STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106127	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solaris Healthcare Celebration	1290 Celebration Blvd Kissimmee, FL 34747

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48878 Based on observation, interview, and record review, the facility failed to honor resident's rights to choose their bathing preference for 1 of 3 residents reviewed for choices, of a total sample of 47 residents, (#17). Findings: Review of the medical record revealed resident #17 was admitted to the facility on [DATE] from a skilled nursing facility. His diagnosis included cervical disc disorder, syncope and collapse, difficulty in walking, ataxic gait, major depressive disorder, muscle weakness, and need for assistance with personal care. Resident #17's Annual Minimum Data Set (MDS) with an assessment reference date of 4/08/24 revealed the resident scored 13 out of 15 on the Brief Interview for Mental Status which indicated he did not have any cognitive impairment. The MDS assessment also indicated it was very important to the resident to choose his bathing preferences. The MDS assessment showed the resident required substantial/maximal assistance for bathing and noted the resident did not exhibit behavior symptoms or rejection of care necessary to achieve the resident's goals for health and well-being. Review of resident #17's medical record revealed a care plan was initiated on 4/04/23 and revised on 4/10/24 which indicated the resident had an activities of daily living (ADL) self-care performance deficit related to need for assistance with personal care. Interventions included 2-person assistance with mechanical lift for transfers and 1 person assistance with showering. The bathing task report for resident #17 noted he was scheduled to receive showers/bathe self on Wednesdays and Sundays on the 7:00 AM-3:00 PM shift. The task report revealed the resident had a bed/towel bath on 4/24/24, 4/28/24, 5/01/24, 5/05/24, 5/08/24, 5/12/24, 5/15/24, 5/19/24. There was no documentation to show the resident received a shower during the 4 weeks between 4/24/24 and 5/22/24. On 05/20/24 at 1:21 PM, resident #17 stated the nursing aides were consistently giving him bed baths but he preferred showers. He conveyed he had made his preference for showers known to the nurses, aides, and doctor however his preferences were not accommodated by staff. He stated Certified Nursing Assistants (CNAs) told him about a month ago they could not find the shower chair, so he had to have bed baths. He reiterated he had not had a shower in a month. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/22/24 at 10:26 AM, CNA D stated she had worked at the facility for one year on the 7:00 AM-3:00 PM shift. She stated shower chairs were used for residents who could not stand during bathing. CNA D stated there was only one shower chair for the whole building. She conveyed she could not give residents a shower if they could not stand because shower chairs were not easily available. She confirmed resident #330 was given bed baths on Wednesdays and Sundays even though he had asked for showers. She acknowledged the resident mentioned to her he would prefer showers, but she told him she was unable to accommodate his preference because a shower chair was not available. She did acknowledge the residents had the right to choose if they wanted a shower or a bath. On 5/22/24 at 12:17 PM, Licensed Practical Nurse (LPN) E stated residents who could not ambulate were provided a shower chair so they could receive showers. If residents wanted a shower and did not have their own shower chair, the CNA would get one for them from the first floor. On 5/22/24 at 12:34 PM, the Central Supply Manager stated the facility had 1 bariatric shower chair stored on the 200 unit and 2 regular shower chairs stored on the 100 and 400 units for those residents that did not have their own personal shower chair in their bathroom. He stated he had not been advised the facility did not have enough shower chairs to accommodate the residents' needs and was not told to order any additional shower chairs. On 5/22/24 at 2:50 PM, the Director of Nursing (DON) stated it was extremely important for residents to have the option to choose between a bath or a shower. It was their right. The DON acknowledged resident #17 was alert and oriented and able to make his preferences known. She confirmed the resident's preference was to have showers on Wednesdays and Sundays on the 7:00 AM-3:00 PM shift. She conveyed the expectation was the resident would receive showers twice a week unless he chose otherwise. She accessed the resident's task report and confirmed the documentation revealed the resident had a bed/towel bath for the past 30 days with no documentation of shower refusal. The DON acknowledged the resident's bathing preferences should have been honored and he should have had showers instead of the bed/towel baths. The facility's Resident Right's policy read, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to .participate in decisions and care planning .residents are entitled to exercise their rights and privileges to the fullest extent possible.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45646 Based on interview and record review, the facility failed to provide written Notification of Transfer or Discharge forms to the residents or their representative for 3 of 3 residents reviewed for hospitalization , of a total sample of 47 residents, (#51, #64 and #117). Findings: 1. Resident #51 was admitted to the facility on [DATE] with diagnoses including cerebral infarction, gastrointestinal hemorrhage, chronic respiratory failure, type 2 diabetes, chronic obstructive pulmonary disease, Alzheimer's Disease, and cerebrovascular disease. Review of resident #51's medical record revealed she was transferred to the hospital on 3/17/24 due to hypokalemia and on 4/03/24 due to gastrointestinal bleeding. Resident #51 returned to the facility following each hospital transfer. The medical record contained a Notification of Transfer or Discharge form for each hospital transfer. The form dated 3/17/24 indicated resident #51's daughter was notified of the transfer by phone and the form dated 4/03/24 indicated resident #51's husband was notified verbally of the hospital transfer. The medical record did not contain any documentation to indicate the resident or resident's representative had been provided a written notice of the transfer. 2. Resident #64 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, hemiplegia, adult failure to thrive and unspecified dementia. Review of resident #64's medical record revealed she was transferred to the hospital on 1/12/24 due to a wound infection and returned to the facility on [DATE]. The medical record contained a Notification of Transfer or Discharge form dated 1/12/24 which indicated resident #64's son was notified by phone of the hospital transfer. The medical record did not contain any documentation to indicate the resident or resident's representative had been provided a written notice of the transfer. On 5/22/24 at 1:14 PM, the Social Services Director (SSD) stated nurses started the Notification of Transfer or Discharge form. She explained she reviewed the form the next day and made sure the resident representative was notified. The SSD reviewed the medical record and the Notification of Transfer or Discharge for residents #51 and #64. She verified the resident representatives were notified verbally. The SSD acknowledged she had not provided written notification to the resident representatives since they were notified verbally. She stated she would sometimes give a copy to the resident representative if she saw them but was unable to provide proof. On 5/23/24 at 2:01 PM, the Administrator verified the SSD was responsible for completing the Notification of Transfer or Discharge forms and providing to resident or resident representative. She stated the expectation was that the forms would be provided in written format to the resident or resident representative. 46665 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record revealed resident #117, a [AGE] year old female was admitted on [DATE] and readmitted to the facility from an acute care hospital on 3/26/24. The resident was discharged from the facility to the hospital on 3/15/24 and 4/11/24. The State Agency (SA) AHCA (Agency for Healthcare Administration) 3120-0002, April 2014 Nursing Home Transfer and Discharge Notice forms dated 3/15/24 and 4/11/24 noted resident #117's family representative was provided the notices in handwritten documentation as, verbal. In an interview with the Social Services Director on 5/23/24 at 1:16 PM, she said she had not mailed resident #117's written notices and stated, I didn't know it had to be in writing. Review of the facility's standards and guidelines titled Chapter 1 Admission, Transfers, Discharges and dated January 30, 2024, read, . The resident and/or representative (sponsor) will be provided with the following information: a. The reason for the transfer or discharge; b. The effective date of the transfer or discharge; c. The location to which the resident is being transferred or discharged ; d. The name, address, and telephone number of the state long-term care ombudsman; e. The name, address, and telephone number of each individual or agency responsible for the protection and advocacy of mentally ill or developmentally disabled individuals (as applies), and f. The name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35339 Based on observation, interview, and record review, the facility failed to complete an accurate admission assessment coding of the Minimum Data Set (MDS) under Functional Abilities and Goals for 1 of 1 resident reviewed for limited range of motion, of a total sample of 47 resident, (#42). Findings: During an interview with resident #42 on 5/20/24 at 10:53 AM, it was noted he had a left-hand contracture with no carrot, washcloth or palm guard present in the hand. He stated he used to have a splint on every day, but there was nothing in his hand when he didn't have the splint. Review of the Clinical Nursing Admission assessment dated [DATE] at 9:15 PM, showed under the function section a sub-section for occupational therapy (OT), which revealed he was able to move all extremities, and had no contractures. Review of the Care Plan initiated on 3/15/24 revealed no focus for contractures, splints, or positioning for the left hand. Review of the Occupational Evaluation and Plan of Treatment dated 3/17/24 revealed, Functional Limitations Present due to Contracture, grasping with the left hand, and included OT to treat to address contracture impairment. A review of the admission MDS assessment with reference date 3/17/2024 and signed by the MDS Coordinator on 3/22/24 revealed no identified impairments of the upper extremities indicated on the assessment. On 5/22/24 at 4:45 PM, the MDS Coordinator stated normally we do put something in the care plan for resident with contractures, unless we missed it. She confirmed the OT evaluation showed a contracture of the left hand, and she said, We must have missed it. In an interview on 5/23/24 at 9:50 AM, the MDS Coordinator stated to ensure accuracy of assessments, information was captured by reading resident's medical record notes, communicating with the entire interdisciplinary team, and review of therapy recommendations. She stated she was responsible for the MDS accuracy. Centers for Medicare & Medicaid Services Long-Term Care Facility RAI (Resident Assessment Instrument) User's Manual 3.0, v.1.18.11 (October 2023) revealed the definition for functional limitations as a loss of range of motion which included contractures, muscle weakness, fatigue, decreased ability to perform Activities of Daily Living, paresis, or paralysis. Review of the facility nursing policy and procedure with a review date of 1/30/24 revealed a resident's ability to perform activities of daily living will be measured by clinical tools and the MDS. Functional decline or improvement is to be evaluated in reference to the Assessment Reference Date.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 45646 Based on interview and record review, the facility failed to employ a qualified professional to serve as the Activity Director. Findings: On 5/23/24 at 3:37 PM, during a Background Screening review with the Human Resources (HR) Director, the HR Director reported the Activity Director was hired on 1/23/24. A review of the Activity Director's Background Screening revealed she had worked for an Assisted Living Facility (ALF) for 1 year and 8 months prior to her employment date. The HR Director reviewed the Activity Director's personnel file and stated she was unable to locate certification for the Activity Director. Verbal information was provided the Activity Director was enrolled in the course to become certified but was not currently certified. On 5/23/24 at 3:54 PM, the Activity Director verified she was hired 1/23/24. She explained prior to this position she worked as an Activity Assistant at an ALF. The Activity Director stated she enrolled in an online national activity training course in March 2024. She acknowledged she had not completed the course as of 5/23/24. The Activity Director was provided with the requirements for a qualified professional. She reviewed the requirements and acknowledged she did not meet any of the requirements in order to serve as a qualified Activity Director. On 5/23/24 at 4:04 PM, the Administrator stated the Activity Director had two years of experience prior to coming to the facility and was enrolled in an activity professionals training course. The Administrator was informed of the conversation with the Activity Director and shown the requirements for a qualified professional to serve as Activity Director. She reviewed the qualifications and acknowledged the Activity Director did not meet those qualifications when she was hired.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35339 Based on observation, interview, and record review, the facility failed to ensure resident received appropriate health care services to minimize further decrease in range of motion by not applying a palm grip cushion, or carrot for contracted left hand for 1 of 3 residents reviewed for limited range of motion, of a total sample of 47 residents, (#42). Findings: Review of the medical record revealed resident #42 was admitted to the facility on [DATE] with previous admission on 9/05/23, with diagnoses of functional quadriplegia, multiple sclerosis, need for assistance with personal care, and other abnormalities of gait and mobility. Review of the Clinical Nursing Admission assessment dated [DATE] at 9:15 PM, under the function sub section for occupational therapy (OT), revealed resident #42 was able to move all extremities, and had no contractures. Review of the Care Plan initiated on 3/15/24 revealed no focus for contracture, splint, or limited range of motion positioning for the left hand. Review of the Care Plan initiated on 3/15/24 revealed no focus for contracture, splint, restorative or limited positioning for the left hand. A focus for activities of daily living (ADL's) self-care performance deficit showed an intervention for OT evaluation and treatment as ordered by the physician. Review of the Occupational Evaluation and Plan of Treatment dated 3/17/24 at 2:13 PM, revealed, Functional Limitations Present due to Contracture, grasping with the left hand, and OT to treat to address contracture impairment. Further review of resident #42 electronic medical record revealed no physician orders regarding left hand contracture or splint. A review of the Admission Minimum Data Set (MDS) with assessment reference date 3/17/2024 and signed by the MDS Coordinator on 3/22/24 disclosed no identified impairments of the upper extremities. During an interview with resident #42 on 5/20/24 at 10:53 AM, he was observed to be alert, lying in bed, with his left hand closed in a fist. He had no carrot, washcloth or palm guard present in that hand. Resident #42 stated he use to wear a splint every day, and noted there was nothing in his hand when he didn't have the splint on. On 5/20/24 at 12:18 PM, observation of resident #42 lying in bed revealed no carrot, wash cloth or splint present in his left contracted hand. On 5/21/24 at 10:21 AM, resident #42 was again observed lying in bed with his left hand in a tightly closed grasp with no palm guard or splint present. On 5/22/24 at 11:06 AM, observation revealed resident #42 in bed with his left hand closed. He remained unable to open the left hand, or move his fingers, and no wash cloth, palm guard or splint was applied to the left hand for the third day in a row. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/24 at 11:45 AM, Certified Nursing Assistant (CNA) U in the presence of the Director of Nursing (DON) verbalized resident #42 should have something in his contracted left hand. Review of CNA Kardex with CNA U revealed no documentation regarding left hand contracture positioning, interventions for splint, hand cushion, or carrot. She stated ADL care included cleaning the resident carefully, she could put a wash cloth in his hand to keep it a little open, but he did not have a splint or cushion for the left hand. On 5/22/24 at 11:47 AM, the DON stated recommendations for residents with contractures came from therapy. Nursing received the recommendation, MDS updated the CNA Kardex and the residents care plans. This surveyor explained neither the CNA Kardex nor resident #42 care plan revealed a focused problem for limited range of motion, interventions for left hand contracture or a splint. DON reported that resident #42 did not have a physician order for his left-hand contracture. On 5/22/24 at 1:11 PM, OT C explained he worked with resident #42 on mobilization and extension for the digits of his chronic left-hand contracture. He recalled he opened resident #42 left hand to wash it out, cleaned it, but he did not get up to splinting. He stated if he was stretching him out he was going to clean the hand. He acknowledged he did not follow up with a splint for the left-hand contracture because he did not have the opportunity to follow up with resident #42 every day. He stated the resident had these contractures for years. He stated a splint was not appropriate for resident #42 as he had the chronic left-hand contracture for years. He then validated therapy oversaw the treatment plan for limited mobility and contractures. Further review of resident #42's medical record showed an Occupational Evaluation and Plan of Treatment which revealed a section for assessment summary reason for therapy . Due to documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient was at risk for decreased ability to return to prior level of assistance . and the orthotic recommendation was for a resting hand splint which was dated and signed by OT C on 3/17/24 at 2:13 PM. The facility did not ensure resident #42 received appropriate treatment, services or healthcare for increase in or the prevention of further decrease with limited range of motion of his left hand. Nursing fundamentals for mobility revealed limb positioning with assistive devices could be used to prevent and minimize flexion of contracture formation by placing the limb in an arresting position using positioning aids which include handrolls and/or hand wrist splints (2021). (Retrieved on 6/06/2024 from www.ncbi.nlm.nih.gov/books/NBK591828/) Review of the facility policy Rehabilitation and Restorative Care with a revision date of 1/25/23 showed under functional impairments assessment and recognition upon admission to the facility, at a significant change and any time during the resident's stay the physician and staff would assess the resident's physical condition and functional status. The physician and staff would help to identify residents who had recent history of functional decline, who were at risk for additional functional decline, review results, implications of evaluations and use them to guide subsequent care planning. In conjunction with the physician and staff, therapists would propose a rehabilitation or restorative care plan that provided an appropriate intensity, frequency, and duration of interventions to help achieve anticipated goals and expected outcomes efficiently using available resources.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 01800 Based on meal observation, resident and staff interviews, menu review, and medical record review, the facility failed to provide three residents (#43, #106, and #419) their prescribed sodium-restricted diets out of three residents reviewed for food quality and a randomly observed resident during the Dining Observation Task. This occurred at three meals during the four day survey. The findings included: During the Dining Observation task on 5/20/24 at 12:57 PM, Resident #419 was eating lunch in her room. She had her lunch tray and the tray ticket documented NAS [No Added Salt] Regular. There was a salt packet on her tray and saltine crackers. Photographic evidence taken. On 5/22/24 at 9:20 AM. Resident #106 was in bed awake. His wife was setting up his meal tray. He had scrambled eggs, French toast, cranberry juice; milk, oatmeal. The tray ticket documented Liberalized Renal diet. There were two salt packets on his tray. Photographic evidence obtained. On 5/22/24 at 9:33 AM, Resident #419 was in bed and she finished her breakfast and her tray was set aside. She ate her oatmeal and some of the French toast. Her tray ticket documented No Added Salt and there were two salt packets on her tray, although she did not use them. Photographic evidence obtained. On 5/22/24 at 9:39 AM, Resident #43 was out of the room, and her breakfast tray was on the bedside table. The tray ticket documented NAS Regular diet. There were three salt packets on the tray. Photographic evidence taken. Resident #43 was prescribed a NAS diet, regular texture, thin consistency liquids on 5/10/24. The resident had essential high blood pressure. The resident's comprehensive care plan included that the resident was at nutritional/hydration risk (initiated 4/17/24). The care plan approaches included, Provide, serve diet as ordered. Monitor intake. Resident #106 was prescribed a liberalized renal diet, regular texture, thin consistency liquids on 4/17/24. The resident had end stage kidney disease and was receiving hemodialysis. The resident's comprehensive care plan included that the resident was at nutritional/hydration risk (initiated 4/17/24). The care plan approaches included, Provide, serve diet as ordered. Monitor intake and record each meal. Resident #419 was prescribed a NAS diet, regular texture, thin consistency liquids on 5/9/24. The resident had essential high blood pressure. The resident's comprehensive care plan included that the resident was at nutritional/hydration risk (initiated 4/17/24). The care plan approaches included, Provide, serve diet as ordered. Monitor intake and record each meal. On 5/22/24 at 12:41 PM, while observing in the kitchen, there were multiple meal trays - 11 trays on an open cart and approximately 56 trays stacked on a cook's counter, which were already set up with a placemat, tray ticket, salt and pepper packets. Photographic evidence obtained. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Week 4 of the 4 week cycle menu for the days of the survey indicated that the condiments for the NAS diet and the liberalized renal diets do not include salt. During an Interview with the Director of Food and Nutrition Services on 5/22/24 at 4:47 PM, he was asked if a liberalized renal diet include salt on the tray. He replied that they go by the diet and nutritional manual and also it depends on the stage of chronic kidney disease. He printed the menu extension for a liberalized renal diet and it documented that for the condiments that were to be served included sugar and pepper. The Director of Food and Nutrition Services was asked if this means on the menu, that the liberalized renal diet would not get salt as a condiment. He responded, that's a safe assumption. At 4:59 PM, the Director was informed that salt packets were observed on no added salt diet trays. He said staff were trained on tray set up 4/11/24. During a follow up interview with the Director of Food and Nutrition Services, on 5/23/24 at 4:26 PM, the Director was informed about the residents who received salt packets on their trays for NAS diets and the liberalized renal diets. He stated he provided training to staff about these diets. He stated that he does tray audits including diet accuracy and resident satisfaction surveys once a month and they do a shorter version once a week. The facility policy and procedure titled, Tray Identification included the following information: . Policy Interpretation and Implementation: . 2. The Food Services Manager or designee will check trays for correct diets before the food carts or meal trays are delivered to their designated areas. . 3. Nursing staff shall check each food tray for the correct diet before serving the residents. . 4. If there is an error, Nursing will notify the Dietary Department immediately so that the appropriate food tray can be served.

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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** 46665 Based on observation, interviews, and record review, the facility failed to assure safe and accurate medication administration for 1 of 6 residents reviewed for Medication Administration, of a total sample of 47 residents, (#270). Finding: Review of the medical record revealed resident #270, a [AGE] year old male, was admitted to the facility on [DATE] from an acute care hospital with diagnoses of severe chronic kidney disease, nonrheumatic aortic (valve) stenosis, heart failure, cerebral infarction (stroke), hypo-osmolarity and hyponatremia (electrolyte imbalance), gout, hypotension, hypertension, and ataxia (impaired coordination). The Minimum Data Set Admission assessment with assessment reference date 5/16/24 was incomplete and noted as in progress. The Brief Interview for Mental Status 3.0 assessment noted the resident scored 15 out of 15 that indicated he was cognitively intact. The Section GG Documentation evaluation noted the resident required moderate staff assistance to complete his Activities of Daily Living. Resident #270's active physician's medication orders included, aspirin 81 milligrams (MG) once daily for coronary artery disease, Metoprolol Succinate extended release 25 MG once daily for hypertension, Clopidogrel Bisulfate 75 MG once daily for blood clot prevention, Cyanocobalamin (Vitamin B-12) 1000 Micrograms (MCG) once daily for supplementation, Torsemide 100 MG once daily for edema (fluid retention), Omeprazole 40 MG every morning for acid reflux, Renal-Vite 0.8 MG once daily for kidney disease, and Sevelamer HCl 1600 MG three times daily for hypocalcemia (low blood calcium). On 5/21/24 at 8:47 AM, a medication cup that contained 8 pills was observed on resident #270's over bed table. The resident was sitting in bed and stated, I didn't want to take them until I ate something. On 5/21/24 at 8:55 AM, Registered Nurse (RN) B entered the resident's room with a breakfast tray and placed it on the overbed table. The RN acknowledged the cup of pills was left on the table and stated, It's my fault. The RN then left the resident's room without removing the cup containing the medications. In a joint observation on 5/21/24 at 8:58 AM, the Flamingo Unit Manager acknowledged there was a cup that contained pills on resident #270's overbed table. She stated, The nurses are not supposed to leave them there. Review of the Comprehensive Care Plan did not include self-administration of medications. Review of the medical record revealed there were no evaluations for self-administration of medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Director of Nursing (DON) on 5/21/24 at 11:39 AM, the DON explained nurses were expected to witness residents' medication administration unless they had been evaluated through the facility's process for safe self-administration which included locked storage. She said nurses were not supposed to leave medications at the bedside during administration. The DON stated, If they leave them at the bedside somebody can go and take it. Review of the facility's standards and guidelines titled Preparation and General Guidelines IIA2: Medication Administration-General Guidelines dated January 2018 read, . 14) Residents can self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications . 18) The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR, and action is taken as appropriate.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48878 Based on interview and record review, the facility failed to indicate the duration of an as needed (PRN) anti-anxiety/anxiolytic medication for 1 of 1 residents reviewed for psychotropic medications, of a total sample of 47 residents, (#56). Findings: Review of the medical record revealed resident #56 was admitted to the facility on [DATE] and readmitted on [DATE] from the hospital. Her diagnosis included major depressive disorder, generalized anxiety disorder, Alzheimer's disease, encounter for palliative care, and adult failure to thrive. Resident #56's Annual Minimum Data Set (MDS) with an assessment reference date of 4/30/24 revealed the resident had moderately impaired cognitive skills for daily decision making. The Annual MDS noted that the resident received antianxiety medications. The MDS also noted the resident did not exhibit behavior symptoms or rejection of care necessary to achieve the resident's goals for health and well-being. Review of resident #56's medical record revealed a care plan initiated on 8/03/21 and revised on 4/11/24 indicated the resident was taking antianxiety and antidepressant medications for anxiety and depression and had the potential for adverse effects associated with medications. Resident #56's Order Summary Report and the Medication Administration Record (MAR) showed the resident had an active order dated 4/02/24 for Alprazolam 0.25 milligram (mg) by mouth every 8 hours PRN for anxiety with no stop date and Alprazolam 0.25 mg by mouth every 12 hours for anxiety disorder. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include but are not limited to anti-anxiety medication. Based on a comprehensive assessment of the resident, the facility must ensure that PRN orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. (Retrieved on 5/24/24 from www.ecfr.gov.). Review of the MAR revealed the resident received 14 doses of Alprazolam PRN between 4/02/24 and 5/18/24. The 14-day duration for the PRN medication should have been 4/02/24 to 4/16/24. The resident received 8 doses of Alprazolam after the 14-day duration. Further review of the medical record revealed the physician did not provide a rationale for the extended time-period for PRN Alprazolam use and did not indicate a specific duration for the anti-anxiety PRN order. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/21/24 at 12:42 PM, the Assistant Director of Nursing (ADON) stated when an antianxiety medication was prescribed PRN it should have a stop date of 14 days. She conveyed if the psychotropic medication was to be continued, the provider would write a new order with a limited duration of 14 days. She acknowledged a psychotropic medication PRN prescribed to a hospice resident would also be given a 14 day stop date. The ADON confirmed resident #56 had an active order for Alprazolam PRN for anxiety since 4/02/24 with no stop date but the PRN order should have been limited to a 14-day duration. She also confirmed there was not a provider rationale documented for continuing the medication past the 14 days. On 5/21/24 at 12:51 PM, the Director of Nursing (DON) stated the expectation was every resident prescribed a psychotropic medication PRN should have a 14 day stop date. She acknowledged resident #56 had an active routine and PRN order for Alprazolam and the PRN Alprazolam order should have had a 14-day stop date. The DON also acknowledged there was not a rationale documented in the medical record for the PRN Alprazolam to be extended past the 14 days. She stated it got missed and did not know how they missed it. The facility's Medication Order Policy read, New medication orders are subject to automatic stop orders unless the medication orders specify the number of doses or duration of medication .The following classes of medications, whether the order is for routine or as needed (PRN) use, are stopped automatically after the indicated number of days, unless the prescriber specifies a different number of doses or duration of therapy to be given .PRN psychotropic medication orders 14 days.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 01800 Based on meal observation, resident and staff interviews, menu review, and medical record review, the facility failed to provide food that accommodated preferences for one (#106) of three residents reviewed for food quality for two meals out of two meals observed. The findings included: On 5/22/24 at 9:20 AM, Resident #106 was in bed and his wife was setting up his meal tray. He had scrambled eggs, French toast, cranberry juice; milk, oatmeal served for breakfast. The tray ticket documented liberalized renal (kidney) diet, and included his food dislikes including cranberry juice. Resident #106 said he told Food and Nutrition Services that he doesn't like cranberry juice. He said he liked mashed potatoes and wanted them once a day. During the lunch meal observation on 5/23/24 at 1:33 PM, resident #106 had his lunch meal on his bedside table. He was waiting for his wife to come to the facility to heat it up for him. He had pork, white rice, and corn. There was cranberry juice on the tray, even though his tray ticket indicated no cranberry. During an interview with the Director of Food and Nutrition Services on 5/22/24 at 4:58 PM, he was informed about Resident #106 receiving cranberry juice on his tray when cranberry was indicated as a dislike on the tray ticket. The Director of Food and Nutrition Services confirmed that cranberry was a food dislike for Resident #106 and provided a copy of the resident's tray ticket for 5/22/23. On 5/23/24 at 4:36 PM, the Director of Food and Nutrition Services was informed that Resident #106 was served cranberry juice on his lunch tray on 5/23/24. The Director said he had talked to his employees yesterday about this concern. The facility policy and procedure titled, Tray Identification included the following information: . Policy Interpretation and Implementation: . 2. The Food Services Manager or designee will check trays for correct diets before the food carts or meal trays are delivered to their designated areas. . 3. Nursing staff shall check each food tray for the correct diet before serving the residents. . 4. If there is an error, Nursing will notify the Dietary Department immediately so that the appropriate food tray can be served.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 01800 Based on observations, staff interview, cleaning schedule, and policy and procedure review, the facility failed to maintain food safety standards, such as ensuring food employees used beverage containers that prevented contamination from hands; resident Time/Temperature Control for Safety (TCS) food was not stored too long under refrigeration; ensure that food and non-food contact surfaces were clean to sight and touch; bathrooms used by food employees were equipped with handwashing signage; ensure that exposed food, clean equipment and clean utensils were protected from contamination from non-Food and Nutrition Services staff unrestrained hair; and clean equipment and utensils were stored in a clean and dry location and protected from splash. These findings have the potential to cause foodborne illness for 101 out of 109 residents who consumed the facility's food. The findings included: During the Initial Brief Tour of the Kitchen with the Director of Food and Nutrition Services on 5/20/24 at 10:24 AM, there was an employee's bottled water container with a twist off lid and a blue colored insulated beverage container with a twist off lid, stored under the preparation table. Although these beverage containers were closed with tight fitting lids, they were not designed to prevent the contamination of employee hands from saliva. Photographic evidence obtained. During a follow up visit to the kitchen on 5/21/24 at 8:04 AM with the Director of Food and Nutrition Services, there were three bottled water containers that belonged to staff placed on a cart near an exit to the kitchen. The top of the cart was covered with a sheet of parchment paper that had a written statement Staff beverages only. The three water bottle containers had twist off lids and were not designed to prevent employee's hands from being contaminated by saliva. Photographic evidence obtained. On 5/22/24 at 8:57 AM, the resident Maytag refrigerator in the Egret 1 nourishment area had an opened can of whipped cream dated with a hand written date of 4/08/24, The whipped cream was a Time/Temperature Control for Safety (TCS) food (a category of perishable food that requires time and temperature controls to limit the growth of illness causing bacteria) and must not be stored longer than 7 days in refrigeration at 41 degrees Fahrenheit. Additionally, there was an ice wrap stored in the freezer compartment of the Maytag refrigerator. During a follow up visit to the kitchen on 5/22/24 at 4:28 PM there was an accumulation of brown food spatter and rust underneath the shelf installed over the steam table. Photographic evidence obtained. At 4:35 PM, the surface of the grill had rust and a coating of old grease and the front exterior had old, dried food spills (the grill located next to the fryer). The Director stated the grill was not functional, and they've tried to clean it and the rust won't come off. He said that the grill was being used to store pans of food on top of the grill. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Additionally, at 4:40 PM, there were no signs to notify food employees to wash their hands in the men and women's bathroom. There was a sign in the men's bathroom, but the sign documented, Remember to hand wash the FROG way! (Friction Rubs Out Germs), which was about procedures on how to wash hands for infection control. During a follow up visit to the kitchen on 5/23/24 at 10:00 AM, a nursing staff person was observed walking around the front entry of the kitchen near tray carts. This staff person did not wear a hair restraint to protect exposed food, clean equipment, clean utensils, etc., from contamination. At 10:11 AM, dishwashing was occurring. The employee who was on the clean side of the dish machine was placing sanitized bowls on a tray to dry. This tray was on the drain board of the dirty side of the three compartment sink (the dish machine was across from the three compartment sink. Although the three compartment sink was not in use at the time, there were soiled pans stacked in the wash sink compartment on the dirty side of the three compartment sink. Additionally, there were multiple clean pots and utensils hung above the three compartment sink, except over the wash compartment of the sink. These clean pots and utensils were not stored in a clean, dry location, where they were not exposed to splash. Photographic evidence obtained. On 5/23/24 at 4:02 PM, an interview with the Director of Food and Nutrition Services about the kitchen cleaning schedule revealed that the Director assigned his employees to the cleaning of various equipment and areas. He said some things were done daily and weekly and provided a copy of the cleaning schedule. Review of the cleaning schedule also known as the AM and PM Duty Roster that the Director of Food and Nutrition Services provided, which had a Wednesday date of 11/30 indicated that assignments for the cleaning of the flattop grill was N/A (Not Applicable) for both the morning and afternoon duty roster. Additionally, the steam table was to be cleaned by the afternoon shift cook. The Director of Food and Nutrition Services was informed about the food safety concerns identified in the kitchen. He said at that time that the ice wrap should not be stored in the residents' nourishment refrigerator. The Director was asked if he conducted sanitation audits. He stated that they had a contracted service that conducted kitchen sanitation audits every two to three months. The last audit was done 1/04/24 and they scored 93%. The contract service used a formal auditing tool to perform these audits. Additionally, the corporate Registered Dietitian performed a sanitation audit once a month. The facility policy and procedure, titled Cleaning and Sanitizing Procedures, dated 1/30/24, included the following Policy Statement: Cleaning and sanitizing procedures are posted in the kitchen area. Policy Interpretation and Implementation: . Cleaning duties are individually assigned based on job description, on a daily, weekly, or monthly basis, and are posted in the kitchen area. Food service personnel sign when the task is completed. 3. Procedures for cleaning all equipment and work areas are established and posted. 5. Equipment and chemicals are available for proper cleaning and sanitizing of dishes, utensils, pots and pans. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. It is the responsibility of the Food Service Director to: - Review cleaning schedules and to spot check upon completion of cleaning task. The facility policy and procedure, titled, Storage of Foods Brought to Residents by Family/Visitors, dated 2/9/23, included the following: .7. The nursing staff is responsible for discarding perishable foods within 3 days or before the use by/expiration date, whichever comes first. The facility policy and procedure, titled, Food Handling, dated 1/30/24, did not include any information about food employees' beverage containers.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 01800 Based on observation, interview, and policy and procedure review, the facility failed to ensure that a garbage receptacle in the kitchen food preparation area was covered during non peak food production time. This was observed on one out of 4 Kitchen Observation Task visits. The findings included: On 5/22/24 at 4:25 PM, during a follow up kitchen visit to the kitchen, the garbage can in the food preparation area near food preparation sink had no lid. The garbage can was almost full of garbage. Photographic evidence obtained. The Director of Food and Nutrition Services was present at that time and stated that a new lid was on order.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 01800 Based on observation, and interview, the facility failed to ensure staff donned appropriate Personal Protective Equipment (PPE) before or upon entry into the environment of a resident on transmission-based precautions (e.g., contact precautions) for Clostridioides difficile (a germ that causes diarrhea and inflammation of the colon and can be life-threatening) and perform soap and water handwashing before exiting; and failed to ensure nursing staff followed appropriate hand hygiene practice during medication administration for 4 of 8 residents reviewed for medication administration, of a total sample of 47 residents, (#25, #98, #42 and #32) . The findings included: 1. On 5/22/24 at 1:18 PM, the Restorative Certified Nursing Assistant, Staff G entered Resident #37's room to deliver a lunch tray and did not don a gown and gloves before entering the room. Staff G went in and out of the room within a minute, which was not time enough to wash her hands with soap and water before exiting the room. Resident #37 had a diagnosis of recurrent Clostridioides difficile infection and was on transmission-based precautions (TBP) (isolation) to prevent the spread of the infection. The TBP signage on the door to the resident's room documented that staff must don a gown and gloves before entering the room and wash hand with soap and water before exiting. The facility policy and procedure, titled, Transmission-Based Precautions, reviewed 1/30/24, included the following information: . f. Types of Transmission-Based Precautions: i. Contact Precautions: a. Intended to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or the resident's environment. a. Examples of infections requiring Contact Precautions include, but are not limited to: . ii. Diarrhea associated with Clostridium [currently known as Clostridioides] difficile. . d. Certain disease precautions require enhancements to contact precautions that include special enteric precautions that require use of soap and water for hand hygiene before and after entering the room. PPE utilized include gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident environment. 35339 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a medication administration observation on 5/20/24 at 12:10 PM, Registered Nurse (RN) A prepared medication to administer to resident #25. She did not wash or sanitize her hands before preparing the medication. She knocked on resident #25 door, introductions were made, she explained she was going to administer seizure medication. She donned gloves, administered the medication Carbamazepine 200 milligrams (mg) 1 tablet by mouth; she gathered the medication cup, doffed her gloves, placed the supplies into the wastebasket, and then exited the room. She did not wash or sanitize her hands after administering the medication, removing her gloves, or before exiting the residents room. 3. On 5/20/24 at 12:16 PM, RN (A) prepared medication to give to resident #98. RN A knocked, entered the room, and explained to resident #98 that she had his pain medication. She then inquired regarding his pain level. RN A exited the room, then proceeded to prepare Naproxen 220 mg 1 tablet by mouth for administration. Observation revealed RN A did not use the hand sanitizer on top of medication cart to sanitize her hands before preparing the medication for administration. Further observation showed RN A donned gloves, entered resident #98 room, administered the medication, doffed the gloves and threw the medication cup into the trash can next to the exit door then exited resident #98's room. She did not sanitize, or wash her hands after administering the medication. 4. On 5/20/24 at 12:18 PM, RN A was observed preparing Baclofen 20 mg 1 tablet by mouth for resident #42. She prepared the medication, knocked, entered the room and put on her gloves, then explained to the resident she had his Baclofen medication. She administered the medication and assisted resident #42 in drinking clear fluid to swallow the medication. RN A then proceeded to the trash can with the medicine cup, doffed her gloves, and exited the room. She did not wash or sanitize her hands before preparing, after entering or exiting resident #42's room. 5. On 5/20/24 at 12:26 PM, RN A was observed walking from her nursing cart in the hallway outside of resident #42's room to speak to a man dressed in black nursing scrubs. RN A and the man had a conversation in Spanish then RN A hugged the man in black nursing scrubs then returned to her medication cart, pushed the cart around the corner to the right, and prepared medication for administration to resident #32. Observation revealed she did not use the hand sanitizer on top of her medication cart, nor wash her hands after hugging the man in black scrubs before she prepared the medication for resident #32. On 5/20/24 at 12:30 PM, further observation revealed RN A knock on resident #32's door, introduce herself, then explain she was going to administer Diltiazem 90 mg 1 tab by mouth. She donned gloves, administered the medication to resident #32, offered fluids to the resident, doffed the gloves, placed the medication cup and used gloves into the trash can near the doorway and exited resident #32's room again without handwashing or sanitizing her hands. Observations during medication administration pass for 4 of 4 residents revealed RN (A) did not follow good nursing principles and practices by not using hand sanitizer, or washing her hands in between preparing, administering, or exiting residents rooms. On 5/20/24 at 12:38 PM, RN A stated she was aware she should sanitize or wash her hands between residents when doing medication administration pass. She said, I used the hand sanitizer. RN A was reminded she was observed to not sanitize or wash her hands during the medication pass with residents #25, #98, #42, and #32 and was asked when did she wash or sanitize her hands? She paused and acknowledged she did not clean her hands until after after taking resident #32 a beverage with ice. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/24 at 1:23 PM, the Director of Nursing (DON) stated the facility practice was nurses should knock on the door, ask the resident's name, their date of birth, explain the medications, and wash their hands or use hand sanitizer during medication administration pass and between each resident. A review of the policy, Medication Administration- General Guidelines with a revision date January 2018 revealed medications were administered in accordance with good nursing principles and practices. The procedures section indicated for handwashing, and hand sanitization the person administering medications should adhere to good hand hygiene which included washing hands thoroughly before beginning a medication pass. Prior to handling any medications, hand sanitizer can be used between hand washings when returning to the medication cart or preparation area assuming hands have not touched a resident, contaminated surface, and at regular intervals during the medication pass such as after each room.