting him up. Staff H, OTA said she took a wheelchair to the resident's room a week ago, but someone must have taken it out. She said the resident had been receiving therapy in bed due to nursing staff not having him up in a chair. A follow-up interview was conducted on 4/30/25 at 12:00 p.m. with Staff F, LPN. She said she had not seen Resident #7 out of bed since he had been in the facility. She said they were waiting on therapy and she didn't know if therapy had gotten him up or not. An interview was conducted on 4/30/25 at 12:05 p.m. with Staff J, Certified Nursing Assistant (CNA). She said she regularly took care of Resident #7. She confirmed the resident had not been out of bed and that was due to him not having a wheelchair. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A follow-up interview was conducted with Staff H, OTA and the Director of Rehabilitation (DOR). Staff H, OTA said she had no idea where the wheelchair went that therapy provided to Resident #7. She said nursing should not have been waiting on therapy to get the resident out of bed, they should have been getting him up daily. The DOR said therapy does not tell nursing if they can or cannot get a resident out of bed. He said therapy did an evaluation of the resident and let nursing know the level of assistance needed. The DOR said Resident #7 needed a full body mechanical lift to get up and nursing should have been getting him out of bed. An interview was conducted on 4/30/25 at 5:38 p.m. with Staff I, Physical Therapist (PT). Staff I, PT reviewed Resident #7's initial evaluation on 4/17/25 and his current evaluation on 4/30/25. He said Resident #7 declined in his functionality since his admission. Staff I, PT said on 4/17/25 the resident completed sit to stand transfers with moderate assistance and on 4/30/25 he was totally dependent. He said on 4/17/25, the resident was able to ambulate 6 feet using a 2-wheel walker with moderate assistance and on 4/30/25 the resident was unable to do the task. The physical therapy evaluation provided noted Resident #7's decline in function. Staff I, PT said if a resident does not get out of bed it can cause their muscles to atrophy and the resident can weaken and decline in function. An interview was conducted on 4/30/25 at 6:44 p.m. with the Nursing Home Administrator (NHA). The NHA said she would expect staff to be following physician orders. She said she had not been aware of issues with Resident #7's tube feed, antibiotics not being administered correctly, or him being left in bed until today. She said the issues will be addressed. On 4/30/25, the DON stated the facility did not have the requested polices on getting residents out of bed or tube feedings. 37999 2. On 4/29/25 at 9:17 a.m., Resident #7 was observed lying in bed. The resident's bottom teeth were covered with a yellow/tan colored substance and a watery, tan colored liquid was observed in the resident's mouth. An intravenous (IV) pole was standing between the bed and window and hanging from the pole was an empty IV medication bag, labeled with the residents name, name of the medication Zerbaxa, and tubing wrapped around the wings of the pole. The IV medication was dated 4/28/25 and not running. Review of Resident #7s medical record showed a medication list from an acute care facility, printed on 4/17/25 at 10:46 a.m., revealing the resident was to receive ceftolozane-tazobactam 1.5-gram (g) in sodium chloride 0.9%, 100 milliliter (mL) IV piggyback (IVPB) - Infuse 1.5g into a venous catheter every 8 (eight) hours for 35 doses. Last time this was given: April 17, 2025, at 6:05 a.m. Review of Resident #7s Admit/Readmit Assessment, effective 4/17/25 at 5:15 p.m. revealed a temperature reading of 98.5 degrees Fahrenheit taken 4/17/25 at 2:36 p.m., a blood pressure and pulse taken on 4/17/25 at 5:07 p.m. and 5:08 p.m., a weight of 139.0 pounds taken on 3/9/22 at 1:44 p.m. (previous admission), respiration rate of 18 taken 3/13/22 at 3:47 a.m. (previous admission), and a height on 3/6/22 at 2:06 p.m. (previous admission). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #7s April Medication Administration Record (MAR), printed on 4/30/25 at 11:45 a.m., revealed an order for Cetfolozane-Tazobactam Intravenous solution reconstituted 1.5 (1-0.5) gram (GM) (Ceftolozane Sulfate - Tazobactam Sodium) - Use 1.5 gm intravenously three times a day for urinary tract infection (UTI) for 35 administrations. The order was started on 4/17/25 at 10:00 p.m. and discontinued on 4/29/25 at 9:03 a.m. The MAR had X documentation for the 6:00 a.m. and 2:00 p.m. doses on 4/17/25, allowed for 35 doses to be administered, three doses daily on 4/18/25 to 4/28/25 (11 days) and one dose each on 4/17/25 and 4/29/25, the 35th dose to be administered on 4/29/25 at 6:00 a.m., the rest of the order was marked with X. The MAR included the following dosage documentation with corresponding chart codes related to the administration of the resident's antibiotic: - 4/17/25 at 10:00 p.m. - 1 = Absent from home without meds. - 4/18/25 at 6:00a.m. - 1 = Absent from home without meds. - 4/18/25 at 2:00 p.m. - 5 = Hold/See Progress Notes. - 4/19/25 at 10:00 p.m. - no documentation. - 4/24/25 at 6:00 a.m. - 5 = Hold/See Progress Notes. - 4/24/25 at 2:00 p.m. - 5 = Hold/See Progress Notes. - 4/26/25 at 6:00 a.m. - no documentation. - 4/28/25 at 6:00 a.m. - no documentation. The MAR showed the resident missed 8 of the 35 ordered doses. Review of Resident #7s progress notes included the following notes related to the missed doses of Ceftolozane-Tazobactam Intravenous solution: - 4/18 at 1:36 p.m.: Medication unavailable at this time. Not available in [electronic medication dispenser]. MD (Medical Doctor) and representative (RP) aware. No signs/symptoms (s/s) of any adverse reactions. No new orders. Pharmacy to deliver. Plan of care ongoing. - The notes revealed no progress note was written on 4/19/25 for the resident. - 4/24/25 at 8:19 a.m.: Med on hold, MD notified. - 4/24/25 at 8:22 a.m.: Resident antibiotic (ABT) on hold. MD notified. - 4/24/25 at 2:53 p.m.: MD ordered put in hold the medication. - 4/26/25 showed no progress note was written regarding the 6:00 a.m. dose. - 4/28/25 showed no progress notes was written on that day. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A progress note written on 4/29/25 at 9:15 a.m. showed Review of resident's IV medication. Resident received the 35 required doses of the medication. Medication was discontinued. Will follow up with [Infectious Disease] ID. Review of Resident #7's Order Summary Report, active as of 4/30/25 at 11:43 a.m. showed an order Discontinue (D/C) PICC line. Therapy complete, dated 4/29/25. A note, effective 4/29/25 at 1:30 p.m. regarding the Normal Saline flush of Resident #7s Central line/ peripherally inserted central catheter (PICC)/Midline revealed line has been removed. The report did not reveal an active order for Ceftolozane-Tazobactam. An interview was conducted with Staff L, Licensed Practical Nurse/Unit Manager (LPN/UM) on 4/30/25 at 1:15 p.m. The staff member stated, regarding Resident #7's Ceftolozane-Tazobactam, knowing the medication was hard to get from pharmacy due to the cost and the facility was only able to get a couple of days at a time. Staff L, LPN/UM reported there was a time the Director of Nursing (DON) was pre-approving it daily and if it was not available the doctor was to be notified. The staff member stated she was unaware of the physician holding the medication (4/24 doses) and stated wonder if it wasn't some of the nurses who don't speak well put the note in. The LPN/UM reviewed the resident's MAR and stated it did not look like the resident received the ordered 35 doses. The staff reported Staff E, LPN/Infection Preventionist (IP), counted the doses up yesterday and told her the resident received the 35 doses. An interview was conducted with Staff F, LPN on 4/30/25 at 1:31 p.m. The staff member reported administering all of Resident #7's IV antibiotics. The staff member reported not having the medication until pharmacy delivered it and there would have been no reason why the staff member would not have administered them. An interview was conducted with Staff E, LPN/IP on 4/30/25 at 1:40 p.m. The staff member reported starting to work for the facility on 4/17/25. The staff member confirmed Resident #7 was to receive the IV antibiotic Ceftolozane-Tazobactam for 35 doses and the facility had a hard time getting the medication from pharmacy. The staff member reported the facility kept adding doses to the end because of the missed doses. Staff E, LPN/IP stated the original order was for it to end on the 25th of April and the physician extended it out to the 29th. Staff E, LPN/IP stated All I know the nurses said the resident finished the IV's. She reported being unable to pull the MAR and spoken with Infectious Disease (ID) and the physician on the 29th. Staff E, LPN/IP reported informing ID and the physician that according to staff, the resident completed the 35 doses of the antibiotic, and the Assistant Director of Nursing (ADON) spoke with the physician and received an order to pull the IV line. During the interview, at 1:51 p.m. the ADON came into Staff E's office and said she had not spoken with the physician, the DON had spoken with him. The DON stepped into the office and said Staff L, LPN/UM spoke with the physician while in the DON's office. Staff E, LPN/IP reviewed Resident #7's MAR and confirmed No he did not the resident had not received the ordered 35 doses of antibiotic. The DON stated Staff E, LPN/IP came to her and said the resident had all the doses and Staff L, LPN/UM had gotten the order to pull the IV line. The DON reviewed the resident's MAR and said the facility was aware now the resident had not received the 35 doses and the physician was notified of the medication error. Review of Resident #7s MAR showed an order, started on 4/30/25 at 2:45 p.m., to Insert PICC [peripherally inserted central catheter] line. May use 1% lidocaine for insertion. One time only for medication administration for 2 days. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A general nurse's note, created 4/30/25 at 3:03 p.m. by Staff E and effective 4/30/25 at 12:54 a.m., revealed Call placed to Nurse Practitioner (NP) regarding resident IV therapy. Resident requires 8 more doses of ABT. Discussed with NP and order was given to have PICC line reinserted and to give resident remaining required doses. Call made to RP by ADON with verbal consent to have PICC line reinserted. IV Team called and will be out to reinsert line. Resident to follow up with ID next Thursday. On 4/30/25 at 4:36 p.m., Resident #7 was observed lying on right side. The observation did not show a new IV catheter had been placed. Review of the MAR showed a new order for Ceftolozane-Tazobactam was to start on 4/30/25 at 10:00 p.m. The review revealed the resident missed 4 doses of the 8 already missed due to the facility not ensuring 35 doses had been administered and discontinued the PICC line requiring the resident to have another inserted before completing the doses of IV antibiotics. 3. Review of the facility's Incident Log revealed a medication error occurred on 3/28/25 at 5:50 p.m. with Resident #4. Review of Resident #4's Admission Record revealed the resident was admitted on [DATE] and 3/7/25. The record included diagnoses not limited to intraspinal abscess and granuloma, unspecified local infection of the skin and subcutaneous tissue, unspecified organism sepsis, unspecified disorder involving the immune mechanism, osteomyelitis of vertebra lumbar region, and chronic myeloproliferative disease. The resident was transferred to the hospital on 4/19/25 for uncontrolled pain. Review of Resident #4's progress notes revealed the following: - 3/27/25 at 2:58 p.m.: an order was entered for Daptomycin Intravenous Solution Reconstituted 500 mg. - 3/27/25 at 11:04 p.m.: Resident continue with IV treatment. No adverse reactions noted. PICC line on right arm, patent and intact. No redness or swelling noted. Flushed according medical orders. - 3/28/25 at 5:50 p.m.: Resident accidentally received Cefepime HCl (hydrochloride) Intravenous Solution 1 gram/50 milliliter. Family at bedside notified. DON notified. MD states to monitor resident for changes. MD states to perform 24 hour neuro checks. Resident denies pain or discomfort. Resident did not have signs of adverse reactions. Neuro in normal range. - 3/28/25 at 11:00 p.m.: Resident observed resting in bed. Resident denies pain or discomfort. Resident has no signs or symptoms of distress. Neuro check are with in normal range. - The progress notes did not contain a note written on 3/29/25. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Neurological Assessment Flow Sheet read *Med Error only for 24 hr neuro check. The instructions printed on top of the sheet showed neurological assessments to include level of consciousness, motor function (hand grasps), pain response, vital signs, pupil response, extremities (movement) and observations were to bed completed every 15 minutes for 2 hours, every 60 minutes for 4 hours, and every 8 hours for 16 hours. The sheet showed level of consciousness, pupil response, hand grasps, extremities, and vital signs continued as instructed every 15 minutes for 2 hours, every 30 minutes for 2 hours, every 60 minutes for 4 hours, stopping at 12:45 a.m., 6 hours and 45 minutes after the incident. The documentation did not reveal the neurological assessment had continued every 8 hours for 16 hours on 3/29/25. During an interview on 4/29/25 at 10:53 a.m., the DON reported having the position of DON for 2.5 weeks and provided one Investigation Statement regarding Resident #4's medication error. The DON stated Staff K, LPN was assisting another nurse, Staff M, LPN with hanging the IV medication for Resident #4, as Staff M, LPN was not IV certified and Staff K, LPN was. The DON stated Staff M, LPN gave Staff K, LPN the wrong medication. The DON reviewed the Investigation Statement from Staff K, LPN and stated the form was not filled out correctly, the incident was supposed to have been investigated, statements completed by those involved, and education should have been done. The DON reported she had not received education related to medication rights from the previous DON. An interview was conducted on 4/29/25 at 11:12 a.m. with Staff L, LPN/UM. Staff L, LPN/UM reported not finding out about the incident until the next day. Another nurse, Staff M, LPN, who wasn't IV certified, asked Staff K, LPN to hang the medication. Staff M, LPN had the medication all set up for Staff K, LPN and Staff K, LPN, had not checked it before administration. An interview was conducted on 4/30/25 at 6:35 p.m. with the Nursing Home Administrator/Risk Manager (NHA/RM). The NHA reported being informed of the incident when it occurred with the previous DON informing her that education had started. The NHA stated nurses are supposed to be IV certified, not all of them are and did not know if Staff M, LPN had been certified. An interview was conducted on 4/30/25 at 6:45 p.m. with Staff K, LPN. The staff member reported Resident #4 was not on assignment the day of the incident and the error was on him. Staff M, LPN couldn't hang the antibiotic, wasn't IV certified, and came to the staff member a couple of times. Staff K, LPN stated Staff M, LPN had the medication bag and tubing and told the staff member all that had to be done was to hang it. Staff K, LPN did not verify if the medication bag had been spiked prior to receiving it. Staff K, LPN reported asking the other staff member to verify the medication was for the B-bed. Staff K, LPN stated, I should have pulled my own stuff and the medication ran for approximately 5 minutes. Staff K, LPN reported taking over the resident and apologized to the family. Staff K, LPN reported talking to the family a couple of times to update on condition, wrote a statement day of the incident, started neuro checks. Review of the policy titled Medication Administration, undated, revealed the following: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. The policy instructed staff to correct any discrepancies and report to the nurse manager. The compliance guidelines instructed staff: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- 10. Review MAR to identify medication to be administered. - 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. - 17. Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR. Review of the policy titled Abuse, Neglect, and Exploitation, undated, showed the following: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, in misappropriation of resident property. The policy defined neglect as failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy Explanation and Compliance Guidelines included: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; b. Established policies and procedures to investigate any such allegations; and c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, reporting procedures, dementia management, and resident abuse prevention; and d. Establish coordination with the QAPI program. 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. III. Prevention of Abuse, Neglect, and Exploitation. The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: . B. Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/ or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; (continued on next page)

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	106069	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Wales Wellness and Rehabilitation Center	730 N Scenic Hwy Lake Wales, FL 33853

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F 0600 Level of Harm - Actual harm Residents Affected - Few	C. Assuring an assessment of resources needed to provide care and services to all residents is included in the facility assessment; D. Identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents both needs and behaviors which might lead to a conflict or a neglect. IV. Prevention of Abuse, Neglect, and Exploitation A. The facility will have written procedures to assist staff in identifying the types of abuse - mental/ verbal abuse, sexual abuse, physical abuse, and deprivation by an individual of goods and services. B. Possible indicators of abuse include, but are not limited to: . 8. Failure to provide caring needs such as feeding, bathing, dressing, turning and positioning.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, record review, and interviews, the facility failed to thoroughly investigate and provide staff with education following a medication error incident for one resident (#4) of one resident incident involving medication errors. Findings included: Review of Resident #4's Admission Record revealed the resident was admitted on [DATE] and 3/7/25. The record included diagnoses not limited to intraspinal abscess and granuloma, unspecified local infection of the skin and subcutaneous tissue, unspecified organism sepsis, unspecified disorder involving the immune mechanism, osteomyelitis of vertebra lumbar region, and chronic myeloproliferative disease. The resident was transferred to the hospital on 4/19/25 for uncontrolled pain. Review of the facility's Incident Log revealed a medication error occurred on 3/28/25 at 5:50 p.m. with Resident #4. Review of Resident #4's progress notes revealed the following: - 3/27/25 at 2:58 p.m.: an order was entered for Daptomycin Intravenous Solution Reconstituted 500 mg. - 3/27/25 at 11:04 p.m.: Resident continue with IV treatment. No adverse reactions noted. PICC line on right arm, patent and intact. No redness or swelling noted. Flushed according medical orders. - 3/28/25 at 5:50 p.m.: Resident accidentally received Cefepime HCl (hydrochloride) Intravenous Solution 1 gram/50 milliliter. Family at bedside notified. DON notified. MD states to monitor resident for changes. MD states to perform 24 hour neuro checks. Resident denies pain or discomfort. Resident did not have signs of adverse reactions. Neuro in normal range. - 3/28/25 at 11:00 p.m.: Resident observed resting in bed. Resident denies pain or discomfort. Resident has no signs or symptoms of distress. Neuro check are with in normal range. - The progress notes did not contain a note written on 3/29/25. During an interview on 4/29/25 at 10:53 a.m., the Director of Nursing (DON) reported having the position of DON for 2.5 weeks. The DON provided one Investigation Statement completed by Staff K, Licensed Practical Nurse (LPN) regarding Resident #4's medication error. The DON reported Staff K, LPN, hung the wrong medication for Resident #4. Staff M, LPN provided the medication to Staff K, LPN. The DON reviewed the Investigation Statement dated 3/28/25 with information provided by Staff K, LPN and stated the form was not filled out correctly, the incident was supposed to be investigated, statements completed by those involved, and education provided on the seven rights of medication administration. The DON stated the facility could not find any proof education had been at the time of the incident. She stated she would have gotten education from the previous DON related to medication administration at time of incident and had not received any. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the statement written by Staff K, LPN revealed the following questions and responses: - When did you last care for the resident? 3/28/25 5:30 p.m. (1730) - In what capacity were you caring for the resident? Help his nurse hang IV. - Did you witness the incident? Yes - How did you become aware of the incident? Told by fell ow nurse. - What did you see concerning the incident? Wrong IV Med hung. - What did you hear at the time of the incident? Nothing. - What immediate action did you take? MD notified, DON notified, son notified, Neuro check started. - Who did you report the incident to? MD, DON, son - When did you report the incident? 5:50 p.m. (1750) - Was someone assisting you at the time of the incident? No (check mark in box) - Who else may have information regarding the incident? Nurse [Staff M, LPN]. - What, if anything, is your knowledge of the resident? (blank) - What additional information do you have that has not already been discussed regarding the incident? (blank). During an interview on 4/29/25 at 11:12 a.m. Staff L, LPN/Unit Manager (UM) reported not knowing about Resident #4's medication error until the next day. The staff member stated another nurse, who wasn't IV certified, had asked Staff K, LPN to hang the resident's IV medication. Staff L, LPN/UM said Staff M, LPN had the medication all set and asked Staff K, LPN to hang it and the staff member did not check it before hanging. Staff L, LPN/UM stated the previous DON had been on call and, per her understanding, had gotten all the statements. Staff L, LPN/UM stated when the previous DON was talking about the incident, she asked the staff member what the 7 medication rights were. Staff L, LPN/UM reported today was the first time she received formal education on medication rights related to the incident and had not received education on what to do if there was an incident. An interview was conducted on 4/30/25 at 6:35 p.m. with the Nursing Home Administrator/Risk Manager (NHA/RM). The NHA reported being informed of the incident when it occurred with the previous DON informing her that education had started. The NHA stated nurses are supposed to be IV certified, not all of them are and did not know if Staff M, LPN had been certified. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 4/30/25 at 6:45 p.m. with Staff K, LPN. The staff member reported Resident #4 was not on assignment the day of the incident and the error was on him. Staff M, LPN couldn't hang the antibiotic, wasn't IV certified, and came to the staff member a couple of times. Staff K, LPN stated Staff M, LPN had the medication bag and tubing and told the staff member all that had to be done was to hang it. Staff K, LPN did not verify if the medication bag had been spiked prior to receiving it. Staff K, LPN reported asking the other staff member to verify the medication was for the B-bed. Staff K, LPN stated, I should have pulled my own stuff and the medication ran for approximately 5 minutes. Staff K, LPN reported taking over the resident and apologized to the family. Staff K, LPN reported talking to the family a couple of times to update on condition and wrote a statement day of the incident. The staff member reviewed the written statement and confirmed it was not a thorough statement. Review of the policy titled Abuse, Neglect, and Exploitation, undated, showed the following: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, in misappropriation of resident property. The policy defined neglect as failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy Explanation and Compliance Guidelines included: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; b. Established policies and procedures to investigate any such allegations; and c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, reporting procedures, dementia management, and resident abuse prevention; and d. Establish coordination with the QAPI program. 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. III. Prevention of Abuse, Neglect, and Exploitation. The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/ or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; C. Assuring an assessment of resources needed to provide care and services to all residents is included in the facility assessment; D. Identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents both needs and behaviors which might lead to a conflict or a neglect. IV. Prevention of Abuse, Neglect, and Exploitation A. The facility will have written procedures to assist staff in identifying the types of abuse - mental/ verbal abuse, sexual abuse, physical abuse, and deprivation by an individual of goods and services. B. Possible indicators of abuse include, but are not limited to: . 8. Failure to provide caring needs such as feeding, bathing, dressing, turning and positioning. V. Investigation of alleged abuse, neglect, and exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g. Not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation and determining if abuse, neglect, exploitation, and/ or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.

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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** 46234 Based on observations, interviews, and record reviews, the facility did not ensure oxygen therapy was provided as ordered for one resident (#6) out of three residents reviewed with continuous oxygen. Findings included: An observation and interview were conducted on 4/29/25 at 9:50 a.m. of Resident #6 sitting in a wheelchair in her room. The resident had a nasal cannula in place with oxygen tubing attached to a portable oxygen tank on her wheelchair. The oxygen tank was observed to be empty. The resident said she wore oxygen due to asthma and sometimes she wheezed when she was breathing. Review of Admission Records showed Resident #6 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD). Review of Resident #6's care plan showed a focus area of risk for shortness of breath and/or respiratory distress related to diagnosis of COPD. Interventions included oxygen 2 liters (L) via nasal cannula continuous. Review of Resident #6's physician orders showed Oxygen 2L continuous every shift related to COPD, dated 9/30/24. An observation and interview were conducted on 4/29/25 at 11:25 a.m. of Resident #6 sitting in her wheelchair on the covered patio. The resident had the nasal cannula in place and the oxygen tank remained empty. At 1:51 p.m., the resident remained in the same location and her oxygen tank was empty. An interview was conducted on 4/29/25 at 1:19 p.m. with Staff A, Certified Nursing Assistant (CNA). She said if a CNA is getting a resident on continuous oxygen out of the bed to the wheelchair and they are leaving their room, the CNA would move the oxygen tubing from the oxygen concentrator to the portable oxygen tank on their wheelchair and turn it on. She said the CNA should check and make sure the oxygen tank was not on yellow or red, meaning low or empty, when they hook up the tubing and turn the oxygen on. An observation and interview was conducted on 4/29/25 at 1:24 p.m. with Staff B, CNA. Staff B, CNA was observed exiting a back door of the facility and showing where oxygen canisters were located. She showed several empty oxygen tanks and said the metal cage had several full oxygen tanks. Staff B, CNA said there was plenty of stock and she had never known them to run out of full oxygen tanks. Several full oxygen tanks were observed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 4/29/25 at 2:00 p.m. with Staff C, Registered Nurse (RN). She confirmed she was assigned to Resident #6 on 4/29/25 from 7:00 a.m. to 3:00 p.m. She reviewed Resident #6's physician orders and confirmed the resident had an order for oxygen 2 L continuously. She said the CNAs are the ones that hook the residents up to the portable oxygen tank when they transfer them to the wheelchair, and they will replace the tank if it was needed. Staff C, RN said it was unacceptable that Resident #6 had an empty oxygen tank since that morning, and she would get it switched out. An observation and interview was conducted on 4/29/25 at 2:10 p.m. with Staff D, CNA. She confirmed she was assigned Resident #6 on 4/29/25 from 7:00 a.m. to 3:00 p.m. She was observed bringing Resident #6 back to her room to change out the oxygen tank. She said for residents on oxygen, she changed the oxygen tank in the morning and sometimes again before her shift ended if it needed it. She said she changed Resident #6's oxygen tank that morning and even turned it on and heard air come out. Staff D, CNA said she didn't know why the tank was empty all day. Staff D, CNA was observed checking the oxygen tank on Resident #6's wheelchair and confirmed it was empty. An interview was conducted on 4/30/25 at 1:23 p.m. with Staff E, Licensed Practical Nurse (LPN)/Unit Manager (UM). She said she was notified of the concerns with Resident #6's oxygen and agreed it was not acceptable that the resident had an empty oxygen tank. An interview was conducted on 4/30/25 at 2:28 p.m. with the Director of Nursing (DON). She said the CNAs can get the oxygen tanks out of storage and bring them in, but nurses are the ones that should hook it up and turn the oxygen on. She said she was not aware CNAs were hooking up and starting oxygen. The DON said her expectation was oxygen tanks should have been checked and not be empty. Review of a facility policy titled Oxygen Administration, undated, showed: Policy Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Policy Explanations and Compliance Guidelines 1. Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. 2. Personnel authorized to initiate oxygen therapy include physicians, RN's, LPNs, and respiratory therapists. . Photographic Evidence Obtained

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 37999 Based on observations, record review, and interviews, the facility failed to provide staff with the appropriate competencies and skill sets to assure three residents (#4, #7, and #9) received medications as ordered by the physician. Findings included: 1. Review of Resident #4's Admission Record revealed the resident was admitted on [DATE] and 3/7/25. The record included diagnoses not limited to intraspinal abscess and granuloma, unspecified local infection of the skin and subcutaneous tissue, unspecified organism sepsis, unspecified disorder involving the immune mechanism, osteomyelitis of vertebra lumbar region, and chronic myeloproliferative disease. The resident was transferred to the hospital on 4/19/25 for uncontrolled pain. Review of the facility's Incident Log revealed a medication error occurred on 3/28/25 at 5:50 p.m. with Resident #4. Review of Resident #4's progress notes revealed the following: - 3/27/25 at 2:58 p.m.: an order was entered for Daptomycin Intravenous Solution Reconstituted 500 mg. - 3/27/25 at 11:04 p.m.: Resident continue with IV treatment. No adverse reactions noted. PICC line on right arm, patent and intact. No redness or swelling noted. Flushed according medical orders. - 3/28/25 at 5:50 p.m.: Resident accidentally received Cefepime HCl (hydrochloride) Intravenous Solution 1 gram/50 milliliter. Family at bedside notified. DON notified. MD states to monitor resident for changes. MD states to perform 24 hour neuro checks. Resident denies pain or discomfort. Resident did not have signs of adverse reactions. Neuro in normal range. - 3/28/25 at 11:00 p.m.: Resident observed resting in bed. Resident denies pain or discomfort. Resident has no signs or symptoms of distress. Neuro check are with in normal range. - The progress notes did not contain a note written on 3/29/25. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Neurological Assessment Flow Sheet read *Med Error only for 24 hr neuro check. The instructions printed on top of the sheet showed neurological assessments to include level of consciousness, motor function (hand grasps), pain response, vital signs, pupil response, extremities (movement) and observations were to bed completed every 15 minutes for 2 hours, every 60 minutes for 4 hours, and every 8 hours for 16 hours. The sheet showed level of consciousness, pupil response, hand grasps, extremities, and vital signs continued as instructed every 15 minutes for 2 hours, every 30 minutes for 2 hours, every 60 minutes for 4 hours, stopping at 12:45 a.m., 6 hours and 45 minutes after the incident. The documentation did not reveal the neurological assessment had continued every 8 hours for 16 hours on 3/29/25. During an interview on 4/29/25 at 10:53 a.m., the DON reported having the position of DON for 2.5 weeks and provided one Investigation Statement regarding Resident #4's medication error. The DON stated Staff K, LPN was assisting another nurse, Staff M, LPN with hanging the IV medication for Resident #4, as Staff M, LPN was not IV certified and Staff K, LPN was. The DON stated Staff M, LPN gave Staff K, LPN the wrong medication. The DON reviewed the Investigation Statement from Staff K, LPN and stated the form was not filled out correctly, the incident was supposed to have been investigated, statements completed by those involved, and education should have been done. The DON reported she had not received education related to medication rights from the previous DON. During an interview on 4/29/25 at 11:12 a.m. Staff L, LPN/Unit Manager (UM) reported not knowing about Resident #4's medication error until the next day. The staff member stated another nurse, who wasn't IV certified, had asked Staff K, LPN to hang the resident's IV medication. Staff L, LPN/UM said Staff M, LPN had the medication all set and asked Staff K, LPN to hang it and the staff member did not check it before hanging. Staff L, LPN/UM stated the previous DON had been on call and, per her understanding, had gotten all the statements. Staff L, LPN/UM stated when the previous DON was talking about the incident, she asked the staff member what the 7 medication rights were. Staff L, LPN/UM reported today was the first time she received formal education on medication rights related to the incident and had not received education on what to do if there was an incident. An interview was conducted on 4/30/25 at 6:35 p.m. with the Nursing Home Administrator/Risk Manager (NHA/RM). The NHA reported being informed of the incident when it occurred with the previous DON informing her that education had started. The NHA stated nurses are supposed to be IV certified, not all of them are and did not know if Staff M, LPN had been certified. An interview was conducted on 4/30/25 at 6:45 p.m. with Staff K, LPN. The staff member reported Resident #4 was not on assignment the day of the incident and the error was on him. Staff M, LPN couldn't hang the antibiotic, wasn't IV certified, and came to the staff member a couple of times. Staff K, LPN stated Staff M, LPN had the medication bag and tubing and told the staff member all that had to be done was to hang it. Staff K, LPN did not verify if the medication bag had been spiked prior to receiving it. Staff K, LPN reported asking the other staff member to verify the medication was for the B-bed. Staff K, LPN stated, I should have pulled my own stuff and the medication ran for approximately 5 minutes. Staff K, LPN reported taking over the resident and apologized to the family. Staff K, LPN reported talking to the family a couple of times to update on condition, wrote a statement day of the incident, started neuro checks. 2. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/25 at 9:17 a.m., Resident #7 was observed lying in bed. The resident's bottom teeth were covered with a yellow/tan colored substance and a watery, tan colored liquid was observed in the resident's mouth. An intravenous (IV) pole was standing between the bed and window and hanging from the pole was an empty IV medication bag, labeled with the residents name, name of the medication Zerbaxa, and tubing wrapped around the wings of the pole. The IV medication was dated 4/28/25 and not running. Review of Resident #7's Admission Record revealed the resident was admitted [DATE] and readmitted on [DATE], with diagnoses including unspecified organism sepsis, pneumonitis due to inhalation of food and vomit, and resistance to multiple antimicrobial drugs. Review of Resident #7s Admit/Readmit Assessment, effective 4/17/25 at 5:15 p.m. revealed a temperature reading of 98.5 degrees Fahrenheit taken 4/17/25 at 2:36 p.m., a blood pressure and pulse taken on 4/17/25 at 5:07 p.m. and 5:08 p.m., a weight of 139.0 pounds taken on 3/9/22 at 1:44 p.m. (previous admission), respiration rate of 18 taken 3/13/22 at 3:47 a.m. (previous admission), and a height on 3/6/22 at 2:06 p.m. (previous admission). Review of Resident #7s medical record showed a medication list from an acute care facility, printed on 4/17/25 at 10:46 a.m., revealing the resident was to receive ceftolozane-tazobactam 1.5-gram (g) in sodium chloride 0.9%, 100 milliliter (mL) IV piggyback (IVPB) - Infuse 1.5g into a venous catheter every 8 (eight) hours for 35 doses. Last time this was given: April 17, 2025, at 6:05 a.m. Review of Resident #7s April Medication Administration Record (MAR), printed on 4/30/25 at 11:45 a.m., revealed an order for Cetfolozane-Tazobactam Intravenous solution reconstituted 1.5 (1-0.5) gram (GM) (Ceftolozane Sulfate - Tazobactam Sodium) - Use 1.5 gm intravenously three times a day for urinary tract infection (UTI) for 35 administrations. The order was started on 4/17/25 at 10:00 p.m. and discontinued on 4/29/25 at 9:03 a.m. The MAR had X documentation for the 6:00 a.m. and 2:00 p.m. doses on 4/17/25, allowed for 35 doses to be administered, three doses daily on 4/18/25 to 4/28/25 (11 days) and one dose each on 4/17/25 and 4/29/25, the 35th dose to be administered on 4/29/25 at 6:00 a.m., the rest of the order was marked with X. The MAR included the following dosage documentation with corresponding chart codes related to the administration of the resident's antibiotic: - 4/17/25 at 10:00 p.m. - 1 = Absent from home without meds. - 4/18/25 at 6:00a.m. - 1 = Absent from home without meds. - 4/18/25 at 2:00 p.m. - 5 = Hold/See Progress Notes. - 4/19/25 at 10:00 p.m. - no documentation. - 4/24/25 at 6:00 a.m. - 5 = Hold/See Progress Notes. - 4/24/25 at 2:00 p.m. - 5 = Hold/See Progress Notes. - 4/26/25 at 6:00 a.m. - no documentation. - 4/28/25 at 6:00 a.m. - no documentation. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MAR showed the resident missed 8 of the 35 ordered doses. Review of Resident #7s progress notes included the following notes related to the missed doses of Ceftolozane-Tazobactam Intravenous solution: - 4/18 at 1:36 p.m.: Medication unavailable at this time. Not available in [electronic medication dispenser]. MD (Medical Doctor) and representative (RP) aware. No signs/symptoms (s/s) of any adverse reactions. No new orders. Pharmacy to deliver. Plan of care ongoing. - The notes revealed no progress note was written on 4/19/25 for the resident. - 4/24/25 at 8:19 a.m.: Med on hold, MD notified. - 4/24/25 at 8:22 a.m.: Resident antibiotic (ABT) on hold. MD notified. - 4/24/25 at 2:53 p.m.: MD ordered put in hold the medication. - 4/26/25 showed no progress note was written regarding the 6:00 a.m. dose. - 4/28/25 showed no progress notes was written on that day. A progress note written on 4/29/25 at 9:15 a.m. showed Review of resident's IV medication. Resident received the 35 required doses of the medication. Medication was discontinued. Will follow up with [Infectious Disease] ID. Review of Resident #7's Order Summary Report, active as of 4/30/25 at 11:43 a.m. showed an order Discontinue (D/C) PICC line. Therapy complete, dated 4/29/25. A note, effective 4/29/25 at 1:30 p.m. regarding the Normal Saline flush of Resident #7s Central line/ peripherally inserted central catheter (PICC)/Midline revealed line has been removed. The report did not reveal an active order for Ceftolozane-Tazobactam. An interview was conducted with Staff L, Licensed Practical Nurse/Unit Manager (LPN/UM) on 4/30/25 at 1:15 p.m. The staff member stated, regarding Resident #7's Ceftolozane-Tazobactam, knowing the medication was hard to get from pharmacy due to the cost and the facility was only able to get a couple of days at a time. Staff L, LPN/UM reported there was a time the Director of Nursing (DON) was pre-approving it daily and if it was not available the doctor was to be notified. The staff member stated she was unaware of the physician holding the medication (4/24 doses) and stated wonder if it wasn't some of the nurses who don't speak well put the note in. The LPN/UM reviewed the resident's MAR and stated it did not look like the resident received the ordered 35 doses. The staff reported Staff E, LPN/Infection Preventionist (IP), counted the doses up yesterday and told her the resident received the 35 doses. An interview was conducted with Staff F, LPN on 4/30/25 at 1:31 p.m. The staff member reported administering all of Resident #7's IV antibiotics. The staff member reported not having the medication until pharmacy delivered it and there would have been no reason why the staff member would not have administered them. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Staff E, LPN/IP on 4/30/25 at 1:40 p.m. The staff member reported starting to work for the facility on 4/17/25. The staff member confirmed Resident #7 was to receive the IV antibiotic Ceftolozane-Tazobactam for 35 doses and the facility had a hard time getting the medication from pharmacy. The staff member reported the facility kept adding doses to the end because of the missed doses. Staff E, LPN/IP stated the original order was for it to end on the 25th of April and the physician extended it out to the 29th. Staff E, LPN/IP stated All I know the nurses said the resident finished the IV's. She reported being unable to pull the MAR and spoken with Infectious Disease (ID) and the physician on the 29th. Staff E, LPN/IP reported informing ID and the physician that according to staff, the resident completed the 35 doses of the antibiotic, and the Assistant Director of Nursing (ADON) spoke with the physician and received an order to pull the IV line. During the interview, at 1:51 p.m. the ADON came into Staff E's office and said she had not spoken with the physician, the DON had spoken with him. The DON stepped into the office and said Staff L, LPN/UM spoke with the physician while in the DON's office. Staff E, LPN/IP reviewed Resident #7's MAR and confirmed No he did not the resident had not received the ordered 35 doses of antibiotic. The DON stated Staff E, LPN/IP came to her and said the resident had all the doses and Staff L, LPN/UM had gotten the order to pull the IV line. The DON reviewed the resident's MAR and said the facility was aware now the resident had not received the 35 doses and the physician was notified of the medication error. Review of Resident #7s MAR showed an order, started on 4/30/25 at 2:45 p.m., to Insert PICC [peripherally inserted central catheter] line. May use 1% lidocaine for insertion. One time only for medication administration for 2 days. A general nurse's note, created 4/30/25 at 3:03 p.m. by Staff E and effective 4/30/25 at 12:54 a.m., revealed Call placed to Nurse Practitioner (NP) regarding resident IV therapy. Resident requires 8 more doses of ABT. Discussed with NP and order was given to have PICC line reinserted and to give resident remaining required doses. Call made to RP by ADON with verbal consent to have PICC line reinserted. IV Team called and will be out to reinsert line. Resident to follow up with ID next Thursday. On 4/30/25 at 4:36 p.m., Resident #7 was observed lying on right side. The observation did not show a new IV catheter had been placed. Review of the MAR showed a new order for Ceftolozane-Tazobactam was to start on 4/30/25 at 10:00 p.m. The review revealed the resident missed 4 doses of the 8 already missed due to the facility not ensuring 35 doses had been administered and discontinued the PICC line requiring the resident to have another inserted before completing the doses of IV antibiotics. 3. On 4/30/25 at 9:37 a.m., an observation of medication administration with Staff G, Licensed Practical Nurse (LPN) was conducted with Resident #9. The staff member dispensed the following medications for administration to Resident #9: - alprazolam 0.25 milligram (mg) tablet - dicyclomine 10 mg capsule (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Aspirin 81mg enteric coated over-the-counter (otc) tablet - bupropion 75 mg tablet - gabapentin 300 mg capsule - Multi vitamin otc tablet - senna 8.6 mg otc tablet - sucralfate 1 gram (gm) tablet - timolol 0.5% eye drops - latanoprost 0.005% eye drops The staff member confirmed dispensing 8 oral medications and 2 eye drops. Staff G, LPN returned to the resident room and handed the medication cup to the resident, who swallowed medications at one time. The staff member applied gloves, then ungloved to retrieve a roll of paper towel from closet for the resident. Staff G, LPN washed her hands, applied gloves, and administered, at 10:02 a.m., one drop of Latanoprost into the residents left eye, immediately followed by one drop of Timolol in the left eye. Staff G, LPN confirmed both eye drops went into the same eye. The resident reported recently having eye surgery. The staff member left the room, went to the Unit Manager's office, and spoke for a moment before retrieving, at 10:08 a.m., Resident #9's Lantus insulin pen from the medication refrigerator. Staff G, LPN dispensed one capsule of saccharomyces boulardii 500 mg from an over-the-counter bottle in med cart. Staff G, LPN returned to the room, spilled the saccharomyces boulardii capsule on the floor, returned to the medication cart, and re-dispensed the capsule. The staff member washed her hands and administered the probiotic, before returning to the med cart to retrieve an insulin needle. The staff member primed the insulin pen using 2 units, dialed to 35 units, and injected insulin into the upper right arm of Resident #9. Immediately following the observation, Staff G, LPN stated the probiotic saccharomyces given was the generic of Lactobacillus ordered. Review of Resident #9s Medication Administration Record (MAR) revealed the following orders scheduled for 9:00 a.m. - Lactobacillus capsule - Give 1 capsule by mouth two times a day for Diabetes Mellitus (DM), started on 2/6/25 and discontinued on 4/30/25 at 10:56 a.m. The MAR showed the resident received this medication twice daily during the month of April. - Timolol Maleate Ophthalmic solution 0.5% - Instill one drop in left eye one time a day for glaucoma. - Latanoprost Ophthalmic emulsion 0.005% - Instill one drop in left eye two times a day for glaucoma. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/25 at 11:16 a.m., Staff L, LPN/Unit Manager (UM) stated Lactobacillus and Saccharomyces were not technically the same thing. Staff L, LPN/UM stated when a resident came in with Lactobacillus, they were supposed to be changed over to the stock probiotic saccharomyces. Staff L, LPN UM stated staff were supposed to wait 5-10 minutes between administering different types of eye drops. An interview was conducted on 4/30/25 at 2:42 p.m. with the Director of Nursing (DON). The DON stated since we were notified, we changed the order to the stock probiotic saccharomyces but the administration still constituted an error. She reported the facility does not have a policy/procedure for the administration of eye drops, but according to the nurse practice there should be 5-10 minutes between different eye drops. According to the American Academy of Ophthalmology, if taking more than one type of eye drop, wait 3 to 5 minutes between the different drops. https://www.aao.org/eye-health/treatments/how-to-put-in-eye-drops Review of the facility policy titled Medication Administration, undated, instructed staff to: . 10. MAR to identify the medication to be administered. 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. a. Refer 2 drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects. c. If other than oral (PO) route, administer in accordance with facility policy for the relevant route of administration (i.e., injection, eye, ear, rectal, etc.).

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 46234 Based on observations and interviews, the facility did not ensure the posted nurse staffing data was up-to-date and current from 4/18/25 to 4/30/25. Findings included: An observation was conducted on 4/29/25 at 6:15 a.m. of the Daily Nurse Staffing sheet posted in the front lobby of the facility. The posting was dated 4/17/25. The 4/17/25 posting remained in place on 4/29/25 at 1:28 p.m. An interview was conducted on 4/30/25 at 6:13 p.m. with the Staffing Coordinator. She stated she was the person responsible for posting the Daily Nurse Staffing data. She said she prints them out and hangs them or sometimes gives them to the front office to hang. She said she had been coming in later than usual and had not been ensuring it was done. She said she had not realized until 4/30/25 that it had not been updated since 4/17/25 and that is on her. An interview was conducted on 4/30/25 at 6:44 p.m. with the Nursing Home Administrator (NHA). She said she usually checked to ensure the nurse staffing information was posted but she had been slacking off on that. She confirmed it should have been updated daily. The NHA stated the facility did not have a policy related to posting the Daily Nurse Staffing data. Photographic Evidence Obtained

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50570 Based on record review and interviews, the facility did not ensure routine physician-ordered medications were acquired and provided upon admission for two residents (#3 and #8) of two residents reviewed. Findings included: 1. A review of Resident #3's Admission Record revealed an admitted [DATE], and a discharge date of [DATE], with diagnoses to include displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, acute pain due to trauma, chronic pain syndrome, unspecified asthma, uncomplicated, fibromyalgia, and migraine without aura, not intractable, with status migrainosus. A review of Resident #3's Admission Assessment, dated 1/24/25, revealed she came to the facility at approximately 6:30 p.m. A review of the Admission Assessment revealed it was completed by Staff K, Licensed Practical Nurse (LPN). Further review of the assessment revealed no documentation related to medications or communicating with the physician. A review of Resident #3's progress notes revealed the following: - On 1/25/25 at 11:52 p.m., meds have not arrived from pharmacy. new admission. unable to pull. pharmacy stated medication should arrive today. - On 1/26/25 at 7:19 a.m., Slept well. Wanted a pain pill not in from pharmacy yet offered her Tylenol which she didn't. - On 1/26/25 at 3:42 p.m., Lyrica Capsule 300 MG [milligrams] Give 1 capsule by mouth two times a day for Pain Medication not available, medication not administered, PT [patient] needs a script. MD [medical doctor] notified. PT husband notified. PT shows no s/s [signs and symptoms] of distress. - On 1/26/25 at 3:44 p.m., Eletriptan Hydrobromide Oral Tablet 40 MG Give 1 tablet by mouth one time a day for migraine Medication not available; Medication not administered. MD notified. PT husband notified. Pharmacy notified with an eta [estimated time of arrival] of 1/26/25. PT shows no s/s of distress. - On 1/26/25 at 8:15 p.m., Lyrica Capsule 300 MG Give 1 capsule by mouth two times a day for Pain medication not available. contacted pharmacy. MD notified. Resident and family notified. No signs of distress. Offered patient PRN [as needed] ibuprofen for pain. resident refused. A review of Resident #3's physician orders on admission to the facility revealed the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Venlafaxine HCl (hydrochloride) Oral Tablet 75 MG. Give 2 tablet by mouth at bedtime for depression, with an order date of 1/25/25. - Eletriptan Hydrobromide Oral Tablet 40 MG (Eletriptan Hydrobromide). Give 1 tablet by mouth one time a day for migraine, with an order date of 1/25/25. - Lyrica Capsule 300 MG (Pregabalin) *Controlled Drug* Give 1 capsule by mouth two times a day for pain, with an order date of 1/24/25. - Senokot S Oral Tablet 8.6-50 MG (Sennosides-Docusate Sodium) Give 2 tablet by mouth at bedtime for constipation, with an order date of 1/25/25. A review of Resident #3's January 2025 Medication Administration Record (MAR) revealed the following: - Eletriptan Hydrobromide Oral Tablet 40 MG, give 1 tablet by mouth one time a day for migraine, with a start date of 1/25/25, was not administered on 1/25/25 to 1/27/25. On 1/25/25, it was documented with a code of, 5=Hold/See Progress Notes. - Lyrica Capsule 300 MG (Pregabalin), give 1 capsule by mouth two times a day for pain, with a start date of 1/24/25, was not administered on 1/25/25 to 1/27/25. On 1/25/25 and 1/26/25, it was documented with a code of, 5=Hold/See Progress Notes. - Venlafaxine HCl Oral Tablet 75 MG, give 2 tablet by mouth at bedtime for depression, with an order date of 1/25/25, was not administered on 1/25/25. - Senokot S Oral Tablet 8.6-50 MG (Sennosides-Docusate Sodium), give 2 tablet by mouth at bedtime for constipation, with an order date of 1/25/25, was not administered on 1/25/25. 2. On 4/29/25 at 12:53 p.m., Resident #8 was observed sitting up in bed watching television. An interview was conducted where he stated, It was the worst night I ever had, and I want to leave. He said there were no medications last night for him. Resident #8 said he has diabetes and takes medications for that, but it was not provided. A review of Resident #8's Admission Record revealed an admitted [DATE], and a discharge date of [DATE], with diagnoses to include spondylosis without myelopathy or radiculopathy, lumbar region, type 2 diabetes mellitus diabetic nephropathy, other muscle spasm, bacteremia, and repeated falls. A review of Resident #8's Admission Assessment, dated 4/28/25, revealed he came to the facility at approximately 11:19 p.m. A review of the admission assessment revealed it was completed by Staff L, LPN. Further review of the assessment revealed no documentation related to medications or communicating with the physician. A review of Resident #8's progress notes revealed the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 4/28/25, Rosuvastatin Calcium Oral Tablet 5 MG Give 1 tablet by mouth at bedtime for hyperlipidemia new admit. meds pending delivery. - On 4/28/25, Metformin HCl ER Tablet Extended Release 24 Hour 500 MG Give 2 tablet by mouth at bedtime for Diabetes new admit. meds pending delivery. A review of Resident #8's physician orders on admission to the facility revealed the following to include: - Metformin HCl ER (extended release) Tablet Extended Release 24 Hour 500 MG Give 2 tablet by mouth at bedtime for Diabetes, with an order date of 4/28/25. - Rosuvastatin Calcium Oral Tablet 5 MG. Give 1 tablet by mouth at bedtime for hyperlipidemia, with an order date of 4/28/25. A review of Resident #8's April 2025 MAR revealed the following: - metformin HCl ER 500 mg, give 2 tablet by mouth at bedtime for Diabetes, was not provided. On 4/28/25, it was documented with a code of, 5=Hold/See Progress Notes. - rosuvastatin calcium oral tablet 5 mg, give 1 tablet by mouth at bedtime for hyperlipidemia, was not provided On 4/28/25, it was documented with a code of, 5=Hold/See Progress Notes. On 4/30/25 at 11:48 a.m., an interview was conducted with the Social Service Director (SSD) related to Resident #8. She said she spoke to Resident #8 and completed a grievance for him. The SSD confirmed the resident told her he didn't get his medications. She said she reviewed the electronic health record and his medications are, As needed. She said his medications are at the facility, but he needed to request them. A review of the facility's emergency drug kit (EDK) inventory list from 1/31/25 revealed the following medications were available: - pregabalin 25 mg capsules [generic for Lyrica] with 20 capsules on hand at that time. A review of the facility's EDK inventory list from 4/30/25 revealed the following medications are available: - atorvastatin 10 mg tablet with 8 tablets on hand. - metformin 500 mg tablet with 11 tablets on hand. An attempt was made during the survey to conduct phone interviews with Staff K, LPN and Staff N, LPN regarding Resident #3 and Resident #8. The attempts made were unsuccessful. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/25 at 11:29 a.m., an interview was conducted with Staff L, LPN/Unit Manager. She said the re-admission/admission process included obtaining a list of medications to process. She said the admitting nurse is supposed to input medications from the list. She said during daily morning meetings re-admission/new admission medications are reviewed, To make sure that's what it's supposed to be. Staff L, LPN/UM stated, If it's a house med [medication] and we don't have that particular dose, they can call the doctor, and they might say use what you got. She said if the facility does not have the medication, they try to obtain it from the EDK. Staff L, LPN/UM said if the medication is not in the EDK, they call the doctor. She said they call the pharmacy if the medication is a narcotic. She said the facility received medications from the pharmacy for new admissions, Depending on when it's entered. She said the pharmacy staff comes twice a day. She said for the, Night run, the cut off time is 10:00 p.m. She said when there is clarification needed, a high-cost medication or therapeutic interchange, there might be a delay in getting the medication. On 4/30/25 at 1:24 p.m., an interview with Staff F, LPN regarding the admission process, for a resident who comes from the hospital, revealed she receives the paperwork and reviews it. She said she goes through the resident's hospital medication list and checks if there's medication that have been stopped or re-ordered. Staff F, LPN said she puts the medications in the pharmacy order to be delivered. She said there are two cut-off times for pharmacy delivery. She said one of them is 10:00 a.m. for the 2:00 p.m. run. Staff F, LPN said for new admissions, most of the medications can be accessed from the EDK. She said if the medication is not in the facility, they wait for the medication delivery from the pharmacy or try to obtain them from the EDK. She said if it's a 3:00 p.m. admission, the resident is not going to receive the medication until 4:00 or 5:00 a.m. She said most emergency medications, narcotics and metformin, are in the EDK. On 4/30/25 at 3:10 p.m., an interview with the Director of Nursing (DON) was conducted. She said for admissions, staff obtain the discharge summary from the hospital to reconcile medications. She said the expectation is to order medications from the pharmacy and check the EDK to see if the medications are available. The DON said if the medications are not available, the admitting staff should call the doctor and ask for an alternative they might have at the facility. She confirmed nursing staff should have access to the EDK. She said pharmacy delivery comes twice a day, in the middle of night and in the morning around 11:00 a.m. The DON said there should be documentation in the progress notes about the medications not being available or a conversation with the doctor about approving an alternative. For Resident #8, she confirmed the facility has metformin and rosuvastatin in the EDK. She said she could not confirm why the resident did not receive those medications. She stated, Unless we were out of it in the EDK, and confirmed there was no documentation in Resident #8's progress notes. She said there was possibly a lot of other residents who were prescribed the same medications. She said the admitting nurse should have asked the doctor if they would approve rosuvastatin, instead of atorvastatin, for Resident #8. Regarding Resident #2, she stated there was, A totally different pharmacy in January. She said at that time, they had difficulty with obtaining approval for medications and refills. The DON said she is unsure if the medication Resident #2 was prescribed was in that EDK at that time. She stated, I cannot speak on what was in the [vendor name] at that time. On 4/30/25 at 3:32 p.m., an observation of the EDK system, with the DON, revealed there were 11 tablets of metformin 500 mg. She said she doesn't know when the EDK was last refilled by the pharmacy. On 4/30/25 at 4:42 p.m., an interview was conducted with the Nursing Home Administrator (NHA). The NHA said they do not have policies related to acquiring medications from pharmacy services or obtaining medications from the EDK system.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106069	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Wales Wellness and Rehabilitation Center	730 N Scenic Hwy Lake Wales, FL 33853

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 37999 Based on observations, record review, and interviews, the facility failed to ensure a medication administration error rate of less than 5.00%. Twelve medication administration opportunities were observed, and three errors were identified for one resident (#9) of one residents observed. These errors constituted a 25% medication error rate. Findings included: On 4/30/25 at 9:37 a.m., an observation of medication administration with Staff G, Licensed Practical Nurse (LPN) was conducted with Resident #9. The staff member dispensed the following medications for administration to Resident #9: - alprazolam 0.25 milligram (mg) tablet - dicyclomine 10 mg capsule - Aspirin 81mg enteric coated over-the-counter (otc) tablet - bupropion 75 mg tablet - gabapentin 300 mg capsule - Multi vitamin otc tablet - senna 8.6 mg otc tablet - sucralfate 1 gram (gm) tablet - timolol 0.5% eye drops - latanoprost 0.005% eye drops The staff member confirmed dispensing 8 oral medications and 2 eye drops. Staff G, LPN returned to the resident room and handed the medication cup to the resident, who swallowed medications at one time. The staff member applied gloves, then ungloved to retrieve a roll of paper towel from closet for the resident. Staff G, LPN washed her hands, applied gloves, and administered, at 10:02 a.m., one drop of Latanoprost into the residents left eye, immediately followed by one drop of Timolol in the left eye. Staff G, LPN confirmed both eye drops went into the same eye. The resident reported recently having eye surgery. The staff member left the room, went to the Unit Manager's office, and spoke for a moment before retrieving, at 10:08 a.m., Resident #9's Lantus insulin pen from the medication refrigerator. Staff G, LPN dispensed one capsule of saccharomyces boulardii 500 mg from an over-the-counter bottle in med cart. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff G, LPN returned to the room, spilled the saccharomyces boulardii capsule on the floor, returned to the medication cart, and re-dispensed the capsule. The staff member washed her hands and administered the probiotic, before returning to the med cart to retrieve an insulin needle. The staff member primed the insulin pen using 2 units, dialed to 35 units, and injected insulin into the upper right arm of Resident #9. Immediately following the observation, Staff G, LPN stated the probiotic saccharomyces given was the generic of Lactobacillus ordered. Review of Resident #9s Medication Administration Record (MAR) revealed the following orders scheduled for 9:00 a.m. - Lactobacillus capsule - Give 1 capsule by mouth two times a day for Diabetes Mellitus (DM), started on 2/6/25 and discontinued on 4/30/25 at 10:56 a.m. The MAR showed the resident received this medication twice daily during the month of April. - Timolol Maleate Ophthalmic solution 0.5% - Instill one drop in left eye one time a day for glaucoma. - Latanoprost Ophthalmic emulsion 0.005% - Instill one drop in left eye two times a day for glaucoma. During an interview on 4/30/25 at 11:16 a.m., Staff L, LPN/Unit Manager (UM) stated Lactobacillus and Saccharomyces were not technically the same thing. Staff L, LPN/UM stated when a resident came in with Lactobacillus, they were supposed to be changed over to the stock probiotic saccharomyces. Staff L, LPN UM stated staff were supposed to wait 5-10 minutes between administering different types of eye drops. An interview was conducted on 4/30/25 at 2:42 p.m. with the Director of Nursing (DON). The DON stated since we were notified, we changed the order to the stock probiotic saccharomyces but the administration still constituted an error. She reported the facility does not have a policy/procedure for the administration of eye drops, but according to the nurse practice there should be 5-10 minutes between different eye drops. According to the American Academy of Ophthalmology, if taking more than one type of eye drop, wait 3 to 5 minutes between the different drops. https://www.aao.org/eye-health/treatments/how-to-put-in-eye-drops Review of the facility policy titled Medication Administration, undated, instructed staff to: . 10. MAR to identify the medication to be administered. 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Refer 2 drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects. c. If other than oral (PO) route, administer in accordance with facility policy for the relevant route of administration (i.e., injection, eye, ear, rectal, etc.).